Department Of Human Services

PROGRAM EVALUATION REPORT

January 2002

Angus S. King
Governor

Kevin W. Concannon
Commissioner

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Bureau of Elder and Adult Services

Bureau of Family Independence

Bureau of Health

Community Services Center

ATTACHMENTS

Note: All Job Classification listings, Organizational Charts, and Financial Summaries are located at the end of each Bureau section.

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

ANGUS S. KING, JR.
GOVERNOR

KEVIN W. CONCANNON
COMMISSIONER

January 22, 2002

The Honorable Susan W. Longley
Senate Chair, Joint Standing Committee on Health and Human Services
The Honorable Thomas J. Kane
House Chair, Joint Standing Committee on Health and Human Services
Cross Office Building, Room 202
Augusta, Maine 04333

Dear Senator Longley and Representative Kane:

As required under the Governmental Evaluation Act, 3 M.R.S.A. §951 et seq., (the "Act"), enclosed please find the Program Evaluation Report for the Department of Human Services. This report is prepared and submitted to the legislature, through the Health and Human Services Committee.

The Department of Human Services' mission is to protect and preserve the health and well-being of Maine people in order that they may achieve their full potential.

The report gives you a broad overview of the purpose and programs of the Department of Human Services. The Department has taken on new programs and has implemented changes resulting from new state and federal laws. We designed this report to highlight the primary areas in which you may have an interest.

The report also looks forward, providing the Legislature with challenging and changing issues within each Bureau.

The budget and expenditures for each Bureau includes fiscal data for a ten year period (SFY 1992-SFY 2001).

We are confident that the Department has met its legislative purpose and mission for the report period and trust that you will find the report and accompanying information instructive.

We are ready to provide you with additional information you may require and look forward to presenting the report to you.

Sincerely,

Kevin W. Concannon
Commissioner

Cc: The Honorable Angus S. King, Governor
File

DEPARTMENT OF HUMAN SERVICES

MISSION STATEMENT

The mission of the Maine Department of Human Services (DHS) is to protect and preserve the health and well-being of Maine people in order that they may achieve their full potential.

VISION STATEMENT

We the employees of the Department of Human Services envision a time when all people achieve their optimum independence, health, and safety. Therefore, in pursuit of this vision, the Department will:

* Foster cooperation and trust;

* Empower individuals, families, and communities;

* Continue to improve the quality of and access to our services and products;

* Lead in the development of policies and programs in partnership with customers, providers, and funding sources.

DEPARTMENT OF HUMAN SERVICES

GOVERNMENTALEVALUATION PROGRAM ACT
PROGRAM EVALUATION REPORT

January 2002

Submitted to

JOINT STANDING COMMITTEE ON HEALTH AND HUMAN SERVICES

EXECUTIVE SUMMARY

Introduction

The State Government Evaluation Act of 1995 was enacted to provide for orderly review of state departments and agencies to ensure that their future existence, based on past performance, is justified. The statute specifies several areas of information to be included in this evaluation report.

A. Enabling or authorizing law or other relevant mandate, include any federal mandates;

This section includes statutory citations to enabling legislation for the Bureau of Child and Family Services, Bureau of Elder and Adult Services, Bureau of Family Independence, Bureau of Health, Bureau of Medical Services, Administrative Hearings, Office of Management and Budget, and the Community Services Center.

B. A description of programs administered by the agency or independent agency, including the following for each program;

1. ***Established priorities, including goals and objectives in meeting each priority;***
2. ***Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and***
3. ***An assessment by the agency indicating the extent to which it has met the goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives***

The Department has the responsibility of protecting and preserving the health and welfare of Maine citizens through planning, authorization, administration and audit of programs established by law. This report sets forth programmatic descriptions and statements of priorities, goals, objectives, and performance criteria.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

The Department has 2615 authorized positions as of December 31, 2001. The Department is organized into five bureaus: Bureau of Child and Family Services,

Bureau of Elder and Adult Services, Bureau of Family Independence, Bureau of Health and the Bureau of Medical Services.

D. Compliance with federal and state safety and health laws including the Americans with Disabilities Act, the Federal Occupational Safety and health Act, affirmative action requirements and worker's compensation.

The Department of Human Services is in compliance with all applicable federal and state safety and health laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

The Department has attached financial summaries for the past 10 years.

F. When applicable, the regulatory agenda and the summary of rules adopted;

The Department of Human Services has summarized regulatory agendas and rules adopted within each section of this report.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Department has developed a wide variety of relationships with other federal, state and local government agencies. These partnerships enhance the department's ability to provide essential health, safety, support and social services to citizens of Maine. This section sets forth the specific information on each.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The general public and the regulated entities and individuals comprise the primary constituency of the Department.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

Alternative delivery systems have focused on making increasing use of technology and the automation which it offers in order to optimize the effective use of limited human resources. This report offers specific information in the attached sections regarding efforts made.

J. Identification of emerging issues for the agency or program in the coming years.

Emerging issues for this agency include health insurance for children and adults, tobacco use reduction and health promotion, child support and payment enforcement, teen pregnancy reduction, infant mortality, foster care licensing, innovative prescription drug programs, investments in DHS infrastructure, support for seniors and disabled adults, and bio-terrorism prevention to name a few. This report identifies emerging issues for each bureau.

K. Any other information specifically requested by the committee of jurisdiction.

The Department has not received any special requests from the committee, but is ready to provide them with information requested.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

This report provides this specific information in the sections attached.

M. Agency policies for collecting, managing and using personal information over the internet and non-electrically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence t the fair information practice principles of notice, choice, access, integrity and enforcement.

The Department has established and promulgated the rules to be followed while using any or all of the State automation equipment. This policy has been developed in order to provide guidance and protection to DHS employees and to safeguard the technology assets of the State entrusted to DHS employees. The report will provide you with the policy regarding this.

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OFFICE OF THE COMMISSIONER

Office of Programs

Office of Public and Legislative Affairs

Office of Administrative Hearings

Office of Management and Budget

- Division of Financial Services
- Division of Human Resources
- Division of Technology Services
- Regional OMB Operations

DEPARTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE

PROGRAM TITLE: **Commissioner's Office**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

Commissioner's Office Title 22 MRSA §1

B. A description of each program administered by the agency or independent agency, including the following for each program:

Title 22, MRSA Chapter 1, establishes that the Department of Human Services shall be under the control and supervision of a Commissioner of Human Services who shall be appointed by the Governor, subject to review by the Joint Standing Committee on Health and Human Services and to confirmation by the Legislature, and shall serve at the pleasure of the Governor. The Commissioner is responsible for administering the Department which has the responsibility to protect and preserve the health and welfare of Maine citizens through planning, authorization, administration and audit of programs established by law and/or administrative fiat and assigned to the Department by the Maine Legislature, the Governor and other various federal agencies with which the Department has contracts for services.

B1. Established priorities, including the goals and objectives in meeting each priority.

See Individual Bureaus/Divisions/Programs

B2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives.

See Individual Bureaus/Divisions/Programs

B3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria.

See Individual Bureaus/Divisions/Programs

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and departmental organizational chart.

D. With federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Commissioner's Office complies with all of the above federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Office of Management and Budget.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See attached summaries for each program.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including but not limited to cooperative arrangements to coordinate services and eliminated redundant requirements.

See attached for each program.

H. Identification of the constituencies served by the agency or program noting any changes or projected changes.

See Individual Identifications for each bureau.

I. **A summary of effort by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.**

See attached for each program.

J. **Identification of emerging issues for the agency or program in the coming year.**

See attached for each program.

K. **Any other information specifically requested by the committee of jurisdiction.**

No other information has been requested at this time.

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.**

See attached for each program.

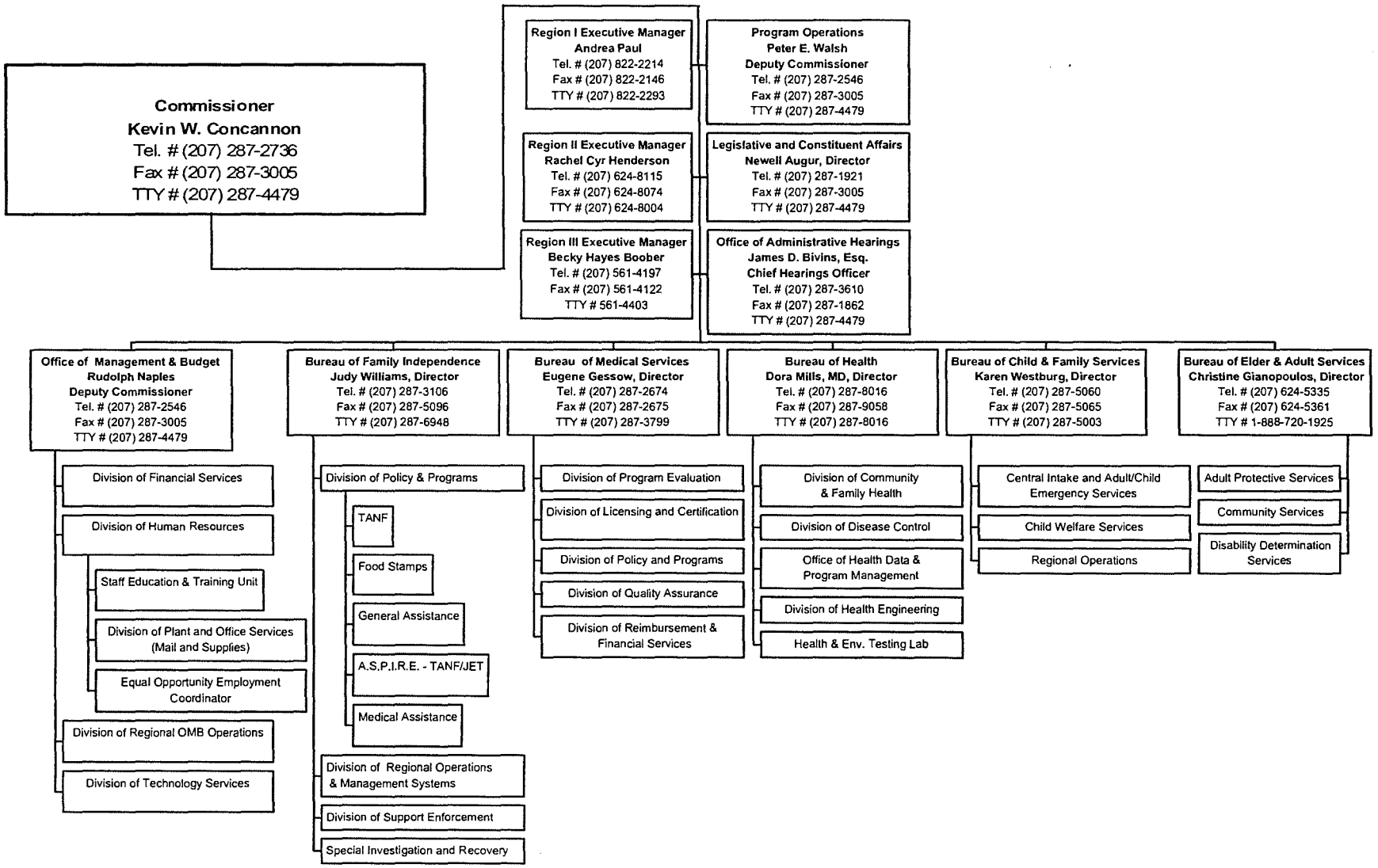
M. **Agency policies for collecting, managing and using personal information over the internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department of Human Services abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only do we comply with Title 22 MRSA, there are also specific IT policies in place that address this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPRTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE

Position Count	Job Classification
1	Commissioner of Human Services
1	Deputy Commissioner of Management and Budget
1	Deputy Commissioner of Health and Medical Services
1	Director Office of Public and Legislative Affairs
1	Director of Community Health Programs
2	Director of Special Projects
3	Regional Executive Managers
1	Senior Administrative Secretary
2	Administrative Secretaries
1	Administrative Assistant
1	Receptionist
1	Clerk Typist II
16	**Total Position Count**

Department of Human Services
January 2002



DEPARTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE

PROGRAM TITLE: **Office of Programs**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

Office of Programs Title 22 MRSA §3

B. A description of each program administered by the agency or independent agency, including the following for each program:

The Office of Programs includes the Bureau of Child and Family Services, Bureau of Family Independence, Bureau of Elder and Adult Services, Bureau of Health and Bureau of Medical Services. Directly responsible to the Commissioner are Deputies for Programs and the Office of Management and Budget, as well as the Director of Public and Legislative Affairs.

B1. Established priorities, including the goals and objectives in meeting each priority.

See attached Bureau/Division/Program

B2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives.

See attached Bureau/Division/Program

B3. An assessment by the agency indicating the extent to which it has met the goals and objectives using the performance criteria.

See attached Bureau/Division/Program

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See the job classification and departmental organizational chart for the Commissioner's Office.

D. With federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

As part of the Commissioner's Office, we comply with all of the above federal and state Laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Office of Management and Budget.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See attached summaries for each program.

G. Identification of those areas where an agency has coordinated it efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including but not limited to cooperative arrangements to coordinate services and eliminate redundant requirements.

See attached for each program.

H. Identification of the constituencies served by the agency or program noting any changes or projected changes.

See individual identifications for each program.

I. **A summary of effort by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.**

See attached for each program.

J. **Identification of emerging issues for the agency or program in the coming year.**

See attached for each program.

K. **Any other information specifically requested by the committee of jurisdiction.**

No other information has been requested at this time.

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.**

See attached for each program.

M. **Agency policies for collecting, managing and using personal information over the internet and non-electronically information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department of Human Services abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only do we comply with Title 22 MRSA, there are also specific IT policies in place that address this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPARTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE

PROGRAM TITLE: Office of Public and Legislative Affairs

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

Office of Public and Legislative Affairs Title 22 MRSA §3

B. Description of each program administered by the agency or independent agency, including the following for each:

The purpose of the Office of Legislative Affairs is to maintain a liaison with the Office of the Governor, the Maine State Legislature, and the public in order to monitor legislation affecting the department; to prepare departmental information for legislative issues at both the local, state and national level; to maintain regular contact with the press, radio and television media, consumer groups, of agencies and community associations; to oversee production of informational pamphlets explaining departmental service or educational programs in the field of health care and social services; to advise program managers on communication methods best suited to promote their programs to develop departmental information programs for employees including publication.

B1. Established priorities, including goals and objectives in meeting each priority;

N/A

B2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving goals and objectives; and

N/A

B3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using performance criteria.

N/A

C. **Organizational structure, including positions count, a job classification and an organizational flow chart including lines of responsibility.**

See the job classification and departmental organizational chart for the Commissioner's Office.

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

As part of the Commissioner's Office, we comply with all of the above federal and state laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Office of Management and Budget.

F. **When applicable, the regulatory agenda and the summary of the rules adopted.**

See attached summaries for each program.

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.**

N/A

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

N/A

I. **A summary of effort to use alternative delivery systems.**

N/A

J. Identification of emerging issues for the agency or program in the coming years.

See answers for each program.

K. Any other information specifically requested by the committee or jurisdiction.

No other information has been requested at this time.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

N/A

M. Agency policies for collecting, managing and using personal information over the internet.

The Department of Human Services abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only do we comply with Title 22 MRSA, there are also specific IT policies in place that address this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPARTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE

PROGRAM TITLE: **Office of Administrative Hearings**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

5 M.R.S.A. §§ 8051-10004
22 M.R.S.A. §§ 3, 7, 42
Federal Medicaid (MaineCare) Laws

(The procedures set out in these regulations supersede and replace any inconsistent or conflicting regulations governing hearings, except where such other regulations may in a particular program be required by state or federal statute or by governing federal regulations.)

B. A description of each program administered by the agency or independent agency.

The Office of Administrative Hearings conducts hearings of appeals of Departmental decisions or actions. It renders binding decisions on behalf of the Commissioner except for certain cases where its findings are advisory to the Commissioner. These hearings include proceedings whereby dissatisfied applicants, recipients, institutions or other persons whose legal rights, duties, or privileges are at issue can obtain review of certain actions or inactions of the Maine Department of Human Services where such legal rights, duties or privileges are required by constitutional law or statute to be determined after an opportunity for hearing. Also covered under the Office of Administrative Hearing regulations are those hearings which are conducted by the Maine Department of Human Services for other State agencies.

B1. Established priorities, including the goals and objectives in meeting each priority;

Where adjudicatory hearings are required to resolve disputes it is the Department's objective that the adjudicatory hearing process provide a meaningful opportunity for parties to present their grievances. It is the intention of the Department, in its conduct of adjudicatory hearings, to ensure that fundamental fairness is accorded to all parties in a manner consistent with carrying out the requirements of the law.

B2. **Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and**

All written decisions are to be issued within 30 days of the close of the record (sooner as required by specific law or rule).

B3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria.**

The Office of Administrative Hearings has met all goals and objectives.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See the attached job classification and departmental organizational chart.

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

As part of the Commissioner's Office, we comply with all of the above federal and state Laws.

E. **Financial Summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See the financial summary for the Bureau of Family Independence.

F. **When applicable, the regulatory agenda and the summary of rules adopted**

N/A

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to,**

cooperative arrangements to coordinate services and eliminate redundant requirements.

N/A

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The public and Department staff.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization I meeting its goals and objectives.

N/A

J. Identification of emerging issues for the agency or program in the coming years.

Possibly the establishment of a Department-wide mediation program.

K. Any other information specifically requested by the committee of jurisdiction.

No other information has been requested at this time.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practices of notice, choice, access, integrity and enforcement.

The Department of Human Services abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature.

DEPARTMENT OF HUMAN SERVICES
ADMINISTRATIVE HEARINGS

Position Count	Job Classification
1	Chief Administrative Hearings Officer
7	Hearing Examiners
1	Senior Legal Secretary
3	Legal Secretary
12	Total Position Count

DEPARTMENT OF HUMAN SERVICES
COMMISSIONER'S OFFICE
PROGRAM EVALUATION REPORT

Program Title: **Office of Management and Budget**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Title 22 M.R.S.A. §3

The primary function of the Office of Management and Budget is to provide general administrative and financial management services for the entire department.

B. A description of each program administered by the agency or independent agency, including the following for each program:

See attached individual descriptions for each program.

Division of Human Resources
Division of Financial Services
Division of Technology Services
Regional OMB Operations

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See job classification and organizational charts for each program.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Non-Discrimination Notice of DHS" EEO/AA Plan

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Office of Management and Budget.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

See attached answers for each program under the Office of Management and Budget.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

See attached answers for each program under the Office of Management and Budget.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

See attached answers for each program under the Office of Management and Budget.

J. Identification of emerging issues for the agency or program in the coming years.

See attached answers for each program under the Office of Management and Budget.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

See attached answers for each program under the Office of Management and Budget.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

See Attached Policy.

DHS Policy MB016- Use of State Automation Equipment

Title 5, Section 7070

DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
PROGRAM EVALUATION REPORT

Program Title: **Division of Financial Services**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Title 22 M.R.S.A. §3

B. A description of each program administered by the agency or independent agency, including the following for each program:

The Division of Financial Services is responsible for all fiscal operations within the Department of Human Services. The Division consists of five units: 1. The Account Management Unit oversees budget preparation, work programs, account management, financial reporting and expenditure and revenue projections. 2. The Accounts Payable Unit processes invoices, expense accounts and purchases. 3. The general Cashier Unit deposits all revenues coming into the Department. 4. The Child Support (Title IV-D) Cashiers Unit processes all child support collections. 5. The Cost Allocation Unit prepares the direct and indirect cost allocation plans which maximize federal matching dollars.

a. Established priorities, including the goals and objectives in meeting each priority;

This Division carries out the budgeting and financial components of the Bureaus' priorities, including their goals and objectives.

b. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

The Division supports the Bureaus' accomplishment of their performance criteria.

c. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

N/A

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

The Division of Financial Services has 36 authorized positions as of December 31, 2001.

See attached job classification.

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

The Bureau complies with all federal and state laws. See Non-Discrimination Notice of DHS" EEO/AA Plan

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Office of Management and Budget.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

N/A

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

The Division works closely with the Department of Administrative and Financial Services in the budgeting, accounting, purchasing, etc. activities of the Department.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The employees of DHS-Financial Services and all individuals applying for jobs with DHS.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

N/A

J. Identification of emerging issues for the agency or program in the coming years.

N/A

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

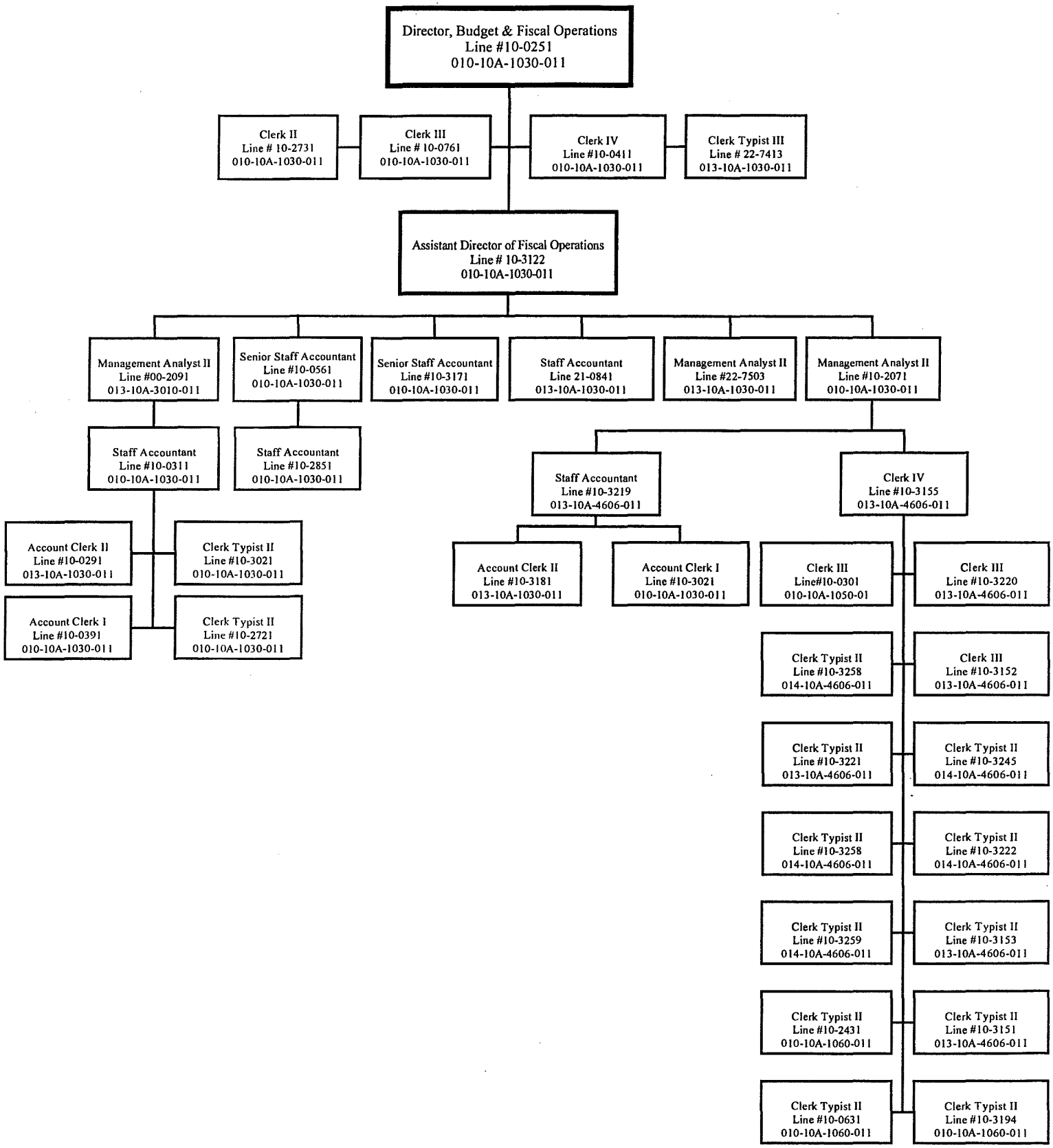
Refer to DHS Policy MB016- Use of State Automation Equipment

Title 5, Section 7070

DEPARTMENT OF HUMAN SERVICES
DIVISION OF OPERATIONS MANAGEMENT AND BUDGET
FINANCIAL SERVICES

Position Count	Job Classification
1	Director Budget and Fiscal Operations, DHS
1	Assistant Director Fiscal Operations, DHS
3	Management Analyst II
2	Senior Staff Accountant
4	Staff Accountant
1	Clerk IV
1	Clerk typist III
3	Account Clerk II
1	Account Clerk I
13	Clerk Typist II
4	Clerk III
1	Clerk II
1	Business Manager I
36	**Total Position Count**

State of Maine
Department of Human Services
Office of Management & Budget
Division of Financial Services



DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
PROGRAM EVALUATION REPORT

Program Title: **Division of Human Resources**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Civil Service Law- Title 5, Chapter 372
State Employee Labor Relations Act- Title 26, Chapter 9-B
Title II of Civil Rights Act of 1964
Section 504 of Rehabilitation Act of 1973
Age Discrimination Act of 1975
ADA
Title IX of Education Amendments of 1972

B. A description of each program administered by the agency or independent agency, including the following for each program:

a. Established priorities, including the goals and objectives in meeting each priority;

Human Resources- Responsible for the administration of human resources/employee relations for DHS. Responsible for all personnel/payroll for a department of 2500 employees

Equal Employment Opportunity Coordinator- Responsible for DHS' compliance with all applicable state and federal rules and regulations regarding equal employment opportunity

Plant and Office Services- Responsible for maintaining a continuously updated inventory of office supplies as well as insuring timely delivery of incoming and outgoing mail.

Staff Education and Training Unit- responsible for designing, implementing, monitoring and evaluating a staff training system and to meet the educational and training needs of DHS and local provider agencies.

b. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

The Division supports the Bureaus' accomplishment of their performance criteria.

c. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

The bureaus successfully meeting their goals and objectives indicate this Division's success in meeting performance criteria.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

The Division of Human Resources has 21.5 authorized positions as of December 31, 2001. An organizational chart is attached indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau complies with all federal and state laws. See Non-Discrimination Notice of DHS" EEO/AA Plan

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

The Division works closely with the Department of Administrative and Financial Services in the areas of human resources and employee relations.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

The employees of DHS-Human Resources and all individuals applying for jobs with DHS.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.**

N/A

J. **Identification of emerging issues for the agency or program in the coming years.**

The recent change in the Social Worker licensing law will have a substantial impact on DHS' ability to recruit and retain licensed social workers.

K. **Any other information specifically requested by the committee of jurisdiction;**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and**

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

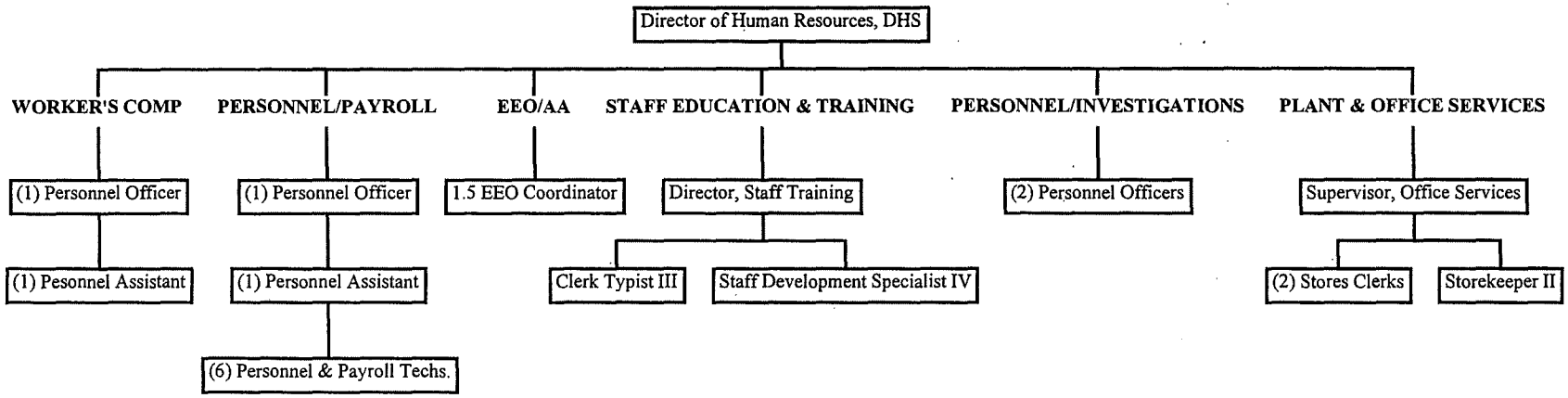
Refer to DHS Policy MB016- Use of State Automation Equipment

Title 5, Section 7070

DEPARTMENT OF HUMAN SERVICES
DIVISION OF OPERATIONS MANAGEMENT AND BUDGET
PERSONNEL/SETU/OFFICE SERVICES

Position Count	Job Classification
1	Director Human Resources, DHS
1	Director Staff Training
4	Personnel Officers
1.5	Equal Opportunity Coordinator
1	Staff Development Specialist IV
1	Supervisor Office Services
2	Personnel Assistant
6	Personnel and Payroll Technician
1	Storekeeper II
1	Clerk Typist III
2	Store Clerk
21.5	**Total Position Count**

DIVISION OF HUMAN RESOURCES



DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
PROGRAM EVALUATION REPORT

Program Title: Division of Technology Services

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Title 22 M.R.S.A. §1

The Deputy Commissioner for Management and Budget is responsible for the department's budget development and administration, Regional OMB Operations, Financial Services, Human Resources, Technology Services and Equal Opportunity and Affirmative Action, plus coordination with the Community Services Center.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Bureau of Family Independence - Automated Client eligibility System (ACES) A web-based, Multi-Tier Client/Server Framework, replacing a 23 year old client eligibility system providing required eligibility for over 100,000 Maine citizens. The project began July, 2000; a pilot will be done in Aroostook County starting April 1, 2002 with full statewide operations to begin June, 2002.

Bureau of Medical Services - Maine Claims Management System (MeCMS) A web based, Multi-tier Client/Server Framework system, replacing a 23 year old system processing Medical Claims, required to process claims for over 5,000 providers and over 100,000 citizens receiving medical services. Three project phases, the first phase development started September, 2001. Statewide operations to begin October, 2002.

Bureau of Health - Health Alert Network (HAN) This system will provide the capacity for rapid, two-way, web-based communication between the Department's Bureau of Health and hospitals and others in the medical and public health community. This is extremely urgent given the continued threat of bio-terrorism. The system is a new initiative that will be starting in March, 2002

Bureau of Elder and Adult Services - Maine Long Term Care Assessment (MeCARE). This is a client-server system that enables trained nursing staff to make long term care assessments at the point of client contact whether that be in-home or at a hospital. The system speeds the assessment process and makes care option available to the client more quickly. This system is fully operational at this time

Bureau of Child and Family Services - Maine Child Welfare Information System (MACWIS) A comprehensive child welfare case management system facility to support case workers and enable them to accurately track and assess their clients. This system is currently operational supporting the efforts of approximately 700 case workers in protecting children across the State, twenty-four hours a day.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

The ACES and MeCMS development effort are currently under contract with third-party service providers based on an exacting schedule of deliverables and subsequent payments. Specific, objective performance measures are included in these agreements. Should the contractor fail to meet any requirements, the Department will withhold payment until it is corrected and may at its sole option have the work correctly completed by another company with this cost absorbed by the original contractor.

The on-going support of the MeCARE and MACWIS systems is provided by Department in-house staff supplemented by third party contractors. These contractors are bound by similar contract protections as noted in the ACES/MeCMS development efforts. An in-house change management process further documents and tracks all efforts applied to these systems.

The HAN system will be the result of an open procurement via the State's Request for Proposal process. The resulting contract will incorporate all the standard protections including those mentioned above.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

To achieve the functionality required in the ACES system, that project was initially extended three months from its original completion date of November 2000 to March 2001. Due to requirement changes as a result of recent State and Federal Legislation further extended the schedule by another four months to June, 2002, to complete this additional work. No further delays are anticipated prior to the implementation in June, 2002.

All other efforts remain on schedule and on budget.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached organizational chart for the Division.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

All the agreements mentioned previously specifically call for all technical work products to be ADA and HIPAA compliant. They include further stringent requirements regarding a drug and smoke free work environment and compel compliance with all other State and Federal regulations. The Division actively seeks diversity in its hiring. Department Information Technology Use policy further enhances an effective work environment.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

All funds expended were cost allocated to funding sources within the various Bureau programs and will be reflected in their figures

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Division regularly coordinates and participates with the Center for Medicare and Medicaid Systems (CMS, formerly Health Care Finance Authority, HCFA), the Centers for Disease Control (CDC), Food and Nutrition Service at the United States Department of Agriculture (FNS/USDA), the Bureau for Development Services (BDS), the Bureau of Information Services and Administration for Children and Families (ACF). The Division currently has a cooperative agreement with the University of Southern Maine under the Department of Human Services Training Institute (DHSTI).

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The Division services approximately 2500 professional staff and management in the Department of Human Services. It provides technology in support of the programmatic objectives.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The Internet is being used to deliver a variety of program objectives including information dissemination, procedural reference, forms and filings, etc. The Division has outsourced much of its new development to allow existing staff to keep current operations intact. Once development is complete the staff will transition into support of the new technologies and systems. The Division is also evaluating wireless technology and Personal Digital Assistants (PDAs) to better support the programmatic missions.

J. Identification of emerging issues for the agency or program in the coming years.

The rapidly changing technological environment needs to be managed so as to provide the right technology in support of the Department mission without interruption of service to the Department's clients.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

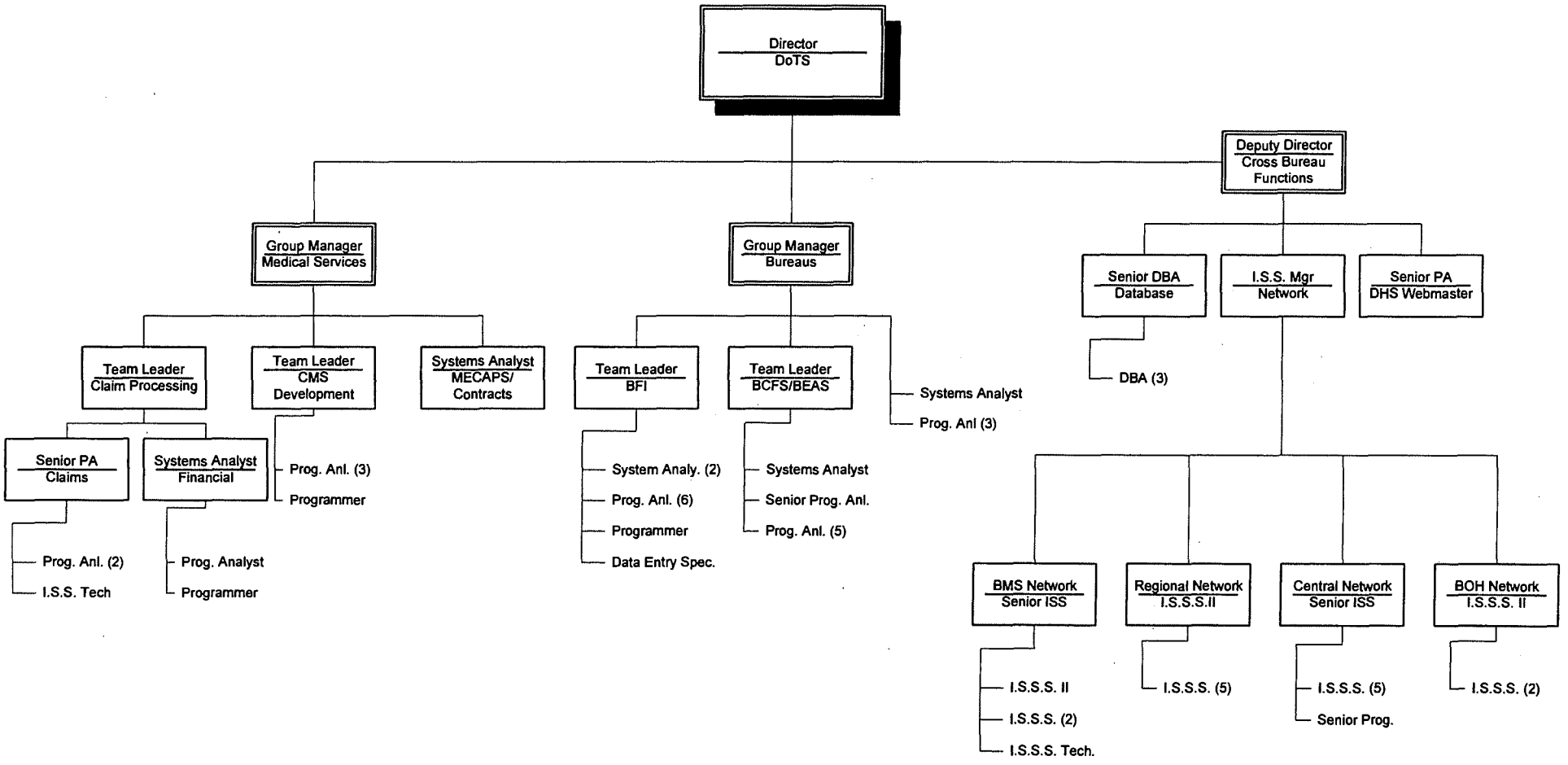
See attached Information Technology Policy and Privacy Statement.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF OPERATIONS MANAGEMENT AND BUDGET
DIVISION OF TECHNOLOGY SERVICES

Position Count	Job Classification
1	Director Data Processing
3	System Group Manager
4	System Team Leader
1	Senior Database Analyst
1	Information System Support Manager
7	Systems Analyst
1	Database Analyst
3	Senior Programmer Analyst
1	Senior Information Systems Support Specialist
13	Programmer Analyst
3	Information Systems Support Specialist
6	Computer Programmer
1	Planning and Research Associate I (project position)
12	Information System Support Specialist
1	Information Systems Support Technician
1	Data Control Specialist
2	Clerk Typist III
61	**Total Position Count**

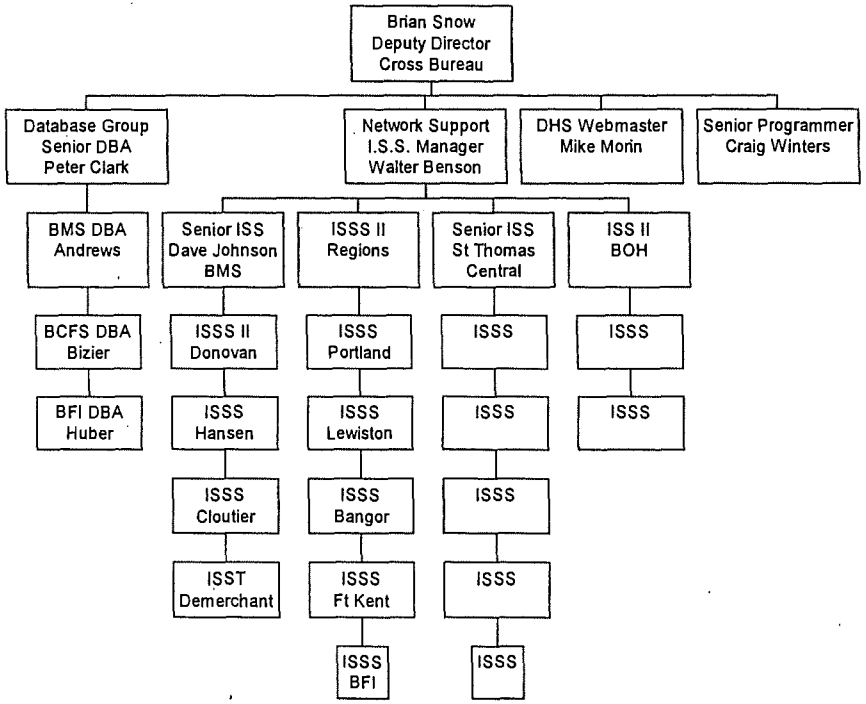
Department of Human Services

Division of Technology Services Organization

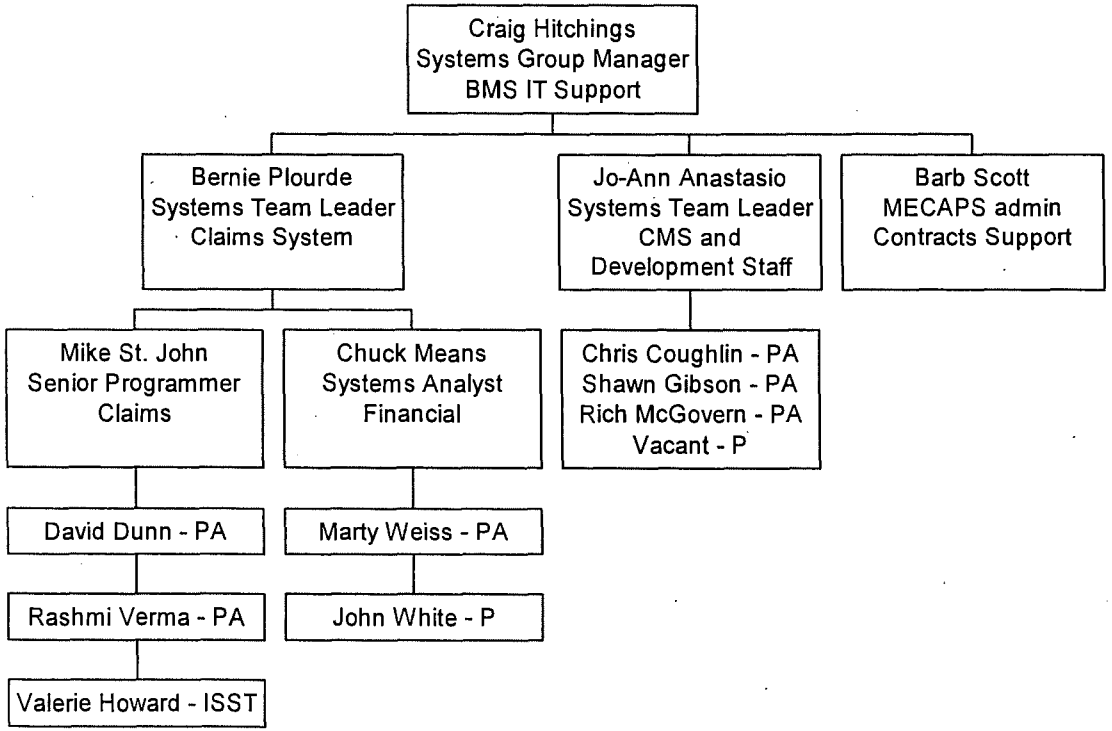


Date of Chart:
Wednesday, January 09, 2002

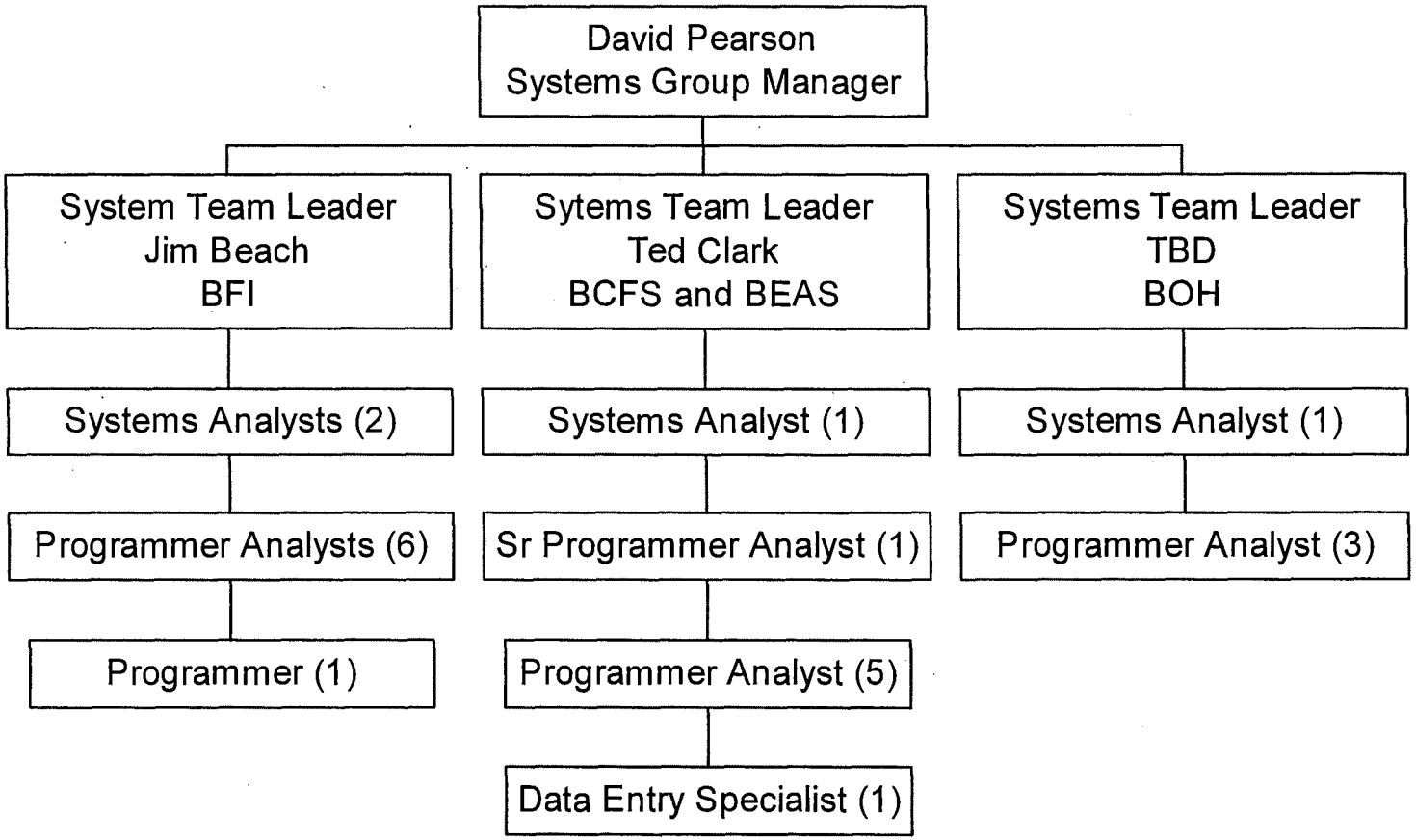
Deputy Director and Cross Bureau Functions



Bureau of Medical Services Support Team



BOH/BFI/BCFS/BEAS Team



DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET

PROGRAM EVALUATION REPORT

Program Title: **Division of Regional OMB Operations**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Policy Area: 03
Umbrella: 10
Unit: 144 R
Legal Citation: 22 M.R.S.A. Sect. 3
Program: 0196

The Division of Regional OMB Operations is responsible for providing business services to all DHS program units housed in the five large regional offices located in Portland, Lewiston, Augusta, Bangor, and Houlton as well as branch offices in Biddeford, Sanford, Farmington, South Paris, Augusta, Rockland, Belfast, Bath, Skowhegan, Bangor, Ellsworth, Machias, Calais, Dover-Foxcroft, Caribou, and Fort Kent. These services are provided for the benefit of the public as well as staff. The several office locations enable the public to receive vitally needed services in all areas of the State. The provision of business services by the Division of Regional OMB Operations, provided within the limited constraints of the available staff and fiscal resources, frees the program staff to focus on its unique functions of providing critical services to some of Maine's neediest individuals.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

i. Office receptionists facilitate the difficult process of seeking public assistance for approximately 1200 Maine citizens who walk into the offices each day. Telephone operators perform similar functions over the telephone for approximately 8900 citizens each day.

ii. Account Clerks arrange approximately 6350 payments each week to vendors and to providers of services who assist the Department

in addressing critical problems regarding child abuse, foster care, adult protective services, support enforcement, ASPIRE training activities, etc. In addition, Account Clerks manage 629 individual checkbooks for the adults in conservatorship.

iii. Financial Resources Specialists work to access, for 3176 children in State custody and for adults in conservatorship, maximum Federal Financial Participation from SSA, SSI, VA, Title IV-E, Title XIX Medical Assistance, etc. in order to maximize the services while minimizing the cost to the Maine taxpayer.

iv. Personnel staff work diligently with program managers and supervisors to ensure the availability of program staff to serve the public, through hiring, orientation of new employees, and all the Human Resources type of administrative activities required to support the program staff. This involves 1529 regional employees.

v. Clerical support staff provide the necessary assistance to all programs, including typing, data entry, telephone answering services, filing, photocopying, mail, supplies, etc.

vi. Other Division staff facilitate the receipt and forwarding of mail between programs and their publics, (3300 outgoing pieces daily), provide the program staff with the equipment and supplies necessary to get the job done, etc.

vii. In addition to overseeing the above, the Division of Regional OMB Operations Business Services Managers focus their efforts on providing an appropriate workplace where services can be delivered. Their focus includes building leases, space planning, space management, janitorial services, air quality, telecommunication services, accessibility, security, etc. for the 22 regional office buildings, which the Division manages.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

1. Length of time to screen and link walk-ins to program staff (to be seen by a program staff member within 20 minutes)

2. Length of time to answer telephone callers (answer within 6 - 8 rings)

3. Payment claims processed by the weekly check select date-Misc. Client Bills (within 7 days)

4. Vendor payroll entries and changes processed by bi-wkly check select date in Child Welfare P/R Sys (within 14 days)

5. Length of time (7 days) for initial Title IV-E eligibility determinations for children coming into state custody

6. Title IV-E, 12 month eligibility reviews for children in state custody (completed within 24 hrs of due date)

7. Clerical support to address most critical program needs (program judgment)

8. Mail forwarded the same day it is produced (same day)

9. Facility complaints, concerns, service requests responded to promptly (within 48 hrs).

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

In spite of a 15% reduction in staff during the early 1990's and expanded programs and caseloads since that time, the Division of Regional OMB Operations has been quite successful in addressing the above goals and objectives. This is due to the effective priority-setting and management efforts of the Business Services Managers as well as the diligence of the majority of general staff.

While the above indicates that the goals and objectives have been successfully achieved, a hiring freeze and/or future staff cuts would clearly jeopardize the Division's ability to continue its performance at the current desired level.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

The Division of Regional OMB Operations has 280.5 authorized positions as of December 31, 2001. See attached organizational chart for the Bureau.

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau complies with all federal and state laws.

The Division of OMB Operations, as a result of its responsibility for building facilities, is heavily involved with the Americans With Disabilities Act (ADA), the Federal Occupational Safety and Health Act (through the Maine DOL Bureau of Labor Standards), the American Society of Heating, Refrigeration Air-conditioning Engineers (ASHRAE) Standards, the ANSI/IES Lighting Standards, etc.

The Division has made excellent strides in the past few years in converting its stock of office facilities from marginal to state-of-the-art, complying with all relevant local, state, and federal health and safety laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Division of Regional OMB Operations works very intensively with the DAFS Bureau of General Services as involves the leasing of regional client services office facilities. The Division is also regularly involved with the DAFS Bureau of Information Services-Telco, the DAFS Division of Purchases, and the DOL Bureau of Labor Standards. Working relationships also exist with the Bureau of Human Resources and the Bureau of the Budget. Finally, the Division cooperates with other client-serving State agencies, most notably DOL, in the area of regional office facilities.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The Division of Regional OMB Operations has many constituencies: (1) the clients who come to regional offices, (2) those who telephone the offices, (3) the children and adults for whom it obtains fiscal resources (Title IV-E, SSA, SSI, etc.) (4) the private providers and vendors of services, (5) the DHS regional program staff whom it supports, and (6) the many other state agencies (DAFS, DOL, etc.) which it serves in accounting and coordinating roles.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Alternate delivery systems have focused on making increasing use of technology and the automation which it offers in order to optimize the effective use of limited human resources (staff) which the Division has.

J. Identification of emerging issues for the agency or program in the coming years.

There are a number of emerging issues for the Division:

a. The DHS clientele is becoming increasingly diverse: refugees, immigrants from all parts of the world, diversity of race, ethnicity, culture, attire, non-English speaking individuals, etc. Receptionists

are dealing with a situation, which is becoming increasingly difficult and complex. It is no longer sufficient to simply be friendly and helpful. The diversity confronted requires additional training and increasing skills. The State Bureau of Human Resources classification and compensation system needs to catch up with the reality confronting the receptionists today.

b. Technology is evolving at a very rapid pace. Technology offers opportunities to complement staffing levels, which levels, in some instances, are barely adequate. In order to seize upon the opportunities which technology offers, technical support staff and funds must be developed beyond the current levels. This is becoming more and more critical in the face of expanded and expanding programs with flat support staffing patterns.

c. Today's employees are no longer committing to the organization as a career. With employees coming and going, it is becoming increasingly critical to offer individuals incentives to commit to the organization for longer periods of time, to develop increasing skills, skills which can be applied within the organization. Incentives obviously include competitive wages, opportunities for training, education, and advancement.

K. Any other information specifically requested by the committee of jurisdiction;

None yet.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

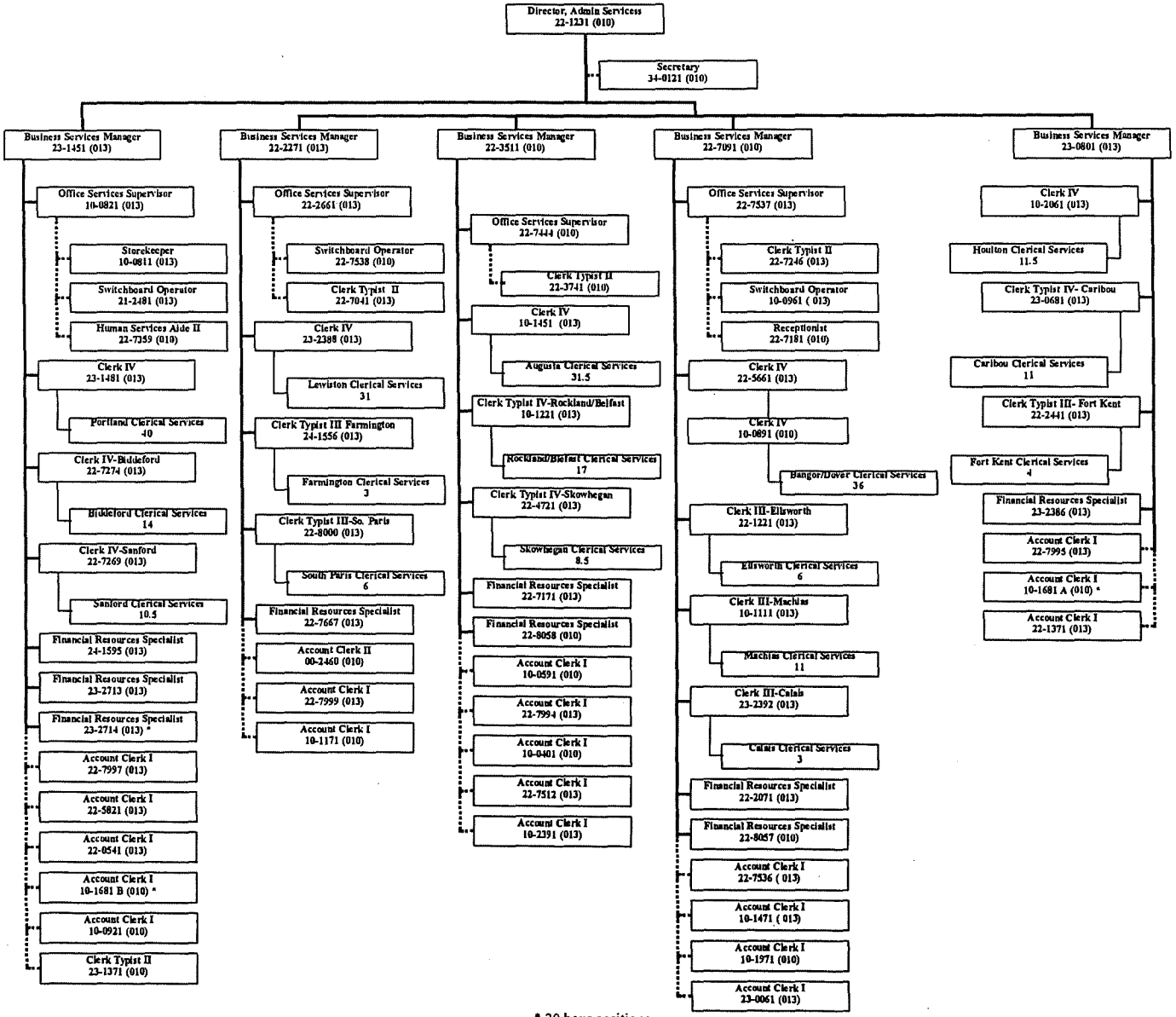
The Division of Regional OMB Operations is subject to Policy # MB016 Policy Concerning the Use of State Automation Equipment.

DEPARTMENT OF HUMAN SERVICES
DIVISION OF OPERATIONS MANAGEMENT AND BUDGET
REGIONAL OMB OPERATIONS

Position Count	Job Classification
1	Director Regional OMB Operations
5	Business Service Managers
4	Supervisor Office Services
8.5	Financial Resource Specialist
11	Clerk IV
1	Secretary
29	Clerk Typist III
15	Account Clerk I
5	Account Clerk II
1	Storekeeper I
2	Human Service Aide II
5	Human Service Aide III
182	Clerk Typist II
3	Switchboard Operator
1	Legal Secretary
2	Clerk Stenographer II
1	Receptionist
1	Clerk II
3	Clerk III
280.5	**Total Position Count**

DEPARTMENT OF HUMAN SERVICES
Division of Regional OMB Operations
(280.5 FTE Positions)

December 26, 2001



* 20 hour positions

DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	OFFICE OF MANAGEMENT AND BUDGET	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	3,628,079	2,832,502	3,857,012	2,692,033	3,325,125	2,714,350	3,312,049	2,828,344	2,983,861	2,862,260
0196	OFFICE OF MANAGEMENT AND BUDGET - REGIONAL OPERATIONS	3,472,922	2,601,736	3,658,940	2,888,668	3,154,973	2,941,595	3,213,771	3,360,780	3,603,435	3,591,997
	GENERAL FUND TOTAL:	7,101,001	5,434,238	7,515,952	5,580,701	6,480,098	5,655,945	6,525,820	6,189,125	6,587,296	6,454,257
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	3,150,372	2,019,757	3,334,634	2,209,207	3,059,109	1,754,174	3,049,923	2,715,905	4,317,187	3,395,401
0196	OFFICE OF MANAGEMENT AND BUDGET - REGIONAL OPERATIONS	3,208,567	2,570,076	3,483,853	2,406,353	2,528,747	1,798,533	2,570,750	2,651,273	3,125,910	2,927,174
	FEDERAL FUND TOTAL:	6,358,939	4,589,833	6,818,487	4,615,560	5,587,856	3,552,706	5,620,673	5,367,178	7,443,097	6,322,575
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	116,480	90,392	124,269	84,410	131,692	85,670	129,504	97,985	123,814	114,362
0196	OFFICE OF MANAGEMENT & BUDGET-REGIONAL OPERATIONS										
	OTHER SPECIAL REVENUE TOTAL:	116,480	90,392	124,269	84,410	131,692	85,670	129,504	97,985	123,814	114,362
0142-01	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	1,292,326	1,290,585	1,849,712	1,383,008	1,647,212	1,643,601	1,642,266	1,494,739	1,646,058	1,644,475
0142-02	OMB CENTRAL TANF										
0196-01	OFFICE OF MANAGEMENT & BUDGET-REGIONAL OPERATIONS- SSBG	3,198,258	1,920,883	3,395,838	2,212,455	2,082,701	2,075,321	2,110,901	2,200,362	2,137,024	2,137,023
0196-02	OMB REGIONAL OPERATIONS -TANF										
0493	TRAINING PROGRAMS & EMPLOYEE ASSISTANCE	325,155	83,045	340,377	68,333	354,015	94,164	368,736	86,574	367,383	76,141
	BLOCK GRANT TOTAL:	4,815,739	3,294,513	5,585,927	3,663,796	4,083,928	3,813,086	4,121,903	3,781,675	4,150,465	3,857,639
	GRAND TOTAL	**18,392,159**	**13,408,976**	**20,044,635**	**13,944,467**	**16,283,574**	**13,107,407**	**16,397,900**	**15,435,963**	**18,304,672**	**16,748,833**

DEPARTMENT OF HUMAN SERVICES
OFFICE OF MANAGEMENT AND BUDGET
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	OFFICE OF MANAGEMENT AND BUDGET	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	2,470,885	2,451,840	2,591,647	2,565,576	2,738,494	2,733,925	2,912,435	2,910,565	3,969,118	3,966,649
0196	OFFICE OF MANAGEMENT AND BUDGET - REGIONAL OPERATIONS	6,546,418	6,418,647	6,734,915	6,705,723	7,275,775	7,051,952	7,792,591	7,520,702	9,309,171	9,169,645
	GENERAL FUND TOTAL:	9,017,303	8,870,487	9,326,562	9,271,299	10,014,269	9,785,877	10,705,026	10,431,266	13,278,289	13,136,295
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	3,380,515	2,742,297	3,099,394	2,811,293	3,340,409	3,324,944	4,125,739	4,095,358	5,438,201	5,122,424
0196	OFFICE OF MANAGEMENT AND BUDGET - REGIONAL OPERATIONS	5,879,718	4,948,361	5,269,884	4,782,711	5,240,257	4,842,947	5,749,558	5,473,376	7,371,841	7,251,114
	FEDERAL FUND TOTAL:	9,260,233	7,690,658	8,369,278	7,594,004	8,580,666	8,167,892	9,875,297	9,568,734	12,810,042	12,373,538
0142	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	97,615	96,255	98,649	90,572	100,406	99,088	117,556	116,903	138,707	118,127
0196	OFFICE OF MANAGEMENT & BUDGET-REGIONAL OPERATIONS	159,583	149,514	167,241	163,672	162,253	142,707	163,239	137,717	174,871	160,221
	OTHER SPECIAL REVENUE TOTAL:	257,198	245,769	265,890	254,245	262,659	241,795	280,795	254,620	313,578	278,348
0142-01	OFFICE OF MANAGEMENT & BUDGET-CENTRAL	1,649,492	1,646,455	1,944,729	1,935,992	1,992,344	1,985,938	2,047,778	2,042,259		
0142-02	OMB CENTRAL TANF			121,418	16,837	126,046	27,532	129,830	31,750	133,725	35,210
0196-01	OFFICE OF MANAGEMENT & BUDGET-REGIONAL OPERATIONS- SSBG	2,341,282	2,323,309	2,543,014	2,543,011	2,536,978	2,522,298	2,549,931	2,336,802	229,293	153,780
0196-02	OMB REGIONAL OPERATIONS -TANF	584,355	584,355	782,140	779,140	811,514	811,460	1,204,176	1,201,613	1,289,672	1,283,817
0493	TRAINING PROGRAMS & EMPLOYEE ASSISTANCE	380,170	81,680	96,235	90,505	88,503	77,852	88,069	77,794	102,606	81,414
	BLOCK GRANT TOTAL:	4,955,299	4,635,800	3,542,807	3,429,492	3,563,041	3,439,141	3,972,006	3,647,960	1,755,296	1,554,220
	GRAND TOTAL	**23,490,033**	**21,442,714**	**21,504,537**	**20,549,040**	**22,420,635**	**21,634,704**	**24,833,124**	**23,902,580**	**28,157,205**	**27,342,400**

BUREAU OF CHILD AND FAMILY SERVICES

Adoption

Child Protective Services

Children Services

Foster Care Licensing

ICPC (Interstate Compact for the Placement of Children)

Independent Living

Quality Assurance/Case Review

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **Adoption**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Adoption and Adoption Assistance
Title 19 MRSA Adoptions - Maine Adoption Laws
Title 22 MRSA Chapter 1071

Federal Law:
Adoption and Adoption Assistance
Adoption and Safe Families Act of 1997
Inter-County Adoption Act (ICAA) of 2000 - P.L. 106-279

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM

Adoption/Adoption Assistance

Adoption-One of the primary goals of the Bureau of Child and Family Services is to assist in the reunification of children with their birth families, when that plan is safe and appropriate. When children cannot be safely returned to their birth family in a reasonable time, then adoption becomes the preferred plan. The Bureau is required to actively promote the adoption of children into safe and permanent adoptive families rather than allow children to remain in the impermanence of foster care. The Bureau provides a range of adoption services to children whose birth parents parental rights terminated and are legally cleared for adoption, as well as for families who are interested in adoptive these children from the foster care system. The Bureau operates on the philosophy that we are "looking for families for children, not children for families". The Bureau focuses our entire program on locating, placing and finalizing families interested in the adoption of school aged children with special needs.

Adoption Assistance- is an ongoing program within the Department of Human Services to make adoption possible for children who otherwise

may not be adopted. It's purpose is to enable a child to become a permanent member of a family and to provide the benefits of family security, love and nurture for children who are presently in the custody of the Department of Human Services or a licensed non-profit adoption agency licensed to operate in Maine. Adoption Assistance may be authorized to supplement the resources of approved adoptive families in order to meet a portion of the special needs of the child without lowering the standard of living of the family.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

a) Assess and prepare the child for adoptive placement in a timely manner.

b) Assess and prepare foster parents transitioning to adoption.

c) Recruit, educate and develop adoptive family resources.

d) Place legally freed children with the best available adoptive family.

e) Finalize and support the adoptive family system through post-legalization services.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

a) Caseloads are to be maintained at the maximum of 15-18 children per staff.

b) The majority of foster parent adoptions are to be completed in nine months from TPR.

c) Adoption Staff is to process an average of eight adoption legalizations annually.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PERFORMANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

During year 2000, the adoption staff has exceeded the goal and has legalized an average of 9.4 child/adoptions per staff person. For this present year (not all information is available at this time) BCFS is projecting that approximately 350 adoptions will be legalized which computes to an average of 7.7 child/adoptions per staff. Given the high staff turnover it is our belief that this number is acceptable.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See attached job classification and organizational chart for the Bureau

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED

The rules of the Adoptive Assistance Program were promulgated and effective on February 15, 1996. We are currently working on updating these rules with the expectation that we will be in compliance with the changes in Federal policy in 2001.

G. **IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVE AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE AGREEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS**

See Attached Question G under Child Protective Services. This section pertains to the entire Bureau.

H. **IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.**

See attached Question H under Child Protective Services.

I. **A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.**

This summary is defined in Question I under Child Protective Services.

J. **IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.**

See Question J under Child Protective Services.

K. **ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.**

N/A

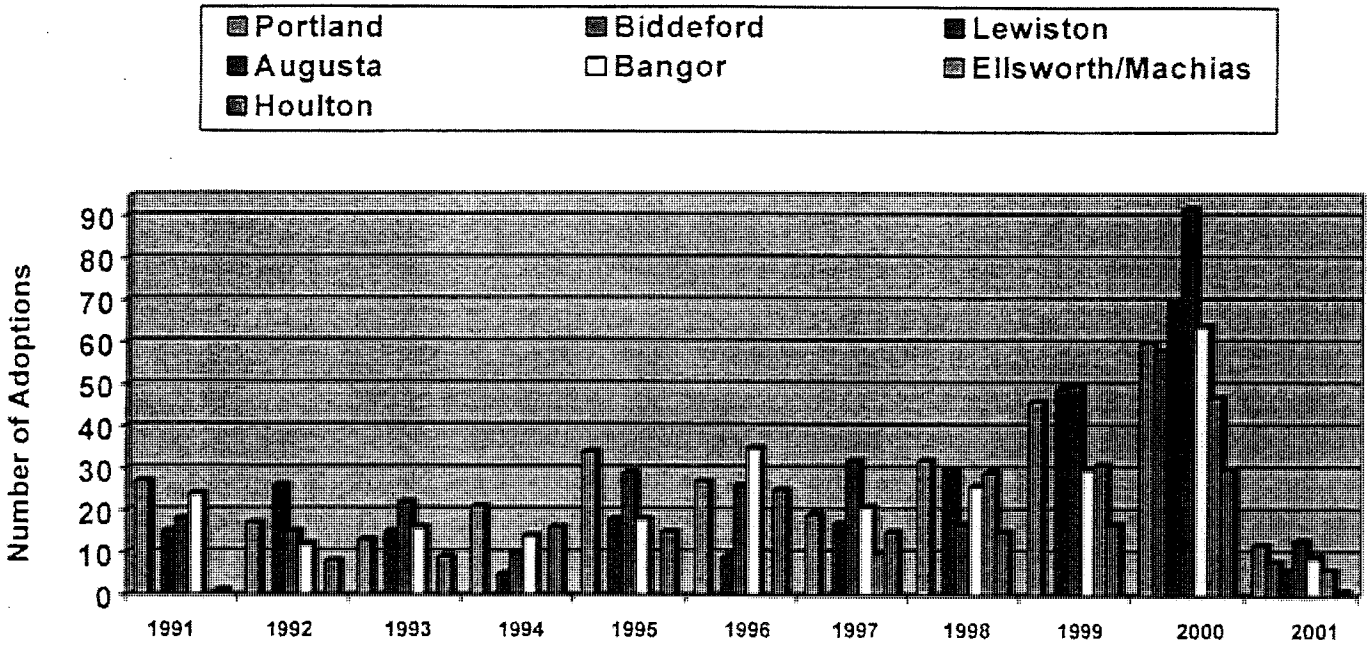
L. **A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.**

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only to we comply with Title 22 MRSA, there are also specific IT policies in place that addresses this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

Adoption Finalizations by Years
for Each Office

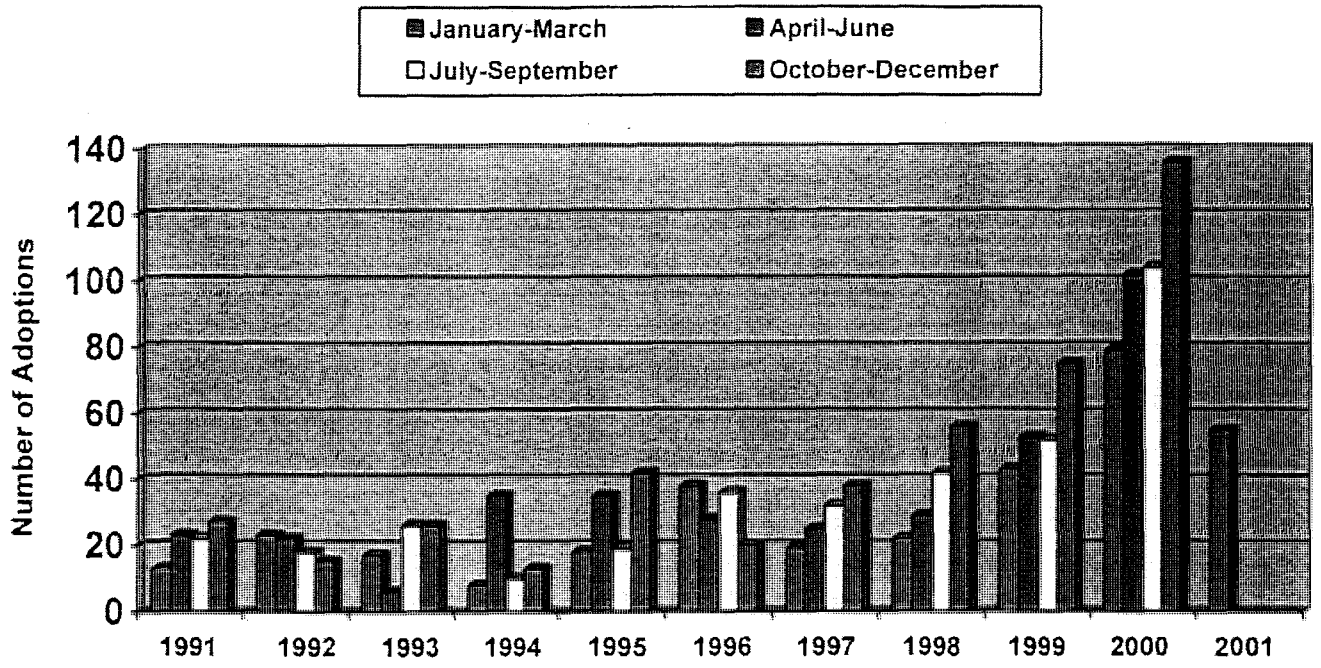


OFFICE	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001 as of 4/1/01	Pending*
Portland	27	17	13	21	34	27	19	32	46	60	12	10
Biddeford										58	8	7
Lewiston	15	26	15	5	18	9	17	30	49	70	6	9
Augusta	18	15	22	10	29	26	32	17	50	92	13	23
Bangor	24	12	16	14	18	35	21	26	30	64	9	4
Ellsworth Machias							10	29	31	47	6	9
Houlton	1	8	9	16	15	25	15	15	17	30	1	5
TOTAL	85	78	75	66	114	122	114	149	223	421	55	67

*Pending means that the Commissioner has signed consent, but finalization has not taken place or at least has not yet been reported.

7/2/2001

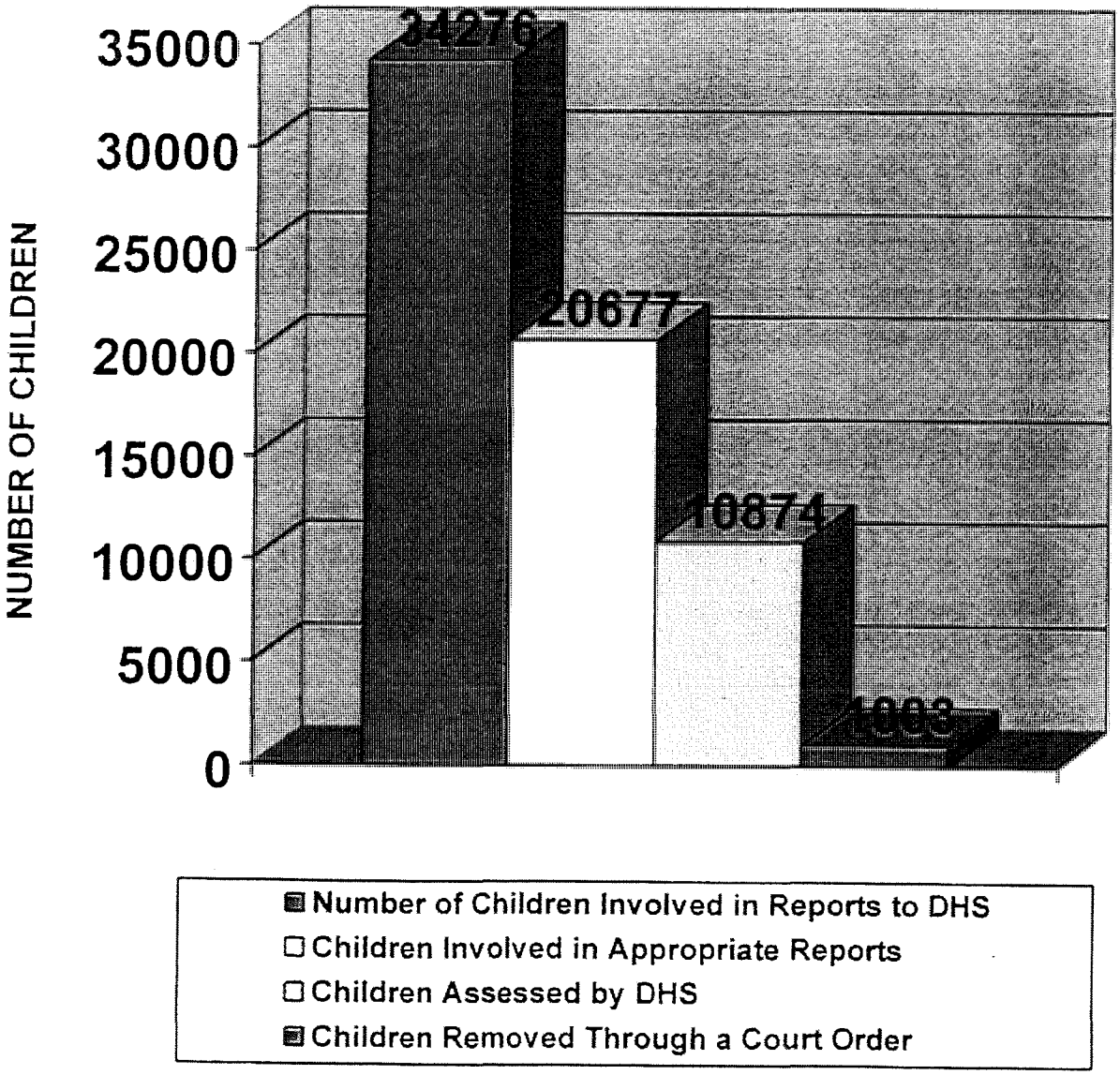
Adoption Finalizations by Years
for Each Month



MONTH	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001 as of 4/1/01
January	3	9	1	0	9	5	4	6	9	31	24
February	8	5	9	4	7	15	5	8	17	17	18
March	2	9	7	4	2	18	10	8	17	31	13
April	4	10	3	15	7	5	9	8	12	36	
May	8	6	2	12	8	12	6	16	14	44	
June	11	6	1	8	20	11	10	5	27	22	
July	5	6	10	1	8	13	8	16	28	35	
August	5	5	6	5	5	13	16	15	13	34	
September	12	7	10	4	6	10	8	11	11	35	
October	8	5	11	1	17	7	20	15	15	33	
November	6	5	8	1	12	4	2	18	9	42	
December	13	5	7	11	13	9	16	23	51	61	
TOTAL	85	78	75	66	114	122	114	149	223	421	55

7/2/2001

Children Brought to Attention of DHS/BCFS Through Child Protective Intake Year 2000



DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **Child Protective Services**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Child Protective Services
Title 22 MRSA Chapter 1071
Title 15 MRSA (Juvenile Code)

Federal Law:
Child Protective Services
Child Abuse & Treatment Act P.L., 104-235
Adoption and Safe Families Act, P.L. 105-89
Indian Child Welfare Act, PL 95-608
Social Security Act, Titles IV-B and IV-E
The Adoption and Safe Families Act of 1997
Department of Human Services, Administration for Children and Families
45 CFR §1355, §1356 and §1357 TIV-E Foster Care Eligibility Reviews and Child and Family Services State Plan Reviews
The Indian Child Welfare Act

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM:

Child Protective Services

Maine's Child and Family Services and Child Protection Act found in 22 M.R.S.A. 4001 et seq. requires that the Bureau of Child and Family Services investigate allegations of suspected child abuse and neglect and determine the degree of harm or threatened harm to the child. The Act further authorizes the Bureau to protect a child from abuse and neglect in their home, to make reasonable efforts to prevent the removal of a child from their home by providing family support services, to seek court intervention when voluntary services have not succeeded in ameliorating the abuse or neglect and to move quickly to develop a permanent plan for a child who cannot be safely returned to his/her home. Child Protective Services program includes the intake process up to the initial court intervention. The Bureau may not remove a child from his/her home absent a court order nor may the Bureau require parents to

participate in services absent a court order. Therefore, most, if not all, of the work of Child Protective Services is voluntary in nature as it relates to parents and caregivers. It is important to note that the Bureau seeks court intervention in approximately 15% of the families it works with each year. Therefore 85% of the families are working voluntarily with the Bureau to ensure the safety and well being of their children in their home.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

Child Protective Services

a) To fulfill our legal mandate to receive all reports of child abuse and neglect

b) The goal is to investigate all appropriate reports of child abuse and neglect. BCFS assigns approximately 53% of all appropriate reports that come to our attention. The remainders of appropriate reports that are unable to be assigned (low/moderate risk of abuse) are given to the Community Intervention Program to assess.

c) Another goal is to determine the level of safety and to provide services that will afford the children an appropriate level of safety. This is done through case planning and the use of a new Child and Family Assessment tool designed to address underlying causes and the protective capacities of the caregiver.

d) In those cases in which there has been a determination that jeopardy exist, it is then the goal to ameliorate the jeopardy in the family so that child(ren) may be safely maintained in their home. When this can't happen, a Child Protection Order is sought that will meet the safety needs of the child.

e) BCFS has the goal to reduce incidences of repeat maltreatment to children. The BCFS is committed to reduce incidence of repeat maltreatment and has made efforts to reduce this. The BCFS has practice guidelines dedicated to this. When children are brought to the attention of the Department and there is a previous finding of abuse or neglect, the case is peer reviewed and decisions are made accordingly.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

Child Protective Services

a) Safety Assessments are to be completed within 15 days of the caseworkers "respond by" date. A monthly report goes to each District to assist with policy compliance efforts.

b) Child & Family Assessments are to be completed five weeks after a Safety Plan is completed and a petition is filed. This process was just implemented in November of 2001. A monthly report will go to each District to assist with policy compliance.

c) Supervisors are the key to quality services for clients and for enhancing caseworkers skills and knowledge. The key to effective use of both the Safety and Child & Family Assessment process is supervision. Therefore, considerable implementation and follow-up efforts are geared toward enhancing supervisory capacity using the assessment process as the teaching medium.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

Child Protective Services

a) Child Protective Services has substantially met it's goal regarding the receipt of all reports of Child Abuse and Neglect. BCFS received 15,234 reports in 2000. CPS Intake has a voice mail system to handle to overflow of calls in the event that all workers are busy with another call. CPS Intake, though creative scheduling and an additional worker, is making attempts to reduce the number of calls going to voicemail.

b) BCFS has increased our efforts to assess more families. BCFS assigns approximately 53% of all appropriate reports that come to our attention. The remainders of appropriate reports that are unable to be assigned (low/moderate risk of abuse) are given to the Community Intervention Program to assess. This is a substantial increase. In the past, low to moderate reports of child abuse and neglect were not being seen for a host of reasons.

c) Another goal is to determine the level of safety and to provide services that will afford the children an appropriate level of safety. This is done through case planning and the use of a new Child and Family Assessment tool designed to address underlying causes and the protective capacities of the caregiver. This new tool has been incorporated in our SACWIS system, MACWIS and there have been ongoing training initiatives in the District offices.

d) In those cases in which there has been a determination that jeopardy exist, it is then the goal to ameliorate the jeopardy in the family so that child(ren) may be safely maintained in their home. When this can't happen, a Child Protection Order is sought that will meet the safety needs of the child. Preliminary figures indicate that the number of children entering the custody of DHS has remained constant over the past 2 years, however the number of children returning home is increasing. The Bureau continues to monitor this though a review process, supervision, and statistical measurements.

e) BCFS has the goal to reduce incidences of repeat maltreatment to children. The BCFS is committed to reduce incidence of repeat maltreatment and has made efforts to reduce this. The BCFS has practice guidelines dedicated to this. When children are brought to the attention of the Department and there is a previous finding of abuse or neglect, the case is peer reviewed and decisions are made accordingly.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

This position count pertains to the entire Bureau. See job classification and organizational chart for the Bureau.

Overview

The Bureau of Child and Family Services has 525.5 positions in 15 offices located in eight districts. There are 28 vacancies in the Bureau at this time. Changes required by the federal Adoption and Safe Families Act, and Maine's Child Welfare Laws, have led the Bureau to modify policy and practice. These modifications focus on Safety, Permanency, and Well-Being for children and families. In some instances however, these efforts have resulted in increased workload for staff. The Bureau is constantly striving to improve job performance, job satisfaction and staff retention in order to better meet the needs of the families the Bureau serves.

Child and Family Services Bureau Director
Oversees all Bureau operations, collaborates with stakeholders within the system, including provider agencies, contracted service providers, families, child, foster families, other Bureaus and Departments, and the public. The Bureau Director reports to the Department of Human Services Commissioner and supervises the **Deputy Director of the Division of Child Welfare Practice** and the **Division Director of Bureau Operations.**

Program Administrators (8) and **Program District Supervisor** (1):
Administrate and oversee district offices, including supervising casework supervisors and maintaining community relations.

Casework/Intake Supervisors (62):
Oversee units of caseworkers including managing workload, assessing casework and cases, and ongoing administration and education to the unit.

Quality Assurance Staff (10):
Review Bureau records and provider agencies' records to ensure quality and compliance with policy and practice standards.

Child Protective Caseworkers (147):
Investigate appropriate referrals on cases of child abuse and neglect in Maine, provide services on a voluntary basis for all appropriate and substantiated cases, and when necessary, initiate court action to protect children and serve families.

Children's Services Caseworkers (133):
Provide services for children in the custody of the Department of Human Services and provide reunification and rehabilitation services to those families and their children.

Adoption Caseworkers (45):
Provide services and matching for children whose parents' rights have been terminated and are in need of adoptive families.

Field Instruction Unit Supervisors (2):
Provide education and supervision for undergraduate and graduate students in Social Work Programs through BCFS office placements.

Independent Living Caseworkers (6):
Provide independent living skill development services to youth in care over the age of 14 which prepare them for adulthood. These workers do not carry cases.

Maine Caring Families Caseworkers (6):
Oversee the Bureau's in-house Therapeutic Foster Care Program including education and support for foster families. These workers do not carry cases.

Maine Youth Center Caseworker (1):
Provide services and liaison work between the Youth Center and the Bureau. This person does not carry cases.

Intake Workers (12):
Take referrals and reports of child abuse and neglect for initial review and forward to district offices. These workers do not carry cases.

After Hours Workers/Duty Workers (10):
Respond after hours and during work hours when caseworkers are not available to crisis situations, both on open cases and in community situations where children need the immediate intervention of the Department of Human Services.

Licensing Workers (20):
Study families and homes where people wish to adopt or provide foster care for children in the custody of the Bureau.

Case Aides (25):
Some Case Aides do case visitation and other direct service for clients while others work in clerical support roles.

Clerks, Paralegal Assistants, Secretaries, and Accountants (11.5):
Provide support to district office field staff.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED

N/A

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVES AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE ARRANGEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS.

Protecting children and assisting families where abuse and neglect is or may be present is a community responsibility. While the Bureau of Child and Family Services has significant responsibility in this area, the Bureau cannot effectively carry out this responsibility without assistance from many agencies and individuals in the community. For this reason, the Bureau has actively sought to establish collaborative efforts designed to improve services to children and their families. ***(The following are programs that pertain to the entire Bureau of Child and Family Services. Further Program Sections will refer back to this question.)***

Community Mentoring Program

The Community Mentoring program provides mentors to assist and support youth in care in preparation for their transition to independent living and adulthood. Mentors, who are carefully screened and receive specialized training, work with these young adults to help them gain independent living skills as well as to develop career goals and employment skills. There are over thirty youth in care who have mentors at this time. The Bureau has contracted with the University of Southern Maine's Muskie School for Public Service to operate and oversee this program for the past three years. The Muskie School has recently received an additional three-year grant to expand the mentoring program to other areas of the state. The Bureau will continue to support these efforts and hopes to be able to continue to participate in the funding on a long-term basis.

Youth Leadership Advisory Team

The Youth Leadership Advisory Team is a statewide organization comprised of approximately 55 youth between the ages of 15 and 21 who are or have been in the care and custody of the Department of

Human Services. These youth have joined together to serve as the "voice" for the needs of all youth in care. The Bureau provides support and funding for a Youth Leadership Advisory Team Coordinator. Members of the Youth Leadership Advisory Team have testified before the Legislature, assisted the Bureau in the development of its policies around older youth in care, participated in trainings for caseworkers and foster parents, developed the nations premier "Answers" Handbook and raised public awareness on critical foster care issues. For more information you may visit YLAT on its Website, www.ylat.usm.maine.edu

Child Death and Serious Injury Review Panel

The Child Death and Serious Injury Review Panel is a statutorily based multi-disciplinary panel set-up to conduct comprehensive reviews of suspicious child deaths and serious injuries.

The Panel makes findings and recommendations to the Bureau and other components of the child protection system. The goal of the Panel is to determine what can be learned from this comprehensive review so that it is less likely that a child will die or be injured in similar circumstances. These recommendations have resulted in training and new policies and procedures for the professionals involved in the child protection system. The Panel has representatives from medicine, mental health, law enforcement, the Department of Attorney General, the Maine Prosecutors Association, child welfare, public health nursing and education.

Court Improvement Project

The Court Improvement Project is a multi-year federal grant program designed to help state court systems improve their handling of child abuse and neglect cases. The grant requirements include an initial assessment by the State of its courts' handling of child protection matters and the development of recommendations for their improvement. This was completed in Maine in March of 1997. The Court Improvement Project continues its efforts under the grant to implement and monitor improvements for the handling of child protection matters within the court system. The Director of the Bureau of Child and Family Services serves as an executive committee member on this multi-disciplinary Project as well as a member of the full committee.

Child Abuse and Neglect Councils

The Department of Human Services provides funds to these community-

based councils located in each county of the State. The Councils initiate and coordinate child abuse prevention activities at the local level. Funded activities include: prevention education programs; public education on issues related to child abuse; collaborative efforts with other agencies to develop needed resources for children and their families; trainings in the area of mandatory reporting and the development of a resource directory.

Indian Child Welfare Act

The Indian Child Welfare Act (ICWA) was passed in 1978 in recognition of the special relationship between the federal government and Indian tribes. The purpose of the Act is to protect the best interest of Indian children and promote the stability and security of Indian tribes and families. The law sets forth a unique set of standards that are applied to Indian children who come in contact with the child welfare system. The Act gives tribes standing in all cases involving Indian children. The standing can involve shared decision-making to exclusive jurisdiction by the Tribes. The state is obligated to carry out both the letter and spirit of the Act. The Director of the Division of Child Welfare serves as the liaison from the Bureau to Tribal officials and assures the Bureau's compliance with the Act. The Bureau and the Tribes have collaborated on training to increase the knowledge and understanding of Indian culture especially aspects of the culture related to family life.

Pediatric Rapid Evaluation Program (PREP)

This program is a partnership between Maine General Hospital and the Bureau. The program is designed to provide a physical and mental health screening for all children entering foster care in a five county area. One emphasis of the screening is the trauma that can be associated with child abuse and neglect. The screening identifies problems requiring either immediate intervention (e.g. previously undiagnosed asthma) or requiring further evaluation (e.g. extreme mood shifts). The program includes a pediatrician and a child psychologist. Foster parents, caseworkers and treatment providers receive the screening reports so that the most effective service can be provided to the children. This program has improved health care for foster children, provided additional supports to foster parents and assured timely and effective services. The program re-evaluates the children after 6-8 months to see if the services and care they are receiving have reduced the impact of the abuse and neglect they experienced.

Clinical Case Management Pilot

This pilot project was initiated through a memorandum of understanding between the Commissioners of the Department of Human Services and the Department of Mental Health, Mental Retardation and Substance

Abuse Services (DMHMRSAS) in the spring of 1998. The program has been operational for two years. DMHMRSAS has contracted with Community Counseling Services in Cumberland County and with Sweetser Children's Services in York County for the following purposes: to provide mental health assessments of children coming into the State's custody who are not already connected with a mental health resource, to connect children with appropriate mental health providers and to provide consultation to the Bureau on the mental health needs of children in State custody and their families. The staff from these agencies are located within the Bureau's office in Biddeford and Portland for a portion of the week. The Bureau is considering expanding this pilot project to its' Rockland office.

Department of Corrections - Juvenile Services

For the past three years the Department of Corrections and the Department of Human Services have been engaged in a collaborative effort in the area of juvenile sex offenders. The project has concentrated its efforts in research, risk assessment instrument development and the development of a continuum of services for juvenile offenders. The project director is Sue Righthand, Ph.D. An annotated bibliography of the literature in this field has been produced, a validated risk assessment tool is being used by the Department of Corrections and a resource development group involving DOC, DMHMRSAS and the Bureau has been developed. The risk assessment tool and its application has become part of a national study funded by NIMH and directed by Robert Prentky, Ph.D. the foremost authority in this country on risk assessment. The annotated bibliography has been published and is circulating worldwide. The DOC juvenile services staff has received training on the use of the tool. The next step is to train Bureau casework and supervisory staff. Efforts are currently underway for the Department of Corrections to be able to use Title IV-E funds to cover that Department's costs of board and care for the youth in the Corrections system. This will likely result in fewer children coming into the Department's custody based primarily on the need to pay for required services.

Public Health Nursing

The Bureau of Public Health Nursing and the Bureau of Child and Family Services often serve the same families. The two bureaus developed a

signed working agreement to clarify reporting requirements, information sharing, and conflict resolution. The agreement also mandates joint training and district level meetings to take place at least yearly. The agreement also sets forth the principles of joint case planning. The agreement is reviewed every two years.

Rural Domestic Violence/CPS Collaboration

The Bureau began an intense collaborative process with the Domestic Violence response community about six years ago. The initial effort was aimed at improving understanding of the role of domestic violence advocates and of Child Protective Services within both groups. The effort resulted in the acceptance and respect of each other's roles, responsibilities and limitations. Many more commonalities were identified than differences. The collaboration continued to increase and the partnership became stronger. The most recent step has resulted in the placement of four domestic violence specialists in four of the Bureau's eight Districts. These specialists provide case consultation, assist in Safety Assessments and provide training. It is clear the Bureau's response to cases where domestic violence co-occurs with child abuse and neglect is more appropriate and more effective.

Maine Youth Center/Caseworker

A Department of Human Services caseworker is stationed at the Maine Youth Center in order to streamline and coordinate services to children who are committed to the Maine Youth Center and yet are in the Department of Human Services custody. While technically the Department's custody is suspended while a youth is committed, this program recognizes and addressees the need to coordinate and plan for the youth cooperatively in order to maintain a regimen of treatment for the youth as well as to plan for their eventual discharge. The many responsibilities delegated to the caseworker at the Maine Youth Center include: participating in the initial mental health diagnostic review, attending and participating in the quarterly clinical team meetings, providing a communication link between the Bureau's district offices and the Maine Youth Center and conducting all well-being reviews for the Bureau's children at the Youth Center.

Child Abuse Action Network (CAAN)

The Child Abuse Action Network (CAAN) is a public/private partnership set up to improve Maine's response to child abuse and neglect in the areas of child welfare, law enforcement and legislation. CAAN is

designated by the Governor to receive and utilize funds from the Children's Justice Act State grant program. The CAAN carries out its responsibilities by focusing primarily on enhancing the knowledge and skills of the professionals who have responsibilities in the child protection system, and by facilitating multi-disciplinary collaboration amongst professional groups. The accomplishments of this Network are extensive. Hundreds of professionals have received training on such topics as assessing risk in adult sex offenders, substance abuse and child abuse, domestic violence, and child neglect. A multi-disciplinary decision-making model for professionals responding to child abuse and neglect was developed and presented at multiple professional gatherings.

For the coming year, the CAAN will be focusing on a yearlong course for mental health providers who work with abused and neglected children and their families. The course will attempt to integrate the various treatment modalities into an eclectic approach to treatment that is based on the individualized needs and capabilities of the child and adult clients. Providers attending this program must commit to providing training to their peers and developing professional peer support groups in order to assure the transfer of the knowledge gained at the training program.

Maine State Police/CPS Protocol

The Maine State Police and Child Protective Services have the joint responsibility of investigating child death cases where the cause of death may be homicide. To assure that effective collaboration occur on these difficult and often complex cases, the two agencies developed a protocol to cover Investigation/assessments, procedures for the release and sharing of information, as well as conflict resolution.

In practice, this protocol has worked well and been used to resolve some critical conflicts resulting in better investigative outcomes. This is a dynamic protocol that is changed to accommodate new laws and new circumstances.

Children's Emergency Response Program

BCFS entered into contracts in 1992 with the Lewiston and Portland police departments. Under the contract, the Bureau agreed to provide funds to these police departments for the hiring of an officer whose primary purpose is early intervention in families in order to identify and ameliorate problems early on, thereby preventing and/or reducing the risk of abuse and neglect. Working closely with the Bureau, the officers conduct an initial assessment and make referrals as appropriate.

Additionally, the officers work with Bureau caseworkers in the investigation of sexual abuse cases, emergency interventions and the court-ordered removal of children from their homes as necessary.

System Access Pilot

This pilot project was initiated through a memorandum of understanding between the Commissioners of the DHS and the DMHMRSAS. The

program is designed to provide a new system for accessing emergency out-of-home placements when children are experiencing a mental health crisis. Through contracts with Sweetser Children's Services in Cumberland County and with Crisis Response Services in York County, services are provided to: determine the child's needs for an out-of-home placement (on-site) whether or not the child is in the State's custody, authorize and arrange for the placement to be made and follow through with the resolution of the crisis if the child is in State's custody.

Adoption

The Adoption Program has actively worked with the Department of Behavioral and Developmental Services to provide specialized training to the targeted case managers to provide the most effective and efficient support services to Adoptive families who have legalized.

Independent Living

Chafee Independent Living Program staff work collaboratively with and refer youth to numerous other state department and community-based programs. Examples include the state's Career Centers under the Department of Labor, Vocational Rehabilitation Services, the Department of Behavioral and Developmental Services, Work Opportunities Unlimited, etc. In addition to these coordinated efforts, the Chafee Foster Care Independence Act requires that the state coordinate with each Native American tribe and band in Maine to develop independent living preparation services for youth under their system of care. Discussion and planning meetings have occurred between Bureau management staff and members of the Wabanaki coalition in Maine.

Interstate Compact on the Placement of Children

ICPC as excellent example of coordination between states because the applicable laws cited above were enacted verbatim in every state in the USA, including the District of Columbia and the U.S. Virgin Islands.

Currently Puerto Rico is working on adopting the same legislation and is working cooperatively with the other active members in the placement of children between member jurisdictions. This DCA is also working cooperatively with the Canadian Provinces of Nova Scotia and New Brunswick, which have similar programs. The national association is the Association of Administrators of the Interstate Compact on the Placement of Children. That is a subdivision of the American Public Human Services Association. This association has worked cooperatively with children's court judges through the National Counsel of Juvenile and Family Court

Judges. We also invite representatives from the American Academy of Adoption Attorneys to participate in our annual meetings and work with them in joint committees.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

The Bureau of Child and Family Services and all programs in it relate to any or all of the following:

1. Children reported and/or found to be abused and neglected and their families
2. Individuals mandated by law to report child abuse and neglect.
3. Any individual wishing to make a report of abuse and neglect
4. Children and their families
5. Children in the legal custody of the Maine Department of Human Services
6. The General Public
7. Foster Parents Providers who provide services (medical, mental health, educators, therapist, child placing agencies, law enforcement etc)
8. Adoption Program has opened the Parent/Children's Support Group to all adopting families regardless of what type of adoption they were involved in (international, domestic, kinship, or independent)
9. Independent Living works with children between ages 15-21

I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

This section pertains to the entire Bureau of Child and Family Services.

The Bureau of Child and Family Services partners with both public and private agencies to provide the needed services for the children and

families that we serve. Child Protective Services contracts with other agencies to provide services to those families that pose a low to moderate risk of abuse. Child Protective Services had reached a point in 1998 where almost 3,800 specific reports of child abuse and neglect were not assigned for assessment. The number of reports had increased beyond the system's ability to respond. The Bureau, after a competitive bidding process, awarded contracts to several agencies throughout the State, which respond to reports of abuse and neglect that appear at the time of the report to be of low or low/moderate severity. These agencies, which became known as Community Intervention Agencies, conduct a family assessment with a focus on the reported abuse and neglect and then provide direct services to the family or arrange for other community agencies to provide the necessary services. The agencies now receive about 4,300 reports from the Bureau. This allows BCFS the ability to focus its resources on those families that require DHS intervention.

The Bureau also partners with child placing agencies to provide therapeutic placements and interventions to the children and families we serve.

The Bureau has established effective public/private partnerships with all of the private non-profit adoption agencies in Maine. These purchased services include recruitment of new adoptive and foster family resources, child specific recruitment efforts, home studies, supervision of adoptive placements and post adoptive services.

The Bureau has a "child welfare demonstration project" in partnership with Casey Family Services and the Muskie School of the University of Southern Maine. This project allows us to enhance our capacity to provide support to adoptive families post-legalization, as well as research and plan for the services that make a difference in supporting adoptive families over an extended time.

The Chafee Independent Living Program has trained all of it's contracted treatment foster care and group and residential care providers (June 2000) to conduct life skills assessments and develop independent living case plans for each youth in their care beginning at age 16. All of these care providers are now using the assessment and teaching model with the youth in their care. In addition, the Independent Living Program Manager and other Bureau of Child and Family Services staff have been working with foster care service providers such as Good-Will Hinckley and other agency programs to develop more community based apartment living programs for youth who continue in voluntary care between the

ages of 18 and 21. More of these types of programs now exist and are providing quality services for these older youth in care.

ICPC is by Regulation No. 5 required to be a "central state compact office". In Maine this is within the Department of Human Services. Privatization was considered and explored for the private Licensed Child Placing Agency referrals as has been done by other states. But the numbers of such referrals decreased so greatly between the time this was first considered to the time we were working on the issue, that it wasn't feasible for this one person unit to a significant amount of time to such a small percentage of the workload. The drop was mostly attributed to the discovery that a high number of CPA referrals were for children from other countries who had had an adoption previously completed in the other country and hence did not require ICPC processing. We have however, started a pilot in Northern Maine whereby training efforts have been concentrated on one caseworker who coordinates all ICPC referrals from the 3 District Offices in that county to and from ICPC. This has worked very well because it eliminates the DCA's need to train each caseworker that has a child needing placement in another member's jurisdiction.

J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

This section pertains to the entire Bureau of Child and Family Services.

The most significant emerging issue for the Bureau is the reality that additional services cannot be provided without an increase in resources. Many of the issues raised during recent hearings are issues that can be rectified with increased staff and other resources.

The increased use of private agencies to carry out what previously had been State functions requires a different type of quality assurance and span of control. The multiple systems of accountability and monitoring to which the Bureau responds, takes staff time and Bureau resources away from direct service supervision and management activities. At the same time that cases have become more complex and difficult, often combining violence, drugs and mental illness, activities related to various kinds of oversight have also significantly increased. While the need is for highly skilled and experienced staff, high turnover related to workload and other personnel issues, has severely limited the Bureau's ability to meet that need. Additionally, our information system is not set up to

readily provide the kind of aggregate information required to satisfy accountability demands.

There may be an emerging political and public perception that many more serious child abuse and neglect cases could be resolved without court intervention and many more children could be returned home sooner if services were provided to families more effectively. An additional aspect of this perception is that the DHS is too aggressive and unfeeling, that parents do not have a strong enough voice in the process and that there are children in foster care unnecessarily. It will be important to use data to present an accurate picture of the issue of child abuse and neglect in Maine. An over emphasis on parent's rights could result in policy changes that compromise child safety.

As the population of Maine becomes more diverse, our capacity to provide services to a much wider range of cultures must be enhanced.

The Bureau is undergoing an effort to standardize the level of care that children in state custody receive. The first of the two reasons for this initiative is the recognition that there is a very high percentage of children in high level, costly placements for long periods of time. Second, children should be in placements best designed to meet their needs. Without a structured system for assessing children's placement needs, we can not be sure that the placement comes as close as we can to meeting the specific needs of the child. This is a major undertaking and the BCFS has created a new position located at the BCFS Central Office to specifically address this issue. The Bureau is also scheduled to have the Federal Child and Family Service Review in the year 2003 and there are efforts taking place to ensure that required outcome measures are identified and that our SACWIS system, MACWIS, is able to assist in these measures and goals. Another major initiative that is occurring is our effort to be HIPAA compliant in the coming year.

There is increasing demand for due process at all levels of CPS work. This will become a major workload and resource issue.

Similarly there is increased demand for access to records, particularly historical information. Developing a system to accommodate this need will be costly.

The latest federal requirements of our state plan now include a mandatory count of the children from international adoptions who enter DHS custody after their legalized adoption. This is a result of a new federal law called "The Inter-Country Adoption Act" [ICAA] of 2000 P.L.

106-279. We must describe the activities that DHS has undertaken for children adopted from other counties, including the provision of adoption and post-adoption services. We must also report the numbers and reason for the child's adoption having dissolved or disrupted, as well as identifying the agency handling the adoption and the plans for the child.

The total number of older youth in care has grown by about 100 youth per year during the past few years. The current number of older youth in care between the ages of 15 and 21 is near 1,000. It is becoming increasingly difficult to provide all older youth in care with the specialized independent living preparation services of an experienced Life Skills

Educator. There are not enough federal funds available in the current level of the Chafee Independence Act allocation to support any new Life Skills Educator positions. This is a growing problem.

Quality Assurance/Case Review continues to develop ways to provide the Bureau information concerning child welfare practice. This includes identification of strengths and areas needing improvement. One use for unit staff would be to develop systems to prepare the state for upcoming federal reviews and to further monitor state compliance with federal requirements. A system of doing "mock reviews" would help identify areas needing attention and activities that would help the state prepare for a federal review. The unit will be used to develop any reviews that would provide useful information to Bureau management.

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

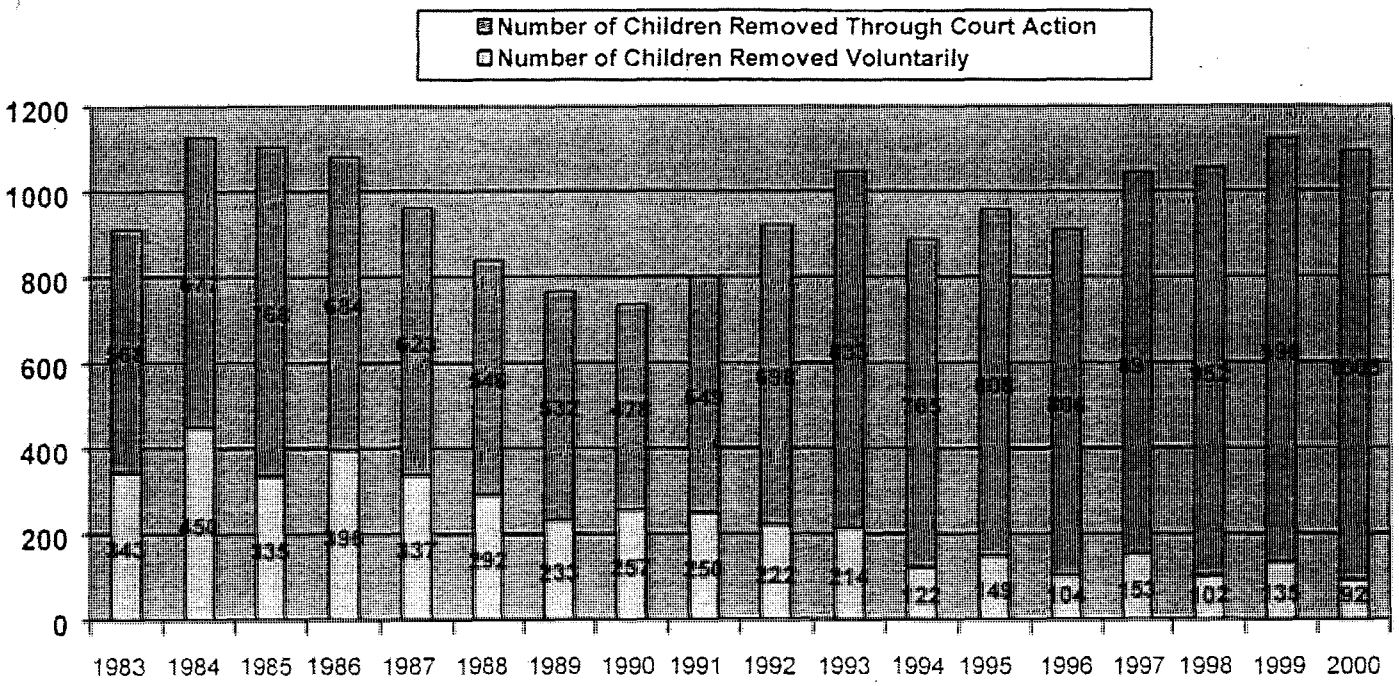
L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

The Bureau made significant efforts to ensure that out policy supports best practice and that the policy also mirrors that of State Laws (title 22 MRSA) as well as Federal Laws (ASFA). We are committed to delivering the highest quality of services to the children and families that we serve. The foster care licensing rules are currently being revised. One of the revisions reflects the changes in the federal law by the finalization rules governing the Adoption and Safe Families Act. These rules pertain to criminal histories of potential foster parent resources.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature

Number of Children Removed From Home

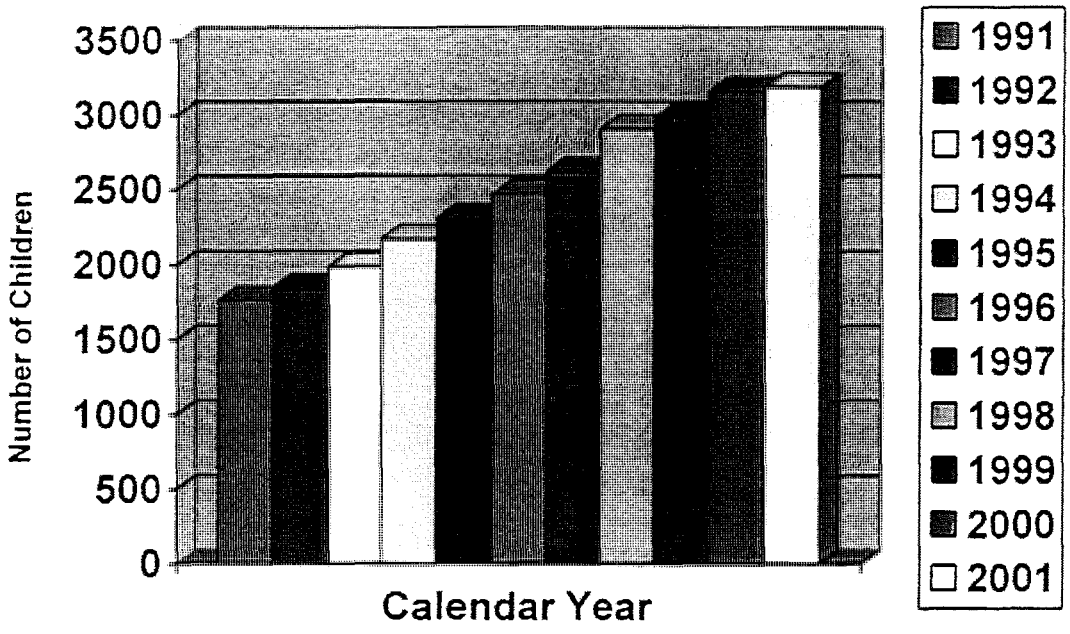


YEAR	NUMBER OF CHILDREN REMOVED VOLUNTARILY	NUMBER OF CHILDREN REMOVED THROUGH COURT ACTION
1983	343	568
1984	450	677
1985	335	768
1986	396	684
1987	337	623
1988	292	546
1989	233	532
1990	257	478
1991	250	549
1992	222	698
1993	214	833
1994	122	765
1995	149	808
1996	104	806
1997	153	891
1998	102	952
1999	135	990
2000	92	1003

Data Source: Child and Family Services Monitor

4/9/2001

Number of Children in DHS Care
As of January 1, 2001

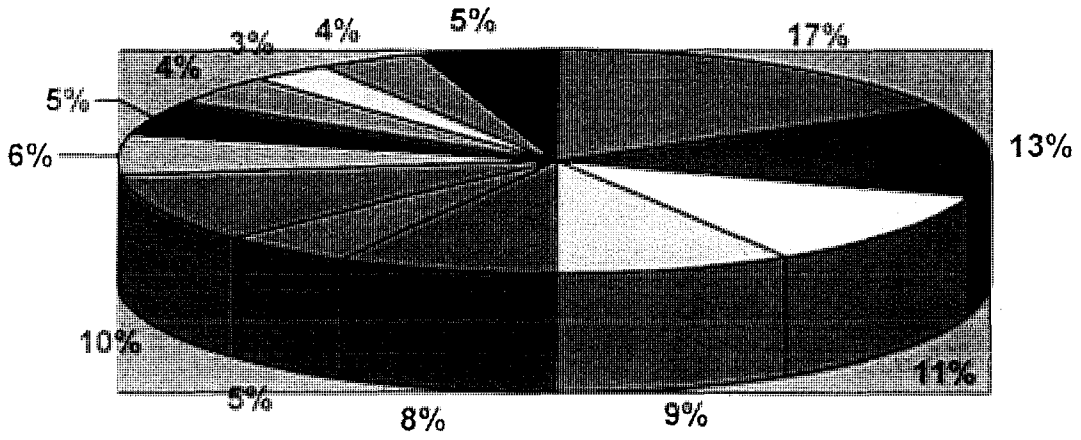


CALENDAR YEAR	NUMBER OF CHILDREN
1991	1763
1992	1847
1993	1989
1994	2172
1995	2312
1996	2472
1997	2623
1998	2908
1999	2982
2000	3161
2001	3190

Data Source: Legal Status Reports

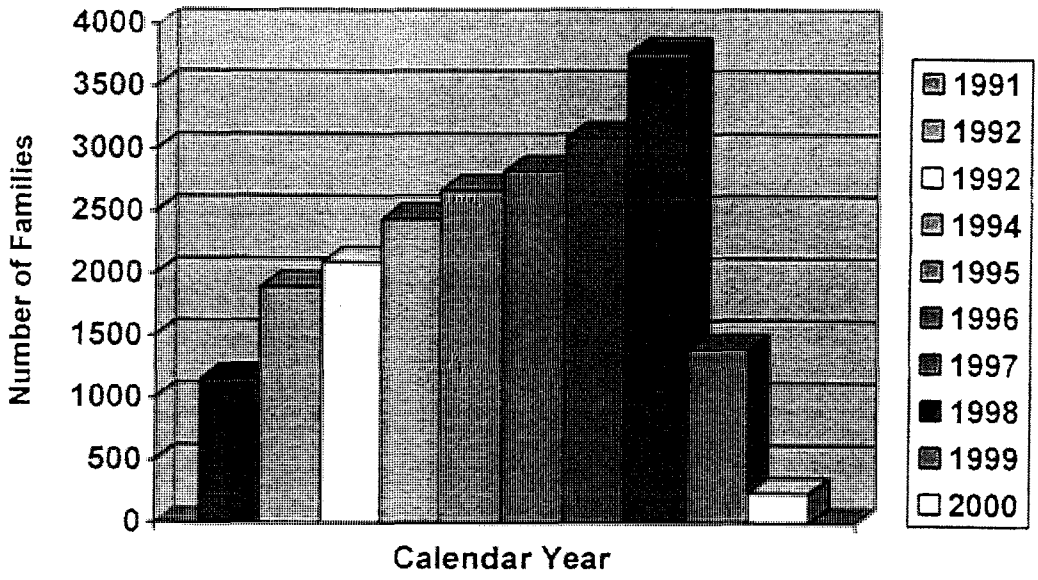
4/9/2001

Length of Time in Care



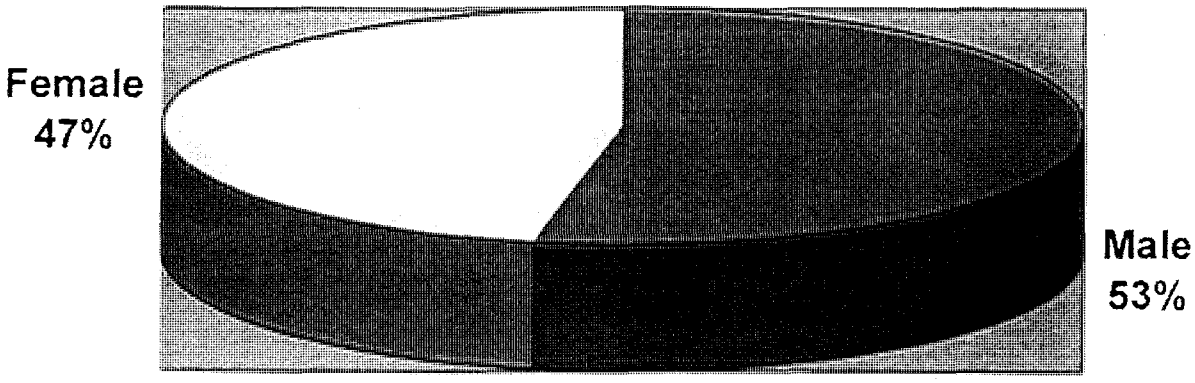
	LENGTH OF TIME IN CARE
Less than 6 months	17%
Six Months-One Year	13%
One Year-18 Months	11%
18 Months-2 Years	9%
2 Years-30 Months	8%
30 Months-36 Months	5%
3-4 Years	10%
4-5 Years	6%
5-6 Years	5%
6-7 Years	4%
7-8 Years	3%
8-10 Years	4%
10 Years and More	5%

Appropriate Referrals Not Assigned (PC40's)



CALENDAR YEAR	NUMBER OF FAMILIES
1991	1152
1992	1894
1993	2093
1994	2438
1995	2669
1996	2823
1997	3095
1998	3770
1999	1390
2000	241

Characteristics of Children in Care/Custody By Gender
As of April 2001



GENDER	CHILDREN IN CARE
Female	47%
Male	53%

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **Children Services**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Children Services
Title 22 MRSA Chapter 1071
Subchapter IV - Child and Family Services and Child Protection Act
Subchapter VI - Protection Orders
Subchapter V - Family Reunification
Subchapter VI - Termination of Parental Rights
Subchapter VII - Care of Child in Custody

B. DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM:

Children's Services

Program serves children in the care and custody of DHS who have been abused or neglected and are in out-of-home placements, including family foster homes, group homes, residential treatment homes and shelters. Emphasis is placed on meeting each child's individual needs and providing permanency plans through rehabilitation and reunification services to families or developing an alternative plan.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

Children Services

a) *Reunification and Rehabilitation Efforts*-The goal is to ameliorate the jeopardy in the family of origin so the child(ren) may be safely returned home.

b) *Safety and Well-Being* - Ensuring the child's needs are met and they are placed in a safe, nurturing environment that is the least restrictive setting able to meet their needs.

c) *Permanency Planning* - The goal is to ensure that a child has a permanent living situation. If the goal of reunification is

unsuccessful other permanent plans are made for the child, that may include termination of parental rights, freeing a child for adoption or other permanent plans as appropriate.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

Children Services

a) Reunification and Rehabilitation Efforts - This objective is measured and time framed in a several ways including: Child and Family Services Case Plan and progress in services; Judicial Reviews; Permanency Planning Hearings; Case Conferences; time frames for hearings and permanency planning are set forth through the Federal Adoption and Safe Families Act of 1997.

b) Safety and Well-Being - This objective is monitored internally, through team meetings, case planning and Safety and Well-Being reviews conducted by the caseworker every three months. These activities are overseen by through Supervision and by the courts during reviews.

c) Permanency Planning - This objective is met by providing services to the family of origin to work toward family reunification. Progress is monitored by the caseworker and overseen by the supervisor, as well as being monitored by the courts. The time frames to achieve permanency for a child are outlined in both state and federal law.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

Children Services

a) With regard to reunification and rehabilitation efforts the Bureau continues to improve in this area. While there is an increase of children being placed with parents, these efforts are more likely measured on a case-by- case basis as each situation is specific to the individual child(ren) and family issues.

b) The goal of safety and wellbeing has been substantially met. The Bureau has a compliance rate of 90% of wellbeing and safety checks and has incorporated this in the MACWIS system which provides a tool and a way to measure the success.

The goal of permanency planning has been substantially met. The Bureau continues to decrease the amount of time a child is in foster care.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See attached job classification and organization chart for the Bureau.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See Attached Summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED:

N/A for Children Services.

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVES AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE ARRANGEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS

See Question G under Child Protective Services.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

See Question H under Child Protective Services.

I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

See Question I under Child Protective Services

J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

See Question J under Child Protective Services

K. OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only to we comply with Title 22 MRSA, there are also specific IT policies in place that addresses this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

PROGRAM TITLE: **Foster Care Licensing**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Foster Care Licensing
Title 22 MRSA Subtitle 6 §8101 and §8102

Rules:
Foster Care Licensing
Chapter 16 - Rules Providing for the Licensing of Family Foster Homes for Children (10-DHS; 148-BCFS)
Chapter 16 - Family Foster Homes for Children
Chapter 15 - Rules Providing for the Licensing of Specialized Children's Foster Homes (10-DHS; 148 BCFS)
Chapter 15 - Specialized Children's Foster Homes

Federal Rules/Regulations:
Foster Care Licensing
Department of Health and Human Services, Administration for Children and Families 45 CFR §1355, §1356 and §1357 - TIV-E Foster Care Eligibility Reviews and Child and family Services State Plan Reviews (Regulations pertaining to the Adoption and Safe Families Act)
The Multi-Ethnic Placement Act
The Indian Children Welfare Act

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM:

Foster Care Licensing

Federal Law requires that all foster homes be licensed in order for a state to be eligible for Federal funding. The authority for licensure is left to the Sates. The Bureau has adopted licensing rules and strives to promote quality out-of-home foster care for Maine's children through equitable licensing practice. There are two categories of foster home licenses': Family Foster Homes and Specialized Children's Foster Homes. Foster home licensing is responsible for the initial licensure and renewal of foster home

licenses; ensuring that families comply with licensing rules; involved in the recruitment and retention of foster family resources.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

Foster Care Licensing

a) Ensuring that foster home licenses are renewed in a timely fashion with the goal of having no foster home license in renewal status as well as educating foster parents as to the importance of returning information required to renew licenses and make corrections as needed to the physical plant.

b) Ensuring that foster homes meet all compliance standards.

c) Investigating licensing violations as identified by the Institutional Abuse Unit or other Department staff in order to ensure the safety of children in foster home placements.

d) Taking corrective action if a home is out of compliance with licensing rules so as to ensure the safety of children in foster placements.

e) Ensuring that families applying for a foster home license understand the process and helping them to become a licensed resource so as to educate families interested in becoming a resource in the types of children served by the Department, expectations of foster families, and rules and regulations of the children.

f) Recruiting families that can meet the special needs of the children we serve, as well as reflecting the diversity of the children we serve.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

Foster Care Licensing

a) Ensuring that foster home licenses are renewed in a timely fashion is accomplished through the use of the automated tracking tool, supervision and Central Office oversight. The education of the foster parent community has been achieved through mailing to all foster parents, articles in the foster parent newsletter, through support groups and in conjunction with Child Placing Agencies.

b) The goal of ensuring that foster homes meet all compliance with licensing rules is achieved through monitoring the data on the automated tracking tool and through collaborative efforts with the Division of Health Engineering and the State Fire Marshall's Office.

c) The goal of investigating licensing violations is done through supervision and the use of MACWIS.

d) Taking appropriate corrective actions regarding foster homes in monitored through supervision

e) Ensuring that families applying for a foster home license understand the process is achieved through attendance at informational meetings, the home study process and pre-service training.

f) Recruiting families that can meet the special needs of the children is done through conducting recruitment activities in various geographical areas, well as reaching out to the different ethnic populations in Maine.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

Foster Care Licensing

The Bureau has substantially met the above goal as evidenced by the number of foster homes in full compliance that we were able to claim IV-E reimbursements. With regard to recruitment a great deal of work has been done however, it is too soon to judge the outcome measures.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See Attached Job Classification and Organizational Chart for the Bureau.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED:

Foster Care Licensing

1997 Regulatory Agenda; the rules were effective 4/20/98. The rules describe the procedures and standards of licensing family foster homes and specialized foster homes for children under 18 years of age.

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVES AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE ARRANGEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS

See Question G under Child Protective Services.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

See Question H under Child Protective Services.

I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

See Question I under Child Protective Services.

J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

See Question J under Child Protective Services

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only to we comply with Title 22 MRSA, there are also specific IT policies in place that addresses this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **ICPC (Interstate Compact for the Placement of Children)**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Interstate Compact for the Placement of Children
Title 22 MRSA Chapter 1153, §4191 through §4199, and §4241 through §4247
Regulations promulgated under Section 4197 - Article VII
Title 18-A, Article IX, §537-A (1 through 5)

Rules:
Interstate Compact for the Placement of Children
Chapter 19 - Providing for the Licensing of Child Placing Agencies With and Without Adoption Programs, 12.D.(3) (10-DHS; 148 BCFS)

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM

Interstate Compact for the Placement of Children

ICPC is a cooperative effort of all the states, which enacted the same state laws throughout the country. It is a program that allows Child Protective Services to extend its control and supervision of children in other jurisdictions and is closely tied in with the Adoption and Safe Families Act.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

N. Interstate Compact for the Placement of Children

To have children covered by the ICPC placed and supervised in accordance with the above laws and rules, and as described in the APHSA Training Manuals and in the Departments Policies, Section XV. D., in placements not contrary to their interests and protected by the means offered by those laws and rules and policies

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

O. ICPC (Interstate Compact for the Placement of Children)

Normal Referrals are to be sent to our District Offices or to the other state's ICPC Office within five days, as set by the above mentioned APHSA manual. Court Ordered Priority Studies are to be sent out within two business days of being received. Normal studies are to be completed within 30 business days by the previously mentioned standards. Regulation 7 studies are to be done in 20 business days in accordance with Regulation 7, which has the force of law. Children in agency adoption placements open to ICPC are supervised and progress reports written and sent through ICPC in accordance with Rules for the Licensing of Child Placing Agencies and the Department's policies.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

ICPC

In general, referrals are usually sent using the above-mentioned time frames. Supervision is, for the most part, done in a timely fashion though reports are sometimes late in being received. The greatest failure is not completing home studies in the time frames prescribed in the ICPC. This is generally due to staff shortages. Although this Department has contracted studies out to a private agency, the contracts don't require the private agency to complete the studies in the ICPC required time frames and they are not received for 4 to 10 months from the date assigned to our District Offices. This issue will be handled though our contracts with the agencies.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See attached job classification and organizational chart for the Bureau.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED:

N/A

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVE AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE AGREEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS

See Question G under Child Protective Services.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

See Question H under Program 1 - Child Protective Services

I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

This summary is defined in Question I under Child Protective Services.

J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

See Question J under Child Protective Services. This section summarizes emerging issues for the Bureau.

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only to we comply with Title 22 MRSA, there are also specific IT policies in place that addresses this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **Independent Living**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:

Independent Living

State of Maine Public Law 216 (H.P. 501 - L.D. 708 and H.P. 1909 - L.D. 2657 as amended)

Section 1 MRSA Chapter 429A - An Act to Provide Educational Opportunities for Persons Who Resided in Foster Care as Children

Federal Law:

Independent Living

Title IV-E of the Social Security Act - §471, §472, §474, §475, and §477

Title I - Improved Independent Living Program, P.L. 106-109

Foster Care Independence Act of 1999 governs the operation of the state's Independent Living Program

The Chafee Foster Care Independence Act of 1999 - P.L. 106-109 was enacted into law on December 14, 1999, amending section 477 of the Social Security Act.

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM

Independent Living

The Department of Human Services, Bureau of Child and Family Services administer the Chafee Foster Care Independence Program. Program priorities include: increasing the number of older youth in care who pursue post-secondary education and/or specific job skills training; continuing the work of the Youth Leadership Advisory Team to educate the public, care providers, and child welfare staff about the needs of all youth in care; advise policymakers with respect to policy and practice with youth in foster care; improve the service provider delivery system with regard to independent living preparation work with older youth in care; and continue collaborative work with other state departments and public and private service providers to improve post-foster care outcomes for older youth in the foster care system.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

Independent Living

a) Increasing the number of older youth in care who pursue post-secondary education and/or specific job skills training

b) Continuing the work of the Youth Leadership Advisory Team to educate the public, care providers, and child welfare staff about the needs of all youth in care and to advise policymakers with respect to policy and practice with youth in foster care.

c) Improve the service provider delivery system with regard to independent living preparation work with older youth in care

d) Continue collaborative work with other state department, public and private service providers to improve post-foster care outcomes for older youth in the foster care system.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

Independent Living

The Chafee Foster Care Independence Act of 1999, has mandated that states work with the HHS Administration for Children and Families to develop a formal outcome measure tracking system that will be fully implemented in the Fall of 2003. Outcome measure areas include level of employment, educational status, living arrangement, use of public welfare systems, etc. Work has begun and draft outcome measures have been developed and are being pilot tested in some selected states.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

Independent Living

The Chafee Foster Care Independence Program in Maine has experienced improved outcomes in the area of more youth in care participating in a post-secondary education program. The number of older youth in care participating in a post-secondary educational program has doubled over the past 2 years. The five-year-old Youth Leadership Advisory Team has been a great success in

terms of working with Bureau staff to educate adults within and outside the system with respect to the needs of children in the care of the system.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See attached job classification and organizational chart for the Bureau.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

The Bureau of Child and Family Services complies with all of the above Federal and State Laws and had dedicated state positions to oversee this compliance.

E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED:

N/A

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVE AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE AGREEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS

See Question G under Child Protective Services. This question pertains to entire Bureau of Child and Family Services.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

See Question H under Program 1 - Child Protective Services. This question pertains to the entire Bureau of Child and Family Services.

I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

This summary is defined in Question I under Child Protective Services.

J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

See Question J under Child Protective Services. This section summarizes emerging issues for the Bureau.

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

The Bureau abides by State Law with regard to the handling of all information that is case specific regardless if it is electronic or non-electronic in nature. Not only to we comply with Title 22 MRSA, there are also specific IT policies in place that addresses this issue. The laws and our policy specifically address the above issues. Our efforts at complying with HIPAA also address privacy and security issues.

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

PROGRAM TITLE: **Quality Assurance/Case Review**

A. ENABLING OR AUTHORIZING LAW OR OTHER RELEVANT MANDATE, INCLUDING ANY FEDERAL MANDATES.

State Law:
Quality Assurance/Case Review
Title 22 MRSA Chapter 1071 (Ensures compliance with all related Federal Laws and Rules).

B. A DESCRIPTION OF EACH PROGRAM ADMINISTERED BY THE AGENCY OR INDEPENDENT AGENCY, INCLUDING THE FOLLOWING FOR EACH PROGRAM

Quality Assurance/Case Review

The Case Review and Quality Assurance Unit located within BCFS provides ongoing internal assessment, data collection and feedback of the Bureau's compliance and performance regarding federal law and regulations, state law and agency policy. The Unit is comprised of eight managers located in districts throughout the state. In addition to the reviews outlined below, the unit often responds to specific requests for studies and reviews. The managers perform the following reviews: Internal; Long Term Foster Care Agreements; Administrative Cases; Therapeutic Foster Care Agencies; Community Intervention Agencies; and Substantiations.

B 1. ESTABLISHED PRIORITIES, INCLUDING THE GOALS AND OBJECTIVES IN MEETING EACH PRIORITY;

Quality Assurance

a) Each unit manager will conduct a minimum of ten internal reviews per month in their assigned districts. Data generated from these internal reviews is then documented on a monthly grid that is then provided to program administrators and Bureau management staff.

b) Unit managers conduct case assessments for clients that are being considered for the permanency goal of a long-term foster care agreement. Written recommendations are provided to district supervisors and program administrators. These reviews are done upon request of district staff and are to be completed within a month of the request.

c) Yearly case reviews are conducted by unit managers on cases where the permanency plan is long-term foster care agreements. The court reviews these cases yearly. Cases that are reviewed every

six months by the court are exempt from the administrative case reviews.

d) Agency quality assurance reviews are done yearly with community therapeutic foster care agencies and community intervention agencies. Unit mangers assess the quality, timeliness and appropriateness of services provided to clients. Written recommendations are sent to agencies in an effort to improve the quality of the services they provide to clients.

e) Reviews of substantiation decisions conducted by unit managers must be completed within 45 days of the receipt of the appeal letter.

B 2. PERFORMANCE CRITERIA, TIMETABLES OR OTHER BENCHMARKS USED BY AGENCY TO MEASURE ITS PROGRESS IN ACHIEVING THE GOALS AND OBJECTIVES;

Quality Assurance/Case Review

Each unit manager identifies trends in child welfare practice related to state and federal policies through the monthly internal review process. This information is shared in writing with district program administrators and Bureau management staff.

Agency specific data is documented in a report done by the unit supervisor after each yearly review of the therapeutic foster care agencies and the community intervention agencies. Written recommendations are sent to the agencies along with a letter requesting that the agency develop a written plan to address the recommendations. The agency plan is used in follow up quality assurance reviews to determine the agency's progress in achieving goals and objectives.

The unit supervisor, prior to a letter being sent to the appellant, reviews reports written by unit managers documenting the decisions on substantiation appeals. These activities must meet the 45-day requirement.

B 3. AN ASSESSMENT BY THE AGENCY INDICATING THE EXTENT TO WHICH IT HAS MET THE GOALS AND OBJECTIVES, USING THE PEROFMRANCE CRITERIA. WHEN AN AGENCY HAS NOT MET ITS GOALS AND OBJECTIVES, THE AGENCY SHALL IDENTIFY THE REASONS FOR NOT MEETING THEM AND THE CORRECTIVE MEASURES THE AGENCY HAS TAKEN TO MEET THE GOALS AND OBJECTIVES.

Quality Assurance

All reviews conducted by the case review/quality assurance unit have specific timeframes for completion. If timeframes are not met, the unit supervisor will

determine the reason that the objective was not met and address this with the unit manager.

C. ORGANIZATIONAL STRUCTURE, INCLUDING A POSITION COUNT, A JOB CLASSIFICATION AND AN ORGANIZATIONAL FLOW CHART INDICATING LINES OF RESPONSIBILITY

See attached job classification and organizational chart for the Bureau.

D. COMPLIANCE WITH FEDERAL AND STATE HEALTH AND SAFETY LAWS, INCLUDING THE AMERICAN WITH DISABILITIES ACT, THE FEDERAL OCCUPATIONAL SAFETY AND HEALTH ACT, AFFIRMATIVE ACTION REQUIREMENTS AND WORKERS' COMPENSATION

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E. FINANCIAL SUMMARY, INCLUDING SOURCES OF FUNDING BY PROGRAM AND THE AMOUNTS ALLOCATED OR APPROPRIATED AND EXPENDED OVER THE PAST 10 YEARS

See attached financial summary for the Bureau.

F. WHEN APPLICABLE, THE REGULATORY AGENDA AND THE SUMMARY OF RULES ADOPTED:

N/A

G. IDENTIFICATION OF THOSE AREAS WHERE AN AGENCY HAS COORDINATED ITS EFFORTS WITH OTHER STATE AND FEDERAL AGENCIES IN ACHIEVING PROGRAM OBJECTIVE AND OTHER AREAS IN WHICH AN AGENCY COULD ESTABLISH COOPERATIVE ARRANGEMENTS, INCLUDING, BUT NOT LIMITED TO, COOPERATIVE AGREEMENTS TO COORDINATE SERVICES AND ELIMINATE REDUNDANT REQUIREMENTS

See Question G under Child Protective Services. This question pertains to the entire Bureau of Child and Family Services.

H. IDENTIFICATION OF THE CONSTITUENCIES SERVED BY THE AGENCY OR PROGRAM, NOTING ANY CHANGES OR PROJECTED CHANGES.

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I. A SUMMARY OF EFFORT BY AN AGENCY OR PROGRAM REGARDING THE USE OF ALTERNATIVE DELIVERY SYSTEMS, INCLUDING PRIVATIZATION IN MEETING ITS GOALS AND OBJECTIVES.

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J. IDENTIFICATION OF EMERGING ISSUES FOR THE AGENCY OR PROGRAM IN THE COMING YEAR.

See Question J under Child Protective Services.

K. ANY OTHER INFORMATION SPECIFICALLY REQUESTED BY THE COMMITTEE OF JURISDICTION.

N/A

L. A COMPARISON OF ANY RELATED FEDERAL LAWS AND REGULATIONS TO THE STATE LAWS GOVERNING THE AGENCY OR PROGRAM AND THE RULES IMPLEMENTED BY THE AGENCY OR PROGRAM.

See Question L under Child Protective Services.

M. AGENCY POLICIES FOR COLLECTING, MANAGING AND USING PERSONAL INFORMATION OVER THE INTERNET AND NON-ELECTRONICALLY, INFORMATION ON THE AGENCY'S IMPLEMENTATION OF INFORMATION TECHNOLOGIES AND AN EVALUATION OF THE AGENCY'S ADHERENCE TO THE FAIR INFORMATION PRACTICE PRINCIPLES OF NOTICE, CHOICE, ACCESS, INTEGRITY AND ENFORCEMENT.

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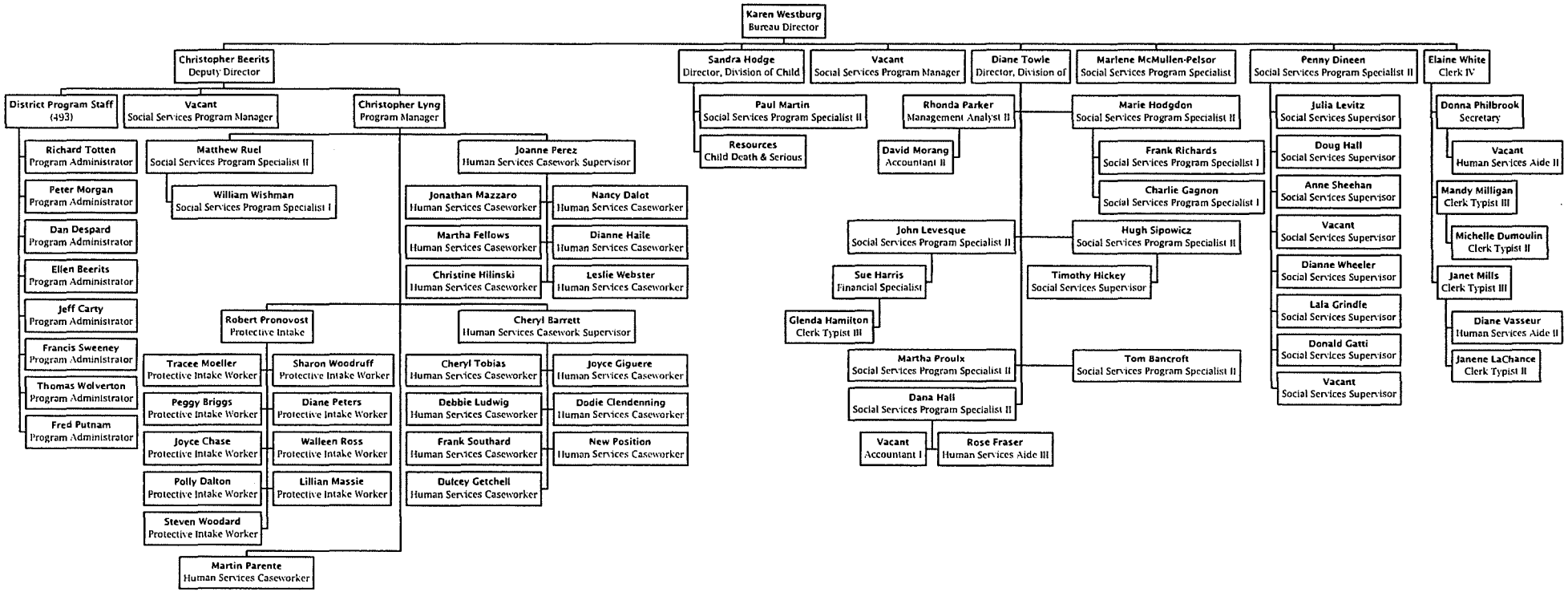
DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES

Position Count	Job Classification
1	Assistant Director of Human Services
1	Director Bureau of Child and Family Services
2	Deputy Director Bureau of Child and Family Services
2	Director Division of Child Welfare
2	Social Services Manager I
11	Social Services Supervisor
2	Social Services Program Manager
11	Social Services Program Specialist II (includes 2 project positions-end date 4/12/02)
3	Social Services Program Specialist I
8	Program Administrator Protective Services
1	Protective Intake Program Supervisor
8	Protective Intake Worker
20	Community Care Worker
1	Paralegal Assistant
62	Human Services Caseworker Supervisor
368	Human Services Caseworker
1	Management Analyst II
1	Accountant II
1	Accountant I
1	Financial Resources Specialist
1	Clerk IV
1	Secretary
3	Clerk Typist III
1.5	Clerk Typist II
26	Human Services Aide II
15	Human Services Aide III
553.5	**Total Position Count**

Maine Department of Human Services
Bureau of Child and Family Services
Augusta Central Office



DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	BUREAU OF CHILD AND FAMILY SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0128	AID TO CHARITABLE INSTITUTIONS	284,000	251,207	284,000	215,571	278,432	339,523	278,432	245,057	303,037	278,264
0137	FOSTER CARE	2,937,889	2,937,889	4,333,606	4,333,606	6,240,582	6,240,582	8,182,022	8,182,022	8,608,503	8,574,326
0139	CHILD WELFARE SERVICES	8,359,875	8,359,875	9,780,112	9,780,112	13,366,989	13,366,989	15,875,734	15,875,734	16,616,209	16,202,970
0307	CHILD & FAMILY SERVICES - CENTRAL	3,190,719	2,459,184	3,381,240	2,531,169	3,203,792.0	2,477,371	3,186,813	2,627,247	2,955,533	2,952,046
0452	CHILD & FAMILY SERVICES - REGIONAL	16,388,811	14,966,480	17,534,732	15,797,957	18857139	15,677,740	18,818,358	17,225,132	18,758,088	18,208,363
	GENERAL FUND TOTAL:	31,161,294	28,974,635	35,313,690	32,658,416	41,946,934	38,102,205	46,341,359	44,155,192	47,241,370	46,215,969
0137	FOSTER CARE	11,221,285	10,115,276	11,619,954	11,619,954	12,836,176	12,379,270	15,022,130	15,022,130	21,546,039	19,955,115
0139	CHILD WELFARE SERVICES	1,516,664	1,308,940	1,667,527	1,349,961	1,679,562	1,418,090	16,695,858	1,618,182	4,412,229	4,140,709
0307-01	CHILD & FAMILY SERVICES - CENTRAL	1,410,946	826,749	1,423,591	906,374	1,207,904	1,110,528	1,255,227	1,154,894	3,319,075	2,186,892
0452	CHILD & FAMILY SERVICES - REGIONAL										
	FEDERAL FUND TOTAL:	14,148,895	12,250,966	14,711,072	13,876,288	15,723,642	14,907,888	32,973,215	17,795,206	29,277,343	26,282,715
0137	FOSTER CARE	1,914,360	1,615,318	1,910,801	1,910,801	1,914,360	1,076,744	1,914,360	1,914,360	2,105,796	2,105,796
0139	CHILD WELFARE SERVICES		-								
0307	CHILD & FAMILY SERVICES - CENTRAL	156,970	131,544	156,958	22,195	156,444	25,923	156,658	18,135	29,638	21,107
0452	CHILD & FAMILY SERVICES - REGIONAL	154,350	115,763	162,067	1,874	162,067	-	162,067	-	64,409	168
	OTHER SPECIAL REVENUE TOTAL:	2,225,680	1,862,625	2,229,826	1,934,870	2,232,871	1,102,667	2,233,085	1,932,495	2,199,843	2,127,072
0307	CHILD & FAMILY SERVICES CENTRAL	11,746	11,746	213,894	213,894	335,845	246,877	338,300	248,325	353,983	296,645
	BLOCK GRANT TOTAL:	11,746	11,746	213,894	213,894	335,845	246,877	338,300	248,325	353,983	296,645
	GRAND TOTAL	**47,547,615**	**43,099,971**	**52,468,482**	**48,683,468**	**60,239,292**	**54,359,637**	**81,885,959**	**64,131,218**	**79,072,539**	**74,922,402**

DEPARTMENT OF HUMAN SERVICES
BUREAU OF CHILD AND FAMILY SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	BUREAU OF CHILD AND FAMILY SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0128	AID TO CHARITABLE INSTITUTIONS	278,517	257,339	278,432	262,301	281,420	281,420	279,342	279,341	279,200	270,728
0137	FOSTER CARE	10,458,198	10,307,627	11,569,857	10,990,991	13,974,144	13,847,696	17,565,378	15,432,758	20,677,472	17,873,127
0139	CHILD WELFARE SERVICES	21,905,525	20,036,297	23,982,564	23,114,181	25,471,293	23,637,101	26,901,898	24,144,369	31,338,583	30,335,714
0307	CHILD & FAMILY SERVICES - CENTRAL	1,408,199	1,279,277	1,390,089	1,349,153	1,474,184	1,299,346	1,687,650	1,483,616	1,455,124	1,447,048
0452	CHILD & FAMILY SERVICES - REGIONAL	19,920,930	19,075,856	20,043,396	20,043,005	20,736,495	20,096,917	20,766,009	20,545,676	21,947,670	21,924,927
	GENERAL FUND TOTAL:	53,971,369	50,956,396	57,264,338	55,759,630	61,937,536	59,162,481	67,200,277	61,885,760	75,698,049	71,851,545
0137	FOSTER CARE	24,133,373	23,799,808	30,927,373	30,750,058	32,440,779	31,856,009	40,843,095	38,237,996	40,808,351	39,782,886
0139	CHILD WELFARE SERVICES	4,809,570	3,329,449	2,927,979	2,629,236	2,963,696	2,028,906	2,483,705	1,301,445	2,647,382	2,376,957
0307-01	CHILD & FAMILY SERVICES - CENTRAL	10,560,338	10,343,234	13,096,369	10,986,328	7,198,525	6,360,471	7,750,301	7,515,968	9,068,081	8,614,176
0452	CHILD & FAMILY SERVICES - REGIONAL		-					524,655	83,654	546,167	351,193
	FEDERAL FUND TOTAL:	39,503,281	37,472,491	46,951,721	44,365,623	42,603,000	40,245,385	51,601,756	47,139,064	53,069,981	51,125,211
0137	FOSTER CARE	2,316,376	2,316,376	2,740,296	2,740,291	2,849,363	1,958,825	3,788,624	3,788,623	3,111,845	3,111,845
0139	CHILD WELFARE SERVICES	500	-							4,500,000	405,641
0307	CHILD & FAMILY SERVICES - CENTRAL	2,906,193	2,900,427	6,334,792	4,676,309	2,417,879	2,154,448	2,419,808	2,065,238	2,234,854	2,181,460
0452	CHILD & FAMILY SERVICES - REGIONAL	149,287	-	152,103	38,436	153,624	8,254	39,694	39,694	40,847	40,826
	OTHER SPECIAL REVENUE TOTAL:	5,372,356	5,216,803	9,227,191	7,455,036	5,420,866	4,121,528	6,248,126	5,893,555	9,887,546	5,739,772
0307	CHILD & FAMILY SERVICES CENTRAL	3,525,211	2,418,806	440,187	430,433	52,989	51,779				
	BLOCK GRANT TOTAL:	3,525,211	2,418,806	440,187	430,433	52,989	51,779	-	-	-	-
	GRAND TOTAL	**102,372,217**	**96,064,496**	**113,883,437**	**108,010,722**	**110,014,391**	**103,581,173**	**125,050,159**	**114,918,379**	**138,655,576**	**128,716,528**

BUREAU OF ELDER AND ADULT SERVICES

Adult Protective Services

Advocacy

Community Services

Disability Determination Services

Home and Community/Long Term Care

Resource Development/Assisted Living

BUREAU OF ELDER AND ADULT SERVICES
PROGRAM EVALUATION REPORT

Program Title: **Adult Protective Services**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

The Bureau of Elder and Adult Services in the Maine Department of Human Services (DHS) is the designated State Agency (SA) responsible, under the direction of the Commissioner of the Department of Human Services, for planning, coordination and implementation of all activities in the State pursuant to:
Older Americans Act of 1965; and
Title 22 M.R.S.A. c. 1451, 1453, 1455, 1457 and 1665
Title 22 M.R.S.A. c. 958-A
Title 22 M.R.S.A. c. 1621, 1623, 1625
Title 22 M.R.S.A. c. 103
Title 24-A c.

BEAS factual and policy basis are the authority and requirements conferred by the following Federal and State laws and regulations:

(1) Public Law 89-73 Older Americans Act of 1965, As Amended
(2) Title 45 of the Code of Federal Regulations:
Part 16 - Procedures of the Departmental Grant Appeals Board;
Part 74 - Administration of Grants, except Subpart N;
Part 80 - Nondiscrimination under Programs receiving Federal Assistance through the Department of Health, Education, and Welfare: Effectuation of Title VI of the Civil rights Act of 1964;
Part 81 - Practice and Procedure for Hearings under Part 80 of this Title;
Part 84 - Nondiscrimination on the Basis of Handicap in Programs and activities receiving or benefiting from Federal Financial Assistance; and
Part 90 - Nondiscrimination on the Basis of Age; and
Part 100- Intergovernmental Review of Department of Health and Human Services Programs and Activities;
Part 1321 - Grants to State and Community Programs on Aging.
(3) Title 5 of the Code of Federal Regulations, Part 900, Subpart F, Standards for a Merit System of Personnel Administration.
(4) The Privacy Act, 5 U.S.C.A. Section 552a.
(5) The Freedom of Information Act, 5 U.S.C.A. Section 552.
(6) Section 504 of the Rehabilitation Act, 29 U.S.C.A. Section 794.
(7) Freedom of Access Law, 1 M.R.S.A. Section 401 et seq.
(8) Priority Social Services Program, 22 M.R.S.A. c. 1501 and 1503.

(9) Bureau of Elder and Adult Services, Title 22 M.R.S.A. c. 1453.
(10) Omnibus Budget Reconciliation Act of 1981, Title XX of the Social Security Act, Block Grant to States for Social Services, 42 U.S.C.A. Section 1397.
(11) In-Home and Community Support Services for Adults With Long Term Care Needs, 22 M.R.S.A. Subtitle 5, c. 1621-1625.
(12) Title XIX of the Social Security Act as amended; 42 U.S.C.A. Section 1396 et seq.
(13) Congregate Housing Services Program, 22 M.R.S.A. Chapter 1665, Section 7901-B (Assisted Living Program) and Section 7915(Congregate Housing).
(14) "An Act to Expand the Number of Elder Volunteers in the Retired Senior Volunteer Programs, Foster Grandparent Programs and the Senior Companion Program," P.L. 1985 c. 461.
(15) Maine Uniform Accounting and Auditing Practices Act for Community Agencies Title 5, Chapter 148-C.
(16) A-87, Cost Principles for State and Local Governments.
(17) A-110, Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-Profit Organizations, Issued November 29, 1993.
(18) A-122, Cost Principles for Non-Profit Organizations.
(19) A-133, Audits of Institutions of Higher Education and Other Non-Profit Institutions, Issued April 30, 1996.
(20) A-21, Cost Principles for Educational Institutions.
(21) A-88, Indirect Cost Rates, Audit and Audit Follow-up at Education Institutions.
(22) System of Performance Based Agreements for the Provision of Certain Social Services, 5 M.R.S.A., Section 2, Section 20005.A.
(23) Performance Budgeting, 5 M.R.S.A., Sections 1710- P and Q.
(24) BME Fiscal Policy and Procedures Manual and any revision thereto.
(25) Administrative Procedures Act as required under Title 5 M.R.S.A. c. 375 and 377

B. A description of each program administered by the agency or independent agency.

Goal

To assist elder and adults with disabilities to remain independent and to protect incapacitated and dependent adults from neglect, abuse and exploitation.

Objective

Maintain a level of supports and services for Maine's elders and adults with disabilities to improve their opportunities for independence and safety.

Adult Protective Services

Works with dependent and incapacitated adults, age 18+, who are at risk of abuse, neglect or exploitation. Services are provided by staff located in DHS regional offices statewide.

1. Established priorities, including goals and objectives in meeting each priority:

- Design and implement an Adult Services Automated Information system
- Advocate for statutory changes to facilitate prosecution of perpetrators of adult abuse and neglect
- Coordinate with programs serving victims of domestic violence in order to improve services to older victims.
- Use information from Adult Protective Services time study and other sources to improve planning for allocation of staff and program resources
- Obtain continued funding for Assistant Attorney General staff to assist with investigations of financial exploitation cases
- Increase number of persons from varying cultural backgrounds who are employed in and receive aging services

2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives.

Adult Protective Services investigations that result in service provision:
2000-01 = 83%
2001-02 = 87%
2002-03 = 87%

3. Assessment by the agency of the extent to which Adult Protective Services has met the goals and objectives, using the performance criteria:

- Provided protective and public guardianship services to 3675 clients.
- Adult Protective centralized intake call center in Houlton responded to more than 10,000 calls last year.
- Conducted a time study to assess caseworker workloads and to improve planning for allocation of staff and program resources.
- In partnership with the Maine Bankers Association, Maine Credit Union League and the Maine Association of Community Banks provided training to bank employees, chiefs of police, and probate judges on reporting financial exploitation.
- Co-sponsored with AARP, law enforcement and Office of the Attorney General several regional programs on preventing elder abuse.
- Obtained continued federal funding for an elder financial exploitation investigator in the AAG office.
- Provided training in elder abuse at Maine Criminal Justice Academy
- Coordinated DHS implementation activities under the AMHI Consent Decree.

- Worked with Dept of Behavioral and Developmental Services to improve coordination of services to older adults with mental illness or mental retardation and dementia
- Funded TRIAD projects, which are partnerships between law enforcement and seniors to promote crime prevention.
- Represent BEAS on the Domestic Violence and Sexual Assault Commission
- Sent two representatives to the first National Summit on Elder Abuse

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

<u>Adult Protective Services</u>

See attached job classification and organizational chart for the Bureau.

- Functions: Works with incapacitated or dependent adults, age 18+, who are at risk of abuse, neglect or exploitation. Services are provided by caseworkers located in DHS regional offices statewide.

D. **Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

The Bureau complies with all federal and state laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary.

F. **When applicable, the regulatory agenda and the summary of rules adopted.**

See answer to Question F in Adult Protective Services section.

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.**

See answer to Question F in Adult Protective Services section.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

See answer to Question H in Adult Protective Services section.

I. **A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.**

See answer to Question I in Adult Protective Services section.

J. **Identification of emerging issues in the coming years.**

See answer to Question J in Adult Protective Services section.

K. **Any other information specifically requested by the committee of jurisdiction.**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.**

N/A

M. **Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Bureau complies with all policies within the Department.

BUREAU OF ELDER AND ADULT SERVICES
PROGRAM EVALUATION REPORT

Program Title: Advocacy

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

See answer to Question A in Adult Protective Services section.

B. A description of each program administered by the agency or independent agency.

Advocacy

As the State Unit on Aging designated under the federal Older Americans Act, BEAS advocates for the needs of Maine's older citizens.

1. Established priorities, including goals and objectives in meeting each priority

- Advocate for legal reform on issues affecting the elderly in Maine
- Advocate for older people by working with the area agencies on aging, Legal Services for the Elderly, Long-Term Care Ombudsman Program, the Senior Legislative Advocacy Coalition, Maine Advisory Council on Elder Affairs, the State Independent Living Council and the Joint Advisory Committee on Select Services for Older Persons
- Contract for and monitor the provision of Legal Services for the Elderly and Long-Term Care Ombudsman Program
- Update Bureau of Elder and Adult Services publications such as Aging: Taking Care of Business and the Resource Directory for Older People in Maine

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives.

N/A

3. Assessment by the agency of the extent to which Advocacy has met the goals and objectives, using the performance criteria:

- Administering contracts with Legal Services for the Elderly and Long-term Care Ombudsman programs. The two programs served more than 7000 people last year.
- Issued Request for Proposal for the first statewide consumer satisfaction survey of nursing facility residents.
- Staffing the Bank Reporting project.

- Develop and distributed more than 30,000 copies of "Resource Directory for Older People in Maine," "Aging: Taking Care of Business, A Guide to Advance Directives," and "Home Care: Where to Find It."
- Staff the Department's Long-term Care Steering Committee, an all consumer committee that advises the Commissioner.
- Supported changes to Adult Protective and Endangering Welfare of Adults statutes to promote more effective response to adult abuse and neglect.
- Maintain an interactive website to provide information and assistance on local, state and national aging services.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See answer to Question F in Adult Protective Services section.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.

See answer to Question G in Adult Protective Services section.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

See answer to Question I in Adult Protective Services section.

J. Identification of emerging issues in the coming years.

See answer to Question J in Adult Protective Services section.

K. Any other information specifically requested by the committee of jurisdiction.

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

N/A

M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with all policies within the Department.

Program Title: **Community Services**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

See answer to Question A in Adult Protective Services section.

B. A description of each program administered by the agency or independent agency.

Community Services
Includes services such as nutrition, outreach, ombudsman, legal, employment, volunteer, transportation, and respite that assist older people to remain independent in their homes and communities.

1. Established priorities, including goals and objectives in meeting each priority:

- Work with the area agencies on aging to increase awareness about the extent of depression among older people and about the availability of treatment and services, and to develop volunteer friendly visitor services to help reduce the impact of isolation and loneliness among the elderly
- Implement the Older Americans Act Family Caregiver Initiative, building on Maine's existing state-funded respite programs
- Increase number of persons from varying cultural backgrounds who are employed in and receive aging services
- Cooperate with AARP to identify and develop more elder leadership for advocacy on public policy issues
- Work with the Bureaus of Medical Services and Family Independence in implementing Federal options that will enable people with disabilities to work and maintain Medicaid insurance coverage. Manage HCFA grant to study feasibility of expanding Medicaid for employed, disabled adults
- Collaborate with the Bureau of Health and other agencies to obtain funds to support initiatives to promote healthy lifestyles and reduce the impact of physical inactivity and poor eating habits
- Increase awareness of Medicare savings programs and assist people with the application process
- Increase the number of home delivered meals participants at high risk of malnutrition who get follow up counseling
- Improve transportation options for medical needs by determining the extent of need, advocate for additional funds, and promote the use of volunteers

- Increase number of Senior Community Service Employment Program (SCSEP) participants who find jobs in their communities
- Increase the number of consumers who report satisfaction with benefits counseling. Participate in and assist with staffing of the Governor's Retirement Industry Council
- Staff the planning committee for the 2001 Blaine House Conference on Aging
- Revise and expand the Bureau website to make it an easy-to-use source of public information on aging issues
- Work with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Joint Advisory Committee on Select Services for Older Persons to implement recommendations jointly submitted to the Legislature regarding the mental health and substance abuse service needs of older people, and the needs of aging persons with mental retardation and aging family caregivers
- Implement the new federally funded Alzheimer's Project to insure that Maine's long term care system is responsive to the needs of people with Alzheimer's Disease and other dementias and their family caregivers
- Assist the Department of Corrections to identify the need for long-term care services among the correctional population
- Work with the Area Agencies on Aging to generate interest in expanding the "Money Minder" program and explore with the Administration on Aging Regional Office implementation of their financial literacy initiative
- Review 2000 census data and update Older Americans Act funding distribution formula for Maine.

2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and

	2000-01	2001-02	2002-03
Maine Adults who use area agencies on aging as a source of information	34%	39%	40%
Meals on Wheels participants at high risk of malnutrition receiving follow-up counseling	25%	28%	30%
Older persons served as percentage of total elderly population in Maine	28%	30%	30%
Consumers reporting satisfaction with benefits counseling	70	74	75
Persons receiving transportation assistance	1,694	2,180	2,190

3. Assessment by the agency of the extent to which Community Services programs have met the goals and objectives, using the performance criteria:

- 14,000 persons received either Meals on Wheels, or attended a community dining center. A total of 1,159,767 meals were served.

- 38,000 people were assisted with information and counseling about health insurance and other benefits, including education on preventing Medicare and Medicare fraud and abuse.
- Implemented the new, federally-funded National Family Caregiver Support program in partnership with the five Area Agencies on Aging. The program will offer information to caregivers about available services, individual counseling, organization of support groups and caregiver training, respite care and supplemental services, on a limited basis, to complement the care provided by caregivers.
- Co-sponsored the Senior FarmShare program, with the Department of Agriculture, Cooperative Extension, the Area Agencies on Aging and other partners. The program provided 5,000 low-income seniors with "farm shares" with a local farmer of their choice. The shares enabled each senior to get $100 worth of fresh, locally grown fruits and vegetables from a local farmer during the growing season. It provided fresh food to seniors and was a great financial boost to local farmers. Participants also received recipes and nutritional tips through the Nutrition Network. Meals on Wheels, community meals sites for the elderly and food pantries also received produce from local farmers.
- Awarded funds to three Area Agencies on Aging to train older adults in techniques to avoid falls and other injuries. Falls account for a high percent of hospitalizations among older persons.
- BEAS and the Bureau of Family Independence were one of three states to receive a federal grant to assist eligible older persons to apply for Food Stamps.
- Conducted a statewide, comparative pricing survey for 15 frequently used prescription drugs.
- Revised and reissued the Prescription Drug booklet
- Provided staff support, along with the State Planning Office, for the Governor's Conference on Retirement and Aging held in October 2001.
- Provided additional funds to Area Agencies on Aging and Legal Services for the Elderly to expand their health insurance counseling programs.
- Awarded $100,000 in additional funds to aging agencies for nutrition programs.
- 89 low-income older persons were enrolled in the Senior Community Service Employment Program where they learned new skills and received support and assistance in their job search for unsubsidized employment. The BEAS SCSEP met the Federal placement goal of 20% of enrollees placed in unsubsidized employment.
- Sponsored a federally-funded Nutrition Education project to address the needs of elders at risk of malnutrition.
- Maine was one of only two states to receive continued funding for an Alzheimer's Disease Demonstration grant after having had a federally funded Alzheimer's Demonstration Project for seven years. The program funds dementia evaluation services statewide, caregiver respite services, and the specialized "Best Friends" approach to dementia care training for nursing homes, assisted living and home care staff.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

- Functions: Through contracts with five Area Agencies on Aging and other community providers, the Bureau' central office serves older people and disabled adults. It also provides services directly to incapacitated and dependent adults in danger of abuse, neglect, or exploitation. Program areas are: Adult Protective Services, Home and Community Based Care, Community Services, Certificate of Need for Long-term Care Projects and MaineNET

D. Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See answer to Question F in Adult Protective Services section.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.

See answer to Question G in Adult Protective Services section.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

See answer to Question I in Adult Protective Services section.

J. Identification of emerging issues in the coming years.

See answer to Question J in Adult Protective Services section.

K. Any other information specifically requested by the committee of jurisdiction.

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

N/A

M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with all policies within the Department.

Program Title: **Disability Determination Services**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

See answer to Question A in Adult Protective Services section.

B. A description of each program administered by the agency or independent agency.

Disability Determination Services

This program, which is funded with all federal funds, reviews and makes determinations on applications for disability payments under the Social Security program. The mission of the program is to provide quality, timely, and cost effective decisions to all claimants to social security disability benefits, in accordance with Social Security policy and procedures.

1. Established priorities, including goals and objectives in meeting each priority

- To provide high quality Social Security Disability decisions in a timely and cost effective manner.
- Train staff in new elements of the disability determination process
- Train and mentor staff to improve their ability to make quality medical assessments on cases
- Increase efficient use of medical consultant time
- Educate the public and advocacy groups about the disability determination process

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives.

	2000-01	2001-02	2002-03
Initial decision per year per reviewer	550	550	550
Average procession time at less than 70 days per case	68	68	68
Errors that affect decisions will be less than 5%	3%	3%	3%

3. Assessment by the agency of the extent to which Disability Determination Services has met the goals and objectives, using the performance criteria:

- Reviewed 19,006 cases with an average processing time of 74 days, which is below the national average of 91 days

- The accuracy rate for Maine DDS decisions was 96.6%, compared to a national accuracy average of 94.7%
- Medical costs per case were $91.93, compared to the national average of $108.69
- DDS processes the claims of Canadian citizens from Quebec and the Maritime Provinces who are eligible for Social Security benefits.
- DDS continues to participate in the Single Decision Maker pilot, which expands the authority of case deciders.
-

Staffing shortages have resulted in a significant back-log of cases, causing delays for disabled people eligible for benefits. Despite this, the Maine DDS continues to demonstrate excellent performance when compared to other DDS's across the nation.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

Disability Determination Services

See attached job classification and organizational chart for the Bureau.

- Functions: This program, which is funded with all federal funds, reviews and makes determinations on applications for disability payments under the Social Security Program.

D. Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See answer to Question F in Adult Protective Services section.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.

See answer to Question G in Adult Protective Service section.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. **A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.**

See answer to Question I in Adult Protective Services section.

J. **Identification of emerging issues in the coming years.**

See answer to Question J in Adult Protective Services section.

K. **Any other information specifically requested by the committee of jurisdiction.**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.**

N/A

M. **Agency policies for collecting, managing and using personal information over the internet and no electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Bureau complies with all policies within the Department.

Program Title: **Home and Community/Long Term Care**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

See answer to Question A in Adult Protective Services section.

B. A description of each program administered by the agency or independent agency.

Home and Community/Long-term Care

Promotes affordable home care options consistent with individual assessed needs to prevent or delay institutionalization.

1. Established priorities, including goals and objectives in meeting each priority:

- Advocate for system changes that will promote a qualified, stable home care workforce. Work with providers and Legislature to address the workforce issues regarding wages and benefits, dignity and respect for the job, and development of career ladders and opportunities for advancement
- Support the development of a system that will allow consumers and providers to easily obtain information about the training and experience of unlicensed assisted personnel
- Promote more consumer direction and control of home care services by adding a consumer-directed option to the Elderly and Adults with Disabilities Waivers by July 2001
- Work with consumers and providers to establish quality indicators for home care that build on indicators used for nursing homes and residential care facilities
- Amend rules for state and Medicaid home care programs to create more uniformity across programs in order to ease the transition for consumers moving from one funding source to another
- Identify ways to make greater use of technology, such as telemedicine, to assist consumers to remain at home
- Advocate for changes in the Nurse Practice Act to allow more flexible use of certified nursing assistants
- Support programs and policies that assist families as caregivers
- Design an acuity based system for authorizing home care service plans
- Increase public access to care giving information via the BEAS website
- Review Department long-term care pre-admission assessment policies to ensure compliance with the Olmstead court decision
- Participate in planning workgroup to ensure that Maine's plan for complying with the Olmstead decision reflects the needs of older adults

- Study feasibility of extending pre-admission screening to include residential care facilities
- Complete a Home and Community-based Waiver quality assurance plan to comply with new guidelines issued by the Health Care Financing Administration
- Coordinate with the Bureau of Medical Services to develop and implement methods of better managing health care services for Medicaid eligible elders and adults with disabilities.
-

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives.**

	2000-01	2001-02	2002-03
Home care consumers equal to or greater than 50% of total long-term care consumers	49%	54%	54%
Home care consumers who report having a choice of services	85%	92%	92%
Home care consumers who report that independence is maintained or improved	88%	90%	90%
Improve percent of service hours delivered to hours authorized per the assessment	80%	85%	85%
Per capita home care costs will remain at or below 40% of institutional care	21%	30%	35%

3. **Assessment by the agency of the extent to which Home and Community/Long-term Care has met the goals and objectives, using the performance criteria:**

- The number of persons served in home or non-institutional settings grew from 9858 in 1995 to 17,180 last year.
- Reduced Medicaid nursing homes census by 17% since 1995.
- Total long-term care spending grew an average of 4% per year, well below the national average of 7% per year.
- Established a uniform assessment process for state and Medicaid funded nursing home and home care services.
- Consolidated management of home care programs and reduced administrative costs by 30%.
- Implemented "Partners in Caring," a state funded respite service for families caring for persons with Alzheimer's disease or other dementia.
- Developed MECARE, a computerized system for determining eligibility and collecting data on who uses publicly funded long-term care services. MECARE provides more timely and accurate decisions for consumers and families.
- Expanded adult day services programs, which help family caregivers who work outside the home and provided funds for physical plant improvements.
- Promoted use of vouchers and other consumer-directed options for arranging services
- Awarded one-time funds to 45 home care agencies to assist with recruitment and retention of staff.

- Provided reimbursement to home care agencies for costs of training Personal Care Attendants in order to support efforts to recruit PCA.
- Supported proposed changes to the Nurse Practice Act that will allow more flexible use of Certified Nursing Assistants in home care.
- Maine was one of three states chosen to serve on the federal advisory committee for home and community based care
- Obtained continued federal funding for "CHOICES,"a grant which promotes access to competitive employment for adults with disabilities. More than 700 adults with disabilities have participated in the Department's Medicaid for Workers with Disabilities Option.
- Participated on the Plan Development Work Group for Community-based Living, which will recommend policies and programs to promote community-based living options for all persons with disabilities.
- Received a grant from the Mental Health Funding Collaborative/Bingham Foundation to study use of psychotropic drugs among home care consumers.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for the Bureau.

D. **Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

The Bureau complies with all federal and state laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted.**

See answer to Question F in Adult Protective Services section.

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.**

See answer to Question G in Adult Protective Services section.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. Summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

See answer to Question I in Adult Protective Services section.

J. Identification of emerging issues in the coming years.

See answer to Question J in Adult Protective Services section.

K. Any other information specifically requested by the committee of jurisdiction.

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

N/A

M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with all policies within the Department.

D. Compliance with federal and state health...compensation (to be inserted at 221)

E. Financial Summary (to be inserted by John M.)

F. Regulatory Agenda for 2001-2002

For
October 1, 2001 to October 1, 2002

AGENCY UMBRELLA -UNIT NUMBER: 10-149

AGENCY NAME: Bureau of Elder and Adult Services (BEAS)

CONTACT PERSON: Betty Forsythe, Assistant to the Director, #11 State House Station, Augusta, ME 04333-0011. Tel: (207) 624-5335

EMERGENCY RULES ADOPTED SINCE THE LAST AGENDA: None

EXPECTED OCTOBER 1, 2001 to OCTOBER 1, 2001 RULE-MAKING ACTIVITY:

CHAPTER 5: BEAS Policy Manual:
BEAS will amend Section 61 - Adult Day Services, Section 62 - Congregate Housing Services, Section 63 - In-home and Community Support Services for Elderly and Other Adults, Section 68 - Respite Care for People with Alzheimer's or Related Disorders, Section 69 - BEAS Administered Homemaker Services, Section 73 - Personal Care Assistance for Severely Disabled Adults and Section 74 - Assisted Living Services Programs to conform the rules with waivers of rules made pursuant to Section 40.09 of the manual after final adoption in January 2, 2001 and in Sections 63, 73 and 74 to comply with legislative directives. It will also amend Section 71 - Certificate of Need regarding the standards for project approval and to conform the rules with waivers made pursuant to Section 40.09 of the manual. Chapter 5 will also be amended to reflect other policy and statutory changes.

CHAPTER 113: Pursuant to action taken by the First Regular Session of the 120th Legislature, Assisted Living Licensing will be transferred from the Bureau of Medical Services to the Bureau of Elder and Adult Services.

CHAPTER 117: Pursuant to action taken by the First Regular Session of the 120th Legislature, Adult Day Care Licensing will be transferred from the Bureau of Medical Services to the Bureau of Elder and Adult Services.

CHAPTER 121: Pursuant to action taken by the First Regular Session of the 120th Legislature, Adult Family Care Home Licensing will be transferred from the Bureau of Medical Services to the Bureau of Elder and Adult Services.

STATUTORY AUTHORITY:
Public Law 89-73, Older Americans Act of 1965 as amended
Title 45 CFR: Parts 16, 74, 80, 84, 90, 100 and 1321
Title V, CFR: Part 900, subpart F
Title 22 MRSA:

- Sec. 312 et seq. - Certificate of Need
- Sec. 1812-C, 1812-G - Licensing of Nursing Homes
- Sec. 2053 - Health Facilities Authority
- Sec. 3470 et seq. - Adult Protective Services
- Sec. 5106 et seq. - BEAS Powers and Duties
- Sec. 6108 et seq. - Priority Social Services
- Sec. 6201 et seq. - Adult Day Care
- Sec. 7301 et seq. - In-Home and Community Support Services for Adults with Long-term Care Needs
- Sec. 7341 et seq. - Personal Care Assistance Services for Severely Physically Disabled Adults
- Sec. 7801 - 7804 - Licenses
- Sec. 7901 - A, B, C, 7902 - A, 7903, 7904 - A, B - Assisted Living Programs
- Sec. 7915 et seq.- Congregate Housing Services
- Sec. 8601 - 8605 - Adult Day Care

Title 24-A MRSA:

- Sec. 6214 et seq.- Continuing Care Retirement Communities

Title 32 MRSA

- Sec. 2102 - Nurses and Nursing

PURPOSE: These rules regulate the functioning of the Bureau of Elder and Adult Services as the designated State Agency responsible, under the direction of the Commissioner of the Department of Human Services, for the overall planning, policy, coordination and implementation of all functions and activities conducted or supported which related to Maine's aging population and incapacitated and dependent adults. BEAS also administers the long-term care program for severely disabled adults. Rules are amended to reflect policy and statutory changes.

ANTICIPATED SCHEDULE: It is not possible to predict the timetable for making the changes over the course of the period covered by this agenda since some will be dependent upon Federal law and regulation changes and State legislation and State initiated changes required to remedy identified problems.

AFFECTED PARTIES: Entities with which BEAS has entered into agreement to carry out activities/programs relating to Maine's aging population and incapacitated and dependent adults and the individuals who participate in the activities/programs or are recipients of services.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.

The Bureau coordinates with an array of local, state and federal agencies in order to meet its mission, goals and objectives. The following is a list of agencies and a brief description of the nature of the working relationship:

Department of Human Services: BEAS works most closely with the Bureau of Medical Services. The two Bureaus share responsibility for design, development, and administration of long-term care and other services for elders and adults with disabilities. We work with the Bureau of Family Independence on Food Stamp, Medicaid, Healthy Maine Prescriptions, and Medicare Savings outreach efforts. We coordinate with the Bureau of Child and Family Services on the transition of young adults from the Child Protective to the Adult Protective program.

Department of Behavioral and Developmental Services: On AMHI Consent Decree compliance, and on development of community-based services for persons with mental health, mental retardation and developmental disabilities, with particular emphasis on meeting the needs of older adults and adults under public guardianship. The two departments have jointly staffed the Joint Advisory Committee on Select Services for Older Persons since 1984. The two departments sponsored series of regional meetings to promote better understanding of the mandates services of each department.

Attorney General: BEAS provides federal Victims of Crimes Act (VOCA) funds to the AG to support a full time investigator who works on efforts to prevent and prosecute crimes against elders, especially financial exploitation.

Maine State Housing Authority: To develop affordable assisted living programs for low and moderate income elders; home repair programs for low income, older homeowners, and to promote initiatives to assist older people in dealing with the high cost of heating fuels

Department of Agriculture: On efforts to promote food security for low income elders, through the Senior FarmShare program.

Cooperative Extension: Statewide nutrition education program
Social Security Administration: Administration of the Social Security Disability programs and efforts to reduce barriers to employment for adults with disabilities
Board of Nursing: Efforts to align nursing practice requirements with the needs of a changing home and community care system.
Dept of Education: Coordinating training requirements for unlicensed assistive personnel.

Dept of Public Safety: Efforts to prevent crimes against the elderly (TRIAD) and administration of Life Safety Code requirements in licensed residential settings.
Department of Labor: On efforts to promote employment opportunities for adults with disabilities
Univeristy of Southern Maine: BEAS and BMS have a Cooperative Agreement with the Muskie School of Public Service that supports much of the long-term care research, quality improvement and evaluation efforts of the Department.
Southern Maine Technical College: BEAS contracts with the Behavioral Health Sciences Institute at SMTC to develop training curriculum for unlicensed assistive personnel.
Administration on Aging: AOA provides federal funds through the Older Americans Act that support the community services provided by the five area agencies on Aging, Legal Services for the Elderly and the Long-term Care Ombudsman Program.
Centers for Medicare and Medicaid Services: BEAS and BMS work jointly with this federal agency (formerly HCFA) on the administration of home and community based services for elders and adults with disabilities. BEAS serves on CMS national advisory committee on home and community-based care.

H. Identification of the constitutencies served by the agency or program, noting any changes or projected changes.

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

The Bureau relies on contracted providers to deliver most of its programs. This approach began with the passage of the federal Older Americans Act in 1965. The Act required the establishment of area agencies on aging to develop local systems of services for elders. Many states relied on county government to administer funds. Maine developed five, non-for-profit area agencies on aging, all of which continue to operate today.

Maine's nationally recognized long-term care pre-admission assessment program and home care coordination system both are administered through contracts with private agencies.

J. Identification of emerging issues in the coming years.

- The aging of the population will place greater demands on a health care system that now is not designed or financed to meet the needs of persons with chronic conditions
- Many Maine adults have little or no pension or retirement savings or health care coverage, increasing the likelihood that they will need to remain in the workforce, or will rely on public programs for supportive care.
- Maine lacks a qualified, stable workforce to staff programs and services for elders and adults with disabilities. Maine must address workforce issues inlcuding wages and benefits, dignity and respect for the job, and development of career ladders and opportunities for advancement.
- Financing services to assist those with greatest economic and social need to remain in their homes and communities.

- Supporting family and other informal caregivers who provide up to 80% of care.

- Supporting older people who are isolated from family and friends living in other parts of the country.

- Protecting increasing numbers of both young and older incapacitated adults at risk of abuse, neglect or exploitation from further danger through direct intervention and cooperation with law enforcement and health care personnel.

- Promoting independence for older people and other adults through the development of home-like residential services.

- When people are unable to act on their own behalf, arrange assistance which considers their best interest and encourages maximum self-reliance.

- Increase the effectiveness, efficiency and affordablility of existing programs and services through improved management, technology and competitive bidding.

- Risk factors for Maine's older population and for adults in need of protective and supportive services that can lead to increased dependence and the need for institutional level of care:
- low income,
- functional impairment, due to physical or mental problem,
- malnutrition,
- geographic isolation
- substandard housing.
- lack of transportation

Bureau of Elder and Adult Services

35 Anthony Avenue, 11 State House Station, Augusta, ME 04333-0011

Program Report Comparison - FY 98, FY 99, FY 00, FY 01

	FY 98	FY 99	FY 00	FY 01
Long-Term Care Assessments	12,500	19,340	22,624	23,830
		Consumers Served		
Home Based Care-Elders and Adults	1,772	2,566	3,056	3,863
Elderly Medicaid Waiver	1,204	1,451	1,318	1,142
Adults w/Disability Medicaid Waiver	325	403	433	410
Private Duty Nursing/Personal Care Services	NA	1,131	1,340	1,410
Congregate Housing Services Program	199	272	272	260
Assisted Living	72	111	145	199
Adult Family Care Homes, Medicaid Consumers	NA	34	60	93
Adult Day Services Programs	112	129	82	119
Alpha One - Home Based Care	145	220	219	203
Alpha One - Medicaid Waiver	287	348	339	297
Alpha One - Consumer Directed Medicaid	NA	NA	302	357
Homemaker Services	1,077	1,500	1,301	1,664
Alzheimer's Respite	550	743	437	430
Community Services		**Consumers Served**		
People served meals: community sites and home-delivered	15,557	12,147	14,087	13,565
Senior Community Service Employment Program participants	110	89	88	89
Volunteer service programs	NA	NA	3,491	3,409
Health Insurance Counseling; Outreach & I/A; MMEP	28,716	33,338	25,507	38,553
Transportation	597	1,694	2,158	2,124
Adult Protective Services		**Consumers Served**		
Active Guardianship	640	795	792	782
APS Intake Unit total calls	8,769	9,656	9,998	10,782
Protective Referrals	2,504	2,917	2,797	2,893
Long Term Care Facilities		**Activities Completed**		
Nursing facility beds converted to residential care	NA	358	203	102
Other residential care beds developed	NA	460	65	7
Assisted Living Units developed, Type III and IV CHSP	NA	40 pending	40	59
Adult Family Care Home beds developed	NA	30	36	36
Alzheimers beds developed	66	52	16	0
Certificate of Need decisions on nursing facility projects	NA	8	5	4
Long Term Care Ombudsman		**Services Provided**		
Complaints investigated	1,354	1,476	1,922	1,649
Cases opened	648	1,000	1,424	787
Requests for information handled	800	900	1,000+	1,017
Legal Services for the Elderly		**Consumers Served**		
Consumers served by LSE (includes HIC callers)	5,863	7,753	6,240	6,197
Consumers calling LSE for Health Insurance Counseling	2,500	4,303	2,682	2,734

Program Title: **Resource Development/Assisted Living**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates.

See answer to Question A in Adult Protective Services section.

B. A description of each program administered by the agency or independent agency.

Resource Development/Assisted Living

Works to expand community based long-term care services; manages the Certificate of Need program for nursing facilities; contracts for and licenses assisted living and adult day services programs funded by the Bureau. Also works extensively with nursing facilities to assist them in converting excess capacity to other levels of care.

1. Established priorities, including goals and objectives in meeting each priority:

- Work with the Maine State Housing Authority and others to assure that new elderly housing sites include the physical plant features that will meet the requirements of Congregate Housing Services Programs (CHSP) and qualify for future CHSP funding
- Promote funding needed to renovate existing elderly housing developments to include a supportive services program
- Better coordinate the housing and services planning to ensure elderly CHSP sites are located in areas of greatest need
- Study the feasibility of expanding Medicaid coverage to include supportive services in licensed CHSPs
- Develop models of mixed income CHSP projects, particularly in rural areas
- If funded, implement activities proposed under the Robert Wood Johnson grant to expand affordable assisted living in rural areas
- Develop additional residential programs to serve elders and disabled adults with special needs (dementia, mental health, brain injury)

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives**

	2000-01	2001-02	2002-03
Housing sites that offer support services	67	67	67
Per capita cost will remain at or below 40% of cost of institutional care	20%	20%	20%
Tenants with family involvement	40%	50%	50%

3. **Assessment by the agency of the extent to which Resource Development/Assisted Living Services has met the goals and objectives, using the performance criteria:**

- Participated in the development of a case-mix pricing system for payment of residential care facilities, which was implemented July, 2001
- Participated in the development of quality indicators for residential care facilities
- Maine was one of eight states to receive a planning grant from the Robert Wood Johnson Foundation for affordable assisted living programs for rural areas.
- Reviewed and approved replacement of several antiquated residential care facilities
- Funded six affordable assisted living demonstration programs statewide
- Conducted recruitment efforts that resulted in establishing 21 Adult Family Care homes, which serve up to six people in a home-like setting.
- Specialized residential homes for persons with Alzheimer's disease are available in 10 of Maine's 16 counties
- Development work, with Child and Family Services, on the first residential sex offender treatment facility for young adults under the residential care program
- Managed the conversion of excess nursing home capacity to other uses
- Used Certificate of Need to review/approve replacement of several antiquated nursing facilities and redistribute nursing home resources around the state
- Coordinated DHS receivership of several financially troubled nursing facilities
- Participated in legislative Study Commission on Assisted Living
- Assumed program responsibility for licensing assisted living, adult day services and residential care facilities effective September, 2001
- Contracted with Southern Maine Technical College for the development of a common curriculum for a portion of CNA/RCS/PCA training, and eventual combination of the RCS/PCA training programs
- Managed the sale of real estate of public wards
- Promulgated revised regulations for licensing of assisted living facilities

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for the Bureau.

Division of Assisted Living Licensing Services

- Functions: This division licenses and surveys assisted living settings, which include: residential care facilities, congregate housing, and adult family care homes.

D. Compliance with federal and state health and safety laws, including the Americans with Disability Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

See answer to Question F in Adult Protective Services section.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements.

See answer to Question G in Adult Protective Services section.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Programs and services administered by the Bureau serve elders, age 60 and over, and adults age 18 and over in need or protective or supportive services.

I. A summary of efforts regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives.

See answer to Question I in Adult Protective Services section.

J. Identification of emerging issues in the coming years.

- See answer to Question J in Adult Protective Services section.

K. Any other information specifically requested by the committee of jurisdiction.

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

N/A

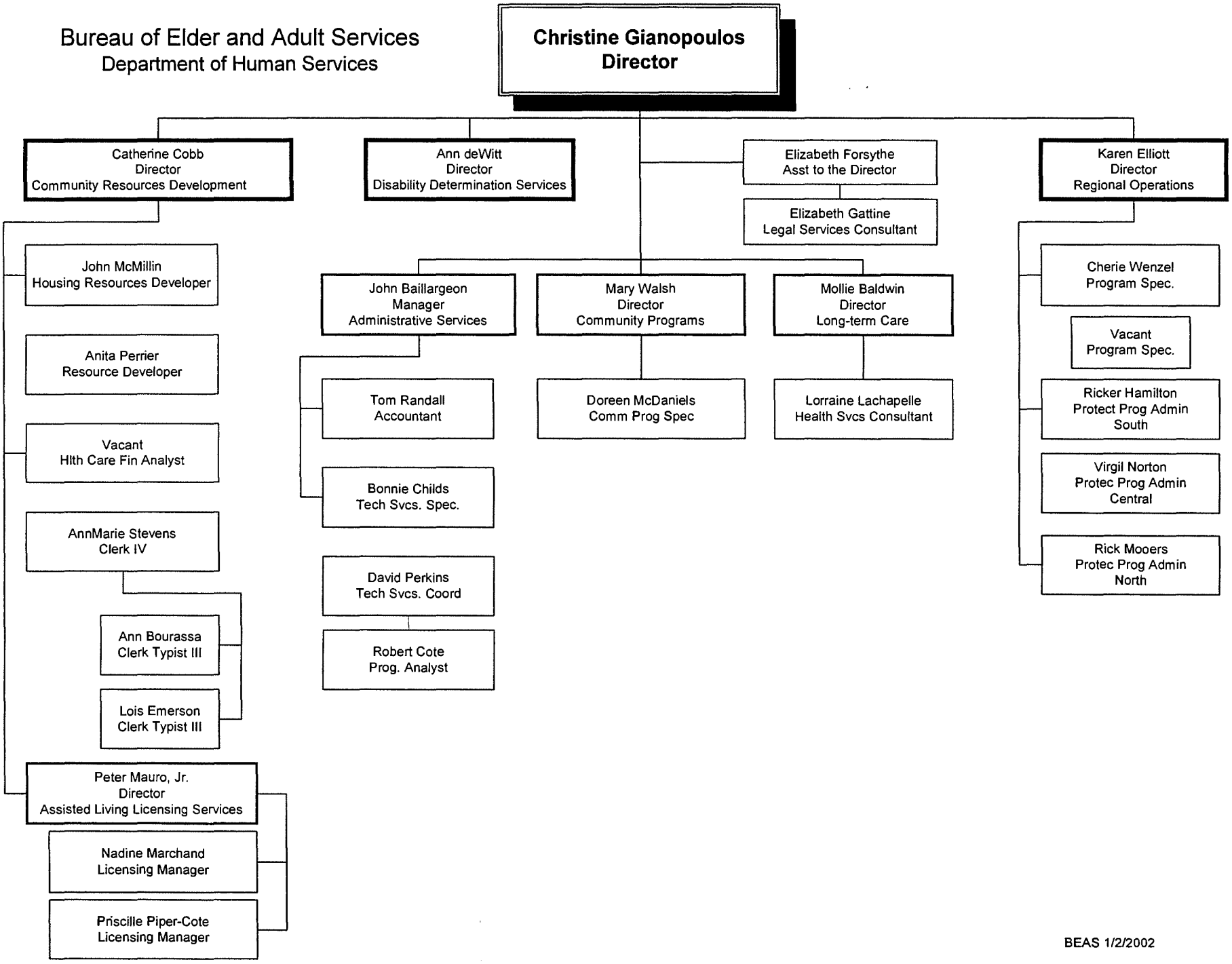
M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with all policies within the Department.

BUREAU OF ELDER AND ADULT SERVICES

Position Count	Job Classification
1	Director, Bureau of Elder and Adult Services
1	Director, Division of Residential Care
1	Director, Division of Adult Services
1	Assistant, Director of Medicaid/Medicare
1	Health Care Financial Analyst
1	Health Services Supervisor
1	Health Services Consultant
2	Health Facility Specialist
4.5	Social Services Program Specialist II
13	Social Services Program Specialist I
1	Social Services Supervisor
1	Social Services Manager
1	Comprehensive Health Planner II (project positions - ends 4/12/02)
.5	Legal Services Consultant
1	Housing Resource Developer
2	Management Analysts II
1	Accountant III
1	Accountant II
1	Account Clerk II
2	Clerk IV
5	Clerk Typist III
2	Clerk Typist II
2	Clerk III
48	
1	Director, Division Disability Services
1	Director of Operations DDS
2	Hearings Examiner
15	Disability Claims Examiner
4	Disability Claims Supervisor
22.5	Disability Claims Adjudicator
4	Human Services Aide III
1	Medical Records Translator
1	Quality Assurance Technician
2	Medical Secretary
1	Information Systems Support Specialist
1	Word Processing Supervisor
55.5	
3	Program Administrator Protective Services
8	Human Services Caseworker Supervisor
53	Human Services Caseworker
1	Comprehensive Health Planner I
65	
168.5	**Total Position Count**

Bureau of Elder and Adult Services
Department of Human Services



BEAS 1/2/2002

DEPARTMENT OF HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	BUREAU OF ELDER AND ADULT SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0140	BUREAU OF ELDER & ADULT SERVICES	5,347,389	4,630,037	5,566,078	4,674,051	5,524,485	4,781,481	5,491,191	5,071,008	5,700,727	5,686,342
0211	CONGREGATE HOUSING ELDERLY	675,307	513,145	675,307	418,566	460,105	452,855	460,105	448,105	460,105	460,105
0420	HOME BASED CARE	5,990,646	5,484,382	5,995,251	5,360,921	5,729,267	5,729,267	5,681,635	4,878,041	4,948,637	4,928,130
	GENERAL FUND TOTAL:	12,013,342	10,627,563	12,236,636	10,453,539	11,713,857	10,963,603	11,632,931	10,397,154	11,109,469	11,074,577
0140	BUREAU OF ELDER & ADULT SERVICES	6,530,065	5,412,893	6,587,636	5,617,406	6,570,735	5,339,571	6,571,211	5,967,845	7,231,819	6,332,987
0208	DIVISION OF DISIBILITY DETERMINATION	3,958,805	4,143,657	4,277,022	4,277,022	4,479,631	4,479,631	4,512,083	4,512,083	5,250,227	5,042,480
	FEDERAL FUND TOTAL:	10,488,870	9,556,550	10,864,658	9,894,428	11,050,366	9,819,201	11,083,294	10,479,928	12,482,046	11,375,466
0140	BUREAU OF ELDER & ADULT SERVICES	40,000	23,466	40,000	462	40,000	8	40,000	-	296,705	143,654
0420	LONG TERM CARE	500,000	429,547	500,000	47,655	500,000	240	500,000	-		
	OTHER SPECIAL REVENUE TOTAL:	540,000	453,012	540,000	48,117	540,000	248	540,000	-	296,705	143,654
	GRAND TOTAL	**23,042,212**	**20,637,126**	**23,641,294**	**20,396,084**	**23,304,223**	**20,783,052**	**23,256,225**	**20,877,082**	**23,888,220**	**22,593,698**

DEPARTMENT OF HUMAN SERVICES
BUREAU OF ELDER AND ADULT SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	BUREAU OF ELDER AND ADULT SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0140	BUREAU OF ELDER & ADULT SERVICES	6,949,844	6,878,975	7,260,313	7,233,772	8,540,943	8,436,669	8,775,881	8,715,744	9,893,404	9,863,355
0211	CONGREGATE HOUSING ELDERLY	564,605	560,105	1,205,847	1,185,052	1,536,997	1,536,996	1,934,150	1,933,631	2,425,147	2,422,262
0420	HOME BASED CARE	8,581,023	8,579,985	8,116,445	8,105,868	13,039,631	13,033,848	16,297,726	16,297,134	18,482,472	18,467,786
	GENERAL FUND TOTAL:	16,095,472	16,019,066	16,582,605	16,524,692	23,117,571	23,007,513	27,007,757	26,946,509	30,801,023	30,753,404
0140	BUREAU OF ELDER & ADULT SERVICES	7,137,077	6,493,607	7,135,490	6,733,439	6,838,517	6,411,940	7,111,576	6,589,312	7,198,352	7,071,063
0208	DIVISION OF DISIBILITY DETERMINATION	6,028,391	5,732,018	6,357,273	6,307,385	6,542,905	6,459,214	6,096,487	6,072,004	6,300,333	6,283,501
	FEDERAL FUND TOTAL:	13,165,468	12,225,625	13,492,763	13,040,824	13,381,422	12,871,154	13,208,063	12,661,316	13,498,685	13,354,564
0140	BUREAU OF ELDER & ADULT SERVICES	304,266	71,270	295,596	291,914	298,559	71,262	328,246	143,350	334,247	28,891
0420	LONG TERM CARE					895,700	895,700				
	OTHER SPECIAL REVENUE TOTAL:	304,266	71,270	295,596	291,914	1,194,259	966,962	328,246	143,350	334,247	28,891
	GRAND TOTAL	**29,565,206**	**28,315,960**	**30,370,964**	**29,857,430**	**37,693,252**	**36,845,629**	**40,544,066**	**39,751,175**	**44,633,955**	**44,136,859**

BUREAU OF FAMILY INDEPENDENCE

Child Support Enforcement

Fraud Investigation and Recovery

Food Stamps

ASPIRE-JET

General Assistance

TANF

PaS and ASPIRE PaS

State Supplemental to SSI

Program Title: **Child Support Enforcement**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

42 USC 602(a)(2) - the State will operate a Child Support Enforcement Program as required by part IV-D of the Social Security Act (42 USC §§651-669b)
42 USC 654 - State Plan for Child & Spousal Support
42 USC 666 - requirement of statutorily prescribed procedures to improve the effectiveness of child support enforcement

19A MRSA §§2251 - 2453 - Alternative Method of Support
19A MRSA §§1601 - 1616 - Expedited Process for the Commencement of Paternity Actions
Maine Child Support Enforcement Manual

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including goals and objectives in meeting each priority;
The Division of Support Enforcement and Recovery is required by federal law to maintain a State Plan that conforms to the federal requirements for program operation. The Division has identified specific program priorities, as they are also defined in the federally required annual Self-Assessment. Please refer to Section IV of the attached Self Assessment Report completed in April of 2001. Section IV gives a brief description of the Division of Support Enforcement and Recovery and outlines the Division's current priorities.

2. Performance criteria, timetables or other benchmarks used by the agency to measure its progress in achieving goals and objectives;
The federal government has mandated specific program criteria in order to measure program performance. The criteria for measuring program performance are: Case Closure; Establishment of Paternity and Child Support Orders; Expedited Processes; Enforcement of Support Obligations; Disbursement of Collections; Securing and Enforcing Medical Support Orders; Review and Adjustment of Support Orders; Interstate Services. The State of Maine uses the federally prescribed process questions to determine the level of performance and achievement during the audit period for each year. See attached Self-Assessment Report.

In addition to Self-Assessment, the Federal Government conducts a "Data Reliability Audit" every year. This audit ensures that DSER's automated system

of record is processing case information in a reliable way. Attached is a copy of the Federal Report dated July 10, 2001. Maine has been determined to have reliable data.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

Attached is a copy of Maine's Self-Assessment completed in April 2001. In Section III of that document, there is a description of performances categories as well as descriptions of how the Division met goals and objectives during the period audited. This section contains an analysis of performance as well as an assessment as to how the program could be improved based on the Assessment results. Maine met all performance categories listed. Two of the categories show 100% compliance in those cases reviewed.

C. Organizational Structure, including position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial statement for the Bureau.

F. When applicable, the regulatory agenda and the summary of the rules adopted:

AGENCY UMBRELLA-UNIT NUMBER: 10-144

EMERGENCY RULES ADOPTED SINCE THE LAST REGULATORY AGENDA: Implementation of the new child support table pursuant to the federally mandated quadrennial review of the child support guidelines. Manual was updated to reflect recodification of family law from Title 19 to Title 19A.

RULES ADOPTED IN 2001: The rule implements the changes made to child support law in P.L. 2001, c. 264, adds the updated Child Support Table and reflects to recodification of family law from Title 19 to Title 19A.

1. Updates the definition of extraordinary medical expenses to mean those in excess of $250.00 per year in accordance with P.L. 2001, c. 264.
2. Removes requirement that the actual incremental cost to a party for providing health insurance coverage for a child be deducted from the party's gross income. The cost is now shared proportionately between the parents in accordance with P.L. 2001, c. 264.
3. Increases the annual income level included in the Child Support Table from $126,000 to $240,000 to reflect the new Table.
4. The new Table also provides for the subsistence needs of the nonprimary care provider by continuing the provision that a nonprimary care provider earning less than the federal poverty guideline for one, pays no more than 10% of income as child support. The Table also provides for a self-support reserve that recognizes obligors need sufficient income to provide for their own basic needs.
5. Provides that the Department may obligate the responsible parent to pay a proportionate share of the health insurance premiums when establishing a support order administratively.
6. Removes the triennial review process in accordance with P.L. 2001, c. 264.

EXPECTED 2001-2002 RULEMAKING ACTIVITY:

CHAPTER 351: Maine Child Support Enforcement Manual
STATUTORY AUTHORITY: 19-A M.R.S.A. § 101 et seq.
PURPOSE: These rules implement Federal statutes, regulations and action transmittals of the U.S. Department of Health and Human Services and State statutes and establish rules of practice governing the conduct of adjudicatory proceedings of the Division of Support Enforcement and Recovery. They will be amended to reflect policy and law changes with clarifications as necessary.
ANTICIPATED SCHEDULE: Year round.
AFFECTED PARTIES: Persons who pay or receive support.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.

Expansion of availability/capacity of judicial system for establishment of paternity and establishment and enforcement of child support obligations, for custodial and non-custodial parents and DSER, via the Family Division of the Maine District Court (Maine Judicial System)

Legal representation of DSER (Maine Department of Attorney General)

Acquisition of New Hire and other identification/location information through the Federal Case Registry (U.S. Office of Child Support Enforcement)

Development/evaluation of new initiatives in child support enforcement (USM, Institute for Public Sector Innovation - DHS Training Institute)

License revocation (all relevant Maine state agencies)

Income Tax Refund offset (IRS and Maine Revenue Services)

Unemployment Insurance Benefit intercept (Maine Dept. Labor)

Maine Lottery Intercept (Maine Liquor & Lottery Commission)

Real Property Lien filing (Maine County Registers)

Workers Compensation benefit intercept (Maine Workers Compensation Board)

Child Support Lien Network, an electronic lien/intercept of personal & property and workers compensation insurance claims of insurance claims/ judgments of non-custodial parents with child support arrears (five Northeastern states)

Financial Institution Data Match Implementation, Multi-state through the U.S. Office of Child Support Enforcement and In-state matching with Tier Technology and twelve other states.

Denial of high-arrears non-custodial parents' applications for passports (U.S. Office of Child Support Enforcement and Department of State)

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Custodial parents

Non-custodial parents

Children in Foster care

Support enforcement agencies of other states

TANF, Food Stamps and Medicaid Eligibility Units, DHS Bureau of Family Independence

Third Party Liability Unit, DHS Bureau of Medical Services

I. A summary of efforts of DSER to use alternative delivery systems.

PAYCO, a collection agency, for the collection of child support arrears, with results that were marginal

Acquisition of VIPRS (now called Kids1st) check scanning system for support enforcement cashier to achieve 2-day turnaround with no additional staff

Maine Acknowledgment of Paternity Project (MAPP) for achievement of increased acknowledgment of paternity rate for Maine through education and training

IV-D Waiver Project for evaluation of beneficial effect of having new court orders for child support automatically become DSER enforcement cases unless custodial parents opt out of such procedure.

Automation of DSER voice response telephone line so that information and inquiries from custodial parents can be received, without limitation on access to DSER, 7 days/week, 24 hours a/day

Availability of New Hire filing on public website

Availability of application for support enforcement services on public website

Access to e-mail communication to DSER via public website

Non-custodial Parent Outreach and Investigation Project (NCPOIP), to reach out to non-custodial parents who do not participate in the paternity establishment process or the payment of child support, and investigate the causes of such non-participation in order to increase the group's participation in both processes

J. Emerging issues for the agency or program in the coming years.

1. Capped pool on incentive funding;

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the welfare program across this country. The incentive payment structure to state child support programs was also revamped. The initial incentive bill attempted to reward states for better performance; however, just before enactment (in attempts to keep this section cost neutral) Congress capped incentive payments. This action has resulted in small states, like Maine who continue to improve in all measured categories, actually doing better but receiving less incentive money. Larger, poorer performing states can improve slightly in their programs and receive significantly greater amounts of this capped incentive money. Maine has little room for improvement as we have actually maximized three areas of our incentives, and as other states improve, Maine will receive less money as the capped pool is spread thinner amongst all who qualify in each category.

2. Medical support enforcement;

The National Medical Support Workgroup has been established to look at medical support and its effect on families. This workgroup outlined seventy-six recommendations surrounding medical support. Some of these recommendations should be supported, others should be challenged and

others need additional research to determine the impact on states and families. Maine's child support program is reaching out to other impacted state agencies in order to work collaboratively amongst all groups so that the best interests of all programs are used in the decision making process.

3. Emergence of collection agencies in child support enforcement;

   Unregulated private collection agencies offer quasi child support enforcement services to selected custodial parents. The Maine child support program must provide all child support services to any party who applies. Private collection agencies claim to be child support collection agencies, but are not regulated like one (privacy, distribution and case closure). The Fair Debt Collection Act does regulate some of these areas. The Child support program sends 100% of current support to non-welfare families, while private collection agencies would treat that same payment as arrears and keep 35% or more for administrative fees depriving the family of much needed support. Maine's DSER program has actually received postcards from at least one private company with the non-custodial and custodial parent's social security number clearly visible. We, therefore, are concerned about their adherence to confidentiality requirements. Maine's child support program will close a case at the request of a custodial parent, however, private collection agencies enter into contracts, refusing to allow the custodial parent to close the case until one year after the last child support payment (which may have been collected by Maine's program or another states child support program).

K. Any other information specifically requested by the committee of jurisdiction:

The Division of Support Enforcement and Recovery provides a report to the Legislature and the Governor biennially on the license revocation activities and outcomes for the purposes of support enforcement pursuant to 19A MRSA §2201 and §2202.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program:

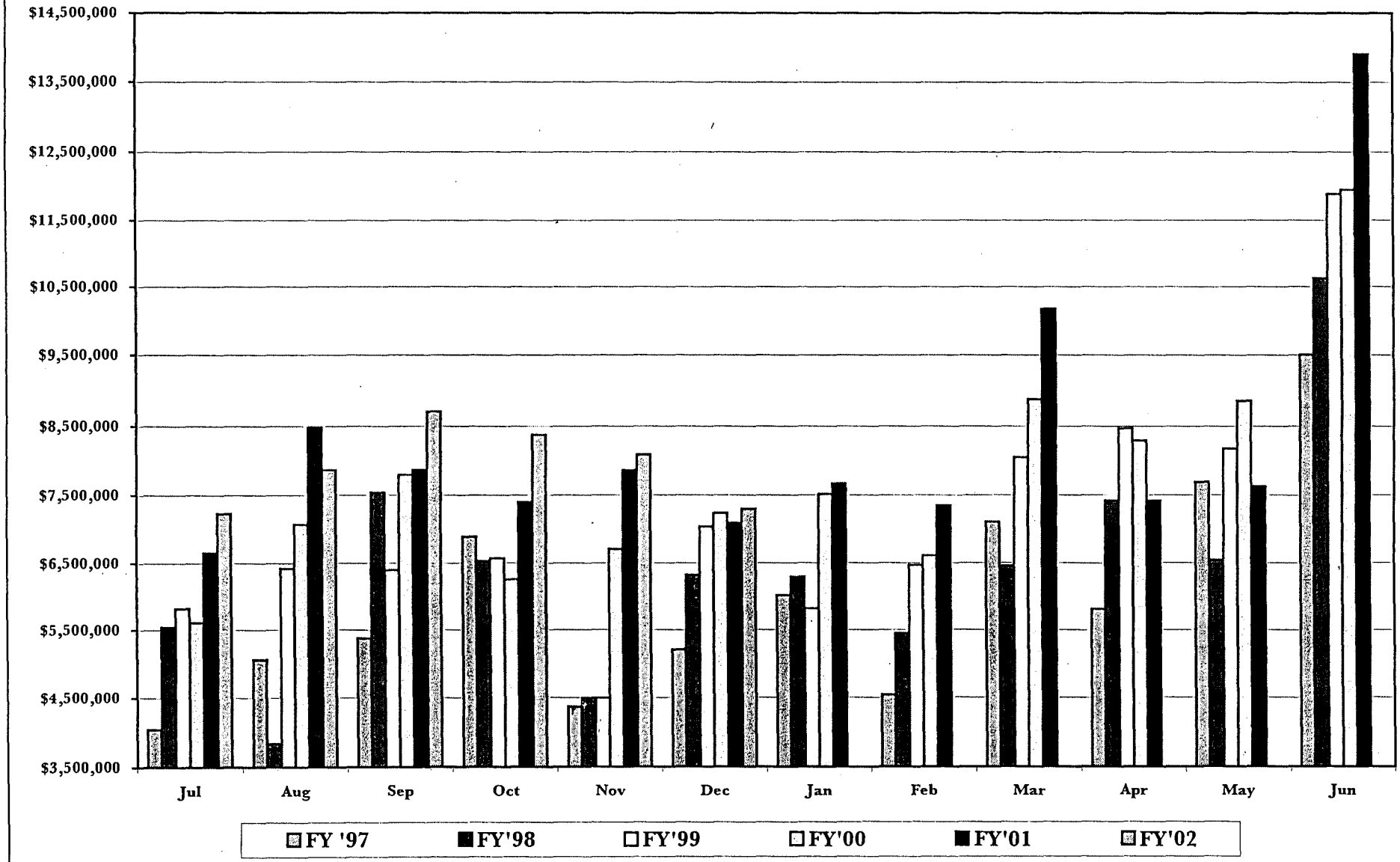
Federal law mandates that States operate a Child Support Enforcement Program (42 USC §654) in order to receive public assistance funds from the federal government. 42 USC §654 requires States to implement federally mandate policies and procedures to improve the effectiveness of child support enforcement (42 USC §666). Maine has implemented the federally mandated procedures: income withholding (19A MRSA §2306 and §2652); expedited administrative procedures for paternity establishment and genetic testing; (19A MRSA §§1601-1616) and order establishment and enforcement (19A MRSA §§2251-2453); state tax refund intercept (36 MRSA §5276-A); liens (19A MRSA §2352 and §2357); reporting arrearages to credit bureaus (10 MRSA §1311 et

seq.); 3 year cycle of order review (19A MRSA §2157); locator information (19A MRSA §2151); license revocation for failure to pay support (19A MRSA §2201 and §2202); financial institution data matches (22 MRSA §17); and Uniform Interstate Family Support Act (19A MRSA §§2801-3401.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practices of notice, choice, access, integrity and enforcement.

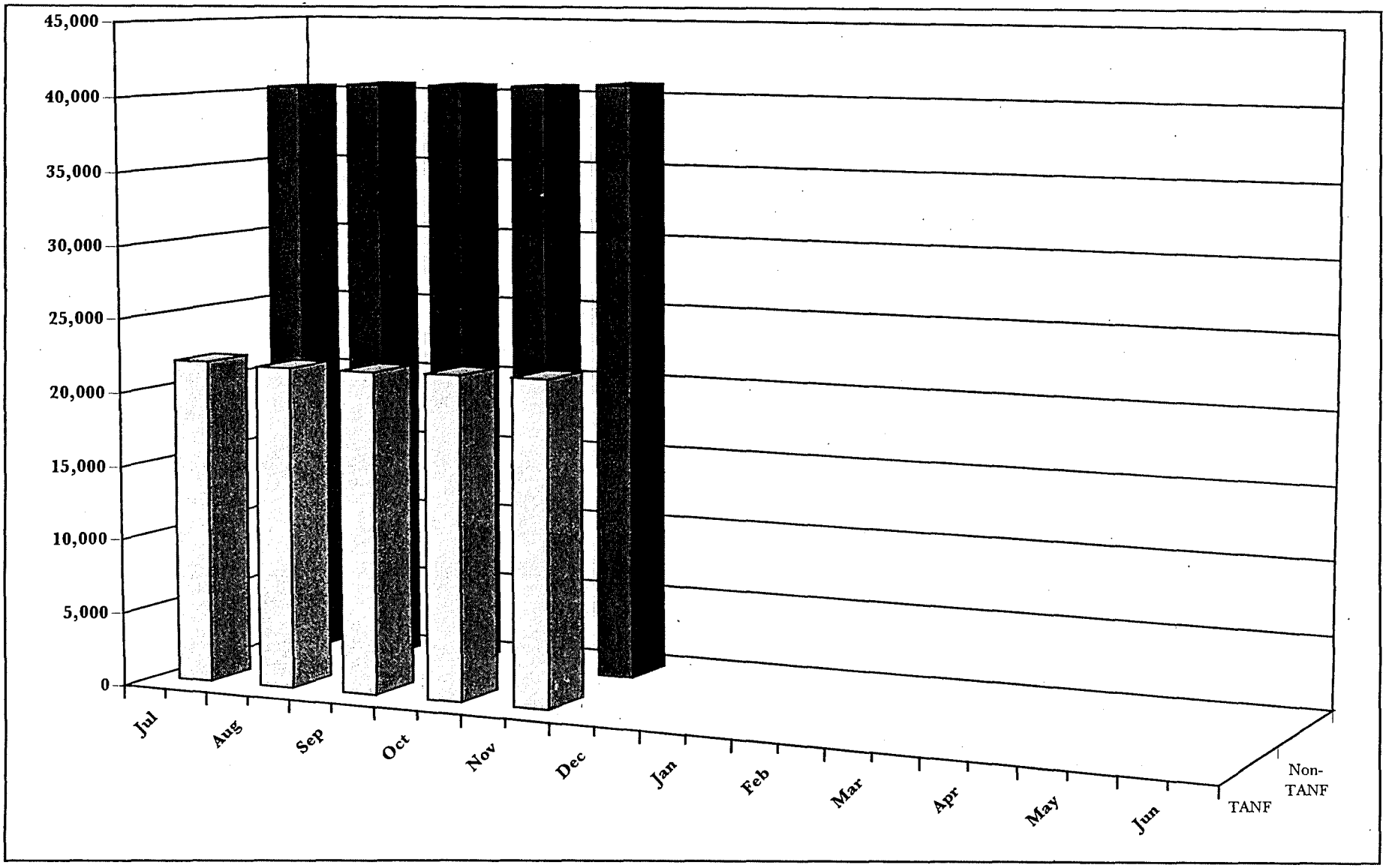
The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

FY'97 to FY'02 Child Support Collections by Month



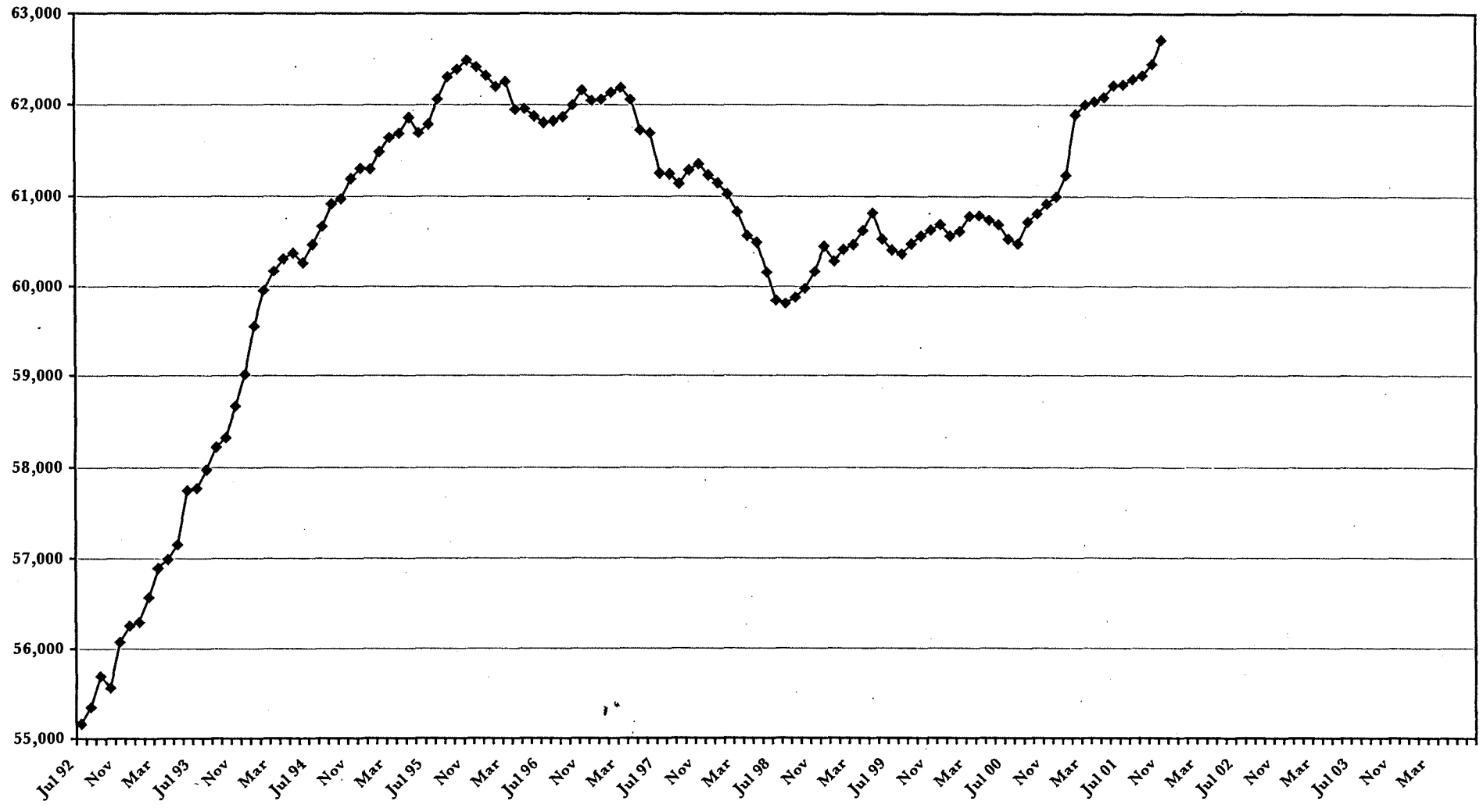
Actual	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY '97	4,034,737	5,064,985	5,375,355	6,886,838	4,361,578	5,206,235	6,009,549	4,538,182	7,106,983	5,803,020	7,691,033	9,501,943
FY'98	5,540,661	3,831,906	7,537,381	6,528,111	4,495,121	6,318,382	6,288,417	5,444,515	6,450,755	7,416,086	6,537,157	10,627,221
FY'99	5,816,424	6,419,970	6,393,184	6,570,458	4,494,291	7,034,783	5,814,324	6,463,941	8,049,895	8,466,842	8,176,359	11,890,328
FY'00	5,605,382	7,072,944	7,794,334	6,254,813	6,703,136	7,234,736	7,510,822	6,602,654	8,887,797	8,290,484	8,862,842	11,952,478
FY'01	6,650,074	8,487,091	7,866,295	7,396,603	7,862,283	7,090,669	7,668,960	7,347,959	10,167,122	7,411,283	7,621,369	13,900,559
FY'02	7,230,217	7,867,994	8,710,385	8,376,440	8,089,658	7,296,636						

of Non- Custodial Parent Cases - July 2001 to June 2002



FY'02	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
TANF	21,944	21,768	21,782	21,872	21,916							
Non-TANF	40,267	40,502	40,532	40,569	40,790							
Unknown	14	14	13	12	12							
Inactive	212	210	216	217	174							
Total	**62,437**	**62,494**	**62,543**	**62,670**	**62,892**							

of Non-Custodial Parent Cases - July 1992 to June 2003



Date	Jul'99	Aug	Sep	Oct	Nov	Dec	Jan'00	Feb	Mar	Apr	May	Jun	Jul'00	Aug	Sep	Oct
# of Cases	60,408	60,366	60,476	60,562	60,626	60,685	60,560	60,610	60,779	60,787	60,735	60,685	60,527	60,478	60,715	60,807
Date	**Nov**	**Dec**	**Jan'01**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul'01**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan'02**	**Feb**
# of Cases	60,916	60,995	61,231	61,893	61,999	62,034	62,082	62,216	62,225	62,284	62,327	62,453	62,718			
Date	**Mar**	**Apr**	**May**	**Jun**	**Jul'02**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan'03**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
# of Cases																

Does not include inactive cases.

Graph represents data beginning July 1, 1992

Department of Human Services

Bureau of Family Independence

Division of Support Enforcement and Recovery (DSER)

Director, Stephen L. Hussey

-SELF-ASSESSMENT-

CONTENTS

I. EXECUTIVE SUMMARY

Maine's Self Assessment was initiated to determine whether the state was in compliance with Federal requirements outlined in OCSE-AT-00-09 for the period covering October 1, 1999 through September 30, 2000. Maine's Self Assessment for this audit period combined automated and manual review of cases. The Division of Support Enforcement and Recovery (DSER) used the Self Assessment Report issued in March 2000 to establish a baseline for program improvement and further development of the goals stated at that time. The goals of the Self Assessment in Maine are:

1. Complete the Self Assessment for the audit period covering October 1, 1999 through September 30, 2000.
2. Continue the development of Maine's model for Self Assessment that can easily be developed into an automated review and assessment.
3. Use the results of Self Assessment as a tool to evaluate program, region, district and individual performances on an ongoing basis.
4. By automating this process, give management and supervisory staff the ability to draw on this information immediately.

For this review period, (10-01-99 to 09-30-00) Maine reviewed all eight criteria outlined in OCSE-AT-00-09. Maine's Self Assessment revealed that Maine has exceeded performance minimums in all categories.

Category	% Of cases in Compliance
Case Closure	97.56%
Establishment	100%
Expedited Processes	100%
Enforcement	94.23%
Disbursement	99.74%
Medical Support	85.6%
Order Review and Adjustment	97.67%
Interstate	92.34%

II. BACKGROUND

Section 342. Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) "Federal and State Reviews and Audits," amended Section 454 of Title IV-D of the Social Security Act to require the States to provide for a process of annual reviews of and reports to the Secretary, HHS on the State Child Support Program. The report to the Secretary of Health and Human Services includes such information as may be necessary to measure State compliance with Federal requirements for expedited procedures.

The Maine IV-D program is one of several programs in the country that is primarily administrative. Approximately 95% of all the IV-D program activities are accomplished using an administrative rather than judicial process. Roadblocks

that are sometimes created by a more formal judicial system are not experienced in Maine.

The IV-D program, however, has recognized and used the Maine Superior and District Courts to establish orders for support and to enforce orders against individuals who are chronic non payers. In April 1997, the Family Division of the Maine District Court was created to specifically address family and child support related issues. It has become a forum to judicially "expedite" proceedings to help children as quickly as possible. The new forum has been a resounding success. Maine's paternity and unobligated caseloads are at record lows for the IV-D program. Total collections are at record highs.

- The Maine IV-D Program consists of a Central Office which is responsible for program oversight and performing the following functions:
- Operating State Parent Locator Service,
- Processing referrals form public assistance agencies,
- Coordinating interstate activity under UIFSA,
- Operating central case registries,
- New hire reporting,
- Central order registry,
- Operating the tax refund offset programs,
- Operating a customer service unit,
- Evaluating program operations,
- Monitoring district operations,

- Establishing IV-D policy and procedures, and,
- Reporting statistical data to Federal OCSE.
- Child Support Lien Network processing,
- Financial Institution Data Match

As a result of last year's Self Assessment, personnel at the central office have been designated to respond to employers with question about medical support and health insurance. Maine issued notices to employer's informing them of the requirements for medical coverage and when lapses in coverage occur. These requirements are now incorporated in all withholding orders sent to employers. In addition to actions taken to correct medical support processes, a process has been established in our central office to review all case closures before cases are filed and archived.

The Maine IV-D Program operates 15 District Offices in strategic locations throughout Maine. These offices are charged with locating parents, establishing paternity, establishing support orders, enforcing support orders, reviewing and adjusting support orders and maintaining individual case records.

Maine has DHS Cahiers, the Central Disbursement Unit, which operates, to a large extent, independent of the IV-D Agency. This Unit is responsible for processing receipts and forwarding those payments to families. This group also prepares financial data and reports to the Federal OCSE.

Maine does have legal services provided by the Office of the Attorney General. These attorneys represent the IV-D Agency when necessary. They have also provided

valuable opinions to the program when difficult legal issues arise in IV-D casework. And, they have played a valuable role in preparing staff to represent the Department as non attorneys and in defining the complex Uniform Interstate Family Support Act.

Maine's Department of Human Services is a Tribunal. The Administrative Hearings Unit establishes child support obligations and provides a forum for review of specific Department functions. Hearings Officers in that unit hear and decide on any challenges made by obligors affected by the activities of the IV-D Program.

During the past state fiscal year ending June 30, 2000, the Maine IV-D program increased collections over Fiscal Year 1998 from $85.6 million dollars to $92.7 million. These increases came from what appears (as in the prior two Self Assessments) to be a static caseload:

Maine's IV-D Caseload As of State Fiscal Year Ending				
	June 30 1999	June 30, 2000	% of change from 1998 to 1999	As of 02-28-01
Paternity	3,582	2,970	17% decrease	2,960
Unobligated	4,670	4,328	7% decrease	4,814
Obligated	53,018	54,167	2% increase	54,936
Totals	61,270	61,465	<1% increase	62,710
Maine closed approximately 6,000 cases from October 1, 1999 through September 30, 2000. That number alone reveals a significant amount of movement in the make up of the caseloads as well as significant accomplishments.				

Maine increased collections by 8% over the prior year. Approximately $64 million dollars went immediately into the homes of families in the form supplements to

Temporary Assistance for Needy Families (TANF) or non-welfare support. Since 1996, Maine's public assistance caseload has declined dramatically to new modern lows. This is directly attributable to the effort of the IV-D Program. As reported in the Self Assessment last year, assistance collections have increased despite reductions in TANF caseloads and Maine remains a national leader in the area of public assistance cost avoidance and cost recoupment.

SELF-ASSESSMENT IMPLEMENTATION METHODOLOGY

Organizational Placement:

Maine decided to use automation to complete a significant portion of Self Assessment. This has been largely accomplished by select queries using the program's Data Warehouse. In addition Maine has chosen to integrate Self Assessment into the existing organizational structure as a process enhancement tool for use in the daily operation of the IV-D Program. Maine wants Self Assessment to be more than an informational tool.

Maine's project organization is designed to be proactive as well as reactive, address problems/issues at the point of inception, provide for preventative measures as well as corrective ones, avail itself to individuals at every level of the program, encourage it's own consistent use (global participation) and provide immediate feedback. As part of the plan to incorporate Self Assessment into the daily operation of the child support program, Maine disseminated the Data Warehouse capability to all District Supervisors during the Self Assessment period spanning September 1999 through October 2000. Training in the use of the ad hoc report generator (Data Warehouse) was given to the supervisors in February of 2000 and standardized queries have been developed to assist Supervisors to provide more focus to their staff in their daily activities. This has helped Maine to maintain continuing success in establishment and enforcement.

Sampling:

The Division of Support Enforcement & Recovery currently handles 62,710 cases. Eighty-eight percent of Maine's caseload or 54,936 of these cases are obligated. An additional 4,814 are identified as unobligated and 2,960 are paternity cases. Since these cases are spread across the state, Maine chose to use a focused stratified sampling technique ***(See Appendix C).*** Maine used its Data Warehouse to identify all cases that fell into each Self Assessment category during the period reviewed from (10-1-99 through 9-30-00). Using all cases subject to each process we establish a universe of cases to draw a sample from. The universe and sample size for each category is listed below.

Category	Universe of Cases	Sample Cases
Case Closure	9,369	369
Establishment Of Paternity and Child Support Orders	4,939	357
Expedited Processes	3,601	347
Enforcement of Support Obligations	43,541	381
Disbursement of Collections	33,559	380
Securing and Enforcing Medical Obligations	10,348	375
Review and Adjustment of Orders	1,389	301
Interstate Services (Initiating)	12,732	373
Interstate Services (Responding)	2,457	332

Using the Data Warehouse, Maine IV-D was able to identify all cases where particular processes were an issue during the Self Assessment period. After identifying the entire range (universe) of cases where there was a category issue, a sample was selected using the 'Sample Size Calculator' created by Creative Research Systems and available at http://www.surveysystem.com/sscalc.htm. After selecting samples representative of each process, Maine used Microsoft Access databases to organize and review cases by running multiple Data Warehouse queries to collect and verify caseload activity. Since Maine does not have the technical ability to collect all case specific data regarding performance, the model allowed for a significant manual review of cases. Maine's Data Warehouse does not provide all required Self Assessment information. It is anticipated that the Data Warehouse construction will be near completion within the year. The Medical Support category, after sampling, was an entirely manual review. Though Maine does have the ability to answer a large part of the medical category using automation, Maine was concerned, given the performance reflected in the first Self Assessment, March 1999 (22%), that the information that resulted from this Self Assessment be verified.

Scope of Review:

Self-Assessment is viewed as an opportunity to develop a tool for continuous improvement because Maine has a relatively small caseload. Though audit periods will be important to OCSE, and the required results will be filed, Maine is interested in the continuous evaluation of the entire caseload at any point in time. We are confident that the establishment of this concept will result in Maine easily meeting Federal requirements in future audit periods. It is anticipated that future samples using an automated method would consist of Maine's entire caseload. Since the last Self Assessment, Maine IV-D has automated Case Closure, Paternity and Order Establishment, Expedited Processes, and Disbursement of Collections. This has dramatically reduced the time spent looking at each case. Maine believes that there will always be the need to pull files and manually review cases to verify the caseload activity as it is reflected by automation. We are confident the daily/weekly review of cases using the Data Warehouse will improve program performance significantly. As envisioned at the beginning stages of Self Assessment, there was still a need to pull files to determine exactly what had been the activity in cases. Maine IV-D is still developing the queries for the remaining categories. Much of the success will be dependent on the expansion of the IV-D Program's Data Warehouse.

Review Period:

October 1, 1999 through **September 30, 2000**

III. REQUIRED PROGRAM COMPLIANCE CRITERIA *(See Appendix F)*

1. Case Closure:

Of the 369 cases reviewed, there were only 9 error cases. The errors reflected two problems. Some employees continue to misinterpret the case closure policy or fail to generate a 60-day letter when it is appropriate. Maine's performance in this category has actually decreased by two percent. We attribute this change to using the focused stratified sampling technique and actually pulled down a sample more representative of case closure activity.

C1. If the case was closed, did it meet one or more of the Federal Closure Criteria? **Maine had 4 cases that failed this question for the reasons stated above. Maine has installed another level of supervisory intervention into the case closure process. We have the closed cases reviewed as they arrive at our Central office from field locations. If the closure is not done correctly, it is shipped back to the field. We also discovered that Central Office staff, when performing an administrative closing of the cases, were not using correct data entry as outlined in prior instructional memoranda. This has been repaired.**

C2. If closed, was 60-day notice sent, if appropriate?

Maine had five error cases. Maine anticipates that the extra layer of supervisory review at the Central office level will prevent closures that do not include proper notification to parents. The rate of error is small and we believe this supervisory intervention should further improve an already excellent performance.

2. *Establishment of Paternity and Support Orders:*

As in year's past, the Self Assessment automation leaned in favor of "potential error". The Self Assessment for this period was very positive at 100%. We attribute this excellent score to the ongoing, daily, capability in our field operations to review the caseloads using the Data Warehouse. Eighty-eight percent of Maine's caseload is obligated! Paternity and Unobligated cases continue to go down despite an influx of approximately 400 new cases per month.

OEI. Was a child support order established during the review period? **Maine moves to establish paternity and an order in individual cases typically within six months. This is largely due to the fact that once a putative father is served with a Notice of Paternity Proceeding, and fails to respond, the failure results in a default before the courts or the issuance of an order after an administrative notice of proceeding to establish an order.**

OE2. If the non custodial parent was located, was service accomplished within 90 calendar days of locate, or if service was unsuccessful, were unsuccessful attempts documented in accordance with the state's definition of diligent efforts? **Though none of the cases reviewed fell into this category, it should be noted that the IV-D computer system in Maine has an automated locate subsystem that routinely searches for individuals. Because caseloads in each district are so small and continuing to decline, Maine has done a complete job of locating and serving putative parents (as in OE1, once served, a putative parent must respond or an order will be entered) with the necessary paperwork. In Maine, the automated system will automatically re-open the locate function once an address or employment is ended.**

OE3. If location was needed, was the latest federal locate requirement met? **None**

OE4. If case opening was needed, was the federal requirement met? **None**

Maine believes that this is an outstanding performance. We believe that we have the best set of laws in the nation to deal with Paternity and Order Establishment. Our unestablished Paternity caseload has been dropping dramatically since 1991 when the Expedited Process for the Commencement of Paternity Actions was enacted. This is also true of expedited Order Establishment that was implemented in January of 1995.

3. Expedited Processes:

Maine was 100% in this category. As in the Paternity Establishment and the Administrative Establishment of Parental Support Obligations, the expedited order establishment process in Maine, is very effective. The unobligated caseload continues to decline. Once served, parents with a duty to provide support who choose to ignore the process are quickly ordered to pay support. Typically, this occurs within 90 days.

EP1. Were actions taken to establish support orders (and paternity if needed) from the date of service to the time of disposition within 6 months? (If long-arm jurisdiction used, credit given for 6-month standard if action completed within 12 months.)

EP2. Were actions taken to establish support orders (and paternity if needed) from the date of service to the time of disposition within 12 months?

Maine has strong administrative laws that enable the IV-D program to establish support orders without involving the Maine Judiciary. The Maine Judiciary recently established a Family Division within the Maine District Court. The Family Division was created to focus on children's issues. Like

the expedited processes, there have been no significant delays in obtaining final decisions from the new Family Division.

During the past review period, District Supervisors made significant use of the Data Warehouse to track and move their cases toward completion. Because the caseload sizes are dropping, staff has been able to give location and service issues more attention.

4. Enforcement of Orders:

Maine pulled a focused stratified sample of 381 cases from a universe of over 43,000 cases. Of the 381 cases, there were 16 error cases, for a 94.23% efficiency rating. We attribute the lower score to the shift from simple random sampling to a focused stratified sampling. Though this is a good score, we were able to identify areas that could be improved. This improvement will involve staff training and motivating staff to take extraordinary action against chronic non-paying cases using the powerful sanctions available through the Maine Court system.

E1. Was wage withholding (ww) collection received in the last quarter of the review period?

E2. If ww not appropriate, was any collection received as a result of an enforcement action?

Of the sample of 381 cases, Maine identified 217 cases or 57% with payments by wage withholding or other payments during the last quarter of the review period. Our Data Warehouse information was able to identify payments made, but not by type of receipt. We anticipate that we will have the technical ability by the next Self Assessment review.

E3. If ww was appropriate was ww actions initiated within required time frames? **There were two error cases in this category. The automated system had alerted employees of the potential wage withholding remedy and the employee failed to activate wage withholding. Since this is a caseload management issue, we have already developed a strategy using the Data Warehouse to identify potential actions for supervisory review. This is particularly important with New Hire alerts. The ability to focus using the Data Warehouse has given enforcement agents the ability to give these actions priority.**

E4. If ww was not appropriate, was other appropriate enforcement action(s) initiated within federal time frames, or if service of process necessary but unsuccessful, were unsuccessful attempts documented to meet state's diligent efforts definition? **Maine had two error cases in this category. Both errors were instances where License Revocation or an action using the courts would have been appropriate. We do run queries to identify "non-paying" cases for enforcement personnel. We have also realigned office operations, in almost**

all field offices, to target specifically enforcement related cases for action. Supervisors have begun to use the new focus provided by the Data Warehouse to direct staff toward the most meaningful activity for each case.

E5. If non-custodial parent's address and/or employer needed to be located, was the latest federal requirement met? **There were 12 error cases in this category. We learned through this review that this error was systems related. When enforcement personnel learned that a non-custodial parent was no longer at a specific place of employment, they did not close the employer account in the system. As a result, the open employer prevented the system from recognizing the need to initiate automated locate. The automated locate subsystem initiates locate requests to a range of sources until a new employer is found. Again, the corrective action will be focused queries using the Data Warehouse that will identify non-paying cases with open/active employers. Enforcement supervisors are currently using this query.**

E6. If case opening required, was the Federal requirement met? **None.**

E7. If case had arrearages, was it submitted for federal and state tax refund offsets, if appropriate? **Maine has developed an automated submittal that submits obligors to the administrative offset on a weekly basis. Maine has legally established debts for enforcement purposes in almost 99% of its obligated caseload.**

5. *Disbursement of Collections:*

Maine has a 99.74% efficiency rating for this category. The process is entirely automated. Of 380 cases reviewed, there was only one error case. Maine has taken steps to make certain that all receipts are posted the day they arrive at Maine DHS Cashiers, Maine's Central Disbursement Unit. Maine also established an undistributed receipts project to clean up receipts being held for any reason. The team targeted receipts that were specifically related to systems errors.

D1. From the date of receipt, did the state disburse amounts payable under subsection 457(a) of the Act within two business days after the receipt from the employer or other source of income? **We continue to monitor the same day processing at the Cashiers Division at the DHS central office. We have loaned staff to that group when it appeared that they would not meet their same day deadlines due to staffing problems or scheduled vacations.**

6. *Securing and Enforcing Medical Support:*

Maine drew a focused stratified sample of 375 cases for this Self Assessment period. There were 54 error cases. Maine has continued to emphasize corrective action for Medical Support. Though the scores reflect a better

performance, we believe there is still much room for improvement. Particularly in the area of enforcing medical obligations after we obtain them. During the review period Maine did establish a process that will bring about compliance with medical support requirements.

MS1. For support orders being established or modified, was medical support ordered? If not ordered, was medical support included in the petition for support?
All of Maine's petitions and legal referrals contain the information necessary to obtain medical support. We are satisfied that we will continue to meet this requirement easily.

MS2. If medical support ordered, did IV-D take steps to determine if health insurance was available?
There were 3 error cases. Maine's automated system includes requests for insurance information as a routine part information collecting. With the exception of the three cases, this activity was strong. The error occurred when staff did not routinely make use of the form to contact the non-custodial parents regarding insurance. This is a training issue for staff. Since we have issued direction to staff regarding the process, our corrective action will take the form of re-training and re-issuance of earlier instructions.

MS3. If medical insurance was available, but not obtained, were steps taken to enforce the order?

There were 48 error cases for this question. This is a training issue for staff. We need to continue to emphasize the need to collect and act on insurance information. In each case, we failed to "pull the enforcement trigger" when the opportunity existed. When we interviewed staff about the lack of information about their efforts to enforce medical obligations, many indicated that the Statement of Resources that non custodial parents are required to complete before the Department will enter into an agreement typically included the parent's statement about the availability of insurance. Enforcement Agents were taking their statements at face value without attempting to verify those statements further. The Division does have enforcement tools that can compel negotiations regarding medical support. During the coming year, we will direct staff to make use of the license revocation provision for medical support as well as the courts when appropriate.

MS4. If health insurance was obtained was the Medicaid agency informed?

There were three errors for this question. These were errors in data entry. Staff had the information and simply failed to load it into the NECSES system. This portion of the Medical Support performance has improved and will continue to improve. We have monthly meetings with supervisors regarding the Division's uniform practice. This issue has been introduced on several occasions. We will continue to expect that staff will complete the data

input of this valuable information. Once this is done, the NECSES system notifies the Medicaid agency of the coverage and other vital information.

MS5. If health insurance obtained, was the custodial parent notified?

None. When medical support information is loaded into NECSES, the custodial parent is notified by the system as well.

MS6. Did IV-D request insurance provider to inform them of lapses of coverage?

None. In January 2000, using the Data Warehouse, Maine notified all employers of the need to inform the Department of lapse in coverage. Prior to the period audited, Maine modified Income Withholding forms to include this instruction. We identified a contact at our central office to employers who had questions about the requirement. At first, there was a heavy response to the notification. Now, most questions are directed to field offices where withholdings are routinely generated.

MS7. If non custodial parent was providing health insurance coverage and changes employment and the new employer provides health care coverage, did the state transfer notice of health care provision to the new employer, which would enroll the child in the non custodial parent's health plan unless the non custodial parent contested the notice?

None. Maine implemented the new Income Withholding form in January 2000. Employers have been advised of their responsibility.

Maine IV-D has revamped the Medical Support process in its district offices. Though there is still much to do, the instructions issued to-date more than adequately describe what is required of personnel. Until we are confident that enforcement agents are turning their attention to medical support in all of their negotiations for support, we will insist that supervisors provide focused direction in the medical support category. This would specifically include any negotiated agreements between the non-custodial parent and the Department. For the time being, we need to make certain that medical support discussions and investigations are documented and any agreement that does not include required medical support obligations are justified or are overturned by supervisors.

On the positive side:

- Documentation of medical support activities improved considerably over prior performances and continues to improve.
- Maine has developed and implemented forms, letters, and practices to specifically deal with gathering medical support information and notification to obligors of their responsibilities.
- Maine has notified employers of their responsibilities regarding medical support.
- Maine has implemented an order to enroll dependents when insurance coverage is available

Plan of Action:

Maine will continue to implement the corrective action plan for medical support. Maine recognizes that there are still problems with the process, largely due to the fact that much of the correction occurred at the end of this review period. Maine staff is now giving the medical support issue priority. Maine intends to continue to improve on this performance.

7. Review and Adjustment:

Using its Data Warehouse capability, Maine drew a focused stratified sample of 301 cases from a universe of 1,389 cases where Review and Modification was an issue during the period reviewed. There were seven error cases. We were pleased with the sample which exceeded the samples drawn in prior years Self Assessment. It also highlighted our Administrative Review process for us. In prior Self Assessments, we had not taken the opportunity to outline the very efficient order review process established during 1995 when we also implemented our expedited hearings processes. This order review process has been very effective. We have also developed a new automated Order Review and Modification subsystem under a Federal Grant that we believe will significantly increase collections, particularly in the incentive category of current support collections.

R1. If case was reviewed and adjusted, or a determination is made, as a result of a review, during the review period, that an adjustment was not needed, the state will be considered to have taken appropriate action. **All seven errors occurred at this question. The problem was simple. Staff were contacted, a request for Order Review made, and no action taken to determine if it was feasible to proceed to modification. The implementation of the new automated Review and Modification system in June of 2001 should eliminate this problem entirely.**

R2. If request received during the review period and a review is necessary was both parties given 30 days to contest any adjustment to that support order if the cost of living or automated methods had been utilized? **None**

R3. Was review completed within 180 days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later? **None**

R4. Were the custodial and non custodial parents provided notices not less often then every three years informing them of their right to request a review? **None**

R5. If the non custodial parent's address and/or employer needed to be located, was the latest Federal Requirement met? **None**

As stated above, Maine has completed the development of the new Review and Modification system that will essentially bring Review and Modification to staff as a proactive opportunity to increase collections! Initial results in laying the baseline for the project evaluation show that this new automated system will have a positive effect on current support collections. Tracking the process will be entirely automated. Future Self Assessments will also be entirely automated.

8. Interstate Services:

Maine used focused stratified sampling for Interstate Services. Last Self Assessment, we used the Simple Random Sampling method. We believe this year's Self Assessment is a more accurate representation of Interstate Activity. **Maine has improved the Interstate process considerably by implementing the automated CSENET, FPLS (particularly New Hire), Multi-State Financial Institution Data Match (MSFIDM), and Case Registry. At present, the Interstate caseload is collecting about 51% of current support owed, a significant improvement over the early nineties when the unit collected only about 25% of current. During the period being audited, July 2000, Maine provided all professional staff with UIFSA training and organized reference materials to support the often-complex determinations under the UIFSA law.**

IN1. Were interstate time frames met? (Initiating Cases) **Maine identified 12,732 cases that had an Interstate issue during the review period. Of that**

universe, Maine chose a focused stratified sample of 373 cases. Of those 373 cases, there were 44 error cases or an 88% score in the Interstate Initiating category. What we found the error cases to be much like what we have seen in prior reviews. Unlike most states initiating cases, Maine has done much work generating "one state", "direct enforcement". Typically, Maine's Interstate staff exhaust all "one state" alternatives before requesting the more traditional "two state" actions that would require the assistance of other states. As in many states, our enforcement personnel have become a little cynical about the possibility of success using other states. Generally, they see other states throwing up obstacles rather than assisting in the successful accomplishment of the goal to obtain support for children and families. Though this perception may not be true in all instances, it certainly is an ingrained idea when agents determine what the most meaningful actions should be. As a result, uniformly, Maine did not initiate "two state" actions after cursory reviews revealed that there were no opportunities to directly enforce a case under UIFSA. In answer to this problem, our Interstate unit was re-aligned operationally. We separated paying cases from non-paying cases in order to focus on the non-payers. Using the Data Warehouse, we have identified cases where two state processes need initiating immediately and have begun those processes.

Location was another issue. This was improved over last review period with the implementation of the expanded FPLS and particularly the advent of the

New Hire program on the national level, but the problem persists. We view this as largely an organizational issue. It is our intention to shift the focus of our support staff to these areas to guarantee immediate action to locate individuals and to take action when valuable information is discovered.

IN2. Were interstate time frames met? (Responding cases)

Using the Data Warehouse, Maine identified 2,457 cases subject to Interstate Responding processes. Of that universe, Maine selected a focused stratified sample of 332 cases. After reviewing those cases, there were 10 error cases or a score of 97% in the category of Interstate Responding. Maine is particularly strong in this area because caseload management and the automated system do not differentiate between a responding cases and any other "in-state" case. Maine law allows the IV-D agency to act on debt establishment and enforcement without involving the more formalized court system. Actions in these cases are often "expedited" quickly. Since the information from other states is often quite good, collections can occur within weeks of receiving a case. When we evaluated this performance, it was often in light of the enforcement actions that we would take in any case. For example, using the Data Warehouse we were able to determine that 232 cases (or 70% of our sample) had payments as the result of enforcement actions in the last quarter of the period being reviewed; better than our in-state caseload averages. Errors occurred in this category because Maine did not act on information provided after cases had been established. We are certain

that this error, as in Interstate Initiating, is part of a dilemma involving how staff will be allocated given operational need. One solution we have considered has been to delegate specific tasks away from agents to their support staff. This has worked in some areas, but it is only a partial solution to resource problems.

IV. PROGRAM DIRECTION:

Summary of Maine's Caseloads and Collections

- Maine is an administrative state.
- Maine has strong laws and expedited processes.
- Maine's Judiciary has recently created a Family Division that facilitates the resolution of IV-D issues.
- Maine has 61,465 cases: ***(See Appendix G)*** 54,167 are obligated (88%); 2,960 are paternity (5%); 4,328 are unobligated (7%). All improved since last years Self-Assessment Report.
- Maine's expedited processes are extremely effective. Since 1992, the combined standing caseloads for paternity and unobligated caseloads have decreased by 63%. When incoming new cases are factored into the equation, Maine has moved approximately 48,000 cases from paternity and unobligated status since January 1992.

- In January 1992, Maine's obligated caseload (37,151 cases) represented 67% of the entire caseload. As of March 2000, the obligated caseload (54,167 cases) is 88% of the entire caseload. Maine's entire caseload has increased only 11% since 1992 (55,262 cases to 61,457 cases) and only about 100 cases since the last review period.
- With the increase in obligated cases, there has been a corresponding increase in collections. As of FFY ending June 1992, Maine collected approximately $41 million from about 37,000 obligated cases. As of FFY ending June 2000, Maine collected $92.7 million from 54,000 obligated cases and is currently $5 million ahead of fiscal year 2000 and obligated cases have increased to 54,936 as of February 28, 2001.
- Child support debts are legally established for enforcement purposes in over 98% of Maine's obligated IV-D caseload.
- Maine is currently collecting 65% of the current support owed in a month from instate cases (up 3% over last SA period)
- Maine collects about 51% of current support owed in a month from Interstate cases.
- Maine's collection rate in Interstate Responding cases is actually better than its In-State caseload.

Maine DSER Priorities:

Distribution: Maine has completed the Distribution Re-Write required by PRWORA for the certified NECSES system. Since distribution was the first

priority, much of Maine's programming resources will be re-focused once that new financial subsystem goes into full production. It is anticipated that much of the Data Warehouse needing completion will be accomplished. Once this is done, Maine will fully integrate Self Assessment with daily, weekly, monthly performance management.

Medical Support: This remains a top priority continuing from last year. During the last review period Maine accomplished needed revisions in the Medical Support establishment and enforcement processes. Enforcement forms, wage withholding to employers specifically, have been updated to include instruct to employers regarding changes and lapses in insurance coverage. We anticipate further training of staff in follow-up and enforcement of medical obligations.

Automating Self-Assessment: Maine is committed to the idea that Self Assessment should be embraced and incorporated into the IV-D agency's daily practice. During the past year, a significant portion of Self Assessment has been captured in the Data Warehouse. Though the program is not at the level of automation envisioned in the first Self Assessment, Maine continues to work toward that goal.

Improving Federal Reports: Maine has implemented the OCSE 34A and OCSE 157 and has passed the Data Reliability audit. Maine continues to work on automation and report generation.

Financial Institution Matches: Maine participated in the consortium spearheaded by Michigan for the in-state financial institution data match. The MSFIDM information has been loaded in the NECSES system for almost a year.

We estimate that we collected approximately $250,000 from MSFIDM matches during the past year.

EFT/EDI: Processing financial transactions electronically will give Maine a greater ability to conserve resources and dedicate staff to other program functions.

Enhancement of the Voice Response System: Maine has implemented an updated Voice Response System to be used by custodial, non custodial parents and employers to answer basic questions about child support cases. Maine is currently working on a plan to provide custodial parents with more access and information to the Child Support Program by implementing enhancements to the Voice Response – an interactive voice script as well as mass mailing of printed informational materials.

Order Review and Modification: Maine has developed a system that will select and track cases for the order review process. The system will be placed in production in June of 2001. It is anticipated that significant increases in collections will result from the implementation of this automated process.

Appear and Disclose: The Maine Legislature gave IV-D staff the ability to order non paying parents to appear at the Department of Human Services and be deposed regarding their ability to provide support for their children. This tool has proven to be invaluable in cases where an individual is working and not reporting income, or is self-employed and refusing to pay. In tough cases, Maine has used the discovery process to compel individuals to seek work. In most cases where "seek work" has been ordered, individuals have found work and now pay support pursuant to agreements. Maine has re-structured most offices after the Model

Office configuration of "monitor" (paying) caseloads and "enforcement" caseloads. This has increased the number of actions taken against the "chronic" non-payers.

License Revocation: In a report to Congress, the U.S. Inspector General identified the Maine License Revocation process as the best of its kind in the nation. The Inspector General recommended that states adopting license revocation use Maine's model. Since the implementation in 1993, over $140 million collected are attributable to License Revocation. Only 5,500 licenses have been revoked since 1993 and 70% of the individuals who lost their licenses have come into compliance with their child support obligation.

Optical Imaging: Maine has further expanded on optical imaging as a means to conserve space. During the past year, an RFP was issued and a vendor hired to construct a storage facility for Maine's Bureau of Family Independence. This new system will enable Maine's child support program to speedily recall cases from closed status back to open/active status.

Child Support Lien Network: Maine has entered into a cooperative agreement with the State of Rhodes Island to become a part of a grant to seize settlements and Insurance awards through a unique Rhode Island law that requires insurers to check the registry before issuing settlements. At present, 95% of the insurance industry is involved with the registry. Maine has begun to see some significant success in this area.

Financial Institution Data Matches: Maine has implemented the multi-state FIDM and is currently implementing the in-state FIDM as a part of the consortium initiated by the State of Michigan. Enforcement personnel have been trained to use the FIDM information to garnish financial assets. Maine has collected approximately $250,000 since the inception of FIDM by seizing financial assets.

Expanded FPLS: The expansion of the FPLS has profoundly affected Interstate enforcement. Specifically, the New Hire information now is fed to our NECSES system and made available to staff. It was a morale booster. For weeks, "one state" actions were flying out of Maine's Interstate Units. These innovations, coupled with UIFSA, have increased the annual rate of collection in the Interstate Units by over 15% during the past two years.

IV. PRESENTATION OF RESULTS: (APPENDICES)

APPENDIX A - Self-Assessment Results: State wide

TEGORY	QUESTION	#REVIEWED	YES	NO	N/A	ACTION	ERROR	QUESTION EFFICIENCY RATE %	CATEGORY EFFICIENCY RATE %	QUESTION ACTION TYPE
1	1	369	369	0						
1	C1	369	360	9			9			
1	C2	369	360	9		360	9	97.6%		
									97.56%	ACTION CASE
2	2	357	357	0						
2	OE1	357	182	175	0	182		51.0%		
2	OE2	175	132	43	0	132	43	75.4%		
2	OE3	43	43	0	0	43	0	100.0%		
2	OE4	0	0	0	0	0	0	#DIV/0!		
									100.00%	ACTION CASE
3	3	347	347	0						
3	EP1	347	347	0	0	347	0	100.0%	100.00%	ACTION (6 MO's)
3	EP2	347	347	0	0	347	0	100.0%	100.00%	ACTION (12 MO's)
									100.00%	ACTION CASE
4	4	381	381	0						
4	E1	381	0	0	0	0		0.0%		
4	E2	381	217	164	0	217		57.0%		
4	E3	164	45	2	0	45	2	27.4%		
4	E4	164	26	2	0	26	2	15.9%		
4	E5	164	69	12	0	69	12	42.1%		
4	E6	164	2	0	0	2	0	1.2%		
4	E7	381	381	0	0	381	0	100.0%	100.00%	ACTION CASE
									94.23%	ACTION CASE
5	5	380	380	0						
5	D1	380	379	0	0	379	0	99.7%		
									99.74%	ACTION CASE
6	6	375	375	0						
6	MS1	375	297	0	72	297	0	79.2%		
6	MS2	375	186	3	186	186	3	49.6%		
6	MS3	375	29	48	318	29	48	7.7%		
6	MS4	375	10	3	362	10	3	2.7%		
6	MS5	375	8	0	367	8	0	2.1%		
6	MS6	375	38	0	337	38	0	10.1%		
6	MS7	375	375	0	0	375	0	100.0%		
									85.60%	ACTION CASE
7	7	301	301	0						
7	R1	301	294	7	0	294	7	97.7%		
7	R2	301				0	0	0.0%		
7	R3	301				0	0	0.0%		
7	R4	301				0	0	0.0%		
7	R5	301				0	0	0.0%		
									97.67%	ACTION CASE
8	8	705	705	0						
8	IN1	373	329	44		329	44	88.2%		
8	IN2	332	322	10		322	10	97.0%		
									92.34%	ACTION CASE

APPENDIX B - Federal Self-Assessment Questions

Case Closure					
Questions	**Yes**	**No**	**Reasons for Deficiency**	**References**	**Comments**
1. Was case closed during the review period?					If Yes, continue with Question C1. If No, go to Question 2.
C1. If the case was closed, did it meet one or more of the Federal closure criteria?				§303.11(b)(1) - (12)	If Yes, go to Question C2. No represents an Error case.
C2. If closed, was 60-day notice sent, if appropriate?				§303.11(c)	Yes or N/A represents an Action case. No represents an Error case.

General Case Closure Comments:

ESTABLISHMENT OF PATERNITY AND CHILD SUPPORT ORDERS

Questions	Yes	No	Reasons for Deficiency	References	Comments
2. Was child support order establishment an issue during the review period?					If Yes, Continue with Question OE1; If No, Go to Question #3.
OE1. Was a child support order established during the review period?				303.4	Yes represents an "Outcome Action Case"; go to Question #3. If No, go to Question OE2.
ONLY EVALUATE ONE QUESTION BETWEEN OE2 AND OE4:					Evaluate the last required action during the review period for which the time frame can be evaluated.
OE2. If the non-custodial parent was located, was service accomplished within 90 calendar days of locate, or if service was unsuccessful, were unsuccessful attempts documented in accordance with State's definition of diligent efforts.				303.4(d) and 303.3(c)	Yes represents a "Process Action Case"; go to Question #3. No represents an Error case.
OE3. If location was needed, was the latest Federal locate requirement met?				303.3(b)(3) and (5)	Yes represents a "locate action case" go to question #3. No represents an Error case.
OE4: If case opening was needed, was the Federal requirement met?				303.2(b)	Yes represents a "case opening action case." No represents an Error case.

General Establishment Comments:

EXPEDITED PROCESSES

Question	Yes	No	Reason for Deficiency	References	Comments
3. Was expedited process an issue (support order need to be established in the review period and non-custodial parent had been served either prior to or during the review period)?					If Yes, Continue with Question EP1; If No, Go to Question 4.
EP1. Were actions taken to establish support orders (and paternity if needed) from the date of service to the time of disposition within 6 months? (If long-arm jurisdiction used, credit given for 6-month standard if action completed within 12 months.)				§303.101(b)(2)(i) and §303.101(b)(2)(iii)	Yes represents an **"Outcome Action Case." Also, EP2 would also receive a Yes for the second time frame.** If No, Go to Question EP 2. N/A if insufficient time to complete.
EP2. Were actions taken to establish support orders (and paternity if needed) from the date of service to the time of disposition within 12 months?				§303.101(b)(2)(i)	Yes represents an **"Outcome Action Case",** go to Question 4. No represents an error case. N/A if insufficient time to complete.

General Expedited Process Comments:

ENFORCEMENT OF SUPPORT OBLIGATIONS					
Question	**Yes**	**No**	**Reason for Deficiency**	**References**	**Comments**
4. Was Enforcement of Support Obligations an issue during the review period?					If Yes, Continue with Question E1; If No, Go to Question 5.
E1. Was a wage withholding (ww) collection received in the last quarter of the review period?				303.6(c)(1)	Yes represents an **"Outcome Action Case"** and do not need to review time frames; but must also review question E7. If No, go to Question E2.
E2. If ww not appropriate, was any collection received as a result of an enforcement action?				303.6(c)(2)	Yes represents an **"Outcome Action Case"** and do not need to review time frames; but must also review question E7 If no, go to Question E3.
ONLY EVALUATE ONE QUESTION between E3 and E6 :					Evaluate the last required action during the review period for which the time frame can be evaluated.
E3. If ww was appropriate, was ww actions initiated within required time frames?				303.100(c)(2) and 303.100(f)(2)	If yes, go to Question E7 to determine if all Enforcement requirements met. No represents an Error case; go to Question 5.

E4. If ww was not appropriate, was other appropriate enforcement action(s) initiated within Federal time frames, or if service of process necessary but unsuccessful, were unsuccessful attempts documented to meet State's diligent efforts definition?				303.6(b), 303.6(c)(2), and 303.3(c)	If yes, go to Question E7 to determine if all Enforcement requirements met. No represents an Error case; go to Question 5.
E5. If non-custodial parent's address and/or employer needed to be located, was the latest Federal requirement met?				303.3(b)(3) and 303.3(b)(5)	If yes, go to Question E7 to determine if all Enforcement requirements met. No represents an Error case; go to Question 5.
E6. If case opening required, was the Federal requirement met?				303.2(b)	If yes, go to Question E7 to determine if all Enforcement requirements met. No represents an Error case; go to Question 5.
ANSWER THE FOLLOWING QUESTION IF CASE HAS ARREARS					
E7. If case had arrearages, was it submitted for Federal and State Tax Refund Offsets, if appropriate?				303.6(c)(3), 303.72(a), and 303.102(a)	If yes or N/A, and previous Federal requirements met (Question E2 through E6), then Case is an Action case. No represents an Error case; go to Question 5.

General Enforcement Comments:

DISBURSEMENT OF COLLECTIONS

Questions	Yes	No	Reasons for Deficiency	References	Comments
5. Were collections received during the last quarter of the review period? (If more than one collection, review the latest collection received during the last quarter of the review period.)					If Yes, Continue with Question d1; If No, Go to Question 6. **This requirement is effective 10/1/98 or 10/1/99 (for courts handling collections prior to PRWORA)**
D1. From date of receipt, did the State disburse amounts payable under §457(a) of the Act within 2 business days after receipt from the employer or other source of income?				§454B(c)(1) of the SSA	Yes represents an **"Outcome Action Case"**, go to Question 6. No represents an "**Error**" **case.**

General Disbursement of Collections Comments:

Securing and Enforcing Medical Support Orders

Questions	Yes	No	Reasons for Deficiency	References	Comments
6. Was securing and enforcing a Medical Support Obligation an issue during the review period?					If Yes, Begin with Question MS1; If No, Go to Question 7.
MS1. For Support orders being established Or modified, was medical support ordered? If not ordered, was medical support included in the petition for support?				§303.30(b)(2)	If yes, go to Question MS2. If No, go to Question 7.
MS2. If medical support ordered, did IV-D take steps to determine if health insurance was available?				§303.31(b)(1)	If Yes or N/A, go to Question MS3. No represents an Error case.
MS3 If medical insurance was available, but not obtained, were steps taken to enforce the order?				§303.30(a)(7) and §303.30(a)	No represents Error case.
MS4. If health insurance was obtained, was the Medicaid agency informed?				§303.3 1 (b)(7)	No represents Error case.
MS5. If health insurance obtained, was custodial parent notified?				§303.31(b)(6)	No represents Error case.
MS6. Did IV-D request insurance provider to inform them of lapses of coverage?				§303.31(b)(5)	No represents Error case.
MS7. If non-custodial parent was providing health insurance coverage and changes and changes employment and the new employer provides health care coverage, did the State transfer notice of 'the health care provision to the new employer, which would enroll the child in the non-custodial parent's health plan, unless the non-custodial parent contested the notice?				§303.31(b)(9)	No represents Error case.

General Medical Support Comments:

REVIEW AND ADJUSTMENT OF ORDERS

Questions	Yes	No	Reasons for Deficiency	References	Comments
7. Was review and adjustment an issue during the review period?					If Yes, Continue with Question R1; If No, Go to Question 8.
R1. If case was reviewed and adjusted, or a determination is made, as a result of a review, during the review period, that an adjustment was not needed, the State will be considered to have taken appropriate action.				§303.8(f)(3)	Yes represents an **Action Case,** go to Question 8. If no, answer appropriate question R2 through R5.
ONLY EVALUATE ONE QUESTION between R2 and R5 :					
R2. If request received during the review period and a review is necessary, was both parties given 30 days to contest any adjustment to that support order if the cost-of living or automated methods had been utilized?				§466(a)(10)(A)(ii) of the Act	Yes represents an Action case. No represents an Error case.
R3. Was a review completed within 180 days of determining that a review should be conducted or locating the non-requesting parent, whichever occurs later?				§303.8(f)(1)(ii)	Yes represents an Action case. No represents an Error case.
R4. Were the custodial and non-custodial parents provided notices not less often then once every three years informing them of their right to request a review?				Section 466 (a)(10)(C) of the Act	Yes represents an Action case. No represents an Error case.
R5. If non-custodial parent's address and/or employer needed to be located, was the latest Federal requirement met?				303.3(b)(3) and 303.3(b)(5)	Yes represents an Action case. No represents an Error case.
General Review and Adjustment Comments:					

INTERSTATE SERVICES

Questions	Yes	No	Reasons for Deficiency	References	Comments
8. Was Interstate an issue during the review period?					If Yes, Continue with Question IN1; If No, not applicable.
INITIATING INTERSTATE CASE:					
IN1: Were interstate time frames met?				§303.7(b)(2), §303.7(b)(4), §303.7(b)(5), and §303.7(b)(6)	Yes represents an Action case. No represents an Error case.
RESPONDING INTERSTATE CASE:					
IN2: Were interstate time frames met?				§303.7(a)(2), §303.7(a)(4), §303.7(c)(5), §303.7(c)(6), §303.7(c)(7)(iv), and 303.7(c)(9).	Yes represents an Action case. No represents an Error case.

General Interstate Comments:

JUL 16 2001

DEPARTMENT OF HEALTH & HUMAN SERVICES

Audit Report No. ME-00-DRA

ADMINISTRATION FOR CHILDREN AND FAMIL
370 L'Enfant Promenade, S.W.
Washington, D.C. 20447

July 10, 2001

Mr. Kevin W. Concannon
Commissioner
Department Of Human Services
11 State House Station
Augusta, Maine 04333

Dear Mr. Concannon:

The Administration for Children and Families (ACF), Office of Child Support Enforcement (OCSE), Office of Audit has completed a Data Reliability Audit (DRA) in Maine for the fiscal year (FY) 2000 reporting period. Pursuant to section 452(a)(4)(C)(i) of the Social Security Act (Act), OCSE is required to conduct audits to assess the completeness, reliability, and security of the data and the accuracy of the reporting systems used in calculating performance indicator data under sections 452(g) and 458A.

This audit report presents only those areas where exceptions were identified. We did not identify any major deficiencies in any of the 8 performance indicator lines that are reported on the OCSE-157, "Child Support Enforcement Annual Data Report." A major deficiency was determined to be any performance indicator line item for which the State did not have an adequate audit trail or a line item with an efficiency rate of less than 90 percent. We did not identify any major deficiencies for the Cost Effectiveness performance indicator. The appropriate ACF official will make any final determination as to the reliability of Maine's reported performance indicator data.

BACKGROUND

Under Section 341(a) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), Public Law (P.L.) 104-193, the Secretary of Health and Human Services, in consultation with Directors of State Child Support Enforcement Programs, was required to recommend to Congress a new incentive funding scheme for States, based on program performance. As a result of this process, in the Child Support Performance and Incentive Act of 1998, P.L. 105-200, Congress enacted a new incentive system under which incentive payments may be made to each State based on its performance on each of the following performance indicators:

- **Paternity Establishment Performance Level;**
- **Support Order Performance Level;**
- **Current Payments Performance Level;**

- **Arrearage Payments Performance Level; and**
- **Cost-Effectiveness Performance Level.**

Section 458A(b)(5)(B) of the Act requires the Secretary to determine that State-reported data used to determine the performance levels are complete and reliable. That determination will be made each FY based on an audit of the performance indicator data. The new incentive provisions will be phased in over three years, with one-third of incentives paid under the new formula for FY 2000, two-thirds for FY 2001, and all incentives paid under the new formula beginning in FY 2002. FY 1999 was the base year used in calculating incentives for FY 2000 under the new formula.

SCOPE OF AUDIT

The audit was conducted to determine whether the system used by the Maine IV-D program to report performance measurement data was reliable and that the data generated by that system was accurate, complete, and secure. Our objective was also to determine whether data used to compute the performance indicators met OCSE's reporting requirements and fairly represented the reported performance indicator data, as required by the General Accounting Office's (GAO's) guide, Assessing the Reliability of Computer-Processed Data, issued in September 1990. To the extent applicable, we also evaluated information that was reported by the State, which will be utilized for performance measurement calculations, but may not have been generated through the official IV-D system, such as the data from vital statistics and data on the OCSE-396A "Child Support Enforcement Program Financial Report."

The audit was conducted in accordance with GAO's Government Auditing Standards and the OCSE Office of Audit's "Data Reliability Audit Guide". Information concerning the IV-D automated system and other reporting systems was obtained from inspection of pertinent documentation and discussions with appropriate program officials. The audit was performed during January through February 2001. Fieldwork was performed at the Central IV-D Office, Financial Services and the Bureau of Information Services in Augusta, Maine. The results of our review of performance indicator data reported for the period October 1, 1999 through September 30, 2000, are presented in the Schedule at the end of this report. This Schedule provides an efficiency rate for each performance indicator line item reviewed on the OCSE-157.

The scope of our current audit was limited to assessing program logic/data definitions and data testing of performance indicator lines reported on the OCSE-157. To review the Cost-Effectiveness performance indicator, we also evaluated whether selected amounts reported on the OCSE-34A, "Child Support Enforcement Program Quarterly Report of Collections" and the OCSE-396A "Child Support Enforcement Program Financial Report," could be verified to the first level of State documentation. In addition, the data definitions used by the State to complete the OCSE-34A were reviewed for compliance with Federal reporting instructions. The State's physical security and access controls were evaluated. We also reviewed the interface between the IV-A/IV-D systems and did not find any deficiencies.

Program logic and data definitions were reviewed during the FY 1999 data reliability audits. If any programming or definitional revisions were made after the FY 1999 audits, they were

evaluated to determine if the data used to compute performance indicators and the programs used to compile and report the data met OCSE reporting requirements. For data testing purposes, States were requested to provide the area audit offices with files containing their child support universe and audit trails as outlined in Dear Colleague letter DC-00-77, "Data Reliability Audit Requirements for FFY 2000," dated July 20, 2000.

Data testing was conducted on performance indicator line items from the OCSE-157, dated September 30, 2000, to determine whether reported performance indicator data was reliable and complete. To determine if case information was correctly reported, we selected a simple random sample of 408 cases from the Child Support System Universe. We verified whether our sample of open cases and cases closed during the fiscal year were supported by information on the State systems and/or to supporting documentation and whether they were correctly reported on the applicable lines. For the non-IV-D cases and cases closed prior to the audit period, we verified whether any of these cases were reported on the performance indicator lines. However, if we determined that any of these cases were included on one or more of the lines, they were included in the regular case review process.

Documentation was obtained for these cases and used for reviewing Lines 1, 2, 5, 6, 24, 25, 28, and 29 of the OCSE-157. We determined whether the data that should have been included on any given line actually was included, and whether the data that was included on any given line should have been included. Sample results were evaluated using the confidence interval method to compute the degree of sampling error associated with that estimate, and to present the range of values within which the true universe parameter being measured is expected to occur. Percentages have been rounded to the nearest whole number. A complete discussion of the sampling methodology can be found in the DRA Audit Guide.

We did not evaluate whether collections were distributed in accordance with Federal regulations. This analysis lies outside the scope of this audit. An evaluation of whether collections were distributed in accordance with Federal regulations will be performed during the PRWORA certification reviews.

DETAILED AUDIT RESULTS AND RECOMMENDATIONS

Our review of sample cases did not identify any performance indicator lines with an efficiency rate[1] of less than 90 percent. See the enclosed Schedule for the case review results of each of the performance indicator lines.

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[1]The efficiency rate for lines 1, 2, 5, 6, 28, and 29 is calculated by dividing the number of cases that were correctly reported by the total number of cases reviewed for a given line item. Based on the results obtained from sample data for each line item reviewed the upper and lower confidence limits for each efficiency rate were calculated at the 95 percent confidence level.

Thank you for the assistance and cooperation provided by your staff during the conduct of this audit.

Sincerely yours,

Keith E. Bassett, Director
Office of Audit, OCSE

Enclosures

cc: Mr. Stephen Hussey, Director of Support Enforcement and Recovery, DHS, Maine
Mr. Frank Fuentes, Acting Commissioner, OCSE
Mr. Hugh Galligan, Regional Administrator, Region I, ACF
Mr. Stanley Gardner, OCSE Program Manager, Region I, ACF
Mr. Charles K. Jenson Manager, North Audit Region, OCSE
Mr. Robert P. Edson Supervisor, Boston Area Audit Office, OCSE

OCSE Office Audit SCHEDULE

Assignment Code: ME - 00 - DRA

Case Review Summary

Line Description	DATA TESTING RESULTS					STATISTICAL ANALYSIS		
	Amount Reported on OCSE-157	Number Reviewed	Should have been Reported	Reported on OCSE-157	Errors	Efficiency Rate 1/, 3/	Confidence Interval for a 95 % Confidence Level	
							Lower Bound	Upper Bound
OCSE-157, Line 1, Cases Open at the End of the Fiscal Year	61,514	176	176	176	0	100%	98%	100%
OCSE-157, Line 2, Cases Open at the End of the Fiscal Year With Support Orders Established	54,526	165	165	165	0	100%	98%	100%
OCSE-157, Line 5, Children in IV-D Cases Open at the End of the Fiscal Year Who Were Born Out-of-Wedlock	38,169	88	88	88	0	100%	96%	100%
OCSE-157, Line 6, Children in IV-D Cases Open During or at the End of the Fiscal Year With Paternity Established or Acknowledged	33,750	87	87	87	0	100%	96%	100%
OCSE-157, Line 8, Children in the State Born Out-of-Wedlock During the Fiscal Year (Statewide)	0	0	0	0	0	0%	0%	0%
OCSE-157, Line 9, Children in the State With Paternity Established or Acknowledged During the Fiscal Year (Statewide)	0	0	0	0	0	0%	0%	0%
OCSE-157, Line 24, Total Amount of Current Support Due for the Fiscal Year 2/	$101,116,697	117	$401,548	$401,548	$0	100%	100%	100%
OCSE-157, Line 25, Total Amount of Support Distributed as Current Support During the Fiscal Year 2/	$57,939,190	87	$247,677	$245,463	$2,410	99%	97%	100%
OCSE-157, Line 28, Cases with Arrears Due During the Fiscal Year	49,092	152	152	142	10	93%	88%	97%
OCSE-157, Line 29, Cases Paying Toward Arrearages During the Fiscal Year	33,710	97	97	96	1	99%	94%	100%

1/ The efficiency rate for lines 1, 2, 5, 6, 8, 9, 28, and 29 is calculated by dividing the number of cases that were properly reported by the total number of cases reviewed for a given line item. Based on the results obtained from sample data for each line item reviewed the upper and lower confidence limits for each efficiency rate were calculated at the 95 percent confidence level.

2/ Since lines 24 and 25 are dollar figures (aggregate ratios) and not case counts (proportions), the efficiency rates for these lines are calculated differently than the other lines. The efficiency rates for these lines are calculated by dividing the aggregate amount of dollars reported incorrectly by the aggregate amount of dollars that should have been reported as per audit and subtracting this percentage from 100 percent. Both the upper and lower confidence limits about the efficiency rate were then calculated at the 95 percent confidence level.

3/ Percentages have been rounded to the nearest whole number.

Program Title: **Fraud, Investigation and Recovery**

A. Enabling or authorizing law or other relevant mandates, including any federal mandates:

- Title 22, MRSA, §13 creates the Human Services Fraud Investigation Unit
- Title 22, MRSA, §§ 3811 through 3824 enables the unit to recover public assistance debt through the administrative process.
- Title 36, MRSA, §5276-A allows the unit to recover public assistance debt through the Maine state income tax offset.
- Title 17-A, MRSA, §§8, 57, 354, 362, 452, 453, 702, and 703 covering various criminal statutes and prosecution requirements used by the unit.
- Title 7, Code of Federal Regulations, §273.18 provides instruction in the development and collection of food stamp claims (overpaid benefits) and the collection of the same.
- Title 45, Code of Federal Regulations, §233.20 and §§235.110 through 235.112 provides instruction in the development and collection of AFDC and TANF claims (overpaid benefits) and the collection of the same.
- The Debt Collection Act or 1982, as amended by the Debt Collection Improvement Act of 1986, 5 U.S.C. §5514, *et seq.*, allows the unit to use the Treasury Offset Program to intercept federal payments to recover food stamp debt.
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), 42 U.S.C. (Public Law 104-193)

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goal and objectives in meeting each priority

Fraud, Investigation and Recovery (FIR) administers no programs. It is instead responsible for the prosecution of fraud, attempted fraud and the mishandling of funds administered by the Department. Although the prime enabling statute is written broadly, the emphasis within the unit is limited, primarily by its small size, to those areas dealing with the public assistance programs, TANF/AFDC, Food Stamps, and, to a lesser degree, GA. The unit's connection with Maine Care fraud is very limited. The unit is also charged by the same statute with assisting the Attorney General in

the recovery of fraudulently received benefits. Administratively, FIR has been charged with the recovery of overpaid public assistance benefits using the administrative recovery law in 22 MRSA 3811, *et seq.* Among the goals and objectives are:

- Increase the amount collected through direct activity of the unit and through recoupment of benefits.
- Select appropriate cases for prosecution.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

FIR attempts to refer between 15 and 20 fraud cases to the Attorney General for prosecution each year. In addition, the unit, generally, has increased collections of overpaid benefits between five and ten percent each year. It has been successful in reaching these levels in most years since 1991.

- In FY 2001, total collections applied towards overpaid public assistance debt approached 1.4 million dollars. This was an increase of approximately 9% over FY 2000.
- In FY 2001, 2247 new overpayments were created and 1334 cases were closed as paid in full.
- In FY 2001, 31 criminal acts were referred. Nine individuals were convicted of felony crimes and 13 cases remain in a pending status for the year.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goal and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

- FIR has set goals and objectives with the intent of obtaining the results over time and not necessarily year-to-year. The validity of those goals and objectives is demonstrated by looking back to FY1991 when the total collections were about $650,000. This past year the total collections had increased by slightly more than 100%, or an average of 10% a year.
- In 1991, one conviction was obtained using one-half of the services of an Assistant Attorney General. This past year nine convictions were obtained and 13 cases are pending, utilizing 100% of the services of an Assistant Attorney General.

C. **Organizational Structure, including a position count, a job classification, and an organizational flow chart indicating lines of responsibility.**

- The unit consists of the Director, Fraud Investigation, a Family Independence Unit Supervisor, nine (9) Fraud Investigators, one (1)

Human Services Aide III and one (1) Clerk Typist II. (See attached job classification and organizational chart).

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

Rule changes are based on federal and state regulatory changes for Food Stamps, TANF, GA and, to a lesser degree, Maine Care.

- In 1993 Title 22, MRSA, §3811 to 3824 passed by the legislature, provided an administrative recovery process for the collection of public assistance debts. This law was limited to any overpayment, whether occurring before or after the passage of the law, and classified as having resulted from the intentional acts of recipients to collect benefits to which they were not entitled.
- In 1995, administrative rules were created and adopted to closely follow the wording of the law.
- In 1997 Title 22 MRSA §3811, et seq., was amended to include all overpayments, whether before or after the effective date of the change, regardless of the intent of the recipient where benefits were paid as the result of an inaccuracy and, in keeping with the requirements of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), those instances where benefits were improperly received as the result of the providing agency's error.
- In 1997, the administrative rules were changed and adopted to closely follow the wording of the amended law.
- Both the original rules and the amended law and rules provide for a Notice to Repay, placing the recipient of overpaid benefits on notice that the Department is owed the amount of the overpayment and the remaining balance will be collected using the various methods provided in the law. These include income withholding orders, personal and real property liens, assignments of earnings and reporting the debt to credit reporting agencies.

The Notice also provides notice of the rights of the recipient to request a limited hearing relative to the amount owed and the manner of providing notice.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to cooperative arrangements to coordinate services and eliminate redundant requirements.

- In 1991, FIR attempted, for the first time, to submit debts caused by overpaid benefits to the State Tax Assessor for the purpose of recovering a portion of the debt owed from income tax offset. meeting with very limited success.
- In 1992, FIR, as the Department's representative agency, became the first state in the northeastern area of the country to participate in an attempt to recover Food Stamp debt through the Internal Revenue Service's Tax Offset Program. This was very successful and led to patterning the submission requirements to the State Tax Assessor after the Federal program. The Federal program has been expanded from just income tax refund offset to the offsetting of most Federal payments. This program, however, is limited to the overpayment of Food Stamp benefits
- In 1992, FIR expanded the submission of AFDC (now TANF) benefit overpayments and Food Stamp benefits overpayments to the State Tax Assessor, following much the same requirements as used in the federal program, but for both programs.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

FIR serves Maine households and taxpayers.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

FIR has not explored alternative delivery systems, especially privatization, due to the rigid confidentiality requirements imposed by the Federal government in particular.

J. Identification of emerging issues for the agency or program in the coming years.

- Collections occur by benefit reductions or by various collection methods through FIR. As caseloads increase for FIR, the demand on staff to establish and collect overpayments increases which may result in backlogs.

K. Any other information specifically requested by the committee of jurisdiction:

None known.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program:

None known.

M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practices of notice, choice, access, integrity and enforcement.

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

BUREAU OF FAMILY INDEPENDENCE
PROGRAM EVALUATION REPORT

2002
DHHS
GEA Review

Program Title: **Food Stamps**

A. Enabling or authorizing law or relevant mandate, including any federal mandates:

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Sec. 801 -891
Food Stamp Act of 1977 (as amended by P.L. 106-540, December 8, 2000)
7 CFR 271-273
22 MRSA 3104

B. A description of each program administered by the agency or independent agency, including the following for each program:

Description:

The Food Stamp program is designed to promote the general welfare and to safeguard the health and well being of the Nation's population by raising the levels of nutrition among low-income households, and by providing benefits to increase access to food products.

1. Established priorities, including goals and objectives in meeting each priority;

The Program's priorities, goals and objectives are to:

Provide food assistance to eligible households while emphasizing access to the program as well as maintaining integrity of the program.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;

(a). The latest national statistics, for 1998, show that Maine is fourth in the nation in participation rates for the program. Maine is at 82% while the national average is 59%.

(b). Maine's Quality Assurance rate is just at the national average rate for FFY 2001. Final figures will not be available until spring. For FFY 2000, Maine was just above the national average. Maine has an agreement with USDA to reinvest funds to improve payment accuracy.

(c). Each year the Food and Nutrition Service provides Maine with target areas for its Food Stamp Management Evaluation. The objectives of the evaluation process are to provide a systematic method of monitoring and assessing program operations in the project areas; to provide a basis for project areas to improve and strengthen program operations by

identifying and correcting deficiencies; and to provide a continuing flow of information between project areas, the States, and FNS, necessary to develop the solutions to problems in program policy and procedures.

The following are target areas for FFY 2002:

1). Customer Service
2.) Recipient Claims Management
3.) Payment Accuracy
4.) State Staffing Standards
5.) Program Participation By ABAWDs
6.) Civil Rights
7.) Corrective Action
8.) Triennial Reviews of Coupon Issuers and Bulk Storage Points
9.) State Purchasing of Food Stamp Coupon
10.) FSP Reinvestment of Quality Control Penalties.

(d). Each year the Department submits a FNS-366B report which includes information concerning:

1). Number of applications and re-certifications for food stamp households both with and without public assistance
2). Number of those which are approved as well as denied and overdue.
3). Number of fair hearings requested, held, upheld, overruled, overdue and pending.
4). Number of disqualification hearings scheduled, waivers signed, upheld, overruled, overdue, pending and cancelled.
5). Claims activity which is also reported quarterly on the FSN-209 report.
6). Number of fraud investigations both at prior certification and dollars involved, number of investigations either cancelled or pending. In addition, the numbers of cases referred for disqualification hearings, those with signed waivers, upheld convictions, acquittals, program dollars, as well as pending or overdue decisions.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

Maine's high participation rate is the result of a number of initiatives:

(1). The Maine State Housing Authority and the Maine Department of Human Services have resolved an issue concerning the receipt of HEAP. If a household receives a HEAP payment, regardless of the amount, the household can receive credit for paying for heating costs.

This increases the utility allowance in the budget for food stamp allotments. Those in subsidized housing, with heat included, are eligible for a $1 HEAP payment, which allows the Department to use the full utility standard in its calculations.

(2). Waivers—there are a number of waivers that Maine has requested and received which allow either further access to the program or ease in the administration of the program. See Section L.

(3). Maine has adopted a 10-10-12 rule, which results in fewer client errors. Clients have 10 days to report a change, the Department has 10 days to act on the change, and if the change is adverse, the Department gives a 12-day notice that allows 2 days for mailing.

(4). Maine has developed an abbreviated application form for Food Stamps and Maine Care for elderly and disabled applicants.

(5). Maine allows categorical eligibility for those households that include a child age 18 and younger (or 19 and in secondary school full time) and who lives with a parent or caretaker relative. By being deemed categorical, some barriers such as gross income tests, are waived.

(6). Maine has been awarded a USDA grant in the amount of $334,692 for an elder grant project in Waldo County. This is one of six grants nationwide to increase participation in the program of the elderly population. The project has been named FACES (Food Assistance—Connecting Eligible Seniors) and is set to begin by February 2002 and will last for two years.

(7). Maine has a restaurant meals program that allows participants who are elderly, disabled or homeless to purchase meals in authorized restaurants. There are currently 31 restaurants in Maine who are authorized by USDA to accept Food Stamps.

(8). To assist Maine in decreasing errors, the Bureau of Family Independence is creating ACES (Automated Client Eligibility System) that will be running effective June 2001. This system will determine eligibility and will decrease agency errors.

(9). In conjunction with ACES, the Department will be requesting waivers that will allow longer certification periods and will ease reporting requirements for our earned income households. If granted, these waivers will encourage participation by working households by lessening the burden of receiving Food Stamp benefits.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

The Bureau of Family Independence has integrated service delivery in each of its sixteen field and satellite offices. This means that Family Independence Specialists handle Maine Care (Medicaid/Cub Care), State Supplement, Food Stamps, Emergency Assistance, Temporary Assistance for Needy Families (TANF), Parents as Scholars (PaS), and Alternative Aid. The Deputy Bureau Director supervises eight (8) Family Independence Regional Program Administrators who supervise thirty-seven (37) Family Independence Unit Supervisors who in turn supervise three hundred forty three (343) Family Independence Specialists and eighteen (18) Human Service Aide IIIs. A Family Independence Program Manager interprets federal and state law, writes program policy and provides technical assistance and direction to regional operations as it relates to the program. The Food Stamp Program Manager also supervises a Business Manager I who supervises the Food Stamp Issuance Unit consisting of a Clerk IV, an Account Clerk II, a Clerk Typist II, a Stores Clerk and a Clerk Typist I.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial statement for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted:

The Food Stamp program is a federal program. Other than rules concerning the aforementioned waivers, Maine's Food Stamp program adopts those that are mandated by the federal government as they become known. Occasionally, there is some State legislation connected with the Food Stamp program such as State funded coverage for lawfully admitted immigrants not covered by federal law.

Below are approved policies for Calendar Year 2001:

FOOD STAMP APPROVED POLICIES
(January, 2001 through December, 2001)

117A Increase in the Full Standard Utility Allowance and the Non Heat Utility Allowance effective January 2001 and an increase in the Excess Shelter Deduction effective March 2001
Effective: January 1, 2001 and March 1, 2001

118A Updated List of Exempt Geographic Areas for Work Requirements and Waived Areas for the Three (3) Month Time Limited Rule for ABAWDS
Effective: June 1, 2001

119A Reporting Illegal Aliens, Interviews, Sponsored Aliens, Vehicles, Self-Employment, Categorical Eligibility, Excluded Income, Shelter Costs, Utility Allowances, and Certification Periods
Effective: June 1, 2001

119A(a) Heat Utility Standards and Lengthening Certification Periods (was done to correct 119A which was approved with two missing pages)
Effective: June 1, 2001

120A Claims and Collections, Legal Aliens
Effective: August 1, 2001

121A Categorical Eligibility, Denials for Failure to Provide Verification, Shelter Costs
Effective: September 1, 2001

122A Increase in Income Limits, Maximum Allotments and Excess Shelter Deduction; Quarterly Earnings for Social Security; Disqualifications; Work Exemptions; Regaining of Eligibility for ABAWDS and EITC
Effective: October 1, 2001

123A Means Test for TANF Funded Services of Categorically Eligible Households and Excess Medical Deduction Clarification
Effective: November 1, 2001

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

1. The Bureau of Family Independence has coordinated its efforts to increase participation with by resolving the issue of the receipt of HEAP (in the amount of $1) for residents of subsidized housing.

2. The Bureau of Family Independence has coordinated its efforts to maximize the enrollment of the school lunch program by sharing participant names with the Department of Education.

3. The Department assists the Nutrition Education Plan by requesting waivers, receiving grant money and by mailing information to Food Stamp participants about nutrition education. The Bureau of Family Independence works with all three components of the plan (the Maine Nutrition Network Nutrition for Seniors, and the University of Maine Cooperative Extension) in their endeavors.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

The Food Stamp program serves all Maine households who meet eligibility requirements.

Changes in eligibility occur following changes in federal regulations. There is a possibility that some legal immigrants will be allowed federal authorization that was lost as a result of PRWORA. If federal regulations allow those individuals to receive federal benefits, Maine will no longer need to have its State funded program.

The Food Stamp program is going through a reauthorization process at the federal level. We expect a number of changes as a result. The process is to be completed effective October 2002.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.**

DHS is required by State law to operate this program; there are no plans for privatization.

The State is in the process of developing an EBT (electronic benefit transfer) system (see description in section "J" below).

J. **Identification of emerging issues for the agency or program in the coming years.**

All states are under a federal mandate to have an electronic benefits transfer (EBT) for the issuance of Food Stamps by October 2002. The State Legislature has funded this project and it is under development. The system will enable recipients to access their Food Stamp and TANF or PaS benefits with the use of a debit card.

Federal reauthorization may also change some policy requirements.

K. Any other information specifically requested by the committee of jurisdiction;

No additional information has been requested as of this date.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

Below are waivers that give the State some variance from Federal regulations:

1. #93002—Allows the face-to-face interview to be waived for those households in which all members are elderly, receiving SSI or SSDI or who are disabled. The face-to-face interview is waived for both applications and re-certifications.

2. #940048—Allows the face-to-face interview to be waived for those households with earned income except for one a year. These households are certified for a three-month period. Three reviews per year are "paper" reviews.

3. #940049—Allows a face-to-face interview on all other cases to be conducted at every other re-certification.

4. #940051—Allowed a combined notice of expiration and the re-certification form. New regulations allow this without a waiver.

5. #920040—Allows the Department to deny applications after 10 days when the applicant has failed to provide necessary information. This "alerts" the applicant earlier than necessary of their responsibility to provide information so that the Department can determine eligibility. Applicants who are subsequently found to by eligible receive benefits sooner than they would otherwise.

6. #970315, #970140 and #970141—Allows certain geographic areas to be exempt from work requirements (including ABAWD requirements) due to high unemployment rates. The areas are either by county or labor market areas.

7. #971001—Allows our three nutrition education programs to deliver services to non-Food Stamp households, which are potentially eligible for FS. Their programs reach those who may be eligible and who, hopefully, apply for the program. Either way, they benefit be receiving nutrition education.

8. #981001—Allows our three nutrition education programs to use private donations as part of the State match. This increases their resources to develop their nutrition education plans.

M. **Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

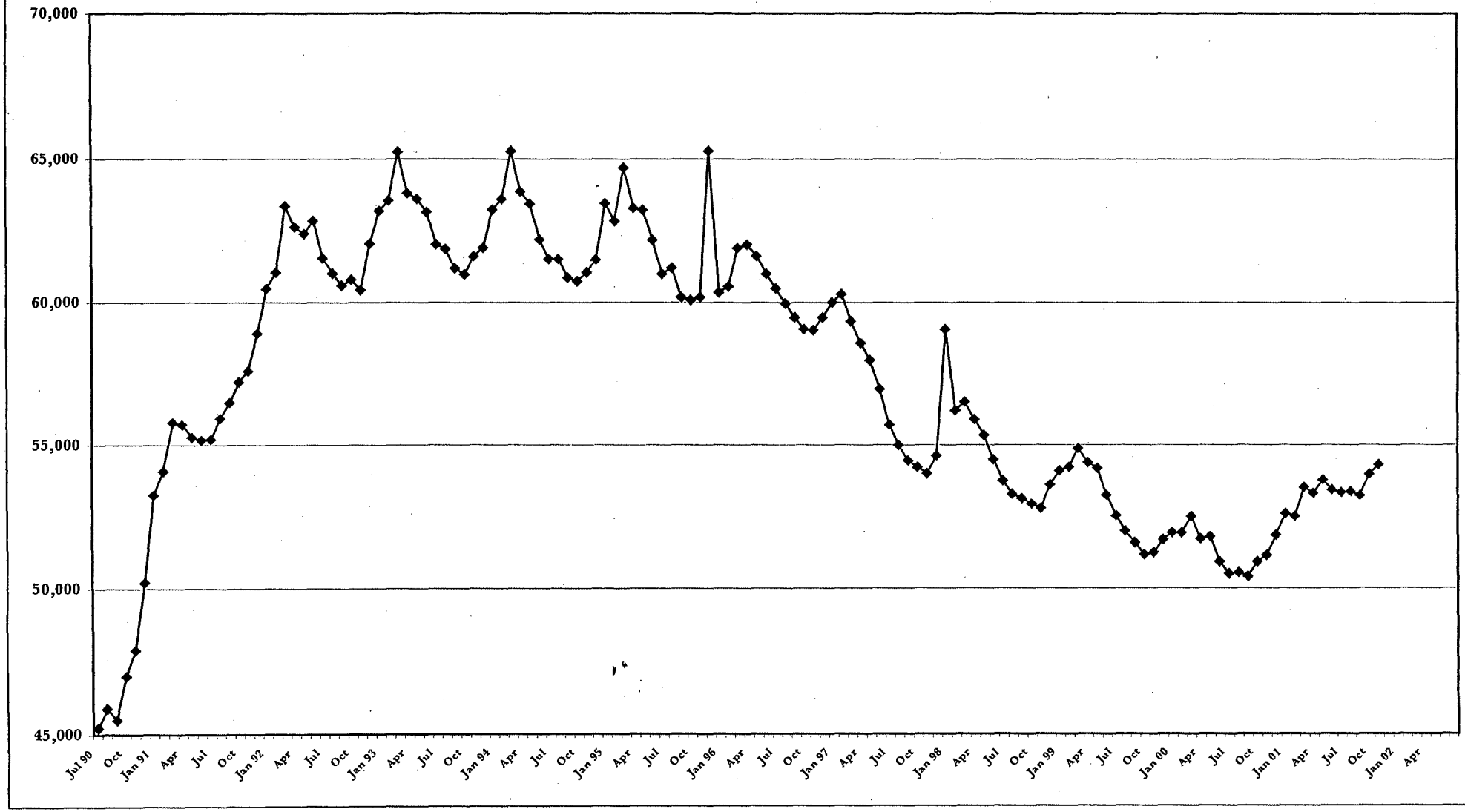
of Food Stamp Households

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
January	42,741	54,096	58,691	53,004	56,008	52,360	49,850	48,124	43,472	38,972	39,039	43,191	53,250	60,465	63,162	63,198
February	45,096	56,039	59,726	53,766	56,573	52,485	51,007	48,822	43,706	39,071	39,557	43,556	54,065	61,021	63,529	63,578
March	46,027	57,114	59,682	53,988	56,842	51,857	50,861	48,439	43,840	39,605	40,633	45,107	55,792	63,334	65,239	65,264
April	41,704	55,657	58,563	53,043	55,089	51,506	50,910	48,406	43,529	39,334	39,529	44,902	55,720	62,612	63,793	63,844
May	44,606	54,200	57,198	51,716	54,178	49,757	49,384	47,163	42,438	38,436	39,885	45,217	55,260	62,377	63,590	63,408
June	39,626	54,117	55,540	50,827	52,476	49,658	47,747	46,268	41,187	37,644	39,511	45,048	55,154	62,815	63,124	62,176
July	44,161	56,741	55,965	50,795	50,847	48,117	46,553	44,532	40,006	37,171	39,206	45,226	55,186	61,533	62,009	61,500
August	45,370	54,285	55,209	51,064	50,733	47,625	47,224	44,582	39,644	37,010	39,523	45,883	55,946	60,991	61,843	61,490
September	45,689	54,956	54,375	50,878	49,562	47,537	46,537	43,644	38,314	36,541	38,810	45,487	56,511	60,576	61,164	60,841
October	47,022	55,725	52,845	50,869	49,337	46,362	45,670	42,830	38,279	36,848	39,892	46,987	57,246	60,780	60,958	60,717
November	48,272	54,458	50,749	51,767	49,943	47,879	46,720	42,815	38,218	36,660	40,055	47,885	57,626	60,420	61,588	61,034
December	50,615	56,191	51,582	53,956	51,040	48,596	47,216	42,329	37,899	37,554	41,412	50,203	58,935	62,030	61,885	61,467
Average	**45,069**	**55,298**	**55,844**	**52,139**	**52,719**	**49,478**	**48,307**	**45,663**	**40,878**	**37,904**	**39,754**	**45,724**	**55,891**	**61,580**	**62,657**	**62,376**

	1995	1996	1997	1998	1999	2000	2001
January	63,418	60,333	60,001	59,070	54,085	51,906	52,571
February	62,816	60,536	60,273	56,211	54,210	51,899	52,481
March	64,696	61,874	59,350	56,518	54,868	52,473	53,501
April	63,260	61,997	58,590	55,892	54,365	51,698	53,295
May	63,191	61,593	57,989	55,331	54,163	51,771	53,757
June	62,159	60,976	56,991	54,472	53,231	50,898	53,411
July	60,972	60,472	55,697	53,732	52,494	50,485	53,324
August	61,180	59,956	54,981	53,267	51,969	50,536	53,353
September	60,177	59,478	54,427	53,113	51,561	50,394	53,217
October	60,075	59,074	54,195	52,921	51,151	50,902	53,960
November	60,177	59,043	53,985	52,758	51,227	51,127	54,290
December	65,273	59,481	54,606	53,595	51,662	51,824	
Average	**62,283**	**60,401**	**56,757**	**54,740**	**52,916**	**51,326**	**53,378**

Light shading = lowest month, dark shading = highest month.

Monthly Food Stamps Caseload - July 1990 to June 2002



Date	Jan 98	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 99	Feb	Mar	Apr	May	Jun
Cases	59,070	56,211	56,518	55,892	55,331	54,472	53,732	53,267	53,113	52,921	52,758	53,595	54,085	54,210	54,868	54,365	54,163	53,231
Date	**Jul 99**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan 00**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Cases	52,494	51,969	51,561	51,151	51,227	51,662	51,906	51,899	52,473	51,698	51,771	50,898	50,485	50,536	50,394	50,902	51,127	51,824
Date	**Jan 01**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan 02**	**Feb**	**Mar**	**Apr**	**May**	**Jun**
Cases	52,571	52,481	53,501	53,295	53,757	53,411	53,324	53,353	53,217	53,960	54,290							

Graph based on data from July 1990.

of Food Stamp Clients

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
January	122,047	142,115	150,262	137,933	144,441	132,229	124,425	118,616	105,769	91,829	89,755	99,481	123,587	139,975	144,335	142,155
February	128,392	146,543	152,491	140,306	146,076	133,429	127,795	120,463	106,137	91,710	91,203	100,662	126,004	141,377	145,233	143,324
March	128,748	145,267	152,175	140,958	146,847	131,315	127,288	119,203	106,349	93,543	93,747	104,605	130,152	146,282	148,926	147,112
April	115,088	145,736	149,271	138,631	142,617	130,550	127,998	120,110	106,015	92,895	91,186	104,225	130,111	144,807	145,930	143,406
May	122,630	142,204	144,979	134,634	140,526	124,941	123,438	116,780	102,969	90,176	92,112	104,887	129,026	143,704	144,993	141,965
June	108,321	141,727	140,358	131,938	136,257	125,418	119,538	114,560	99,181	87,805	90,839	104,481	128,511	144,538	143,955	139,056
July	119,778	147,936	141,629	131,396	131,535	120,646	114,852	109,010	95,528	86,296	89,809	104,792	128,759	141,337	141,249	137,582
August	122,870	141,138	139,955	131,894	131,479	119,493	117,370	110,020	94,644	85,737	90,791	106,324	129,985	139,712	140,576	137,258
September	123,188	142,610	137,793	131,302	127,672	119,366	115,031	106,479	89,910	83,716	88,523	104,953	131,010	137,147	138,623	134,960
October	126,006	143,451	134,648	130,978	126,214	114,677	112,020	103,577	89,837	84,311	91,171	108,270	132,412	138,420	137,663	133,808
November	127,791	140,133	130,735	133,501	127,456	119,241	115,367	104,009	89,699	83,362	91,589	110,517	133,339	138,036	138,848	134,802
December	133,523	144,214	133,594	139,179	130,487	120,889	116,257	102,237	88,430	85,849	94,972	116,870	136,274	141,717	139,731	135,317
Average	**123,199**	**143,923**	**142,324**	**135,221**	**135,967**	**124,350**	**120,115**	**112,089**	**97,872**	**88,102**	**91,308**	**105,797**	**129,931**	**141,421**	**142,505**	**139,229**

	1995	1996	1997	1998	1999	2000	2001
January	139,449	128,914	126,149	122,902	109,151	101,750	102,618
February	138,251	129,522	126,777	115,634	109,505	101,663	102,885
March	142,379	132,140	125,477	116,628	110,817	102,820	104,911
April	139,027	132,416	123,877	115,175	109,585	101,081	104,534
May	138,414	131,220	122,453	113,732	109,167	100,742	105,615
June	135,937	129,786	120,246	111,300	106,791	98,649	104,628
July	132,864	128,319	117,120	109,604	105,048	97,714	104,335
August	133,498	127,032	115,175	108,327	103,388	97,758	104,200
September	130,580	125,305	112,836	107,579	101,960	97,337	103,643
October	130,125	124,150	111,837	106,743	100,556	98,307	105,302
November	130,048	123,909	111,320	106,214	100,630	98,994	106,181
December	138,703	125,042	112,402	108,052	101,429	100,692	
Average	**135,773**	**128,146**	**118,806**	**111,824**	**105,669**	**99,792**	**104,441**

Light shading = lowest month, dark shading = highest month.

Food Stamps Cost

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991
January	4,070,988	5,283,588	6,474,914	5,621,187	6,236,098	5,488,876	5,244,056	4,933,887	4,294,621	4,069,235	3,943,659	5,269,604	7,223,531
February	4,233,432	5,418,250	6,562,621	5,788,897	6,376,585	5,615,755	5,514,564	5,059,742	4,382,016	4,093,048	4,084,942	5,212,684	7,206,478
March	4,218,692	5,469,373	6,475,759	5,785,684	6,341,538	5,629,913	5,426,360	4,877,910	4,353,295	4,140,059	4,174,570	5,396,096	7,363,368
April	3,307,972	5,287,415	6,308,083	6,543,151	6,207,354	5,564,299	5,435,829	4,950,482	4,355,728	4,135,763	4,052,416	5,375,434	7,329,070
May	3,686,506	4,828,546	6,131,694	5,496,051	6,067,939	5,223,603	5,215,931	4,968,187	4,251,596	3,995,158	4,151,490	5,374,724	7,227,531
June	3,658,485	4,860,743	5,596,802	5,375,689	5,749,744	5,312,782	5,080,146	4,823,691	4,025,982	3,854,646	4,007,326	5,315,973	7,236,778
July	4,114,272	5,078,508	5,629,398	5,157,950	5,542,117	5,036,362	4,836,606	4,501,837	3,820,689	3,791,795	4,018,307	5,405,542	7,291,988
August	4,184,092	4,767,048	5,499,243	5,224,092	5,461,114	4,958,953	4,942,391	4,572,665	3,830,257	3,760,855	4,071,810	5,451,471	7,440,279
September	4,162,442	4,822,431	5,369,282	5,199,465	5,247,559	4,923,916	4,823,095	4,422,381	3,608,634	3,671,839	3,939,700	5,423,608	7,677,771
October	4,233,370	5,101,235	5,101,363	5,726,918	5,201,027	4,929,714	4,687,854	4,337,326	4,057,573	3,971,551	4,832,809	6,208,421	8,485,861
November	4,574,280	4,976,603	5,358,983	5,785,569	5,253,284	5,221,586	4,833,679	4,371,539	4,047,178	3,882,086	4,898,617	6,381,775	8,629,399
December	5,437,294	5,124,414	5,473,435	6,029,362	5,358,481	5,378,573	4,876,626	4,243,076	3,969,219	4,011,795	5,074,086	6,749,555	8,836,898
Totals	**49,881,825**	**61,018,154**	**69,981,577**	**67,734,015**	**69,042,840**	**63,284,332**	**60,917,137**	**56,062,723**	**48,996,788**	**47,377,830**	**51,249,732**	**67,564,887**	**91,948,952**
Average	**4,156,819**	**5,084,846**	**5,831,798**	**5,644,501**	**5,753,570**	**5,273,694**	**5,076,428**	**4,671,894**	**4,083,066**	**3,948,153**	**4,270,811**	**5,630,407**	**7,662,413**
Avg. per Case	**92.23**	**91.95**	**104.43**	**108.26**	**109.14**	**106.59**	**105.09**	**102.31**	**99.88**	**104.16**	**107.43**	**123.14**	**137.10**

	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
January	8,958,114	9,561,252	9,257,364	9,604,349	9,535,997	8,993,318	14,310,103	7,614,266	6,919,460	7,287,913
February	8,990,719	9,585,450	9,403,621	9,540,827	9,545,824	9,068,155	8,707,537	7,701,669	6,938,053	7,259,178
March	9,561,956	9,823,136	9,657,948	9,786,836	9,767,984	8,900,661	8,188,715	7,663,125	7,035,792	7,455,163
April	9,354,943	9,513,846	9,475,564	9,597,958	9,786,746	8,733,777	7,988,636	7,680,210	6,859,804	7,447,056
May	9,384,616	9,422,436	9,388,796	9,524,309	9,664,561	8,594,957	7,812,586	7,610,593	6,859,476	7,497,911
June	9,489,925	9,265,853	9,061,055	9,279,449	9,458,525	8,370,132	7,643,432	7,376,336	6,625,051	7,362,282
July	9,349,076	9,087,312	9,111,304	9,132,268	9,367,786	8,150,458	7,470,757	7,128,951	6,599,041	7,369,380
August	9,223,571	9,121,781	9,159,064	9,115,273	9,265,119	7,977,815	7,326,663	7,022,615	6,573,386	7,334,254
September	9,105,199	8,942,562	8,996,872	8,924,386	9,181,810	7,841,780	7,313,713	6,876,644	6,508,407	7,318,609
October	9,271,674	9,133,088	9,301,466	9,356,583	9,092,238	7,959,636	7,531,763	6,929,908	6,790,510	7,852,872
November	9,276,096	9,201,668	9,394,753	9,199,301	8,983,064	7,897,525	7,473,435	6,953,513	6,777,586	7,966,157
December	9,412,658	9,219,067	9,436,512	9,375,149	9,051,546	8,007,144	7,608,618	7,006,176	6,916,942	
Totals	**111,378,547**	**111,877,451**	**111,644,319**	**112,436,688**	**112,701,200**	**100,490,358**	**99,375,958**	**87,764,006**	**81,403,508**	**82,150,775**
Average	**9,281,546**	**9,323,121**	**9,303,693**	**9,369,724**	**9,391,767**	**8,374,197**	**8,281,330**	**7,313,667**	**6,783,626**	**7,468,252**
Avg. per Case	**150.72**	**148.80**	**149.15**	**150.44**	**155.49**	**147.54**	**151.28**	**138.21**	**132.17**	**139.91**

Light shading = lowest month, dark shading = highest month.

% of Population Receiving Food Stamps

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994
January	11.4	13.3	14.0	12.9	12.8	11.8	11.1	10.5	9.4	8.2	8.0	8.8	10.1	11.4	11.8	11.6
February	10.8	13.7	14.2	13.1	13.0	11.9	11.4	10.7	9.4	8.1	8.1	8.9	10.3	11.5	11.8	11.7
March	12.0	13.9	14.2	13.2	13.1	11.7	11.3	10.6	9.5	8.3	8.3	9.3	10.6	11.9	12.1	12.0
April	10.7	13.9	13.9	12.9	12.7	11.6	11.4	10.7	9.4	8.3	8.1	9.3	10.6	11.8	11.9	11.7
May	11.4	13.3	13.5	12.5	12.5	11.1	11.0	10.4	9.2	8.0	8.2	9.3	10.5	11.7	11.8	11.6
June	10.1	13.2	13.1	12.3	12.1	11.1	10.6	10.2	8.8	7.8	8.1	9.3	10.5	11.8	11.7	11.3
July	11.2	13.8	13.2	11.7	11.7	10.7	10.2	9.7	8.5	7.7	8.0	9.3	10.5	11.5	11.5	11.2
August	11.5	13.2	13.1	11.7	11.7	10.6	10.4	9.8	8.4	7.6	8.1	9.5	10.6	11.4	11.4	11.2
September	11.5	13.3	12.8	11.7	11.4	10.6	10.2	9.5	8.0	7.4	7.9	9.3	10.7	11.3	11.3	11.0
October	11.8	13.4	12.5	11.6	11.2	10.2	10.0	9.2	8.0	7.5	8.1	9.6	10.8	11.3	11.2	10.9
November	11.9	13.1	12.2	11.8	11.3	10.6	10.3	9.2	8.0	7.4	8.1	9.8	10.9	11.3	11.3	11.0
December	12.5	13.5	12.4	12.4	11.6	10.7	10.3	9.1	7.9	7.6	8.4	10.3	11.1	11.5	11.4	11.0
Average	**11.4**	**13.5**	**13.3**	**12.3**	**12.1**	**11.1**	**10.7**	**10.0**	**8.7**	**7.8**	**8.1**	**9.4**	**10.6**	**11.5**	**11.6**	**11.4**

	1995	1996	1997	1998	1999	2000	2001
January	11.4	10.5	10.3	10.0	8.9	8.3	8.4
February	11.3	10.5	10.3	9.4	8.9	8.3	8.4
March	11.6	10.8	10.2	9.5	9.0	8.4	8.5
April	11.3	10.8	10.1	9.4	8.9	8.2	8.5
May	11.3	10.7	10.0	9.3	8.9	8.2	8.3
June	11.1	10.6	9.8	9.1	8.7	8.0	8.2
July	10.8	10.5	9.5	8.9	8.6	8.0	8.2
August	10.9	10.3	9.4	8.8	8.4	8.0	8.2
September	10.6	10.2	9.2	8.8	8.3	7.9	8.1
October	10.6	10.1	9.1	8.7	8.2	8.0	8.3
November	10.6	10.1	9.1	8.6	8.2	8.1	8.3
December	11.3	10.2	9.2	8.8	8.3	8.2	
Average	**11.1**	**10.4**	**9.7**	**9.1**	**8.6**	**8.1**	**8.3**

May 2001 new 2000 census data used to dertermine population percentages

Light shading = lowest month, dark shading = highest month.

Program Title: **ASPIRE-JET Program for Food Stamp Recipients**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Sec. 801 -891
Food Stamp Act of 1977 (as amended by P.L. 106-540, December 8, 2000)
7 CFR 271-273
22 MRSA 3104

B. A description of each program administered by the agency or independent agency, including the following for each program:

The ASPIRE-JET (Job Exploration and Training) Program is a sub-program of the Food Stamp program with a current annual budget of $511,940 of which $203,430 are State dollars and $308,510 are federal dollars provide by the US Department of Agriculture. It provides job search assistance, support services, and some education and job training services to individuals who receive only Food Stamp, to help them obtain employment. The program is available on a limited basis in part or all of nine Maine counties. Service areas are based on unemployment rates approved in a yearly plan submitted to the USDA. They correspond to areas approved by USDA for the Food Stamp Program where Able Bodied Adults Without Dependents (ABAWDS) are required to meet special work requirements. The State is required by federal law to have a Food Stamp Employment and Training Program.

1. Established priorities, including the goals and objectives in meeting each priority;

The priority is to provide services to Food Stamp recipients who must work register in order to receive Food Stamps. Services are then provided to volunteers. A major federal thrust under PRWORA was to provide services to the ABAWD population, and 80% of federal program funding was tied to serving this population. Unfortunately, few ABAWDs choose to avail themselves of these services, so in recent years, Maine has not even applied for this funding as it could not be drawn down. Training and placement standards were eliminated under PRWORA and replaced by the ABAWD funding mechanism.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

   Other than the service to the ABAWD population, and the funding that is tied to it, there are no specific federal standards set forth at this time for this program, other than that participants spend a minimum of 12 hours per month for two months (not to exceed 120 hours a month) in program activities and make a minimum number of employer contacts when doing job search.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   As of November 30, 2001, for SFY 2001, 120 individuals completed assessment, 23 completed job readiness activities, 13 completed secondary education, 22 completed job skills training, 57 completed job search, 18 completed a work activity (workfare) and 211 completed job entry, for a total of 464 participants.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

The ASPIRE-JET Program is operated by ASPIRE-TANF staff on a time allocation basis.

The ASPIRE-TANF Program has eight (8) Regional Program Supervisors who supervise fifty-two (52) ASPIRE Specialists and twenty-nine (29) Human Services Aide IIIs.

A Family Independence Program Manager interprets Federal laws and writes program policy, and provides technical assistance to regional offices.

See attached job classification and organizational chart for the Bureau.

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

The Bureau complies with all laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted.

Policy and procedure changes are made based on changes in federal law.

ASPIRE-JET RULES ADOPTED
(January 2001 - December 2001)

1-A - Repeal of former rules governing program operations and adoption of new rules to reflect changes in Federal Law and to update terminology. Effective: August 1, 2001

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

Federal law changes require that the Department of Labor's Workforce Development System operate ASPIRE-JET education, training and job search components. The Bureau is waiting for DOL to develop Memoranda of Agreement to implement this requirement. ASPIRE-JET has always made use of community agencies and adult education to provide services on a referral basis.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Food Stamp recipients who are mandated or volunteer to work register.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Other than developing the required relationship with the Department of Labor, no other efforts are planned at this time.

J. Identification of emerging issues for the agency or program in the coming years.

There is an effort nationally through organizations like the American Public Human Services Association to lobby Congress to change the funding emphasis on ABAWDs. If this is accomplished, many more dollars will be available to serve the Food Stamp population as a whole. Support services dollars are, at this point, extremely limited.

K. Any other information specifically requested by the committee of jurisdiction;

None at this time

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.

All mandates for program operation at this point come from the USDA.

M. Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

Program Title: General Assistance

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

22 MRSA 4300 to 4323

B. A description of each program administered by the agency or independent agency, including the following for each program:

General Assistance Mission Statement:

To provide assistance for basic needs for eligible applicants who cannot provide for themselves and their families.

Description:

- General Assistance is administered at the local municipality level. This means that each of the 494 municipalities administers their own General Assistance Program. Each municipality is mandated to have a program. The State is responsible for the administration of the program for the residents of the unorganized territories. Contracting with agents and surrounding municipalities to administer the program for the State accomplishes delivery of services.
- The State is responsible for oversight and auditing of the GA programs administered locally.
- The basic needs that General Assistance can assist with include but are not limited to rent/mortgage, food, fuel, utilities, clothing, non-elective medical services as prescribed by a physician, and prescription drugs and over the counter drugs

1. Established priorities, including the goals and objectives in meeting each priority;

(a) To assist the municipalities and the contracted agents in administering General Assistance.
(b) To assure compliance with State law and local GA ordinance.
(c) To reimburse the municipalities that are in compliance for direct costs to clients. The Department does not reimburse for administrative costs. Each municipality has an obligation, which is .0003% of their most recent tax evaluation. Once the expenditures for direct costs reach this obligation, the municipality is eligible for 90% reimbursement. For the expenditures from zero up to the obligation, municipalities have two

choices: 1) to receive 50% up to their obligation and then to receive 90%; or 2) receive 10% for the entire year keeping in mind that once the obligation is met the municipality would receive 100%.
(d) To administer the SSI Interim Assistance Reimbursement Program in order to assist needy individuals with basic needs while the Social Security Administration determines eligibility for SSI and to assist municipalities and the State to recoup the assistance given.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

(a) Conduct a yearly review at each municipality to determine if the municipality is complying with 22MRSA§4300-4323, the DHS policy, and the municipal ordinance.
(b) Offer a Hotline for municipalities, clients, advocates, and other interested parties to use Monday through Friday. The calls help us to monitor the issues that arise in the municipalities when recipients apply for General Assistance.
(c) Provide training either one-on-one or group training as requested.
(d) General Assistance has a contract with the Social Security Administration to administer the SSI Interim Assistance Reimbursement Program. This program allows the State to recoup the monies spent on a General Assistance recipient who received assistance from a municipality while waiting to receive SSI. The money recouped is taken from the SSI retroactive payment.
(e) Monitor length of time to reimburse municipalities.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

Goals:

a. Conduct a yearly audit to determine if the municipality is in compliance:
There are 3 Field Examiner IIs that are responsible for the audits. Those municipalities with very little activity are given mail-in reviews. This is tracked internally plus there are random surveys sent out. In fiscal year 2001, the audits processed 454 out of 494 reviews. A number of those not processed were mail-in reviews and the municipality never responded.

b. Provide a Hotline: The calls have increased (currently 2,990 calls a year) We believe this is because we promote the use of the Hotline when we speak at functions.
c. Provide trainings: The number of trainings varies by the need. This past year there have been a number of changes in the municipal offices and we have been called to provide training more often.

d. The amount of money recouped through the SSI Interim Assistance Reimbursement Program:

Fiscal year 1998	
Received	$1,666,242.41
Reimbursed to the municipalities	240,833.86
Reimbursed to clients	1,023,207.67
State Share	402,626.79
Fiscal year 1999	
Received	$3,334,919.07
Reimbursed to the municipality	461,253.67
Reimbursed to client	2,023,016.77
State Share	697,145.41
Fiscal year 2000	
Received	$2,211,799.95
Reimbursed to the municipalities	237,883.01
Reimbursed to clients	1,502,672.92
State Share	363,056.57
Fiscal year 2001	
Received	$1,802,738.24
Reimbursed to the municipalities	219,523.94
Reimbursed to clients	1,323,858.81
State Share	280,448.89

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

1 Program Manager who supervises:
3 Field Examiner IIs
1 Clerk Typist II, who is part of the clerical pool
1 Account Clerk II, who is supervised by the Financial Manager

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Rule changes are based on statutory changes enacted by the Legislature.

In May 2001 there was a policy change (11A) to the General Assistance policy manual. The change clarified the language around the SSI Interim Assistance Reimbursement Program that resulted from the newest contract between the Department and the Social Security Administration. The major change was that the municipality has only 30 days from the date that the GA applicant signs the Authorization form to provide the Social Security Administration with a copy of the form. If the form is not received by the 30th, the municipality needs to have the applicant sign a new form and there is a potential loss of the reimbursement for the time frame between the signing of the form and the receipt of the form at the Social Security Administration.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

a. The municipalities administer General Assistance so there is a strong working relationship between all the municipalities and the Department.
b.The Department also works with the State of Maine Department of Audit to administer General Assistance in the unorganized territories.
c. The Department has a contract with the Social Security administration to administer the SSI Interim Assistance Reimbursement Program.
d. The Department works with the Maine Municipal Association to assist the municipalities in administering General Assistance. Maine Municipal Association provides the municipalities with a number of services such as: the printing of forms that the municipalities can purchase, updates of the ordinance that most of the municipalities adopt and use to administer GA, a training manual that is updated periodically, the language hotline, and the use of a technical advisor to answer legal questions that arise. The Department works with MMA to make sure that all of these services follow 22MRSA§4300—4323 and the DHS policy. The technical advisor is a participant of the Policy Rewrite Committee as well as a number of other committees that the Department and the Welfare Directors are a part of.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The people served by General Assistance are the most needy of Maine's citizens. They are often the people who are not eligible to receive benefits from any of the other programs offered by the Department and other agencies. In some areas of the State, affordable housing is an issue. Until there is more affordable housing, the GA population may continue to grow and need assistance. In the spring of 2001, Maine experienced an increase in the number of people from Somalia who had come into the United States as refugees and relocated here. The opinion of Catholic Charities and other groups is that there is the potential for a large Somali population to resettle in Maine. When the families leave one area and move to another they often bring nothing with them and usually they have little or no money. This has caused an increase in GA spending in the communities where these individuals and families have settled.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

During the 1990s the program was downsized. The Department has not privatized though we do contract for agents to administer GA in the unorganized territories. A number of municipalities have contracted with an outside agency to administer the program for them.

J. Identification of emerging issues for the agency or program in the coming years.

The amount of money allotted to General Assistance has changed over the years. In the late 1980s, General assistance was spending $20 million. Because of numerous law changes and the fact that the economy improved General Assistance is now spending about $6.8 million a year (the State is reimbursing the municipalities about $4.6 million). Because the economy is changing again and we are seeing more secondary migrants, there may be more requests for General Assistance.

K. Any other information specifically requested by the committee of jurisdiction;

No additional information has been requested as of this date.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program;

Food Stamp Code of Federal Regulation (§CFR272.1) states that "The coupon allotment provided to an eligible household shall not be considered income or resources for any purpose under Federal, State, or local laws including,

but not limited to, laws on taxation, welfare, and public assistance programs. No participating state or political subdivision shall decrease any assistance provided an individual or individuals because of the receipt of a coupon allotment." General Assistance does not count Food Stamps as income or a resource.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

Program Title: **TANF and ASPIRE-TANF**
(Temporary Assistance for Needy Families)
(Additional Support for People In Retraining and Employment)

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Personal Responsibility and Work Opportunity Reconciliation Act of 1996
45 CFR Part 260, TANF Final Rules
22 MRSA 3741, 3762, 3790

B. A description of each program administered by the agency or independent agency, including the following for each program:

TANF and ASPIRE-TANF Mission Statement:

To assist families in becoming self supporting while providing temporary financial assistance to meet their basic needs.

Description:

TANF and ASPIRE-TANF are two parts of the same program:

- TANF provides temporary financial assistance to needy, dependent deprived children and their parents (or caretaker relatives) to meet their basic needs while being cared for in their homes.
- Simultaneously, ASPIRE-TANF provides case management and support services to help families prepare for, find, and keep employment.

1. Established priorities, including the goals and objectives in meeting each priority;

The Program's priorities, goals, and objectives are to:

(a) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

(b) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage;

(c) Prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies; and

(d) Encourage the formation and maintenance of two-parent families.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

Goals:

a. provide temporary financial assistance, and
b. reduce dependency on government assistance:

Federal Regulations require states to meet the following minimum participation rates:

If the fiscal year is:	Then the minimum participation rate for the overall caseload is:		Then the minimum participation rate for 2-parent caseload is:
1997	25%		75%
1998	30%		75%
1999	35%		90%
2000	40%		90%
2001	45%		90%
2002 and thereafter	50%		90%

In December 1991, the Public Assistance Caseload was at it's highest with over 23,000 families receiving assistance. In December 2001, the caseload was 10,400. This represents a reduction of 54%. Approximately 20% of the caseload is working.

c. prevent and reduce out-of-wedlock pregnancies:

The Department's goal is to reduce the pregnancy rate of 10-14 year olds to 0 per 1,000 females, the pregnancy rate of 15-17 year olds to 30 per 1,000 females, and the pregnancy rate of 18-19 year olds to 80 per 1,000 females by 2005. (Maine baseline: 0.7 per 1,000 for 10-14 year olds, 37.9 per 1,000 for 15-17 year olds, and 101.4 per 1,000 for 18-19 year olds in 1992.)

d. encourage formation and maintenance of 2-parent families:

Although states are not mandated to provide assistance to 2-parent families, the Department provides assistance to 2-parent families when one parent is disabled or the principle wage earner is under-employed as defined in policy.

Additionally, policy allows stepparents to be included or excluded from participation in the program. The family elects whichever option is best for their family.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

Goals:

a. provide temporary assistance, and
b. reduce dependency on government assistance:

The chart below indicates that Maine's TANF and ASPIRE-TANF programs met the Federal Government goals referred to above.

Column 1: identifies the report.
Column 2: indicates the work participation rate that must be met.
Column 3: indicates the credit Maine gets for reducing its caseload since the AFDC Program was abolished and the TANF and ASPIRE-TANF Program began.
Column 4: indicates the adjusted work participation rate Maine must meet to achieve its work participation requirements.
Column 5: indicates the actual work participation rate achieved by Maine.

Example: Report Year 2000 Goal =	40.0%
Minus Credit for Reducing Caseload =	-30.7%
Adjusted Rate Maine is Required to Meet =	9.3%
Maine's Actual Achievement =	40.0%

Summary: Maine has surpassed its participation requirement in all categories for the last 3 years and expects to do the same for FY 2001.

WORK PARTICIPATION RATE DATA

	ALL FAMILIES						2-Parent families				
FFY	Mandatory Work Part. Rate	Caseload Reduction Credit	Adjusted Work Part. Rate	Achieved Work Part. Rate	Penalty		Mandatory Work Part. Rate	Caseload Reduction Credit	Adjusted Work Part. Rate	Achieved Work Part. Rate	Penalty
1997 (7/97-9/97)	25%	-05.7%	19.3%	41.6%	N/A		75%	-13.2%	61.7%	50.5%	MOE expenses increase 5% (75%-80% of FY94 expenses)
1998 (10/97-9/98)	30%	-14.9%	15.1%	45.6%	N/A		75%	-39.7%	35.3%	49.9%	N/A
1999 (10/98-9/99)	35%	-29.1%	5.9%	54.9%	N/A		90%	-66.4%	23.6%	51.0%	N/A
2000 (10/99-9/00)	40%	-30.7%	9.3%	40.0%	N/A		90%	-69.1%	20.9%	53.7%	N/A
2001 (10/00-9/01)	45%						90%				
2002 (10/01-9/02)	50%						90%				

Light Shaded area = Met Work Participation Requirements Updated 05/01/01 rm/nj

c. reduce out-of-wedlock pregnancies:
Department's goals are for 2005.
Maine Bureau of Health reports its most recent data for 1998 as:

0.6 for 10-14 Year Olds
24.1 for 15-17 Year Olds
73.7 for 18-19 Year Olds

d. encourage formation and maintenance of 2-parent households:
Maine continues to administer programs for 2-parent families, including stepparent households. Federal regulations do not require numeric goals for this item.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

The ASPIRE-TANF Program has eight (8) Regional Program Supervisors who supervise fifty-two (52) ASPIRE Specialists and twenty-nine (29) Human Services Aide IIIs.

There is a Family Independence Program Manager for each program (TANF and ASPIRE-TANF) who interprets federal and state law, writes program policy and provides technical assistance and direction to regional operations as it relates to the program.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Policy and procedures changes result from federal and state statutory law.

ASPIRE APPROVED POLICY
(January 2001 - December 2001)

12A Changes in the ASPIRE-TANF Program Rules to correct omissions/make clarifications from prior rule changes. In addition, rules providing for supervisory review of all proposed actions to sanction program participants are being included. Finally, new policy relating to exploration of good cause reasons for failure to abide by program rules is added to the ASPIRE-TANF Program Manual.

Effective: October 1, 2001

TANF APPROVED POLICIES
(January 2001 - December 2001)

53A Updating the Federal Poverty Income Guidelines

Effective: May 1, 2001

54A Miscellaneous Policy Clarifications and Amendments

Effective: September 1, 2001

55A Benefit Increase

Effective: October 1, 2001

56A TANF Time Limit

Effective: November 1, 2001

57A TCC Guidelines

Effective: December 1, 2001

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Department of Human Services works with other State Departments (including, but not limited to, the Departments of Education, Labor and Behavioral Services) to eliminate redundancy of work and to share information that will assist in providing quality services. Representatives of each of these Departments are part of an effort to increase the skills of learners in the Adult Education system and to improve childcare for Maine residents, particularly low-income people. Both of these areas are of particular importance to TANF recipients.

The Program Manager of the ASPIRE-TANF program is part of a statewide Family Literacy Council, chaired by Mary Herman, that brings together many State agencies, as well as private organizations, to coordinate efforts to increase literacy in Maine.

In addition, the Bureau of Family Independence has a cooperative agreement with the Community Services Center to provide services to children with special needs, and works with that group to provide Transitional Child Care to TANF leavers.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The TANF program serves individuals who meet the program's eligibility criteria.

The ASPIRE-TANF program works with TANF recipients who are required to participate in a work, training or educational activity, with the purpose of achieving sustainable employment for the family.

There are no projected changes in the operation of either program (except for future changes in Federal or State laws that affect these programs).

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

To aid in meeting work participation requirements (and to provide needed services to TANF recipients), the Department of Human Services, Bureau of Family Independence, has in place contracts with several non-profit organizations to provide specific services to targeted TANF recipients. While Department personnel retain case management, the contractors provide their expertise to ameliorate issues such as substance abuse, domestic violence and mental health impairments, which can negatively impact on a TANF recipient's ability to secure and maintain employment. In addition, other contracted services include self-employment counseling and business assessment, and assisting TANF recipients with their transportation needs (including access to low-interest loans for used vehicles).

In response to budgetary concerns, and to provide more local control to Regional DHS offices in meeting the service needs of people in the counties they cover, many contracts now in place will be amended or terminated during SFY '03.

There is no plan to privatize the operation of either the TANF or ASPIRE-TANF programs.

J. Identification of emerging issues for the agency or program in the coming years.

When Congress created TANF Block Grants, which fund TANF and ASPIRE-TANF, it only authorized funding through September 30, 2002. For TANF to continue, Congress must reauthorize funding for the program prior to that date.

States expect Congress to discuss funding levels as part of reauthorization. Simultaneously, states expect TANF caseloads to increase due to economic changes. Depending on the final design of reauthorization, the State may need to revisit existing state statutes.

K. Any other information specifically requested by the committee of jurisdiction;

No additional information has been requested as of this date.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program;

Federal Law
Limits the number of families who get TANF benefits beyond 60 months to 20% of the prior year's or current year's average monthly caseload.

State Law
Allows TANF benefits beyond the Federal government's 20% limit.

Federal Law
Requires most families from FY2000 and thereafter to participate in work requirements for a minimum of 30-35 hours weekly.

State Law
Requires most individuals to work a minimum of 20 hours weekly.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

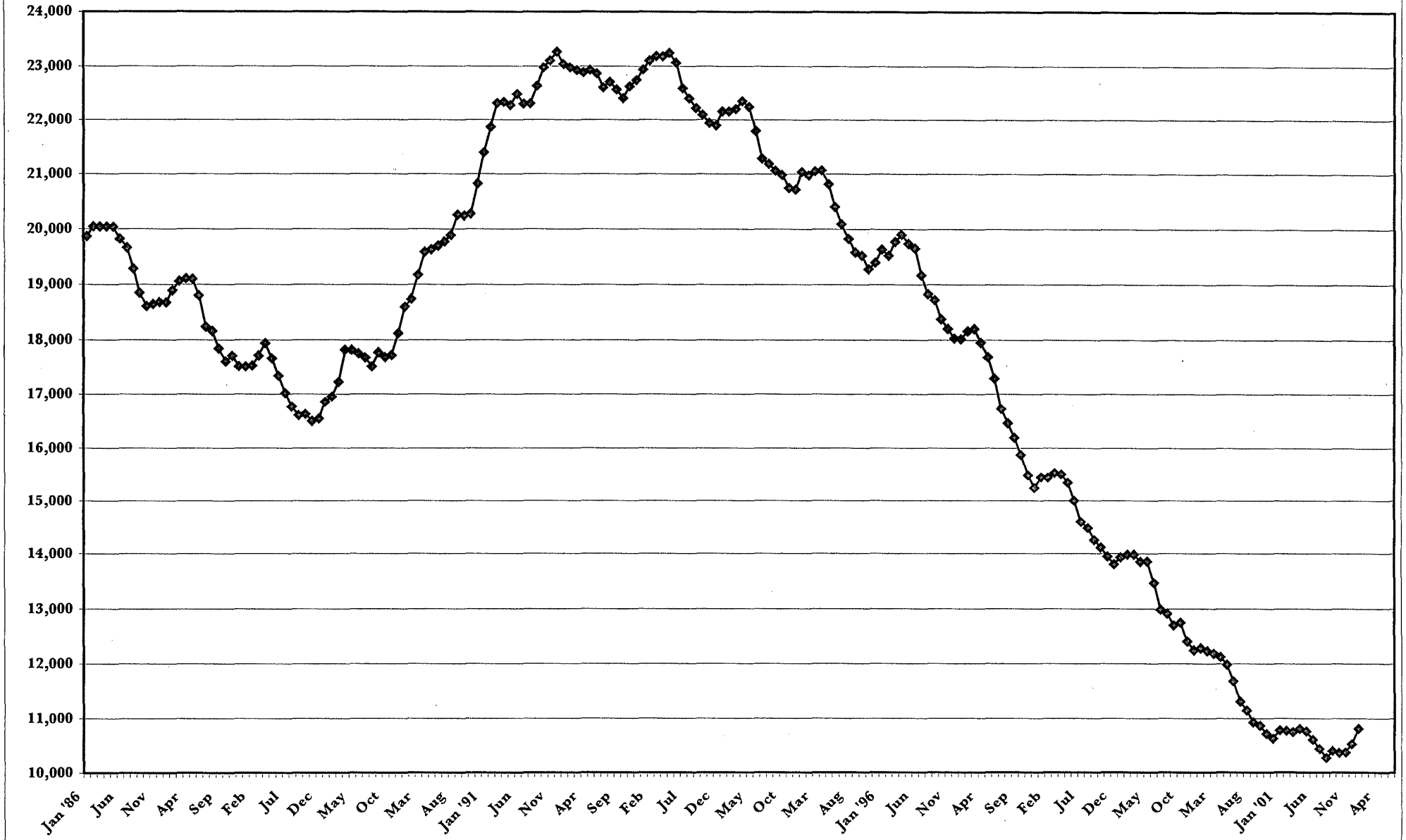
of TANF and PaS Cases

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
January	19,867	18,676	17,514	16,851	18,594	21,397	23,039	22,937	22,155	21,039	19,632	18,017	15,450	13,929	12,281
February	20,045	18,892	17,530	16,952	18,735	21,866	22,977	23,105	22,156	20,978	19,525	18,162	15,444	13,981	12,231
March	20,041	19,063	17,711	17,224	19,174	22,310	22,925	23,188	22,201	21,051	19,770	18,203	15,532	13,983	12,185
April	20,038	19,108	17,935	17,820	19,587	22,331	22,884	23,182	22,348	21,068	19,897	17,955	15,505	13,850	12,123
May	20,035	19,100	17,661	17,815	19,629	22,273	22,931	23,246	22,242	20,815	19,735	17,687	15,345	13,855	11,982
June	19,820	18,799	17,339	17,750	19,695	22,481	22,862	23,067	21,796	20,403	19,651	17,291	15,002	13,468	11,678
July	19,659	18,235	17,018	17,676	19,770	22,297	22,602	22,588	21,283	20,091	19,169	16,721	14,599	12,986	11,306
August	19,284	18,159	16,757	17,511	19,885	22,300	22,707	22,396	21,190	19,825	18,827	16,453	14,481	12,909	11,145
September	18,850	17,840	16,600	17,771	20,258	22,637	22,563	22,216	21,066	19,583	18,719	16,195	14,252	12,699	10,929
October	18,608	17,602	16,621	17,683	20,238	22,975	22,400	22,094	20,984	19,523	18,376	15,872	14,116	12,747	10,868
November	18,643	17,708	16,490	17,721	20,273	23,105	22,620	21,944	20,746	19,276	18,202	15,490	13,946	12,404	10,715
December	18,678	17,516	16,537	18,121	20,822	23,266	22,740	21,898	20,717	19,396	18,027	15,247	13,807	12,245	10,630
Average	**19,464**	**18,392**	**17,143**	**17,575**	**19,722**	**22,437**	**22,771**	**22,655**	**21,574**	**20,254**	**19,128**	**16,941**	**14,790**	**13,255**	**11,506**

	2001	2002
January	10,782	10,810
February	10,775	
March	10,751	
April	10,808	
May	10,763	
June	10,608	
July	10,436	
August	10,270	
September	10,401	
October	10,361	
November	10,369	
December	10,524	
Average	**10,571**	**10,810**

Light shading = lowest month, dark shading = highest month. Does not include retro checks.

of TANF & PaS Cases - January 1986 to June 2002

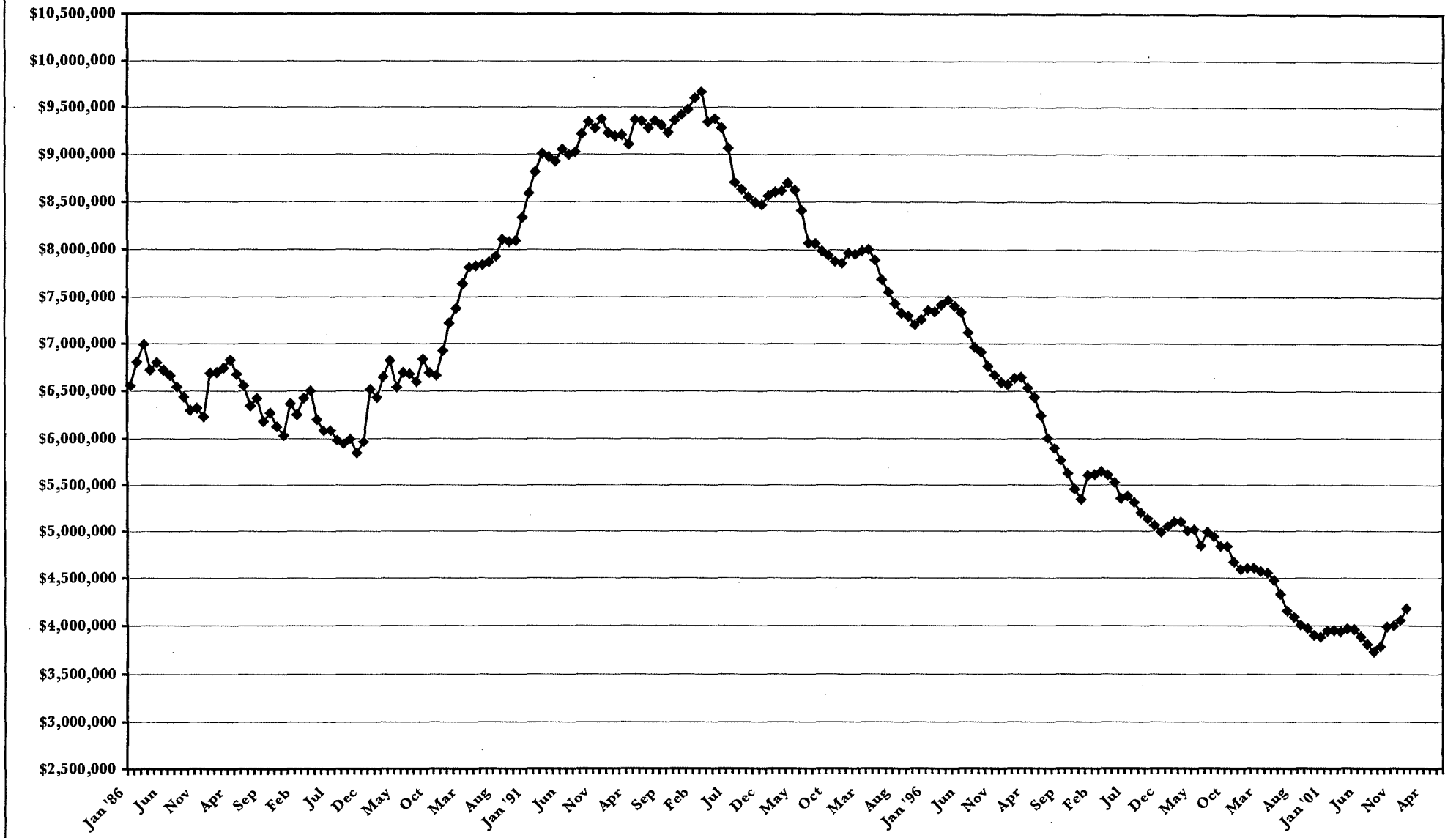


Date	Jul'99	Aug	Sep	Oct	Nov	Dec	Jan '00	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cases	12,986	12,909	12,699	12,747	12,404	12,245	12,281	12,231	12,185	12,123	11,982	11,678	11,306	11,145	10,929	10,868	10,715	10,630

Date	Jan '01	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan '02	Feb	Mar	Apr	May	Jun
Cases	10,782	10,775	10,751	10,808	10,763	10,608	10,436	10,270	10,401	10,361	10,369	10,524	10,810					

Graph based on data from January 1986

TANF & PaS Cost - January 1986 to June 2002



Date	Jul'99	Aug	Sep	Oct	Nov	Dec	Jan '00	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Cost	4,989,941	4,939,263	4,834,679	4,835,212	4,669,062	4,592,183	4,605,221	4,605,082	4,568,857	4,554,439	4,476,006	4,328,978	4,155,185	4,093,137	4,004,816	3,973,680	3,899,830	3,882,123

Date	Jan '01	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan '02	Feb	Mar	Apr	May	Jun
Cost	3,948,762	3,953,035	3,940,933	3,968,886	3,961,403	3,886,449	3,809,406	3,729,923	3,786,869	3,990,956	3,999,628	4,058,706	4,180,257					

Graph based on data from January 1986

Program Title: **PaS and ASPIRE-PaS Program**
(Parents as Scholars)

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

The 118th Legislature authorized the Department to establish and administer this program with State Public Law 530.

22 MRSA 3741, 3762 - 3790

B. A description of each program administered by the agency or independent agency, including the following for each program:

PaS and ASPIRE-PaS Mission Statement:

> To assist families in becoming self-supporting while providing temporary financial assistance to meet their basic needs.

Description:

Pas and ASPIRE-PaS are two parts of the same program:

- PaS provides financial assistance to needy, dependent deprived children and their parents (or caretaker relatives) to meet their basic needs while being cared for in their homes. While receiving PaS assistance, parents attend post-secondary educational institutions.

- Simultaneously, ASPIRE-PaS provides case management and support services to help families prepare for, find, and keep employment.

The Parent as Scholars (PaS) Program is a program to provide alternative means of achieving self-support for some parents. PaS allows participants to receive a package of financial aid, medical assistance and support services while attending post- secondary undergraduate 2-and 4-year degree-granting programs on a full-time basis. It is recognized as a student financial aid program, while still operating under many of the same rules that govern the TANF and ASPIRE-TANF Program.

1. **Established priorities, including the goals and objectives in meeting each priority:**

   The Program's priorities, goals, and objectives are to:

   (a) Provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives;

   (b) End the dependence of needy parents on government benefits by promoting job preparation, work, and marriage.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives:**

   An average of 850 families per month participated in the PaS Program for calendar year 2001.

   An enrollee receiving aid under this program must be enrolled full-time with the expectation that the degree (either 2-year or 4-year) will be obtained within the normal time frame for the particular degree. The enrollee must make satisfactory progress as defined in Section 3, III, A of the ASPIRE Policy Manual. All enrollees must maintain a minimum of a 2.0 GPA (Grade Point Average).

   The average starting wage for graduates of the PaS program is tracked, and compared to the average starting wage of TANF recipients who become employed.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   All goals and objectives established for the PaS program have been met or exceeded. Individual participants have written Family Contract Amendments that specify the program requirements; these are reviewed and re-written at least every six months. Individuals not meeting program requirements are put on probation, and are mandated to bring their school activity into compliance by the following semester. Data reports are generated on a periodic basis to assess program performance, including monitoring the application process to make sure that no one applying for the program is improperly denied access, and to track specific school information (fields of study; hours of participation; graduation dates; etc.).

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

PaS and ASPIRE/PaS are administered by the same personnel who administer TANF and ASPIRE-TANF.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See Attached Financial Summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Policy and procedures changes result from federal and state statutory law. There are no recent rules adopted for the PaS Program.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Department of Human Services has established links with all of the University of Maine campuses and Technical Colleges to aid in the smooth operation of the PaS program. A list of contact persons for these institutions has been made available to all regional DHS offices, so that communication between the majority of schools attended by PaS participants and DHS can flow unimpeded.

DHS also works with low-income advocacy groups and the TANF Advisory Council (a group that provides input relative to program improvements for the TANF and PaS programs to the Commissioner of DHS) to improve the PaS program wherever possible.

DHS has convened a conference with all parties associated with, or interested in, the successful operation of the PaS program, and has followed-up with constructive suggestions that have come out of this conference.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The PaS program serves those individuals who meet all of the eligibility requirements associated with the TANF program (household composition; income; assets; etc.) and who are matriculated in a degree-granting 2- or 4-year post-secondary educational institution on a full-time basis.

There are no projected or anticipated changes in this program.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

DHS is required by State law to operate this program; there are no plans for privatization.

J. Identification of emerging issues for the agency or program in the coming years.

There are no imminent issues identified at this time.

K. Any other information specifically requested by the committee of jurisdiction;

No additional information has been requested as of this date.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

There are no federal laws governing the PaS and ASPIRE-PaS Program.

M. Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

Program Title: **State Supplement to Supplemental Security Income (SSI)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Social Security Act
20 CFR 416, Sub part T
22 MRSA 3271-3279
1905(j)

B. A description of each program administered by the agency or independent agency, including the following for each program:

This program provides a monthly cash benefit to aged, blind and disabled recipients of SSI, and others who are eligible based on financial criteria.

1. Established priorities, including the goals and objectives in meeting each priority;

The State must meet a Maintenance of Effort (MOE) requirement by maintaining at a minimum the level of payment for each calendar year as the previous calendar year. All State Supplement recipients are eligible for Maine Care.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

There is an annual accounting to confirm the maintenance of effort requirement is met. Electronic transfer of information ensures that SSI eligibles get the appropriate State Supplement benefit. All Maine Care applications are screened for eligibility for the State Supplement.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

Maine has constantly met its Maintenance of Effort Agreement each year by maintaining annual payments from one calendar year to the next. As of 12/15/01 there are 35,139 individuals getting a State Supplement

payment. 91% also get an SSI payment. 85% get the $10 monthly payment. 15% get up to $219 because they reside in a residential facility. If the State fails to meet the MOE, the State is required to issue a lump sum payment to eligible recipients to make up for the shortage. Failure to meet MOE would result in loss of federal match in the Medicaid Program.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

A Family Independence Program Manager interprets federal and state law, writes program policy and provides technical assistance and direction to regional operations as it relates to the program.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau complies with all laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Policy and procedures changes result from federal and state statutory law.

STATE SUPPLEMENT APPROVED POLICY
(January 2001 - December 2001)

#189 Annual Cost of Living Adjustment (COLA
Effective: January 2001

#194 One dollar adjustment due to federal error on COLA calculation
Effective: August 2001

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

Everyone getting a Supplemental Security Income (SSI) benefit from the Federal Government through Social Security also gets a State Supplement payment. DHS gets bi-weekly electronic notification of all individuals opened for or closed from an SSI benefit. This triggers a DHS action to start or end the State Supplement payment.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Low income individuals who are age 65 or over or who are disabled. They may reside in their own home, nursing home or a residential care facility.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Federal Rules require this service must be provided by the State Maine Care agency.

J. Identification of emerging issues for the agency or program in the coming years.

The State is exploring the feasibility of using an electronic application for benefits as opposed to the paper application.

K. Any other information specifically requested by the committee of jurisdiction;

No information has been requested.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

Federal Law defines who gets a benefit, the minimum amount and the Maintenance of Effort requirement. State Law enables the Federal Legislation.

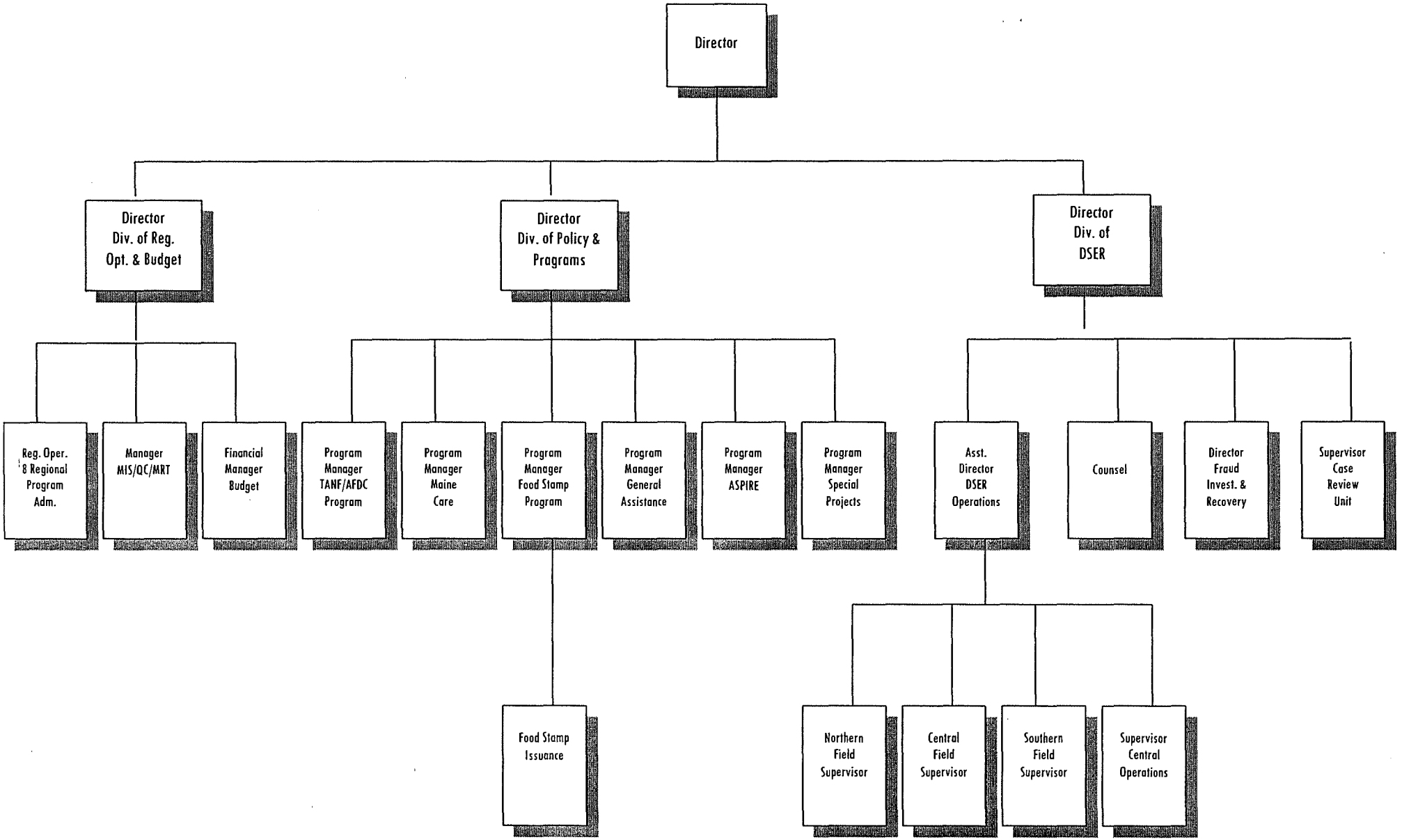
M. **Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Bureau complies with state and federal law regarding the handling of information on a case-by-case basis regardless of whether it is transferred electronically or non-electronically.

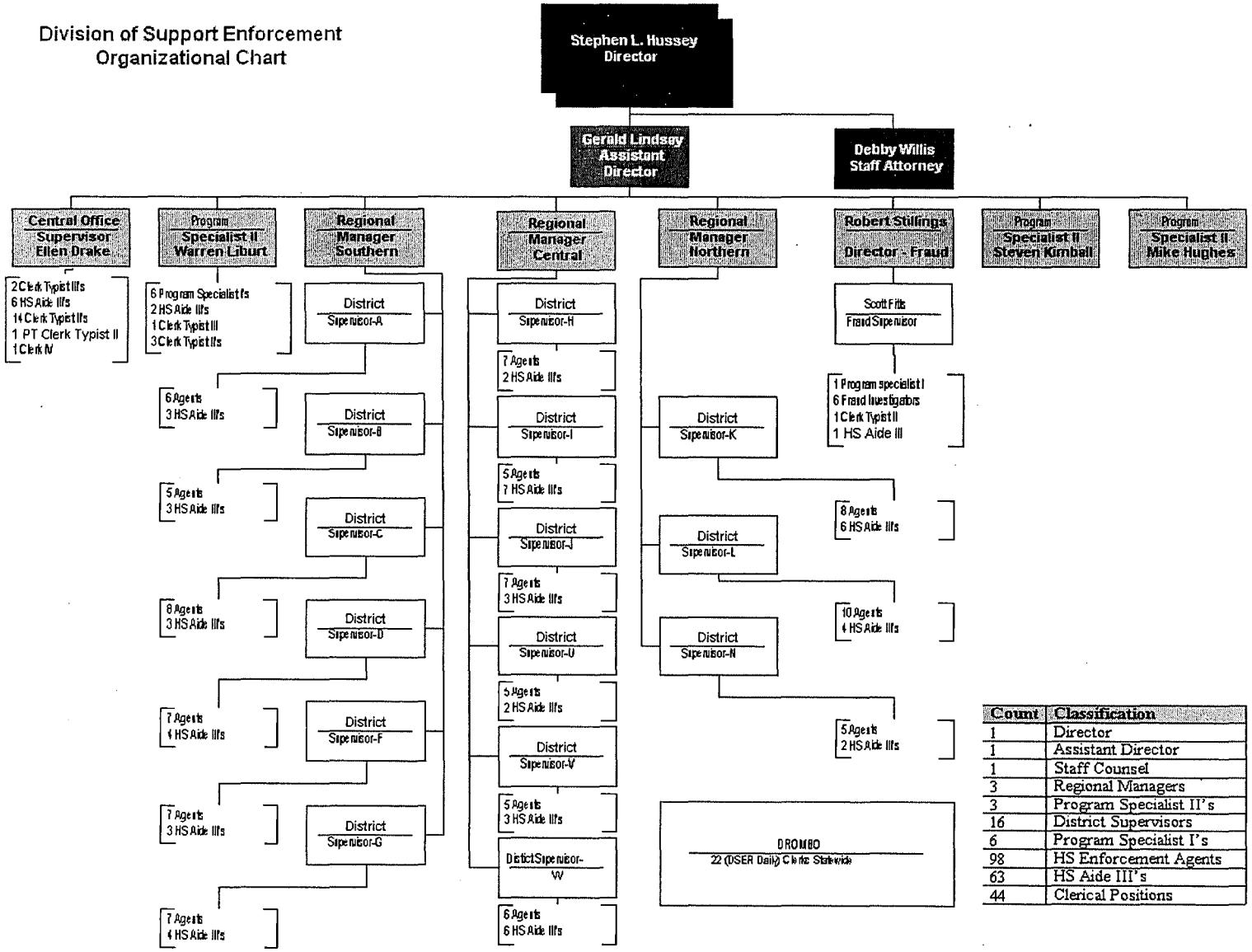
DEPARTMENT OF HUMAN SERVICES
BUREAU OF FAMILY INDEPENDENCE

Position Count	Job Classification
1	Director Bureau of Family Independence
1	Deputy Director of Human Services Programs
1	Director Division of Quality Assurance/Management Info.
1	Director Division of Policy and Programs
1	Director Support Enforcement and Recovery
1	Assistant Director Support Enforcement and Recovery
1	Director Fraud Investigation
9	Fraud Investigator
16	Support Enforcement District Supervisor
98	Human Services Enforcement Agent
3	Support Enforcement Field Supervisor
6	Family Independence Program Manager
37	Family Independence Unit Supervisor
343	Family Independence Specialist
8	Program Manager Family Independence
8	ASPIRE Regional Program Supervisor
52	ASPIRE Specialist
1	Social Services Supervisor
4	Social Services Program Specialist II
6	Social Services Program Specialist I
1	Counselor
1	Management Analyst
1	Disability Claims Adjuster
3	Disability Claims Examiner
3	Field Examiner II
1	Planning and Research Assistant
1	Business Manager I
1	Store Clerk
3	Clerk IV
95	Human Service Aide III
6	Clerk Typist III
28	Clerk Typist II
1	Clerk Typist I
1	Clerk II
2	Account Clerk II
746	**Total Position Count**

Bureau of Family Independence



Division of Support Enforcement
Organizational Chart



Count	Classification
1	Director
1	Assistant Director
1	Staff Counsel
3	Regional Managers
3	Program Specialist II's
16	District Supervisors
6	Program Specialist I's
98	HS Enforcement Agents
63	HS Aide III's
44	Clerical Positions

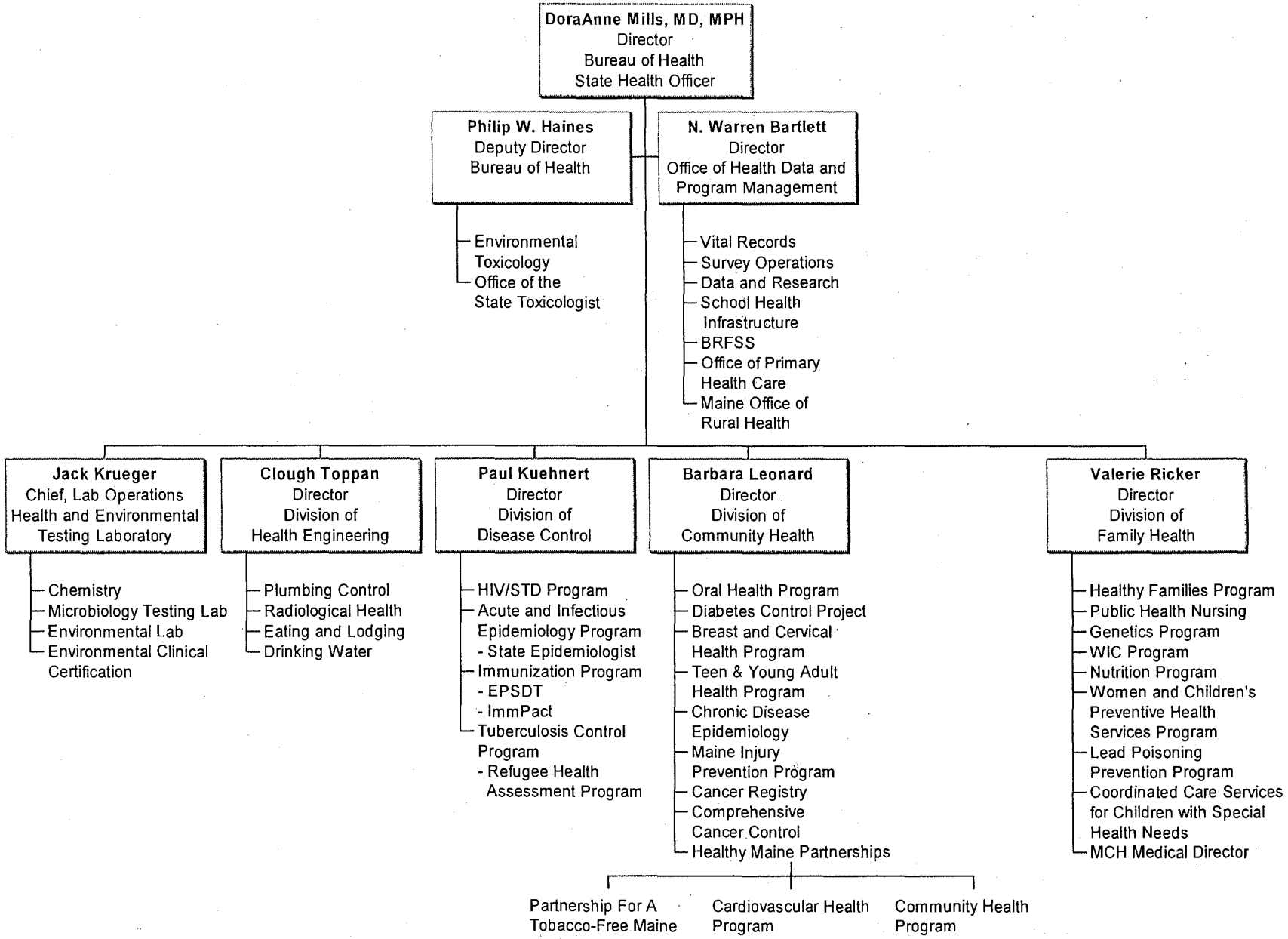
DEPARTMENT OF HUMAN SERVICES
BUREAU OF FAMILY INDEPENDENCE
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	BUREAU OF FAMILY INDEPENDENCE	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0100	FAMILY INDEPENDENCE - CENTRAL	4,270,826	3,717,253	4,594,033	4,484,150	5,225,802	4,337,181	5,293,784	4,665,838	6,188,369	6,053,318
0130	GENERAL ASSISTANCE	17,424,463	17,424,463	12,421,924	8,573,461	8,984,089	8,240,793	8,984,089	6,076,119	5,815,429	5,808,382
0131	SUPPLEMENTAL PAYMENTS FOR SSI	16,767,000	15,001,169	17,994,000	14,061,625	15,584,758	12,688,922	15,584,758	16,223,142	20,746,944	19,574,069
0138	AFDC / TANF	40,505,627	40,505,627	37,273,309	37,273,309	40,495,720	37,449,247	40,495,720	32,339,347	21,783,570	21,765,531
0146	ASPIRE	4,806,914	2,924,189	4,889,881	3,015,302	3,706,135	3,432,715	3,784,168	4,727,220	5,391,951	5,243,497
0453	FAMILY INDEPENDENCE - REGIONAL	9,820,132	7,986,139	10,522,133	8,039,934	10,071,000	7,934,948	10,014,567	8,761,766	8,697,193	8,687,734
0503	FAMILY SERVICES PROGRAM	1,378,487	641,570	1,426,704	737,294	1,312,701.0	1,214,383	1,328,814	22,919		
	GENERAL FUND TOTAL:	94,973,449	88,200,409	89,121,984	76,185,074	85,380,205	75,298,190	85,485,900	72,816,351	68,623,456	67,132,530
0100	FAMILY INDEPENDENCE - CENTRAL	14,463,188	9,740,558	15,362,669	10,943,114	17,731,731	10,071,912	17,903,740	11,580,789	19,832,538	12,015,781
0130	GENERAL ASSISTANCE	750,000	634,188	750,000	334,655	732,000	303,149	732,000	382,800	732,000	357,564
0138	AFDC - At Risk Child Care	267,972	267,972	1,347,789	1,347,789	1,347,789	316,678	1,145,267	1,145,267	1,300,000	1,297,633
0138	AFDC	83,085,478	71,530,705	64,103,894	64,103,894	70,174,014	62,248,843	70,174,014	60,597,929	49,451,616	49,450,317
0146	ASPIRE	7,541,935	2,491,675	8,066,332	3,103,053	7,997,564	3,172,882	8,278,783	5,431,173	10,444,554	6,184,186
0453	FAMILY INDEPENDENCE - REGIONAL	10,101,332	8,211,281	10,864,024	8,037,803	10,727,708	7,933,689	10,707,082	9,084,903	9,718,292	8,877,343
0503	FAMILY SERVICES PROGRAM	3,376,964	656,320	1,461,021	479,951	1,471,454	372,219	1,498,691	4,733		
	FEDERAL FUND TOTAL:	119,586,869	93,532,697	101,955,729	88,350,259	110,182,260	84,419,373	110,439,577	88,227,594	91,479,000	78,182,824
0100	FAMILY INDEPENDENCE - CENTRAL	2,761,701	1,514,120	2,939,235	2,397,291	3,390,246	3,390,246	4,241,960	4,241,960	5,236,093	3,844,763
0130	GENERAL ASSISTANCE STRIPPER WELL			1,999,987	1,999,987	249,971	249,971	200,000	200,000	247,000	-
0138	CHILD SUPPORT COLLECTIONS	45,300,000	31,427,088	48,555,000	44,767,522	48,555,000	43,813,042	48,555,000	47,047,247	70,618,563	64,589,174
0146	ASPIRE PLUS										
	OTHER SPECIAL REVENUE TOTAL:	48,061,701	32,941,208	53,494,222	49,164,799	52,195,218	47,453,260	52,996,960	51,489,207	76,101,656	68,433,937
0100	FAMILY INDEPENDENCE TANF										
0130	GENERAL ASSISTANCE TANF										
0138	TEMPORARY ASSIST TO NEEDY FAMILIES										
0146	ASPIRE TANF										
0453	REGIONAL FAMILY INDEPENDENCE TANF										
	BLOCK GRANT TOTAL:	-	-	-	-	-	-	-	-	-	-
	GRAND TOTAL	**262,622,019**	**214,674,314**	**244,571,934**	**213,700,133**	**247,757,683**	**207,170,822**	**248,922,437**	**212,533,153**	**236,204,112**	**213,749,291**

DEPARTMENT OF HUMAN SERVICES
BUREAU OF FAMILY INDEPENDENCE
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	BUREAU OF FAMILY INDEPENDENCE	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0100	FAMILY INDEPENDENCE - CENTRAL	7,711,380	7,585,423	8,320,355	8,252,082	7,044,685	6,986,110	7,710,377	7,603,826	8,094,879	8,064,374
0130	GENERAL ASSISTANCE	5,763,113	5,756,433	5,468,022	5,463,901	5,989,450	5,479,801	5,538,219	4,949,784	5,139,022	4,544,881
0131	SUPPLEMENTAL PAYMENTS FOR SSI	24,217,038	24,215,428	8,949,354	8,372,075	8,865,252	8,503,650	8,949,354	8,944,309	8,954,350	8,783,039
0138	AFDC / TANF	20,528,190	20,512,794	23,163,967	21,069,180	21,212,364	21,203,468	23,163,967	23,163,965	23,163,967	22,750,008
0146	ASPIRE	5,833,968	5,782,862	5,818,342	5,803,068	5,867,337	5,860,566	5,914,996	5,909,292	6,027,832	6,009,353
0453	FAMILY INDEPENDENCE - REGIONAL	7,543,567	7,426,155	7,329,940	7,327,221	7,988,000	7,782,329	8,196,815	7,890,014	8,349,573	8,310,958
0503	FAMILY SERVICES PROGRAM										
	GENERAL FUND TOTAL:	71,597,256	71,279,093	59,049,980	56,287,526	56,967,088	55,815,924	59,473,728	58,461,190	59,729,623	58,462,614
0100	FAMILY INDEPENDENCE - CENTRAL	20,088,858	12,550,217	15,926,596	13,805,050	14,731,477	14,569,454	20,221,857	15,806,232	21,222,410	15,971,560
0130	GENERAL ASSISTANCE	732,000	99,055	2,292,780	2,292,780	1,419,096	180				
0138	AFDC - At Risk Child Care	1,373,984	1,153,309	580,656							
0138	AFDC	45,477,514	15,691,133	5,309							
0146	ASPIRE	11,245,660	3,850,905	4,495,984	520,230	4,113,521	1,024,600	2,424,643	901,428	1,915,547	532,716
0453	FAMILY INDEPENDENCE - REGIONAL	8,080,403	6,249,320	5,859,574	5,558,217	5,933,955	5,539,951	6,326,949	5,477,071	6,968,103	6,598,620
0503	FAMILY SERVICES PROGRAM										
	FEDERAL FUND TOTAL:	86,998,419	39,593,940	29,160,899	22,176,276	26,198,049	21,134,184	28,973,449	22,184,731	30,106,060	23,102,896
0100	FAMILY INDEPENDENCE - CENTRAL	4,822,859	3,712,215	5,477,890	3,824,893	6,146,891	4,162,042	8,361,341	7,650,462	8,718,370	8,082,930
0130	GENERAL ASSISTANCE STRIPPER WELL	200,000	60,000	140,028	140,028						
0138	CHILD SUPPORT COLLECTIONS	73,665,551	62,007,989	73,665,551	65,646,572	73,665,551	69,581,780	90,016,583	85,598,323	94,211,000	76,064,239
0146	ASPIRE PLUS	125,000	-	200,000	-	200,000	-				
	OTHER SPECIAL REVENUE TOTAL:	78,813,410	65,780,205	79,483,469	69,611,493	80,012,442	73,743,822	98,377,924	93,248,785	102,929,370	84,147,169
0100	FAMILY INDEPENDENCE TANF	701,624	329,544	5,781,998	511,643	5,453,063	4,008,314	8,466,237	7,698,954	6,896,931	2,712,254
0130	GENERAL ASSISTANCE TANF	924,000	297,288	1,432,000	1,291,971	1,432,000	25,768	1,458,198	1,103,952	1,453,000	23,414
0138	TEMPORARY ASSIST TO NEEDY FAMILIES	37,945,308	35,786,032	44,351,657	41,463,948	41,638,020	41,637,166	47,239,365	40,190,376	45,795,511	32,001,810
0146	ASPIRE TANF	7,379,173	4,118,675	17,528,897	14,112,485	19,617,923	16,047,365	19,072,154	18,614,470	23,080,071	20,041,697
0453	REGIONAL FAMILY INDEPENDENCE TANF	1,539,543	921,129	3,102,724	1,758,088	3,126,812	2,031,072	3,755,465	2,919,691	2,903,723	2,337,803
	BLOCK GRANT TOTAL:	48,489,648	41,452,668	72,197,276	59,138,134	71,267,818	63,749,684	79,991,419	70,527,443	80,129,236	57,116,979
	GRAND TOTAL	**285,898,733**	**218,105,906**	**239,891,624**	**207,213,429**	**234,445,397**	**214,443,615**	**266,816,520**	**244,422,149**	**272,894,289**	**222,829,658**

Organizational Chart - Bureau of Health



Mar 8, 2002

BUREAU OF HEALTH

Environmental Toxicology Program

Behavioral Risk Factor Surveillance System

Vital Statistics

Coordinating School Health Programs

Office of Rural Health and Primary Care

Division of Disease Control

Division of Health Engineering

Health and Environmental Testing Laboratory

Division of Family Health

Division of Community Health

- Teen and Young Adult Health
- The Maine Breast and Cervical Health
- Oral Health
- Maine Cardiovascular Health
- Maine Diabetes Control
- Maine Cancer Registry
- Community Health Promotion
- Partnership For A Tobacco-Free Maine
- Maine Injury Prevention
- Comprehensive Cancer Control
- Maine Asthma Program

Program Title: **Environmental Toxicology Program**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

The authorizing law for the Environmental Toxicology Program (ETP) is Title 22 MRSA, Chapter 271(I), §1692, which established the Environmental Health Program (EHP) in 1981. The EHP was given a broad mandate that is currently met through the collective activities of the Environmental Toxicology Program and other Bureau of Health Programs (most notably the Maine Cancer Registry). Specifically, the ETP performs duties related to the original mandates for the EHP provided under 22 MRSA, Chapter 271(I), §1692, items 2-5. The ETP has the primary responsibility for carrying out the Hazardous Air Pollutants mandate for the EHP under 22 MRSA, Chapter 271(I), §1696, and the mandate for issuance of noncommercial fishing advisories under 22 MRSA, Chapter 271(I), §1696-I. The ETP has recently assumed the Department of Human Services mandate to maintain and operate a statewide occupational disease reporting system, as per 22 MRSA, Chapter 259-A, §1492.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

The current priorities of the ETP are:

Assess health threats for persons consuming freshwater and anadromous fish and issue advisories of the public health threat;

The goal is to provide safe eating guidelines for fish that are contaminated with pollutants, and to effectively disseminate the information to individuals likely to be at risk. Objectives have been to increase awareness and knowledge of fish consumption advisories.

Maintain data bases on exposure guidelines for hazardous chemicals in drinking water and ambient air.

The goal is to provide reference benchmarks for use by the public and state agencies in evaluating chemical contamination of either drinking water or ambient air. Objectives have been to update listings of guidelines with current toxicological information on a timely basis, and to expand listings in response to new discoveries of chemical contamination.

Conduct investigations as necessary to identify health problems related to environmental factors.

The goal is to identify potential exposures to chemical contaminants that may pose significant risks to public health and provide information intended to result in actions to reduce exposures. The objectives have been to respond in a timely manner to emerging environmental health issues in need of investigation to better identify potential for exposure to pollutants and/or actions to reduce exposures.

Advise and assist state agencies.

The goal is to provide high quality toxicology and risk assessment assistance to state agencies, boards and legislature for use in evaluating the health implications of their actions. The objectives have been to respond in a timely manner to requests from state agencies, boards, and the legislature to requests for toxicology and risk assessment expertise.

Provide the public with and advise them as to preventative and corrective actions in the area of environmental health.

The goal is provide the public with information so they can make informed decisions on their need for action to respond to concerns about exposure to chemical pollutants. The objectives have been to make toxicologists more directly accessible to the public, develop information materials for the public, and to make materials disseminated by the ETP more easy-to-read and comprehensible by the lay public.

Maintain and operate a statewide occupational disease reporting system.

The goal is identify risk factors associated with occupational diseases that can in turn be used to develop strategies to prevent or reduce these risks. The objectives have been to maintain and operate a database of reportable occupational diseases, to analyze these data to identify risk factors associated with these diseases, and to prepare reports of such analyses for release to the public and the Department of Labor for their use in identifying strategies to reduce occupational disease.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

Performance criteria, timetables and benchmarks used by the ETP are:

i. *Assess health threats for persons consuming freshwater and anadromous fish and issue advisories of the public health threat;*

Strong reliance on U.S. EPA derived and peer reviewed toxicity databases and risk assessment methodology have been used as performance criteria. Assessments of health threats are performed in response to new data on contaminant levels in fish tissue sufficient to warrant a revision of existing advisories. Assessments have typically been performed on an annual basis in response to data collected from the previous summer/fall fish collection seasons. Comparisons of fish tissue action levels with those in other states, and surveys of public knowledge about advisories have been used as benchmarks for the development and effectiveness of advisories.

ii. *Maintain data bases on exposure guidelines for hazardous chemicals in drinking water and ambient air;*

Strong reliance on U.S. EPA derived and peer reviewed toxicity databases and assessment methodology have been used as performance criteria. Comparisons of numerical values of guidelines with those developed by other states, federal agencies, countries and organizations (e.g. World Health Organization) serve as benchmarks.

iii. *Conduct investigations as necessary to identify health problems related to environmental factors;*

The primary performance criterion is to subject study methods and findings to independent scientific peer review. Studies involving human subjects must additionally undergo a review by a Human Subjects Committee Internal Review Board in accordance with federal regulations.

iv. *Advise and assist state agencies.*

The primary performance criterion is client feedback and requested assistance completed on schedule.

v. *Advise the public as to preventative and corrective actions in the area of environmental health.*

Performance criteria focus on effectiveness of written materials in providing needed information. Developed materials are tested for reading level (goal is 8th grade or lower). Focus groups are additionally used to test comprehension and interest in materials. Surveys of awareness of materials are sometimes performed to assess effectiveness of outreach efforts.

vi. *Maintain and operate a statewide occupational disease reporting system.*

Performance criteria are under development.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

i. *Assess health threats for persons consuming freshwater and anadromous fish and issue advisories of the public health threat;*

Goals and objectives are being met. Available fish tissue data are regularly reviewed and advisories have been updated as new data become available through the Department of Environmental Protection. Surveys indicate awareness of statewide advisories due to mercury contamination was the highest among a study of 12 states, though still below desired awareness levels. A major new

risk communication initiative was launched in 2000 and follow-up surveys are planned for 2003.

ii. *Maintain data bases on exposure guidelines for hazardous chemicals in drinking water and ambient air*;

Goals and objectives are on target for being met by 2003. The drinking water guidelines were updated in 2000. Ambient air guidelines are currently being reviewed to be updated in 2002. Updates have not been as timely as desired (prior updates for drinking water and ambient air guidelines were 1992 and 1993, respectively). Delays are largely a consequence of past staff vacancies compounded by hiring freezes that were filled 1996-1997.

iii. *Conduct investigations as necessary to identify health problems related to environmental factors;*

Goals and objectives are being met. Studies have been conducted or are underway on

a) the statewide occurrence of MTBE in Maine's drinking water;
b) risk factors associated with an outbreak of carbon monoxide poisoning after a major ice storm in Maine;
c) potential exposure to dislodgeable arsenic from CCA pressure treated wood;
d) fish consumption, mercury exposure, and awareness of consumption advisories among women of childbearing age, and
e) potential exposure to arsenic from bathing in arsenic containing water. The first study was written up as a report and was the basis for Maine's decision to drop out of the reformulated gasoline program. The second study was published in *The Journal of Emergency Medicine*, and identified improper use of gasoline generators as the major risk factor for carbon monoxide poisoning during the a winter power outage. The third study has been shared with US Environmental Protection Agency that has regulatory over-sight of CCA wood, and led to Maine's State Toxicologist being place on the federal agency's external Scientific Advisory Panel to review a children's health risk assessment for exposure to Arsenic from CCA wood. The latter two are still underway.

iv. *Advise and assist state agencies.*

Goals and objectives are being met. The State Toxicologist specifically, and Environmental Toxicology Program generally, have received letters of gratitude for services provided by the Commissioner of the Department of Environmental Protection and the Senate and House chairs of the Natural Resources Committee, Maine State Legislature.

v. *Advise the public as to preventative and corrective actions in the area of environmental health.*

Goals and objectives are being met. The ETP has established a toll-free number for Maine citizens to contact toxicologists with questions about chemical exposures. New brochures on safe eating guidelines for fish and for arsenic and uranium in well water have been developed with reading levels of 8th grade or lower, in some cases have been tested in focus groups, and are now being distributed.

vi. *Maintain and operate a statewide occupational disease reporting system.*

Goals and objectives are not being met. A loss of federal funding for staff led the Bureau of temporarily close its Occupational Health Program. A recent decision was made to have the ETP take over operation and maintenance of the Occupational Disease Reporting System. The reporting system is operational again after a several month closure.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

Sources of funding:

- General Fund EHP appropriation, 22 MRSA, Chapter 271(I), §1695.sec3: 1 FTE (state toxicologist) and between a third or half of all other funds ($28,500 in 1982/83).
- General Fund Hazardous Air Pollutant appropriation, PL1985, Chapter 825: 1 FTE (toxicologist) and $10,000 all other in 1984/85.
- General Fund Occupation Disease Reporting appropriation, 22 MRSA c. 259-A §1494 Sec. 2: 0.5 FTE (Planning and Research Assoc. I) and $8000 all other as of 1986/87.
- Federal funds (NIOSH) for purchase of adult blood lead data from Occupational Disease Reporting System, $24800 for 2001/2002.
- Federal funds (USEPA) through a grant from Univ. of Wisconsin for development and distribution of risk communication materials for fish consumption advisories, $35000 for 1999-2001.

F. When applicable, the regulatory agenda and the summary of rules adopted;

10-144 Chapter 254, Occupational Disease Reporting Rules and Regulations. Effective March 29, 1996, Amended Nov 14, 1989, Amended September 26, 1994.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The ETP provides toxicology and risk assessment services to the Department of Environmental Protection (DEP) under a formal memorandum of agreement. The DEP in turn provides funds into a Bureau of Health dedicated revenue account to contract for 1 FTE of toxicology services. This arrangement negates the need for the DEP to request additional staff with training in toxicology, and provides toxicology services at a lower cost than obtainable from the private sector.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

(1) Department of Human Services, Bureau of Health (Drinking Water Program, Health and Environmental Testing Laboratory, Administration).
(2) Department of Environmental Protection & Board of Environmental Protection
(3) Department of Marine Resources
(4) Medical Advisory Committee, Board of Pesticides Control
(5) Department of Labor
(6) Bureau of General Services
(7) Maine State Legislature (Natural Resources Committee)
(8) General public (toxicology consults)

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The ETP has on occasion used temporary hires to meet short-term demands for additional toxicology staff. Certain risk communication work (development of easy-to-read materials) has been contracted out to the University of New England Health Literacy Center. The ETP has increasingly made use of its website as a means of providing information to the public.

J. Identification of emerging issues for the agency or program in the coming years.

Chemical terrorism preparedness, statewide occurrence of arsenic and uranium in private household well water, dislodgeable arsenic from CCA pressure treated wood, heavy metal content of fertilizers, fish and game consumption advisories due to chemical contamination, environmental contamination with brominated diphenyl ethers (used as a flame retardant), reassessment of dioxin toxicity and exposure, indoor air quality.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The ETP policies are in accordance with overarching DHS policy and State and Federal requirements. Confidentiality of information obtained under the Occupational Disease Reporting System is governed by 22 MRSA c. 259-A §1494.

Program Title: **Behavioral Risk Factor Surveillance System**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Enabling legislation is broadly defined under Title 22, Subtitle 2, Chapter 101.

B. A description of each program administered by the agency or independent agency, including the following for each program:

Description: Measuring health risks through public health surveillance is the essential underpinning for health promotion and disease prevention. Public health surveillance, such as the Behavioral Risk Factor Surveillance System (BRFSS), is the tool that provides the necessary data to define the disease burden, identify populations at highest risk.

BRFSS estimates the prevalence of health behaviors related to many of the nation's most prevalent chronic diseases. Chronic diseases are now our nation's leading killers, unlike the situation a century ago. Two chronic diseases, cardiovascular disease and cancer, account for almost two-thirds of all deaths among Americans. The roots of chronic diseases are grounded in a limited number of health-damaging behaviors practiced by people every day for much of their lives.

These behaviors include:

- Lack of physical activity.
- Poor nutrition (e.g., high-fat, low-fiber diets).
- Tobacco use.
- Under use of known prevention strategies, such as breast, cervical, and colorectal cancer screening.

Reducing the prevalence of these and other behaviors that endanger the health of Americans demands strategies such as public and provider education, prevention research, and policy and environmental changes that facilitate healthy living. To be effective, however, these strategies must be supported by ongoing surveillance of health risks.

1. Established priorities, including the goals and objectives in meeting each priority

The BRFSS supports various Healthy Maine 2010 goals and objectives related to data collection, surveillance and health data analysis and the performance based budgeting objective to "improve efficiency of

surveillance and monitoring, data and records management." Specific BRFSS goals and objectives include:

Goal: To determine the prevalence of health risks and behaviors associated with chronic and disease, and guide and evaluate disease prevention efforts at the national, state, and local level.

Objectives:

a) Use standard procedures to collect data from a series of monthly telephone interviews of a sample of randomly selected Maine adults.

b) Use the data to

- Determine priority health issues and identify populations at highest risk.
- Develop strategic plans and target prevention programs, including development of the Health Maine 2010 Objectives.
- Monitor the effectiveness of intervention strategies and progress toward achieving prevention goals.
- Educate the public, the health community, and policy makers about disease prevention.
- Support community policies that promote health and prevent disease.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

a) Using standard procedures developed by the Centers for Disease Control and Prevention (CDC) conduct a predetermined number of telephone interviews from of a sample of randomly selected Maine adults. (In 2001, 2400 interviews were completed.)

b) Data use criteria:

i. Monitor Maine's accomplishment of the Healthy Maine 2010 goals and objectives and the Healthy People 2000 health objectives for the nation by providing appropriate data and interpretation for evaluation of Healthy People 2000 health objectives to the Director of the Bureau of Health and the HP2010 Committee.

ii. Provide appropriate data and interpretation for planning and evaluation by Maine Bureau of Health programs, including: the Cardiovascular Health Program; Partnership for a Tobacco Free Maine; The Maine Injury Prevention Program; the Maternal and Child Health Program; Diabetes Program and the HIV-STD Prevention Program.

iii. Regularly disseminate BRFSS data in the form of a news letter and/or annual report to Maine public health community, health policy makers, educators and others.

3. **An assessment of the agency indicating the extent to which it has met the goals and objectives, using performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

All goals and objectives have been consistently met.

a) Maine BRFSS was established in 1987. CDC standards have been used consistently for data collection and management.

The number of interviews completed has increased annually from 1,260 in 1993 to an average of 2,400 a year since 1999.

b) Data use criteria:

i. BRFSS data were used for the development and monitoring of Maine Health People 2000 and are being used for the development and monitoring of Maine Health People 2010.
ii. BRFSS data and interpretation are used for planning and evaluation of Maine Bureau by Health programs, including: the Cardiovascular Health Program; Partnership for a Tobacco Free Maine; The Maine Injury Prevention Program; the Maternal and Child Health Program; Diabetes Program and the HIV-STD Prevention Program.
iii. BRFSS data have been regularly disseminated to a list of data users in the form of a news letter.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See Attached Job Classification and Organizational Chart for the Bureau.

The BRFSS program currently consists of one FTE position, the BRFSS coordinator:

Title: PLANNING & RESEARCH ASSOC II

The BRFSS coordinator reports to the Director of the Office Of Health Data And Program Management in the Bureau of Health

D. Compliance with federal and state safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

The Bureau is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See Attached Financial Summary for the Bureau.

F. When applicable, the regulatory agenda and summary of the rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which a agency could establish cooperative agreements, including but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.

BRFSS is partially funded by a cooperative agreement with the Behavioral Sciences Branch (BSB) of the Center for Chronic Disease Prevention and Health Promotion, CDC.
BSB provides standards for data collection and management and extensive technical assistance for data analysis and dissemination.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

BRFSS provide data used by public health public agencies (both public and private), policy makers and individuals throughout the state of Maine

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

BRFSS is not a service-delivery program.

J. Identification of emerging issues for the agency or program in the coming years.

Two emerging issues have been identified for Maine BRFSS:

1) Falling response rates for telephone surveys is a national phenomena that has begun to affect BRFSS in Maine and the US. A combination of factors may be responsible including increased use of telephone for solicitation and surveys and a corresponding increase in caller pre-screening of calls (for example use of "caller-id").
Potential strategies to increase our response rate include increasing the public's awareness of BRFSS and beginning to sample cell phones.

2) Maine BRFSS has traditionally distributed its data through a standard newsletter and responses to individual requests for data. Additional distribution methods need to be explored including web-based data and publishing topic-specific reports targeted at specific audiences.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency program and the rules implemented by the agency or program; and

M. Agency policies for collecting, managing, and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau abides by the Department Policy - Use of Automated Equipment.

Personal identifiers are not collected by Maine BRFSS. Telephone numbers are only distributed without the last 4 digits to assure confidentiality of the respondent.

Program Title: **Vital Statistics**

A. **Enabling or authorizing law or other relevant mandate, including and federal mandates:**

22 MRSA §2701. Duties of department

The Department of Human Services shall establish an Office of Vital Statistics, which shall maintain a state-wide system for the registration of vital statistics.

1. Registrar. The Commissioner of Human Services shall appoint a State Registrar of Vital Statistics, who shall be qualified in accordance with the standards of education and experience prescribed by the Bureau of Human Resources.

2. Supervision. The state registrar shall have charge of the Office of Vital Statistics and be custodian of its files and records. He shall preserve all certificates, records and other reports returned to him under this Title. He shall have general supervision of this Title and the regulations of the department relating to the registration of vital statistics. He shall direct, supervise and control the activities of all persons when they are engaged in activities pertaining to the operation of the system of vital statistics. He shall conduct training programs to promote uniformity of policy and procedures throughout the State in matters pertaining to the system of vital statistics. He shall monitor the accuracy, completeness and validity of all information returned to him under this Title.

3. Forms and reports. The state registrar shall prescribe and furnish forms and issue instructions necessary to the administration of the vital statistics system. He shall prepare and publish annual reports of vital statistics and such other reports as are requested by the department.

4. The forms of certificates, records and other reports required by the laws governing the registration of vital statistics shall be designed with due consideration for national uniformity in vital statistics and record service.

B. **A description of each program administered by the agency or independent agency including the following for each program:**

Private citizens require vital records, such as birth and death certificates, as proof of identity and citizenship for school entrance, passports, employment, filing insurance claims and other purposes. Statistical information from vital records are used by public and private agencies, organizations and businesses as well as school districts, universities and the public. The data are used for

public health surveillance of diseases and problems prevalent in the population and for planning at the national, state, community and program levels of government. They are also used to estimate and project population for use in municipal and school district planning efforts and the allocation of state revenue sharing monies.

1. **Established priorities, including the goals and objectives in meeting each priority:**

   The Vital Statistics Program supports various Health Maine 2010 goals and objectives and the performance based contracting objective to improve efficiency of surveillance and monitoring, data and records management." Specific program objectives include:

   Replacement of the current electronic birth certificate.
   Imaging and electronic storage and retrieval of vital records.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives:**

   Failure to replace the Electronic Birth Certificate jeopardizes the State's commitment to provide data electronically to several federal agencies and could result in the loss of funds. Reverting to a paper system requires the hiring of additional staff. Implementation of an imaging and electronic storage system will enable the program to better serve its customers.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives:**

   The current Electronic Birth Certificate system is more than five years old and cannot be updated because the software company is no longer in business. Currently, no funding exists for either project.

C. **Organizational structure, including a position count, a job classification and an organization flow chart indicating lines of responsibility:**

   See Attached Job Classification and Organizational Chart.

   State Registrar
   <u>Office of Vital Records</u>
   Deputy State Registrar
   Clerk IV
   Clerk Typist II
   Clerk Typist II
   Clerk Typist II
   Clerk Typist II

Office of Data, Research and Vital Statistics
Director
Clerk Typist III
Statistical Services
Supervisor, Data and Research
Comprehensive Health Planner II
Comprehensive Health Planner II
Planning and Research Associate II
Planning and Research Associate I
Planning and Research Assistant
Programmer Analyst
Programmer Analyst
Survey Operations
Supervisor, Data and Research
Comprehensive Health Planner II
Clerk Typist II
Planning and Research Associate II
Clerk Typist III
Planning and Research Associate I

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation:**

The Bureau is compliance with all federal and state laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted:**

Vital Statistic Rules are promulgated as necessary. It is anticipated the Rules regarding fee increases will be announced this fiscal year.

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements:**

Data from the Maine vital statistics system are provided to the National Center for Health Statistics for use in compiling national statistics. Summary data are provided to the U. S. Census Bureau for use in developing national, state and county population estimates. Through the Enumeration at Birth

Program, Maine provides parents the option of requesting a social security number for their newborn at the time the birth certificate is filed with the state. The vital statistics system transmits such parental requests, and the information needed to complete them, to the Social Security Administration electronically. Death certificate information is provided to both the Social Security Administration and the Maine State Retirement System, for use in purging the retirement benefits files of deceased persons. Data from the birth certificate are used by Maine's Immunization Program to population the IMMPACT data base. Birth and death certificate data are a key component of the MMDSS.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes:**

Constituencies include private citizens requiring personal documentation, uses of data (researchers, health planners, municipalities, hospitals, community agencies, private business, schools, etc.), public health epidemiologists conducting disease surveillance.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives:**

In 1996, an electronic birth certificate developed by J.K., Inc, a small software
development company was implemented in Maine. The software enabled hospitals to enter birth certificate information locally and transmit the data to the State of Maine, where the births were registered electronically. The company went out of business in January 1999, leaving the birth registration system without technical support for the software. The software is becoming less and less compatible with existing technology, cannot be updated to meet changes in reporting requirements, and must be replaced.

J. **Identification of emerging issues for the agency or program in the coming years:**

Replacement of the current electronic birth registration system is the main issue facing the vital statistics system. Failure to replace the current electronic birth certificate will result in the loss of $131,269 annually in federal funds, causing Maine's vital statistics system to either shut down or operate at a greatly reduced capacity. Data feeds to several important state programs (i.e., IMMPACT, the Birth Defects Program, and the MMDSS) will be severed, because the information needed will not be available. Delays in the registration of vital events and the availability of records needed by the public will be experienced. Data on vital events used in program planning and evaluation, as well as detecting and monitoring public health problems, will no longer be available.

Also facing the vital statistics system are issues regarding the storage and retrieval of permanent retention records (birth, death, marriage and divorce records). More than 3 million records currently need to be maintained and made accessible to the public, a number that is growing by about 45,000 records per year. An optical imaging system is needed to facilitate the safe storage and retrieval of records and ensure continued service to the public.

K. **Any other information specifically requested by the committee of jurisdiction:**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program:**

M. **Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement:**

22 MRSA §2706. Disclosure of vital records

Custodians of certificates and records of births, marriage and death may permit inspection of records, or issue certified copies of certificates or records, or any parts thereof, when satisfied that the applicant therefore has a direct and legitimate interest in the matter recorded, the decision of the state registrar or clerk of a municipality being subject to review by the Superior Court, under the limitations of this section.

1. Illegitimacy. No official in this State shall permit inspection, or issue a certified copy of any certificate or record of birth disclosing illegitimacy. Such a record may be disclosed or a certified copy issued upon request of the illegitimate himself, his parent or his legal guardian or counsel or of petitioners for adoption or in response to court process.

2. Statistical research. The state registrar may permit the use of data contained in vital records for purposes of statistical research. Such data shall not be used in a manner, which will identify any individual.

3. National statistics. The national agency responsible for compiling national vital statistics may be furnished such copies or data as it may require for national statistics. The State shall be reimbursed for cost of furnishing such copies or data, and such data shall not be used in a manner, which will identify any individual, except as authorized by the state registrar.

4. Unlawful disclosure of data. It shall be unlawful for any employee of the State or of any municipality in the State to disclose data contained in such records, except as authorized in this section and except that a clerk of a municipality may cause to be printed in the annual town report the deaths reported within the year covered by said report, by date of death, name, and location by city or town where death occurred. All other details of death shall not be available to the general public.

5. Persons own record disclosed. Vital records of a person shall be made available at any reasonable time upon his request or to his duly designated attorney or agent or attorney for an agent designated by such person or by a court having jurisdiction over said person by mail, telephone or otherwise, provided the registrar is satisfied as to the identity of the requester, and if an attorney or agent, provided the registrar is satisfied as to his authority to act as such agent or attorney. If such agent or attorney has been appointed by a court of competent jurisdiction, or his appearance for such person is entered therein, the registrar shall upon request so ascertain by telephone call to the registrar, clerk or recorder of said court, and this shall be deemed sufficient jurisdiction to compel compliance with the request for said record. The state registrar shall, as soon as possible, designate persons in the Office of Vital Statistics who may act in his absence, or in the case of his disqualification, to carry out the intent of this subsection.

Program Title: **Coordinating School Health Programs**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

This program is a requirement of a cooperative agreement between the State of Maine and the Division of Adolescent and School Health of the Centers for Disease Control and Health Promotion.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority.

The following have been our program goals for four years. Each year the objectives towards meeting these goals change.

Goal #1: Develop a state-of-the art system that is strategic in nature, is driven by data, and achieves measurable student health and learning outcomes.

Goal #2: Establish a common language and State standards for Coordinated School Health Programs.

Goal #3: Obtain an active, ongoing commitment from State and local policy makers for coordinating school health programs.

Goal #4: Coordinate appropriation and distribution of resources to actively support the implementation of coordinated school health programs in all schools for the benefit of all students.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

Progress reports are submitted to CDC every 6 months.

3. **An assessment of the agency indicating the extent to which it has met the goals and objectives, using performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

This program has satisfactorily met its goals and objectives since funding was awarded four years ago.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility. Our program has

See job classification and organizational chart for the Bureau.

* One Health Program Manager
* One Planning and Research Asst. II

D. Compliance with federal and state safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and summary of the rules adopted;

Not applicable

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which a agency could establish cooperative agreements, including but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.

1) Our program is part of the Governor's Children Cabinet agenda, which encourages collaboration among all child serving state agencies.
2) The Bureau of Health is the lead partner with the Maine Department of Education in this cooperative agreement with CDC. There are five other state agencies that are collaborating partners. We meet monthly to update and plan together related to youth health initiatives in schools.
3) Our program will be coordinating with the Maine Marks indicators to measure the impact of CSHP on child health
4) Our program cooperates with health and education national professional associations e.g. Council of Chief State School Officers, National Governors Association, National School Boards Association, American School Health Association.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

1) We serve other state agencies and non-government organizations whose missions are also to improve the health and education of children

2) We serve local school health coordinators in 31 partnerships across the State. We provide training and technical assistance for these coordinators.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

We use new computer and communication technology as alternatives to traditional delivery of training and technical assistance, e.g. ITV, a web site and a web-based assessment tool.

J. Identification of emerging issues for the agency or program in the coming years.

1) The major emerging issue for CSHP is the need for continued funding. We are entering the 5th year of a five year cooperative agreement with CDC. We plan to reapply for funding, without which we will be unlikely to employ staff to continue the systems that we have developed to promote youth health.
2) It would be very helpful if the State could supplement CDC funding that is solely for positions, with funding for programs and training.

K. Any other information specifically requested by the committee of jurisdiction:

CSHP program has made multiple presentations to the Mental Health Oversight Committee about the role of schools in promoting mental health. We have also provided testimony regarding school health issues to other Legislative committees as requested.

L. A comparison of any related federal laws and regulations to the state laws governing the agency program and the rules implemented by the agency or program;

N/A

M. Agency policies for collecting, managing, and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

No personal information is transmitted by our program.

Program Title: **Office of Rural Health and Primary Care**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

1. Primary Care Office - Section 333 (D) Public Health Service Act as amended.
2. State Loan Repayment Program - Section 339 (O) Public Health Service Act as amended.
3. Foreign Trained Physician (J1 Waiver) State 20 Program - P.L. 103-416.
4. Rural Health Office - Section 338 (J) Public Health Service Act as amended.
5. Rural Hospital Flexibility Program - 42 OSC 293 (J) Section 746 (F).

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities; including the goals and objectives in meeting each priority;

a. Increase access to underserved populations.
b. Increase numbers of health professionals in health professional shortage areas to meet the needs of the medically underserved.
c. To assist rural health care facilities and providers to ensure access and quality of health care.
d. Enhance rural health care delivery system and strengthen small rural hospitals.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

Each area is analyzed for access to mental health, dental health and primary care services on a routine basis to determine progress and needs. Performance criteria are spelled out in federal guidance.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

Goals and objectives are met based on grant applications for funding to the federal government.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

Program Manager
Program Manager
Planning and Research Assoc. II
Planning and Research Assoc I
Word Processor Operator

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Foreign Trained Physicians (J1 Program) 10-144 ch 513
Establishes the process for petitioning DHS for a waiver of recommendation.
State Loan Repayment Program 10-144 ch 508
Establishes the prioritization process for determining greatest need among health professional shortage areas to make them eligible for loan repayors.
Maine Rural Hospital Flexibility Program Plan
Establishes critical hospital program criteria and priorities for program

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

All programs are thoroughly coordinated with federal funding agencies, as well as other appropriate state agencies and the Maine Ambulatory Care Coalition.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

The programs target rural, underserved and disparate populations as well as assisting in maintenance and development of health care infrastructure.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.**

These programs work equally with the private sector health care system and the publicly funded systems.

J. **Identification of emerging issues for the agency or program in the coming years.**

The number one issue is to identify a supply of dentists to meet the needs of the underserved.

K. **Any other information specifically requested by the committee of jurisdiction**;

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and**

The state regulations adhere to the federal laws.

M. **Agency policies for collecting, managing and using personal information over the Internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Bureau abides by all Department policies concerning the Use of Automated Equipment and Confidentiality statement.

The Office of Rural Health and Primary Care has a website with various links. No personal information on providers is distributed over the Internet or non-electronically.

Program Title: **Division of Disease Control**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

22 MRSA, Chapters 250, Control of Communicable Diseases, Sections 801-825.

Rules for the Control of Notifiable Conditions, DHS 10/144, Chapters 208, 251, 258, and 261,

Title 22 M.R.S.A. Ch. 252-A, Section 1341. Rules Governing the Implementation of Hypodermic Apparatus Exchange Programs.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;
2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and
3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

The Division of Disease Control promotes and protects the health of the citizens of Maine through four programs focusing on the prevention and control of infectious diseases: HIV/STD, Immunization, Infectious Epidemiology and Tuberculosis. The Division's work is guided by its three-year strategic plan. The plan sets strategic directions common to the entire Division and these directions then drive the operational plans of each program.

These six strategic directions have been identified by the Division of Disease Control for the 2001-2003 period:

I. Promote and support workplace excellence by enhancing and improving the DDC work environment and professional development practices.

II. Increase the communication and coordination between DDC programs and, when practical, integrate our efforts.

III. Promote sound public policy and resource allocation for the prevention and control of infectious diseases through active, collaborative partnerships with community members, community agencies, and governmental agencies.

IV. Develop and incorporate an active evaluative process into all aspects of our work.

V. Improve our capacity to accomplish our mission by creatively applying the latest information technology tools.

VI. Enhance our communication and education efforts with our partners and the general public.

The implementation of the plan is monitored by a cross-program Strategic Planning Committee, which meets on a quarterly basis.

While the Division of Disease Control must maintain the flexibility to respond to newly emerging and re-emerging infectious disease threats (such as West Nile Virus), as well as detect and respond to potential catastrophic infectious disease threats (such as bioterrorism or naturally occurring pandemic influenza), its day-to-day operations are driven by goals and objectives determined on decennial basis and currently reflected in the draft document, Healthy Maine 2010. These goals and objectives are summarized in the table that follows (taken from Healthy Maine 2010):

CHAPTER V. IMMUNIZATION AND INFECTIOUS DISEASE ***Goal: Prevent disease, disability, and death from infectious diseases, including vaccine-preventable diseases.***	
FOOD SAFETY	
10-1	Reduce infections caused by key food borne pathogens.
10-1a	Campylobacter species
10-1b	Escherichia coli O157:H7
10-1c	Listeria monocytogenes
10-1d	Salmonella species
10-1e	Developmental: Cyclospora cayetanensis
10-1f	Developmental: Postdiarrheal hemolytic uremic syndrome
10-1g	Developmental: Congenital Toxoplasma gongli
HIV	
Maine Specific	Increase the number of high risk (HIV) individuals who test at public sites by 20%

Maine Specific	Increase the proportion of STD clinic patients who receive 3 doses of hepatitis B vaccine.
	IMMUNIZATION AND INFECTIOUS DISEASE
14-1	Reduce or eliminate indigenous cases of vaccine-preventable disease.
14-1a	Congenital rubella syndrome
14-1b	Diphtheria (persons < 35 years)
14-1c	Haemophilus influenzae tybe b* (children < 5) **includes cases with type b and unknown serotype*
14-1d	Hepatitis B (persons aged 2-18 years)
14-1e	Measles
14-1f	Mumps
14-1g	Pertussis (children < 7)
14-1h	Polio (wild type virus)
14-1i	Rubella
14-1j	Tetanus(persons < 35 years)
14-1k	Varicella (chicken pox)
New	Streptococcus Pneumonia (Sp ?)
14-10	(Developmental) Increase the proportion of persons with chronic hepatitis C infection identified by State and local health departments.
14-11	Reduce Tuberculosis.
14-18	Reduce the number of courses of antibiotics for ear infections for young children.
14-22	Achieve and maintain effective vaccination coverage levels for universally recommended vaccines among young children.
14-22a	4 doses diphtheria-tetanus-pertussis (DtaP) vaccine
14-22b	3 doses Haemophilus influenzae type b (Hib) vaccine
14-22c	3 doses hepatis B vaccine (hep B)
14-22d	1 dose measles-mumps-rubella (MMR) vaccine
14-22e	3 doses polio vaccine
14-22f	1 dose varicella vaccine

14-26	Increase the proportion of children who participate in fully operational population-based immunization registries.
14-29	Increase the proportions of adults who are vaccinated annually against influenza and ever vaccinated against pneumococcal disease.
Non-institutionalized adults aged 65 years and older	
14-29a	Influenza vaccine
14-29b	Pneumococcal vaccine
SEXUALLY TRANSMITTED DISEASES	
Maine Specific	Reduce Chlamydia trachomatis infections in females 15-24 to no more than 900 per 100,000
Maine Specific	Reduce Chlamydia trachomatis infections in males 15-24 to no more than 214 per 100,000

Specific strategies are developed by programs to address each of these objectives. Progress is reviewed on an annual basis by the programs and is synthesized by the Division and the Bureau into mid-point and final review documents each decade. Corrective actions are taken at any point it becomes apparent that an objective is not being successfully addressed. Examples of this process in action over the past decade are found in the documents: Healthy Maine 2000: Mid-Course Review and Healthy Maine 2000: A Decade in Review.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

The ability to conduct communicable disease surveillance stems from Rules for the Control of Notifiable Conditions (DHS, Bureau of Health 10/144A, Chapter 258). These Rules explain the rationale for reporting, discuss confidentiality and immunity from liability for reporting professionals, enumerate the reportable conditions, identify the persons and institutions obligated to make reports, and describe procedures for disease investigation and intervention activities. The Rules were last amended in 1999.

Immunization Requirements for School Children:

The purpose for amending this rule, issued jointly by the Commissioner of Education and the Bureau of Health, Department of Human Services, is to add the varicella (chickenpox) vaccine to the required schedule and to change the standards for immunization exemptions in accordance with the governing statutes.

Immunization Requirements for Health-Care Workers:

Many health-care workers are at risk for exposure to and possible transmission of vaccine-preventable diseases, because of their contact with patients or infectious material from patients. The heath and safety of health-care workers and the patients they care for is an essential area of concern. This rule is issued by the Commissioner of the Department of Human Services to implement the provisions of the statute governing immunization requirements for hospital/health facility personnel. It prescribes the dosage for required immunizations and defines responsibilities, exclusion periods, record keeping and reporting requirements for officials of hospitals and health facilities.

Immunization Information System (IIS) Rules:

The Immunization Information system is intended to be a repository for accurate and up to date immunization records for all persons born, residing, or receiving vaccine in the State of Maine. The primary purpose of the system is to collect data related to vaccine administration, and to promote effective and cost efficient prevention of vaccine preventable diseases. Administration of the system shall be performed by the Department's Immunization Program. The proposed Rule, authorized by 22 MRSA § 1064, will apply to all Immunization Providers and other entities who have a contract or Memorandum of Agreement with the Department to participate in the vaccine distribution system, the Immunization Information System or to provide support services.

Title 22 M.R.S.A. Ch. 252-A, Section 1341
Rules Governing the Implementation of Hypodermic Apparatus Exchange Programs. This rule governs the implementation of hypodermic apparatus exchange programs aimed at decreasing infectious disease transmission. Organizations planning to operate hypodermic apparatus exchange programs will be required to be certified by the Bureau of Health. This rule describes the requirements of the certification process.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

In Maine, during the late 1990's, collaboration among public health professionals, medical providers, government agencies, laboratorians, patient advocates, and other professional has begun to flourish in the approach to some problem areas. Funding from the Centers for Disease Control and Prevention has been used to improve disease surveillance and laboratory capacities. Our efforts have resulted in the achievement of the vast majority of the infectious disease-related Healthy Maine 2000 objectives. Continued efforts to build partnerships and creatively apply public health to the unique conditions of Maine will allow us to meet the challenges posed by infectious diseases at the beginning of the 21st century.

Examples of collaborative efforts from each of the programs of the DDC include:

The ***Infectious Disease Epidemiology Section*** relies on collaboration with many other state and federal agencies to achieve its objectives. Funding for almost all program activities is through cooperative agreements with the Centers for Disease Control and Prevention. Other collaborations include:

Maine Department of Conservation (Surveillance and control of Lyme disease, West Nile Virus, Powassan virus encephalitis)
Maine Department of Agriculture (Food safety, rabies prevention and control)
University of Maine (West Nile Mosquito Studies)
Maine Department of Environmental Protection (Mosquito control)

The ***Maine Immunization Program*** has a collaborative relationship with The Bureau of Medical Services for support and follow-up of the health concerns of Medicaid-eligible children. Early, Periodic Screening, Diagnosis and Treatment (EPSDT) staff are located within the Immunization Program and participate as key team members to ensure that the health concerns of vulnerable children receive timely attention and follow-up. The ImmPact immunization information

system incorporates electronic versions of the Bright Futures child health screening guidelines, and allows for electronic submission by participating healthcare providers.

Another collaborative relationship with Medicaid allows the purchase of influenza vaccine for distribution free of charge, to healthcare providers who participate with the Maine Immunization Program. Through this arrangement, nearly 250,000 doses of influenza vaccine were distributed across the State in the fall of 2001.

The Immunization Program is also exploring collaborative relationships for early child screening and support with WIC and Maternal and Child Health.

To support the financing of vaccines under Maine's universal child immunization status, the Immunization Program has developed a relationship with the Maine HMO Council for the purpose of cost-sharing. Participating HMO's agree to reimburse the Immunization Program for the cost of vaccines provided to their covered population. Because the State Program purchases vaccine at government contract rates, the cost is significantly below market price; subsequently this agreement benefits both the State and the private sector.

The Immunization Program also collaborates with municipal health departments in Portland, Auburn and Bangor to provide Hepatitis A and B vaccine free of charge to clients of municipal STD clinics, who are deemed at high-risk for hepatitis exposure and transmission.

Additionally, one-year capacity-building grants were developed with four tribal health departments.

The ***Maine Tuberculosis Control Program*** has:

- Field services provided by state Public Health Nurses, per a Memorandum of Understanding;
- Contracts with eight private physicians who have expertise in diagnosis and treatment of TB disease to provide clinical services directly to persons with TB infection and disease or consultative services to other physicians managing TB patients
- A Cooperative agreement relationship with CDC TB Elimination program resulting in the placement of a Senior Public Health Advisor in Maine

The ***Maine HIV/STD Program*** contracts for HIV Prevention services, STD prevention, clinic services and disease follow up with community based organizations (AIDS Service Organizations, Family Planning agencies, municipal health departments), using funds provided through cooperative agreements with the Centers for Disease Control and Prevention. The AIDS Drug Assistance Program is operated through a collaborative effort with the Community Services Center.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The Division of Disease Control serves the entire population of the state of Maine.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

As noted in section G. above, the Division of Disease Control delivers the vast majority of its services in partnership with private medical care providers throughout the state.

J. Identification of emerging issues for the agency or program in the coming years.

Emerging priority issues for Division of Disease Control include:

1. Bioterrorism surveillance and response
2. Tickborne disease surveillance, prevention, and education
3. Surveillance and prevention of Mosquitoborne diseases including West Nile Virus and Eastern Equine Encephalitis
4. Continuing the control and working toward the eventual elimination of sexually transmitted diseases such as HIV, syphilis, gonorrhea and chlamydia
5. Integration of Hepatitis A, B and C prevention, monitoring and treatment services
6. Rapid response to infectious disease emergencies (non-bioterrorism related) such as pandemic influenza
7. Improving epidemiologic surveillance and response capacities at regional and local levels
8. Maintaining TB awareness and expertise in the diagnosis and treatment of TB among health care professionals in a very low incidence state. Such awareness is needed for timely detection and treatment to prevent a TB disease outbreak
9. Challenges surrounding vaccine production and supply; during the 2001-2002 year, vaccine manufacturing issues led to national temporary and spot shortages and delayed distribution of influenza vaccine and vaccines for four of the eleven diseases preventable through routine vaccination of children: diptheria, tetanus, pertussis, and pneumococcal disease. Based on recent information from the federal Centers for Disease Control and Prevention, shortages are expected to continue until at least mid-2002.
10. Vaccine financing is expected to remain a significant challenge to the Program, particularly as the cost of vaccines continues to escalate. This challenge will manifest as a particular concern to maintain Maine's universal distribution of childhood vaccines, subsequently eliminating

cost as a barrier to immunization. Maine continues to have some of the highest childhood immunization rates in the country, and this is largely due to our ability to sustain universal vaccine distribution.

11. Further developing and sustaining sophisticated information systems that meet healthcare provider and public health system needs for rapid and organized immunization and infectious disease reporting and related data. The use of information technology among health care and public health systems continues to increase, and the current ImmPact information system plays a lead role in Maine's public health information system. Over the next few years there will be an increasing urgency to integrate public health information systems and develop systems that are meaningful and user-friendly for Maine's healthcare providers. Significant resources will need to ensure that the ImmPact registry is adequately integrated and maximized in this effort.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

Control of communicable diseases is a state function. Our laws and rules are comparable to those of most other states.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

DDC policies are consistent with DHS policies and procedures in this area. Our only separate policy in this area is captured in the rules referenced above regarding operations of the Immunization Information System. We are currently assuring compliance with federal HIPPA rules in all program areas.

Program Title: **Division of Health Engineering**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

1. Drinking Water Program: 22 § 2601 et seq.
2. Eating and Lodging Program: 22 § 2491 et seq.
3. Wastewater and Plumbing Control Program: Rules - 22 § 42 et seq., Permits - 30A § 4201 et seq.
4. Soil Site Evaluation Licensing; 22 § 42 et seq.
5. Radiation Control Program: 22 §671 et seq.
6. Well Drillers and Pump Installers board: 22 §1689 et seq.
7. Water Operators Certification Licensing: 22 § 2621 et seq.
8. Construction or Expansion of Cemeteries: 13 § 1342 et seq.
9. Mass Gathering Permits: 22 §1601
10. Establishment and Approval of Resource Protection Areas for Public Water Systems: 22 §2601-A et seq.
11. Approval of Sewage Systems Pursuant to the Minimum Lot Size Law: 12 § 4807 et seq.
12. Approval of Sewage Systems of a Converted Seasonal Dwelling Pursuant to the 30A § 4215
13. Licensing of Tattoo Artists: 32 § 4201 et seq.
14. Licensing of Micropigmentation Practitioners: 32 § 4311 et seq.
15. Licensing of Body Piercing Practitioners: 32 § 4321 et seq.
16. Retail Tobacco Licensing: 22 § 1551 et seq.
17. Prohibition of Smoking in Restaurants and Other Public Places: 22 § 1541 et seq.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Located within the Department of Human Services, the Division of Health Engineering has responsibility for protecting public health through engineering provided services and oversight to reduce the risk of disease by (1) controlling environmental hazards to human health; and (2) promoting health and wellness through education and access to technical health engineering professionals. There are four major program areas:

i. Drinking Water Program: To protect human health through maintenance of drinking water quality.

ii. Radiation Control Program: To minimize necessary radiation exposure through the licensing and inspection of sources of radiation, oversight of low-level radioactive waste generators, and conducting environmental surveillance at the Maine Yankee nuclear facility, and to minimize the health hazards associated with indoor air complaints.

iii. Eating and Lodging Program: To minimize unnecessary health hazards associated with food sanitation and recreation activities. The program also provides field support for the Division's programs.

iv. Wastewater and Plumbing Control Program: To minimize health and safety hazards associated with improperly installed subsurface wastewater disposal systems.

1. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

The Division of Health Engineering has varying timetables mandated by federal agencies or state regulations.

2. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

All programs have some degree of oversight by the federal government, through annual program audits. The Division of Health Engineering performs continuous regulatory functions. Therefore, most work is self regulated and evaluated.

Regulatory and licensing output for the Division of Health Engineering:

- 257 Master and Journeyman licensed well drillers; Annual fee: Master-$120.00, Journeyman-$88.00
- 309 licensed water pump Installers; Annual fee: $60.00
- 626 Water Treatment plant operators (total of 6 different categories); Annual fee: $8.00
- 40,000 plumbing permits processed annually
- $290,000 dedicated revenue from plumbing permit and subsurface disposal system permit fees
- 320 Site Evaluators licensed, $40 biennial fee
- Appointment and oversight of 300 Local Plumbing Inspectors (certified by State Planning Office in conjunction with DHS)
- 2,763 licensed x-ray machines and mammography machines (1,025 facilities)
- 160 licensed users of radioactive material
- 12 facilities that generate Low Level Radioactive Waste

- 430 licensed artificial tanning establishments
- $60,000 received from 3,000 sellers of retail tobacco products
- $682,000 received from 8,720 licensed eating and lodging establishments
- 3,100 year round eating establishments; 2,000 seasonal
- 9 full-time State public health sanitarians
- Most eating and lodging establishments inspected every 3 years
- 2,200 Public water Supplies, Total population served is 894,000
- 400 drinking water enforcement actions yearly
- 278 drinking water rule violations including 55 Engineering/Consent orders
- $12,500,000 available for Revolving Loan Infrastructure Fund
- $750,000 annual Public Water System grant from US Environmental Protection Agency

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

EATING & LODGING PROGRAM

- Chapter 200: State of Maine Food Code
- Chapter 201: Rules Relating Lodging Places
- Chapter 202: Rules Relating to Swimming Pools and Spas
- Chapter 205: Rules Relating to Campgrounds, Tent and Recreational Vehicle Parks, Wilderness Recreational Parks, Agricultural Fair Campgrounds, and Temporary Campgrounds
- Chapter 206: [Proposed] Rules Relating to the Licensing and Enforcement of Establishments that are Licensed by the Eating and Lodging Program
- Chapter 208: Boys, Girls, Boys and Girls, Day Camps and Primitive and Trip Camping
- Chapter 209: Body Piercing Rules
- Chapter 210: Rules Relating to Tattooing
- Chapter 211: Micropigmentation Rules
- Chapter 214: Mass Gathering Rules
- Chapter 225: Rules Relating To The Licensing of Suppliers of Compressed Air Used In Self-Contained Breathing Apparatus
- Chapter 250: Rules Relating to Smoking in Restaurants

WASTE WATER & PLUMBING CONTROL PROGRAM

- Chapter 240: Rules for Appointment and Administration of Local Plumbing Inspectors
- Chapter 241: Maine Subsurface Wastewater Disposal System Rules
- Chapter 242: Rules for Conversion of Seasonal Dwelling Units into Year-Round Residences in the Shoreland Zone
- Chapter 243: Minimum Lot Size Law Variance Rules
- Chapter 245: Maine Rules for Site Evaluators of Subsurface Wastewater Disposal Systems

DRINKING WATER PROGRAM

- Chapter 226: Rules Relating to Cross Connections
- Chapter 228: Rules Relating to Fluoridation of Public Water Systems
- Chapter 230: Rules Relating to Drinking Water State Revolving Loan Fund
- Chapter 231: Rules Relating to Drinking Water
- Chapter 232: Rules Relating to Water Well Drillers and Pump Installers
- Chapter 233: Test of Private Water Systems for Potentially Hazardous Contaminants
- Chapter 235: Rules Relating to Bottled Water, Bulk Water, and Water Vending Machines
- 90-429: Water Treatment Plant Operators Board

RADIATION CONTROL PROGRAM

- Chapter 220: Rules Relating To Radiation Protection
- Chapter 223: Rules Relating to Tanning Facilities
- Chapter 224: Air and Water Radon Service Provider Registration Rules

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

See Chart Attached.

	Drinking Water Program	Wastewater and Plumbing Control Program	Eating and Lodging Program	Radiation Control Program
U.S. Environmental Protection Agency	X	X		X
U.S. Nuclear Regulatory Commission				X
U.S. FDA (Centers for Disease Control)			X	X
Maine Department of Environmental Protection	X	X	X	X
Maine Department of Conservation	X	X	X	
Maine Department of Public Safety	X		X	X
Maine Department of Defense, Veterans and Emergency Management	X			X
Department of Economic and Community Development	X		X	
Department of Agriculture, Food and Rural Resources	X	X	X	

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Maine Water Utilities Association, Maine Rural Water Association, Maine Groundwater Association, Water Operators Certification Board, Maine Drinking Water Commission, Maine Campground Association, Maine Innkeepers Association, Maine Restaurant Association, Maine Association of Site Evaluators, Maine Building Officials and Inspectors Association, Radon Technologists, Maine Medical Association, Maine Dental Association.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

a. Five private party inspectors inspect over 2,763 x-ray and mammographic machines representing 1,025 facilities, (97.7%)
b. Ten municipal sanitarians inspect over 800 eating establishments, (8.6%)
c. The Drinking Water Program (DWP) maintains Memorandums of Understanding with the Maine Water Utilities Association and the Maine Rural Water Association to provide funding for outreach and education to small water systems (<10,000 population).
d. The DWP maintains a Memorandum of Understanding with the Department of Environmental Protection to establish a process to share information when hydrocarbon or hazardous waste spills occur near public water supplies.
e. The DWP and the DEP formed an interagency coordinating committee that meets quarterly to discuss shared issues and to maintain open lines of communication.
f. The Wastewater and Plumbing Control Program maintains a Memorandum of Understanding with the Department of Environmental Protection to review large (engineered) subsurface wastewater disposal systems.

J. Identification of emerging issues for the agency or program in the coming years.

- Division of Health Engineering is fully involved in counter-terrorism efforts
- Establish methods to effectively deal with multi-language clients
- Bathing beaches serving the public
- Revision of the State's Health Officer laws
- Revision of the State's Mass Gathering law
- Closure of roadside springs
- Inspection of Eating and Lodging establishments using risk-based criteria
- Electronic inspection of Eating and Lodging establishments
- Licensure of scrap metal dealers
- Mandatory training in the food service industry for first-time food service providers
- Transfer the review and approval of sewage disposal systems pursuant to the Minimum Lot Size Law and the Seasonal Conversion Permit to the municipalities.

K. Any other information specifically requested by the committee of jurisdiction;

The Division of Health Engineering is an organization that deals with a wide variety of activities, some rather arcane. As a result, the Division occasionally becomes responsible for activities not clearly delegated in Maine law. An example is providing support to the public for indoor air quality complaints from the public.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

N/A

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Bureau abides by all Department policies concerning the Use of Automated Equipment and the Confidentiality statement.
BOH Program Evaluation Report, DHE,, 1/3/02 Contact person: Clough Toppan 287-5686

Program Title: **Health and Environmental Testing Laboratory**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

22 MRSA, Chapter 157-A (sections 565-568), and section 2602

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Mission Statement: The goals of the Health and Environmental Testing Laboratory are to isolate, identify, analyze and monitor any biological, chemical, or radiological hazards that are capable of causing harm. We will assist other agencies in the prevention, treatment, and control of such hazards that threaten the community or environment. These essential services shall be provided cost effectively through a fee schedule established with the flexibility of making them available regardless of the public's ability to pay. Other roles include consultation with other agencies on state policy development and the quality assurance oversight of services provided by the public and private sectors.

Discussion:

The Health and Environmental Testing Laboratory (HETL) was created to diagnose and detect diseases, and to provide testing to assure safe drinking water. Since its inception, it has also been tasked to ensure nuclear (radiation) safety, and by statute in 1991, to provide analytical services in support of the Department of Environmental Protection. In addition, it is the state's analytical resource for testing of drivers operating under the influence of alcohol or drugs, and for testing confiscated illicit drugs. It is the State's benchmark for comprehensive testing of drinking water for compliance with the Safe Drinking Water Act.

It provides unique services, not available anywhere else in the state of Maine, and in some cases such as rabies testing, not anywhere in the private sector. No other laboratory in the state offers the comprehensive testing capabilities available here. The HETL's role in compliance testing

for DEP is valuable for both its reliability and the assurance of impartiality.

The HETL's role in disease identification and detection has been significantly strengthened in the recent biennium, in preparation for "emerging infectious diseases" and for possible bioterrorism. This effort was critical in the State's response to recent bioterrorism scares.

The HETL is certified by the United States Environmental Protection Agency for drinking water, environmental and radiation testing. It is approved by the Health Care Finance Administration for medical testing in microbiology and chemistry.

Over 80% of the HETL's operating budget comes from fees charged to users, including other state agencies. By statute and policy, the HETL provides testing in support of the public health and the public good.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

Increase number and quality of testing services: Baseline 65,481 (Budget document for 2001-02, and 2002-03).

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective** measures the agency has taken to meet the goals and objectives.

Although quality of testing has increased, number of tests may fall short of goals, due to funding issues in other State agencies utilizing HETL services. This may have an adverse impact on the ability of the HETL to meet testing needs in times of emergencies.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

REGULATORY AGENDA
FY 2002

Maine Drug Testing Laboratory Rules - Amendment concerning specimen collection procedures and specimen tampering.

Pursuant to 1990 PL 832

Purpose: to adopt procedural requirements for collection of second specimens in cases of tampering with first specimens, and application of other changes mandated by law, or dictated by current good practice.

Adoption expected by June of 2002

Regulated parties: Workplace substance of abuse testing programs
Benefited parties: Workers affected by such programs.

Maine Medical Laboratory Rules - Amendment concerning testing for certain analytes without a physician's order.

Pursuant to 1990 PL 665.

Purpose: To adopt procedures and regulations to promulgate the legislative provision allowing persons to order certain medical laboratory tests without physician referral.

Adoption expected by June, 2002

Regulated parties: Independent medical laboratories
Benefitted parties: Clients of such labs.

Maine Medical Laboratory Rules - Amendment regulating Maternal serum alpha-fetoprotein testing.

Pursuant to 1989 PL 72

Purpose: To adopt provisions regulating the performance of this particularly critical test and to ensure that appropriate programmatic support exists to surround the test process.

Adoption expected by June 30, 2002

Regulated parties: Medical Laboratories
Benefited parties: Women undergoing maternal alpha-fetoprotein testing.

Maine Medical Laboratory Rules - Amendment regarding fee schedules for licensure of medical laboratories.

Pursuant to 1991 PL 591

Purpose: To re-establish fees for licensure of medical laboratories, and to establish new fees for such licensure, in accord with law.

Adoption expected by: Final rules by October 30, 2002, and subsequent dates.

Regulated parties: Medical laboratories
Benefited parties: State citizens

Maine Medical Laboratory Rules - Amendments to bring Maine rules into compliance with requirements with the Federal Clinical Laboratory Improvement Act of 1988, and other current standards of practice.

Pursuant to 22 MRSA Section 2011 et seq.

Purpose: to bring Maine's Medical Laboratory regulation into concurrence with Federal standards

Adoption expected by: June, 2002

Regulated parties: Medical Laboratories
Benefited parties: State citizens, which benefit from quality in laboratory testing and Medical Laboratories, including Independent, Hospital, Health Screening, and Physician Office

Rules Concerning Certification of Environmental and Drinking Water Testing Laboratories

Pursuant to 1991 PL 499

Purpose: To set standards and requirements for certification of Environmental and Drinking Water laboratories, in order to assure that state agencies utilizing data produced by such laboratories are receiving accurate and reliable results, and to protect Maine people by assuring proper performance of such laboratories.

Amendment expected by January 31, 2002 and subsequent dates

Regulated parties: Environmental and Drinking water labs, and other laboratories.

Benefited parties: State agencies and other users of lab data (i.e. the Drinking Water Program and the Department of Environmental Protection) which benefit from accurate analyses of environmental samples, and laboratories (certified and currently not certified) which do environmental testing for compliance purposes.

Schedule of Charges for Diagnostic Laboratory of the Department of Human Services - Amendment

Pursuant to 22 MRSA 565

Purpose: To amend and revise charges as required by budgetary needs and by law.

Adoption expected by: Jan, 15 2002

Regulated parties: DHS labs
Benefited parties: Programs and citizens served

Rules for Sample Collection and Drug Testing in Suspected Operating Under the Influence Cases

Rules Governing Self Contained Breath Alcohol Testing Equipment

Certification Standards for Persons Conducting Chemical Analysis of Blood and Breath for the Purpose of Determining Blood Alcohol Level

Certification Standards for Persons Drawing Blood for the Purpose of Determining Blood Alcohol Level

(Amendments)

Pursuant to 29 MRSA section 1312 (6).

Purpose: To amend the appropriate rules as required by current good practice or as needed to comply with changes in the law.

Expected date of adoption: by June 15, 2002

Regulated parties: Chemists, Phlebotomists, DRTs, Law enforcement officers using specified equipment.
Benefited parties: Maine citizens, especially those involved either as suspects or victims in OUI situations.

Certification Standards for Persons Conducting Chemical Analysis for the Detection and Identification of Drugs - Amendment

Pursuant to: 17-A MRSA section 1112.

Purpose: To amend as needed in response to change in practice or change in law.

Adoption expected by: June 10, 2002

Regulated parties: Chemists analyzing drugs.
Benefited parties: Suspects in cases of alleged possession of drugs.

Regulations Regarding Rabies Immunization Requirements for Dog Licensure - Amendment

Pursuant to: 7 MRSA 3922 (3).

Purpose: To amend requirements for protection of the public health, as regards rabies

Adoption expected by: June 15, 2002

Regulated parties: Animal (dog) owners
Benefited parties: Maine citizens

Rules Relating to Testing of Private Water Systems for Potentially Hazardous Contaminants - Amendment

Pursuant to: 22 MRSA Section 2602-A

Purpose: To amend rules for the protection of public health and/or for compliance with current standards of practice and current hazards.

Adoption expected by: June 15, 2002

Regulated parties: Health and Environmental Testing Lab, and Maine Citizens

Benefited parties: Maine citizens.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The HETL works in conjunction with several federal agencies to assure the most accurate and reliable testing, and timely reporting of unexpected events. Federal agencies include USEPA, US Nuclear Regulatory Commission, US DHHS/Centers for Disease Control and Prevention, US Department of Agriculture,

The HETL provides services to a number of state and local agencies, most notably the Department of Environmental Protection, and the Department

of Public Safety. These agencies, in turn, provide substantial fee or contract support for the HETL.

The HETL is the only laboratory in the State providing diagnostic services for many of the diseases of public health significance, such as TB, some foodborne diseases, West Nile virus, anthrax, and others. As such, it is a critical part of the Bureau of Health's mission to protect Mainers from disease threats.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The HETL serves the entire state of Maine, and on occasion, provides mutual aid support for public health laboratories in other New England states. Services are provided to individuals, physicians and medical practices, utilities, municipalities, other state agencies, and our own agency.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Alternative delivery systems have been explored several times in the last 10 years, and no reasonable alternative has been found. Some testing, such as drinking water testing, is already available in the private sector, at competitive prices. However, many tests performed by the HETL are unique to this Laboratory, and cannot be provided elsewhere in the state, or in reasonable proximity.

J. Identification of emerging issues for the agency or program in the coming years.

Two urgent emerging issues face the Health and Environmental Testing Laboratory:

1. Federal grants have enabled the HETL to develop test methods and protocols for many new agents (both emerging infections such as West Nile, and bioterrorism agents such as anthrax). However, there has been no ongoing increase in funding for staff. This has placed an insurmountable burden on the HETL's fee-based funding structure. Adequate funding will be crucial in the very near future.

2. The HETL's physical facility was built in 1967-68. Although renovations have kept the facility usable, and are providing safe workspace for the current need, the facility is functionally obsolete and plans should begin for replacement of this critical part of the Public Health system.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

As noted above, the HETL is certified by USEPA and DHHS/HCFA. No other federal law issues are noted.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

HETL policies are in accordance with overarching DHS policy and State and Federal requirements.

Program Title: **Division of Family Health**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Federal authorizing legislation includes: Title V of the Social Security Act - P.L. 74-271) and 7 CFR, Part 246- Special Supplemental Nutrition Program for Women, Infants and Children.

State authorizing legislation includes: Title 22, Chapters: 252, 1, 407, 409, 408, and Title 20 Chapter 223. (Maine law mandated screening of newborns for causes of mental retardation in 1965. (updated 1989) 22 MRSA § 1532
The Genetics Program was established in 1985 following the passage of 22 MRSA § 1533 in 1983.Two new initiatives within the Genetics Program were authorized by statute: The Birth Defects Program: 22 MRSA § 8941 (passed in 1998) and the Newborn Hearing Program: 22 MRSA c. 1687 (passed in 1999); The Public Health Nursing (PHN) Program is authorized by MSRA Chapter 408.22, Subsection 1961, 1962, 1963. The PHN Program provides school nurse services as authorized by Title 20 MSRA Part 3, Chapter 223, Subchapter 111, Subsection 6403-A. (4).; State - Title 22, Chapter 1: §10, §12, §42; Title 22, Chapter 407: §1950, §1951; Title 22, Chapter 409: §2000, §2001.; and In 1996, legislation (LD 540) was passed to pilot the Healthy Start (AKA Healthy Families) program with 3 pilot sites and an evaluation component. In 1997 additional monies were authorized to fund 3 additional pilot sites. In 1999 legislation (LD 956 and 1315) was passed to expand home visiting services to the parents of newborn children. This expanded the program to include services provided by models other than Healthy Families. It added Parents Are Teachers, Too and Parents As Teachers models.)

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Priorities, goals and objectives vary depending upon the program and the population served. For the Children with Special Health Needs (CSHN) Program priorities are based on the requirements of the Maternal and Child Health Block Grant (MCHBG). Priorities are based on the needs of children with special health care issues, such as provision of or payment

for specialty and subspecialty clinical services, care coordination, development of systems of care for these children as they grow and develop, and development of transition systems as they move into adulthood. For PHN, Women and Children's Preventive Health Services (WCPHS) and Healthy Families (HF) priorities address health promotion and disease prevention issues/services for pregnant and postpartum women, infants, children, and their families. The goals are to assure the availability, accessibility and appropriateness of health care and social service information and services that target this population and assure that services meet clinical standards of care. For Maine Childhood Lead Poisoning Prevention (MCLPP) and MCH Nutrition Programs priorities are based on related Healthy People 2010 and Healthy Maine 2010 goals and objectives. For MCLPP this means the elimination of childhood lead poisoning by the year 2010. For MCH Nutrition this means improve the overall nutrition and physical activity status of Maine citizens. The WIC Program's priorities also focus on nutrition such as providing WIC benefits to eligible Maine citizens, improve the value of nutrition education to the participants, increase the % of WIC infants that are breastfed, and effective and efficient administration of the program. The Maine Genetics Program has 4 components: comprehensive genetic services, newborn screening, newborn hearing screening and birth defects surveillance. All components help to meet the overall goal: To assure Maine individuals and families will have access to comprehensive genetic services that will enable them to reach informed choices and to increase their ability to live healthy and productive lives. Priorities include: to screening all newborns for causes of mental retardation and selected genetic disorders; to assure access to genetic services; to establish the new Birth Defects Program and the new Newborn Hearing Program.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

The performance criteria used vary depending upon the program and the population served. For PHN, WCPHS, and HF the monitored health status indicators monitored are reductions in: infant mortality, prenatal risk factors, childbirth complications, infant illness, and poor childhood outcomes. PHN also benchmark their services through a Client Satisfaction Survey, Referent Satisfaction Survey, incident reports, and infection control logs. The CSHN program measures its progress using the established performance measures in the MCHBG. If it does not satisfy these measures, it is required to describe fully those methods used to obtain the stated objectives. CSHN has established performance indicators used with their various grantees to evaluate achievement of the service goals and objectives. MCH Nutrition uses objectives from Healthy People (HP) 2010 and Healthy Maine (HM) 2010 to measure progress.

[a)Reduce to 5% the proportion of children and adolescents who are overweight or obese, b)Reduce to no more than 15% the proportion of adults who are obese, c)Increase to greater than 30% the proportion of Maine citizens who engage in moderate physical activity daily] MCLPP uses blood lead screening rates and lead poisoning prevalence rates to measures its progress. The progress of the WIC Program is measured by participation rates, retention of 1 year olds through their 2nd birthday, and breastfeeding rates. [10% increase in participation rates; retain at least 75% of one year olds at their 18 month and 24 month recertification visits; Increase from 19% to 25% the number of WIC infants who are breastfed; and Develop a Vendor Advisory Committee, conduct at least 6 Management Evaluation Reviews at local WIC agencies, and revise and update the State policy and procedures manuals to ensure consistent and accurate interpretation of WIC Nutrition Program policies and procedures.] The progress of the Genetics Program is measured by screening rates and receipt of treatment within a set period after confirmation of diagnosis. [Newborn Screening: over 99% of newborns will be screened for these disorders and 100% of those confirmed with a disorder will receive treatment within one week of diagnosis; Genetic services: individuals and families will have timely access to genetic services. Over 75% of pregnant women with a genetic concern about the current pregnancy will receive genetic services within two weeks of a referral; Birth Defects Program: to establish a birth defects program including registry, referral system and prevention activities; Newborn Hearing Program: to establish a newborn hearing program including registry, tracking and referral system.]

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

Satisfaction of performance criteria is monitored on a quarterly basis for all grants and contracts stemming from programs within the Division. When reports are delayed or do not meet performance criteria the manager at the grantee/contract agency is contacted to determine corrective actions that will be taken. The following are examples of program specific assessments. Within the past 18 months the PHN program established a quality improvement program. In the event a benchmark was not met a Quality Improvement Team is chartered to further study and resolve the issue. The CSHN Program is accountable to the Federal Maternal Child Health Bureau to achieve performance measures as outlined in the MCHBG. If a program fails to meet those objectives an account must be given as to why it wasn't met and corrective measures need to be taken to meet said performance

measures. For the MCLPP screening rates are increasing; poisoning rates are decreasing; although this varies by county. For the MCH Nutrition Program, the 2000 BRFSS reports: 20% Maine adults are obese, 36% are overweight, while the 2001 YRBS reports: 10% Maine high school students are overweight, and 11% middle school students are overweight.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Bureau is in compliance with federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Four programs within the Division have established rules. CSHN- 10-144 Chapter 272, Genetics- 10-144 Chapter 283 (it also has rules pending for its Birth Defects and its Newborn Hearing Screening Programs, therefore chapters have not been assigned), WIC-10-144 Chapter 286, and MCLPP-10-144 Chapter 292.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

Most programs within the Division of Family Health have very limited staff and contract out for most services related to their population. The work of the DFH programs requires collaboration and coordination with other programs within the Bureau, other state and federal government agencies, and entities outside state government. Examples of coordination and collaboration include:

WIC working with PHN, Oral Health (OH), CSHN, MCH Nutrition, Bureau of Medical Services (BMS), and the Immunization Program
MCLPP working with PHN, Department of Environmental Protection (DEP), Maine State Housing Authority (MSHA), Barbara Bush Children's Hospital, Maine Lead Action Project, Local Public Health or community health agencies, and the Health and Environmental Testing Laboratory (HETL).
Genetics working with the HETL, CSHN, PHN, Child Development Services (CDS), Governor Baxter School for the Deaf, Perinatal Nurse Managers, and Foundation for Blood Research (FBR).
CSHN working with PHN, Genetics, BMS, Department of Education (DOE), Bureau of Special Services, CDS, Bureau of Children Services within the Department of Behavioral and Developmental Services, EPSDT, MCLPP, and WIC.
PHN, WCPHS, and HF working with each other and other agencies providing home visitation services to avoid duplication.
PHN working with CSHN, OH, MCLPP, Genetics, WIC, Maine Breast and Cervical Health, TB Control Program, Division of Disease Control, Medical Examiners Office, International and Migrant Health Clinics, schools in the provision of school nurse services, Immunization Program, and Bureau of Child and Family Services. PHN has formalized their relationship with some agencies through MOUs.
MCH Nutrition working with DOE, Maine Nutrition Network, Maine School Food Service Association, WIC, Bureau of Family Independence, University of Maine Cooperative Extension, University of Maine System (UMO and USM), Maine Center for Public Health, and Harvard Prevention Research Center.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

In general the Division of Family Health serves all women of reproductive age and children through their 21st birthday. Some programs such as MCH Nutrition and PHN serve all Maine residents. Others have more limited populations as listed below.

WIC: Pregnant, postpartum, and breastfeeding women, infants and children up to the age of five.

HF: Pregnant and postpartum women, newborns, children and their families through the child's 5th birthday.

WCPHS: High-risk pre and postnatal women, newborns and children and children with special health needs.

CSHN: Children with special health care needs from birth up until the age of 18. Legislation has been submitted to amend the age from birth through age 21.

Genetics: Serves individuals and families with, or at increased risk for having a birth defect or genetic condition, assuring access to comprehensive genetic services through grantee agencies, even if uninsured or underinsured. All newborns are tested for conditions through the Newborn Screening Program for causes of mental retardation, serious health problems and/or death.
MCLPP: All children less than 6 years of age and their families, and property owners of lead contaminated buildings.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

As previously stated, most programs within the Division of Family Health have very limited staff and contract out for most services related to their population. Contracts are awarded through a competitive bid process and are based on the state performance based contracting requirements.
MCLPP: The Maine CLPPP recently changed its process and procedures to a) refer all nursing case management to Public Health Nurses at lower intervention levels than in the past, and b) refer all environmental investigations to lead inspectors in private or non-profit agencies. Previously, Maine CLPPP staff had conducted all environmental investigations.
Genetics: Program staff work with appropriate agencies, providers and organizations through contracts, grants and other agreements to meet program goals, including the Foundation for Blood Research, Eastern Maine Medical Center, Maine Medical Center, Maine Hemophilia Treatment Center, the Maine Parent Federation, the University of Maine and the March of Dimes.
CSHN: Contracts with hospitals and home health care agencies to provide outpatient clinical based services to children with spina bifida, cystic fibrosis, cancer, developmental disabilities, and cerebral palsy. This type of delivery system provides clients with services that are more accessible to their homes.
WCPHS: The WCPHS has one staff position and as 5 contracts that include 9 agencies primarily home health agencies.
HF: The HF program has 1.5 staff and contracts with 16 home health or social service agencies to provide services to the population listed in "H".
WIC: Contracts with 11 local health agencies (located throughout the state) to provide WIC services to Maine citizens.
MCH Nutrition: The MCH Nutrition Program has 1 staff position and contracts with 3 other agencies to achieve program goals.
PHN: Has cooperative agreements with many of the agencies listed in "G". It also has contracts with Catholic Charities and the AT&T Language Line for the provision of interpretive services.

J. Identification of emerging issues for the agency or program in the coming years.

The challenge now is to determine which children in the state remain at risk for lead exposure and to target screening and testing to those children.

Emerging issues vary across the programs with specifics listed below. Cross cutting issues involve funding (often level funding that results in decreased purchased services due to increases in the cost of doing business), technology (data systems, alternative communication systems, testing and treatment systems), and health status issues.
PHN: development of a comprehensive data collection and documentation system; level funding that is eroded by the increased costs of doing business; opportunities for professional development within the field of PHN (need to create a career ladder); the balance between the provision of direct services, population based services and core public health services; coordination with other home visiting programs, ability to measure outcomes.

Genetics: The field of genetics is expanding rapidly. Serving larger numbers of individuals for an increasing number of genetic conditions will be challenging with existing financial and human resources; decisions regarding what conditions included in testing newborns and others as a public health effort and to assure access to health care for those identified through the program; and the need to expand the current scope of the program further to integrate genetics into primary medical care and public health programs.

MCH Nutrition: Overweight and obesity, physical inactivity, and food security.

WIC: Coordination and location of service delivery within communities so it is more accessible to eligible participants; expand the range and scope of nutrition and breastfeeding education through multiple education strategies; and expedite the implementation of a MIS that facilitates efficient and reliable service delivery.

HF: Coordination with other home visiting programs, ability to measure outcomes, time to show impact of program, funding is a target when shortfalls occur in the state revenue.

WCPHS: Funding remains flat with no cost of living increase which equates to less available services for the same amount of monies; coordination with other home visitation programs, ability to measure outcomes.

CSHN: involvement of families of CSHN in decision making and satisfaction with services received; connection of children receiving services through the program with a medical home; adequate private and/or public insurance to pay for services needed by CSHN; early and continuous screening for special health care needs; community based services that are easy for families to use; provision of services needed for CSHN to make the transition to all aspects of adult life, including adult heath care, work and independence; funding remains level with no cost of living increase.

MCLPP: The goal of eliminating childhood lead poisoning, will be difficult to fully met until Maine has adequate resources to address the underlying housing issues; public advocacy groups express concern about Maine's low blood lead screening rates; inadequate resources to address lead hazards in housing; and poor screening rates in the children insured through Medicaid despite the mandate to screen ALL children enrolled in Medicaid at 1 and 2 years of age.

K. Any other information specifically requested by the committee of jurisdiction;

None requested.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

MCLPP: All Maine laws and regulations reflect current federal laws. Laws related to lead poisoning prevention at the state and federal level span DEP, HUD, and CMS (formerly HCFA).

CSHN: Title V of the Social Security Act states that services should be provided to children with special health care needs until the age of 21 years. State law only requires that services be provided until the age of 18. The CSHN Program has submitted legislation to amend the law to read "through the age of 21."

WIC: The state rules for WIC are consistent with the federal regulations, which govern the program and in some cases expand upon the federal regulations.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Division of Family Health requires all staff upon employment in the DFH to sign the DHS "Policy concerning the use of state automation equipment" and the DHS "Confidentiality rules and statement.

BUREAU OF HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Division of Community Health**

The Division of Community Health includes the following programs:

Teen and Young Adult Health Program
Maine Breast and Cervical Health Program
Oral Health Program
Maine Cardiovascular Health Program
Maine Diabetes Control Program
Maine Cancer Registry
Community Health Promotion Program
Partnership for a Tobacco-Free Maine
Maine Injury Prevention Program
Comprehensive Cancer Control Program
Maine Asthma Program

All programs in the Division relate to one or more of the following Performance Budgeting Goals and Objectives:

- Preserve, protect and promote the health and well being of Maine citizens.
- Reduce the rate of preventable chronic disease, infectious disease, injuries, and disease from environmental causes.
- Promote health through education, motivation, surveillance and implementation of public health policies.
- Improve efficiency of surveillance and monitoring, data and records management
- Maintain the number of local grants/contracts for health promotion, disease prevention, early detection
- Maintain the number of diseases for which disease management services, based on best practices, are provided.
- Provide a variety of direct services and preventive health programs aimed at improving the health of Maine women, infants, children and their families.
- Support primary and secondary dental disease prevention efforts.
- Provide support for community-based cardiovascular disease reduction.
- Reduce adolescent and unintended pregnancy.
- Provide quality family planning services to low income women and adolescents in order to reduce unintended pregnancies.
- Increase the ability of communities to improve the health of their residents.
- Provide training and technical assistance to communities for community organizing around basic health issues.

- Improve effectiveness of dental programs and services.
- Support primary and secondary dental disease prevention efforts.

In addition, all programs are related to multiple objectives in Healthy Maine 2000/Healthy Maine 2010. Healthy Maine 2010 Objectives are in final draft form and will be available later in January 2001. Healthy Maine 2000 documents are available from the Bureau of Health upon request. Many programs are driven by goals and objectives defined by federal categorical programs or by federal block grants, specifically the Preventive Health and Health Services Block Grant and the Maternal and Child Health Block Grant (Title V). Specific details about priorities, goals and objectives and performance criteria, timetables and benchmarks are listed below by program. Position counts and job classification listings are provided within each program description. Organizational charts for all programs are attached as an appendix to this section.

Several critical staff positions in the Division are not state positions, but federal. A Public Health Advisor from the Centers for Disease Control and Prevention manages the Comprehensive Cancer Control Program. This position will be maintained in Maine for an additional two to three years. The Division also houses an Epidemiologic Investigation Service Officer from the Centers for Disease Control and Prevention whose focus is chronic disease and maternal and child health epidemiology. This placement ends in June, 2002.

Finally, the Maine Asthma Program is supported completely through staffing at the University of Southern Maine, Institute for Public Sector Innovation. Several other programs have contracts with external agencies to perform major aspects of their work; this is noted within each program's description.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Teen and Young Adult Health Program (TYAHP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- Recent new state appropriations for Family Planning and School Based Health Centers.
- Ongoing state appropriations for Adolescent Pregnancy and Parenting Projects, and Peer Leader Training Program.
- Federal Title V (Maternal and Child Health Block Grant) requirements for adolescent health and for teen parents and their children.
- Federal Title V Abstinence Only Education grant requirements.
-

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Goal and indicators established through the stakeholder process for the 1996 State Performance Measurement Statute:

> "Maine adolescents, young adults and their children will be able to attain a safe, healthy environment in order to achieve self sufficiency and a successful transition into adulthood."

Indicators: Health (increase), Safety (increase), Self-sufficiency (increase)

- Healthy Maine 2000 (2010 goals in development):
  - Teen pregnancy rates for ages 10-14, 15-17 and 18-19
  - Repeat pregnancies in adolescents aged 10-19
  - Teens receiving prenatal care in the first trimester
- MCHBG federal and state specific objectives:

Primary objectives for TYAHP:
- Birth rate for teens aged 15-17
- Unintended births for women less than 24 years

Secondary objectives for which TYAHP programs include interventions:
- Immunizations through age 2
- Breastfeeding at hospital discharge
- Very Low Birth Weight Babies
- Prenatal care in the first trimester
- Women in WIC breastfeeding at six months

    - Adolescents receiving routine dental care
    - Overweight adolescents
- Abstinence Only Education (Title V) federal and state-specific objectives:

    - Pregnancy rate for teens aged 15-17
    - Proportion of teens 17 years and less engaging in sexual activity
    - STD incidence of teens aged 15-19
    - Birth rate for teens aged 15-17
    - Frequency of adolescents 12-17 who view aired "Not Me Not Now" messages.
    - Percent of parents who request communication guides on talking about sexuality with their teens.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

    - Ten-year targets for Healthy Maine 2000 goals (Healthy Maine 2010 goals currently being set).
    - Five years of targets for Title V (MCHBG and Abstinence Only Education grant) established and measured annually
    - Objectives established in Requests for Proposals and revised yearly in contracts relating to health, safety and self-sufficiency and to the above Title V targets.
    - Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

    - Teen pregnancy and birth rate targets have consistently been met.
    - Prenatal care targets not met, but rates have consistently improved. Rates for those served through Adolescent Pregnancy and Parenting projects for this and other infant and child indicators have been generally met.
    - Indicators of health safety and self-sufficiency have been difficult to measure. Work with an evaluation consultant has improved measures in the past two years and better tracking is expected.
    - Viewership targets for Abstinence Only Education have been met, parental information target has not. Changes in the methods for parents to request communication guides have been made.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attach job classification for the Bureau and organizational charts.

Total Positions: 3
Health Program Manager
Comprehensive Health Planner I
Clerk Typist II
(See appendix for organizational chart)

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Chapter 287: Rules for Family Planning Funding adopted April 1999:
Summary: "This chapter required all funding provided through state government for family planning services comply with the current Federal Title X regulations."

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

- Jointly administering grants for adolescent pregnancy and parenting services with the Community Services Center.
- Jointly issued RFP with other Division of Community Health programs and the Department of Education for School-based Health Centers and related Coordinated School-Health programs.
- Developing joint performance measures between public health nursing, community health nursing, adolescent pregnancy and parenting projects and other home visitation for first-time parents programs.
- Collaboration with Department of Education on support for local school districts in the development of comprehensive school health education.

- Collaboration with the Department of Education and the Department of Behavioral and Developmental Services on collecting health-related data in schools.
- Collaboration with Bureau of Medical Services on outreach for Medicaid and CubCare for adolescents.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Constituencies include adolescents and their families; pregnant and parenting teens, their children and significant others; schools; community-based health and social service agencies that serve these populations.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

Working with advocacy groups and insurance organizations to increase reimbursement in school-based health centers. Support for grantee efforts to contract with HMOs in school-based health centers and family planning clinics. Support for the establishment of School-Based Health Centers as an alternative system to improve adolescents' access to health care.

J. Identification of emerging issues for the agency or program in the coming years.

- Continuing changes in health care reimbursement system will affect school-based health centers and family planning clinics.
- Need to improve response in program to the increasing obesity and physical inactivity among youth.
- Need to improve integration of physical and mental health services for adolescence in response to the increasing needs for mental health early intervention in the population.
- Current research indicates the need for holistic community responses to promote healthy youth development. This increasing the need for collaboration among programs addressing risky behaviors in youth.
- As public insurance coverage for children increases and employer coverage decrease, access to health insurance in the young adult population and access to services for adolescents covered in public health insurance programs (especially oral and mental health care) will need to be addressed.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

- State Rule for Family Planning Funding aligns federal regulations with state rules.
- New HIPAA regulations may supercede state laws on confidentiality of care for adolescents in family planning, substance abuse and mental health care, but these rules have not yet been finalized. (Current proposal would give parents more access to information that State law permits.)

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

- No directly identifiable individual information is collected by TYAHP. Agencies submit de-identified data for program monitoring and evaluation, which is released only in aggregate form.
- TYAHP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
Program Evaluation Report

Program Title: **The Maine Breast and Cervical Health Program (MBCHP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Public Law 101-354 "Breast and Cervical Cancer Mortality Prevention Act of 1990" established the National Breast and Cervical Cancer Early Detection Programs. Federal funds are managed by the Centers for Disease Control and Prevention, which provides funding through cooperative agreements to all states (as well as territories and some tribal organizations). The federal legislation establishing the program requires a state match on a $1 (state) for every $3 (federal) basis.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

The purpose of the MBCHP is to reduce breast and cervical cancer morbidity and mortality through early detection, public and professional education, quality assurance and surveillance. Major components are listed below.

Service Delivery: To provide comprehensive screening and follow-up services for eligible women by maintaining established administrative, operational, and clinical services delivery mechanisms and to assure the quality of the clinical services delivered through the MBCHP by: Providing mammograms to at least 3,800 women per year and Pap tests to at least 3,000 women per year; assuring that all MBCHP clients with abnormal results receive a diagnostic work-up and treatment in a timely manner; achieving and maintaining a 50% rescreening rate; achieving CDC clinical performance indicators; generating timely provider audit reports to ensure Provider compliance with MBCHP Quality Assurance Performance Indicators.

Public Information, Education and Outreach: To utilize appropriate messages and strategies to recruit eligible women for breast and cervical cancer screening, to increase all Maine women's knowledge, motivation and skills to seek screening, and to support all Maine women in ongoing positive behavior related to risk reduction and early detection by: achieving and maintaining a program enrollment of at least 3,500

women; maintaining community-based interventions including partnerships and mini-grants; implementing an ongoing statewide media campaign and recruitment plan; continuing to increase women's knowledge as measured by state-wide Behavioral Risk Factors Surveillance System survey results and Knowledge, Attitudes, and Practices survey results; increasing enrollment of special populations, including racial, ethnic and cultural minorities, lesbians, Franco American women, and rural women.

Surveillance and Evaluation: To measure program effectiveness and facilitate program planning, development, and implementation by: maintaining a surveillance system to ensure collection of complete, accurate, and timely data for 100% of MBCHP indicators; conducting analysis of data to determine trends and to direct program planning, policy analysis, and evaluation of program objectives on a quarterly basis; disseminating and presenting breast and cervical cancer program and surveillance data to advisory groups, state and national meetings and other interested parties for planning, education, and marketing on a quarterly basis.

Professional Education and Quality Improvement: To increase the number of women in the priority population who regularly receive high quality breast and cervical cancer screening and to improve the quality of screening and follow-up services by: conducting ongoing assessments of PCP professional education and quality assurance needs; disseminating and updating clinical practice guidelines for breast and cervical cancer early detection and follow-up to 100% of new MBCHP Primary Care Providers; developing written guidance for MBCHP providers on an issue selected by the Program Advisory Group and/or based on provider audit results; developing and supporting quality improvement activities at audited PCP sites with deficiencies; responding to requests for speakers on a variety of subjects related to breast and cervical cancer annually; developing and disseminating medical education programs on a topic of relevance to providers of breast and cervical cancer screening services annually; collaborating with organizations with related objectives to increase professional knowledge of breast and cervical cancer control; sponsoring Continuing Medical Education (CME) programs for radiologic technologists and cytotechnologists.

Partnership Development and Community Involvement: To assure appropriate guidance for the MBCHP and to enhance the scope and impact of the MBCHP through linkages and coordination with other organizations and groups by: convening meetings of the Program Advisory Group and of the Breast Health Cooperative; maintaining a roster of at least fifteen clinical advisors to the MBCHP; providing support for the Annual Breast Cancer Awareness Month Tea at the Governor's Residence.

Management and Organizational Structure: To support a structure to ensure implementation of the Maine Breast and Cervical Health Program and to ensure sound fiscal management of the MBCHP by: assuring a highly skilled and motivated staff and to maintaining staff turnover of 20% or less each year; assuring that 100% of CDC reporting requirements are met each year; assuring that matching and cost allocation requirements are met each year; assuring that program expenditures conform to budget each year.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

   - Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
   - Biannual submission of Centers for Disease Control and Prevention (CDC) required Minimum Data Elements (MDEs)
   - Biannual submission of CDC required Progress Reports
   - Annual submission of CDC required System for Technical Assistance and Reporting (STAR) Reports
   - Annual submission of CDC required Program Work Plans
   - Regular review of program performance based on evaluation plan (currently under revision)
   - Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   The MBCHP has met goals and objectives each year, and thus has continued to receive funding (with modest increases) from the Centers for Disease Control and Prevention. Increasing numbers of women are being served through the program, and Maine is among the best performing states in the country in tracking and assuring appropriate clinical follow up for those who receive screening and diagnostic services. Areas for additional improvement are noted below is section J, emerging issues.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification for the Bureau and an organizational chart.

Total Positions: 13
Senior Health Program Manager
Comprehensive Health Planner II
Comprehensive Health Planner I
Medical Care Coordinator

Clerk Typist III
Clerk Typist II
Human Services Aid III
Nursing Education Consultant
Public Health Educator III
Public Health Educator II
Information Systems Support Specialist I
Staff Accountant
Epidemiologist
(See organizational chart)

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

N/A

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

The MBCHP has a MOA with the Bureau of Medical Services (BMS) and the Division of Technology Services (DoTS). The BMS provides support to the MBCHP by processing provider payments for breast and cervical screening and diagnostic services for MBCHP clients. The DoTS provides technical support to the program. The MBCHP works with the Bureau of Family Independence (BFI) to assure women diagnosed with breast or cervical cancer are provided Medicaid coverage for treatment. The MBCHP also works with Public Health Nursing from time to time for follow up on clients with abnormal screening results.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The MBCHP serves women age 40 and older who are uninsured or underinsured and under 250% of the federal poverty level. The program also serves health care providers and allied health professionals that provide screening and diagnostic services related to breast and cervical cancer early detection. A recent change is increased focus on women who have never had or who have not recently had a Pap test.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The MBCHP contracts with six community partnerships to deliver public education, peer education programs, transportation and other support services. The MBCHP contracts with Medical Care Development for development and implementation of professional education and quality assurance activities. The MBCHP funds nearly 300 clinical sites in the state to provide screening and diagnostic services on a fee-for-service basis.

J. Identification of emerging issues for the agency or program in the coming years.

The following are emerging issues for the MBCHP: reaching an increased target level of screening by providing 3800 women mammograms and 3000 women Pap smears; reaching women never or rarely screened for cervical cancer (defined as those who have either never had a Pap test or not had one for at least 5 years); reaching more racial and ethnic minority women.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA), federal law allows states to amend their Medicaid plans to allow women diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Programs to qualify for Medicaid for their treatment. The state match was included in the state budget effective October 1, 2001.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

MBCHP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Oral Health Program (OHP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

22 MRSA ch. 415 (cited as the 1975 Dental Health Act), subchapters I and II, § 2091 *et. seq.*, established the Office of Dental Health. Subsequently, PL 152 (LD 1147 in the 115th Legislature) changed the title to the Division of Dental Health in 1991. Later reorganizations within the Department of Human Services and the Bureau of Health resulted in the establishment of the Oral Health Program within what is now the Division of Community Health.

School Dental Health Programs were established pursuant to 22 MRSA c. 416, the Dental Health Education Act [109th Legislature, 1979]. Responsibility for the administration of this overall program, now known as the School Oral Health Program, was assigned to what was then the Office of Dental Health (§2124), and continues to rest with the current Oral Health Program.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Overall Priority: The Oral Health Program (OHP) seeks to improve the oral health of Maine people, with an emphasis on low-income, underserved, under- and uninsured children and their families.

Goals:

a. to provide public leadership to enable communities to prevent, control and reduce oral diseases;
b. to plan, implement and evaluate programs for oral health promotion and disease prevention; and
c. to provide statewide coordination and integration of community-based oral health services through increased access and removal of barriers.

Objectives:

- Provide funding and technical assistance to schools, school districts and community agencies to support school-based oral health education programs, with fluoride supplement and dental sealant components; provide funding to

community agencies to support community-based oral health promotion and treatment capacity.

- Work with other programs in the Bureau of Health and within DHS to provide an oral health presence, by providing training, consultation and technical assistance to assist them in providing oral health education and disease prevention strategies to their clients.
- Assist communities in authorizing community water fluoridation and monitor water fluoridation compliance.
- Conduct studies to document oral health needs and provide technical assistance and consultation to public and community agencies.
- Provide training and technical assistance to dental and other health professionals on oral health issues.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

- Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
- The level of funding and technical assistance to schools, school districts and community agencies to support school-based oral health education programs is maintained and/or increased; numbers of participating schools and children receiving education and preventive services through school-based and school-linked oral health programs are maintained and/or increased; the level of funding and assistance to communities to support community-based oral health promotion and treatment capacity is maintained.
- Consultation, training, and technical assistance are provided as needed/requested to other BOH/DHS programs.
- Communities are provided with assistance in pursuing authorization of community water fluoridation; water fluoridation compliance is maintained through monitoring and surveillance of public water systems in collaboration with the Drinking Water Program.
- Studies and reports are compiled and disseminated; technical assistance and consultation are provided to communities.
- Training and technical assistance are provided to dental and other health professionals on oral health issues (examples of publications and training agendas are available).
- Employee performance evaluation expectations.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

Within staffing and funding constraints, goals and objectives are adequately met.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for the Bureau.

Total Positions: 4
Health Program Manager
Public Health Educator III
Public Health Educator II
Clerk Typist III

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

10-144 Department of Human Services, Bureau of Health
Chapter 295: Dental Services Development and Subsidy Programs

Adopted: April 2, 2001

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

- Cooperative Agreement with Department of Education from the Centers for Disease Control, Award #U58/CCU117108-02, Oral Disease Prevention in School Aged Children, "The Maine School Oral Health Initiative". Project Period 9/30/00 - 9/29/02
- CISS Oral Health Systems Development Grant from the Health Resources & Services Administration, Maternal & Child Health Bureau, Award #H47MC00013, "The Maine Oral Health Partnership Project". Project Period 8/1/99 - 5/31/03

- CISS Community and School Based Sealant Grant from the Health Resources & Services Administration, Maternal & Child Health Bureau, Award #H45MC00012, "The Maine Dental Sealant Project." Project Period 8/1/99 - 7/31/02.

Memoranda of agreement in place with Drinking Water Program and Health & Environmental Testing Laboratory relative to monitoring and surveillance of fluoridated public water supplies.

The Oral Health Program holds over 80 contracts for School Oral Health Programs in approximately 250 schools. Over 20 additional grants and contracts with local agencies support a variety of activities including development and expansion of dental services, subsidy programs for dental services, donated dental services, and other programs.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

- Constituency served: All Maine residents, especially those with low incomes and children.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

- Grant funding to schools, school districts and community agencies acting on behalf of schools to provide school-based/school-linked oral health education and prevention programs
- Grant funding, technical assistance, and consultation to community agencies to assist them in developing, expanding, and maintaining community-based capacity to provide oral health prevention and restorative services as part of an infrastructure that also includes the private practice delivery system.

J. Identification of emerging issues for the agency or program in the coming years.

- Dental professional workforce capacity is a serious emerging issue that will have ramifications for oral public health efforts and programs.
- Limitations on public funding will have impact on continued effectiveness of program efforts.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

- No directly identifiable individual information is collected by TYAHP. Agencies submit de-identified data for program monitoring and evaluation, which is released only in aggregate form.
- OHP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Maine Cardiovascular Health Program (MCHP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Cooperative agreement received from the Centers for Disease Control and Prevention to fund the Maine Cardiovascular Health Program. 47-2370 (50) in legislative information from last session states: "Allocates a cardiovascular disease federal grant and establishes one Cardiovascular Health Epidemiologist position required by the grant."

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Program Goals:

- To reduce death, disability and health care costs due to cardiovascular disease (CVD).
- To reduce the controllable risks for CVD; physical inactivity, poor nutrition, tobacco use, high blood cholesterol, and high blood pressure.

Program Activities:

- Assist the Partnership for a Tobacco-Free Maine in supporting the thirty-one community-school partnerships funded through the Tobacco Settlement to address tobacco use, physical inactivity, poor nutrition, and inform them of strategies to address high blood pressure and high cholesterol.
- Assess and provide technical assistance to worksites to address CVD risk factors and conduct regional trainings for Maine businesses on worksite health promotion.
- Provide regional trainings for clinicians on cardiovascular disease secondary prevention guidelines, tobacco, physical activity, nutrition, blood pressure, and cholesterol screening. (In partnership with American Heart Association and Maine Cardiovascular Health Council.)
- Develop and conduct a statewide media campaign for physical activity and nutrition (funded by USDA) in coordination with the tobacco control media campaign funded through the Fund for a Healthy Maine.
- Develop state-level policies to address the risk factors of physical inactivity, poor nutrition, tobacco use, high blood pressure, and high cholesterol.
- Conduct an evaluation of the Maine Cardiovascular Health Program.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;**

   - Ten-year targets for Healthy Maine 2000 goals (Healthy Maine 2010 goals currently being set).
   - Biannual submission of CDC required Progress Reports
   - Annual submission of CDC required Program Work Plans
   - Regular review of program performance based on evaluation plan (currently under development)
   - Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   The program is under two years old. Thus far, objectives in the annual workplans submitted to CDC have been met according to proposed timelines. The program evaluation plan is currently under development and will be used to direct future assessment of success in meeting goals and objectives.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

   See attached job classification for the Bureau and the organizational chart.

   Total Positions: 3.5
   Health Program Manager
   Public Health Educator III
   Epidemiologist
   Clerk Typist II (1/2 time—shared with Community Health Promotion)

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

   See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

   See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

Coordination of efforts through:

- Maine Nutrition Network (a program if the University of Southern Maine, Institute for Public Sector Improvement) - trainings, development of social marketing campaign for physical activity and nutrition
- Maternal and Child Nutrition Program, Maine Bureau of Health - trainings, information dissemination
- Partnership For A Tobacco-Free Maine - technical assistance and evaluation of 31 funded community school sites to address physical inactivity, poor nutrition, and tobacco use. Establishment of a Women and Cardiovascular Health Strategic Plan, development of a Tobacco-free Kids and Soccer kit.
- Community Health Promotion Program - funding of trainings for community members to address public health topics, establishment of a library for resources.
- Coordinating School Health Programs (within Dept. of Education and the Bureau of Health) - establishment of guidelines for coordinated school health in Maine schools. Piloting trainings for schoolteachers. Establishment of the Eat Smart Play Hard campaign for youth 9-14 years old and their families.
- Division of Disease Control - Establishment and funding of one contract that addresses multiple risk factors for 4 Native American tribes in Maine.
- Department of Transportation - work with department to develop a Safe Ways to School research project assessing and implementing strategies to address barriers identified in a pilot set of Maine schools in an effort to increase biking and walking to school by youth; benefits alternative transportation and increased physical activity for Maine youth.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Thirty-one Healthy Maine Partnership sites, Community leaders, local policy makers, hospital personnel, cardiovascular rehabilitation personnel, town personnel interested in promoting use of alternative transportation, fitness facilities, recreational facilities, trail enthusiasts, voluntary organizations and agencies, American Heart Association New England Affiliate, Maine Hospital Association, Maine Cardiovascular Health Council, Governor's Council on Physical Fitness and Sports, Department of Education, school personnel, food service personnel, teachers, coaches, East Coast Greenway, Rails to Trails, National Park

Service, Bureau of Parks and Lands, Bicycle Coalition of Maine, Maine Parks and Recreation Association, Maine Municipal Assoc.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The Maine Cardiovascular Health Program uses outside agencies for many of its program components. The Maine Cardiovascular Health Council (housed at Medical Care Development) is an active part of many of our initiatives, especially for secondary prevention efforts. Positions funded by the MCHP and the Cardiovascular Health Council include: technical assistance for the 31 funded community and school partnerships, a worksite coordinator, a policy director, and staff support to the Maine Cardiovascular Health Council and the Governor's Council on Physical Fitness and Sports. A contract with the Gallup Organization has recently been developed to address evaluation needs for the program.

J. Identification of emerging issues for the agency or program in the coming years.

The risk factors of physical inactivity, poor nutrition, and overweight/obesity are all independent risk factors for development of cardiovascular disease and subsequent increased health care expenditures in Maine. Maine now has the highest rate of obesity in New England, and the rate has increased by 63% in the past decade. It is imperative for Maine to address the issues of unprecedented increases in overweight/obesity as well as the aging population and the sedentary lifestyle that many Maine citizens lead. Lack of adequate staff internal to the Bureau of Health to address these emerging issues is a concern.

K. Any other information specifically requested by the committee of jurisdiction;

None.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

No data on individuals are collected by the program. MCHP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Maine Diabetes Control Program (MDCP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates

2. Public Law 592- An Act to require That Diabetes Supplies and Self-management Training be Covered by Health Insurance Policies (with "Provision of medical services: The diabetes outpatient self-management training and education a services are providing through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health.)
3. Maine Medicaid Program: Medicaid policy stipulates coverage of the Maine Diabetes Control Program's Ambulatory Diabetes Education and Follow-up (ADEF) Program.
4. Federal Cooperative Agreement with the Centers for Disease Control and Prevention's Division of Diabetes Translation.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Maine DCP coordinates the development of a variety of community interventions, that address: local health promotion and disease prevention activities; physical activity and nutrition improvement activities; diabetes quality improvement office system interventions; and diabetes surveillance activities. Maine's lack of conventional public health resources will be utilized by the DCP to stimulate health care providers in the private sector to bridge the gap in diabetes service delivery.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

- Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
- By 2004, the Maine DCP will demonstrate success in achieving an increase in persons with diabetes who receive foot exams, eye exams, vaccinations and hemoglobin A1c (HgA1c) tests.
- By 2004, the Maine DCP will demonstrate progress in establishing linkages for the promotion of wellness and physical activity for persons

with diabetes.
- By 2004, the Maine DCP will demonstrate progress in reducing health disparities for high-risk populations with respect to diabetes prevention and control.
- Employee performance evaluation expectations.

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

- The Maine Diabetes Control Program has created a surveillance system by which the performance measures can be measured. Largely, data from the Maine Behavioral Risk Factor Surveillance System has been used to measure change in foot exams, eye exams, vaccinations and hemoglobin A1c (HgA1c) tests.
- The DCP is actively monitoring ira involvement with the Bureau of Health's Healthy Partnerships, and this initiative's overall impact on promotion of wellness and physical activity for persons with diabetes.
- The DCP is defining "high-risk populations " as Maine's rural and low-income populations, and working to define healthy disparities by geographical location in the state and by health insurance coverage in the state.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

Total Positions: 5
Health Program Manager
Nursing Education Consultant
Nutrition Consultant
Comprehensive Health Planner I
Clerk Typist III

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

None

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

Maine DCP is funded under a federal Cooperative Agreement from the Centers for Disease Control and Prevention/ Division of Diabetes Translation. Maine DCP has partnered with the Maine Medicaid Program, Maine Public Health Nursing, and Maine Cardiovascular Health Program

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Maine DCP constituents are all health care professionals that care for persons with diabetes. State-level organizations and groups involved with providing or paying for diabetes care. Future work may include increased collaboration with organizations involved with promoting physical activity and nutrition for primary prevention.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Maine DCP provides no direct services to persons with diabetes. The DCP cooperates and collaborates with individual health care delivery systems in Maine that provide services to persons with diabetes to accomplish its program goals and objectives.

J. Identification of emerging issues for the agency or program in the coming years.

Currently, the Maine DCP is involved in secondary prevention initiatives around diabetes control. Potential changes in program direction by the federal CDC include prioritization of primary prevention activities with no change/increase in program funding. Until diabetes mellitus is cured and/or prevented,

adequate program funds will still be required to address health disparities in diabetes care and treatment around the state. The source of these funds is currently in question.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

Public Law 592 and Maine's MaineCares Program both stipulate health plan coverage of the DCP's diabetes self-management education program. However, federal Medicare coverage of diabetes self-management education stipulates an education program must be certified by a national accreditation organization, as well as reimburses for a less comprehensive education program when compared to the Maine ADEF Program. Result of this difference in state and federal regulations: Maine Medicare beneficiaries are receiving a less comprehensive diabetes education service and/or beneficiaries are paying more for the service then persons with diabetes that are covered by PL 592 or MaineCare.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

Maine DCP does not collect personal information. MDCP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
Program Evaluation Report

Program Title: **Maine Cancer Registry (MCR)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

State:
Title 22 § 1401-1405A (Chapter 255, Cancer)

Federal:
USC Sec 280e (Cancer Registries Amendment Act)

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

The primary goal of this program is to achieve complete, accurate and timely reporting of all cancers within the State in order to facilitate cancer prevention and control. Activities include: 1) collecting statewide cancer incidence and mortality data 2) identifying cancer trends among Maine citizens and 3) responding to queries and data requests from researchers, other agencies and the public.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

- Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
- The CDC National Program of Cancer Registries (NPCR) produces a detailed set of standards by which MCR performance and future funding is judged. These standards cover:
  - Legislation and regulations
  - Uniform data elements, codes and record layout
  - Completeness of reporting
  - Timeliness of reporting
  - Data quality
  - Monitoring completeness, timeliness and quality
  - Registry computer system
  - Annual report publication
  - Data utilization plan
  - Data monitoring
- Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

The Registry currently meets all CDC standards except for timeliness. According to a recent site visit report:
"MCR has made impressive progress in processing a large backlog of cases and is now more timely than in previous reviews. Nevertheless, the registry continues to be behind, and data are not timely...Staffing is inadequate for the caseload of 6,500, especially given the backlog of cases and the history of staff turnover...Any future vacancies, including state-funded positions, should be promptly filled in order for the state to be able to meet its reporting requirements to the CDC."

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for the Bureau.

Total: 5 plus 2 half time
Medical Director (Public Health Physician)
Administrative Manager (Planning & Research Associate II)
Epidemiologist
Data Quality Manager (Planning & Research Associate II)
Medical Secretary
Medical Records Technician (20 hrs per week)
Planning and Research Associate I (20 hrs per week)

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

Rules and Regulations adopted by the Maine Cancer Registry (10-144 Department of Human Services Bureau of Health Chapter 255 Maine Cancer Registry Rules and Regulations) were last amended in March, 1996 and cover the following: definitions (reportable cases, facilities required to report); the objectives of the MCR; required data elements; data submission procedures; functions of the Cancer Prevention and Control Advisory Committee and its Data Subcommittee; and confidentiality procedures.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The MCR has worked with the Department of Human Services' Office of Data Research and Vital Statistics (ODRVS) in producing cancer mortality rates for the state. It works regularly with the CDC in meeting its requirements for funding. MCR staff have participated in the private/public partnership forming the Maine Comprehensive Cancer Control Consortium. MCR will be collaborating with the National Cancer Institute (NCI) on a research study on bladder cancer.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Constituencies served by the MCR fall into two categories: 1) reporting facilities (hospitals, labs, physician offices, etc.) and 2) those requesting data or information (researchers, public/private agencies and organizations, hospitals, universities, legislators, planners, the media and the public). The most significant projected change is the increasing emphasis on improving reporting from physician offices as more cancer-related procedures are performed on an out-patient basis.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Not applicable

J. Identification of emerging issues for the agency or program in the coming years.

The biggest challenge the MCR faces as noted in B.3. above (assessment of goals met) is the lack of adequate staff to do the required work. Maine's inability to

comply with timeliness requirements has been noted by our funding agency (CDC), the agency that funds cancer registries in most of the other states in the nation. The impact of the lack of adequate staff is becoming more acute as the CDC requires more data elements, higher data quality, better timeliness and more advanced activities (including research).

K. Any other information specifically requested by the committee of jurisdiction;

None.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

MCR policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Community Health Promotion Program (CHPP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

There are no federal mandates for this program. Funding comes from the Preventive Health and Health Services Block Grant (PHHSBG). Through public health planning efforts in the division recommendations were made to develop local community health programs/coalitions. Over 50% of the "All Other" funds available through the PHHSBG are directed toward this program, with the majority of these funds designated for grants to local communities.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

This program's focus is to identify local health issues and to mobilize to conduct effective interventions. Maine currently has 19 community based health promotion programs scattered throughout the State. These programs cover about 60% of the population and receive technical assistance from staff in the Community Health Promotion Program. Many of these communities address direct health issues such as chronic diseases and others address the economic, social, and infrastructure determinants of health. Examples of these determinants are jobs, education, social connections, housing, and transportation.

Program Goal: to help local communities to establish coalitions to plan, implement and evaluate interventions that address the Year 2010 health objectives.

Priority Populations: rural low-income communities, Native Americans, other populations with identified health disparities.

Program Objectives: objectives are listed below. They relate to selected Essential Services for Public Health as defined by the federal DHHS and key national organizations including the American Public health Association.

Essential Service1 - Monitor Health Status
By September 30, 2002, assure collection and analysis of local data for community health planning purposes.

Essential Service 4 - Mobilize Partnerships
By September 30, 2002, maintain the number of local communities (19) that have a community-based health promotion coalition that developed a comprehensive plan to improve community health.

By September 30, 2002, develop at least three key state level partnerships to support the development of local community-based health planning processes.

Essential Service 5 - Develop Policies and Plans
By July 3, 2002, require that all funded Healthy Communities sites submit a community health plan that addresses at least two of the Healthy People 2010 Objectives.

By September 30, 2002, increase local communities knowledge and skills related to policy and environmental changes for tobacco, physical activity and nutrition.

Essential Service 8 - Assure Competent Workforce
By September 30, 2002, increase knowledge and skills in health promotion for the public health workforce.

Essential Service 9 - Evaluate Health Programs
By September 30, 2002, the CHPP will monitor the health promotion activities of community partners through an on-line reporting system that will assess the number of local health promotion activities addressing the three leading behavioral health risk factors (tobacco use, physical inactivity, poor nutrition) in Maine and monitor the community development process.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

- Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
- Regular review of program performance based on evaluation plan (currently under development)
- Review of information submitted by local sites to on-line reporting system (currently under development)
- Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

The CHPP has met goals and objectives each year. Program goals and objectives have been influenced in the past 18 months by the establishment of the Healthy Maine Partnerships through the Tobacco Settlement, and by Maine's successful receipt of federal funding for cardiovascular disease prevention. The goals and

objectives reflected here represent refined purpose based on these significant changes. Program evaluation plans will be adjusted accordingly, with support from the Maine Center for Public Health.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

Total Positions: 3.5

Health Program Manager
Public Health Educator III (2)
Clerk Typist III (1/2 time—shared with Cardiovascular Health)
(See appendix for organizational chart)

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

This program coordinates with a number of partners internal to the Bureau of Health and external to the Bureau of Health. We have partnered in the past with the Tobacco Program and the Cardiovascular
Health Program in the Bureau of Health. We partner with the Bingham Foundation, the Maine Network of Healthy Communities, the Maine Center for Public Health and the Turning Point Initiative.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

Constituents include local Maine communities, a broad variety state level agencies and organizations (including Communities for Children, the Department of Education, the Maine Center for Public Health, and the Bingham Program) and focus on priority populations listed above.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The CHPP does not provide direct services to Maine citizens. In order to ensure diversity of support for local Healthy Communities efforts, the CHPP partners with national and state level foundations, and government programs to identify resources. The Bingham Program supports five Healthy Communities that the CHPP is unable to fund.

J. Identification of emerging issues for the agency or program in the coming years.

Emerging issues are sustaining the community coalitions invested in over the past 15 years and working with other key public health constituents to define the new infrastructure for public health and the Healthy Communities role in this.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

No data on individuals are collected by the program. CHPP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Partnership For A Tobacco-Free Maine (PTM)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Maine Law: Sec D-2. 22 MRSA c. 102
Federal: CDC Cooperative Agreement U1A/CCU116955
Comprehensive State-Based Tobacco Use Prevention and Control Programs - Grant #93-283

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

Goal I: Eliminate exposure to environmental tobacco smoke by:

- mobilizing communities
- developing and implementing an effective media campaign
- strengthening tobacco-free policies and enforcement measures at both the state and the local level
-

Objectives:

- By May 31, 2002, the PTM will have completed the first year of statewide training and technical assistance for the 31 "Healthy Maine Partnerships" programs
- By May 31, 2002, the PTM will have continued the implementation of a strategically designed multi-media plan to create an enhanced capacity for normative change re: Tobacco and Environmental Tobacco Smoke.
- By May 31, 2002, the PTM through its established collaboration with the Enforcement Collaborating Agency (ECA) of the Department of the Attorney General (DAG) will have enhanced the statewide compliance rate with current public laws re: minor's access to tobacco products and re: ETS in public settings.
- By May 31, 2002, the PTM will have published an annual evaluation report including an executive summary, with comparisons to baseline and to national data.

Goal II: Promote tobacco-use cessation among young people and adults by:

- developing a statewide coordinated system of tobacco treatment services
- encouraging non-use and exposing tobacco company manipulation through public awareness

- providing affordable tobacco treatment that is accessible by all Maine residents.
  Objectives:
  - By May 31, 2002 the PTM Will have developed and implemented through contracted services a Toll-free tobacco dependence quit line, a tobacco dependence medication program for Mainers who do not have drug insurance coverage and regional basic level training sessions for health care professionals in tobacco dependence treatment.
  - By May 31, 2002 the PTM Will have developed and implemented an outreach and treatment program targeting low-income pregnant women who smoke.
  - By May 31, 2002 the PTM will have expanded its Network Initiative with the addition of a resource and distribution center, threaded online discussion group and statewide Youth Advocacy movement.

Goal III: Prevent initiation of tobacco use by young people by
- Designing and implementing an anti-tobacco public awareness campaign with the active involvement of youth
- Establishing research-based policies addressing access and retailing issues
- Developing programs that empower youth in resisting tobacco industry efforts and manipulation
- Assuring enforcement of laws related to tobacco sales to minors (see Goal I above)
  Objectives:
  - By May 31, 2002, the PTM will have reduced the percentage of young people in both the grade 6-8 and grade 9-12 cohorts reporting that they have ever tried a cigarette.
  - By May 31, 2002, the PTM will have increased the number of schools and School Administrative Districts (SAD) with a written 24 hour a day, seven day a week Tobacco Free Policy that includes procedures regarding violations of the policy.
  - By May 31, 2002, the PTM will have increased the number of schools and School Administrative Districts (SAD) with a written 24 hour a day, seven day a week Tobacco Free Policy that includes procedures regarding violations of the policy.

Goal IV: Identify and eliminate disparities among populations that are disproportionately effected by tobacco use by:
- designing program elements that can be tailored to address the needs of specific subgroups
- reducing barriers to full inclusion for all segments of the population
- creating a variety of public awareness media messages to reach a range of audiences, both smoker and non-smokers

Objectives:
- By May 31, 2002, the PTM will have fully implemented its Tobacco Dependence Treatment Initiative for the delivery of accessible, affordable treatment services and expansion of certified cessation specialists across the state.
- By May 31, 2002, the PTM will have assisted all "Healthy Maine Partnership" Community/School Partnerships in their identification of populations within their attached areas who are statistically defined as at greater or disproportionate risk for tobacco use and tobacco related chronic disease.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

   - Ten-year targets for Healthy Maine 2000 goals (Healthy Maine 2010 goals currently being set).
   - Biannual submission of CDC required Progress Reports
   - Annual submission of CDC required Program Work Plans
   - Regular review of program performance based on evaluation plan
   - Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

The program has met goals and objectives each year, and continues to receive funding from the Centers for Disease Control and Prevention in addition to state funding. Since the PTM receives such a significant amount of state funding, greater detail is provided than for other programs.

- PTM in collaboration with other BOH programs and the DOE has held 2 of the 4 scheduled statewide trainings and 2 of the 4 regional meetings for the HMP community programs so far this contract year - the remaining trainings and regional meetings will be held on schedule prior to May 31, 2001. At least one component of the training program focused on smoke-free workplaces and the development of policies.
- Random Unannounced Inspection trainings held regionally. No Buts!, a responsible retailing outreach and training program was developed - nearly all of the chain stores in Maine are participating in the program and have incorporated the training components and materials into their tobacco retail practices.
- PTM is currently engaged in a statewide second hand smoke campaign called Tobacco-Free Places, Spaces and Automobiles which involves promoting the development of tobacco-free policies and smoke-free environments that include community playing fields, private homes and cars, and work places. PTM is running TV ads focused on protecting bar workers from secondhand smoke. Evaluation data indicates an increased public awareness of the hazards of secondhand smoke among smokers and non-smokers and less satisfaction with personal exposure to secondhand smoke.
- PTM grantees - the HMP community programs are promoting the Tobacco-Free Places, Spaces and Automobiles program at the local level across the state. YRBS and YTS results show high school smoking rates have dropped substantially, youth are more likely to be asked to prove age when attempting to buy and youth have increased their awareness of the dangers of secondhand smoke.

- Life Skills Training Program trainings have been held across the state so far this contract year. Most of the 54 School districts that are participating in the Healthy Maine Partnerships have had teachers trained to implement at least the first year of the middle school curriculum.
- HMP project directors have received training and materials in the responsible retailing program, No Buts!. Trainings and manuals and materials have been provided to the HMP community grantees for the PTM school policy initiative and the PTM Good Work!, creating a smoke-free workplace initiative. The materials are also available on the PTM website.
- HMP community programs are working to link the state secondhand smoke media campaign with their efforts at the local level in the Tobacco-Free Places, Spaces and Automobiles initiative by placing ads in the local papers and participating in local events to promote the concept of tobacco-free environments. HMP community grantees receive information kits for each PTM media campaign. Survey results show an increase in the number of homes where smokers do not smoke inside their homes.
- Trainings have not yet been held for the local HMP programs in motivating healthcare providers to routinely screen for secondhand smoke exposure. Trainings for the HMP grantees planned for the spring of 2002 will address the issue of advocating to healthcare providers for the routine screening of children for exposure to secondhand smoke.
- PTM treatment contractors have held 2 regional trainings that include a session on the PHS Guidelines for treating tobacco use and dependence. PTM treatment contractors are scheduled to hold a training specifically for the HMP grantees on promoting the PHS Guidelines for treating tobacco use and dependence to local healthcare providers in the spring of 2002.
- PTM has been working on the first phase of the youth program that focuses on developing the local youth advocacy programs before developing the statewide youth advocacy network. Nearly 600 Youth from all over Maine have been trained in tobacco prevention and leadership at Camp Kiev. The youth advisory board will be developed in the spring of 2002.
- Trainings have been held and technical assistance has been provided to the HMP grantees by the BOH project officers and other relevant staff as well as by PTM contractors.
- Compliance checks have been completed according to SYNAR regulations

- No Buts!, a responsible retailing outreach and training program was developed - nearly all of the chain stores in Maine are participating in the program and have incorporated the training components and materials into their tobacco retail practices. HMP community programs are participating in the promotion and training of the retailers. It is too early to tell if this program will impact compliance rates.
- Maine tobacco sales violations have gone from 44% in 1994-95 to only 7% in 2001. Gallup Report - Adult Tobacco Survey (ATS) results show an increase in awareness of the dangers of secondhand smoke exposure as well as approval for laws and policies designed to protect the public from exposure to secondhand smoke.
- The Gallup Organization is still in the process of production of the PTM Evaluation Technical Report and Executive Summary. It will be completed in the spring of 2002.
- The Bureau is currently working with a consultant to design a monitoring and reporting system for the community programs that will enable us to evaluate their progress over the life of the grant. The 31 grantees currently report in narrative form.
- The tobacco treatment initiative has made great progress. The Maine Tobacco HelpLine is up and running as of August 22, 2001. Calls to the HelpLine were initially low, ranging from 5 to 10 per day. These were boosted slightly by adding the toll-free number as a tag to commercials. In mid-December PTM produced and ran ads specifically designed to promote the HelpLine and calls jumped to 50 plus per day. Tobacco treatment Trainings have been held in 2 geographic locations since February with a very good turnout of healthcare and school professionals. The Medication voucher program is close to being implemented, pending final contract review, after which tobacco treatment medications will be available through the HelpLine.
- Two basic level tobacco treatment trainings have been held - one in Northern Maine and one in Central Maine. The PTM treatment contractors will develop the advanced training curriculum in the spring of 2002 and be prepared to implement in the following contract year. Treatment contractor is not yet going to provider offices for trainings. Materials for providers are developed.
- An outreach and treatment program for pregnant women who smoke is in the final stages of development. The program, "Every Mother's Wish" has an informational/motivational video, self help materials, incentives for the pregnant woman to stop smoking and a mechanism for the providers to send the patient information to the HelpLine (with signed permission from the women) and have the counselors proactively call the women with help and support.
- PTM Website is up and running at www.tobaccofreemaine.org.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See attached job classification and organizational chart for the Bureau.

Total Positions: 12
Health Program Manager
Comprehensive Health Planner II
Public Health Educator III (4)
Public Health Educator II (2)
Accountant I
Planning and Research Assistant
Clerk Typist III
Clerk Typist II

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau/

F. When applicable, the regulatory agenda and the summary of rules adopted;

The Bureau of Health has drafted rules for the enforcement of 22 M.R.S.A. § 1541 *et seq.* Regulating smoking in public places (pursuant to 22 M.R.S.A. § 3). These Rules are intended to clarify the requirements for compliance with this law and will be presented during the current legislative session.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

PTM coordinates and collaborates with the Maine chapters of the American Cancer Society (ACS), American lung Association (ALA) and the American Heart Association (AHA) as well as many other agencies and organizations dedicated to the reduction of tobacco use through involvement in the Maine Coalition on Smoking OR Health as well as having representatives from the voluntary agencies on the PTM advisory Council. Information is shared with the intent of avoiding duplication of effort and

services. Specifically PTM coordinates and collaborates with ALA in our treatment initiative through the training of teen cessation group facilitators throughout Maine and on development of strategies to educate providers around screening for secondhand smoke exposure and tobacco use especially as it relates to asthma.

PTM coordinates with the American Legacy Foundation on the pregnant woman and smoking campaign, and other media campaigns. PTM also coordinates with the CDC and supplements PTM's original media spots with CDC-supplied TV spots developed in other states.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

The Partnership For A Tobacco-Free Maine serves all Maine citizens through its comprehensive statewide program designed to prevent youth from starting to use tobacco products, reduce tobacco use by citizens already addicted, and protect the public from second hand smoke. Funding is also provided to 31 communities to implement local programs to support these same goals.

There are, however, specific population groups for whom PTM has developed targeted programs. Prevention programs are directed to Maine youth through the "Youth Advocacy Programs" in the local 31 community programs. The Life Skills Training Program is offered free to all Maine middle schools, and the "Tobacco-Free Athletes" program targets youth who participate in school or community sports programs.

The "No Buts" program equips Maine retailers with the tools they need to effectively block underage tobacco sales therefore reducing youth access to tobacco products.

The Maine Tobacco HelpLine serves smokers who want to quit by offering one-on-one professional counseling and support at no cost. A projected program change will be the development and implementation of an outreach and treatment program targeted to pregnant women who smoke.

Through a supplemental grant from the Centers for Disease Control and Prevention, PTM implement a strategic planning process, to identify those people in Maine who are disproportionately affected by tobacco use and exposure to secondhand smoke. Strategies for addressing the disparities will then be developed and implemented.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

PTM contracts out a large portion of the work. The contractors are chosen through a competitive bidding process required by Maine State government. The Maine Tobacco HelpLine contract is held by MaineHealth.

J. Identification of emerging issues for the agency or program in the coming years.

- Initiation of smoking by young adults and college smoking campus policies
- Identifying and eliminating disparities related to tobacco use among population groups.
- Women's smoking rates and resultant tobacco related disease

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. **Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

PTM policies are in accordance with overarching DHS policy and state and federal regulations.

Program Title: **Maine Injury Prevention Program**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- Maternal and Child Health Block Grant Performance Measures:
  - The Child Death Rate per 100,000 Children ages 1 - 14.
  - The Rate per 100,000 of suicide deaths among youths aged 15 - 19.
  - The Motor Vehicle Death Rate among children 15 - 21 years of age.
  - The Rate of Deaths to Children ages 1 - 14 Caused by Motor Vehicle Crashes per 100,000 Children.

- Legislative Resolve Encouraging Public Schools to Adopt Conflict Resolution Model

- National Highway Traffic Safety Administrative Grant Requirements

- Maine Child Death Review Committee Statute

- Maine Children's Cabinet Requirement to Conduct Youth Suicide and Violence Prevention Programs.

- Legislative Appropriations Providing Funding to the Maine Poison Center.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority.

The Maine Injury Prevention Program's mission is to provide leadership and coordination to assure a statewide, comprehensive and integrated injury prevention program that serves as a resource for professionals, communities, agencies, and professional organizations in both the public and private sectors. Goals and objectives include:

To integrate core elements of comprehensive injury prevention practice at the state and local levels.

- To design, implement and evaluate a comprehensive plan to address the leading causes of injury, violence, and suicide as determined by data and relevant mandates.

- A comprehensive injury surveillance system for the routine collection, analysis and dissemination of injury, violence and suicide data will be operational by 2010.
- The Maine Injury Prevention Program will promote and support effective injury, violence and suicide prevention policymaking, enforcement, and technology advancement by disseminating data and information on effective injury, violence, and suicide prevention.
- By 2005, the state program and local communities will have increased funding to develop, implement, and evaluate injury, violence and suicide prevention programs for children, teens and young adults at highest risk.
- At least 50% of the state level public health and safety agencies partnering with the MIPP will have injury prevention strategies, policies and messages integrated into their routine activities and services by 2004.
- All staff will participate in at least one national, state, regional or local continuing education event per year. The MIPP will support injury prevention training for grantee representatives and other local providers as resources allow.
- To conduct activities to reduce the incidence of intentional injuries and deaths.
- The suicide attempt rate for youth ages 10 - 24 will decrease by 50% by 2010.
- Hospital medical coding technicians 100% of the time will correctly code shaken Baby Syndrome by 2010.
- The incidence of threats, assaults, fights, bullying and harassment among children and youth within schools will be reduced by 25% by 2010.
- To conduct activities to reduce the incidence of unintentional injuries and deaths.
- Unintentional injuries to children in and around the home will decrease to 5% by 2010.
- The correct selection, use and installation of child safety restraints will increase by 25% by 2010.
- Safety belt usage rates among young drivers ages 15 - 24 will increase by 10 % by 2010. 15-19 The rate of death and hospitalizations for young drivers involved in crashes will be reduced by 10%.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

- Ten-year targets for healthy Maine 2000 (Healthy Maine 2010 goals currently being set)
- MIPP Strategic Plan 10 year targets.
- Objectives established in contracts for services with grantee agencies.
- Employee performance evaluation expectations.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   - Child death rates in motor vehicle crashes have declined.
   - Child deaths from unintentional injuries have declined.
   - Youth suicide rates have fluctuated, but remain approximately level.
   - Data on hospital discharges for injuries and other non-fatal sources of injury data have begun to be collected, but cannot be compared to previous periods due to lack of these data in prior years.
   - Lack of an injury surveillance system has impeded the accurate collection and analysis of injury data.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for the Bureau..

Total Positions: 7
Director of Special Projects
Health Program Manager
Comprehensive Health Planner I
Public Health Educator III (2)
Clerk Typist III
Clerk Typist II

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

None

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

a. Intentional injury prevention activities are conducted in coordination and collaboration with the state Departments of Behavioral and Developmental Services, Education, Corrections, and Public Safety. Individuals from the private sector participate on Advisory Committees to these activities. Youth suicide prevention activities have been coordinated with recommendations of the Surgeon General's Office, MCHB, S.A.M.S.H.A., and the Centers for Disease Control and Prevention (CDC).
b. Unintentional injury prevention activities are conducted in coordination and collaboration with the Bureau of Highway Safety and the Fire Marshal's Office in the Department of Public Safety, as well as other state agencies when appropriate. Individuals from the private sector participate on committees and coalitions to carry out these activities. In the past, the program entered into a cooperative agreement with the CDC to conduct fire prevention activities. The Program is active on the Maine Transportation Safety Coalition, a coalition made up of several departments of state and federal government as well as private organizations, that works toward traffic safety in the state of Maine.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

- State and local health, safety, mental health, education professionals and other service providers are the primary constituents of the program.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

- The program does not provide direct services.

J. Identification of emerging issues for the agency or program in the coming years.

- The most prominent emerging issue is securing funding for state program activities and for community based grantees.
- Establishing an effective injury surveillance system to monitor injury deaths and non-fatal injuries.
- Securing ongoing consultation with an Epidemiologist.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

- See A above.

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

MIPP policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Comprehensive Cancer Control (CCC)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

Strategic Planning in the division has identified Comprehensive Cancer Control as a priority. The Centers for Disease Control and Prevention is providing funding to some states for Comprehensive Cancer Control, and has also provided technical assistance and planning. Maine has been awarded direct assistance in the form of a full-time staff person to support Comprehensive Cancer Control.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

The goals of the Comprehensive Cancer Control Program are:

- To increase statewide integration, coordination, and provision of quality prevention, treatment, palliative, and end of life care services in Maine.
- To increase access to high quality cancer prevention, treatment, palliative, and end of life care information and services for all Maine residents regardless of geographic, financial and other demographic factors.
- To increase the proportion of Maine residents who appropriately utilize screening, follow-up, treatment, rehabilitation, survivorship, hospice and palliative care services.
- To improve the quality and coordination of cancer surveillance and other data systems and the extent to which these and other evaluation data are used for comprehensive cancer control programming and management.

Working with the Maine Consortium for Comprehensive Cancer Control, an organization of 40 organizations representing over 150 individuals and communities, goals, objectives and strategies have been developed and are described in the state's comprehensive cancer control plan. The Comprehensive Cancer Control Program has oversight and coordination responsibilities for implementation of all of the objectives and strategies.

Additionally, the Comprehensive Cancer Control Program uses the Healthy Maine 2000 goals (2010 goals in development):

- Teen and adult tobacco use

- Physical activity
- Nutrition
- Breast and cervical cancer screening

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

- Five-year targets for the state cancer plan goals are reviewed and measured annually.
- Ten-year targets for Healthy Maine 2000 goals (Healthy Maine 2010 goals currently being set).

3. An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

- This is the first year for the annual review of the state cancer plan; therefore, this is the first year of benchmarking program progress.
- Several short-term strategies have been conducted.
- Since changes in behavior and systems occur over time, it is difficult to measure the immediate impact of the Comprehensive Cancer Control Program and its goals and strategies.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

The Comprehensive Cancer Control Program is staffed by a federal assignee from the Centers for Disease Control and Prevention. Her federal classification is a Public Health Advisor. She is the only staff for this program.
(See attached job classification and organizational chart for the Bureau)

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

Since its creation in 1998, the Comprehensive Cancer Control Program has not received any funding. Incidental expenses have been paid for by the Maine Breast and Cervical Health Program, the Maine Cancer Registry, the Preventive Health and Health Services Block Grant, and the American Cancer Society.

F. When applicable, the regulatory agenda and the summary of rules adopted;

None

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

The Comprehensive Cancer Control Program has coordinated its efforts with over 40 organizations in Maine, which have formed the Maine Consortium for Comprehensive Cancer Control. The organizations are listed below.

AFL-CIO
American Cancer Society
American Lung Association
Androscoggin Home Health Services
Anthem Blue Cross and Blue Shield
CancerCare of Maine
Cancer Community Center
Central Maine Medical Center
CHANS Home Health Center
City of Portland, Public Health Division
CLEAN: Maine
Department of Education
Department of Human Services
  Bureau of Elder and Adult Services
  Bureau of Health
  Bureau of Medical Services
Downeast Association of Physician Ast's
Eastern Area Agency on Aging
Eastern Maine Medical Center
Family Planning Associatin of Maine
Harvard Pilgrim Health Care
[illegible] Network Hospice
[illegible] Source of Maine, Inc.
Home Care Alliance of Maine
Maine Academy of Family Physicians
Maine Ambulatory Care Coalition
Maine Association of Nurse Practitioners
Maine Breast Cancer Coalition
Maine Dietetic Association
MaineGeneral Medical Center
Maine Health
Maine Health Learning Resource Cntr
Maine Hospice Council
Maine Hospital Association
Maine Medical Association
Maine Medical Center
Medical Care Development
New England Rehabilitation Hospital
NYLCare Health Plans of Maine, Inc.
Organization of Maine Nurse Exec's
Penobscot Bay Medical Center
Pine Tree Family Practice
Redington-Fairview General Hospital
Southern Maine Health & Homecare
Southern Maine Medical Center
So. Maine Oncology Nurses Society
St. Mary's Regional Medical Center
Togus VA Medical Center
Tufts Health Plan of New England
[illegible] of New England College
of Osteopathic Medicine
University of Southern Maine/Muskie
  School of Public Service
VNA Home Healthcare

Maine Center for Cancer and Blood Disorders
Maine Center for Public Health
Maine Chapter of the American College of Physicians
Maine Dartmouth Family Practice Residency Program

Additionally, the Comprehensive Cancer Control Program has coordinated its efforts with several Bureau of Health programs, which are listed below. The Comprehensive Cancer Control Program does not have any cooperative agreements.

Breast and Cervical Health Program
Cancer Registry
Cardiovascular Health Program
Chronic Disease Epidemiology
Community Health Promotion Program

Coordinated Care Services for Children with Special Health Needs

Environmental Lab
Healthy Maine Partnerships
HIV/STD Program
Oral Health Program
Partnership for a Tobacco-Free Maine
Public Health Nursing
Radiological Health
Toxicology Program

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

All Maine citizens; children and adolescents; those diagnosed with cancer, their families and caregivers; health care providers; cancer support service providers; and the Maine Consortium for Comprehensive Cancer Control.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

Not applicable

J. Identification of emerging issues for the agency or program in the coming years.

Emerging issues for the Comprehensive Cancer Control Program include:

- Securing funding to implement the state cancer plan
- Identifying and securing additional staff resources
- Monitoring the research around prostate cancer screening
- Improving coordination and collaboration of partner agencies to achieve goals and objectives
- Developing a communication system for partners
- Evaluating comprehensive cancer control planning and implementation
- Improving cancer data quality and timeliness

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

CCC policies are in accordance with overarching DHS policy and state and federal regulations.

BUREAU OF HEALTH
DIVISION OF COMMUNITY HEALTH
PROGRAM EVALUATION REPORT

Program Title: **Maine Asthma Program (MAP)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- Funding from the Centers for Disease Control and Prevention through its "Addressing Asthma from a Public Health Perspective" program. Catalog of Federal Domestic Assistance Number 93.283.

B. A description of each program administered by the agency or independent agency, including the following for each program:

1. Established priorities, including the goals and objectives in meeting each priority;

- Assess the public health impact of asthma in Maine and monitor trends in asthma prevalence and asthma-related utilization of health care and drugs, hospitalizations, and mortality in a systematic manner on a routine basis.
- Monitor variation within Maine in asthma prevalence, utilization of health care and drugs for asthma hospitalizations, and asthma mortality by geographic, demographic, and behavioral risk factors. These data will be available to guide Maine's public health, medical and academic communities in their efforts to target interventions and conduct prevention research.
- Demonstrate the need for public health intervention programs for asthma prevention to support the allocation of new resources.
- Expand existing system for reviewing pediatric asthma deaths to include deaths for all residents under age 35.
- Develop a school-based health examination survey for a representative random sample of kindergarten and third grade students in Maine to be conducted every other year.
- Demonstrate the need for better ascertainment of emergency department visits and identify the resources to begin the needed improvements.
- Provide ongoing support for the Maine Asthma Council for coordination among stakeholders in the development and implementation of a public health approach to asthma.
- Develop and implement plans for public and provider education using an established planning framework.
- Engage stakeholders, through the Maine Asthma Council, in a strategic planning process designed to advance asthma as a public

health issue through the development of a "Public Health Action Plan for Asthma in Maine."
- Develop linkages with other state public health, human services, environmental and education agencies.
- Provide technical assistance and consultation to all asthma intervention sites in Maine.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

   - Ten-year targets for Healthy Maine 2000 goals (Healthy Maine 2010 goals currently being set).
   - Biannual submission of CDC required Progress Reports
   - Annual submission of CDC required Program Work Plans
   - Regular review of program performance based on evaluation plan (currently under development)

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   - The program is under two years old. Thus far, objectives in the annual work plans submitted to CDC have been met according to proposed timelines. The program evaluation plan is currently under development and will be used to direct future assessment of success in meeting goals and objectives.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

This program is maintained through a contract with the University of Southern Maine, Institute for Public Sector Innovation.
(See attached job classification and organizational chart for the Bureau)

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;**

See Department of Human Services statement regarding federal and state health and safety laws, affirmative action requirements and workers' compensation.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for the Bureau.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

N/A

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

- Collaboration with the University of Southern Maine on program management.
- Collaboration with the American Lung Association of Maine on oversight of Maine Asthma Council activities.
- Collaboration with many statewide organizations and local providers of asthma care and education on the Maine Asthma Council.
- Collaboration with Department of Education on development of asthma surveys.
- Collaboration with the Centers for Disease Control and Prevention, the program's funding agency.
- Collaboration with other state Asthma Programs.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

Statewide and local organizations and programs that provide health care services and patient education related to asthma, organizations focused on clean indoor and outdoor air, hospitals, schools, Departments of Education and Environmental Protection.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.**

The program does not deliver direct services. Program objectives are focused on improving collaboration and coordination statewide to address asthma.

J. **Identification of emerging issues for the agency or program in the coming years.**

- Maine was identified as having the highest rate of adult asthma in the country based on a single year of Behavioral Risk Factor Surveillance System data. Asthma is growing public health issue, and at this time no state staff are dedicated to address it.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

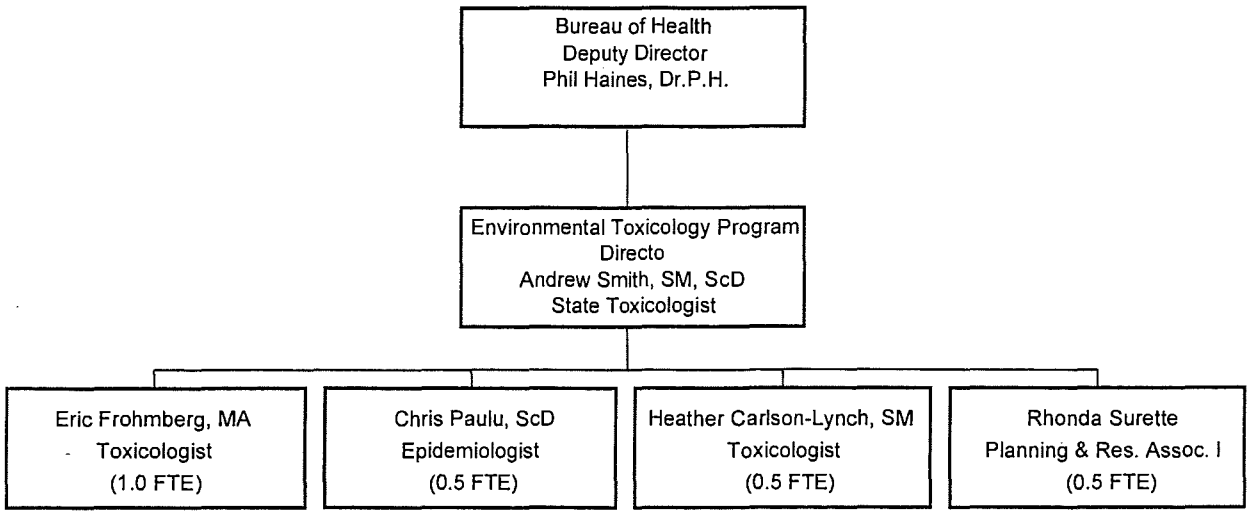
MAP policies are in accordance with overarching DHS policy and state and federal regulations.

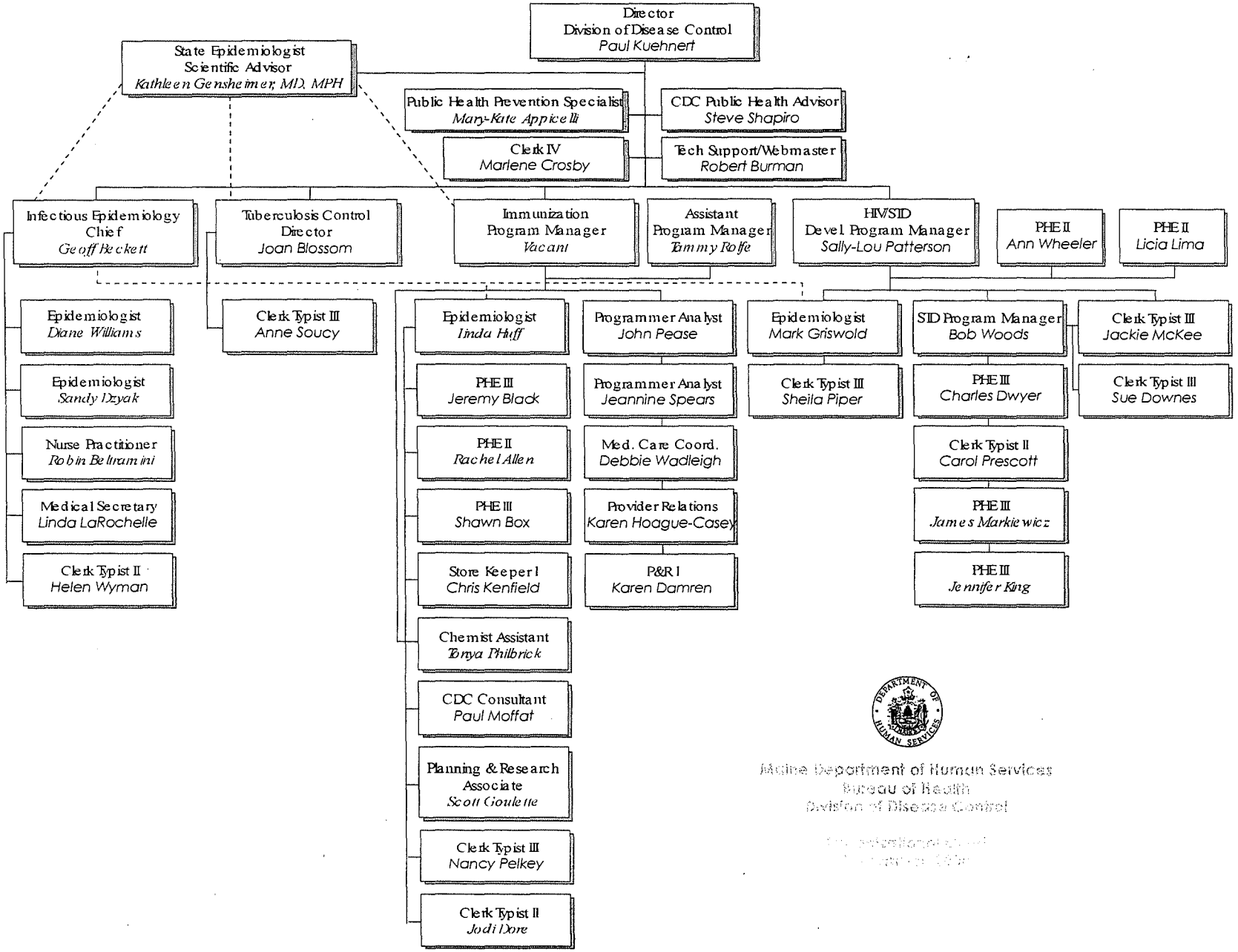
DEPARTMENT OF HUMAN SERVICES
BUREAU OF HEALTH

Position Count	Job Classifications
1	Director Bureau of Health
3	Director Division Health Programs
1	Director Public Health Engineering
1	Director Wastewater and Plumbing Con.
1	Director Drinking Water Program
1	Director Office Health, Data and Programs
1	Director Division Data and Research
1	Deputy Director Environmental Health Policy and Programs
1	Operations Manager HETL
4	Chemist III
11	Chemist II
8	Chemist I
6	Chemist Assistants (5 are seasonal positions)
1	Forensic Chemist I
2	Microbiologist Supervisor
2	Microbiologist III
8	Microbiologist II
3	Microbiologist I
1	Laboratory Technician III
6	Laboratory Technician II
2	Laboratory Technician I
1	Quality Assurance Office
1	Supervisor Data and Research
1	Supervisor Vital Statistics
2	Director Special Projects
2	Child Special Health Needs Coordinator
3	Nutrition Consultants
1	State Toxicologist
2	Toxicologist
1	Development Program Manager
1	Chief Communication Health Pro
1	State Nuclear Inspector
1	Nuclear Engineer Specialist
1	Soil Site Evaluator
3	Public Health Physicians
26.5	Public Health Nurse I
27	Public Health Nurse II
2	Nursing Ed Consultant
1	Medical Claims Adjuster
4	Senior Health Program Manager
16	Health Program Managers
1	Systems Analyst
1	Management Analyst II
2	Programmer Analyst
1	Senior Geologist
1	Hydro-Geologist
4	Environmental Specialist IV
8	Environmental Specialist III
9	Environmental Specialist II
2	Engineer Technician IV

2	Engineer Technician III
5	Assistant Engineer
1	Plumbing Inspector
5	Public Health Nurse Supervisor
6	Public Health Nurse Con.
8	Epidemiologist
1	Physicians Assistant DHS
7	Comprehensive Health Planner II
9	Comprehensive Health Planner I
8	Planning and Research Associate I
5	Planning and Research Assistant
20	Public Health Educator III
7	Public Health Educator II
1	Supervisor Public Health Sanitation
3	Sanitarian Engineer III
2	Sanitarian Engineer II
11	Sanitarian II
1	Information System Support Specialist II
2	Information System Support Specialist
1	Provider Relations Specialist
3	Medical Care Coordinator
1	Warehouse Superintendent
1	Staff Accountant
2	Accountant II
1	Accountant I
1	Account Clerk II
1	Store Clerk
.5	Medical Records Technician
1	Word Processing Operator
5.5	Planning and Research Associate II
4	Medical Secretary
1	Storekeeper II
3	Storekeeper I
7	Clerk IV
27	Clerk Typist III
1	Clerk III
20.5	Clerk Typist II
1	Data Control Specialist
1	Data Control Clerk
1	Human Services Aide III
1	Department Computer Operator
1	Data Entry Specialist
380	**Total Position Count**

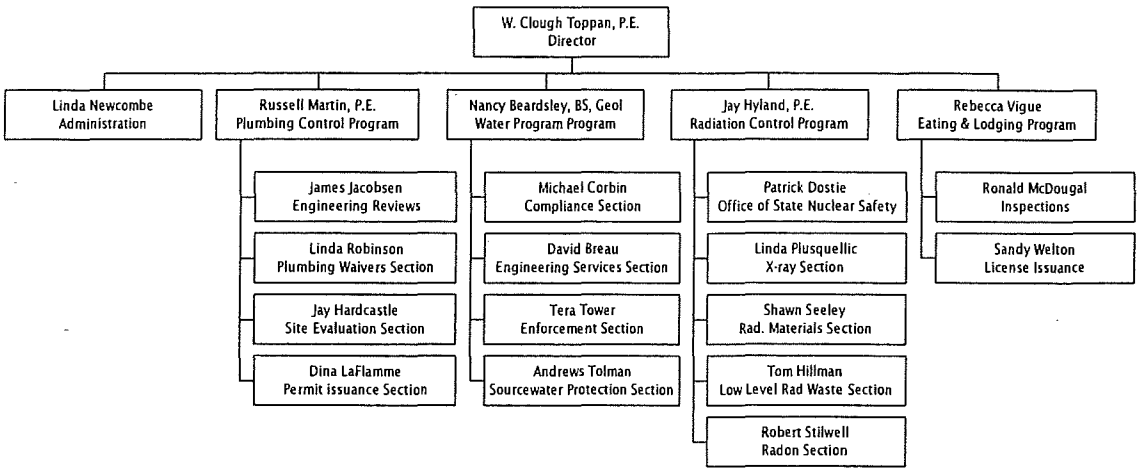
BUREAU OF HEALTH



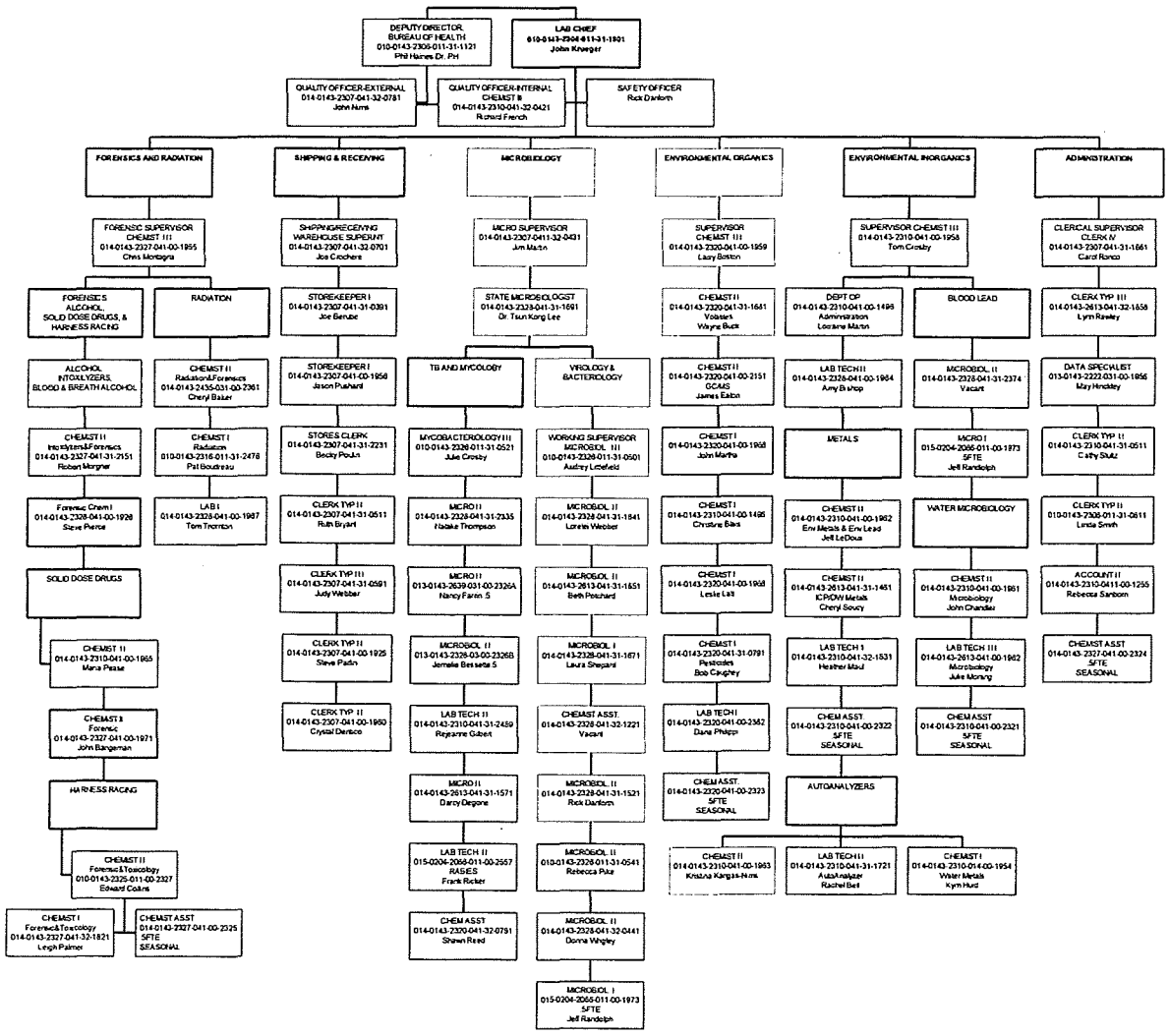

Director
Division of Disease Control
Paul Kuehnert
State Epidemiologist
Scientific Advisor
Kathleen Gensheimer, MD, MPH
Public Health Prevention Specialist
Mary-Kate Appicelli
CDC Public Health Advisor
Steve Shapiro
Clerk IV
Marlene Crosby
Tech Support/Webmaster
Robert Burman
Infectious Epidemiology Chief
Geoff Beckett
Tuberculosis Control Director
Joan Blossom
Immunization Program Manager
Vacant
Assistant Program Manager
Tammy Rolfe
HIV/STD Devel Program Manager
Sally-Lou Patterson
PHE II
Ann Wheeler
PHE II
Licia Lima
Epidemiologist
Diane Williams
Epidemiologist
Sandy Dzyak
Nurse Practitioner
Robin Beltramini
Medical Secretary
Linda LaRochelle
Clerk Typist II
Helen Wyman
Clerk Typist III
Anne Soucy
Epidemiologist
Linda Huff
PHE III
Jeremy Black
PHE II
Rachel Allen
PHE III
Shawn Box
Store Keeper I
Chris Kenfield
Chemist Assistant
Tonya Philbrick
CDC Consultant
Paul Moffat
Planning & Research Associate
Scott Goulette
Clerk Typist III
Nancy Pelkey
Clerk Typist II
Jodi Dore
Programmer Analyst
John Pease
Programmer Analyst
Jeannine Spears
Med. Care Coord.
Debbie Wadleigh
Provider Relations
Karen Hoague-Casey
P&R I
Karen Damren
Epidemiologist
Mark Griswold
Clerk Typist III
Sheila Piper
STD Program Manager
Bob Woods
PHE III
Charles Dwyer
Clerk Typist II
Carol Prescott
PHE III
James Markiewicz
PHE III
Jennifer King
Clerk Typist III
Jackie McKee
Clerk Typist III
Sue Downes
DEPARTMENT OF HUMAN SERVICES
Maine Department of Human Services
Bureau of Health
Division of Disease Control

DIVISION OF HEALTH ENGINEERING, BUREAU OF HEALTH
Administration and Program Managers

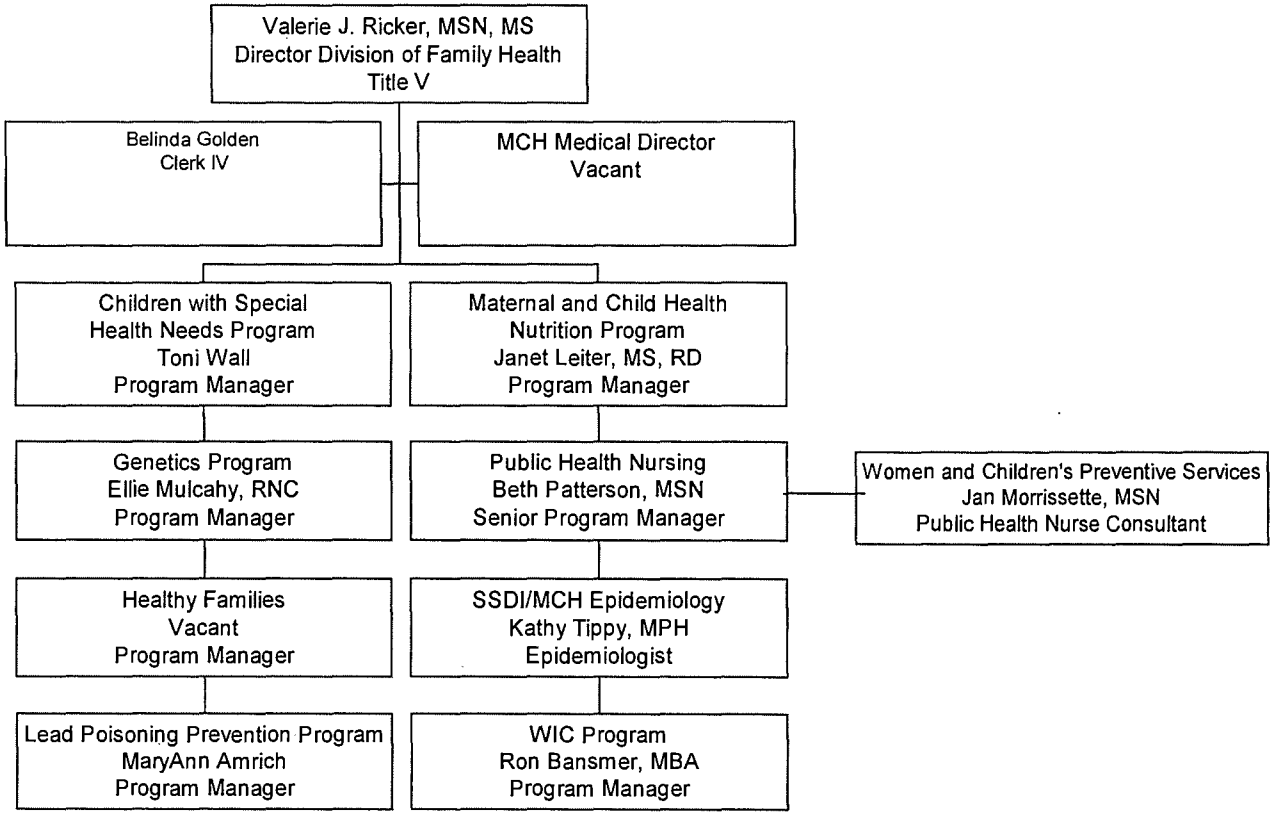
1/2/02



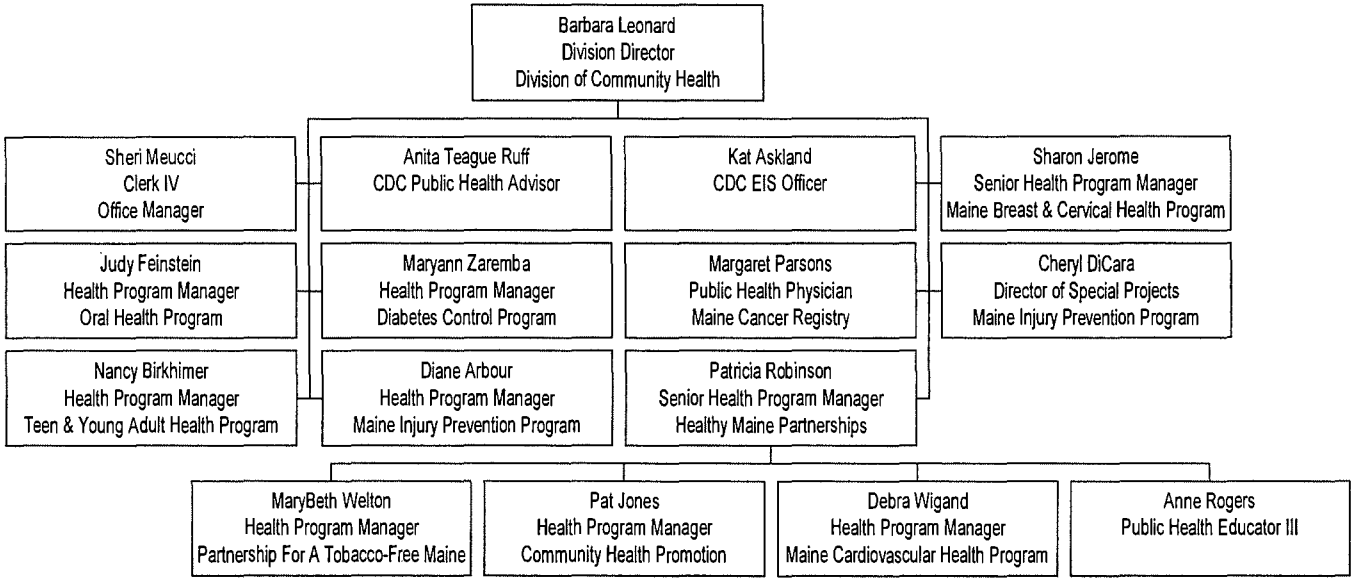
DEPARTMENT OF HUMAN SERVICES BUREAU OF HEALTH
HEALTH AND ENVIRONMENTAL TESTING LAB 09/01/01



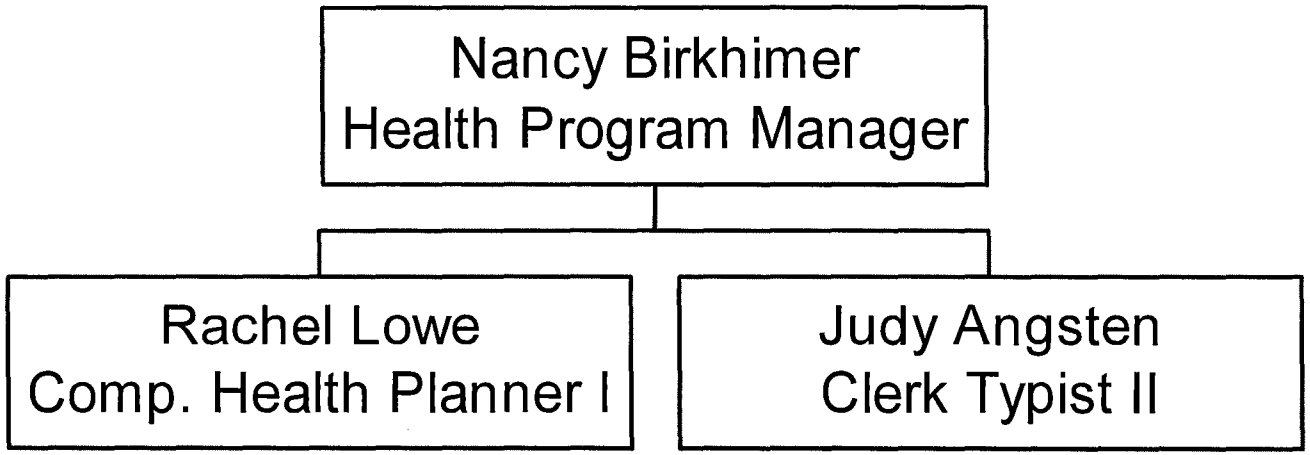
Division of Family Health



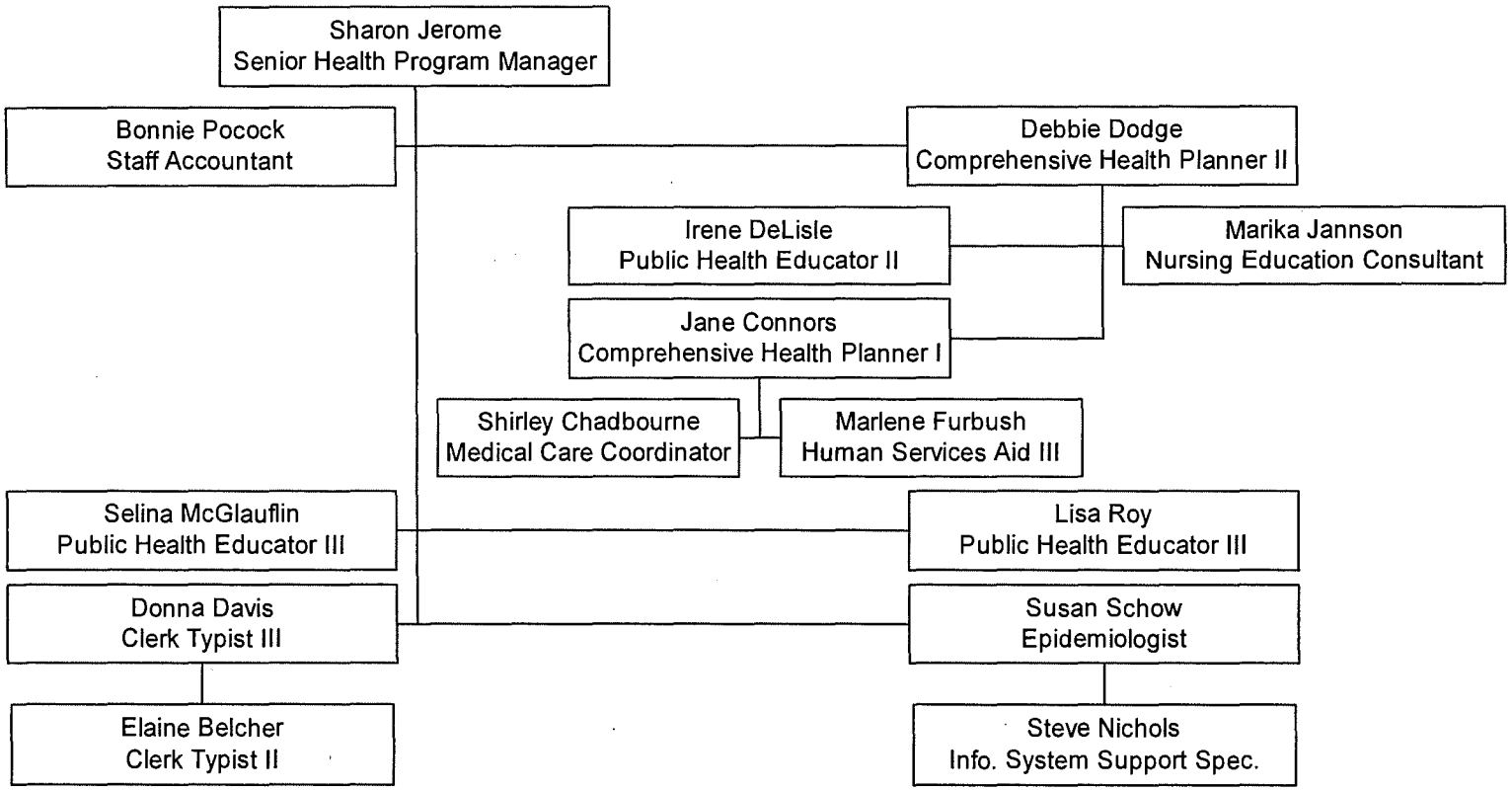
Division of Community Health Administration



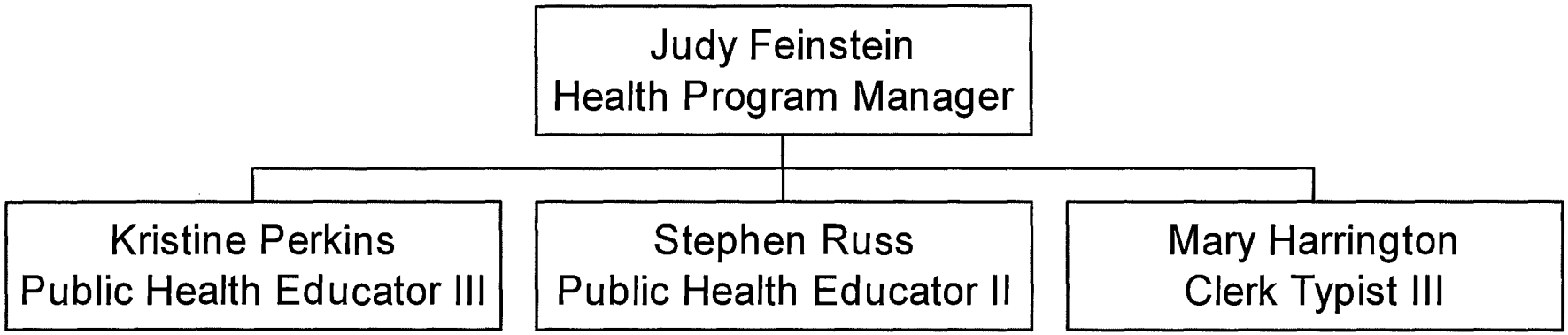
Teen and Young Adult Health Program



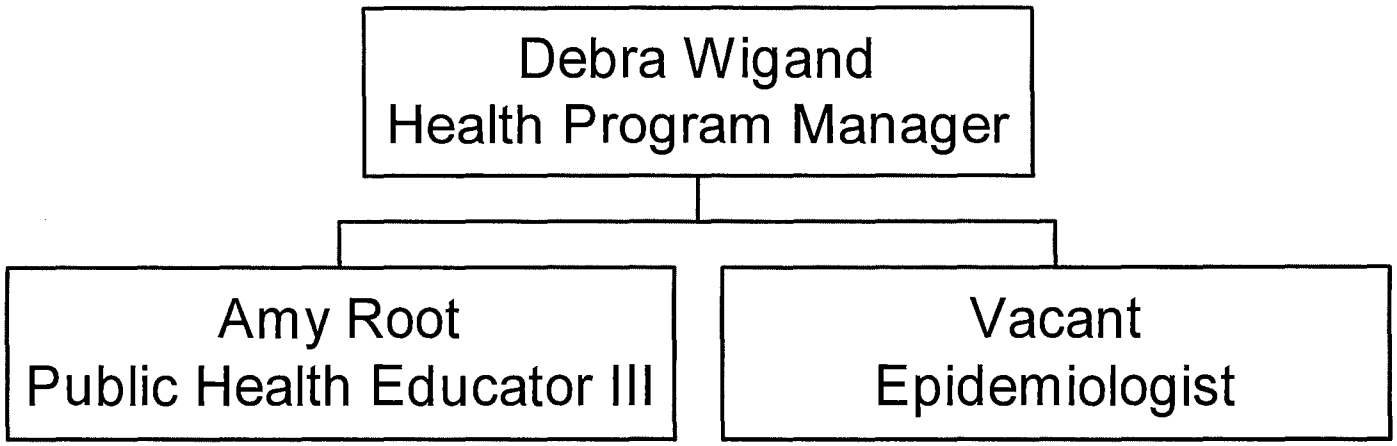
Maine Breast and Cervical Health Program



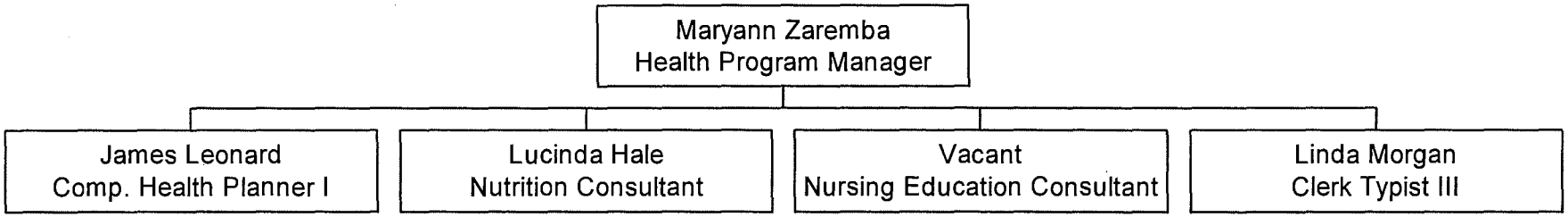
Oral Health Program



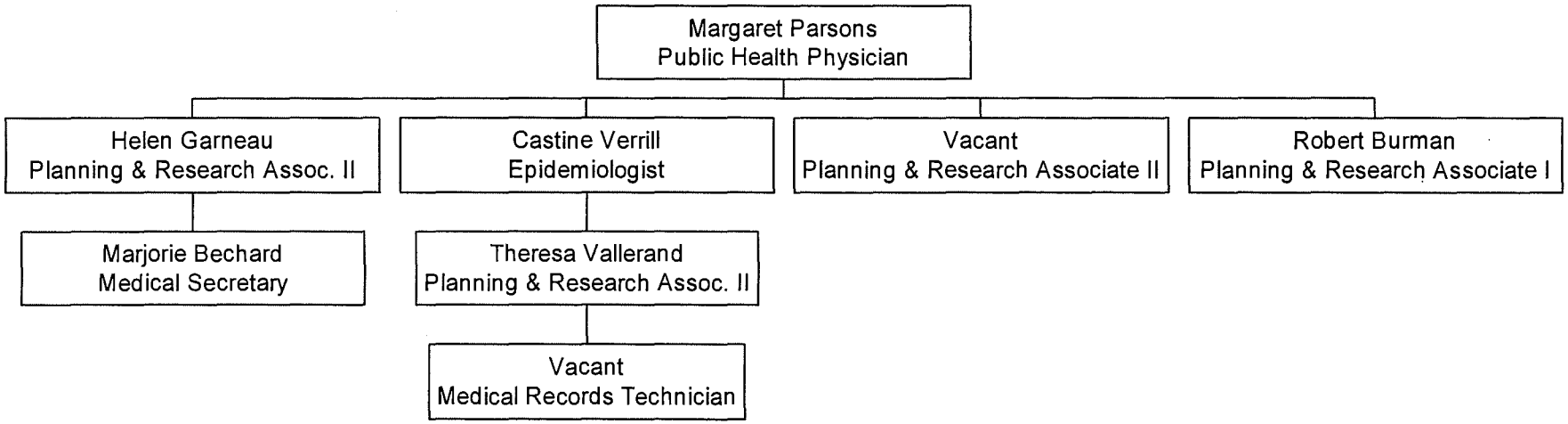
Cardiovascular Health Program



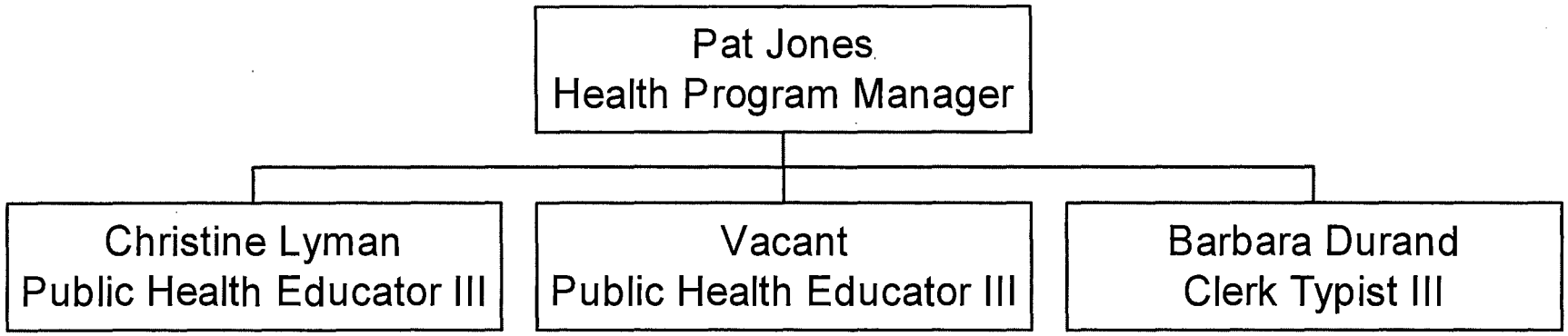
Diabetes Control Program



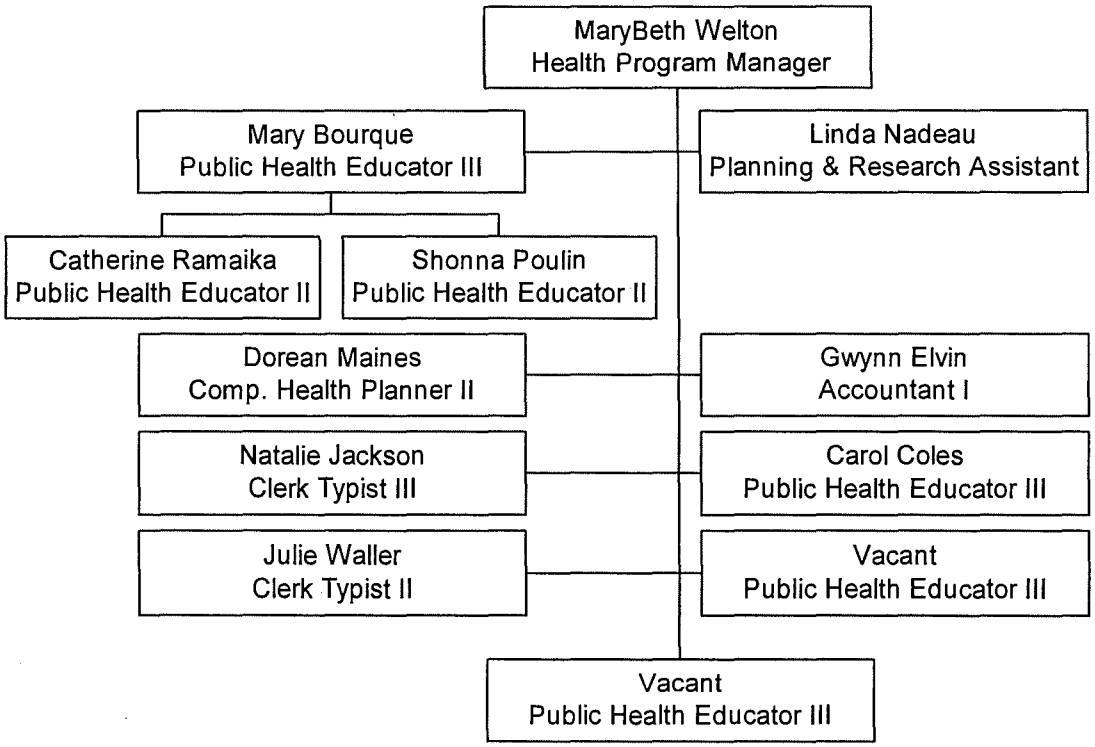
Maine Cancer Registry



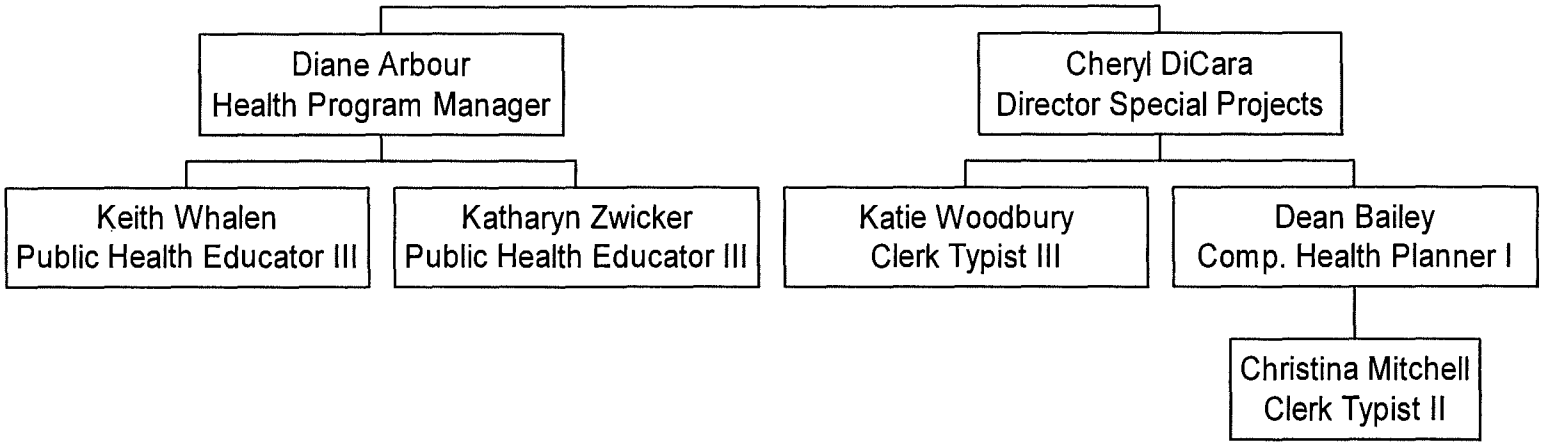
Community Health Promotion Program



Partnership For A Tobacco-Free Maine



Maine Injury Prevention Program



DEPARTMENT OF HUMAN SERVICES
BUREAU OF HEALTH
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	BUREAU OF HEALTH	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0107	UNITED CEREBRAL PALSY	80,000	71,167	800,000	67,389	75,987	75,982	75,987	61,582	90,397	90,395
0143	BUREAU OF HEALTH	9,165,146	6,539,486	9,569,788	6,055,552	7,404,996	5,721,755	7,388,759	5,686,641	5,920,934	5,596,764
0143	BUREAU OF HEALTH CARRYING ACCOUNT										
0167	TREATMENT OF CYSTIC FIBROSIS	5,000	4,941	5,000	27	4,902	4,902	4,902		4,902	4,901
0204	SPECIAL CHILDRENS SERVICES	234,069	37,482	247,484	1,643	8,126	2,366	8,334	1,364	9,013	-
0466	COMMUNITY FAMILY PLANNING	521,748	514,952	521,748	511,517	511,518	211,502	511,518	211,399	211,518	208,815
0518	AIDS LODGING HOUSE	70,000	34,590	70,000	28,604	34,314	39,506	34,314	34,314	34,314	33,796
0905	DONATED DENTAL SERVICES										
	GENERAL FUND TOTAL:	10,075,963	7,202,618	11,214,020	6,664,732	8,039,843	6,056,013	8,023,814	5,995,300	6,271,078	5,934,671
0143-01	BUREAU OF HEALTH										
0143-03	FEDERAL PROJECTS GRANT	17,198,117	16,381,137	18,435,343	13,744,283	19,698,194	19,000,784	20,219,944	17,991,102	30,743,039	21,901,433
0191	MATERNAL & CHILD HEALTH									364,522	156,292
0926	NEWBORN HEARING PROGRAM										
	FEDERAL FUND TOTAL:	17,198,117	16,381,137	18,435,343	13,744,283	19,698,194	19,000,784	20,219,944	17,991,102	31,107,561	22,057,725
0076	HUMAN LEUKOCYTE ANTIGEN SCREENING FUND										
0143-01	BUREAU OF HEALTH	1,230	-	1,304	3,148	1,341	339	1,384	1,107	21,731	10,144
0143-02	TOBACCO TAX RELIEF FUND										
0143-03	SPECIAL REVENUE HEALTH	476,072	299,228	512,410	363,498	705,579	576,034	710,032	538,294	1,285,010	603,950
0143-04	HEALTH & ENVIRONMENTAL TESTING LAB	1,950,450	2,278,519	2,075,022	2,664,390	3,342,393	2,665,920	3,411,078	3,050,565	5,050,619	3,517,835
0143-06	HEALTHY MAINE										
0143-07	HEALTHY MAINE										
0205	CONTROL OVER PLUMBING	277,331	253,306	295,791	252,539	311,639	226,347	313,808	199,308	317,226	219,170
0207	NUCLEAR SAFETY PROGRAM			679	679	19,565	19,565	37,280	37,280		
0466	COMMUNITY FAMILY PLANNING										
0697	MAINE WATER WELL DRILLING PROGRAM	10,287	10,287	7,070	7,070	33,381	1,891	33,563	28,299	56,627	48,819
0728	PUBLIC DRINKING WATER FUND					21,880	21,880	242,166	242,166	472,848	359,262
0905	DONATED DENTAL SERVICES										
	OTHER SPECIAL REVENUE TOTAL:	2,715,370	2,841,339	2,892,276	3,291,325	4,435,778	3,511,977	4,749,311	4,097,019	7,204,061	4,759,180
0143	ADMINISTRATION - PHHSBG	10,666	6,737	156,049	156,049	213,681	147,738	217,360	349,022	1,741,866	1,263,297
0191	MATERNAL & CHILD HEALTH	3,072,980	2,374,391	2,513,950	2,513,950	2,557,464	2,424,604	2,513,566	2,773,812	4,187,971	3,253,159
0204	SPECIAL CHILDREN SERVICES	872,078	777,956	919,815	645,485	1,059,469	870,491	1,059,615	992,484	1,126,343	900,599
0486	DENTAL DISEASE PREVENTION	165,257	157,994	175,974	154,977	186,449	159,066	186,434	182,430	222,540	182,764
0487	HYPERTENSION CONTROL	170,046	156,433	173,261	149,612	179,729	165,863	184,328	147,530	233,925	192,214
0488	RAPE CRISIS CONTROL	16,901	16,901	16,901	1,653	32,656	32,656	17,930		56,937	51,941
0489	RISK REDUCTION PROGRAM	179,826	146,582	195,214	169,503	413,899	326,508	519,957	519,957	444,475	246,157
0496	SEXUALLY TRANSMITTED DISEASES	23,807	10,331	26,063	21,678	26,704	23,667	27,398	18,255	28,185	27,977
0497	TUBERCULOSIS CONTROL PROGRAM	30,820	21,004	32,862	31,249	34,172	32,407	33,802	30,921	35,772	31,700
0884	ABSTINENCE EDUCATION										
	BLOCK GRANT TOTAL:	4,542,381	3,668,329	4,210,089	3,844,156	4,704,223	4,183,000	4,760,390	5,014,412	8,078,014	6,149,807
	GRAND TOTAL	**34,531,831**	**30,093,423**	**36,751,727**	**27,544,496**	**36,878,038**	**32,751,775**	**37,753,458**	**33,097,833**	**52,660,714**	**38,901,383**

DEPARTMENT OF HUMAN SERVICES
BUREAU OF HEALTH
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	BUREAU OF HEALTH	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0107	UNITED CEREBRAL PALSY	75,987	75,985	75,989	75,985	75,987	72,493	91,818	84,612	75,987	75,986
0143	BUREAU OF HEALTH	6,045,099	5,852,302	6,529,826	6,501,465	6,663,662	6,562,774	6,957,278	6,754,702	7,609,846	7,556,981
0143	BUREAU OF HEALTH CARRYING ACCOUNT									1,500,000	1,496,381
0167	TREATMENT OF CYSTIC FIBROSIS	4,902	4,902	4,902	3,268	4,902	4,902	4,902		4,902	4,902
0204	SPECIAL CHILDRENS SERVICES	8,366	-								
0466	COMMUNITY FAMILY PLANNING	211,518	207,394	264,393	264,393	211,518	211,517	212,998	212,516	211,518	211,502
0518	AIDS LODGING HOUSE	34,314	33,796	38,870	38,352	36,929	36,928	34,626	33,635	36,987	36,922
0905	DONATED DENTAL SERVICES							33,940	33,940		
	GENERAL FUND TOTAL:	6,380,186	6,174,379	6,913,980	6,883,463	6,992,998	6,888,615	7,335,562	7,119,405	9,439,240	9,382,674
0143-01	BUREAU OF HEALTH										
0143-03	FEDERAL PROJECTS GRANT	31,835,469	26,606,562	33,903,152	31,085,095	32,175,876	28,302,002	31,695,469	25,407,224	35,050,957	28,008,701
0191	MATERNAL & CHILD HEALTH	502,239	461,372	600,874	538,435	625,147	565,755	809,437	717,428	811,750	743,734
0926	NEWBORN HEARING PROGRAM									93,574	22,961
	FEDERAL FUND TOTAL:	32,337,708	27,067,934	34,504,026	31,623,530	32,801,023	28,867,757	32,504,906	26,124,652	35,956,281	28,775,397
0076	HUMAN LEUKOCYTE ANTIGEN SCREENING FUND									250,000	63,855
0143-01	BUREAU OF HEALTH									530,000	527,384
0143-02	TOBACCO TAX RELIEF FUND			3,500,000	3,460,163	6,486,723	5,455,066	6,493,089	5,349,261	8,287,341	7,523,821
0143-03	SPECIAL REVENUE HEALTH	1,343,501	681,402	1,119,455	742,208	989,458	790,136	874,598	772,138	1,256,407	1,134,067
0143-04	HEALTH & ENVIRONMENTAL TESTING LAB	5,112,401	3,716,273	4,395,756	3,510,115	4,466,249	3,557,772	3,985,752	3,762,429	4,852,744	4,320,224
0143-06	HEALTHY MAINE									3,465,000	3,464,376
0143-07	HEALTHY MAINE									4,110,000	4,109,997
0205	CONTROL OVER PLUMBING	300,199	246,031	331,087	303,428	401,653	301,802	448,725	322,912	462,883	368,129
0207	NUCLEAR SAFETY PROGRAM										
0466	COMMUNITY FAMILY PLANNING									400,000	400,000
0697	MAINE WATER WELL DRILLING PROGRAM	63,935	49,354	69,038	46,142	72,864	42,345	52,282	50,741	52,971	47,835
0728	PUBLIC DRINKING WATER FUND	489,220	407,969	444,328	413,830	782,508	538,587	1,068,244	909,848	1,225,809	1,105,751
0905	DONATED DENTAL SERVICES									33,940	33,940
	OTHER SPECIAL REVENUE TOTAL:	7,309,256	5,101,029	9,859,664	8,475,885	13,199,455	10,685,708	12,922,690	11,167,328	24,927,095	23,099,379
0143	ADMINISTRATION - PHHSBG	1,580,880	1,099,837	1,400,253	1,108,627	1,660,231	1,119,994	1,249,119	827,587	899,033	740,918
0191	MATERNAL & CHILD HEALTH	3,824,312	3,320,219	4,580,789	3,286,703	4,407,204	2,651,906	2,733,621	2,454,985	2,889,260	2,682,707
0204	SPECIAL CHILDREN SERVICES	998,412	836,932	1,005,645	969,964	1,055,353	779,509	913,762	771,878	905,911	858,915
0486	DENTAL DISEASE PREVENTION	232,861	189,798	217,407	206,925	213,564	204,088	153,330	137,590	167,220	144,826
0487	HYPERTENSION CONTROL	238,169	229,718	257,235	249,124	232,270	218,766	116,566	94,067	58,642	42,739
0488	RAPE CRISIS CONTROL	39,419	27,580	217,428	216,181	185,862	185,860	225,175	220,952	237,659	236,650
0489	RISK REDUCTION PROGRAM	421,056	214,650	475,192	310,182	502,107	291,899	295,283	293,843	307,767	270,818
0496	SEXUALLY TRANSMITTED DISEASES	28,616	25,777	47,623	43,623	38,572	24,973	34,959	29,053	39,305	38,287
0497	TUBERCULOSIS CONTROL PROGRAM	35,999	34,915	37,555	33,494	36,084	34,498	34,855	34,728	38,215	37,067
0884	ABSTINENCE EDUCATION			172,468	-	172,468	167,832	187,274	162,142	237,091	220,556
	BLOCK GRANT TOTAL:	7,399,724	5,979,427	8,411,595	6,424,822	8,503,715	5,679,325	5,943,944	5,026,825	5,780,103	5,273,483
	GRAND TOTAL	**53,426,874**	**44,322,768**	**59,689,265**	**53,407,700**	**61,497,191**	**52,121,405**	**58,707,102**	**49,438,211**	**76,102,719**	**66,530,932**

BUREAU OF MEDICAL SERVICES

Maine Care (Medical Services)

Certificate of Need (CON)

Division of Licensing and Certification

Quality Oversight of Commercial Health Maintenance Organizations (HMO)

BUREAU OF MEDICAL SERVICES
PROGRAM EVALUATION PROGRAM

Program Title: **Maine Care (Medical Services)**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

Medicaid: Fed: Title XIX, Social Security Act
State: 22 MRSA §10 & 12, §3172-3273

CubCare: Fed: Title XXI, Social Security Act
State: 22 MRSA§3174-T

Pharmacy

Healthy Maine Prescriptions: Fed: Section 1115, Social Security Act; State: 22 MRSA §258
Drugs for the Elderly and Disabled State: 22 MRSA §254
Maine RX State: 22 MRSA §2681-2698
Medical Eye Care State: 22 MRSA §3251
Cost Reimbursed Boarding Homes State: 22 MRSA §10 & 3173

Hospitals

Disproportionate Share Fed: Title XIX, Social Security Act
Free Care State: 22 MRSA §1715-1716

B. A description of the program including: goals and objectives, performance measures, an evaluation of performance and future plans.

Maine Care provides medical services through its network of health care providers to residents of Maine who meet the applicable eligibility requirements. These include:

a) acute care and long term care services provided under the Medicaid, Cub Care programs;
b) the pharmacy discount provided under the Healthy Maine Prescriptions (HMP) program (and pharmacy benefit provided under the drugs for the elderly and disabled component of HMP) and the pharmacy discount to be provided under the Maine RX program once its legal status is resolved;
c) medical benefits provided to residents of cost reimbursement boarding homes;
d) adult mental health services in Institutes of Mental Disease provided to Maine Care members and other low income adults under the federal disproportionate share program; and
e) free care required to be provided by Maine hospitals to individuals with incomes at or below 100% of the federal poverty level.

Exhibit 1 and the accompanying notes describe who is eligible for Maine Care benefits.

Exhibit 2 and the accompanying notes describe the services provided by Maine Care and some of the rules relating to access to these services.

Listed below are seven goals for the Maine Care program, the strategies used to promote those goals, an evaluation of the extent to which the program has succeeded in achieving these goals and additional strategies in development to further the program goals.

Goal I: Enroll all Eligibles

Strategies:

- Outreach Efforts

  The Bureau of Medical Services contracted with the Maine Ambulatory Care Coalition to implement a statewide outreach campaign to identify and enroll eligible children and their parents in Maine Care. Outreach activities included the following:

  - ✓ technical training sessions on Maine Care eligibility policies and the application process for staff of community based agencies serving individuals and families who might be eligible;
  - ✓ general training sessions on the availability of Maine Care coverage for organizations like the Elks Club or Lions Club; and
  - ✓ a hospital sign-up day conducted in collaboration with the Maine Hospital Association.

- Application Process/Applications

  Individuals may apply for Maine Care by mail or at a Department of Human Services regional office. The Department has several application forms, including a one-page application for families with children and pregnant women and a single TANF/Medicaid application. All of the applications will be revised by July 1, 2002 to reference Maine Care.

  Attached is a copy of the application currently used by children and their parents and pregnant women to apply for Maine Care. This application has been translated into the following languages: Serbian, Spanish, Farsi, Arabic, Amharic, Chinese, French, Russian, Somali, Vietnamese, and Cambodian. A sample foreign language application is also included as an attachment.

- School Mailings

  The Department of Human Services and the Department of Education work collaboratively to ensure that each school in the State has Maine Care applications to send home with children during the first week of school.

- 12-Month Continuous Eligibility

  Effective October 1, 2001, the Department provides 12 months of continuous eligibility for children regardless of any changes in family circumstances such as income.

Performance Measure:

- Uninsured Rate (See also attached Press Release)

  The Department of Human Services has conducted two random household surveys to gauge the incidence of uninsurance for children in Maine. The results of the two surveys are summarized below.

FPL Income Level	# Uninsured Children Age 18 & Under **(1997)**	# Uninsured Children Age 18 & Under **(2000)**
<125%	7,600	5,416
125%-185%	11,357	4,674
186%-200%	2,338	687
>200%	6,557	5,910
No Income Data	4,071	1,407
Total	31, 923	18,094

Future:

- Coverage of "Noncategoricals" - In January 2002, the Department plans to submit a waiver to the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) to expand Maine Care coverage to childless adults with income at or below 125% of the Federal Poverty Level (FPL). In the first year, the Department expects to provide coverage to childless adults with income at or below 100% of the FPL with expansion to 125% of FPL occurring as funding allows.

- HIV - The Centers for Medicare and Medicaid approved the HIV/AIDS waiver. This coverage will be implemented as soon as state funds are available for this initiative.

Goal II: Ensure Access to All Covered Health Services for Enrollees

Strategies:

- Adequate Provider Network
  - ✓ Claims Processing - The Department is developing a claims processing system that will allow Web-based access for the submission of claims, verification of eligibility and status of claims. This system will be compliant with the Health Insurance Portability and Accountability Act

- ✓ requirements. Paper claims will continue to be allowed, however, the Department is moving to three standard claim forms: UB92, HCFA 1500, and Dental
- ✓ Rates - The Department develops rates in keeping with the Federal requirements to set rates at a level which maintains adequate access. While there are problems with access in certain areas of the State for specific services (dental, in-home supports) these are more closely related to workforce issues.
- ✓ Provider Inquiry/Voice Response - Providers may call the Maine Care Provider Inquiry Line and the Provider Relations Unit for policy interpretation and assistance with billing problems.
- ✓ Provider Education - A variety of provider education sessions are hosted over the course of a year, including individual provider office meetings and group sessions to explain new policies and policy changes.
- ✓ Manuals - The full Maine Medical Assistance Manual (MMAM) is mailed to all providers upon request and is available at the Secretary of State's Website. Individual sections of the MMAM are included in the enrollment packet for providers and updates are mailed to pertinent providers.

- Transportation Assistance

  Maine Care provides coverage for transportation to Maine Care covered services for people who have no other means of transportation. This coverage also provides assistance in purchasing gas for individuals who have a vehicle.

- Cultural Sensitivity/Interpreter Services

  While all providers are encouraged to provide services in a culturally sensitive manner, managed care providers are required to do so. In addition, Maine Care provides coverage for interpreter services for people of different languages and for individuals who are deaf or hard of hearing.

- Member Service Function

  Maine Care Member Services is available to all Maine Care members through a single toll free number. Member Services addresses a variety of consumer inquiries including those about Maine Care coverage and managed care enrollment and coverage. Member Services also has a resource directory (see attachment) to enable them to provide consumers with assistance in obtaining a Maine Care provider. The AT&T Language Line is available for individuals who need interpreter services.

- Provider Accessibility

  Provider recruitment continues for Maine Care managed care participation. Maine Care has a healthy enrollment of primary care providers across the State.

  Participation as a primary care provider (PCP) under Maine Care managed care requires being accessible to Maine Care members 24 hours a day, 7 days a week. Maine Care members are required to call their PCP prior to obtaining non-emergency care. BMS staff verifies this 24/7 coverage on a quarterly basis by calling PCP offices during off hours on a random basis.

Performance Measure:
- Member Complaints - Member complaints are logged and tracked.
- Primary Care Provider Capacity Survey in process

Future
- MeCMS - The Department is focusing much of its energy on the development of the new claims processing system. This system will provide an easier method for providers to submit electronic claims and to verify status of claims.
- HIPAA - The Maine Care program must become compliant with the requirements of the Health Insurance Portability and Accountability Act. All electronic claims transactions and codes will be HIPAA compliant. In addition, the Department is in the process of becoming compliant in the areas of privacy and security.

Goal III: Promotion of Prevention

Strategies:
- Prevention
  - ✓ Smoking Cessation - Increased reimbursement for counseling following "U.S. Public Health Service Guidelines for Treating Tobacco Use and Dependence." (See attached guidelines.) Maine Care also provides reimbursement for tobacco treatment medications.
  - ✓ Asthma - Clinical participation in Maine's AH! (Asthma Health) Program, Maine Care reimbursement for Asthma self management programs and for targeted case management and participation in the New England Coalition for Asthma Prevention.
  - ✓ Diabetes - Disease Management and diabetes education classes are provided under Maine Care. Four measures in the Primary Care Provider Incentive Payment. The development of Maine Care benefits are coordinated with the Bureau of Health Diabetes Control Program.
  - ✓ Cardiovascular Disease - Disease Management is provided. Maine Care staff has developed protocols with Franklin Memorial Hospital/University of Maine at Farmington. BMS also contracts with

Medical Care Development (MeCares) to provide support for infrastructure development for CVD

- ✓ Bright Futures - The mission of Bright Futures is to promote and improve the health, education, and well being of infants, children, adolescents, families and communities. (See attached Bright Futures Forms.)
- ✓ Medical Home - Maine Care managed care encourages providers to coordinate all aspects of the members preventive and acute health care needs.
- ✓ Government Performance and Results Act (GPRA) - Collaboration between Centers for Disease Control and Prevention and Centers for Medicare and Medicaid Services on increasing immunization levels in Medicaid members.
- ✓ Periodicity Mailings - Monthly information is mailed to Medicaid members who will need a well child or dental visit in the upcoming month. (See attached sample mailings.)

Performance Measure:

- Childhood Immunization Rates at 72%
- Mammography Rates experienced a 5% increase from 1998 to 2000
- Cervical Cancer Screening Rates experienced a 5% increase from 1999 to 2000
- Quarterly Monitoring for ER usage - 36% decrease in ER use between 1995 and 1997; Ongoing monitoring with ongoing education to avoid unnecessary utilization

Future:

- Continued monitoring/improvement in childhood immunization rates
- Adolescent Health Survey - Baseline assessment of the health status and behaviors of adolescents
- ScoreKeeper for Health Software utilization for Cardiovascular Disease
- Future Disease Management coverage
- Develop health status report for all Medicaid members - will help target resources for targeted interventions
- Aggregate date by provider, county and overall for assessment and targeted quality improvement efforts in the following areas: lead screening rates, diabetes monitoring by Hemoglobin A1C tests, and Bright Futures Screening rates.

Goal IV: Reduce Pharmacy Costs for Mainers

Strategies:

- Healthy Maine Prescriptions (HMP)
- Drugs for the Elderly (DEL)
- Maine Rx - Maine won the lawsuit on appeal
- Website

Performance Measure:

- HMP - 108,885 members enrolled

- All but one Maine pharmacy enrolled as Maine Care providers

Future:
- More legal challenges by pharmaceutical manufacturers. The Department of the Attorney General leads the legal defense.

Goal V: Promote Quality of Care

Strategies:
- Maine Care managed care provides a "medical home" for members.
- Physician Incentive Payment Program (a part of Maine Prime Care)
- Physician Directed Drug Initiative
- Care Plan Requirements - All long term care and most mental health service providers must have a care plan for members in their care.
- Case Mix Sensitive Rates - NF and Residential Care
- Emphasis on Community-based Care -
- State and Federal licensing and certification requirements linked to provider eligibility
- Quality Indicators for NFs
- Annual Surveillance and Utilization Control of all psychiatric hospitals for appropriateness and necessity of acute care services reimbursed by Maine Care
- Drug Utilization Review (clinical)

Performance:
- Customer Surveys indicate 79% of the Maine Care members are satisfied with the quality of their care under Maine Care managed care; giving the managed care benefit a program rating of "10"

Future
- Continuation of efforts to survey consumers.

Goal VI: Control Costs and Maximize Program Revenue

Strategies: Cost Control
- Member education on appropriate management of mild illness to help avoid unnecessary ER visits
- Cost Avoidance - Medicare, TPL
- Prior Authorization
- Long term care assessment requirement for determination of most appropriate services and service site
- Pharmacy Prior Authorization, Upper Payment Limits (Federal and State), Single Prescriber, Cost Avoidance
- Rates

Strategies: Revenue Maximization
- Estate Recovery
- 90% Federal Dollars for system enhancements

- Title XXI: Maine was one of ten states that spent all of its FFY 98 Title XXI allotment. Consequently, the CMS awarded Maine an additional $4.5 million of FFY 98 redistributed dollars to provide coverage to eligible children.
- Health Care services whenever appropriate.

Goal VII: Ensure that Maine Care Policy is Consistent with and Promotes State Health Care Goals

Strategy:

- Disease management activities and member outreach and education are coordinated with other programs at the Bureau of Health, specifically: Immunization, Breast and Cervical Health, Lead Screening, WIC, Oral Health, TB Control, Diabetes Control, Teen Health, Partnership for a Tobacco Free Maine, Maternal and Child Health Program. BMS staff also coordinate with the Bureau of Children with Special Needs as well as the State General Assistance Program and the Department of Behavioral and Developmental Health.
- Medicaid dollars provided as match for State expenditures for public health services benefiting Maine Care members.

C. Organizational structure, including a position count, a job classification and organization chart.

The Maine Care program is the responsibility of the Department of Human Services. However, certain program responsibilities are shared with other departments of Maine State government. The Department of Behavioral and Developmental Services, in particular, takes the lead in matters relating to behavioral and developmental health services.

The Bureau of Medical Services is the unit within DHS, which has lead responsibility for the program. However, other Bureaus within the department play major roles in the program. In particular the Bureau of Family Independence takes applications and determines eligibility for most components of the Maine Care program and the Bureau of Elder and Adult Services is the policy lead on all matters relating to long-term care policy for the physically.

See attached organizational chart for the Maine Care program.

There are 251 positions in the Bureau of Medical Services. Of these 93 relate to the Licensing and Certification program and 3 to the CON program. The number of positions in each job classification for the Medical Services program is contained in the attached Job classification list.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

See the Department of Human Services Department-wide compliance statement.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years;

See attached financial summary

F. When applicable, the regulatory agenda and the summary of rules adopted;

See attached regulatory agenda and the list of rules that govern the Maine Care Program.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies I achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements;

The Bureau works closely with several state agencies to help fund services through Maine Care, that otherwise would be funded completely with State dollars. These services include:

1. A wide array of mental health, mental retardation and substance abuse treatment benefits coordinated with the Department of Behavioral and Developmental Services;

2. School based rehabilitation, day treatment, education programs and early intervention services coordinated with the Department of Education and local school districts;

3. Mental health services with the Department of Corrections;

4. A wide array of case management services with various State and local agencies;

5. Child protective services which are therapeutic in nature;

6. Bureau of Health programs, including coverage for women identified with cancer through the Breast and Cervical Center Screening program; and

7. Bureau of Elder and Adult Services to provide long-term care services to the elderly and disabled.

The Bureau of Medical Services has written agreements with the following Bureaus, Federal and State Agencies to administer the Maine Care Program, certify and license health care facilities and services:

- ✓ Office of the Governor
- ✓ Office of the State Fire Marshall
- ✓ Bureau of Elder and Adult Services
- ✓ Department of Behavioral and Developmental Services
- ✓ Department of Professional and Financial Regulation
- ✓ United States Department of Health and Human Services

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes;

Maine Care has several constituencies, the first being its members. There are currently approximately 245,000 individuals enrolled in Maine Care. These include low-income children, parents, elders and disabled who set the full array of benefits. Also, other individuals up to 300% of poverty can get limited pharmacy benefits. The Bureau is currently submitting a waiver to the Centers for Medicare and Medicaid Services to expand full benefits coverage to very low-income childless adults. (See attached eligibility chart).

The second is its providers. These 17,000 providers are critical to the program's ability to serve its members. These providers range in size from major institutions, including tertiary care hospitals to independent providers. Cumulatively, they provide over 60 different categories of service. (See attached Maine Care benefits chart).

Third, the Bureau serves other State agencies and Department bureaus by working with them to maximize federal revenue and coordinate administration of important clinical programs. (See G above).

Finally, the Federal government is our partner in the Maine Care program.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives;

Managed Care: The Bureau has used two different types of managed care service delivery systems, commercial organizations and state-run primary care case management. In early 1996, the Federal government authorized Maine to contract with commercial managed care organizations (MCOs). MCOs were invited to bid and while several expressed interested, only one

eventually bid. A contract was awarded to AETNA, U.S. Health Care (formerly NYLCare).

On May 1, 1997 AETNA began administering Medicaid managed care services in select counties. By this time, the State was also running a primary care case management program called "PrimeCare" in the State's northern counties. The long-term plan included giving Maine Care members a choice between the two managed care modalities on a statewide basis. These plans were never realized. Financial considerations on the part of both Aetna and DHS led to termination of the contract in November 2000.

DHS has since expanded primary care case management statewide and to date there are over 100,000 members enrolled. Dually eligible individuals and special needs individuals are not required to enroll.

Home and Community Based Waivers: The Bureau has four different waiver benefit packages under which individuals can receive services in the home or community that would not necessarily otherwise be available in order to avoid institutionalization. These benefits are available to the elderly, the disabled and the mentally retarded.

Non-pharmacy Maine Care Claims Processing: The current State operated/owned system is over 23 years old and no longer meets federal certification requirements. In 2000 DHS initiated a project to secure federal funding and replace this old system with a web-based system to meet certification and HIPAA requirements. Funding was secured and a contract was awarded in 2001 to develop and implement the new system by late CY 2002. The new system will enhance efficiency of claims processing and improve quality of services with access to data.

Pharmacy Claims Processing/Services: Pharmacy claims processing services were contracted out in 1996 and separated from the State-operated system. Additional services were included under contract to meet requirements of the Maine Care Program and reduce escalating rate of pharmacy costs. A competitive reacquisition of pharmacy claims processing/services is in process. A contract award is anticipated prior to the end of FY 2002.

J. Identification of emerging issues for the agency or program in the coming years;

✓ Encouraging eligibles to stay health and to get healthy (e.g. heart, diabetes, asthma.) Need to integrate with overall State public health strategy (obesity, smoking, led, child and adult immunization, dental health.)
✓ Accessing dental services.
✓ Managing costs in a largely rural state; especially hospital services (critical access hospitals)

✓ Managing costs without a great deal of competition in the Maine health care marketplace.
✓ Shifting from cost-based to value-based purchasing strategies.
✓ Program Administration: HIPAA implementation, development of new claims management system.
✓ Long Term: Demographics - Anticipated increases in elderly and disabled eligibles with rising expectations among both groups as to scope of services that should be available.
✓ Long Term: Continuing access to affordable commercial insurance products for businesses and families. (i.e. Need to avoid cost shifting from Medicaid).
✓ Long Term: Advances in medical technology: May increase and/or decrease costs (e.g. Alzheimer's treatment.) Includes, but not limited to, pharmacy.
✓ Long Term: Health Care provider shortages (especially direct care workers for the elderly and disabled in both institutional and community settings, RNs and LPNs, dentists, mental health professionals.)
✓ Long Term: Coherent strategy for dual eligibles Medicaid/Medicare.

K. Any other information specifically requested by the committee of jurisdiction;

None

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

The Centers for Medicare and Medicaid Services set minimal standards for operation of the Maine Care program, both in terms of eligibility and service provision. Maine Care meets, and often exceeds, applicable standards including providing many services that are not mandated.

Maine Care often follows Medicare service and fiscal guidelines, although given budget constraints and a different population from that enrolled in Medicare, substantial variation is appropriate. HIPAA implementation should ensure greater consistency.

M. Agency policies for collecting managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

See the Department of Human Services Department-wide Compliance Statement.

EXHIBIT 1

MAINE CARE ELIGIBILITY

MAINE CARE FULL BENEFITS

Eligibles	Income Level	Asset Test	Comments
Children • Age 0 - 18	200% of FPL	No	• 12 month continuous eligibility. • For families with income between 150% - 200% of FPL there is a monthly premium of $5 - $40 depending on income and family size. • Children who lose eligibility due to family income can purchase coverage for up to 18 months.
• Age 19 – 20	150% of FPL	Yes	
Adults Age 21 - 64 • Parents or relatives living with their children under age 18	150% of FPL	Yes	
• People with disabilities — not working	100% of FPL	Yes	
— working	250% of FPL	Yes	• Unearned income must be under 100% of FPL; total unearned and earned income under 250% of FPL. • Depending on income, there may be a monthly premium of $10 - $20.
Adults Age 65 and older	100% of FPL	Yes	
Pregnant Women	200% of FPL	No	Coverage continues for 2 months after the end of the pregnancy.
Women with breast or cervical cancer	250% of FPL	No	Must be diagnosed through Bureau of Health, be age 40 – 64 and without insurance.

Note: In order to get services in a nursing facility, certain residential care facilities, or nursing care services at home, there are different and additional financial and medical requirements that must be met.

MAINE CARE ELIGIBILITY

MAINE CARE PRESCRIPTION DRUG BENEFITS ONLY

Eligibles	Income Level	Asset Test	Comments
• At least age 62 or age 19 and older if disabled	185% of 2001 FPL indexed annually using Social Security COLA	No	Drugs for certain diseases, generic drugs, and catastrophic drug benefit.
• Most Maine residents	Under 300% of FPL	No	Prescription drugs are discounted up to 25%

MAINE CARE EMERGENCY BENEFITS ONLY

Eligibles	Income Level	Asset Test	Comments
Non-citizens who are visiting or here without INS documents.	See comment	See comment	Individuals must be otherwise eligible for full benefits.

MAINE CARE LIMITED BENEFITS

Eligibles	Income Level	Asset Test	Comments
Individuals with HIV/AIDS	300% of FPL	No	Implementation pending State appropriation.

MAINE CARE MEDICARE BUY IN BENEFITS

Eligibles	Income Level	Asset Test	Comments
Individuals eligible for Medicare Part A	175% of FPL	Yes	Maine Care helps pay for Medicare Part B and/or co-insurance and deductibles depending on income.

MAINE CARE EYE CARE BENEFITS ONLY

Eligibles	Income Level	Asset Test	Comments
People with significant eye disorders that may lead to blindness if untreated or have corrected vision of 20/70 or worse in the better eye	80% or less of State's median income	No	All services must be prior authorized.

Notes on Services

- Subject to the limitations described in these Notes, in Exhibit 1, and in the Maine Medicaid Manual, MaineCare will pay for the health care services listed in **Exhibit 1**[1] if :
  1. They are medically necessary for the prevention, diagnosis or treatment of disease; and
  2. They are provided to a member who is eligible to receive the particular service; and
  3. They are provided by an appropriately licensed health care professional, agency or facility, acting within the scope of their professional, facility or agency license, which has entered into a provider agreement with the Department of Human Services (an, in some instances with the Department of Behavioral and Developmental Services)

- Not all covered services are automatically available to all Members from all eligible providers.
  1. An individual enrolled in Maine Prime Care will require a referral from his or her Primary Care Physician to access most medical specialists.
  2. An individual seeking long term care services, including nursing home services, residential care services, home health services, personal care attendent services and private duty nursing services must complete a medically necessity assessment conducted by an authorized agent of the Department of Human Services.
  3. Hospitals conduct an internal review of the need for inpatient hospital services and Member may be denied service if the internal review committee fails to approve inpatient care for the treatment of his or her condition.
  4. In order to access certain drugs, certain durable medical equipment and supplies and certain health care procedures, it is necessary to secure prior approval from the professional claims unit with the Bureau of Medical Services or the Bureau's authorized agent.
  5. In some cases, there are limits to the amount of services that an individual is otherwise eligible to access during a given time frame.
  6. Many long term care and certain other services are covered only if provided pursuant to an individual plan of care approved by a physician.
  7. Certain services are provided by individual practitioners, but also by hospitals, clinics, nursing homes and other types of facilities and agencies. A member may not be able to access the services he seeks at all facilities which provide those services. For example: Indian Health Centers are accessible only to Native Americans. Nursing homes generally provide physical and occupational therapy to their residents --- but not to the general public.

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[1] Title XIX of the Social Security Act does not require that states provide all of the services listed in Exhibit 1 to individuals in a state's Medicaid program. Only the following services are mandatory: Inpatient hospital, physician, children's dental, home health, nursing facility care.

8. A Member who has other insurance, in addition to Medicaid, may be required to access that insurance before he or she will be covered by Medicaid. To access that insurance, he or she will have to comply with the conditions which the insurance company places on receiving care. These may include seeking prior authorization from the insurer before receiving the care.
9. Certain - sometimes non-medical - services (so-called "waiver services") are available to an individual living in the community only if, but for the availability of these waiver services, he or she would require nursing home level care.
10. Few Maine Care services are available without the prior approval of a physician.
11. Certain individuals covered by Maine Care and Medicare receive, no covered services under Maine Care. Maine Care does, however pay their:
    - Medicare Part B Premiums
    - Medicare Part B C-Payments and deductibles. for individuals age 65 and older with incomes above 120% of the federal poverty level.
12. In some cases a member may be charged a nominal co-pay for the service. When an individual is responsible for a co-pay, the amount of the co-pay is deducted from the payment to the provider. However, an individual may not be denied medical services because, at the time service is required, he or she is unable to pay the amount due.[2] Unpaid co-pays do, however, remain an obligation of the member.

1. The following services require a nominal co-payment:
2. However, the following members are exempt from co-payments.

- Providers must accept as payment in full, the amount Maine Care pays. They are prohibited from charging members anything above the Maine Care fee even if the member is prepared to make an additional payment.
- Maine Care generally makes all payments for services directly to providers. No payments are made to Members.

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[2] Members accessing the Healthy Maine Prescription program, including the drugs for the elderly program within the Healthy Maine program. Likewise, MaineCare members living in a nursing home, who do not have a spouse living at home, must contribute all of their income towards payment of the costs of nursing home care, although they are allowed to retain $30 per month as a personal needs allowance.

Maine Care Benefits[1]	Exhibit 2							
						Medical[3,4]		
		Eligible	Service	Reimbursement	Member	Necessity	"Seeding"	
	Service Description	Members	Cap?[2]	Method	Payment	Determination	Agency[5]	
PHYSICIAN AND NURSING SERVICES								
Inpatient Services								
Hospital Inpatient	All inpatient services	All	no	cost settled	copay	PCP	DHS	
Outpatient Services								
Physician	Physician	All	no	fee for service	copay	member	DHS	
Hospital Outpatient	All outpatient services	All	no	fee for service	copay	PCP	DHS	
Federally Qualified Health Center	Comprehensive ambulatory care	In catchment area	no	cost settled	-	PCP	DHS	
Rural Health Clinic	Comprehensive ambulatory care	All	no	cost settled	-	PCP	DHS	
Indian Health Center	Comprehensive ambulatory care	Indians	no	federal rate	-	PCP	federal	
Ambulatory Surgical Center	Outpatient surgery	All	no	fee for service	-	PCP	DHS	
Family Planning Agency	Family planning and limited primary care	Primarily child bearing age	no	fee for service	-	member	DHS	
Ambulatory Care Clinics	Primary care	Varies by clinic type	no	varies by clinic type	-	member	various	
Advanced Practice Nursing	Independent nurses (midwives, CRNAs, etc.)	All	no	fee for service	-	PCP	DHS	
V.D. Screening Clinic	STD screening, treatment & followup	All	no	fee for service	-	member	DHS	
Case Management								
Primary Care Case Management	Managed care service coordination	Managed care members	no	monthly fee	-	automatic	DHS	
Disease Management	Care & drug mgmt for some chronic illnesses	Chronically ill	no	various	-	PCP	DHS	
LONG TERM CARE SVCS-ELDERS/DISAB								
Residential								
Nursing Facility	Nursing facility	All	no	cost settled	assessment	assessment	DHS	
Adult Family Care	Residential personal care	Adults	no	fee for service	assessment	assessment	DHS	
PNMI	Residential personal care	Adults	no	cost settled	assessment	assessment	DHS	
Community Based								
Home Health	Skilled nursing, CNAs,PT, OT, ST & med soc svcs.	All	no	fee for service	copay	assessment	DHS	
Private Duty Nursing and Personal Care	In home nursing & personal care	All	for adults	fee for service	copay	assessment	DHS	
Consumer Directed Attendant	Consumer directed personal care	Cognitively competent disabled	yes	fee for service	-	assessment	DHS	
Day Health	Adult day care	Adults	no	fee for service	-	assessment	DHS	
Waiver for the Physically Disabled	Consumer directed personal care	Cognitively competent disabled	yes	fee for service	assessment	assessment	DHS	
Waivers for the Elderly & Disabled	Comprehensive package of services	Elderly & disabled adults	yes	fee for service	assessment	assessment	DHS	
Hospice	Comprehensive end of life care	Terminally ill	no	bundled fee	-	PCP	DHS	
Case Management	Case management	Long term care needs		negotiated rate	-	assessment	DHS	
AUXILIARY SERVICES								
Pharmacy								
Full pharmacy benefit	All needed prescriptions drugs and some OTC	All	no	avg wholesale-10%	copay	PCP	DHS	
Healthy Maine Prescriptions	Discounted drugs	Under 300%, not full Maine Care	no	avg wholesale-10%	discount price	PCP	DHS	
Drugs for the Elderly	Drugs for some diseases, generic & catastrophic	Under 185% poverty, elders/disabled	yes	avg wholesale-10%	80% of MaineCare	PCP	DHS-all state	
Medical Supplies and Equipment								
Durable Medical Equipment & Supplies	Medical supplies and equipment	All	no	largely cost based	copay	PCP	DHS	
Prosthetics, Orthotics	Prosthetics and orthotics	All	no	cost based	copay	PCP	DHS	
Hearing Aids	Hearing aids	Children/NF residents	no	combination	copay	PCP	DHS	

Maine Care Benefits[1]	Exhibit 2							
		Eligible	Service	Reimbursement	Member	Medical[3,4] Necessity	"Seeding"	
	Service Description	Members	Cap?[2]	Method	Payment	Determination	Agency[5]	
Vision Services								
Opticians/Optometrists	Optician/Optometry	All	for adults	fee for service	copay	PCP	DHS	
Eyeglasses	Glasses	All	for adults	volume contract	-	optometrist	DHS	
Limited benefits - eye care only	Array of vision services	Sig. vision defect,<80% med. income	no	fee for service	-	all provider	DHS-all state	
Therapies								
Physical Therapy	Physical Therapy	All	no	fee for service	copay	PCP	DHS	
Occupational Therapy	Occupational Therapy	All	no	fee for service	copay	PCP	DHS	
Speech-Language Pathology	Speech-Language Therapy	All	no	fee for service	copay	PCP	DHS	
All therapies	Also by hosps, home health agcies	All	no	various	copay	PCP	DHS	
Other Health Professionals								
Dentists	Dental	All	for adults	fee for service	-	member	DHS	
Audiologists	Audiology	All	for adults	fee for service	-	PCP	DHS	
Chiropractors	Chiropractic		yes	fee for service	copay	PCP	DHS	
Podiatrists	Podiatric	All		fee for service	copay	PCP	DHS	
Other Services								
Laboratory	Laboratory	All	no	fee for service	copay	PCP	DHS	
Medical Imaging	X-rays, MRIs, sonograms, etc.	All	no	fee for service	copay	PCP	DHS	
TRANSPORTATION SERVICES								
Ambulance	Ambulance	All	no	fee for service	copay	member	DHS	
Transportation	Transportation to covered services	All	no	combination	-	member	DHS/DBDS	
MENTAL HEALTH								
Residential								
Psychiatric Hospitals	Psychiatric Hospitals	Children & elderly	no	cost settled	copay	provider	DHS/DBDS	
Private Non-Medical Institution	Res care for mentally ill	All	no	cost settled	assessment	PCP	DBDS	
NonResidential								
Mental Health Agencies	Comprehensive array of MH services	All	no	negotiated rate	copay	provider	DBDS	
Psychologists	Psychologists	All	no	fee for service	copay	provider	DHS	
Community Support	Comprehensive adult MH	Adults	no	negotiated rate	-	provider	DBDS	
Developmental and Behavioral Clinic	Developmental and Behavioral Clinic	Children	yes	fee for service	-	PCP	DHS	
Home Based Mental Health	Short term intensive mental health services	Children	duration	fee for service	-	provider	various	
Case Management	Case Management	Various target groups	no	negotiated rate	-	varies	DBDS	
Counseling Services	Provided by physicians, nurses, clinics	All	no	various	-	provider	DHS	
MENTAL RETARDATION								
Residential								
Intermediate Care Facility-MR	Residential care for mentally retarded	Mentally retarded	no	cost settled	-	assessment	DBDS	
Private Non-Medical Institution	Residential care for mentally retarded	Mentally retarded	no	cost settled	-	PCP	DBDS	

Maine Care Benefits[1]	Exhibit 2							
						Medical[3,4]		
		Eligible	Service	Reimbursement	Member	Necessity	"Seeding"	
	Service Description	Members	Cap?[2]	Method	Payment	Determination	Agency[5]	
NonResidential								
Day Habilitation for Children	in home supports	Children	no	cost based	-	BDS	DBDS	
Day Habilitation for Adults	structured day program	Adults	yes	cost settled	-	BDS	DBDS	
Waiver for Persons With Mental Retardation	Comprehensive service package, includes res care	Mentally retarded	yes	cost based	-	assessment	DBDS	
Case Management	Case management	Mentally retarded	no	negotiated rate	-	provider	DBDS	
SUBSTANCE ABUSE								
Residential								
Private Non-Medical Institution	Residential treatment programs for sub abusers	Substance abusers	no	cost settled	-	PCP	DBDS	
NonResidential								
Substance Abuse Treatment	Drug and alcohol abuse treatment	Substance abusers	no	fee for service	copay	provider	DBDS	
Case Management	Case management for substance abusers	Substance abusers	no	negotiated rate	-	provider	DBDS	
BRAIN INJURY								
Residential								
See PNMI & NF	Specialized residential programs	Brain injured	no	cost settled	-	PCP/assess.	DHS	
NonResidential								
Rehabilitation for Brain Injured	Bundled day services for brain injured	Brain injured	no	fee for service	-	provider	DHS	
SPECIAL NEEDS EDUCATION								
Day Treatment	Special needs alternative education	School age	no	negotiated rate	-	Schools	Schools	
School Based Rehabilitative	Spec. educ., inc PT, OT, ST, dev ther.	School age	no	bundled fee	-	school	Schools	
Early Intervention	Developmental & therapy services	Preschool	no	combination	-	PCP	DHS	
Case Management	Case management school age & preschool	Children	no	negotiated rate	-	CDS/Schools/BOH	various	
PROTECTIVE SERVICES								
Residential								
Private Non-Medical Institution	Therapeutic foster care	Special needs children in foster care	no	cost settled	-	BCFS	DHS	
Community Based								
Independent Social Worker	Child protective/adult protective	BCFS/BEAS clients	no	fee for service	-	BCFS/BEAS	DHS	
Case Management	Case management for adults and children	BCFS/BEAS clients	no	negotiated rate	-	BCFS/BEAS	DHS	
OTHER CASE MANAGEMENT SERVICES								
Juvenile justice	Case management	In juvenile justice system	no	negotiated rate	-	DOC	DOC	
Community-based health & mental health	Case management	Various	no	negotiated rate	-	various	various	

Notes:[1] Maine Care is a complex program, this chart is a general representation of the program. For further detail see Maine Care Benefits Manual http://www.state.me.us/sos/cec/rcn/apa/10/ch101.htm

[2]Limits may exist within policies, the "Cap" column only indicates an absolute overall cap.

[3]Specific services within a category of service may need prior authorization.

[4]PCPs are Primary Care Providers within the Maine Care primary care case management plan. This indicates a referral is necessary to get at least some services under this category, unless in some cases the provider may function as the member's PCP (e.g. clinics)

[5]In some instances, small portions of costs may be seeded by other agencies.

Exhibit 3

MaineCare (Medical Services)

DEPARTMENT OF HUMAN SERVICES
(SINGLE STATE AGENCY - MEDICAID TITLE XIX)
Kevin W. Concannon - Commissioner

Rudolph Naples, Deputy Commissioner, Finance Peter Walsh, Deputy Commissioner , Programs

BUREAU OF FAMILY INDEPENDENCE
Judy Williams - Director

Member Enrollment

Eligibility Determinations
Outreach

BUREAU OF MEDICAL SERVICES
Eugene I. Gessow - Director
Chris Zukas-Lessard - Deputy Director
Jim Lewis - Assistant Director

Financial Management Division - David S. Winslow, Acting Director

A. Financial Management

Claims Processing (Adjudication and Payment)
Provider Rates
Third Party Liability and Recovery
Estate Recovery
Pharmacy Rebate Assessment and Collection
Budget, Accounting, Financial Reporting and Financial Analysis

Policy and Programs Division - Marianne Ringel, Director

B. Policy

Policy Analysis
Regulations (Maine Medical Assistance Manual)
Regulations (Hospital Free Care)
Title XIX and Title XXI State Plans and Waivers

Provider Network

Provider Enrollment and Records
Provider Inquiry
Provider Education

Quality Improvement Division - Jude Walsh, Director

C. Professional Claims Review and Quality Management

Prior Authorization
Long Term Care - Eligibility Assessment for Children
Katie Becket - Eligibility Assessment

Surveillance and Utilization Review
Nursing Home and Residential Care - Case Mix Review
Bright Futures - Maine's Early, Periodic, Screening, Diagnosis, Treatment Program
Medical Director and Clinical Consultants (Dental and Psychiatric)

Pharmacy Benefits
Claims Processing
Prior Authorization
Maine Upper Payment Limit Pricing
Drug Utilization Review Committee
Healthy Maine Prescriptions (inc Drugs for the Elderly and Disabled)
Maine RX

MaineCare Managed Care (Maine Prime Care)
Member Enrollment
Provider Enrollment

Research and Resource Development Division - Mark Greenfield, Director

Research
Program Data Reporting and Analysis

D. Resource Development
Software Application Development
Employee Training and
HIPAA Compliance

BUREAU OF ELDER AND ADULT SERVICES
Christine Gianopolous - Director
Long Term Care
Policy - MaineCare Covered Services for the Elderly and Disabled
Assessments - Long Term Care

BUREAU OF CHILD AND FAMILY SERVICES
Karen Westburg - Director

Special Health Care Needs for Children In State Care
MaineCare Enrollment
MaineCare Covered Evaluation and Case Management Services

BUREAU OF HEALTH
Dora Anne Mills, MD, MPH - Director

Prevention Programs (Covered by MaineCare)
Early Periodic Screening, Diagnosis and Treatment

Administrative Hearings Unit

James Bivins - Director

Adminstrative Hearings

MaineCare Members
MaineCare Providers

Financial Services

Rudolph Naples - Deputy Commissioner

Provider Financial Audits

Hospitals, Nursing Facilities, Private Non-medical Institutions

Federal Financial Reporting

HCFA Form 64 - Medicaid and Title XXI Program Quarterly Expenditure Report

Information Services

Medicaid Management Information System - Operations

MeCMS (Maine Claims Management System) -Development & Operation
IMMPACT - Immunization Registry and EPSDT - Development and Operation
MEPOPs (Maine Pharmacy Claims Processing System) - Contract Management

Department of Behavorial and Developmental Services

Lynn Duby - Commissioner

MaineCare Behavorial and Developmental Health Services

Includes: Services to Adults in Institutes for Mental Diseases Which Are Covered Under the Federal Disproportionate Share Payment Program

Department of Education

Commissioner

School-based (Covered) Health Services

School-based Clinics
Rehabilitation Program Services Provided Pursuant to Individual Education Plan
Day Treatment Services Provided Pursuant to Individual Education Plan

Department of the Attorney General
Steven Rowe - Attorney General

Dori Harnett - Deputy Attorney General - Medicaid

Legal Representation & Counsel

Administrative Hearings
Courts

Notes on Services

State of Maine

10
Department of Human Services

2000-2001 Regulatory Agenda

AGENCY UMBRELLA-UNIT NUMBER: 10-144
AGENCY NAME: Department of Human Services, Bureau of Medical Services

CONTACT PERSON: Marianne Ringel, Director, Policy and Program Division, 11 State House Station, Augusta, ME 03333-0011, Tel. (207) 624-5518

EMERGENCY RULES ADOPTED SINCE THE LAST REGULATORY AGENDA: Ch. 101, Maine Medical Assistance Manual, Chapter III Section 22, Chapter II Section 65, Chapter 106 Maine Drugs for the Elderly Program,

EXPECTED 2001-2002 RULEMAKING ACTIVITY:

CHAPTER 101, MAINE MEDICAL ASSISTANCE MANUAL: Chapters I, II, III, IV, V, VI, VII, VIII and relevant Principles of Reimbursement
STATUTORY AUTHORITY: 22 M.R.S.A. § 42, § 3173
PURPOSE: These rules describe requirements for the provision and reimbursement of services under the Medicaid program. It also describes certain administrative functions necessary for the operation of the Medicaid Program. They will be amended to comply with federal changes, to update policy and to implement new services and regulations, as necessary.
ANTICIPATED SCHEDULE: It is not possible to predict when all of the changes will be made to these regulations because of the nature of this work. Federal regulation changes, state legislation, and state-initiated changes as a result of identified problems require the timely amendment or adoption of new rules over the course of the year.
AFFECTED PARTIES: Medicaid clients, Medicaid providers, and Managed Care Organizations

CHAPTER 112, REGULATIONS FOR THE LICENSURE OF GENERAL AND SPECIALTY HOSPITALS IN THE STATE OF MAINE
STATUTORY AUTHORITY 22 MRSA Chapter 1, §§ 3, 5, 6, 42, 1708-1711, 1715, 1811-1818, 1820-3, 1829, 1831.
PURPOSE: These rules govern the licensing and functioning of Hospitals.
ANTICIPATED SCHEDULE: Chapters VI, VIII, XI, XX, XXVIII will be revised in the next calendar year to reflect current standards of practice. Federal regulation changes, State legislation and State-initiated changes as a result of identified problems, require the timely amendment of adoption of new rules over the course of the year.
AFFECTED PARTIES: Hospital providers and consumers/patients

CHAPTER 120, REGULATIONS GOVERNING THE LICENSING AND FUNCTIONING OF HOSPICE PROGRAMS
STATUTORY AUTHORITY: 22 MRSA, Chapter 1681, §§ 8621-8631
PURPOSE: These regulations govern the licensing of hospices in the State of Maine. These regulations will be amended to comply with Federal changes, statutory changes and will reflect current health care standards or practices as needed.
ANTICIPATED SCHEDULE: Chapter 5G. will reflect a change in hours for direct care personnel who are not full time hospice employees. The regulations will be amended by January 2001 to comply with Federal changes, statutory changes, and reflect current health care standards or

practices as needed.
AFFECTED PARTIES: Hospices, consumers, and managed care organizations

CHAPTER 113, REGULATIONS FOR LICENSING AND FUNCTIONING OF ASSISTED LIVING FACILITIES
STATUTORY AUTHORITY: Title 22, Chapter 405, §§ 1812-C, 1812-G; Chapter 413, § 2053; Chapter 1453, § 5107-A; Chapter 1663, §§ 7801-7802; Chapter 1665, § 7901-A, 7901-B, 7901-C, 7902-A, 7903, 7904-A, 7904-B, 7914, 7915; Chapter 1666, § 7922; Title 32, Chapter 31, § 2102
PURPOSE: These rules govern the licensing and functioning of assisted living facilities.
ANTICIPATED SCHEDULE: These regulations will be amended to include a new Chapter V that will reflect licensing of Adult Family Care Homes. Other minor revisions to the existing regulations will be done at the same time. It is anticipated that the necessary changes will be made by November 2000.
AFFECTED PARTIES: Assisted living services providers and consumers

CHAPTER 121, REGULATIONS GOVERNING THE LICENSING OF ADULT FAMILY CARE HOMES
STATUTORY AUTHORITY: 22 MRSA
PURPOSE: These rules govern the licensing of Adult Family Care Homes.
ANTICIPATED SCHEDULE: It is anticipated that these rules will be added to the Regulations for the Licensing and functioning of Assisted Living Facilities. Necessary changes will be made by November 2000.
AFFECTED PARTIES: All current and prospective Adult Family Care Home providers and consumers

CHAPTER 117, REGULATIONS GOVERNING THE LICENSING OF ADULT DAY SERVICES PROGRAMS
STATUTORY AUTHORITY: Title 22, Chapter 958-A, §§ 3470-3487; Chapter 1505, §§ 6201-6209; Chapter 1663, §§ 7801-7804; Chapter 1665, § 5107-A; Chapter 1679, §§ 8601-8605
PURPOSE: These rules govern the licensing and functioning of Adult Day Services Programs.
ANTICIPATED SCHEDULE: It is anticipated that these regulations will be changed to allow Adult Day Services programs located in an Assisted Living Facility or a Nursing Facility to be surveyed and licensed as part of the whole facility's survey and license. The necessary changes will be made by November 2000.
AFFECTED PARTIES: All providers and consumers of Adult Day Services Programs

CHAPTER 119, REGULATIONS GOVERNING THE LICENSING AND FUNCTIONING OF HOME HEALTH CARE SERVICES
STATUTORY AUTHORITY: 22 M.R.S.A., § 2141 et seq.
PURPOSE: These regulations describe the minimum requirements for the licensing of home health agencies. It also functions as the standard of care for Maine's citizens in need of home health services. They will be amended to comply with Federal changes and to update standards of care as necessary.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to these regulations because of the nature of the work. Federal regulation changes, State legislature and State initiated changes as a result of identified problems, require the timely amendment or adoption of new rules over the course of the year.
AFFECTED PARTIES: Home health providers, consumers and managed care organizations

CHAPTER 110, REGULATIONS GOVERNING THE LICENSING OF NURSING FACILITIES

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-6
PURPOSE: This rule requires the Department of Human Services to amend its rules to provide for default licensing for new facilities when a new applicant has filed a completed application, and has not been provided the necessary notifications, inspections or services for a period of more

than 90 days.
ANTICIPATED SCHEDULE: These rules are expected to be in effect by January 1, 2001.
AFFECTED PARTIES: Nursing facility providers

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-11
PURPOSE: This rule requires the Department of Human Services to amend the rules for minimum staffing ratios in nursing facilities and to provide definitions of direct care providers and direct care.
ANTICIPATED SCHEDULE: It is expected that these rules will be effective in October, 2000
AFFECTED PARTIES: Nursing facility residents, and nursing facility providers

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-12
PURPOSE: This rule requires the Department of Human Services to amend its rules regarding the duration of licenses for providers of long term care services and the surveys required of those providers.
ANTICIPATED SCHEDULE: These rules are expected to be in effect by January 1, 2001.
AFFECTED PARTIES: Nursing Facility Providers

CHAPTER 106, MAINE'S DRUGS FOR THE ELDERLY PROGRAM

STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 254
PURPOSE: These rules govern the operation of Maine's State-funded drug program for certain eligible elderly individuals. They will be amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Elderly individuals found eligible for this program as well as pharmacies

STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 3174
PURPOSE: These rules will govern the operation of Maine's drug rebate program for Cub Care eligible children. They will be adopted and amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children eligible for Cub Care as well as pharmacies

CHAPTER 130, MAINE Rx PROGRAM
STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 603
PURPOSE: These rules govern the operation of Maine's State-run drug cost containment program. They will be adopted and amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Uninsured Maine residents as well as pharmacies

CHAPTER 107, MAINE EYE CARE PROGRAM
STATUTORY AUTHORITY: 22 M.R.S.A. § 42, § 3173
PURPOSE: These rules govern the operation of Maine's State-funded Eye Care Program. They will be amended to reflect administrative changes found necessary through monitoring of this program.

ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children and Adults not eligible for Medicaid for whom the State would reimburse certain eye care services as well as the providers of these services

CUB CARE
STATUTORY AUTHORITY: P.L. 99 Chapter 777
PURPOSE: These rules establish the Children's Health Insurance Program. They will be amended to reflect federal changes or administrative changes found necessary through monitoring this program in accordance with State statute.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children under the age of 19 found eligible for this program

Chapter 101:
Maine Medical Assistance Manual

Ch. I - General Administrative Policies and Procedures

Ch. II - Specific Policies By Service

Ch. II - Section 17: Community Support Services
Ch. II - Section 18: Home and Community-Based Waiver Services for Adults with Disabilities
Ch. II - Section 19: Home and Community Based Waiver Services for the Elderly
Ch. II - Section 21: Home and Community Based Waiver Services for Persons With Mental Retardation
Ch. II - Section 22: Home and Community Based Waiver Services for the Physically Disabled
Ch. II - Section 23: Developmental and Behavioral Clinic Services
Ch. II - Section 24: Day Habilitation Services for Persons with Mental Retardation
Ch. II - Section 25: Dental Services
Ch. II - Section 26: Day Health Services
Ch. II - Section 27: Early Intervention Services
Ch. II - Section 30: Family Planning Agency Services
Ch. II - Section 31: Federally Qualified Health Center Services
Ch. II - Section 35: Hearing Aids and Services
Ch. II - Section 37: Home Based Mental Health Services
Ch. II - Section 40: Home Health Services
Ch. II - Section 41: Day Treatment Services
Ch. II - Section 43: Hospice Services
Ch. II - Section 45: Hospital Services
Ch. II - Section 46: Psychiatric Facility Services
Ch. II - Section 50: ICF-MR Services
Ch. II - Section 55: Laboratory Services
Ch. II - Section 58: Licensed Clinical Social Worker Services
Ch. II - Section 60: Medical Supplies and Durable Medical Equipment
Ch. II - Section 62: Genetic Testing and Clinical Genetic Services
Ch. II - Section 65: Mental Health Services
Ch. II - Section 67: Nursing Facility Services
Ch. II - Section 68: Occupational Therapy Services
Ch. II - Section 70: Optician Services
Ch. II - Section 75: Optometry Services
Ch. II - Section 80: Pharmacy Services
Ch. II - Section 85: Physical Therapy Services
Ch. II - Section 90: Physician Services
Ch. II - Section 95: Podiatric Services
Ch. II - Section 96: Private Duty Nursing and Personal Care Services
Ch. II - Section 97: Private Non-Medical Institution Services
Ch. II - Section 100: Psychological Services
Ch. II - Section 101: Medical Imaging Services
Ch. II - Section 102: Rehabilitative Services
Ch. II - Section 103: Rural Health Clinic Services
Ch. II - Section 104: School Based Rehabilitative Services
Ch. II - Section 105: Speech and Hearing Agencies
Ch. II - Section 110: Speech-Language Pathology Services
Ch. II - Section 111: Substance Abuse Treatment Services

Ch. II - Section 113: Transportation Services
Ch. II - Section 150: V.D. Screening Clinic Services

Chapter III - Allowances for Services

Ch. III - Section 2: Adult Family Care Services
Ch. III - Section 3: Ambulatory Care Clinic Services
Ch. III - Section 4: Ambulatory Surgical Center Services
Ch. III - Section 5: Ambulance Services
Ch. III - Section 10: Audiology Services
Ch. III - Section 12: Consumer Directed Attendant Services
Ch. III - Section 13: Case Management Services

Ch. III - Section 14: Certified Family and Pediatric Nurse Practitioner Services
Ch. III - Section 15: Chiropractic Services
Ch. III - Section 17: Community Support Services
Ch. III - Section 18: Home and Community-Based Waiver Services for Adults with Disabilities
Ch. III - Section 19: Home and Community Based Waiver Services for the Elderly
Ch. III - Section 21: Home and Community Based Waiver Services for Persons with Mental Retardation
Ch. III - Section 22: Home and Community Based Waiver Services for the Physically Disabled
Ch. III - Section 23: Developmental and Behavioral Clinic Services
Ch. III - Section 24: Day Habilitation Services for Persons with Mental Retardation
Ch. III - Section 25: Dental Services
Ch. III - Section 26: Day Health Services
Ch. III - Section 27: Early Intervention Services
Ch. III - Section 28: Principles of Reimbursement for Early and Periodic Screening, Diagnosis, and Treatment Agency Services
Ch. III - Section 30: Family Planning Agency Services
Ch. III - Section 31: Federally Qualified Health Center Services
Ch. III - Section 35: Hearing Aids and Services
Ch. III - Section 37: Home Based Mental Health Services
Ch. III - Section 40: Home Health Services
Ch. III - Section 41: Day Treatment Services
Ch. III - Section 43: Hospice Services
Ch. III - Section 45: Hospital Services
Ch. III - Section 46: Psychiatric Facility Services
Ch. III - Section 50: Principles of Reimbursement for Intermediate Care Facilities for the Mentally Retarded
Ch. III - Section 58: Licensed Clinical Social Worker Services
Ch. III - Section 60: Medical Supplies and Durable Medical Equipment
Ch. III - Section 62: Genetic Testing and Clinical Genetic Services
Ch. III - Section 65: Mental Health Clinic Services
Ch. III - Section 67: Principles of Reimbursement for Nursing Facilities

Ch. III - Section 68: Occupational Therapy Services
Ch. III - Section 70: Optician Services
Ch. III - Section 75: Optometry Services
Ch. III - Section 85: Physical Therapy Services
Ch. III - Section 90: Physician Services
Ch. III - Section 95: Podiatric Services
Ch. III - Section 96: Private Duty Nursing and Personal Care Services

Ch. III - Section 97: Private Non-Medical Institution Services

Appendix A: Cost Report for Private Non-Medical Institutions (PNMI)
Appendix B: Principles of Reimbursement for Substance Abuse Treatment
Appendix C: Principles of Reimbursement for Medical and Remedial Service Facilities
Appendix D: Principles of Reimbursement for Child Care Facilities
Appendix E: Principles of Reimbursement for Community Residences for Persons with Mental Illness
Appendix F: Principles of Reimbursement for Community Residences for Persons with Mental Retardation

Ch. III - Section 100: Psychological Services
Ch. III - Section 102: Rehabilitative Services
Ch. III - Section 103: Rural Health Clinic Services
Ch. III - Section 104: School Based Rehabilitative Services
Ch. III - Section 105: Speech and Hearing Agencies
Ch. III - Section 110: Speech-Language Pathology Services
Ch. III - Section 111: Substance Abuse Treatment Services
Ch. III - Section 113: Transportation Services
Ch. III - Section 150: V.D. Screening Clinic Services

Chapter IV

Ch. IV - Section 1: Recipient Restriction Program

Chapter V

Ch. V - Section 2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Chapter VI

Ch. VI - Section 1: Primary Care Case Management
Ch. VI - Section 2: Mandatory Managed Care Initiative
Ch. VI - Section 3: MaineNET

Chapter VII

Ch. VII - Section 2: Medicaid Managed Care Initiative
Ch. VII - Section 5: Estate Recovery

Chapter VIII - Maine Children's Health Insurance Program

Ch. VIII - Section 1: Cub Care
Ch. VIII - Section 2: Health Insurance Purchase Option

Chapter IX

Ch. IX - Section 1: Healthy Maine Prescriptions
Ch. IX - Section 2: Maine Drugs for the Elderly Program

BUREAU OF MEDICAL SERVICES
PROGRAM EVALUATION REPORT

Program Title: **Certificate of Need**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

22 MRSA c.103, {301 et.seq.}
See attachment A

There are no federal laws governing Certificate of Need

B. A description of each program including: goals and objectives, performance measures, an evaluation of performance and future plans.

The Certificate of Need program is established to support effective health planning by requiring healthcare facility construction and modifications, as well as new services or technology to be measured by criteria that factor in the costs to state and local health expenditures. The Certificate of Need program limits duplication of services while ensuring access to cost effective quality services. Certificate of Need staff forward a complete record and recommendation to the Commissioner of Human Services for the final agency action.

Goals/Objectives/Measures/Performance/Corrective Action

Goal 1 : Support Effective health planning

Strategy:

- Assess the need of the proposal.
- Research current health planning with related state agencies.
- Review state and national documented standard(s).

Performance measure:

- Affirmation by pertinent state agency of staff recommendation.

Goal 2 : Avoid Excessive duplication

Strategy:

- Compare new proposals to what is currently available for services and technology in a designated service area.
- Utilize a competitive review process.

Performance measure:

- Determine recommendation by measuring national standards for service/technology and numbers per population base.

Goal 3 : Access to cost effective quality services:

Strategy:

- Evaluate proposals on their financial impact to the healthcare system.
- Provide all documentation from applications to third party payors within the state.
- Approved proposals must utilize outside quality assurance programs.

Performance measure:

- Measure charges and reimbursement pre and post CON approval.
- Receive quarterly documentation from outside quality assurance programs.

1. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives.**

The Certificate of Need Unit provides the Commissioner with a detailed analysis and recommendations that meet all statutory requirements. The Certificate of Need statute also allows a party to ask for the reconsideration of a decision if the party feels that the decision was in error. During the last five years, no decisions have required a full reconsideration.

2. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   All goals and objectives met.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines or responsibility;**

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Department is in compliance with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years;

The total budget for the Certificate of Need Unit is $160,067 and has remained relatively stable for the last 10 years. The Certificate of Need Unit has three FTE.

F. When applicable, the regulatory agenda and the summary of rules adopted;

See Attachment B

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements;

The Certificate of Need Unit coordinates closely with the Department of Professional and Financial Regulation and the Bureau of Insurance to make sure that all policies and procedures are consistent across all three regulatory agencies. The Director of the Bureau of Medical Services and the Commissioner of Human Services also sit on the Healthcare Sub-Cabinet and coordinate closely with other state agencies at those meetings.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes;

The constituencies served by the Certificate of Need Unit include:

Healthcare providers required to obtain Certificates of Need
Third Party Payors, including HMO's and Health Insurance Carriers
Healthcare consumers

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives;

The Certificate of Need Unit has recently relied on private consulting firms to gather data on emerging technologies. Healthcare technology is progressing so quickly that there is often not enough expertise within the state to gather the relevant data and it becomes necessary to employ consultants. This is a trend that will likely continue into the future.

J. **Identification of emerging issues for the agency or program in the coming years;**

See Attachment C
Governor King has submitted *L.D. 1799, An Act to Strengthen the Certificate of Need Law*, that will modernize the Certificate of Need process and streamline it for both applicants and the Department Of Human Services.

K. **Any other information specifically requested by the committee of jurisdiction;**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and**

There are no Federal Laws governing the Certificate of Need Program.

M. **Agency policies for collecting, managing and using personal information over the internet and non-electronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

See Department of Human Service's Department-wide Policy.

A

MAINE CERTIFICATE OF NEED ACT

(As Amended)

UPDATED May 1998
(22 MRSA c. 103, {301 et seq.})

THIS DOCUMENT REPRESENTS A CONSOLIDATION OF SEVERAL SEPARATE ACTS AFFECTING THE ORIGINAL MAINE CERTIFICATE OF NEED ACT OF 1978 AND HAS BEEN TYPED IN THIS FORM TO MAKE READING OF THE FULL RANGE OF PROVISIONS MORE CONVENIENT.

To the best of our knowledge and ability,
this document is accurate and complete.

EDITING NOTE: Material in brackets ([]) represents corrections of apparent typographical errors or errors in updating specific sections of the Act.

EFFECTIVE DATE/ORIGINAL CON ACT:	APPROVED	CHAPTER
March 30, 1978	March 30, 1978 By Governor	687 Public Law

(INCLUDES ALL AMENDMENTS ENACTED THROUGH MAY 1998)
Integrated in Proper Sequence

Prepared by the Bureau of Medical Services' Analysis and Development Unit
Maine Department of Human Services
35 Anthony Avenue. State House Station #11
Augusta, Maine 04333

STATE OF MAINE

In the Year of Our Lord Nineteen Hundred Seventy-Eight

S.P. 652 L.D. 2013

AN ACT Relating to Certificate of Need.

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

Whereas, the National Health Planning Act of 1974 and its accompanying regulations require the State to implement a certificate of need program by July 1, 1978, or be subject to the loss of federal funds for health planning as well as other purposes; and

Whereas, this bill may not become effective until after July 1, 1978, if it is not enacted as an emergency; and

Whereas, the loss of federal funds might severely restrict the state's efforts in health planning; and

Whereas, in the judgement 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:

Sec. 1. 22 MRSA c. 103, is enacted to read:

CHAPTER 103

CERTIFICATE OF NEED

Section 301. Short title

This chapter may be cited as the "Maine Certificate of Need Act of 1978."

Section 302. Declaration of findings and purposes

1. **Findings.** The Legislature finds that unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services.

2. **Purposes.** The purposes of this chapter are to:

   A. Support effective health planning;

   B. Support the provision of quality health care in a manner that ensures access to cost-effective services;

   C-1. Support reasonable choice in health care services while avoiding excessive duplication;

   D. Ensure that state funds are used prudently in the provision of health care services;

   F. Ensure public participation in the process of determining the array, distribution, quantity, quality and cost of these services;

   H. Improve the availability of health care services throughout the State;

   I. Support the development and availability of health care services regardless of the consumer's ability to pay; and

   J. Seek a balance, to the extent a balance assists in achieving the purposes of this subsection, between competition and regulation in the provision of health care.

Section 303. Definitions

As used in this chapter, unless the context otherwise indicates, the following words and phrases shall have the following meanings.

1. **Ambulatory surgical facility.** "Ambulatory surgical facility" means a facility, not part of a hospital, which provides surgical treatment to patients not requiring hospitalization. This term does not include the offices of private physicians or dentists, whether in individual or group practice.

2. **Repealed.**

2-A. **Annual operating costs.** For purposes of section 304-A, subsection 4, paragraph B, "annual operating costs" means the total incremental costs to the institution which are directly attributable to the addition of a new health service.

2-B. **Appropriately capitalized expenditures.** "Appropriately capitalized expenditures" means those expenditures which would be capitalized if the project were implemented.

3. **Capital expenditure.** "Capital expenditure" means an expenditure, including a force account expenditure or predevelopment activities, which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance and, for the purposes of this chapter, shall include capitalized interest on borrowed funds and the fair market value of any property or equipment which is acquired under lease or comparable arrangement or by donation.

4. **Construction.** "Construction," when used in connection with "health care facility," means the establishment, erection, building, purchase or other acquisition of a health care facility.

5. **Department.** "Department" means the Department of Human Services, but does not include the Certificate of Need Advisory Committee.

6. **Development.** "Development," when used in connection with "health service," means the undertaking of those activities which on their completion will result in the offering of a new health service to the public.

6-A. **Expenditure minimum for annual operating costs.** The "expenditure minimum for annual operating costs" is, for services commenced after October 1, 1998, $350,000 for the 3rd fiscal year, including a partial first year, as adjusted pursuant to section 305-A.

6-B. **Generally accepted accounting principles.** "Generally accepted accounting principles" means accounting principles approved by the American Institute of Certified Public Accountants.

7. **Health care facility.** "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including free-standing hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center or cancer treatment center. The term does not include the office of a private physician or physicians, dentist or dentists, whether in individual or group practice.

8. **Health maintenance organization.** "Health maintenance organization" means a public or private organization that:

A. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health services: Usual

physician services, hospitalization, laboratory, x-ray, emergency and preventive health services and out-of-area coverage;

B. Is compensated, except for copayments, for the provision of the basic health services to enrolled participants on a predetermined periodic rate basis; and

C. Provides physicians' services primarily through physicians who are either employees or partners of the organization or through arrangements with individual physicians or one or more groups of physicians.

9. **Health services.** "Health services" means clinically related services that are diagnostic, treatment, rehabilitative services or nursing services provided by a nursing facility and includes alcohol, drug abuse and mental health services.

10. **Repealed.**

11. **Repealed.**

11-A. **Repealed April 11, 1996**

11-B. **Hospital.** "Hospital" means an institution which primarily provides to inpatients by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons or rehabilitation services for the rehabilitation of injured, disable or sick persons. This term also includes psychiatric and tuberculosis hospitals.

11.C **Hospital swing bed.** "Hospital swing bed" means acute care beds licensed by the Division of Licensure and Certification, Bureau of Medical Services for use also as nursing care beds. Swing beds may be established only in rural hospitals with fewer than 100 licensed acute care beds.

12. **Repealed April 11, 1996.**

12-A. **Major medical equipment.** "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions used to provide medical and other health services and that costs $1,000,000 or more. This term does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services, if the clinical laboratory is independent of a physician's office and a hospital and has been determined under the United States Social Security Act, Title XVIII, to meet the requirements of Section 1861(s), paragraphs 10 and 11 of that Act. In determining whether medical equipment costs more than $1,000,000, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment must be included. If the

equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

12-B. **Nursing facility.** "Nursing facility" means any facility defined under section 1812-A.

13. **Modification.** "Modification" means the alteration, improvement, expansion, extension, renovation or replacement of a health care facility or health maintenance organization or portion thereof, including initial equipment thereof and the replacement of equipment or existing buildings.

13-A. **Obligation.** An "obligation" for a capital expenditure is considered to be incurred by or on behalf of a health care facility:

A. when a contract, enforceable under Maine law, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset;

B. when the governing board of the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or

C. in the case of donated property, on the date on which the gift is completed under applicable Maine law.

14. **Offer.** "Offer," when used in connection with "health services," means that the health care facility or health maintenance organization holds itself out as capable of providing or having the means to provide a health service.

15. **Person.** "Person" means an individual, trust or estate, partnership, corporation, including associations, joint stock companies and insurance companies, the State or a political subdivision or instrumentality, including a municipal corporation of the State, or any other legal entity recognized by state law.

16. **Predevelopment activities.** "Predevelopment activities" means any appropriately capitalized expenditure by or on behalf of a health care facility made in preparation for the offering or development of a new health service for which a certificate of need would be required and arrangements or commitments made for financing the offering or development of the new health service; and shall include site acquisitions, surveys, studies, expenditures for architectural designs, plans, working drawings and specifications.

17. **Project.** "Project" means any acquisition, capital expenditure, new health service or change in a health service, predevelopment activity or other activity that requires a certificate of need under section 304-A.

17-A. **Rehabilitation facility.** "Rehabilitation facility" means an inpatient facility which is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical and other services which are provided under competent professional supervision.

17-B. **Replacement equipment.** "Replacement equipment" means a piece of capital equipment that replaces another piece of capital equipment that performs essentially the same functions as the replaced equipment.

18. **Repealed**

19. **Repealed**

20. **Repealed.**

21. **Repealed.**

22. **Repealed.**

Section 304. Repealed.

Section 304-A. Certificate of need required

No person may enter into any commitment for financing a project that requires a certificate of need or incur an expenditure for the project without having sought and received a certificate of need, except that this prohibition does not apply to obligations for financing conditioned upon the receipt of a certificate of need or to obligations for predevelopment activities.

Except as provided in section 304-E, a certificate of need from the department is required for:

1. **Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control.** Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase; except in emergencies when that acquisition of control is at the direction of the department;

2. **Acquisitions of certain major medical equipment.** Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more, as adjusted pursuant to section 305-A. The use of major medical equipment on a temporary basis in the case of a natural disaster, major accident or equipment failure and the use of replacement equipment does not require a certificate of need;

3. **Capital expenditures.** Except as provided in subsection 8-A, the obligation by or on behalf of a health care facility of any capital expenditure of $2,000,000 or more, as adjusted pursuant to section 305-A. Capital expenditures in the case of a natural disaster, major accident or equipment failure, for replacement equipment or for parking lots and garages, information and communications systems and physician office space do not require a certificate of need;

4. **New health services.** The offering or development of any new health service. For purposes of this section, "new health service" includes only the following:

   A. The obligation of any capital expenditures by or on behalf of a health care facility of $100,000 or more, as adjusted pursuant to section 305-A, that is associated with the addition of a health service that was not offered on a regular basis by or on behalf of the facility within the 12-month period prior to the time the services would be offered;

   B. The addition of a health service that is to be offered by or on behalf of a health care facility that was not offered on a regular basis by or on behalf of the facility within the 12-month period prior to the time the services would be offered, and that, for the 3rd fiscal year of operation, including a partial first year, following addition of that service is projected to entail annual operating costs of at least $350,000 as adjusted pursuant to section 305-A.

C. A certificate of need is not required for a health care facility that extends a current service within the defined primary service area of the facility by purchasing within a 12-month time period new equipment costing in the aggregate less than $1,000,000, as adjusted pursuant to section 305-A;

5. **Repealed**

6. **Changes in bed complement.** Any increase in the existing licensed bed complement or any increase in the licensed bed category of a health care facility;

7. Repealed

8. Repealed

8-A. **Nursing facilities.** The obligation by a nursing facility, when related to nursing services provided by the nursing facility, of any capital expenditures of $500,000 or more, as adjusted pursuant to section 305-A.

A certificate of need is not required for a nursing facility to convert beds used for the provision of nursing services to beds to be used for the provision of residential care services. If such a conversion occurs, public funds are not obligated for payment of services provided in the converted beds; and

9. **Other circumstances.** In the following circumstances:

   A. Any proposed use of major medical equipment to serve inpatients of a hospital, if the equipment is not located in a health care facility and was acquired without a certificate of need, except acquisitions exempt from review under subsection 2 or 3; or

   B. If a person adds a health service not subject to review under subsection 4, paragraph A and not deemed subject to review under subsection 4, paragraph B at the time it was established and not reviewed and approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost, as adjusted by an appropriate inflation deflator promulgated by the department exceeds the expenditure minimum for annual operating cost in the 3rd fiscal year of operation following addition of these services.

Section 304-B. Subsequent review

Where a certificate of need has been issued, and changes occur as specified in this section, a subsequent review is required.

1. **Criteria for subsequent review**. The following activities require subsequent review and approval, if the department has previously issued a certificate of need and if within 3 years after the approved activity is undertaken:

   A. There is a significant change in financing;

   B. There is a change affecting the licensed or certified bed capacity as approved in the certificate of need;

   C. There is a change involving the addition or termination of the health services proposed to be rendered;

   D. There is a change in the site or the location of the proposed facility; or

   E. There is a substantial change proposed in the design of the facility or the type of construction.

2. **Procedures for subsequent review.** Any person proposing to undertake any activity requiring subsequent review and approval shall file with the department, within 30 days of the time that person first has actual knowledge of the circumstances requiring subsequent review, a notice setting forth the following information:

   A. The nature of the proposed change;

B. The rationale for the change including, where appropriate, an explanation of why the change was not set forth in the original application or letter of intent; and

C. Other pertinent detail subject to the procedures and criteria set forth in section 309.

The department shall, within 30 days of receipt of the information, advise that person in writing whether the proposed change is approved. If not approved, the application shall be treated as incomplete and reviewed in accordance with the application procedures in section 306-A, subsection 4. If approved, the department shall amend the certificate of need as appropriate.

Section 304-C. Repealed.
Section 304-D Repealed.
Section 304-E. Waiver of certificate of need review when review is unnecessary and serves no public purpose

1. **Request for waiver.** An applicant for a project requiring a certificate of need-may request a waiver of the review requirements under this chapter. The applicant shall submit, with the request, sufficient written documentation to demonstrate that the proposed project meets the conditions of this section and that sufficient public notice of the proposed waiver has been given.

2. **Public notice**. The applicant shall give public notice, on a form provided by the department, of its intention to seek a waiver of full review. This notice shall be given in the Kennebec Journal and in a daily newspaper of general circulation in the applicant's service area. The public shall be given 10 days from the date of publication within which to submit to the department any comments concerning the proposed waiver of review.

3. **Criteria for waiver.** The department may waive the requirement for a full certificate of need review of a project, if the department finds that the waiver, rather than full review, would best further the purposes of the Maine Certificate of Need Act, as set forth in section 302, subsection 2. When making this determination, the department shall consider a number of factors including, but not limited to:

   A. Whether the proposed project would incur no or minimal additional expense to the public or to the health care facility's clients;

   B. Whether the proposed project is or will be in compliance with other state and local laws and regulations;

   C. Whether the proposed project primarily involves the maintenance of a health care facility as is; and

D. Whether the health and welfare of any person the health care facility is already serving will be significantly adversely affected if a waiver is not granted.

4. **Other action by department.** If the department finds that the proposal is not clearly eligible for a waiver of the review requirements, it may elect to conduct an emergency review, a simplified review pursuant to Section 308, subsection 1, or a full review.

5. **Notification of decision**. The department shall notify the applicant of its decision in writing as soon as it determines whether to grant or deny the request for a waiver or decides to conduct a different review in accordance with subsection 4. The notice shall include a brief summary of the reasons for the department's decision.

6. **Report to legislature.** The department shall submit an annual report to the joint standing committee of the Legislature having jurisdiction over health and human services matters on the implementation and operation of this section no later than February 15th of each year.

Section 304-F. Procedures after voluntary nursing facility reductions

1. **Procedures.** A nursing facility that voluntarily reduces the number of its licensed beds for any reason except to create private rooms may convert the beds back and thereby increase the number of nursing facility beds to no more than the previously licensed number of nursing facility beds, after obtaining a certificate of need in accordance with this section, provided the facility has been in continuous operation and has not been purchased or leased. To convert beds back to nursing facility beds under this subsection, the nursing facility must:

   A. Give notice of its intent to preserve conversion options to the department no later than 30 days after the effective date of the license reduction; and

   B. Obtain a certificate of need to convert beds back under section 309, except that if no construction is required for the conversion of beds back, the application must be processed in accordance with subsection 2.

2. **Expedited review.** Except as provided in subsection 1, paragraph B, an application for a certificate of need to reopen beds reserved in accordance with this section must be processed on an expedited basis in accordance with rules adopted by the department providing for shortened review time and for a public hearing if requested by a directly affected person. The department shall consider and decide upon these applications as follows:

   A. Review of applications that meet the requirements of this section must be based on the requirements of section 309, subsection 1, except that the determinations required by section 309, subsection 1, paragraph B must be based on the historical costs of operating the beds and must consider whether the projected

costs are consistent with the costs of the beds prior to closure, adjusted for inflation; and

B. Conversion of beds back under this section must be requested within 4 years of the effective date of the license reduction. For good cause shown, the department may extend the 4-year period for conversion for one additional 4-year period.

3. **Effect on other review proceedings.** Nursing facility beds that have been voluntarily reduced under this section must be counted as available nursing facility beds for the purpose of evaluating need under section 309 so long as the facility retains the ability to convert them back to nursing facility use under the terms of this section, unless the facility indicates, in response to an inquiry from the department in connection with an ongoing project review, that it is unwilling to convert them to meet a need identified in that project review.

4. **Rulemaking.** Rules adopted pursuant to this section are major substantive rules as defined by Title 5, chapter 375, subchapter II-A.

Section 304-G. Nursing facility projects

Nursing facility projects that propose to add new nursing facility beds to the inventory of nursing facility beds within the State may be grouped for competitive review purposes consistent with appropriations made available for that purpose by the Legislature. A nursing facility project that proposes renovation, replacement or other actions that will increase Medicaid costs may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs, except that the department may approve, without a prior appropriation for the express purpose, projects to reopen beds previously reserved by a nursing facility through a voluntary reduction pursuant to section 304-F, if the annual total of reopened beds approved does not exceed 100.

Section 305-A. Annual proposal to adjust for inflation

By December 1st annually, the department shall submit to the joint standing committee of the Legislature having jurisdiction over health and human services matters proposed legislation to adjust the monetary figures contained in this chapter to reflect changes in the Consumer Price Index medical index.

Section 306. Repealed.

Section 306-A. Application Process for a Certificate of Need

1. **Letter of intent.** Prior to filing an application for a certificate of need, an applicant shall file a letter of intent with the department. The letter of intent shall form the basis for determining the applicability of this chapter to the proposed expenditure or action.

A letter of intent shall be deemed withdrawn one year after receipt by the department, unless sooner superseded by an application; provided that the applicant shall not be precluded from resubmitting the same letter of intent.

2. **Application filed.** Upon a determination by the department that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need shall be filed with the department if the applicant wishes to proceed with the project. Prior to filing a formal application for a certificate of need, the applicant is required to meet with the department staff in order to assist the department in understanding the application and to receive technical assistance concerning the nature, extent and format of the documentary evidence, statistical data and financial data required for the department to evaluate the proposal. The department shall not accept an application for review until the applicant has satisfied this technical assistance requirement unless waived in writing by both parties. The technical assistance meeting shall take place within 30 days subsequent to receipt of the letter of intent, unless waived in writing by both parties.

3. **Additional information required.** Additional information may be required or requested as follows.

   A. If, after receipt of an application, the department determines that additional information is necessary before the application can be considered complete, the department may:

      (1) Require the applicant to respond to one set of requests for additional information from the department. Applicants must submit additional information requested by the department within 30 business days or within a longer period of time, provided that the department and the applicant agree; and

      (2) Request, but not require, the applicant to respond to additional sets of requests for information, provided that each request is directly related to the last request or to the information provided in response to the last request.

   B. Repealed.

   C. Within 15 business days after the filing of an application or response to any information request, whichever is applicable, with the department, the department shall notify the applicant in writing that:

      (1) The application contains all necessary information required and is complete; or

      (2) Additional information is required by the department. If, after receipt of the applicant's response to the first or any subsequent request, the

department determines that additional information is required, the notification shall also include a statement of the basis and rationale for that determination.

4. **Review of incomplete application.** Upon receipt of the 2nd or any subsequent notice described in subsection 3, paragraph C, subparagraph 2, the applicant must notify the department in writing that:

   A. It will provide the additional information requested by the department. Following completion, it shall be entered into the next review cycle; or

   B. That it is not able to or does not intend to provide the information requested and requests the application be entered into the next appropriate review cycle. In that case the applicant shall be prohibited from submitting the information it had declined to provide into the record after the 25th day of the review cycle and the information shall not be considered in the determination to issue or to deny a certificate of need. If the applicant provides the information requested prior to the 25th day of the review cycle, the application may, at the discretion of the department, be returned to the beginning of the review cycle. Failure to submit additional information requested by the department may result in an unfavorable recommendation and may result in subsequent denial of the application by the department, as long as the denial is related to applicable criteria and standards.

5. **Competitive reviews.** In cases of competitive reviews, applicants shall submit additional information requested by the department within 30 business days or within a longer period of time, provided that the department and all competing applicants agree.

5-A. **Public informational meeting**. Within 30 days of the filing of an application, the department shall advertise and conduct in a location convenient to the proposal location a public informational meeting at which the applicant shall present information about the proposal.

6. **Automatic withdrawal.** Any incomplete application is considered withdrawn if the applicant fails to respond to a request for additional required information within 180 days of the date the request was forwarded by the department.

7. **Voluntary withdrawal of application.** During the review period, prior to the date that staff submit a final report to the commissioner, an applicant may withdraw an application without prejudice. Written notice of the withdrawal must be submitted to the department. A withdrawn application may be resubmitted at a later date, as a new application, requiring a new letter of intent and new filing fees, docketing and review.

8. **Filing fee.** A nonrefundable filing fee must be paid at the time an application is filed with the department.

A. The department shall establish minimum and maximum filing fees, pursuant to section 312, to be paid per application.

B. If the approved capital expenditure or operating cost upon which the fees were based is higher than the initially proposed capital expenditure, then the filing fee must be recalculated and the difference in fees, if any, must be paid before the certificate of need may be issued.

C. Rules adopted pursuant to this subsection are routine technical rules as defined by Title 5, chapter 375, subchapter II-A.

306-B. Certificate of Need Advisory Committee

The Certificate of Need Advisory Committee, established by Title 5, section 12004-I, subsection 38 and referred to in this section as the "committee," shall participate with the department in the public hearing process under section 307, subsection 2-B.

1. Appointment. The members of the Certificate of Need Advisory Committee are appointed according to this subsection.

A. The committee is composed of 10 members, 9 of whom are appointed by the Governor. The commissioner shall name a person employed by the department as the commissioner's designee to serve as an ex officio, nonvoting member of the committee. The 9 members appointed by the Governor must be selected in accordance with the following requirements.

(1) Four members must be appointed as follows:

(a) One member must represent the hospitals;

(b) One member must represent the nursing home industry;

(c) One member must represent major 3rd-party payors; and

(d) One member must represent providers.

In appointing these representatives, the Governor shall consider recommendations made by the Maine Hospital Association, the Maine Health Care Association, the Maine Medical Association, the Maine Osteopathic Association and other representative organizations.

(2) Five public members must be appointed as consumers of health care. One of these members must be designated on an annual basis by the Governor as chair of the committee. Neither the public members nor their spouses or children may, within 12 months preceding the appointment, have been affiliated with, employed by or have had any professional

affiliation with any health care facility or institution or nursing facility, health product manufacturer or corporation or insurer providing coverage for hospital or medical care; however, neither membership in or subscription to a service plan maintained by a nonprofit hospital and medical service organization, nor enrollment in a health maintenance organization, nor membership as a policy holder in a mutual insurer or coverage under such a policy, nor the purchase of or coverage under a policy issued by a stock insurer may disqualify a person from serving as a public member.

B. Appointed members of the committee serve for terms of 4 years. Members are limited to 2 4-year terms.

C. Vacancies among appointed members must be filled by appointment by the Governor for the unexpired term. A vacancy in the office of the chair must be filled by the Governor, who shall designate a new chair for the balance of the member's term as chair. The Governor may remove any appointed member who becomes disqualified by virtue of the requirements of paragraph A or for neglect of any duty required by law or incompetency or dishonorable conduct.

D. Each appointed member of the committee is entitled to compensation according to Title 5, chapter 379.

E. Five members of the committee constitute a quorum. Actions of the committee must be by majority vote.

2. Duties. The committee shall perform the following duties:

A. Review proposed rules, criteria, standards and procedures for the certificate of need process and the state health plan prior to their adoption, review the annual certificate of need report prepared by the department and advise the commissioner with regard to certificate of need; and

B. Conduct the public hearing required under section 307, subsection 2-B.

Section 307. Review process

1. Notice. Upon determination that an application is complete, or upon receipt of a notice under section 306-A, subsection 4, paragraph B, or upon grouping of the application with other pending applications, the department shall provide for written notification of the beginning of a review. Public notice shall be given by publication in the Kennebec Journal and in a newspaper of general circulation in the area in which the proposed expenditure or other action will occur. The notice shall be provided to all persons who have requested notification by means of asking that their names be placed on a mailing list maintained by the department for this purpose. This notice shall include:

A. A brief description of the proposed expenditure or other action;

B. The proposed schedule for the review;

C. A statement that a public hearing will be held during the course of a review if requested by persons directly affected by the review and the date by which the requests must be received by the department;

D. A description of the manner in which public notice will be given of a public hearing if one is to be held during the course of the review; and

E. A statement of the manner and time in which persons may register as affected persons.

2. Repealed.

2-B. Public hearing. A public hearing shall be held during the course of a review by the Certificate of Need Advisory Committee if requested by persons directly affected by the review pursuant to subsection 1. Nothing in this section may be construed to prevent the department from holding informational meetings with applicants and interested and affected persons prior to the conduct of the hearing. In the event no hearing has been requested prior to an informational meeting or receipt of the preliminary staff report, the applicant or any directly affected persons may request a hearing within 10 days of either circumstance, provided that the review period shall be extended by 60 days if such a hearing is requested. In the case of grouped applications, the extension shall apply to all competing applications.

A. The committee or agency shall provide notice of its hearings in accordance with the procedure described in subsection 1.

B. Findings, recommendations, reports, analyses, and related documents prepared by the staff of the agency shall be in final form and be made available to affected persons at least 5 business days prior to its hearings. The department shall make its preliminary staff report available to the committee and affected persons at least 5 business days prior to a public hearing conducted by the committee.

C. In a hearing conducted by the committee, any person shall have the right to be represented by counsel or to present oral or written arguments and evidence relevant to the matter which is the subject of the hearing. Any person directly affected by the matter may conduct reasonable questioning of persons who make relevant factual allegations.

D. The chair serves as a voting presiding officer and, in consultation with the members of the committee, shall rule on the relevance of argument and evidence and make determinations as to reasonable questioning. The department's

administrative hearing unit shall provide technical support to the committee for the conducting of hearings as necessary. Members of the committee may conduct reasonable questioning in the course of a hearing.

E. The department or agency shall record all hearings and any subsequent proceedings of the committee with respect to the application in a form susceptible to transcription. The department shall transcribe the recording when necessary for the prosecution of an appeal.

F. During the first 7 business days following the close of a public hearing conducted by the committee interested or affected persons may submit written comments concerning the review under consideration. The department shall provide copies of comments submitted in that manner to all person registered as affected persons and to appointed members of the committee. In reviews where no hearing is held, interested or affected persons may submit comments 10 days after the submission of the preliminary staff report, but no later than the 70th day of a 90-day review cycle or the 130th day of a 150-day review cycle.

G. In the event that circumstances require the department to obtain further information from any source or to otherwise contact registered affected persons following the public hearing and submission of comments under paragraph F or, when no hearing is held, following the 80th day of a 90-day review cycle or the 140th day of a 150-day review cycle, the department shall:

(1) Provide written notice to all registered affected persons who shall have at least 3 business days to respond; or

(2) Convene a public meeting with reasonable notice with participation of the committee at its discretion and affording directly affected persons the opportunity to conduct reasonable questioning.

In either event, notwithstanding any other provision of this chapter, the time period in which a decision is required shall be extended 20 days. Any written comments shall be forwarded to the committee.

H. At its next meeting following the receipt of comments pursuant to paragraph F or G, or in the case of a public hearing pursuant to paragraph G, the committee shall make a recommendation of approval, disapproval or approval with conditions with respect to the application or applications under consideration. This meeting is open to the public; however, during the committee's deliberations, participation is limited to committee members. The recommendation must be determined by majority vote of the appointed members present and voting. Members of the committee may make additional oral comments or submit written comments, as they consider appropriate, with respect to the basis for their recommendations or their individual views. The committee recommendation and any accompanying comments must be

forwarded to the commissioner. If the committee is unable to obtain a majority on a recommendation, the committee shall report to the commissioner the result of any vote taken.

I. At the time the staff submits its final report to the commissioner, a copy of the report shall be sent to the applicant and a notification shall be sent to all registered affected persons. No further comments may be accepted.

J. After a hearing commences, no appointed members of the committee or the department may communicate directly or indirectly in connection with any application with any affected party or anyone acting in their behalf, except upon notice and opportunity for all affected parties to participate. This paragraph shall not prohibit the department from communicating with any affected party or anyone acting on their behalf for the purpose of arranging a public meeting pursuant to paragraph G.

3. **Reviews.** To the extent practicable, a review shall be completed and the department shall make its decision within 90 days after the date of notification under subsection 1. The department shall establish criteria for determining when it is not practicable to complete a review within 90 days. Whenever it is not practicable to complete a review within 90 days, the department may extend the review period up to an additional 60 days.

Any review period may be extended with the written consent of the applicant. The request to extend the review period may be initiated by the applicant or the department. If the request is initiated by the department, it shall not be effective unless consented to by the applicant in writing. If the request is initiated by the applicant, the department shall agree to the requested extension if it determines that the request is for good cause. The department shall acknowledge the extension of the review period in writing.

4. **Repealed.**

5. **Repealed.**

5-A. **Decision by the department**. Decisions by the commissioner shall be made in accordance with the following procedures.

A. The department shall prepare its final staff report based solely on the record developed to date, as defined in paragraph C, subparagraphs (1) to (6).

B. After reviewing each application, the commissioner shall make a decision either to issue a certificate of need or to deny the application for a certificate of need. The decision of the commissioner must be based on the informational record developed in the course of review as specified in paragraph C. The commissioner may issue a certificate of need with specific conditions. Notice of

the decision must be sent to the applicant and the committee. This notice must incorporate written findings that state the basis of the decision, including the findings required by section 309, subsection 1. If the decision is not consistent with the recommendations of the Certificate of Need Advisory Committee, the commissioner shall provide a detailed statement of the reasons for the inconsistency.

C. For purposes of this subsection, "informational record developed in the course of review" includes the following:

(1) All applications, filings, correspondence and documentary material submitted by applicants and interested or affected persons prior to the termination of the public comment period under subsection 2-B, paragraph F or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(2) All documentary material reflecting information generated by the department prior to termination of the public comment period or, if no hearing is held, prior to the 80th day of a 90-day review cycle and prior to the 140th day of a 150-day review cycle;

(3) Stenographic or electronic recording of any public hearing or meeting held during the course of review, whether or not transcribed;

(4) All material submitted or obtained in accordance with the procedures in subsection 2-B, paragraph G;

(5) The staff report of the agency, the preliminary staff report of the department and the recommendations of the committee;

(6) Officially noticed facts; and

(7) The final staff report of the department.

Documentary materials may be incorporated in the record by reference, provided that registered affected persons are afforded the opportunity to examine the materials.

In making a determination on any pending application under the certificate of need program, the department shall not rely on the contents of any documents relating to the application when those documents are submitted to the department anonymously.

6. Repealed.

6-A. Review cycles. The department shall establish review cycles for the review of applications. There must be at least one review cycle for each type or category of project each calendar year, the dates for which must be published at least 3 months in advance. An application must be reviewed during the next scheduled review cycle following the date on which the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B. The department may hold an application for up to 90 days following the commencement of the next scheduled review cycle if, on the basis of one or more letters of intent on file at the time the application is either declared complete or submitted for review pursuant to section 306-A, subsection 4, paragraph B, the department expects to receive within the additional 90 days one or more other applications pertaining to similar types of services, facilities or equipment affecting the same health service area. Pertinent health service areas must be defined in rules adopted by the department pursuant to section 312.

Section 308. Waiver of requirements; emergency certificate of need

1. Waiver of full review. The department may waive otherwise applicable requirements and establish a simplified review process for projects which do not warrant a full review. Procedures for conducting these reviews shall be established by the department in its rules. These procedures shall provide for a shortened review and for a public hearing to be held during the course of a review, if requested by any person directly affected by the review. In order to waive requirements for a full review, the department shall find that the proposed project:

A. Meets an already demonstrated need as established by applicable state health plans or by the rules of the department; and

B. Repealed

C. Is required to meet federal, state or local life safety codes or other applicable requirements.

1-A. Acquisition of control. The department shall waive the requirements of section 309, subsection 1, paragraphs C and D and conduct a simplified review process in accordance with this section for an acquisition of control of health care facilities pursuant to section 304-A, subsection 1, if the acquisition consists of a management agreement or similar arrangement and primarily involves day-to-day operation of the facility in its current form. The department shall complete its review of arrangements qualifying for simplified review within 45 days of the filing of a completed application.

2. Waiver of other requirements. In order to expedite the review of an application submitted in response to an emergency situation, the department may:

A. **Repealed.**

B. **Repealed.**

C. Establish a schedule for the review of an application which commences on a day other than the first day of an established review cycle.

3. **Emergency certificate of need.** The department shall determine that an emergency situation exists whenever it finds that an applicant has demonstrated:

A. The necessity for immediate or temporary relief due to natural disaster, fire, unforeseen safety consideration, major accident, equipment failure, foreclosure, receivership or action of the department or other circumstances determined appropriate by the department;

B. The serious adverse effect of delay on the applicant and the community that would be occasioned by compliance with the regular requirements of this chapter and the rules adopted by the department; and

C. The lack of substantial change in the facility or services that existed before the emergency situation.

In an emergency situation the department may waive in writing any penalties for failure to receive a certificate of need for an otherwise reviewable project. After the emergency is resolved the department shall review the action to determine whether any additional review is required.

Section 309. Principles governing the review of applications

1. **Determinations for issue of certificate.** A certificate of need shall be issued whenever the department determines:

A. That the applicant is fit, willing and able to provide the proposed services at the proper standard of care;

B. That economic feasibility of the proposed services is demonstrated in terms of: Effect on the existing and projected operating budget of the applicant; the applicant's ability to establish and operate the facility or services in accordance with licensure rules adopted under pertinent state laws; the projected impact on the facility's costs and rates; the total health care expenditures in the community and the State; and the availability of State funds;

C. That there is a public need for the proposed services; and

D. That the proposed services are consistent with the orderly and economic development of health facilities and health resources for the State, that the citizens of the State have the ability to underwrite the additional costs of the proposed services and that the proposed services are in accordance with standards, criteria or plans adopted and approved pursuant to the state health plan developed by the department.

2. Repealed April 11, 1996.

2-A. Criteria for certificate of need. In determining whether to issue or deny a certificate of need under subsection 1, the department shall, among other criteria, consider the following:

A. Whether the project will substantially address specific problems or unmet needs in the area to be served by the project;

B. Whether the project will have a positive impact on the health status indicators of the population to be served;

C. Whether the services affected by the project will be accessible to all residents of the area proposed to be served. Accessibility is determined through analysis of the area including population, topography and availability of transportation and health services;

D. Whether there are less costly or more effective alternate methods of reasonably meeting identified health service needs of the project;

E. Whether the project is financially feasible in both an intermediate and long-term time frame;

F. Whether the project would produce a cost benefit in the existing health care system of the State and the area in which the project is proposed;

G. Whether the quality of any health care provided by the applicant in the past meets industry standards; and

H. Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project.

3. Repealed

4. Required approvals. Approval of proposed capital expenditures shall comply with the following:

A. Except as provided in paragraph B, the department shall issue a certificate of need for a proposed capital expenditure if:

(1) The capital expenditure is required to eliminate or prevent imminent safety hazards, as defined by applicable fire, building or life-safety codes and regulations; to comply with state licensure standards; or to comply with accreditation or certification standards which must be met to receive reimbursement under the United States Social Security Act, Title XVIII, or payments under a state plan for medical assistance approved under Title XIX of that Act; and

(2) The department has determined that the facility or service for which capital expenditure is proposed is needed; the obligation of the capital expenditure is consistent with the state health plan; and the corrective action proposed by the applicant is the most cost effective alternative available under the circumstances.

B. Those portions of a proposed project which are not required to eliminate or prevent safety hazards or to comply with licensure, certification or accreditation standards are subject to review in accordance with the criteria established under section 312.

5. **Standards applied in certificate of need.** The commissioner shall, in issuing a certificate of need, make the decision, to the maximum extent practicable, directly related to criteria established under federal laws and standards or criteria prescribed in rules adopted by the department pursuant to subsections 1 to 4 and section 312.

The commissioner may not deny issuance of a certificate of need, or make the decision subject to fulfillment of a condition on the part of the applicant, except when the denial or condition directly relates to criteria established under federal laws and standards or criteria prescribed in rules adopted by the department in accordance with subsections 1 to 4 and section 312 that are pertinent to the application.

6. **Repealed**

7. **Repealed**

Section 310. Reconsideration

Any person directly affected by a review may, for good cause shown, request in writing a hearing for the purposes of reconsideration of the decision of the department to issue or to deny a certificate of need. The department, if it determines that good cause has been demonstrated, shall hold a hearing to reconsider its decision. To be effective, a request for the hearing shall be received within 30 days of the department's decision. If the Department of Human Services determines that good cause for a hearing has been demonstrated, the hearing shall commence within 30 days of receipt of the request. A decision shall be rendered within 60 days of the commencement of the hearing. The decision may be rendered beyond this time period by mutual

consent of the parties. For purposes of this section, a request for a hearing shall be deemed to have shown good cause if it:

1. **New information.** Presents significant, relevant information not previously considered by the department;

2. **Changes in circumstances**. Demonstrates that there have been significant changes in factors or circumstances relied upon by the department in reaching its decision;

3. **Failure to follow procedures.** Demonstrates that the department has materially failed to follow its adopted procedures in reaching its decision; or

4. **Other bases**. Provides other bases for a hearing that the department has determined constitutes good cause.

Section 311. Remedy

Any person aggrieved by a final decision of the department made under the provisions of this Act shall be entitled to review in accordance with Title 5, chapter 375, subchapter VII, of the Administrative Procedure Act. A decision of the department to issue a certificate of need or to deny an application for a certificate of need shall not be considered final until the department has taken final action on a request for reconsideration under section 310.

A decision by the department is not final where opportunity for reconsideration under section 310 exists with respect to matters involving new information or changes in circumstances. Where new information or changes in circumstances are not alleged by the applicant or other person aggrieved by the decision, a person aggrieved by a decision of the department may, at its option, seek reconsideration under section 310 or may seek direct judicial review under this section.

In civil actions involving competitive reviews of proposals to construct new nursing facility beds, the court shall require the party seeking judicial review to give security in such sums as the court deems proper, for the payment of such costs and damages as may be incurred or suffered by any other party who is found to have been wrongfully delayed or restrained from proceeding to implement the certificate of need, provided that for good cause shown and recited in the order, the court may waive the giving of security. A surety upon a bond or undertaking under this paragraph submits the surety to the jurisdiction of the court and irrevocably appoints the clerk of the court as the agent for the surety upon whom any papers affecting liability on the bond or undertaking may be served. The liability of the surety may be enforced on motion without the necessity of an independent action. The motion and such notice of the motion as the court prescribes may be served on the clerk of the court who shall forthwith mail copies to the persons giving the security if their addresses are known.

Section 312. Rules

The department shall adopt any rules, standards, criteria , plans or procedures that may be necessary to carry out the provisions and purposes of this Act. The department shall, to the extent applicable, take into consideration recommendations contained in the state health plan as and the recommendations of the Certificate of Need Advisory Committee under section 306-A, subsection 2, paragraph A. The department shall provide for public notice and hearing on all proposed rules, standards, criteria, plans, procedures or schedules pursuant to Title 5, chapter 375. Unless otherwise provided by the chapter, rules adopted pursuant to this chapter are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. The department is authorized to accept any federal funds to be used for the purposes of carrying out this chapter.

Section 313. Public information

The general public shall have reasonable access to all applications reviewed by the department and to all other written material pertinent to its review of these applications. The department shall prepare and publish at least annually a report on its activities conducted pursuant to this Act.

Section 314. Conflict of interest

In addition to the limitations of Title 5, section 18, a member or employee of the Department of Human Services or Certificate of Need Advisory Committee who has a substantial economic or fiduciary interest which would be affected by a recommendation or decision to issue or deny a certificate of need, or who has a close relative or economic associate whose interest would be so affected shall be ineligible to participate in the review, recommendation or decision making process with respect to any application for which the conflict of interest exists.

Section 315. Division of project to evade cost limitation prohibited

No health care facility or other party required to obtain a certificate of need shall separate portions of a single project into components, including, but not limited to, site facility and equipment, to evade the cost limitations or other requirements of section 304.

Section 316. Repealed.

Section 316-A. Exemptions

Except as otherwise specifically provided, nothing in this Act may be construed to preempt, replace or otherwise negate the requirements of any other laws or regulations governing health care facilities. The requirements of this Act do not apply with respect to:

1. **Health care facilities**. Any health care facility:

   A. Operated by religious groups relying solely on spiritual means through prayer for healing;

2. **Activities; acquisitions.** Activities or acquisitions by or on behalf of a health maintenance organization or a health care facility controlled, directly or indirectly, by a health maintenance organization or combination of health maintenance organizations to the extent mandated by the National Health Planning and Resources Development Act of 1974, as amended and its accompanying regulations;

3. **Home health care services**. Home health care services offered by a home health care provider; and

4. **Repealed.**

5. **Hospice.** Hospice services and programs.

6. **Assisted living.** Assisted living programs and services regulated under chapter 1665;

7. **Existing capacity.** The use by an ambulatory surgical facility licensed on January 1, 1998 of capacity in existence on January 1, 1998;

Section 317. Repealed.

Section 317-A. Scope of certificate of need

1. **Application determinative**. A certificate of need shall be valid only for the defined scope, premises and facility or person named in the application and shall not be transferrable or assignable.

2. **Maximum expenditure.** In issuing a certificate of need, the department shall specify the maximum capital expenditures that may be obligated under this certificate. The department shall, by rules adopted pursuant to section 312, prescribe the method to be used to determine capital expenditure maximums, establish procedures to monitor capital expenditures obligated under certificates and establish procedures to review projects for which the capital expenditure maximum is exceeded or expected to be exceeded.

3. **Periodic review.** After the issuance of a certificate of need, the department shall periodically review the progress of the holder of the certificate in meeting the timetable for making the service or equipment available or for completing the project specified in the approved application. A certificate of need expires if the project for which the certificate has been issued is not commenced within 12 months following the issuance of the certificate. The department may grant an extension of a certificate for an additional specified time not to exceed 12 months if good cause is shown why the project has not commenced. The department may require evidence of the continuing feasibility and availability of financing for a project as a condition for extending the life of certificate. In addition if on the basis of its periodic review of progress under the certificate, the department determines that the holder of a certificate is not otherwise meeting the timetable and is not making a good faith effort to meet it, the department may, after a hearing, withdraw the certificate of need. The department shall in accordance with section 312 adopt rules for withdrawal of certificates of need.

Section 318. Withholding of license

No new health care facility, as defined in section 303, shall be eligible to obtain a license under the applicable state law, if the facility has not obtained a certificate of need as required by this chapter. The license of any facility shall not extend to include or otherwise be deemed to allow the delivery of any services, the use of any equipment which has been acquired, the use of any portion of a facility or any other change for which a certificate of need as required by this Act has not been obtained. Any unauthorized delivery of services, use of equipment or portion of a facility, or other change shall be deemed to be in violation of the respective chapter under which the facility is licensed.

Section 319. Withholding of funds

No health care facility or other provider may be eligible to apply for or receive any reimbursement, payment or other financial assistance from any state agency or other 3rd party payor, either directly or indirectly, for any capital expenditure or operating costs attributable to any project for which a certificate of need as required by this Act has not been obtained. For the purposes of this section, the department shall determine the eligibility of a facility to receive reimbursement for all projects subject to the provisions of this Act.

Section 320. Injunction

The Attorney General, upon the request of the department, shall seek to enjoin any project for which a certificate of need as required by this Act has not been obtained, and shall take any other action as may be appropriate to enforce this Act.

Section 321. Penalty

Whoever violates any provision of this chapter or any rate, rule or regulation established hereunder shall be subject to a civil penalty payable to the State of not more than $5,000 to be recovered in a civil action. The Department may hold these funds in a special revenue account which shall be used only to support certificate of need reviews, such as for hiring expert analysts on a short-term consulting basis.

Section 322. Implementation reports

The holder of a certificate of need shall make a written report at the end of each 6-month period following its issuance regarding implementation activities, obligations incurred and expenditures made and any other matters as the department may require. A summary report shall be made when the service or services for which the certificate of need was issued becomes operational. For a period of one year following the implementation of the service or services for which the certificate of need was granted, the provider shall file, at 6-month intervals, reports concerning the costs and utilization. The department, in its rules, shall prescribe the form and contents of the reports. Any holder of a certificate of need which has been issued for the construction or modification of a facility or portion thereof shall file final plans and specifications therefor with the department within 6 months, or any other time that the department may allow, following the issuance of the certificate for review by the department to determine that the plans and specifications are in compliance with the certificate of need which has been issued therefor and are in compliance with applicable licensure, life safety code and accreditation standards. The department may revoke any certificate of need it has issued when the person to whom it has been issued fails to file reports or plans and specifications required by this section on a timely basis.

Section 323 Repealed

Section 324. Review

The department shall convene meetings of the public, providers and consumers of health care, state agencies, insurers and managed care entities, the Certificate of Need Advisory Committee and interested parties to examine the operation of the certificate of need laws, rules, standards, criteria and procedures and shall report to the legislative joint standing committee of the Legislature having jurisdiction over health and human services matters not later than January 31, 2001 on the continuing feasibility of this chapter.

B

MAINE CERTIFICATE OF NEED
PROCEDURES MANUAL
for Health Care Facilities
(other than Nursing Care Facilities)

EFFECTIVE

1998

Angus King, Governor
Kevin Concannon, Commissioner

MAINE DEPARTMENT OF HUMAN SERVICES
State House Station 11
35 Anthony Avenue
Augusta, Maine 04333

Produced under Appropriation Number 010 0129 3031 011

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

Sec. 1. 22 MRSA c. 103, as amended, is repealed.

Sec. 2. 22 MRSA c. 103-A is enacted to read:

CHAPTER 103-A

CERTIFICATE OF NEED

§326. Short title

This chapter is known and may be cited as the "Maine Certificate of Need Act of 2001."

§327. Declaration of findings and purposes

1. Findings. The Legislature finds that:

A. Unnecessary construction or modification of health care facilities and duplication of health services are substantial factors in the cost of health care and the ability of the public to obtain necessary medical services; and

B. Health facility investments in primary and secondary preventive health care services should accompany the expansion of health care facilities, expenditures for major medical equipment and the addition of new health care services.

2. Purposes. The purposes of this chapter are to:

A. Support effective health planning;

B. Support the provision of quality health care in a manner that ensures access to cost-effective services;

C. Support reasonable choice in health care services while avoiding excessive duplication;

D. Ensure that state funds are used prudently in the provision of health care services;

E. Ensure public participation in the process of determining the array, distribution, quantity, quality and cost of these health care services;

F. Improve the availability of health care services throughout the State;

G. Support the development and availability of health care services regardless of the consumer's ability to pay;

H. Seek a balance, to the extent a balance assists in achieving the purposes of this subsection, between competition and regulation in the provision of health care; and

I. Promote the development of primary and secondary preventive health care services.

§328. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Access to care. "Access to care" means the timely ability to obtain needed personal health services to achieve the best possible health outcomes balanced by the health system's resource limitations. Access to care may be influenced by many factors, including, without limitation, travel, distance, waiting time, available resources, availability of a source of care and the health status of the population served.

2. Ambulatory surgical facility. "Ambulatory surgical facility" means a facility, not part of a hospital, that provides surgical treatment to patients not requiring hospitalization. "Ambulatory surgical facility" does not include the offices of private physicians or dentists, whether in individual or group practice.

3. Annual operating costs. For purposes of section 329, subsection 4, paragraph B, "annual operating costs" means the total incremental costs to the institution that are directly attributable to the addition of a new health service.

4. Capital expenditure. "Capital expenditure" means an expenditure, including a force account expenditure or predevelopment activities, that under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance and, for the purposes of this chapter, includes capitalized interest on borrowed funds and the fair market value of any property or equipment that is acquired under lease or comparable arrangement or by donation.

5. Construction. "Construction," when used in connection with "health care facility," means the establishment, erection, building, purchase or other acquisition of a health care facility.

6. Development. "Development," when used in connection with health service, means the undertaking of those activities that on their completion will result in the offering of a new health service to the public.

7. Expenditure minimum for annual operating costs. "Expenditure minimum for annual operating costs" means, for services commenced after October 1, 1998, $350,000 for the 3rd fiscal year, including a partial first year.

8. Generally accepted accounting principles. "Generally accepted accounting principles" means accounting principles approved by the American Institute of Certified Public Accountants.

9. Health care facility. "Health care facility" means a hospital, psychiatric hospital, nursing facility, kidney disease treatment center including a free-standing hemodialysis facility, rehabilitation facility, ambulatory surgical facility, independent radiological service center, independent cardiac catheterization center or cancer treatment center. "Health care facility" does not include the office of a private physician or physicians or a dentist or dentists, whether in individual or group practice.

10. Health maintenance organization. "Health maintenance organization" means a public or private organization that:

A. Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health services: usual physician services, hospitalization services, laboratory services, x-ray services, emergency and preventive health services and out-of-area coverage;

B. Is compensated, except for copayments, for the provision of the basic health services to enrolled participants on a predetermined periodic rate basis; and

C. Provides physicians' services primarily through physicians who are either employees or partners of the organization or through arrangements with individual physicians or one or more groups of physicians.

11. Health need. "Health need" means a situation or a condition of a person, expressed in health outcome measures such as mortality, morbidity or disability, that is considered undesirable and is likely to exist in the future.

12. Health planning. "Health planning" means data assembly and analysis, goal determination and the formulation of action recommendations regarding health services.

13. Health services. "Health services" means clinically related services that are diagnostic, treatment, rehabilitative services or nursing services provided by a nursing facility. "Health services" includes alcohol abuse, drug abuse and mental health services.

14. Health status. "Health status" means patient or population measures, or both, of good and poor health practices, rates of death and disease, both chronic and infectious, and the prevalence of symptoms or conditions, or both, of illness and wellness.

15. Hospital. "Hospital" means an institution that primarily provides to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons or rehabilitation services for the rehabilitation of injured, disabled or sick persons. "Hospital" also includes psychiatric and tuberculosis hospitals.

16. Major medical equipment. "Major medical equipment" means a single unit of medical equipment or a single system of components with related functions used to provide medical and other health services that costs $1,000,000 or more. "Major medical equipment" does not include medical equipment acquired by or on behalf of a clinical laboratory to provide clinical laboratory services if the clinical laboratory is independent of a physician's office and a hospital and has been determined to meet the requirements of the United States Social Security Act, Title XVIII, Section 1861(s), paragraphs 10 and 11. In determining whether medical equipment costs more than $1,000,000, the cost of studies, surveys, designs, plans, working drawings, specifications and other activities essential to acquiring the equipment must be included. If the equipment is acquired for less than fair market value, the term "cost" includes the fair market value.

17. Nursing facility. "Nursing facility" means any facility defined under section 1812-A.

18. Modification. "Modification" means the alteration, improvement, expansion, extension, renovation or replacement of a health care facility or health maintenance organization or portions thereof, including the initial equipment, and the replacement of equipment or existing buildings.

19. Obligation. An "obligation" for a capital expenditure that is considered to be incurred by or on behalf of a health care facility:

A. When a contract, enforceable under Maine law, is entered into by or on behalf of the health care facility for the construction, acquisition, lease or financing of a capital asset;

B. When the governing board of the health care facility takes formal action to commit its own funds for a construction project undertaken by the health care facility as its own contractor; or

C. In the case of donated property, on the date on which the gift is completed under applicable Maine law.

20. Offer. "Offer," when used in connection with "health services," means that the health care facility or health maintenance organization holds itself out as capable of providing or having the means to provide a health service.

21. Person. "Person" means an individual; trust or estate; partnership; corporation, including associations, joint stock companies and insurance companies; the State or a political subdivision or instrumentality of the State, including a municipal corporation of the State; or any other legal entity recognized by state law.

22. Predevelopment activity. "Predevelopment activity" means any appropriately capitalized expenditure by or on behalf of a health care facility made in preparation for the offering or development of a new health service for which a certificate of need would be required and arrangements or commitments made for financing the offering or development of the new health service and includes site acquisitions, surveys, studies, expenditures for architectural designs, plans, working drawings and specifications.

23. Primary and secondary preventive services. "Primary preventive services" means health care services including, without limitation, health education that seeks to prevent the occurrence of disease or injury, generally reducing exposure or risk factor levels that cause disease. "Secondary preventive services" means health care services that seek to treat and control the severity of disease processes in their early stages before the onset of acute symptoms and events.

24. Project. "Project" means any acquisition, capital expenditure, new health service or change in a health service, predevelopment activity or other activity that requires a certificate of need under section 329.

25. Rehabilitation facility. "Rehabilitation facility" means an inpatient facility that is operated for the primary purpose of assisting in the rehabilitation of disabled persons through an integrated program of medical services and other services that are provided under competent professional supervision.

26. Replacement equipment. "Replacement equipment" means a piece of capital equipment that replaces another piece of capital equipment that performs essentially the same functions as the replaced equipment.

§329. Certificate of need required

A person may not enter into any commitment for financing a project that requires a certificate of need or incur an expenditure for the project without having sought and received a certificate of need, except that this prohibition does not apply to obligations for financing conditioned upon the receipt of a certificate of need or to obligations for predevelopment activities.

A certificate of need from the department is required for:

1. Transfer of ownership; acquisition by lease, donation, transfer; acquisition of control. Any transfer of ownership or acquisition under lease or comparable arrangement or through donation or any acquisition of control of a health care facility under lease, management agreement or comparable arrangement or through donation that would have required review if the transfer or acquisition had been by purchase, except in emergencies when that acquisition of control is at the direction of the department;

2. Acquisitions of certain major medical equipment. Acquisitions of major medical equipment with a cost in the aggregate of $1,000,000 or more. The use of major medical equipment on a temporary basis in the case of a natural disaster, major accident or equipment failure and the use of replacement equipment do not require a certificate of need;

3. Capital expenditures. Except as provided in subsection 6, the obligation by or on behalf of a health care facility of any capital expenditure of $2,000,000 or more. Capital expenditures in the case of a natural disaster, major accident or equipment

failure for replacement equipment or for parking lots and garages, information and communications systems and physician office space do not require a certificate of need;

4. New health service. The offering or development of any new health service. For purposes of this section, "new health service" includes only the following:

A. The obligation of any capital expenditures by or on behalf of a health care facility of $100,000 or more that is associated with the addition of a health service that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered; or

B. The addition of a health service that is to be offered by or on behalf of a health care facility that was not offered on a regular basis by or on behalf of the health care facility within the 12-month period prior to the time the services would be offered and that, for the 3rd fiscal year of operation, including a partial first year, following addition of that service, is projected to entail annual operating costs of at least $350,000.

A certificate of need is not required for a health care facility that extends a current service within the defined primary service area of the health care facility by purchasing within a 12-month time period new equipment costing in the aggregate less than $1,000,000;

5. Changes in bed complement. An increase in the existing licensed bed complement or an increase in the licensed bed category of a health care facility greater than 10%;

6. Nursing facilities. The obligation by a nursing facility, when related to nursing services provided by the nursing facility, of any capital expenditures of $500,000 or more.

A certificate of need is not required for a nursing facility to convert beds used for the provision of nursing services to beds to be used for the provision of residential care services. If such a conversion occurs, public funds are not obligated for payment of services provided in the converted beds;

7. Other circumstances. The following circumstances:

A. Any proposed use of major medical equipment to serve inpatients of a hospital, if the equipment is not located in a health care facility and was acquired without a

certificate of need, except acquisitions exempt from review under subsection 2 or 3; or

B. If a person adds a health service not subject to review under subsection 4, paragraph A and not subject to review under subsection 4, paragraph B at the time it was established and not reviewed and approved prior to establishment at the request of the applicant, and its actual 3rd fiscal year operating cost exceeds the expenditure minimum for annual operating costs in the 3rd fiscal year of operation following addition of these services; and

8. Related projects. Any projects that the department determines are related projects if such projects, considered in the aggregate, would otherwise require a certificate of need under this section.

§330. Exceptions

Notwithstanding section 329, the requirements of this Act do not apply with respect to:

1. Healing through prayer. A health care facility operated by a religious group relying solely on spiritual means through prayer for healing;

2. Activities; acquisitions. Activities or acquisitions by or on behalf of a health maintenance organization or a health care facility controlled, directly or indirectly, by a health maintenance organization or combination of health maintenance organizations to the extent mandated by the National Health Policy, Planning and Resources Development Act of 1974, as amended, and its accompanying regulations;

3. Home health care services. Home health care services offered by a home health care provider;

4. Hospice. Hospice services and programs;

5. Assisted living. Assisted living programs and services regulated under chapter 1665; and

6. Existing capacity. The use by an ambulatory surgical facility licensed on January 1, 1998 of capacity in existence on January 1, 1998.

§331. Subsequent review

When a certificate of need has been issued and changes occur as specified in this section, a subsequent review is required.

1. Criteria for subsequent review. The following activities require subsequent review and approval, if the department has previously issued a certificate of need and if within 3 years after the approved activity is undertaken:

A. There is a significant change in financing;

B. There is a change affecting the licensed or certified bed capacity as approved in the certificate of need;

C. There is a change involving the addition or termination of the health services proposed to be rendered;

D. There is a change in the site or the location of the proposed health care facility; or

E. There is a substantial change proposed in the design of the health care facility or the type of construction.

2. Procedures for subsequent review. Any person proposing to undertake any activity requiring subsequent review and approval shall file with the department, within 30 days of the time that person first has actual knowledge of the circumstances requiring subsequent review, a notice setting forth the following information:

A. The nature of the proposed change;

B. The rationale for the change including, where appropriate, an explanation of why the change was not set forth in the original application or letter of intent; and

C. Other pertinent detail subject to the procedures and criteria set forth in section 334.

The department shall, within 30 days of receipt of the information, advise that person in writing whether the proposed change is approved. If not approved, the application must be treated as a new application under this Act. If approved, the department shall amend the certificate of need as appropriate.

§332. Procedures after voluntary nursing facility reductions

1. Procedures. A nursing facility that voluntarily reduces the number of its licensed beds for any reason except to create private rooms may convert the beds back and thereby increase the number of nursing facility beds to no more than the previously

licensed number of nursing facility beds, after obtaining a certificate of need in accordance with this section, as long as the nursing facility has been in continuous operation and has not been purchased or leased. To convert beds back to nursing facility beds under this subsection, the nursing facility must:

A. Give notice of its intent to preserve conversion options to the department no later than 30 days after the effective date of the license reduction; and

B. Obtain a certificate of need to convert beds back under section 334, except that, if no construction is required for the conversion of beds back, the application must be processed in accordance with subsection 2.

2. Expedited review. Except as provided in subsection 1, paragraph B, an application for a certificate of need to reopen beds reserved in accordance with this section must be processed on an expedited basis in accordance with rules adopted by the department providing for shortened review time and for a public hearing if requested by a directly affected person. The department shall consider and decide upon these applications as follows:

A. Review of applications that meet the requirements of this section must be based on the requirements of section 334, subsection 3, except that the determinations required by section 334, subsection 3, paragraph B must be based on the historical costs of operating the beds and must consider whether the projected costs are consistent with the costs of the beds prior to closure, adjusted for inflation; and

B. Conversion of beds back under this section must be requested within 4 years of the effective date of the license reduction. For good cause shown, the department may extend the 4-year period for conversion for one additional 4-year period.

3. Effect on other review proceedings. Nursing facility beds that have been voluntarily reduced under this section must be counted as available nursing facility beds for the purpose of evaluating need under section 334 as long as the nursing facility retains the ability to convert them back to nursing facility use under the terms of this section, unless the nursing facility indicates, in response to an inquiry from the department in connection with an ongoing project review, that it is unwilling to convert them to meet a need identified in that project review.

4. Rulemaking. Rules adopted pursuant to this section are major substantive rules as defined by Title 5, chapter 375, subchapter II-A.

§333. Nursing facility projects

Nursing facility projects that propose to add new nursing facility beds to the inventory of nursing facility beds within the State may be grouped for competitive review purposes consistent with appropriations made available for that purpose by the Legislature. A nursing facility project that proposes renovation, replacement or other actions that will increase Medicaid costs may be approved only if appropriations have been made by the Legislature expressly for the purpose of meeting those costs, except that the department may approve, without a prior appropriation for the express purpose, projects to reopen beds previously reserved by a nursing facility through a voluntary reduction pursuant to section 332, if the annual total of reopened beds approved does not exceed 100.

§334. Approval; record

1. Basis for decision. The commissioner shall approve an application for a certificate of need if the commissioner determines that the project meets the conditions set forth in subsection 3.

The commissioner shall make a determination on whether conditions set forth in subsection 3 have been met based solely upon the record created by the department in the course of its review of an application.

Except as otherwise provided in this Act, only a person who is a full-time employee of the department with responsibilities for the certificate of need program, a consultant to the project on matters or a member of the Maine Health Policy Advisory Committee pursuant to section 337 may communicate with the commissioner regarding any application for a certificate of need or any letter of intent. Nothing in this section limits the authority and obligation of the staff of the department with responsibility for the certificate of need program to meet with, or otherwise communicate with, any person who is not a department employee and who wants to provide information to be considered in connection with an application for a certificate of need. A person who is not a department employee may not communicate with any department staff regarding the merits of a certificate of need application except for the purpose of placing that person's views in the application record. All communications with department staff responsible for the certificate of need program from any person, who is not a department employee, that the department staff

reasonably believes is intended to influence the analyses relating to or the decision regarding any application for certificate of need must be memorialized by that department staff and that memorial must be made part of the application record.

The commissioner's determination must be in writing and must contain appropriate references to the record. If the application is denied, the decision must specifically address comments received and made part of the record that favor granting the application. If the application is approved, the decision must specifically address comments received and made part of the record that favor denial of the application.

2. Record. The record created by the department in the course of its review of an application must contain the following:

A. The application and all other materials submitted by the applicant for the purpose of being made part of the record;

B. All information generated by or for the department in the course of gathering material to assist the commissioner in determining whether the conditions for granting an application for a certificate of need have or have not been met. This information may include, without limitation, the report of consultants, memoranda of meetings or conversations with any person interested in commenting on the application, letters, memoranda and documents from other interested agencies of State Government and memoranda describing officially noticed facts;

C. Stenographic or electronic recordings of any public hearing held by the commissioner or the staff of the department at the direction of the commissioner regarding the application;

D. Stenographic or electronic recording of any public informational meeting held by the department pursuant to section 336, subsection 4;

E. Any documents submitted by any person for the purpose of being made part of the record regarding any application for a certificate of need or for the purpose of influencing the outcome of any analyses or decisions regarding an application for certificate of need, except documents that have been submitted anonymously. Such source-identified documents automatically become part of the record upon receipt by the department; and

F. Preliminary and final analyses of the record prepared by the staff.

The record first opens on the day the department publishes its notice that an application for a certificate of need has been filed. From that day, all of the record is a public record, and any person may examine that record and purchase copies of any or all of that record during the normal business hours of the department.

The record is closed 10 days after a public notice of the closing of the record has been published in the a newspaper of general circulation in Kennebec County, in a newspaper published within the service area of the project and on the department's publicly accessible site on the Internet, as long as such notice is not published until after the preliminary staff analysis of the application is made part of the record.

3. Review; approval. Except as provided in section 335, the commissioner shall issue a certificate of need if the commissioner determines and makes specific written findings regarding that determination that:

A. The applicant is fit, willing and able to provide the proposed services at the proper standard of care as demonstrated by, among other factors, whether the quality of any health care provided in the past by the applicant or a related party under the applicant's control meets industry standards;

B. The economic feasibility of the proposed services is demonstrated in terms of the:

(1) Capacity of the applicant to support the project financially over its useful life, in light of the rates the applicant expects to be able to charge for the services to be provided by the project; and

(2) Applicant's ability to establish and operate the project in accordance with existing and reasonably anticipated future changes in federal, state and local licensure and other applicable or potentially applicable rules;

C. There is a public need for the proposed services; as demonstrated by, among other things:

(1) Whether, and the extent to which, the project will substantially address specific health problems as measured by health needs in the area to be served by the project;

(2) Whether the project will have a positive impact on the health status indicators of the population to be served;

(3) Whether the services affected by the project will be accessible to all residents of the area proposed to be served; and

(4) Whether the project will provide demonstrable improvements in quality and outcome measures applicable to the services proposed in the project;

D. The proposed services are consistent with the orderly and economic development of health facilities and health resources for the State as demonstrated by:

(1) The impact of the project on total health care expenditures after taking into account, to the extent practical, both the costs and benefits of the project and the competing demands in the local service area and statewide for available resources for health care;

(2) The availability of state funds to cover any increase in state costs associated with utilization of the project's services; and

(3) The likelihood that more effective, more accessible or less costly alternative technologies or methods of service delivery may become available; and

E. The applicant will dedicate the equivalent of 5% of the first full-year operating expenses and 3% of operating expenses each year thereafter that the project is in service to measurable primary or secondary prevention programs relevant to the service or technology of the certificate of need application and available at no cost to uninsured individuals with incomes at or below 150% of the federal poverty level.

4. Conditional approvals. The commissioner may grant an application subject to conditions that relate to the criteria for approval of the application.

5. Emergency certificate of need. Upon the written or, if more practical, the oral request of an applicant, the department shall immediately determine whether an emergency situation exists and upon finding that an emergency situation does exist shall issue a certificate of need for a project necessary on account of the emergency situation. The scope of the certificate of need may not exceed that which is necessary to remedy or otherwise

effectively address the emergency situation. The certificate of need may be subject to conditions consistent with the purpose of this Act that do not interfere with the applicant's ability to respond effectively to the emergency.

The commissioner shall find an emergency situation exists whenever the commissioner finds that an applicant has demonstrated:

A. The necessity for immediate or temporary relief due to a natural disaster, a fire, an unforeseen safety consideration, a major accident, equipment failure, foreclosure, receivership or an action of the department or other circumstances determined appropriate by the department;

B. The serious adverse effect of delay on the applicant and the community that would be occasioned by compliance with the regular requirements of this chapter and the rules adopted by the department; and

C. The lack of substantial change in the facility or services that existed before the emergency situation.

§335. Simplified review and approval process

Notwithstanding the requirements set forth in section 334, the department shall conduct a simplified review and approval process in accordance with this section.

1. Maintenance projects. The commissioner shall issue a certificate of need for a project that primarily involves the maintenance of a health facility if the commissioner determines that the project:

A. Will result in no or a minimal additional expense to the public or to the health care facility's clients;

B. Will be in compliance with other applicable state and local laws and regulations; and

C. Will significantly improve or, in the alternative, not significantly adversely affect the health and welfare of any person currently being served by the health care facility.

2. Life safety codes; previous certificate of need. The commissioner shall issue a certificate of need for a project that is required solely to meet federal, state or local life safety codes if the project involves a health facility, major medical

equipment or a new health service that has previously received a certificate of need.

3. Acquisition of control. The commissioner shall issue a certificate of need for a project that involves the acquisition of control of a health facility when the acquisition consists of a management agreement or similar arrangement and primarily involves the day-to-day operation of the facility in its current form, if the commissioner determines that:

A. The applicant is fit, willing and able to provide the project services at the proper standard of care as demonstrated by, among other factors, whether the quality of health care provided by the applicant or a related party under the applicant's control meets or in the past met industry standards; and

B. The project is economically feasible in light of its impact on:

(1) The operating budget of the facility and the applicant;

(2) The applicant's ability to establish and operate the facility in accordance with federal and state licensure rules; and

(3) The applicant's ability to operate the facility without increases in the facility's rates beyond those that would otherwise occur absent the acquisition.

4. Capital expenditures. The commissioner shall issue a certificate of need for a proposed capital expenditure upon determining that:

A. The capital expenditure is required to eliminate or prevent imminent safety hazards, as defined by applicable fire, building or life safety codes and regulations; to comply with state licensure standards; or to comply with accreditation or certification standards that must be met to receive reimbursement under the United States Social Security Act, Title XVIII or payments under a state plan for medical assistance approved under Title XIX of that Act;

B. The economic feasibility of the project is demonstrated in terms of its effects on the operating budget of the applicant, including its existing rate structure;

C. There remains a public need for the service to be provided; and

D. The corrective action proposed by the applicant is the most cost effective alternative available under the circumstances.

§336. Application process for certificate of need

1. Letter of intent. Prior to filing an application for a certificate of need, an applicant shall file a letter of intent with the department. The letter of intent forms the basis for determining the applicability of this chapter to the proposed expenditure or action. A letter of intent is deemed withdrawn one year after receipt by the department, unless sooner superseded by an application, except that the applicant is not precluded from resubmitting the same letter of intent.

2. Application filed. Upon a determination by the department that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need must be filed with the department if the applicant wishes to proceed with the project. Prior to filing a formal application for a certificate of need, the applicant shall meet with the department staff in order to assist the department in understanding the application and to receive technical assistance concerning the nature, extent and format of the documentary evidence, statistical data and financial data required for the department to evaluate the proposal. Prior to the technical assistance meeting, but subsequent to receipt of the letter of intent, the department shall issue a letter or checklist, or both, to an applicant that stipulates and clarifies what will be required in the application. The department may not accept an application for review until the applicant has satisfied this technical assistance requirement. The technical assistance meeting must take place within 30 days after receipt of the letter of intent.

3. Application content. An application for a certificate of need must describe with specificity how the proposed project meets each of the conditions for granting a certificate of need required by this Act. A statement or statements that the project will meet the conditions without supporting facts backed by relevant documentation and analyses constitute sufficient cause to deny the application. An application subject to full review must contain, among other information:

A. Measures of health status relevant to the services or technology of the application in the service area of the applicant. These measures must, to the extent possible, be the same as those contained in relevant reports issued by the United States Department of Health and Human Services;

B. Valid and replicable quantitative measures of public health need relevant to the new services or technology in the service area of the applicant for the services. The department may adopt a specific set of measures for certain services when there is consensus in the literature;

C. Quality assurance processes, including measures to be used to assess the new services or technology. The applicant shall specify the quality assurance process including the measures to be used, the time period for reporting and the mechanism that will be used to disseminate quality assurance information to the State and the public. Quality assurance information that the applicant does not consider appropriate for public dissemination must be justified. When possible, quality measures must be similar to those required by hospital accreditation organizations;

D. Current and planned prevention programs relevant to the services or technology of the application and the population to be served. To the extent possible, this information must contain effectiveness measures for existing and planned programs; and

E. Information as to how the proposed services or technology fits into any relevant published health planning report specifically identified by the department.

4. Public notice; public informational meeting. Within 5 business days of the filing of a certificate by an applicant that a complete certificate of need application is on file with the department, public notice that the application has been filed and that a public informational meeting must be held regarding the application must be given by publication in a newspaper of general circulation in Kennebec County and in a newspaper published within the service area in which the proposed expenditure will occur. The notice must also be provided to all persons who have requested notification by means of asking that their names be placed on a mailing list maintained by the department for this purpose. This notice must include:

A. A brief description of the proposed expenditure or other action;

B. A description of the review process and schedule;

C. A statement that any person may examine the application, submit comments in writing to the department regarding the application, and examine the entire record assembled by the department at any time from the date of publication of the

notice until the application process is closed for comment; and

D. The time and location of the public informational meeting and a statement that any person may appear at the meeting to question the applicant regarding the project or the department regarding the conditions that the applicant must satisfy in order to receive a certificate of need for the project.

An application is certified as complete when the applicant delivers to the department a certification in writing that states that the application should be considered complete by the department. Nothing in the foregoing sentence precludes an applicant from submitting information subsequent to the applicant's certification that is responsive to any concern, issue, question or allegation of facts contrary to those in the application by the department or any person whether or not those concerns, issues, questions or allegations have been made part of the record.

The department shall make an electronic or stenographic record of the public informational meeting.

5. Voluntary withdrawal of application. During the review period, prior to the date that department staff submit a final report to the commissioner, an applicant may withdraw an application without prejudice. Written notice of the withdrawal must be submitted to the department. A withdrawn application may be resubmitted at a later date, as a new application, requiring a new letter of intent and new filing fees, docketing and review.

6. Filing fee. A nonrefundable filing fee must be paid at the time an application is filed with the department.

A. The department shall establish minimum and maximum filing fees, pursuant to section 341, to be paid per application.

B. If the approved capital expenditure or operating cost upon which the fees were based is higher than the initially proposed capital expenditure, then the filing fee must be recalculated and the difference in fees, if any, must be paid before the certificate of need may be issued.

§337. Maine Health Policy Advisory Committee

The commissioner may establish a Maine Health Policy Advisory Committee to:

1. Review. Review proposed rules, criteria, standards and procedures; and

2. Evaluate. Evaluate new services, technology or research that could affect the cost, quality and access to care for residents of the State and that results, or is likely to or should result, in keeping with the intent of this Act, in a certificate of need application. This evaluation may involve holding public meetings.

§338. Review process

1. Review process. The review process consists of an evaluation of the project application for a certificate of need by the department in light of:

A. The application itself;

B. Material collected or developed by or for the department staff to test the assertions in the application; and

C. All comments received by any person regarding the project and any other material made part of the record.

2. Public hearing. The commissioner or the commissioner's designee may hold a public hearing regarding the application. An electronic or stenographic record of the public hearing must be made part of the record.

3. Preliminary staff analyses. The department staff shall provide, as soon as practicable, its preliminary analyses of the application and the record to the applicant, the commissioner and any interested person. Notice of the availability of the analyses must be published in the Kennebec Journal and a newspaper of general circulation serving the area in which the project is to be located and on the department's publicly accessible site on the Internet.

4. Final department staff analysis. A final department staff analysis must be submitted to the commissioner, together with the documentary record described in section 334, subsection 2, as soon as practicable after the closing of the record.

5. Reviews. To the extent practicable, a review must be completed and the commissioner shall make a decision within 90 days after the application has been certified as complete by the applicant. The department shall establish criteria for determining when it is not practicable to complete a review within 90 days. Whenever it is not practicable to complete a

review within 90 days, the department may extend the review period for up to an additional 60 days.

The department may delay action on an otherwise complete application for up to 180 days from the time the application has been certified as complete by the applicant if the department finds that a public necessity exists. For purposes of this subsection, the department shall find that a public necessity exists if:

A. The application represents a new service or technology not previously provided within the State;

B. The application represents a potential significant impact on health care system costs;

C. The application represents a new service or technology for which a health care system need has not been previously established; or

D. There are several applications for the same or similar projects before the department.

The department shall notify in writing the applicant and any other person who has requested in writing information regarding the application of the delay.

§338. Reconsideration

1. Reconsideration. Any person directly affected by a review may, for good cause shown, request in writing a hearing for the purpose of reconsideration of the decision of the department to issue or to deny a certificate of need. The department, if it determines that good cause has been demonstrated, shall hold a hearing to reconsider its decision. A request for hearing for consideration must be received within 30 days of the department's decision. If the department determines that good cause for a hearing has been demonstrated, the hearing must commence within 30 days of receipt of the request. A decision must be rendered within 60 days of the commencement of the hearing. The decision may be rendered beyond this time period by mutual consent of the parties. For purposes of this section, a request for a hearing is considered to show good cause if it:

A. Presents significant, relevant information not previously considered by the department;

B. Demonstrates that there have been significant changes in factors or circumstances relied upon by the department in reaching its decision;

C. Demonstrates that the department has materially failed to follow its adopted procedures in reaching its decision; or

D. Provides other bases for a hearing that the department has determined constitute good cause.

2. "Person directly affected by a review" defined. For purposes of this section, a "person directly affected by a review" includes:

A. The applicant;

B. A group of 10 taxpayers residing or located within the health service area served or to be served by the applicant;

C. A health care facility, a health maintenance organization or a health care practitioner that can demonstrate that it provides similar services or, by timely filing a letter of intent with the department for inclusion in the record, has indicated an intention to provide similar services in the future to patients residing in the health service area and whose services would be directly and substantially affected by the application under review;

D. A 3rd-party payor, including, without limitation, a health maintenance organization, who pays health care facilities for services in the health service area in which the project is proposed to be located and whose payments would be directly and substantially affected by approval or disapproval of the application under review; and

E. A person who can demonstrate a direct and substantial effect upon that person's health care as a result of approval or disapproval of an application for a certificate of need.

§340. Remedy

Any person aggrieved by a final decision of the department made under the provisions of this Act is entitled to review in accordance with Title 5, chapter 375, subchapter VII. A decision of the department to issue a certificate of need or to deny an application for a certificate of need is not considered final until the department has taken final action on a request for reconsideration under section 339.

A decision by the department is not final when opportunity for reconsideration under section 339 exists with respect to matters

involving new information or changes in circumstances. When new information or changes in circumstances are not alleged by the applicant or other person aggrieved by the decision, a person aggrieved by a decision of the department may, at its option, seek reconsideration under section 339 or may seek direct judicial review under this section.

In civil actions involving competitive reviews of proposals to construct new nursing facility beds, the court shall require the party seeking judicial review to give security in such sums as the court determines proper for the payment of costs and damages that may be incurred or suffered by any other party who is found to have been wrongfully delayed or restrained from proceeding to implement the certificate of need, except that, for good cause shown and recited in the order, the court may waive the giving of security. A surety upon a bond or undertaking under this paragraph submits the surety to the jurisdiction of the court and irrevocably appoints the clerk of the court as the agent for the surety upon whom any papers affecting liability on the bond or undertaking may be served. The liability of the surety may be enforced on motion without the necessity of an independent action. The motion and such notice of the motion as the court prescribes may be served on the clerk of the court who shall mail copies to the persons giving the security if their addresses are known.

§341. Rules

The department shall adopt any rules, standards, criteria, plans or procedures that may be necessary to carry out the provisions and purposes of this Act. The department shall provide for public notice and hearing on all proposed rules, standards, criteria, plans, procedures or schedules pursuant to Title 5, chapter 375. Unless otherwise provided by this chapter, rules adopted pursuant to this chapter are routine technical rules as defined by Title 5, chapter 375, subchapter II-A. The department is authorized to accept any federal funds to be used for the purposes of carrying out this chapter.

§342. Public information

The department shall prepare and publish at least annually a report on its activities conducted pursuant to this Act.

§343. Conflict of interest

In addition to the limitations of Title 5, section 18, a member or employee of the department who has a substantial economic or fiduciary interest that would be affected by a recommendation or decision to issue or deny a certificate of need

or who has a close relative or economic associate whose interest would be so affected is ineligible to participate in the review, recommendation or decision-making process with respect to any application for which the conflict of interest exists.

§344. Division of project to evade cost limitation prohibited

No health care facility or other party required to obtain a certificate of need may separate portions of a single project into components, including, but not limited to, site facility and equipment, to evade the cost limitations or other requirements of section 329.

§345. Scope of certificate of need

1. Application determinative. A certificate of need is valid only for the defined scope, premises and facility or person named in the application and is not transferable or assignable.

2. Maximum expenditure. In issuing a certificate of need, the department shall specify the maximum capital expenditures that may be obligated under this certificate. The department shall prescribe, by rules adopted pursuant to section 341, the method to be used to determine capital expenditure maximums, establish procedures to monitor capital expenditures obligated under certificates and establish procedures to review projects for which the capital expenditure maximum is exceeded or expected to be exceeded.

3. Periodic review. After the issuance of a certificate of need, the department shall periodically review the progress of the holder of the certificate in meeting the timetable for making the service or equipment available or for completing the project specified in the approved application. A certificate of need expires if the project for which the certificate has been issued is not commenced within 12 months following the issuance of the certificate. The department may grant an extension of a certificate for an additional specified time not to exceed 12 months if good cause is shown why the project has not commenced. The department may require evidence of the continuing feasibility and availability of financing for a project as a condition for extending the life of the certificate. In addition if on the basis of its periodic review of progress under the certificate, the department determines that the holder of a certificate is not otherwise meeting the timetable and is not making a good faith effort to meet it, the department may, after a hearing, withdraw the certificate of need. The department shall in accordance with section 341 adopt rules for withdrawal of certificates of need. The applicant shall issue to the department periodic reports as designated in the certificate of need approval notification on

the impact of the service on the health status, quality of care and health outcomes of the population served. These reports may not be in less than 12-month intervals following the start of service approved in the certificate of need.

§346. Withholding of license

No new health care facility, as defined in section 328, is eligible to obtain a license under the applicable state law if the facility has not obtained a certificate of need as required by this chapter. The license of any facility does not extend to include and may not otherwise be deemed to allow the delivery of any services, the use of any equipment that has been acquired, the use of any portion of a facility or any other change for which a certificate of need as required by this Act has not been obtained. Any unauthorized delivery of services, use of equipment or a portion of a facility or other change is in violation of the respective chapter under which the facility is licensed.

§347. Withholding of funds

No health care facility or other provider may be eligible to apply for or receive any reimbursement, payment or other financial assistance from any state agency or other 3rd-party payor, either directly or indirectly, for any capital expenditure or operating costs attributable to any project for which a certificate of need as required by this Act has not been obtained. For the purposes of this section, the department shall determine the eligibility of a facility to receive reimbursement for all projects subject to the provisions of this Act.

§348. Injunction

The Attorney General, upon the request of the department, shall seek to enjoin any project for which a certificate of need as required by this Act has not been obtained and shall take any other action as may be appropriate to enforce this Act.

§349. Penalty

Whoever violates any provision of this chapter or any rate, rule or regulation pursuant to this Act is subject to a civil penalty payable to the State of not more than $5,000 to be recovered in a civil action. The department may hold these funds in a special revenue account that may be used only to support certificate of need reviews, such as for hiring expert analysts on a short-term consulting basis.

§350. Implementation reports

The holder of a certificate of need shall make a written report at the end of each 6-month period following its issuance regarding implementation activities, obligations incurred and expenditures made and any other matters as the department may require. A summary report must be made when the service or services for which the certificate of need was issued becomes operational. For a period of one year following the implementation of the service or services for which the certificate of need was granted, the provider shall file, at 6-month intervals, reports concerning the costs and utilization. The department, in its rules, shall prescribe the form and contents of the reports. Any holder of a certificate of need that has been issued for the construction or modification of a facility or portion of a facility shall file final plans and specifications for the project with the department within 6 months, or any other time that the department may allow, following the issuance of the certificate for review by the department to determine that the plans and specifications are in compliance with the certificate of need and are in compliance with applicable licensure, life safety code and accreditation standards. The department may revoke any certificate of need it has issued when the person to whom it has been issued fails to file reports or plans and specifications required by this section on a timely basis. The department shall review services that fall below the required volume and quality standards of a certificate of need.

Sec. 3. Preview. The Department of Human Services shall review its rules concerning Certificate of Need Health Care Facility/Agency Space and Needs Guidelines for which the department's Bureau of Medical Services, Division of Licensing and Certification has established service-specific licensure requirements and revise them as necessary to ensure that those guidelines are identical to the licensure requirements.

Sec. 4. Revisor's review; cross-references. The Revisor of Statutes shall review the Maine Revised Statutes and include in the errors and inconsistencies bill submitted to the Second Regular Session of the 120th Legislature pursuant to Title 1, section 94, any sections necessary to correct and update any cross-references in the statutes to provisions of law repealed in this Act.

SUMMARY

This bill repeals and replaces the Maine Certificate of Need Act of 1978. This bill requires that health prevention services be part of reviewable projects, clarifies when certificate of need waivers can be granted, clarifies the ability of the

Department of Human Services to impose conditions on a certificate of need, changes certain dates, eliminates the Certificate of Need Advisory Committee and authorizes the commissioner to establish a new advisory committee.

Program Title: **Division of Licensing and Certification**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates:

Title 1, 5, 22, 34, 34-B, Maine Statutes Revised Annotated; 42 Code of Federal Regulations, Parts 400-429, 430 to End; Section 1864, Social Security Act.

B. A description of each program administered by the agency or independent agency, including the following for each program:

The Division of Licensing and Certification enforces State licensing standards as well as serves as the State Survey Agency for the Center for Medicare and Medicaid Services under Section 1864 of the Social Security Act. In this capacity, the Division is responsible for determining whether participating providers/suppliers meet the requirements of Medicaid and/or Medicare. Currently, the Division licenses and/or certifies over 1,518 providers/suppliers. Of these providers, most participate in Medicare and/or Medicaid. This does not reflect the transfer of 782 assisted living facilities and 18 positions to the Bureau of Elder and Adult Services as of September 24, 2001. There are over 100 new providers added annually.

The Division is responsible for 26 licensing/certification programs that include a wide spectrum of health care providers, including hospitals, home health agencies, rehabilitation agencies, comprehensive outpatient rehabilitation facilities, ambulatory surgical centers, end stage renal disease (ESRD) facilities, rural health clinics, portable x-ray units, nursing homes, and multi-level facilities (nursing homes with assisted living units), etc. The Division operates the Maine Registry for Certified Nursing Assistants, listing over 36,000 CNAs and certifies 922 laboratories under the Comprehensive Laboratory Improvement Amendments of 1988 (CLIA). The paralegal support for the Division handles over 60 hearings per year. Additionally, the unit furnishes consultative services for behavioral management to nursing and assisted living facilities.

The Division has overall responsibility for the Minimum Data Set 2.0. Using quality indicators, it has successfully targeted resident populations in nursing facilities to best utilize its survey resources. It has also implemented use of the Federal Outcome and Assessment Information Set (OASIS) for Maine's home health agencies. It has begun to implement the newest revisions to the Federal Automated Survey Processing Environment (ASPEN) facility and survey management systems in order to integrate the survey database with other State and Federal databases.

The Division conducted over 690 licensing and certification surveys, 373 follow-ups and 700 complaint investigations. It implemented the expanded survey requirements of the Nursing Home Initiative, which included staggered surveys. review of abuse protocols, increased focus on nutrition, hydration, pressure sores and medication administration. It updated and revised hospital and nursing home licensing regulations during this past year.

The Division handles an increased complaint investigation workload due to Federal requirements, which now mandate a 2-day investigation cycle for immediate jeopardy and 10 days for alleged or actual harm. This Unit fields over 1,000 complaints per year.

The Maine Registry of Certified Nursing Assistants now handles over 36,000 certified nursing assistants (CNAs). It has upgraded its computer system to handle the increasing volume of additional CNAs and to begin a long overdue annual recertification process.

1. Established priorities, including the goals and objectives in meeting each priority;

A. Conduct Federal Certification surveys in accordance with national priorities as set by the Centers for Medicare and Medicaid Services.

Goal: Achieve 100% of contracted workload during Federal Fiscal Year.

Objective: Coordinate Federal certification surveys with State licensure to maximize resources.

Objective: Complete all complaint investigations in accordance with Federal and State requirements.

B. Conduct all State licensure surveys during State FY.

Goal: Achieve 100% of all required State licensure surveys.

Objective: Coordinate State licensure surveys with Federal certification surveys to maximize resources.

C. Set up a Long Term Care complaints investigation unit.

Goal: Hire and train and qualify as surveyors all new staff by end of FFY.

D. Establish a new computerized data base for the Maine Registry of Certified Nursing Assistants.

Goal: Complete Phase I of the above project by the end of the FFY.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

The Federal State Agency Performance Standards are used by the Regional Office of the Centers for Medicare and Medicaid Services (CMS) to evaluate the State Survey Agency. They consist of seven standards:

- Timely Surveys
- Supportable Findings
- Federal Observation/Support Systems and Federal Monitoring Surveys
- Enforcement
- Budget
- Complaints
- OSCAR Data Integrity

The State Survey Agency uses an internal Quality Improvement Program to self-evaluate for the above standards. It sends out a questionnaire after each survey of health care facilities/providers to solicit feedback on how the survey was conducted. The results are tabulated quarterly and annually and are used for management and educational/training assessments.

On a weekly basis, the State Survey Agency performs a review of the majority of Statements of Deficiencies to determine compliance with the Federal State Operations Manual and State licensing regulations. It completes a series of checklists/evaluations in this process.

The State Survey Agency undergoes a State Audit Review each year and uses Quarterly Expenditures and workload reports to further evaluate achievement of goals and objectives.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

The State Survey Agency has met the majority of its goals and objectives for the past fiscal year. The objective that is not yet met is setting up a Long Term Care Complaints Investigation Unit. While approval for four (4) additional Federal Complaints Investigator positions was granted by the Legislature, a hiring freeze so far has prevented acquiring the

necessary staff. The Division has budgeted for these positions and is ready to provide the necessary training once the positions are filled.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines or responsibility;

See attached job classification and organizational chart for the Bureau.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation;

The Division of Licensing and Certification is in compliance with the above requirements, coordinating as needed with appropriate State agencies.

As part of its mandate, the Division of Licensing and Certification reviews health care facilities and conducts complaint investigations and reviews compliance with Americans with Disabilities Act, the Federal Occupation Safety and Health Act, etc. It enforces the provisions of Federal and State regulations in these areas, through onsite surveys and complaint investigations.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years;

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted;

The following Regulations for the Licensing of General and Specialty Hospitals in the State of Maine were adopted in 2001:

1. Chapter VI., The Governing Board-addresses the purpose, composition of Bylaws and responsibilities of the Governing Board;

2. Chapter VII., Physical Environment-addresses the physical plant requirements, quality improvement responsibilities, and a new mandatory reporting requirement for the reporting of fires;

3. Chapter XI., Dietary Department-addresses policy revision, staffing system, and patient nutritional care;

4. Chapter XII., Medical Records services-changes the authentication of physician telephone orders from twenty-four (24) hours to seventy-two (72) hours;

5. Chapter XVII., Complementary Department, Section V., Rehabilitation, Physical Therapy and Occupational Therapy-clarifies physician orders;

6. Chapter XVIII., Outpatient Services-includes a definition organization and direction, staffing, policies and procedures, facilities, documentation, and quality improvement responsibilities;

7. Chapter XX., Social Work Services-includes staffing, organization, policies and procedures, and documentation requirements;

8. Chapter XXI., Quality Management-defines the components of the Quality Management Program;

9. Chapter XXIII.C.1c., Psychiatric Unit, Special Medical Records Requirements, Treatment Plan-revises what the written plan shall include;

10. Chapter XXIII,C,d,(1)(a), Psychiatric Unit, Special Medical Records Requirements, Progress Notes-changes the frequency of recording progress notes from at least weekly to a minimum of every forty-eight (48) hours;

11. The addition of Chapter XXIII.G., which includes the seclusion and restraint section of 42 CFR, Chapter IV, Part 248.13;

12. The addition of Chapter XXV.A.2.b, Psychiatric Hospital, which includes the seclusion and restrain section of 42 CFR, Chapter IV, Part 482.13., and re-numbering of that section;

13. Chapter XXVII.C.b(2), Critical Access Hospital, Governing Board, Administrative Requirements-adds the word "average" to the length of stay for acute care

These rules became effective September 1, 200.

The following Regulations Governing the Licensing and Functioning of Home Health Care Services in the State of Maine were adopted in 2001:

1. Chapter 7.A.4., Physician Services-changes the twenty-one (21) day requirement to a thirty (30) day requirement regarding physician's verbal orders.

2. Chapter 7.I., Behavioral Services (Community Support Services)-The Department of Human Services and the Department of Mental Health/Mental Retardation and Office of Substance Abuse, in order not to duplicate Maine's licensure fees and paperwork, have acknowledged Home Health Care Services Providers to provide behavioral mental health services to children under the present Home Health Care Services

licensure process. The Home Health Care Services Provider would not be required to have mental health clinic licensure.

These rules became effective April 1, 2001.

The following Regulations for Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities were adopted in 2001.

Chapter 2 includes requirements for nursing facilities to provide the Department with a forty-five (45) day prospective notice for any increase or decrease in the number of beds. Chapter 8 contains requirements for direct care staff to wear identification badges except in situations where it would be a safety hazard. Chapter 10 contains requirements that nursing facilities provide residents to be discharged with a list of licensed Home Health Care Agencies, which serve their area of residence. Chapter 12 has an updated definition of comprehensive assessment. Chapter 17 contains changes regarding nursing facilities' disposition of and handling Schedule II through V controlled substance. Chapter 22 changes the Grounds for Penalty and identifies the penalty for operating a nursing facility without a license.

These rules are effective February 2, 2001.

The following Regulations for the Licensing and Functioning of Skilled Nursing Facilities and Nursing Facilities were also adopted in 2001.

1. Chapter I provides definitions for direct-care providers and direct care. Direct-care providers means Registered Nurses, Licensed Practical Nurses, and Certified Nurses Assistants who provide direct care to nursing facility residents. Direct-care means hands on care provided to residents, including, but not limited to feeding, bathing, toileting, dressing, lifting, moving residents, treatments, and medication administration. "Direct Care" does not include food preparation, housekeeping or laundry services except in circumstances when such services are required to meet the needs of an individual resident on a give occasion.

2. This final rule also requires the Department to issue a default license when a completed application for a new facility has been submitted and the necessary notifications, inspections or services from the Division of Licensing and Certification and the Department of Public Safety has not been provided.

3. Chapter 6 has an addition which states that nursing facilities must refund any payment received for a period of time that Medicaid eligibility has pending and the resident was eligible for Medicaid.

4. Finally, Chapter 9 changes the minimum staffing ratios to one direct care provider of every five (5) residents on the day shift; one (1) direct-

care provider fore every ten (10) residents on the evening shift, and one (1) direct-care provider for every fifteen (15) residents on the night shift.

These final rules became effective June 1, 2001.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements;

The State Survey Agency has taken the following steps to cooperate with other State and Federal agencies in achieving program objectives:

1. A Best Practices Task Force was established to provide training to providers and survey staff. Representatives of such groups as providers, advocates, professionals and regulators decide on the training. Funding was secured from CMS through use of civil monetary penalties.

2. Licensing reviews were coordinated, where possible, with Federal Certifications surveys to preclude duplication for hospitals, home health agencies, hospices, ambulatory surgical centers and end state renal disease facilities.

3. Multilevel surveys for nursing homes and assisted living facilities were coordinated to do surveys at the same time and these facilities were also issued a license at the same time.

4. Memoranda of Agreement were executed with Professional Licensing Boards for exchange of information.

5. Joint training on survey and certification was coordinated with the Regional Office of CMS for both State and Federal Certification.

6. State survey staff with expertise in hospital surveys, especially psychiatric and critical access hospitals was loaned to CMS and another state to provide training.

7. A Memorandum of Agreement was executed with a neighboring State survey agency to accept each other's certification results if the provider had facilities in each state.

8. Periodic quality assurance meetings with Long Term Care providers were revived.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes;

The Division protects the public by enforcement of Federal certification and State licensing regulations. Constituents served are:

- The public in general, primarily patients or recipients of health services
- All licensed and/or certified providers.
- All Professional Licensing Boards
- Adult/Child Protective Agencies
- Other State Agencies such as the Attorney General, Bureau of Health
- Federal Agencies such as CMS, DEA, etc.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives;

There are no alternatives to the enforcement functions of the Division of Licensing and Certification. The Division has, however, contracted with a number of professional health care providers to complement the survey process such as psychiatrists, physicians, pharmacists and on occasion others such as dietitians to better actively participate or provide consultations.

The Division also has some limited contracts such as use of French interpreter(s) during Long Term Care surveys, in predominantly French areas and has contracted the testing of Certified Nursing Assistants to an agency in the private sector. This particular contract is of no cost to the State.

J. Identification of emerging issues for the agency or program in the coming years;

The State Survey Agency faces a number of issues for the near future:

- Increased Use of Computers: - CMS has required the State Survey Agency to use the Minimum Data Set (MDS) and Outcome and Assessment Information Set (OASIS) assessment data. This requires a data management system that would support a suite of applications/tools designed to provide States and CMS with the ability to use performance information to enhance on-site inspection activities, monitor quality in an ongoing manner, and facilitate providers' efforts related to continuous quality improvement. This overall initiative, known as the Quality Improvement and Evaluation System (QIES), also includes

- Extension of the MDS/OASIS systems to include new provider types in future years (e.g., rehabilitation and long-term care hospitals, end-stage renal disease facilities, ICFs/MR , and other providers):

- Continued development of Windows-based ASPEN integrated with State standard systems;

- Systems to support most day-to-day operations of the survey and certification program, including scheduling, tracking, budgeting and surveyor training functions not now supported by CMS systems;

- And, finally, the integration of these functions and systems into a comprehensive information system, subsuming the functions of the current OSCAR system and integrating a distributed State system with a central repository of assessment and Survey and Certification data linked to other vital CMS systems such as the National Provider System, the Provider Enrollment and Chain Ownership System, and others.

- Appropriate Staffing: - The increase in Federal survey and certification requirements, such as the Federal Nursing Home Initiative has required huge additional workloads that can only be met with additional staffing. While Federal funding is generally available to accomplish these workload increases, the requirement to have the governor and legislature approve additional staffing guarantees that the time lag precludes the State Survey Agency from accomplishing the new mandates on a timely basis.

- Maintaining Professional Clinical Qualifications: - With the tremendous workloads and rapidly changing clinical and technological environments of the many programs reviewed by the State Survey Agency there is an increasing need for survey staff to stay abreast of the latest clinical/technological changes in the provider community.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

The Federal Medicare certification requirements provide the basis as the ground floor for all State licensure regulations promulgated by the Division of Licensing and Certification. Such licensing regulations as those from Hospices, ESRDs, ambulatory surgical centers mirror entirely the Federal certification rules found in 42 Code of Federal Regulations. Other Regulations, primarily those for hospitals, nursing homes and home health agencies have multiple additional provisions reflecting State statutory requirements and specific criteria to protect the public. The Regulations for the Maine Registry of Certified Nursing Assistants reflect the Federal, as well as the State Statutory requirements, for the 150 hour Maine CNA training versus the 75 hour Federal requirement.

M. Agency policies for collecting managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

See the Department of Human Services Department-wide compliance statement.

State of Maine

10
Department of Human Services

2000-2001 Regulatory Agenda

AGENCY UMBRELLA-UNIT NUMBER: 10-144
AGENCY NAME: Department of Human Services, Bureau of Medical Services

CONTACT PERSON: Marianne Ringel, Director, Policy and Program Division, 11 State House Station, Augusta, ME 03333-0011, Tel. (207) 624-5518

EMERGENCY RULES ADOPTED SINCE THE LAST REGULATORY AGENDA: Ch. 101, Maine Medical Assistance Manual, Chapter III Section 22, Chapter II Section 65, Chapter 106 Maine Drugs for the Elderly Program,

EXPECTED 2001-2002 RULEMAKING ACTIVITY:

CHAPTER 101, MAINE MEDICAL ASSISTANCE MANUAL: Chapters I, II, III, IV, V, VI, VII, VIII and relevant Principles of Reimbursement
STATUTORY AUTHORITY: 22 M.R.S.A. § 42, § 3173
PURPOSE: These rules describe requirements for the provision and reimbursement of services under the Medicaid program. It also describes certain administrative functions necessary for the operation of the Medicaid Program. They will be amended to comply with federal changes, to update policy and to implement new services and regulations, as necessary.
ANTICIPATED SCHEDULE: It is not possible to predict when all of the changes will be made to these regulations because of the nature of this work. Federal regulation changes, state legislation, and state-initiated changes as a result of identified problems require the timely amendment or adoption of new rules over the course of the year.
AFFECTED PARTIES: Medicaid clients, Medicaid providers, and Managed Care Organizations

CHAPTER 112, REGULATIONS FOR THE LICENSURE OF GENERAL AND SPECIALTY HOSPITALS IN THE STATE OF MAINE
STATUTORY AUTHORITY 22 MRSA Chapter 1, §§ 3, 5, 6, 42, 1708-1711, 1715, 1811-1818, 1820-3, 1829, 1831.
PURPOSE: These rules govern the licensing and functioning of Hospitals.
ANTICIPATED SCHEDULE: Chapters VI, VIII, XI, XX, XXVIII will be revised in the next calendar year to reflect current standards of practice. Federal regulation changes, State legislation and State-initiated changes as a result of identified problems, require the timely amendment of adoption of new rules over the course of the year.
AFFECTED PARTIES: Hospital providers and consumers/patients

CHAPTER 120, REGULATIONS GOVERNING THE LICENSING AND FUNCTIONING OF HOSPICE PROGRAMS
STATUTORY AUTHORITY: 22 MRSA, Chapter 1681, §§ 8621-8631
PURPOSE: These regulations govern the licensing of hospices in the State of Maine. These regulations will be amended to comply with Federal changes, statutory changes and will reflect current health care standards or practices as needed.
ANTICIPATED SCHEDULE: Chapter 5G. will reflect a change in hours for direct care personnel who are not full time hospice employees. The regulations will be amended by January 2001 to comply with Federal changes, statutory changes, and reflect current health care standards or

practices as needed.
AFFECTED PARTIES: Hospices, consumers, and managed care organizations

CHAPTER 113, REGULATIONS FOR LICENSING AND FUNCTIONING OF ASSISTED LIVING FACILITIES
STATUTORY AUTHORITY: Title 22, Chapter 405, §§ 1812-C, 1812-G; Chapter 413, § 2053; Chapter 1453, § 5107-A; Chapter 1663, §§ 7801-7802; Chapter 1665, § 7901-A, 7901-B, 7901-C, 7902-A, 7903, 7904-A, 7904-B, 7914, 7915; Chapter 1666, § 7922; Title 32, Chapter 31, § 2102
PURPOSE: These rules govern the licensing and functioning of assisted living facilities.
ANTICIPATED SCHEDULE: These regulations will be amended to include a new Chapter V that will reflect licensing of Adult Family Care Homes. Other minor revisions to the existing regulations will be done at the same time. It is anticipated that the necessary changes will be made by November 2000.
AFFECTED PARTIES: Assisted living services providers and consumers

CHAPTER 121, REGULATIONS GOVERNING THE LICENSING OF ADULT FAMILY CARE HOMES
STATUTORY AUTHORITY: 22 MRSA
PURPOSE: These rules govern the licensing of Adult Family Care Homes.
ANTICIPATED SCHEDULE: It is anticipated that these rules will be added to the Regulations for the Licensing and functioning of Assisted Living Facilities. Necessary changes will be made by November 2000.
AFFECTED PARTIES: All current and prospective Adult Family Care Home providers and consumers

CHAPTER 117, REGULATIONS GOVERNING THE LICENSING OF ADULT DAY SERVICES PROGRAMS
STATUTORY AUTHORITY: Title 22, Chapter 958-A, §§ 3470-3487; Chapter 1505, §§ 6201-6209; Chapter 1663, §§ 7801-7804; Chapter 1665, § 5107-A; Chapter 1679, §§ 8601-8605
PURPOSE: These rules govern the licensing and functioning of Adult Day Services Programs.
ANTICIPATED SCHEDULE: It is anticipated that these regulations will be changed to allow Adult Day Services programs located in an Assisted Living Facility or a Nursing Facility to be surveyed and licensed as part of the whole facility's survey and license. The necessary changes will be made by November 2000.
AFFECTED PARTIES: All providers and consumers of Adult Day Services Programs

CHAPTER 119, REGULATIONS GOVERNING THE LICENSING AND FUNCTIONING OF HOME HEALTH CARE SERVICES
STATUTORY AUTHORITY: 22 M.R.S.A., § 2141 et seq.
PURPOSE: These regulations describe the minimum requirements for the licensing of home health agencies. It also functions as the standard of care for Maine's citizens in need of home health services. They will be amended to comply with Federal changes and to update standards of care as necessary.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to these regulations because of the nature of the work. Federal regulation changes, State legislature and State initiated changes as a result of identified problems, require the timely amendment or adoption of new rules over the course of the year.
AFFECTED PARTIES: Home health providers, consumers and managed care organizations

CHAPTER 110, REGULATIONS GOVERNING THE LICENSING OF NURSING FACILITIES

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-6
PURPOSE: This rule requires the Department of Human Services to amend its rules to provide for default licensing for new facilities when a new applicant has filed a completed application, and has not been provided the necessary notifications, inspections or services for a period of more

than 90 days.
ANTICIPATED SCHEDULE: These rules are expected to be in effect by January 1, 2001.
AFFECTED PARTIES: Nursing facility providers

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-11
PURPOSE: This rule requires the Department of Human Services to amend the rules for minimum staffing ratios in nursing facilities and to provide definitions of direct care providers and direct care.
ANTICIPATED SCHEDULE: It is expected that these rules will be effective in October, 2000
AFFECTED PARTIES: Nursing facility residents, and nursing facility providers

STATUTORY AUTHORITY: Title 22 M.R.S.A Chapter 731, BBBB-12
PURPOSE: This rule requires the Department of Human Services to amend its rules regarding the duration of licenses for providers of long term care services and the surveys required of those providers.
ANTICIPATED SCHEDULE: These rules are expected to be in effect by January 1, 2001.
AFFECTED PARTIES: Nursing Facility Providers

CHAPTER 106, MAINE'S DRUGS FOR THE ELDERLY PROGRAM

STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 254
PURPOSE: These rules govern the operation of Maine's State-funded drug program for certain eligible elderly individuals. They will be amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Elderly individuals found eligible for this program as well as pharmacies

STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 3174
PURPOSE: These rules will govern the operation of Maine's drug rebate program for Cub Care eligible children. They will be adopted and amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children eligible for Cub Care as well as pharmacies

CHAPTER 130, MAINE Rx PROGRAM
STATUTORY AUTHORITY: 22 M.R.S.A. Chapter 603
PURPOSE: These rules govern the operation of Maine's State-run drug cost containment program. They will be adopted and amended to conform to State legislation or to implement State-initiated changes to correct problems identified through monitoring of the program.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Uninsured Maine residents as well as pharmacies

CHAPTER 107, MAINE EYE CARE PROGRAM
STATUTORY AUTHORITY: 22 M.R.S.A. § 42, § 3173
PURPOSE: These rules govern the operation of Maine's State-funded Eye Care Program. They will be amended to reflect administrative changes found necessary through monitoring of this program.

ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children and Adults not eligible for Medicaid for whom the State would reimburse certain eye care services as well as the providers of these services

CUB CARE
STATUTORY AUTHORITY: P.L. 99 Chapter 777
PURPOSE: These rules establish the Children's Health Insurance Program. They will be amended to reflect federal changes or administrative changes found necessary through monitoring this program in accordance with State statute.
ANTICIPATED SCHEDULE: It is not possible to predict when changes will be made to the above regulations because of the nature of this policy. State-initiated changes as a result of identified problems will require the timely amendment of the rules.
AFFECTED PARTIES: Children under the age of 19 found eligible for this program

BUREAU OF MEDICAL SERVICES
PROGRAM EVALUATION REPORT

Program Title: Quality Oversight of Commercial Health Maintenance Organizations (HMO)

A. Enabling or authorizing law or other relevant mandate, including any Federal Mandates:

Title 24A. Section 4301, PL 1997,c. 792, Section 2(rpr), "Health Plan Improvement Act." 24-A M.R.S.A., Section 4215. The Bureau of Insurance and the Department of Human Services, as part of an interagency task force will conduct and coordinate reviews, such as the Quality Oversight Project, related to the quality of health care services for health maintenance organizations.

B. A description of each program administered by the agency or independent agency, including the following for each program:

The Bureau of Medical Services, in conjunction with the Bureau of Insurance, is responsible for the quality improvement review of commercial health maintenance organizations licensed in Maine.

B1. Established priorities, including goals and objectives in meeting each priority;

Goal I: To work with the Bureau of Insurance to evaluate the quality of care and services commercial health maintenance organizations provide to privately-insured Maine citizens.

Objective: To conduct tri-annual reviews of licensed commercial health maintenance organizations in conjunction with the Bureau of Insurance.

B2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving goals and objectives;

The Bureau of Medical Services has been working cooperatively with the Bureau of Insurance to develop a data collection tool to assist in the evaluation of commercial health maintenance organizations. The data collection tool was completed and tested through the licensing reviews of health maintenance organizations. In fiscal year 2001, the data collection tool was used and evaluated on one to two commercial health maintenance organizations.

B3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measure the agency has taken to meet the goals and objectives.**

The Bureau of Medical Services conducted the first test of the data collection tool in the fall of 2001. Aetna US HealthCare was the first HMO due for licensing renewal and evaluation. The data collection tool was used and determined to be effective in obtaining needed information to ensure all licensing requirements were met. Any further updates to the data collection tool shall be done in accordance with changes in insurance rules and regulations.

C. **Organizational structure, including a position count, a job classification and an organization flow chart indicating lines or responsibilities:**

Included in the position count for BMS.

Director-Bureau of Medical Services: Reviews final report to be submitted to the Bureau of Insurance regarding the recommendations on licensure. The final report may include all findings compiled during the facility on-site review and recommendations or remedies associated with failure to comply with licensing requirements.

Deputy Director-Bureau of Medical Services: Reviews final report to be submitted to the Director, BMS and the Superintendent, Bureau of Insurance, regarding the recommendations of whether to renew licensure. The final report may include all findings compiled during the facility on-site review and recommendations or remedies associated with failure to comply with licensing requirements.

Comprehensive Health Planner II/Health Services Supervisor (1): Assists in the development and continued revision of the data collection tool. Acts as the team leader, gathers information at survey, pre-survey and post survey on credentialing, quality improvement activities, utilization review, access and availability and complaint and grievance activities. Conducts on-site reviews with NCQA and the State on-site visit. Creation of the summary report of licensure findings and submission to the Quality Improvement Division Director, for review prior to submission to the Deputy Director, BMS.

Health Services Consultant/Contracted Reviewer (1): Survey team member. Participates in the pre-survey document review, on-site visits and summary report creation. Assists in gathering information on utilization review, quality improvement activities, credentialing, complaint/grievance activities and

access/availability activities to determine compliance with licensing requirements.

Medical Director: Responsible for reviewing quality improvement activities, in particular specialized studies to evaluate the relevance of QI activities to the enrolled population. Assists in reviewing appropriateness of medical treatment through complaints/grievances and utilization review activities.

Comprehensive Health Planner II: Responsible for coordinating activities between the Bureau of Insurance and Division of Quality Improvement. Communicates to health maintenance plans the survey dates; pre-survey material needs, and provides the plan with regulations. Updates Rule 109, which directs the quality improvement review conducted by the Quality Improvement Staff.

Muskie School of Public Policy/Contractor: Responsible for the development and updating of the data collection tool used to evaluate licensed health maintenance organizations. This includes incorporating new changes to rules effecting insurance plans licensing requirements, confidentiality and member rights.

Management Analyst I: Responsible for developing an online data collection tool that will allow for retrieval of findings by category, development of quality improvement reports including tracking and trending findings, and creation of an on-line summary report.

D. Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupations Safety and Health Act, affirmative action requirements and workers compensation.

See the Department of Human Services Department-wide Compliance Statement.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for the Bureau.

F. When applicable, the regulatory agenda and the summary of rules adopted:

See attached Regulatory Agenda.

G. Identified of those areas where an agency has coordinated its efforts with other State and Federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including but not limited to cooperative arrangements to coordinate services and eliminate redundant requirements;

The Bureau of Medical Services has worked in conjunction with the Bureau of Insurance and the Muskie Institute for Public Policy to develop a mechanism for evaluating health maintenance organization compliance with licensing requirements.

The National Committee for Quality Assurance (NCQA) is a nationally recognized private agency that credentials health maintenance organizations. Health Maintenance Organizations pay this agency to evaluate and credential them every 3 years. NCQA has developed standards of practice for health maintenance organizations. Many of these standards of practice are part of the Title 24, Sections 850 and 56-A . The interagency task force has worked to develop a tool that allows the NCQA findings to be applied (wherever applicable) to the review findings needed to perform the State licensure survey. This has been effective in reducing any redundancy in the survey process.

H. Identify the constituencies serviced by the agency or program, noting any changes or projected changes;

This program affects all Maine citizens who subscribe to commercial health maintenance organizations licensed in the State of Maine.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

One of the team members who participate in the on-site reviews is a contracted staff person.

In addition, the Bureau of Medical Services has contracted with the Muskie School of Public Policy to create, maintain and update the data collection tool in accordance with regulatory changes.

J. Identification of emerging issues for the agency or program in the coming years;

- Availability of staff to perform the licensure survey
- Long orientation process to train survey members on regulation, rules and survey process
- Increasing cost of the program

K. Any other information specifically requested by the committee of jurisdiction;

None

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program;**

None known

M. **Agency policies for collecting managing and using person information over the internet and non electronically, information on the agency's implementation of information technologies and an evaluation of the agencies adherence to the fair information practice principles of notice, choice access, integrity and enforcement.**

See the Department of Human Services Department-wide Compliance Statement.

DEPARTMENT OF HUMAN SERVICES
BUREAU OF MEDICAL SERVICES

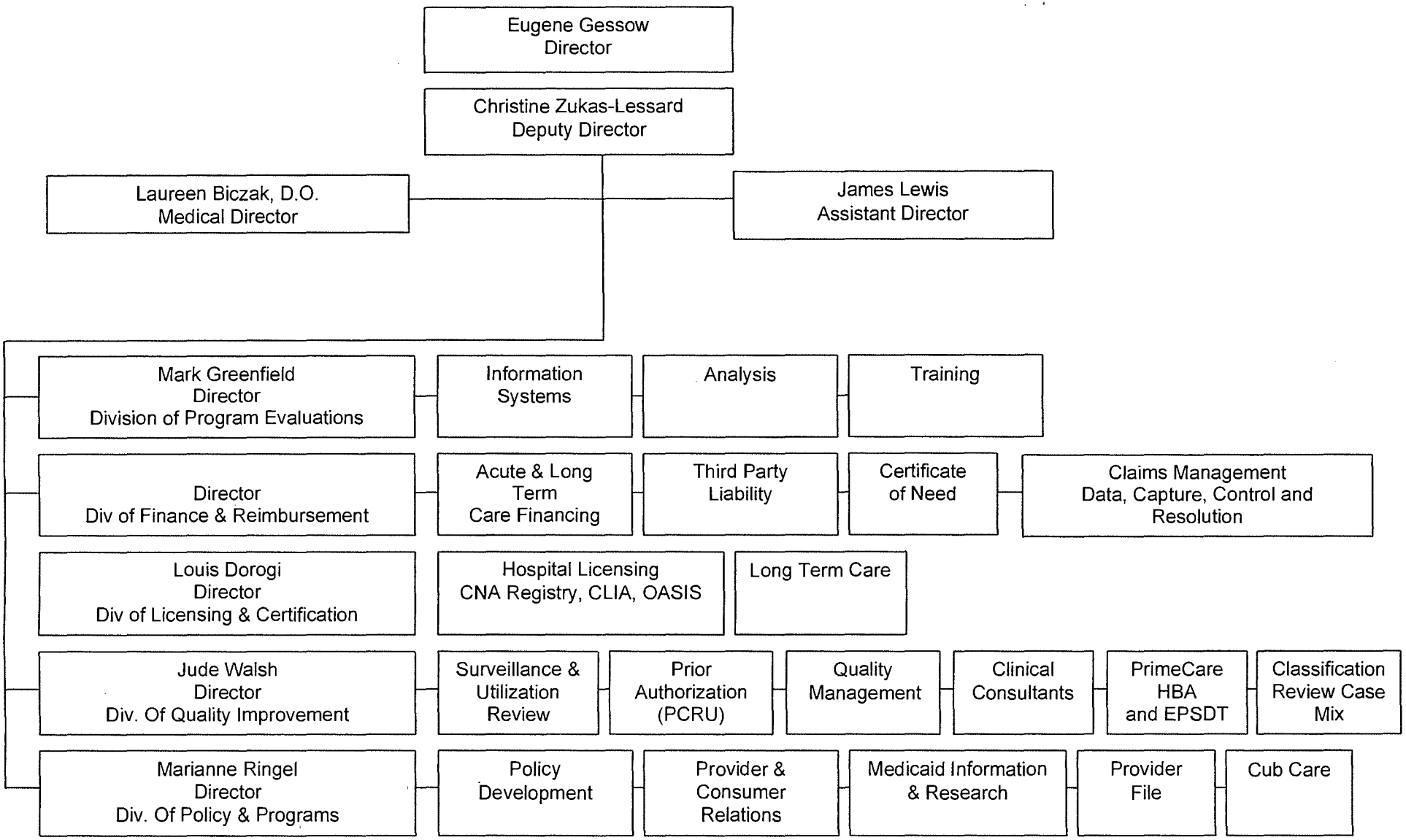
Position Count	Job Classification
1	Director Bureau of Medical Services
1	Deputy Director Bureau of Medical Services
1	Director Management Services
5	Director Division of Medicaid/Medicare
1	Director Pharmacy Services
1	Pharmacist
5	Assistant Director Division of Medicaid/Medicare
1	Medicaid Surveillance and Utilization Supervisor
8	Management Analyst II
8.5	Comprehensive Health Planner II
2	Comprehensive Health Planner I
4	Social Services Program Manager
4	Supervisor Professional Claims Review
3	Planning and Research Associate I
2	Medicare Consultants
1	Field Examiner II
8	Medical Care Coordinator
41	Health Services Consultant
18	Medical Care Coordinator
3	Nursing Education Consultant
1	Para-legal Assistant
1	Medical Secretary
1	Secretary
5	Clerk IV
22	Clerk Typist III
140.5	

12	Medical Claims Evaluator
6	Social Services Program Specialist I
3	Management Analyst I
9.5	Provider Relations Specialist
5	Senior Medical Claims Evaluator
1	Senior Health Care Financial Analyst
4	Financial Analyst
2	Health Care Financial Analyst
3	Manager Benefits Recovery Unit
9	Reimbursement Specialist
9	Senior Medical Claims Adjuster
6	Medical Claims Adjuster

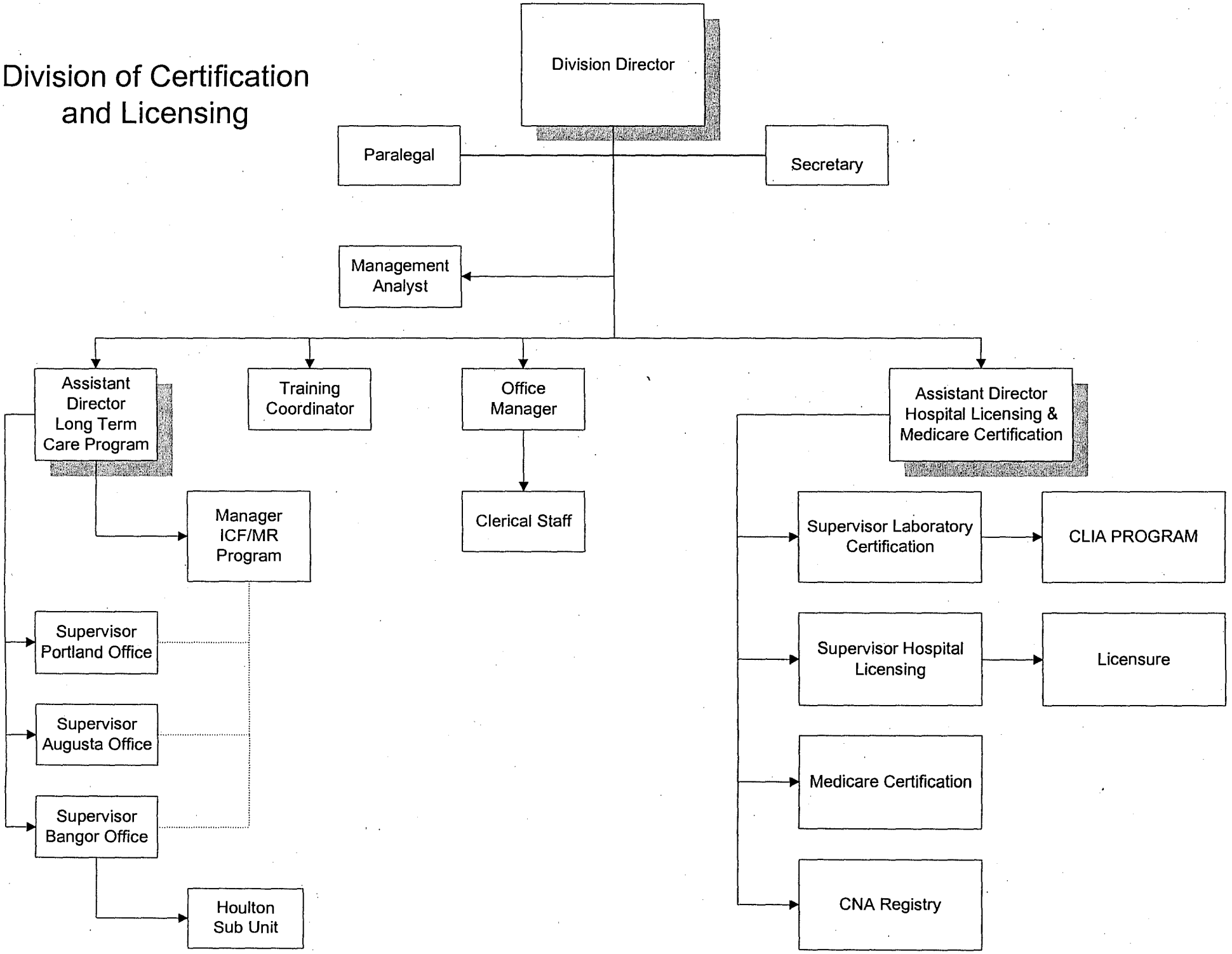
1	Quality Assurance Officer
1	ICFMR License/Certification Supervisor
5	Health Services Supervisor
3	Health Facility Specialist
7	Clerk III
6	Clerk Typist II
10	Clerk II
2	Data Control Specialist
1	Accountant II
1	Accountant I
2	Accounting Technician
2	Data Entry Specialist (includes 1 project position-ends 4/12/02)
110.5	

251 Total Position Count

BUREAU OF MEDICAL SERVICES



Division of Certification and Licensing



DEPARTMENT OF HUMAN SERVICES
BUREAU OF MEDICAL SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	BUREAU OF MEDICAL SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0102	AFFORDABLE HEALTH CARE FUND										
0129	BUREAU OF MEDICAL SERVICES	6,176,347	5,443,620	6,512,269	6,645,118	7,587,782	7,587,782	7,296,512	6,102,085	10,009,111	9,198,069
0147	MEDICAL CARE SERVICES	86,851,881	27,099,754	95,537,069	58,241,024	96,116,015	80,630,992	111,692,235	86,769,123	76,024,504	74,345,431
0148	NURSING FACILITIES	89,883,214	85,115,372	78,783,818	78,783,818	92,357,635	92,357,635	93,630,558	85,318,356	84,987,524	78,466,448
0200	HEALTH PLANNING AND DEVELOPMENT	689,782	371,885	744,142	288,394	463,626	264,587	462,686	342,673	345,684	302,053
0202	DRUGS FOR MAINE'S ELDERLY	4,076,200	4,076,199	4,211,830	4,211,830	4,763,770	3,489,591	5,044,832	3,422,559	3,643,372	3,643,260
0664	MAINE HEALTH PROGRAM	5,779,445	5,779,445	4,655,621	2,723,063	3,811,000	2,015,145	3,925,330	1,003,069		
0927	MAINE RX PROGRAM										
	GENERAL FUND TOTAL:	193,456,869	127,886,276	190,444,749	150,893,248	205,099,828	186,345,732	222,052,153	182,957,866	175,010,195	165,955,261
0129	BUREAU OF MEDICAL SERVICES	9,750,123	9,407,326	10,922,859	10,922,859	12,603,966	12,603,966	19,236,113	19,236,113	26,622,049	23,098,737
0147	MEDICAL CARE SERVICES	387,377,251	254,831,382	291,745,428	291,745,428	303,259,992	326,631,905	334,478,365	397,427,974	413,392,663	408,141,944
0148	NURSING FACILITIES	197,989,857	197,987,767	174,522,269	204,442,888	198,046,704	198,046,704	208,835,603	208,835,603	198,271,503	197,837,669
	FEDERAL FUND TOTAL:	595,117,231	462,226,475	477,190,556	507,111,175	513,910,662	537,282,575	562,550,080	625,499,689	638,286,215	629,078,351
0129	BUREAU OF MEDICAL SERVICES	359,024	88,742	381,329	70,839	383,027	66,802	390,081	82,110	1,515,357	1,201,794
0147	MEDICAL CARE SERVICES	125,594,933	108,914,413	113,417,099	113,417,099	118,293,223	118,293,223	101,768,887	101,768,887	131,455,008	123,154,525
0147-02	HEALTHY MAINE PRESCRIPTION PGM										
0200	CERTIFICATE OF NEEDS			4,344	4,344	38,809	24,015	80,393	80,393	95,402	15,013
0202	DRUGS FOR MAINE'S ELDERLY						-				
0913	PRESCRIPTION DRUG DEDICATED FUND										
0927	MAINE RX DEDICATED FUND										
	OTHER SPECIAL REVENUE TOTAL:	125,953,957	109,003,155	113,802,772	113,492,281	118,715,059	118,384,040	102,239,361	101,931,390	133,065,767	124,371,332
0129	BUREAU OF MEDICAL SERVICES										
0147	MEDICAL CARE SERVICES										
	BLOCK GRANT TOTAL:	-	-	-	-	-	-	-	-	-	-
	GRAND TOTAL	**914,528,057**	**699,115,906**	**781,438,077**	**771,496,704**	**837,725,549**	**842,012,347**	**886,841,594**	**910,388,945**	**946,362,177**	**919,404,943**

DEPARTMENT OF HUMAN SERVICES
BUREAU OF MEDICAL SERVICES
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	BUREAU OF MEDICAL SERVICES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0102	AFFORDABLE HEALTH CARE FUND									49,000	-
0129	BUREAU OF MEDICAL SERVICES	8,765,530	8,072,161	8,904,715	8,477,667	10,949,477	10,665,336	9,765,712	9,302,379	13,126,542	12,976,630
0147	MEDICAL CARE SERVICES	82,256,887	82,114,463	114,471,208	114,038,939	227,043,808	226,784,772	257,388,214	253,302,013	277,153,193	265,950,334
0148	NURSING FACILITIES	86,365,194	72,315,617	69,704,549	61,600,676	61,835,496	60,385,780	66,421,065	66,421,064	68,500,000	65,457,778
0200	HEALTH PLANNING AND DEVELOPMENT	329,638	327,301								
0202	DRUGS FOR MAINE'S ELDERLY	3,874,228	3,502,305	4,043,149	3,748,314	6,140,680	5,425,701	8,242,623	8,232,999	7,143,198	7,043,803
0664	MAINE HEALTH PROGRAM										
0927	MAINE RX PROGRAM									296,936	155,224
	GENERAL FUND TOTAL:	181,591,477	166,331,847	197,123,621	187,865,596	305,969,461	303,261,589	341,817,614	337,258,456	366,268,869	351,583,768
0129	BUREAU OF MEDICAL SERVICES	27,192,019	25,348,196	27,339,385	26,095,896	31,338,951	29,948,670	36,280,877	35,337,416	42,908,085	35,560,484
0147	MEDICAL CARE SERVICES	471,729,679	468,003,601	535,673,372	528,712,221	570,466,133	568,210,252	602,595,546	599,129,854	695,189,240	675,514,762
0148	NURSING FACILITIES	207,238,668	189,998,349	197,003,410	179,693,531	176,823,840	175,408,433	191,372,014	190,381,652	202,671,359	183,172,365
	FEDERAL FUND TOTAL:	706,160,366	683,350,146	760,016,167	734,501,648	778,628,924	773,567,355	830,248,437	824,848,922	940,768,684	894,247,610
0129	BUREAU OF MEDICAL SERVICES	864,915	405,166	1,806,080	397,738	2,413,345	2,405,569	3,449,678	3,050,077	1,852,076	1,536,481
0147	MEDICAL CARE SERVICES	140,830,985	139,455,851	127,670,315	127,593,970			132,659	-	6,812,044	3,500,000
0147-02	HEALTHY MAINE PRESCRIPTION PGM									85,315	-
0200	CERTIFICATE OF NEEDS	62,806	17,966								
0202	DRUGS FOR MAINE'S ELDERLY									10,000,000	9,999,999
0913	PRESCRIPTION DRUG DEDICATED FUND							2,500,000	-	10,000,000	-
0927	MAINE RX DEDICATED FUND									4,582,500	-
	OTHER SPECIAL REVENUE TOTAL:	141,758,706	139,878,983	129,476,395	127,991,708	2,413,345	2,405,569	6,082,337	3,050,077	33,331,935	15,036,480
0129	BUREAU OF MEDICAL SERVICES					249,803	196,430	403,365	399,122	272,734	154,408
0147	MEDICAL CARE SERVICES					5,771,451	231,647	12,002,195	8,981,144	13,579,303	10,436,327
	BLOCK GRANT TOTAL:	-	-	-	-	6,021,254	428,077	12,405,560	9,380,266	13,852,037	10,590,735
	GRAND TOTAL	**1,029,510,549**	**989,560,976**	**1,086,616,183**	**1,050,358,952**	**1,093,032,984**	**1,079,662,591**	**1,190,553,948**	**1,174,537,720**	**1,354,221,525**	**1,271,458,593**

MEDICAID EXPENDITURES BY CATEGORY OF SERVICE

CATEGORY OF SERVICE	SFY 1992	SFY 1993	SFY 1994	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000	SFY 2001
HOSPITAL SPENDING										
01 GENERAL INPATIENT	$183,476,290	$195,727,592	$198,280,648	$201,714,525	$172,381,297	$197,831,519	$193,335,727	$123,427,502	$118,895,717	$113,094,479
02 PSYCH FACILITY SVC	$11,640,758	$17,983,416	$33,689,795	$37,005,279	$34,106,969	$40,492,454	$39,607,953	$41,139,426	$41,350,658	$39,328,116
04 GENERAL OUTPATIENT	$62,456,260	$65,427,132	$69,381,101	$73,777,553	$69,731,709	$83,018,482	$83,361,344	$53,683,008	$49,182,435	$50,500,997
SUBTOTAL HOSPITAL	$257,573,308	$279,138,140	$301,351,544	$312,497,357	$276,219,975	$321,342,455	$316,305,024	$218,249,936	$209,428,810	$202,923,592
PHYSICIAN & RELATED PRACTITIONERS										
06 PHYSICIAN	$29,736,015	$31,638,706	$30,992,326	$31,580,063	$28,875,478	$29,195,225	$28,328,585	$37,185,517	$39,549,180	$42,894,163
18 AMBULATORY SURG CENT	$101,394	$107,085	$177,730	$151,737	$184,371	$175,794	$234,242	$221,865	$241,773	$269,547
30 AMBUL. CARE CLINIC	$34,992	$16,456	$70,741	$72,131	$56,506	$40,484	$29,414	$337,100	$1,011,219	$1,176,451
43 CERT. RURAL HLT. CL.	$1,997,509	$1,782,781	$707,075	$716,591	$2,405,650	$3,400,260	$3,247,459	$3,769,942	$4,160,184	$4,928,577
08 PHP AGENCY	$3,024,642	$3,148,547	$3,024,113	$2,991,297	$345,243	$616,496	$37,360	$0	-$5,316	$0
53 NURSE/MIDWIFE	$0	$52,707	$138,370	$129,592	$136,262	$162,177	$70,507	$54,473	$59,404	$53,732
60 NURSE PRACTITIONER	$0	$3,091	$4,343	$5,267	$19,751	$47,686	$52,300	$103,741	$115,412	$129,485
63 FED. QUAL. HLTH CTR	$0	$848,385	$3,387,888	$4,653,909	$5,136,655	$5,763,630	$5,195,679	$5,493,315	$5,613,119	$7,618,128
09 DENTAL	$5,303,540	$4,991,482	$5,332,047	$5,631,745	$4,976,600	$5,003,898	$6,641,320	$9,567,559	$9,863,575	$10,578,425
07 PODIATRIC	$280,998	$333,795	$297,268	$393,897	$386,719	$346,478	$335,704	$430,451	$437,114	$494,641
32 CHIROPRACTIC	$397,864	$421,229	$408,795	$376,786	$359,034	$340,814	$292,033	$295,922	$268,093	$442,359
31 PHYSICAL THERAPY	$274,034	$575,202	$694,988	$933,972	$1,004,550	$1,057,853	$1,031,192	$960,558	$1,051,314	$1,071,506
33 OCCUPATIONAL THERAPY	$80,094	$179,715	$308,279	$495,717	$487,077	$700,675	$728,109	$579,181	$778,426	$851,891
37 OPTOMETRIC SERVICES	$1,049,292	$1,108,930	$1,200,960	$1,224,143	$1,147,207	$1,119,039	$1,062,392	$1,409,182	$1,345,890	$1,498,115
42 OPTICAL SERVICES	$183,266	$220,635	$269,887	$291,335	$296,679	$299,594	$253,611	$150,582	$181,727	$212,003
27 SPEECH AND HEARING	$400,809	$604,327	$555,354	$584,829	$658,047	$524,854	$540,848	$525,013	$717,542	$1,665,446
46 AUDIOLOGY SERVICES	$14,062	$20,228	$19,344	$22,708	$25,195	$35,726	$31,262	$44,888	$42,779	$52,610
47 SPEECH PATH. SERV.	$739,570	$1,243,988	$1,394,099	$1,857,437	$2,013,736	$2,415,729	$2,383,957	$2,439,067	$2,720,312	$1,778,577
13 SOCIAL WORKER SERVS*	$0	$0	$20,393	$23,369	$43,954	$204,635	$305,307	$299,345	$321,551	$422,543
SUBTOTAL PHYSICIAN AND RELATED	$43,618,081	$47,297,289	$49,004,000	$52,136,525	$48,558,714	$51,451,047	$50,801,281	$63,867,701	$68,473,298	$76,138,199
PRESCRIPTION DRUGS & RELATED										
10 PRESCRIBED DRUGS	$46,565,773	$56,437,630	$64,180,430	$73,324,913	$87,616,834	$98,964,628	$109,697,688	$135,461,600	$167,633,986	$186,599,427
10.2 HMP WAIVER (MEDICAID)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$247,362
XX DRUG REBATES-MAP ACCOUNT-BMS SE	-$6,388,949	-$10,062,658	-$13,255,589	-$13,398,472	-$15,165,308	-$17,206,484	-$20,206,046	-$27,957,863	-$35,978,026	-$34,584,426
14 LAB & X-RAY-INDEP.	$2,805,523	$3,327,667	$3,597,771	$3,891,193	$3,637,765	$3,890,376	$3,660,550	$4,099,497	$4,914,966	$4,086,116
16 SUPPLIES AND DME	$4,346,970	$4,798,769	$5,017,092	$5,514,940	$5,687,346	$6,220,888	$6,905,975	$7,288,240	$7,688,958	$9,445,253
17 PROSTHETIC, ORTHOTIC	$546,033	$714,635	$744,838	$975,319	$936,800	$1,045,508	$1,077,379	$1,193,656	$1,290,186	$1,214,158
45 HEARING AID DEALERS	$56,642	$43,226	$43,295	$53,730	$41,919	$51,386	$51,497	$43,786	$62,948	$55,103
SUBTOTAL PRESCRIPTION DRUGS & RELATED	$47,931,992	$55,259,269	$60,327,837	$70,361,623	$82,755,356	$92,966,302	$101,187,043	$120,128,916	$145,613,018	167,062,993
LONG-TERM CARE & RELATED										
03 NURSING FACILITY	$210,146,435	$220,706,570	$233,626,649	$239,569,164	$219,042,939	$202,292,500	$185,581,203	$184,099,858	$200,535,349	$202,697,747
39 PRIVATE NONMD. INST. (Medicaid)	$10,761,118	$19,712,814	$27,369,898	$33,645,235	$49,969,514	$73,316,357	$90,272,883	$106,710,903	$132,139,973	$147,547,998
56 WAIVERED BOARD HM	$299,997	$318,021	$320,666	$327,704	$396,530	$393,211	$314,537	$392,173	$440,912	$295,558
61 REHABILITATIVE SVCS	$479,843	$945,818	$1,094,619	$1,664,583	$3,325,719	$5,023,575	$6,442,685	$8,487,654	$10,525,190	$13,027,224
11 HOME HEALTH SERVICES	$8,504,911	$9,517,630	$10,800,859	$13,806,200	$13,983,366	$14,434,836	$15,415,570	$15,704,936	$10,731,156	$6,883,316
55 ATTENDANT SERVICES	$0	$0	$0	$900	$1,175,513	$2,123,423	$3,068,619	$3,495,101	$3,314,388	$3,765,039
58 PRIVATE DUTY NURS	$1,246,161	$1,526,373	$1,426,837	$2,371,264	$2,055,338	$2,699,210	$2,387,610	$3,182,176	$3,940,491	$4,283,930
59 PERSONAL CARE SER	$2,843,737	$2,856,969	$2,639,616	$2,377,568	$1,460,911	$210,367	$3,362,683	$4,216,295	$4,913,640	$5,042,374
21 HOSPICE	$80,003	$0	$0	$0	$0	$0	$0	$0	$0	$0
23 SWING BED.*	$0	$0	$0	$12,061	$927	$3,778	$19,183	$75,101	$56,561	$19,808
36 DAY HEALTH	$21,214	$24,855	$25,113	$106,033	$276,536	$424,492	$577,618	$592,650	$711,217	$787,015
22 PHY. DISABLED WAIVER	$1,258,064	$1,479,245	$1,705,689	$1,993,971	$3,440,662	$5,062,143	$5,552,487	$6,185,082	$7,246,772	$7,261,920
57 BME WAIVER	$5,537,696	$5,427,866	$6,172,048	$7,080,916	$8,502,837	$10,272,214	$14,604,975	$21,521,767	$21,190,181	$19,096,433
41 MEDICARE CROSSOVER-A	$1,646,131	$1,987,530	$2,013,723	$2,497,046	$2,652,001	$3,745,538	$3,898,140	$3,078,456	$4,337,161	$3,761,837
50 MEDICARE CROSSOVER-B	$6,097,877	$2,152,719	$4,689,447	$5,565,319	$5,864,489	$8,588,909	$13,684,625	$15,567,929	$17,493,350	$16,001,833
SUBTOTAL LONG-TERM CARE & RELATED	$248,923,187	$266,656,410	$291,885,164	$311,017,964	$312,147,282	$328,590,553	$345,182,818	$373,310,081	$417,576,341	$430,472,032

CATEGORY OF SERVICE	SFY 1992	SFY 1993	SFY 1994	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000	SFY 2001
BEHAVIORAL HEALTH SERVICES										
12 COMMUNITY SUPPORT SV*	$0	$0	$7,343,013	$9,435,417	$12,440,860	$16,282,496	$24,854,070	$28,090,746	$35,588,765	$42,018,181
26 BMR WAIVER	$15,979,327	$22,058,377	$30,049,942	$41,783,780	$49,827,872	$61,729,335	$75,452,653	$93,074,043	$111,561,976	$126,391,963
28 MENTAL HEALTH	$8,004,425	$9,535,793	$9,666,257	$21,718,001	$18,101,453	$20,224,896	$24,671,605	$36,570,004	$47,261,888	$57,820,300
35 DAY HABILITATION	$6,218,139	$6,662,565	$6,825,166	$8,293,235	$7,367,157	$7,890,758	$9,035,340	$10,958,898	$13,672,001	$16,703,571
38 PSYCHOLOGICAL SVCS	$2,486,870	$2,867,702	$3,007,419	$3,232,068	$3,129,271	$3,123,315	$2,659,538	$2,572,509	$2,638,931	$2,816,446
34 ICF/MR SERVICES	$36,856,608	$41,256,544	$47,412,262	-$94,546	$0	$0				
40 ICF/MR (BOARDING)	$18,042,139	$10,384,671	-$43,178	$49,631,824	$44,703,728	$37,362,292	$32,739,328	$31,140,953	$32,433,990	$32,702,942
48 SUBSTANCE ABUSE	$1,703,222	$2,573,790	$2,636,586	$2,707,827	$2,841,730	$3,698,232	$3,865,319	$3,913,548	$3,843,111	$4,238,879
62 HOME BASED M-H	$837,740	$739,272	$1,277,915	$1,317,874	$1,653,548	$1,828,123	$1,826,316	$1,878,774	$2,378,028	$2,351,445
66 DEVLOP/BEHAV CLIN SV	$0	$113,976	$160,292	$298,200	$451,252	$599,674	$524,025	$526,950	$506,000	$600,222
XX AMHI/ BMHI DSH	$43,022,097	$43,362,362	$40,169,536	$43,470,793	$46,631,643	$51,680,711	$50,345,541	$32,075,335	$37,269,428	$38,516,939
SUBTOTAL BEHAVIORAL HEALTH SERVICES	$133,150,567	$139,555,052	$148,505,210	$181,794,473	$187,148,514	$204,419,832	$225,973,735	$240,801,760	$287,154,118	$324,160,888
OTHER MEDICAID SERVICES										
15 TRANSPORTATION	$7,332,260	$8,310,311	$9,565,458	$11,757,948	$11,776,456	$10,594,069	$11,618,120	$12,775,808	$13,954,365	$14,473,000
29 AMBULANCE	$1,318,667	$1,346,957	$1,751,565	$1,806,764	$1,458,559	$1,492,838	$1,673,802	$1,859,966	$2,005,852	$2,109,623
24 CASE MANAGEMENT	$11,633,326	$13,681,370	$12,684,380	$17,430,946	$40,158,200	$25,008,878	$28,819,565	$33,503,742	$46,561,928	$66,232,853
25 FAMILY PLAN-CLINIC	$544,317	$717,264	$989,187	$931,796	$894,552	$890,819	$822,353	$751,575	$710,478	$740,573
44 VD SCREENING	$8,715	$7,225	$13,495	$16,102	$16,345	$12,665	$9,815	$7,765	$7,510	$7,920
65 EARLY INTERVENTION	$17,515	$1,745,211	$2,328,229	$3,783,636	$4,469,423	$5,056,397	$4,953,032	$5,896,210	$6,876,410	$7,035,064
67 NON-TRADITIONAL PHP*	$0	$0	$0	$493,319	$1,157,188	$2,791,715	$14,164,538	$27,777,162	$27,804,709	$22,878,970
52 HMO WAIVER	$1,002,042	$693,011	$1,739	$0	$0	$3,810	$3,503,272	$6,843,139	-$3,295,933	$233,870
SUBTOTAL OTHER MEDICAID SERVICES	$21,856,842	$26,501,349	$27,334,053	$36,220,511	$59,930,723	$45,851,191	$65,564,497	$89,415,367	$101,217,185	$113,711,873
OTHER MEDICAID										
MEDICARE "PART B BUY-IN" PREMIUMS	$8,149,019	$8,650,600	$13,139,822	$13,150,680	$13,955,182	$15,582,696	$8,899,871	$18,543,971	$8,698,066	$17,110,586
TPL CREDITS (checks)-MAP ACCOUNT	$0	$0	-$4,802,946	-$8,577,784	$8,846,598	-$9,806,445	-$11,956,890	-$11,773,040	-$10,930,428	-$12,381,830
"CHIPs" MEDICAID EXPANSIONS-MAP ACCO	$0	$0	$0	$0	$0	$0	$0	$5,337,570	$12,391,229	$17,747,683
TOTAL MEDICAID	$761,202,996	$823,058,109	$886,744,684	$968,601,349	$989,562,344	$1,050,397,631	$1,101,957,379	$1,117,882,262	$1,239,621,637	$1,336,946,016
Adjusted for Elimination of DSH in 1998							$1,008,178,546	$1,117,882,262		
MEDICAID-RELATED STATE-ONLY PAYMENTS										
HMP\DEL PAYMENTS	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,117,880
STATE BOARDING HOME PAYMENTS	$0	$0	$0	$0	$0	$0	$13,764,437	$16,278,274	$22,602,073	$26,018,669
FIN. DISTRESSED HOSPITAL PAYMENTS	$0	$0	$0	$0	$7,740,687	$8,259,313	$0	$0	$1,600,000	$1,600,000
05 SOCIAL SERVICES	$331,888	$476,520	$719,772	$1,045,729	$1,278,992	$1,304,754	$1,288,744	$1,488,817	$1,383,089	$1,237,114
54 CHILD HEALTH	$2,404	$1,514	$1,143	$4,013	$1,760	$5,695	$36,820	$57,445	$19,450	$30,335
OTHER CHILD HEALTH PROGRAMS	$2,405,306	$2,144,887	$2,832,832	$1,874,109	$2,361,712	$2,148,217	$3,208,860	$3,063,840	$3,408,641	$4,313,084
MEDICAL EYE CARE PROGRAM	$591,886	$450,032	$234,975	$47,115	$135,387	$141,412	$183,545	$223,711	$461,355	$421,016
TUBERCULOSIS GRANTS	$209,306	$233,791	$307,934	$217,952	$241,005	$178,917	$141,820	$199,594	$183,648	$310,730
OTHER STATE ONLY PAYMENTS	$39,708	$29,217	$29,204	$5	$0	$105,935	$105,935	$124,893	$126,341	$146,596
SUBTOTAL STATE-ONLY PAYMENTS	$3,580,498	$3,335,961	$4,125,860	$3,188,923	$11,759,543	$12,144,243	$18,730,160	$21,436,574	$29,784,597	$34,077,544
EXPENDITURES-TOTAL	$764,783,494	$826,394,070	$890,870,544	$971,790,272	$1,001,321,887	$1,062,541,874	$1,120,687,540	$1,139,318,836	$1,269,406,234	$1,371,023,560
State Share-TOTAL	288,774,962	317,222,886	342,053,641	362,274,182	374,818,081	394,363,302	399,345,946	397,477,000	446,497,287	485,710,481
Federal Share-TOTAL	476,008,532	509,171,183	548,816,903	609,516,090	626,503,806	668,178,571	721,341,594	741,841,837	822,908,947	885,313,079

MONTHLY MEDICAID ELIGIBLES, SFY 1992-SFY 2001

Exhibit 5

	SFY 1992	SFY 1993	SFY 1994	SFY 1995	SFY 1996	SFY 1997	SFY 1998	SFY 1999	SFY 2000	SFY 2001
JULY	130,827	139,216	152,369	154,859	151,366	152,744	149,503	149,474	158,661	163,634
AUGUST	132,201	139,924	152,641	154,803	150,735	152,603	148,531	149,644	158,838	163,779
SEPTEMBER	133,505	139,609	152,189	154,329	152,043	151,868	148,317	151,586	159,729	171,993
OCTOBER	135,062	139,726	152,506	154,196	150,363	151,255	147,638	153,088	160,142	174,707
NOVEMBER	135,655	140,546	155,070	153,413	150,126	150,220	146,477	153,588	160,454	175,944
DECEMBER	136,003	140,472	154,891	152,843	149,976	150,328	146,197	154,829	161,242	176,953
JANUARY	136,515	143,023	155,812	154,130	150,775	151,040	146,558	155,896	162,184	178,868
FEBRUARY	135,569	not avail.	155,939	153,856	150,226	151,188	147,919	157,068	161,887	180,300
MARCH	138,056	145,984	156,551	154,092	152,136	151,688	149,117	158,472	163,608	182,415
APRIL	138,021	147,494	155,852	151,521	152,905	151,403	149,301	158,825	164,012	183,016
MAY	138,244	152,595	not avail.	151,785	153,109	150,890	148,978	158,760	164,509	184,280
JUNE	139,039	152,789	155,533	151,229	152,889	150,345	149,156	158,627	164,915	230,225
AVE. MO. ELIG.	**135,725**	**143,762**	**154,487**	**153,421**	**151,387**	**151,298**	**148,141**	**154,988**	**161,682**	**180,510**

Medicaid Eligibles and Selected Medical Expenditures, SFY 1992-SFY 2001
Exhibit 5

	Average Monthly Medicaid Eligibles	Total Medicaid Expenditures	State Share Medicaid Expenditures	State Only DEL Expenditures
SFY 1992	135,725	$759,898,957	$283,904,741	$4,076,199
SFY 1993	143,762	$822,047,077	$312,882,153	$4,211,830
SFY 1994	154,487	$886,618,158	$337,706,905	$3,489,591
SFY 1995	153,421	$968,791,685	$358,976,154	$3,422,559
SFY 1996	151,387	$973,662,853	$357,409,199	$3,643,259
SFY 1997	151,298	$1,049,412,481	$381,625,229	$3,453,484
SFY 1998	148,141	$1,102,147,832	$380,485,832	$3,733,775
SFY 1999	154,988	$1,117,513,491	$375,551,330	$4,830,636
SFY 2000	161,682	$1,239,180,725	$416,149,217	$8,232,999
SFY 2001	180,510	$1,336,650,458	$450,098,969	$17,043,802

COMMUNITY SERVICES CENTER

Office of the Director Programs

Audit

Licensing - Child Day Care

Licensing - Children's Residential Facilities

Out of Home Abuse and Neglect Investigation

DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICES CENTER

Program Title: **Office of the Director Programs**

A. Enabling or authorizing law or other relevant mandate, including federal mandates.

- MRSA Title 22, Section 6-C
- MRSA Title 22, Section 12-A
- MRSA Title 5, Sections 19202,19203,19205,19251
- MRSA Title 5, Section 204-A
- MRSA Title 5, section 3360-L
- MRSA Title 15, Section 6101
- MRSA Title 17-A, Section 1172
- MRSA Title 30 A, Section 460
- MRSA Title 5, Section 1812-D
- Victims Of Crime Act, as amended, PL 98-473, Chapter 112
- Family Violence Prevention and Services Act, as amended
- Title XXVI, Part B of the Public Health Services Act
- Title XIX, Section 1905 of the Public Health Services Act

B. A description of each program administered by the agency or independent agency, including the following for each program:

AIDS/HIV Services

The AIDS/HIV Services program provides services to ensure the availability of access to a full range of services needed to maintain and treat HIV infected individuals. These services include: individualized service needs assessment; care planning; and advocacy and coordination of multi-disciplinary state and community services including acute care, home health, nutrition assistance, housing assistance, income assistance, mental health, substance abuse, transportation, and other services as needed. A major portion of the program's federal funds are mandated to be used to assist low-income individuals with HIV/AIDS in the procurement of HIV/AIDS specific medications.

Crime Victims Assistance

The Crime Victims Assistance Program is responsible for coordinating the development and delivery of services for the federal Crime Victims Assistance Program target populations (victims of domestic violence, victims of sexual assault, victims of child abuse, especially child sexual abuse), and other victims of personal/violent crimes. The services provided to victims of domestic violence include 24hour hotline services, crisis response services, individual advocacy, emergency shelter, support groups for adults and children, transitional housing, and community education/community response services. The services provided to victims of sexual assault include 24hour hotline services, crisis response services, medical support, individual advocacy, support groups, and community education/community response services. The services provided to child abuse victims and other victims of personal/violent crimes include individual advocacy, and assistance and support through the prosecutorial and court processes.

1. **Established priorities, including the goals and objectives in meeting each priority;**

The Office of the Director Programs operate under the following goals, objectives and performance criteria.

Goal:
-to ensure that all HIV/AIDS Services and Crime Victims Assistance programs administered by the Department of Human Services meet the needs of and are accountable to Maine people.

Objective:
-Increase the coordination and flexibility of contracted services while maximizing state/federal funding for social services.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and an assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

Performance criteria:
-percent of social service contracts with performance outcomes and identified measures.

As required the program has created performance outcomes and identified measures for all programs and contracts. The program has also provided oversight for the creation of measures in the other Bureaus of the Department and the Department of Behavioral and Developmental Services. The measures were developed through a collaborative process with the service providers and are revised on an ongoing process.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria.**

Each of the program areas administered by the Office of the Director programs has established goals, objectives and performance measures. These goals and objectives for each program area, including the measurements that demonstrate the extent to which the goals and objectives have been met are listed below.

C. **Organizational Structure, including a position count, a job classification and an organizational chart indicating lines of responsibility.**

See attached job classification for CSC and the organizational chart for this Office.

D. **Compliance with federal and state health and safety laws.**

CSC complies with all federal and state laws.

E. **Financial summary, including sources of funding.**

See attached financial summary.

F. **The regulatory agenda and the summary of rules adopted;**

All services purchased by the Office of the Director programs are subject to the applicable State and Federal governing statutes, rules and regulations, as well as, the policies contained in the Purchase of Service Policy Manual promulgated under the Administrative Procedures Act, 10-148, Chapter 5. The Policy Manual is on the regulatory agenda for technical changes in 2002.

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which the agency could establish cooperative agreements, including, but not limited to, cooperative agreements to coordinate services and eliminate redundant requirements.

AIDS/HIV Services

1. U.S. Department of Health and Human Services, Health Resources & Services Administration
2. Center for Disease Control
3. Bureau of Health, Office on AIDS
4. Bureau of Medical Services

Crime Victims Assistance

1. U.S. Department of Justice, Office of Justice Programs, Office of Victims of Crime
2. U.S. Department of Health and Human Services, Administration for Children & Families
3. U.S. Attorney's Offices in Maine
4. State Victim Compensation Program
5. Department of Public Safety, Violence Against Women Grant
6. Department of Corrections, Victims Services
7. Maine State Housing Authority
8. New Hampshire Victims Assistance Program, Attorney General's Office
9. Vermont Crime Victims Assistance/Compensation Program

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes

AIDS/HIV Services

Case Management - All diagnosed HIV+ individuals in Maine
AIDS Drug Assistance - Diagnosed HIV+ individuals under 200% of poverty

Crime Victims Assistance

Victims of domestic violence, sexual assault, child abuse, homicide survivors, other violent crimes.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

The programs administered by the Office of the Director are all contracted or "privatized" to an non-governmental organization (some contracts with local governments and Maine universities). The staff of the programs are responsible for providing guidance to these agencies on the delivery of services according to the Department's goals and objectives as well as to assure that the organizations holding contracts meet performance and financial criteria set forth in each contract.

J. Identification of emerging issues for the agency or program in the coming years.

AIDS/HIV Services

- The introduction of costly drug therapies which prolong life for individuals living with HIV/AIDS are putting a dual strain on the fixed AIDS Drug Assistance program. The new therapies have increased costs per client on the program by as much as 200%. Also, clients are remaining on the program for longer periods of time. The program will need to implement a waiting list process within three months.

- The case management services agencies are encountering an increasingly larger proportion of clients with multiple diagnoses, especially substance abuse and mental health. There is a shortage of available service resources across the state to serve these clients.

- The federal Ryan White Care Act Amendments of 2000 have mandated the establishment of a comprehensive state-level program which cuts across all the federal funding sources that provide services for individuals living with HIV/AIDS. The AIDS/HIV Services program does not have full-time staffing to accomplish the new mandate. If the AIDS/HIV Services program is unable to meet the mandate by FY2003, the federal grant funds are at serious risk.

Crime Victims Assistance

- The level of coordination needed to assure appropriate, cohesive, effective response to victims of violent crime within the service systems and between systems such as law enforcement, the Department's Child Protective Program, and the courts can not be accomplished with the current staffing level for the program.
  This is especially critical in the areas of domestic violence and sexual assault due to the numerous state initiatives.

K. **Any other information specifically requested by the committee.**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program.**

N/A

M. **Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department complies with all policies relating to the Use of Automated Technology Equipment and the Confidentiality statement.

Program Title: **Audit**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- Maine Uniform Accounting & Auditing Practices Act Regulations (MAAP) as promulgated by PL 1995 chapter 402
- OMB circular A-133.
- Title 22 MRSA ,Section 3173
- Title 19 of the Social Security Act.

B. A description of each program administered by the agency or independent agency, including the following for each program:

For Social Services Agencies, the audits cover a multitude of social service programs ranging from Day Care, Transportation, Family Planning, Substance Abuse Services, Mental Health & Retardation, etc.

For Maine Care (Medicaid), the audit programs are Nursing Homes, Assisted Living Facilities, Private Non Medical Institutions, Hospitals, and other programs, such as Day Habilitation, Home Health, Federally Qualified Health Centers, Rural Health, and Intermediate Care Facilities for Mentally Retarded.

1. Established priorities, including the goals and objectives in meeting each priority;

The Division goal is to complete annual audited cost settlements of the Maine organizations receiving state and federal assistance and to insure that public funds are expended in accordance with applicable statutes and regulations. The priority is to complete all audits in a timely manner. The objective is to complete these annual cost settlements in an independent and fair manner.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and

All Agencies are required to file Financial Statements/Cost Reports annually within a predefined regulatory timeframe after the end of their fiscal year. The Division of Audit has an internal data base system for tracking the timeliness of these agency filings. The database also tracks the issuance of annual cost settlements. Monthly, progress reports are

prepared and reviewed for each audit program to monitor our performance in achieving our goals.

There are approximately 1000 organizations that receive in excess of $600,000,000 in state federal funds through the Department of Human Services and the Department of Behavioral and Development Services.

	1996	1997	1998	1999	2000
NURSING HOME FACILITIES	182	185	166	163	157
RESIDENTIAL CARE FACILITIES	137	141	151	151	157
HOSPITALS	42	42	42	41	41
RURAL HEALTH ORGANIZATIONS	21	23	38	35	32
HOME HEALTH AGENCIES	35	37	47	45	41
FEDERALLY QUALIFIED HEALTH CENTERS	29	29	18	16	17
SOCIAL SERVICE AGENCIES	255	259	285	287	297
PRIVATE NON-MEDICAL INSTITUTIONS	96	123	142	144	168
DEVELOPMENTAL TRAINING PROGRAMS	90	93	91	90	96
TOTAL	**887**	**932**	**980**	**972**	**1006**

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

We are currently timely in the audit of all programs for which we are responsible thus we are meeting our goals and objectives.

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart for CSC.

D. **Compliance with federal and state health and safety laws.**

The Community Services Center complies with all federal and state laws.

E. **Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.**

See attached financial summary for CSC.

F. **When applicable, the regulatory agenda and the summary of rules adopted;**

For Social Services Agencies, the Maine Uniform Accounting & Auditing Practices Act Regulations (MAAP) promulgated in 1996 governs our audit oversight responsibilities.

For Maine Care (Medicaid), the Maine Medical Assistance Manual effective 7/1/79 with amendments governs our audit oversight responsibilities

G. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

We are the single State Agency providing audit oversight services for both the Department of Human Service and Department of Behavioral and Development Services of Social Service Contracts and Maine Care programs, thus coordinated single audit services are currently being achieved. We also provide technical advice and coordinate with other Divisions within these two departments to increase financial accountability in non audited and cost settled areas.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

The taxpayers of the State of Maine and the United States are the constituents.

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.**

We have looked at privatization and it is not feasible

J. **Identification of emerging issues for the agency or program in the coming years.**

- The ever increasing programs which are reimbursed on a fee for service and which lack appropriate public accountability. Fee for Service or Pricing does not provide adequate financial accountability.
- Under Maine Care, the potential looming bankruptcies in health care services create difficulty in recovering annual audit settlements.
- The current constrained funding levels in Health Care with the aging "Baby Boomer" population needing additional long-term care could result in reduced services for this age group.

K. **Any other information specifically requested by the committee of jurisdiction;**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and**

For Social Services Agencies, the single audit requirements of the Maine Uniform Accounting & Auditing Practices Act Regulations (MAAP) and the federal audit requirements of OMB circular A-133 are very similar.

For Maine Care (Medicaid), the state regulations are based on Medicare regulations. The state regulations frequently provide for more cost containment through the utilization of many program caps. The State rules must be approved by the Center for Medicare/Medicaid Services (CMS) through the state plan.

M. **Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department complies with all policies relating to the Use of Automated Technology Equipment and the Confidentiality statement.

Program Title: **Licensing - Child Day Care**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- M.R.S.A. 22 § 7701, 7801, 8301, and 8401
- M.R.S.A. 22 § 7701et al: Facilities For Children And Adults, Chapter 1661, General Provisions
- M.R.S.A. 22 § 7801 et al: Chapter 1663, Licenses: License or approval required
- M.R.S.A. 22 § 8301 et al: Chapter 1673 Day Care Facilities
- M.R.S.A. 22 § 8401 et al: Chapter 1675 Nursery Schools

B. A description of each program administered by the agency or independent agency, including the following for each program:

The Child Day Care Licensing Unit is responsible for licensure or certification of all Children's Day Care Centers, Home Day Care providers and Nursery Schools in the State. These facilities are licensed or certified annually. All licensing complaints that are not catagorized as abuse or neglect are assigned to and investigated by this Unit. Licensing or certification actions, including revocation, non-renewal, suspension, and issuance of a conditional license, are taken by the Unit, when appropiate.

1. Established priorities, including the goals and objectives in meeting each priority;

1. Inspections for the annual renewal of licenses and certificates;
2. Processing new applicants in a timely manner;
3. Investigation ofl licensing complaints;
4. Taking licensing action when programs are significantly out of compliance with licensing or certification rules; and
5. Development an/or revision of licensing and certification rules.

Goals and Objectives

Goal: All licensed and certified programs will have a current license.
Objective: To assure that health and safety standards are met in all licensed or certified childcare programs.

Goal: To process new applicants in an efficient, thorough manner.
Objective: To assure that there are sufficient numbers of safe childcare resources for the State

Goal: All complaints will be given time frames based on the risk to children's health and safety. Each complaint will be assigned by management to a line staff with a designated time frame.
Objective: To make best use of assigned staff in assuring the health and safety of children in childcare facilities.

Goal: To consistantly take licensing action that is in the best interest of the public.
Objective: To assure that childcare facilities which are siginificantly out of compliance with licensing or certification rules are brought into rule compliance or denied licensure to provide services.

Goal: To have clear, fair and enforcable minimum standards for childcare facilities to meet that result in healthy and safe programs for the children served.

Objective: To assure the best possible rules are in effect.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

   N/A

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

   N/A

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification and organizational chart.

D. Compliance with federal and state health and safety laws.

The Community Services Center complies with all federal and state laws.

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years.

See attached financial summary for CSC.

F. The regulatory agenda and the summary of rules adopted;

The Child Day Care Licensing Unit licenses all Children's Day Care Centers and Nursery Schools and certifies all Home Day Care providers in the State. The following are the adopted rules:

- *Rules for the Licensing of Children's Day Care Centers* (effective date: July 1, 1998)
- *Rules for Home Day Care Providers* (effective July 1, 1998)
- Title 22 M.R.S.A. § 8401 et al (for Nursery Schools).

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

a. The Child Day Care Licensing Unit has a cooperative agreement with Brunswick Naval Air Station that allows for the Navy to use their resources to assure that health and safety in Naval Day Care Provider Homes.

b. The Child Day Care Licensing Unit works with the Office of Childcare and regional resource development centers in sharing information regarding childcare resources.

c. This Unit coordinates efforts with the Bureau of Health in screening childcare facilities for lead safety.

d. The Unit works cooperatively with the state university system and Roads to Quality program in training efforts to train childcare providers.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

a. Children receiving childcare services in the State of Maine

b. Licensed and certified childcare facilities and nursery schools

c. Families of children receiving childcare services

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meeting its goals and objectives.

N/A

J. Identification of emerging issues for the agency or program in the coming years.

The Children's Day Care Center Rules are in the revision process. These are routine technical rules. It is anticipated that they will become effective in April 2002.

Rules for Nursery Schools that set standards for health and safety are being developed. These are routine technical rules. It is anticipated that they will become effective in June 2002.

K. Any other information specifically requested by the committee of jurisdiction;

Not Applicable

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

None

M. **Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department complies with all policies relating to the Use of Automated Technology Equipment and the Confidentiality statement.

Program Title: **Licensing - Children's Residential Facilities**

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

- M.R.S.A. 22 §7701, 7801, 8101, 8201
- M.R.S.A. 22 §7701 et al: Facilities For Children and Adults, Chapter 1661, General Provisions
- M.R.S.A. 22 7801 et at: Chapter 1663, Licenses: License or Approval required
- M.R.S.A. 22 § et al: 8101 Chapter 1669 Children's Homes
- M.R.S.A. 22 § et al: 8201 Chapter 1671 Child Placing Agency

B. A description of each program administered by the agency or independent agency, including the following for each program:

Children's Residential Licensing program is responsible for the licensing of residential child care facilities, shelters for homeless children, emergency shelters for children and child placing agencies with and without adoption.

1. Established priorities, including the goals and objectives in meeting each priority;

1. Bi-annual inspections for renewal of licenses and certificates
2. Processing of new applications in a timely way
3. Investigations of licensing complaints;
4. Initiating licensing actions against agencies that are not in compliance with licensing rules;
5. Development and revision of licensing rules
6. Providing of technical assistance

Goals and Objectives

Goal: License all facilities in a timely manner.
Objective: To ensure that programs meet minimal health and safety Standards.

Goal: To review all new applications in a timely manner.
Objective: To ensure that programs are licensed in a timely manner and that needed programs come on line as soon as possible.

Goal: To take licensing action in a timely and equitable manner.
Objective: To ensure that facilities are treated fairly and meet minimal Health and safety Standards.

Goal: To have minimum standards that are clear, concise and enforceable.
Objective: To ensure that the best possible rules are in effect.

2. **Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives; and**

N/A

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.**

N/A

C. **Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.**

See attached job classification for CSC and an organizational chart for Residential Licensing.

D. **Compliance with federal and state health and safety laws, including the Americans with Disabilities Act, the Federal Occupational Safety and Health Act, affirmative action requirements and workers' compensation.**

The CSC is in compliance with all federal and state laws.

E. **When applicable, the regulatory agenda and the summary of rules adopted;**

Children's Residential Licensing Rules are currently under review completion date is year 2002.

F. **Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.**

The Children's Residential Licensing Unit works with the Office of the Attorney General in pursuing licensing actions

The Children's Residential Licensing Unit works collaboratively with the Dept. of Behavioral and Developmental Services in the licensing of children's residential facilities.
The Children's Residential Licensing Unit works with the State Fire Marshall's Office .

Children's Residential Licensing Unit works with the Bureau of Public Health, Public Health Lab and with Bureau of Medical Services Lead Prevention Program.

H. **Identification of the constituencies served by the agency or program, noting any changes or projected changes.**

Children in the custody of the Department of Human Services

Children placed in residential facilities through their families or guardians

Families of children placed in residential facilities

The Providers of children's residential services

I. **A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.**

Children's Residential Licensing Unit is utilizing time limited project positions to assist in the licensing of facilities.

J. **Identification of emerging issues for the agency or program in the coming years.**

N/A

K. **Any other information specifically requested by the committee of jurisdiction;**

N/A

L. **A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and**

N/A

M. **Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.**

The Department complies with all policies relating to the Use of Automated Technology Equipment and the Confidentiality statement.

Program Title: **Out of Home Abuse and Neglect Investigation**

A. Enabling or authorizing law or other relevant mandate, including any federal mandate:

- Title 22 MRSA 4088 SUBCHAPTER XI-A. Out of Home Abuse and Neglect Investigation Team.

B. A description of each program administered by the agency or independent agency, including the following for each program:

Out of home abuse and neglect investigative team. Primary function to investigate reports of abuse and neglect of a child which occurs in a facility or by a person subject to licensure or inspection by The Department of Human Services Community Services Center, The Department of Education, The Department of Corrections, and The Department of Behavioral and Developmental Services or in a facility operated by these departments.

1. Established priorities, including the goals and objectives in meeting each priority;

i. To review and disseminate reports in a timely fashion. To prioritize these reports as to severity and to act on these reports in a timely manner.
ii. To set up policies and practice protocols including time frames for which reports will be assessed and investigated.
iii. To continue to work in the best interest of children's safety.

2. Performance criteria, timetables or other benchmarks used by agency to measure its progress in achieving the goals and objectives;

i. Reports with high severity will be assigned and assessed in two weeks.
ii. Reports and past assignments with less severity will be completed in four weeks.
iii. Caseloads will be kept current.

3. **An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance criteria.**

When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives.

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility.

See CSC job classification and the organizational chart for IAU.

D. Compliance with federal and state health and safety laws.

CSC complies with all federal and state laws.

E. Financial summary, including sources of funding by program.

See attached financial summary for CSC.

F. When applicable, the regulatory agenda and the summary of rules adopted;

N/A

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements.

a. Gov. Baxter School for the deaf.
b. Brunswick Naval Air Station.
c. Department of Public Safety
d. Attorney Generals Office
e. Department of Education
f. Department of Behavioral and Developmental Services
g. Bureau of Medical Services.

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes.

- All children statewide receiving services in any/all-licensed facilities.
- The providers of children's services with in the State of Maine.

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization in meetings its goals and objectives.

The unit has worked collaboratively with The Bureau of Child and Family Services to obtain information to facilitate a complete investigation and ensure the safety of children in out of home placements.

J. Identification of emerging issues for the agency or program in the coming years.

Increasing numbers of children in the care of The Department of Human Services. The number of Service providers is increasing, resulting in increasing caseloads.

K. Any other information specifically requested by the committee of jurisdiction;

N/A

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program; and

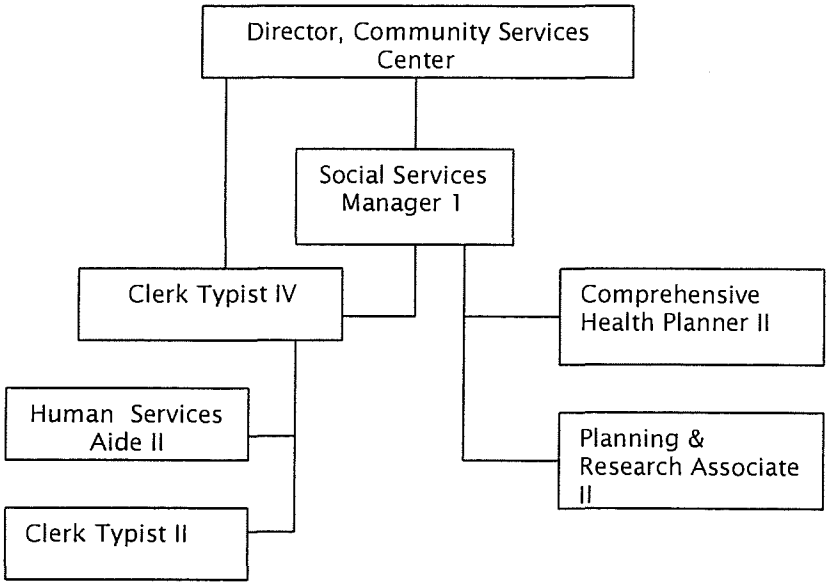
M. Agency policies for collecting, managing and using personal information over the internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement.

The Department complies with all policies relating to the Use of Automated Technology Equipment and the Confidentiality statement.

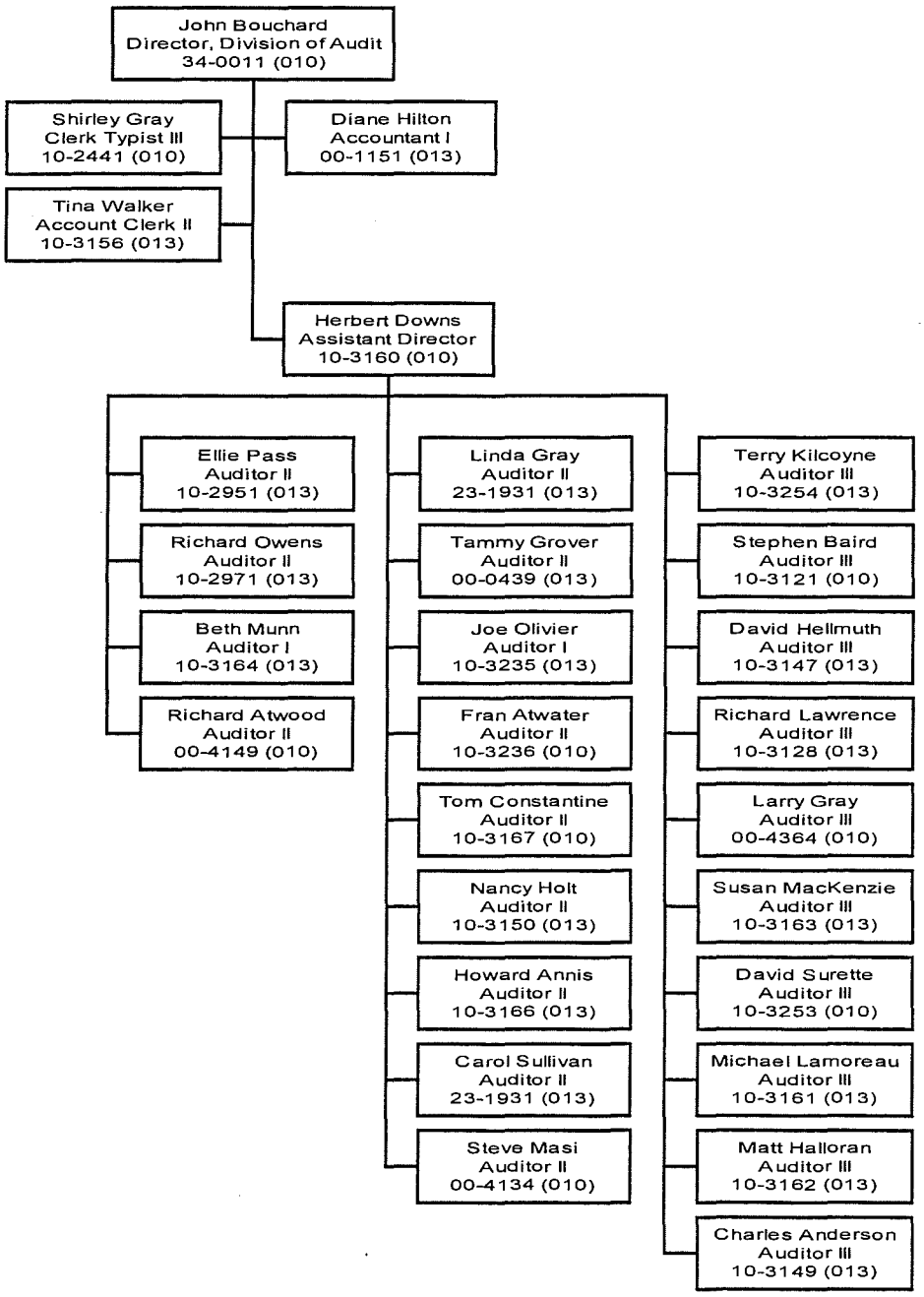
DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICES CENTER

Position Count	Job Classification
1	Director ACL Services Center
1	Director Division Contracted Community Services
1	Director Division Residential Services
1	State Headstart Program Coordinator
2	Social Services Manager I
6	Social Services Program Specialist II
24	Social Services Program Specialist I (includes 5 project positions)
16	Community Care Workers
1	Child Health Planner II
1	Director of Audits
1	Assistant Director of Audits
10	Auditor III
11	Auditor II
2	Auditor I
2	Accountant I
1	Account Clerk II
1	Planning and Research Associate I
1	Clerk IV
2	Clerk Typist III
1	Clerk Typist II
3	Human Services Aide II
89	**Total Position Count**

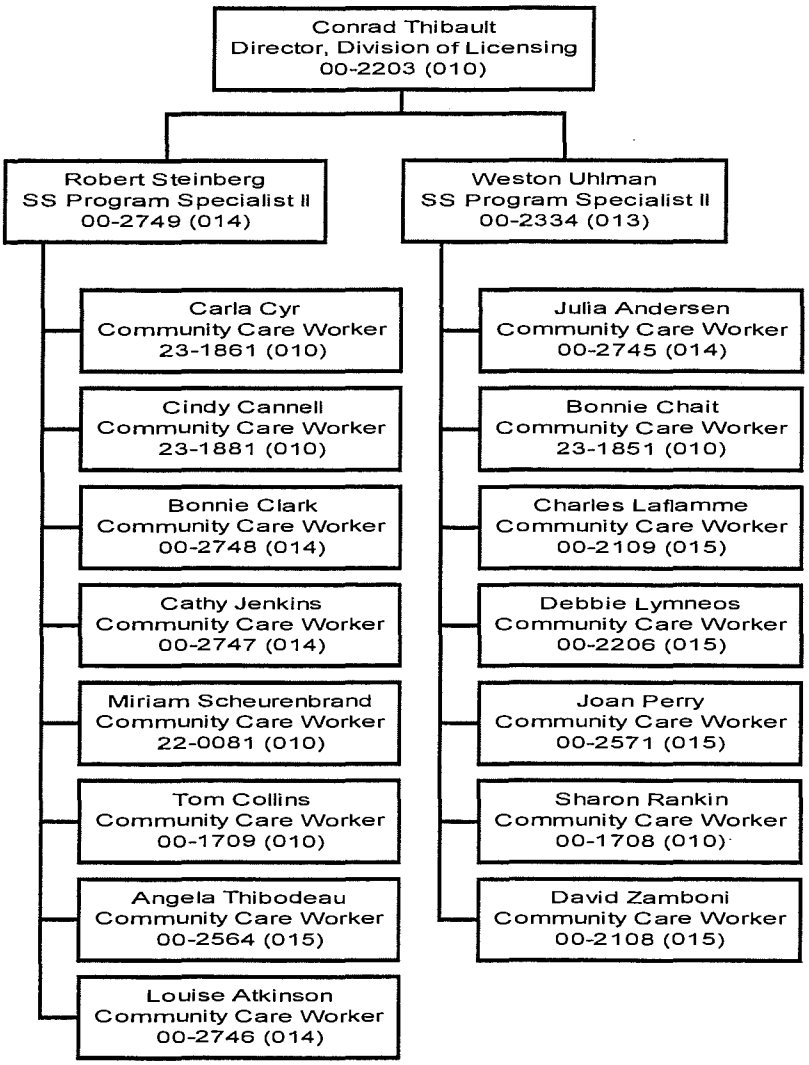
OFFICE OF THE DIRECTOR



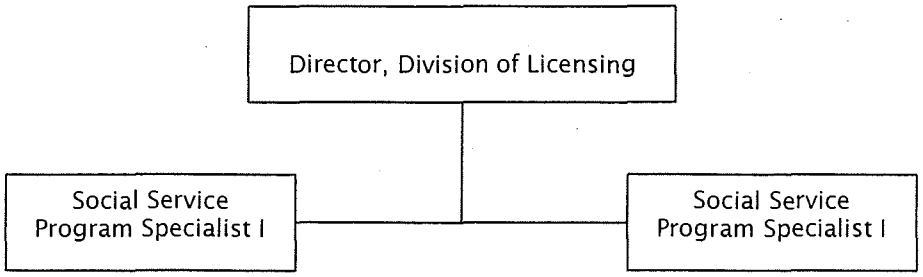
AUDIT


John Bouchard
Director, Division of Audit
34-0011 (010)
Shirley Gray
Clerk Typist III
10-2441 (010)
Diane Hilton
Accountant I
00-1151 (013)
Tina Walker
Account Clerk II
10-3156 (013)
Herbert Downs
Assistant Director
10-3160 (010)
Ellie Pass
Auditor II
10-2951 (013)
Richard Owens
Auditor II
10-2971 (013)
Beth Munn
Auditor I
10-3164 (013)
Richard Atwood
Auditor II
00-4149 (010)
Linda Gray
Auditor II
23-1931 (013)
Tammy Grover
Auditor II
00-0439 (013)
Joe Olivier
Auditor I
10-3235 (013)
Fran Atwater
Auditor II
10-3236 (010)
Tom Constantine
Auditor II
10-3167 (010)
Nancy Holt
Auditor II
10-3150 (013)
Howard Annis
Auditor II
10-3166 (013)
Carol Sullivan
Auditor II
23-1931 (013)
Steve Masi
Auditor II
00-4134 (010)
Terry Kilcoyne
Auditor III
10-3254 (013)
Stephen Baird
Auditor III
10-3121 (010)
David Hellmuth
Auditor III
10-3147 (013)
Richard Lawrence
Auditor III
10-3128 (013)
Larry Gray
Auditor III
00-4364 (010)
Susan MacKenzie
Auditor III
10-3163 (013)
David Surette
Auditor III
10-3253 (010)
Michael Lamoreau
Auditor III
10-3161 (013)
Matt Halloran
Auditor III
10-3162 (013)
Charles Anderson
Auditor III
10-3149 (013)

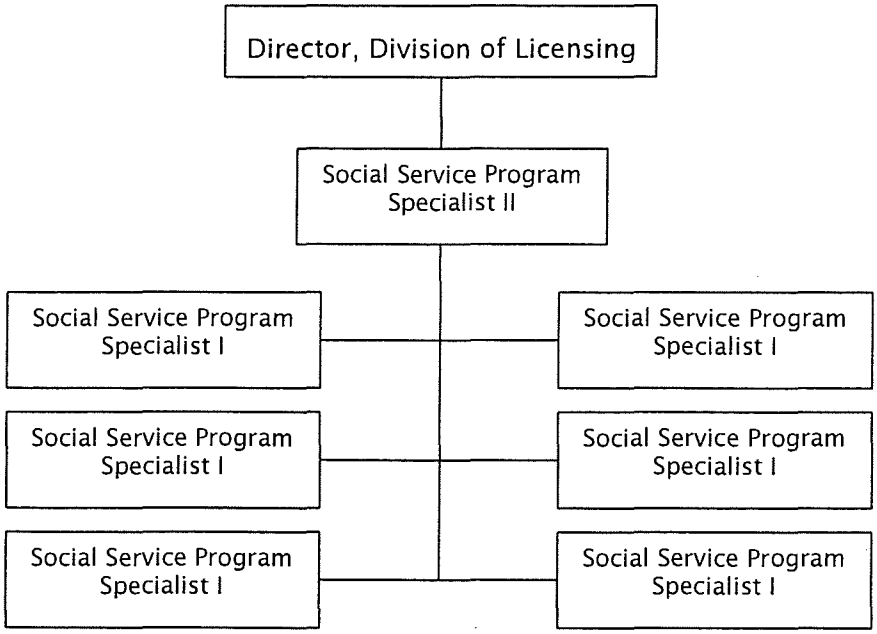
CHILD CARE LICENSING



RESIDENTIAL LICENSING



IAU


Director, Division of Licensing
Social Service Program Specialist II
Social Service Program Specialist I
Social Service Program Specialist I
Social Service Program Specialist I
Social Service Program Specialist I
Social Service Program Specialist I
Social Service Program Specialist I

DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICE CENTER
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1992		SFY 1993		SFY 1994		SFY 1995		SFY 1996	
	COMMUNITY SERVICES CENTER	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0228	PRIORITY SOCIAL SERVICES PROGRAM	9,388,370	7,694,535	9,388,533	8,261,978	9572970	7,402,998	9,572,970	8,839,960	10,382,791	10,118,058
0545	HEAD START	2,419,502	-	2,425,214	2,342,262	2,360,246.0	2,330,212	2,359,866	2,341,568	2,395,265	2,392,351
0563	CHILD CARE SERVICES	1,004,692	720,400	1,004,692	39,484	582302	303,275	582,302	615,447	622,947	616,207
0845-01	ACL - SERVICE CENTER DHS/MHMR										
0923	YOUTH IN NEED OF SERVICES - PILOT PGM										
	GENERAL FUND TOTAL:	12,812,564	8,414,935	12,818,439	10,643,724	12,515,518	10,036,486	12,515,138	11,796,974	13,401,003	13,126,616
0307-02	REFUGEE PROGRAM	798,559	648,800	843,144	638,352	846,657	456,448	845,174	433,646	957,123	646,545
0454	CHILD CARE FOOD PROGRAM	7,741,112	7,741,112	8,392,668	8,392,668	8,920,666	8,920,666	10,968,876	10,968,876	11,866,090	11,690,725
0545	HEAD START	82,182	-	84,170	83,941	87,096	-	87,419	112,848	143,430	124,538
0845-01	ACL - SERVICE CENTER DHS/MHMR - AUDIT										
0845-02	ACL - SERVICE CENTER DHS/MHMR										
	FEDERAL FUND TOTAL:	8,621,853	8,389,912	9,319,982	9,114,961	9,854,419	9,377,114	11,901,469	11,515,370	12,966,643	12,461,808
0228	PRIORITY SOCIAL SERVICES PROGRAM				52,940	172000	-	172,000	-	200,000	-
0545	HEAD START										
0845	ACL - SERVICE CENTER DHS/MHMR										
	OTHER SPECIAL REVENUE TOTAL:	-	-	-	52,940	172,000	-	172,000	-	200,000	-
0228	SOCIAL SERVICES BLOCK GRANT	8,954,946	8,954,946	11,609,960	11,609,960	12,219,592	12,219,592	11,795,610	10,951,907	13,535,265	12,762,032
0563	CHILD CARE DEVELOPMENT FUND BLOCK GRANT										
0716	COMMUNITY SERVICES BLOCK GRANT				1,588,923	2,050,000	2,041,991	2,220,569	2,220,569	2,593,999	2,546,253
0845-01	ACL - SERVICE CENTER DHS/MHMR										
	BLOCK GRANT TOTAL:	8,954,946	8,954,946	11,609,960	13,198,883	14,269,592	14,261,583	14,016,179	13,172,476	16,129,264	15,308,285
	GRAND TOTAL	**30,389,363**	**25,759,794**	**33,748,381**	**33,010,508**	**36,811,529**	**33,675,182**	**38,604,786**	**36,484,820**	**42,696,910**	**40,896,709**

DEPARTMENT OF HUMAN SERVICES
COMMUNITY SERVICE CENTER
BUDGET AND EXPENDITURES
FOR A TEN YEAR PERIOD

		SFY 1997		SFY 1998		SFY 1999		SYY 2000		SFY 2001	
	COMMUNITY SERVICES CENTER	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES	APPROPRIATION	EXPENSES
0228	PRIORITY SOCIAL SERVICES PROGRAM	11,141,809	10,925,890	12,103,361	11,758,949	13,811,587	13,441,813	17,037,250	16,774,793	15,854,678	15,852,176
0545	HEAD START	2,349,136	2,322,515	2,319,301	2,319,293	2,317,304	2,317,304	2,501,887	2,474,580	2,899,186	2,899,169
0563	CHILD CARE SERVICES	675,261	651,502	634,800	633,304	624,133	623,624	641,866	635,806	620,565	619,582
0845-01	ACL - SERVICE CENTER DHS/MHMR	2,098,632	1,995,803	2,110,107	2,002,599	2,134,325	2,017,124	2,062,388	1,985,400	2,160,936	2,152,692
0923	YOUTH IN NEED OF SERVICES - PILOT PGM									510,000	508,273
	GENERAL FUND TOTAL:	16,264,838	15,895,710	17,167,569	16,714,146	18,887,349	18,399,865	22,243,391	21,870,579	22,045,365	22,031,892
0307-02	REFUGEE PROGRAM	917,159	533,988	1,017,125	563,688	1,007,563	710,399	1,109,552	669,931	943,534	556,657
0454	CHILD CARE FOOD PROGRAM	12,078,923	10,766,961	13,286,071	10,200,113	14,614,508	9,919,292	14,614,508	9,515,025	14,614,508	8,790,403
0545	HEAD START	52,690	25,336	99,690	96,503	147,190	145,145	156,629	143,298	115,174	96,759
0845-01	ACL - SERVICE CENTER DHS/MHMR - AUDIT	983,277	967,474	977,491	939,371	1,016,569	961,775	1,037,684	950,484	1,055,392	1,029,858
0845-02	ACL - SERVICE CENTER DHS/MHMR	364,419	357,637	380,391	354,001	378,006	341,793	395,303	367,029	401,811	384,831
	FEDERAL FUND TOTAL:	14,396,468	12,651,395	15,760,768	12,153,676	17,163,836	12,078,404	17,313,676	11,645,768	17,130,419	10,858,509
0228	PRIORITY SOCIAL SERVICES PROGRAM	80,000	-	277,049	277,048	2,359,931	2,285,933	1,080,019	931,567	5,870,186	5,710,065
0545	HEAD START									1,950,000	1,950,000
0845	ACL - SERVICE CENTER DHS/MHMR									444,601	213
	OTHER SPECIAL REVENUE TOTAL:	80,000	-	277,049	277,048	2,359,931	2,285,933	1,080,019	931,567	8,264,787	7,660,278
0228	SOCIAL SERVICES BLOCK GRANT	10,878,853	8,315,909	9,249,715	8,604,247	9,834,378	7,255,789	7,862,648	7,488,117	8,145,959	8,095,092
0563	CHILD CARE DEVELOPMENT FUND BLOCK GRANT	3,174,180	3,166,317	14,001,190	13,152,285	16,696,099	14,852,530	18,313,022	18,194,881	24,380,562	21,030,919
0716	COMMUNITY SERVICES BLOCK GRANT	2,802,118	2,129,688	3,064,831	2,914,246	3,734,198	3,256,975	3,241,193	3,208,488	4,633,069	4,434,958
0845-01	ACL - SERVICE CENTER DHS/MHMR	460,664	402,545	419,386	413,433	439,047	431,940	560,114	559,099	580,628	575,601
	BLOCK GRANT TOTAL:	17,315,815	14,014,459	26,735,122	25,084,211	30,703,722	25,797,235	29,976,977	29,450,585	37,740,218	34,136,571
	GRAND TOTAL	**48,057,121**	**42,561,565**	**59,940,508**	**54,229,081**	**69,114,838**	**58,561,437**	**70,614,063**	**63,898,499**	**85,180,789**	**74,687,250**

APPENDICES

Non Discrimination Notice

Policy Concerning the Use of State Automated Equipment

Privacy Policy

Administrative Procedures and Services

NON-DISCRIMINATION NOTICE

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 1981, 2000d et seq.) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), the Age Discrimination Act of 1975, as amended (42 U.S.C. § 6101 et seq.), Title II of the Americans with Disabilities Act of 1990 (42 U.S.C. § 12131 et seq.), and Title IX of the Education Amendments of 1972, (34 C.F.R. Parts 100, 104, 106 and 110), the Maine Department of Human Services does not discriminate on the basis of sex, race, color, national origin, disability or age in admission or access to or treatment or employment in its programs and activities.

Kim Pierce, Civil Rights Compliance Coordinator, has been designated to coordinate our efforts to comply with the U.S. Department of Health and Human Services regulations (45 C.F.R. Parts 80, 84, and 91), the Department of Justice regulations (28 C.F.R. part 35), and the U.S. Department of Education regulations (34 C.F.R. Part 106) implementing these Federal laws. Inquiries concerning the application of these regulations and our grievance procedures for resolution of complaints alleging discrimination may be referred to Kim Pierce at 221 State Street, Augusta, ME 04333, telephone number: (207) 287-3488 (Voice) or 207-287-4479 (TDD), or the Assistant Secretary of the Office of Civil Rights of the applicable department (e.g. the Department of Education), Washington, D.C.

Policy # MB 016

OFFICE OF THE COMMISSIONER
MAINE DEPARTMENT OF HUMAN SERVICES
POLICY AND PROCEDURE STATEMENT

I. SUBJECT

POLICY CONCERNING THE USE OF STATE AUTOMATION EQUIPMENT:

II. POLICY STATEMENT

The purpose of this policy is to establish and promulgate the rules to be followed while using any or all of the State automation equipment under the control of the Maine Department of Human Services (DHS).

III. RATIONALE

These written policies have been developed and codified in order to provide guidance and protection to DHS employees and to safeguard the technology assets of the State entrusted to DHS employees. DHS provides its employees access to State automation equipment to accomplish tasks, processing, and communications necessary to effectively achieve DHS' mission, as directed by law and the administration. **State automation equipment is made available to employees to conduct official DHS business.** Unofficial and/or unauthorized use of State automation equipment places unanticipated and possibly excessive demands on the State's Information Technology (I.T.) resources. Accessing unofficial and/or unauthorized sources unnecessarily exposes the State to the spread of computer viruses, which may be both costly and disruptive to clean from DHS I.T. and related systems.

IV. PROCEDURE STATEMENT

A. Security of Information

DHS employees are hereby made aware that cell phones and Internet messages are generally not secure and can be easily intercepted by outside parties. Care shall be exercised to avoid inadvertent disclosure of confidential information over these media. **Employees are advised that**

there should be no expectation of privacy when using any State automation equipment.

B. Public Information

E-mail systems, Internet and WorldWide Web browsers, bulletin board systems, etc., are intended to be used for State business purposes. Voice mail and e-mail messages may have backup copies that cannot be deleted by the operator. A history of accessed web sites is recorded by most browser software. All material created, modified, stored, moved, distributed, transferred, printed, imaged, or otherwise manipulated on State automation equipment is considered to be public property and, as such, is subject to examination by the public, except as noted below.

C. Freedom of Access Law

All of this information may be subject to release under a "Freedom of Access Law" request. The State of Maine "Freedom of Access Law" (1 MRSA, § 401-410) clearly provides that any and all materials, files, notes, records, copies, etc., regardless of the media used to store or transmit them (paper, film, microfiche, magnetic media, electronic media, etc.) in public offices or in the possession of public employees while at work which relate in any way to the transaction of public or governmental business are public property. As such, the public has access to those materials.

The law places some very narrow restrictions on public access; such as personnel files, employment applications, employee testing and rating criteria, workers' compensation files, certain investigation files, etc.. However, most materials are subject to public viewing.

D. Use of Automation Equipment

1. The use of State automation equipment to create, record, store, transmit, distribute, image, modify, print, download, or display inappropriate or unprofessional materials that demean, denigrate, or harass individuals or groups of individuals, on the basis of race, ethnic heritage, religious beliefs, disability, sexual orientation, political beliefs, gender, and/or materials that are sexually explicit or pornographic in nature, whether or not the material was intended to demean, denigrate or harass any employee or group of employees, is prohibited.

2. The State's E-mail is not to be used to forward or otherwise broadcast "chain letters," mass communications that are not work related, or solicitations for causes unrelated to the State's business, no matter how worthy the cause may be perceived. [NOTE: In the Capitol area, Capitol Security must give written permission for solicitations. The *Maine State Employees Combined Charitable Appeal* is the only solicitation with on-going, or "blanket" approval. Other charitable solicitations may be allowed only on prior written approval of the Commissioner.]

3. E-mail messages and Internet sites accessed are not private but are property of the Department. The Department may print and review e-mail messages and Internet sites accessed by an employee's system.

4. State automation equipment may not be used to conduct outside business nor may it be used in conjunction with any outside employment activity.

5. Any personal use of State automation equipment must be incidental in nature. Examples of incidental use may include, but are not limited to, brief e-mails, accessing an appropriate subject on the Internet, phone calls of an urgent nature, using computer capabilities for brief correspondence, etc. Certain telephone calls and expenses are allowable under collective bargaining agreements. The use of State-owned supplies represents a cost to the State and, as such, printing and copying for personal use is restricted to incidental use only.

6. Any personal, incidental use of State automation equipment shall not interfere with the DHS' business activities, must not involve solicitation in any form, must not be associated with any outside business or employment activity, and must not potentially embarrass or offend the State of Maine, its residents, its taxpayers, or its employees. As is the case in other situations, the time associated with any incidental personal use of State automation equipment must not intrude into an employee's work responsibilities.

7. An employee will not at any time, without a person's permission, use another's identity to send or receive e-mail. An employee will likewise not retrieve messages or files intended for another.

8. If an employee uses a personal computer that is not provided by the Department, for State business purposes, the PC must have installed and operating the current version of the State-approved anti-virus product.

9. The State's E-mail is not to be used to forward or otherwise broadcast virus warnings or other computer system related announcements. The Division of Technology Services is the only unit authorized to disseminate this information to Department Employees. If you feel you have received information that should be broadcast to some or all of the Department employees, contact the Director of the Division of Technology Services.

10. Personal software will not be permitted on State automation equipment. However, single user non-networked applications that require no communications, i.e. stand-alone PC applications, may

be loaded for evaluation by a qualified, DoTS-approved technician with prior approval from both:

- The Division of Technology Services (DoTS)
- The appropriate supervisor

The technician must review the software prior to installation and is responsible for its support during the evaluation. An evaluation period must comply with all licensing requirements and in no case be longer than ninety (90) days, after which the technician must remove the software. Should the product prove desirable, standard acquisition guidelines and procedures apply.

11. At no time shall any employee, other than a qualified DoTS-approved technician, open, insert, remove or alter any hardware comprising State automation equipment. All configuration changes to State automation hardware or software will be done only by qualified, DoTS-approved technicians.

12. Personal hardware will not be permitted on State automation equipment unless installed by a qualified, DoTS - approved technician with prior approval from both:

    - The Division of Technology Services (DoTS)
    - The appropriate supervisor

    Any service or support of personal hardware is solely the responsibility of the owner, not the Department.

13. No streaming video or audio applications including, but not limited to, weather or satellite maps, stock market updates, news headlines, any service that continually updates your PC, TV channels on the Internet, music videos, movie or entertainment broadcasts, radio music or news broadcasts, live interviews or non-critical audio/video seminars are allowed if not directly needed in the performance of assigned duties.

14. No third-party games may be loaded, downloaded or used on any DHS equipment. Those games which may come as part of standard software, i.e operating systems, etc., must be removed by qualified technical employees prior to distribution to Department employees.

15. Screensavers may be changed to suit personal taste provided they do not add software or conflict with the Department's mission or other portions of this policy.

E. Guidelines And Procedures

1. In the event that an employee is sent, delivered or inadvertently accesses inappropriate or prohibited material, the employee is required to immediately secure the material from view and notify their supervisor. If an employee inadvertently accesses inappropriate or prohibited materials, his or her supervisor or management must be advised of the circumstances surrounding the inadvertent access. This will ensure that the employee is held harmless for inadvertently accessing the inappropriate or prohibited materials.

2. If supervisory or management employees become aware that inappropriate or prohibited materials are being accessed, downloaded, or otherwise transmitted to or by an employee in his or her organization, he or she must act immediately to stop such activity. Supervisors and managers should contact the Human Resources Director, DHS, for guidance and consultation.

3. Each DHS employee is expected to comply with this policy. Violation of this policy may lead to progressive discipline, up to and including dismissal consistent with applicable collective bargaining agreement and/or *Civil Service Rules*.

4. DHS employees and the Department of Administrative & Financial Services, Bureau of Information Services may monitor voice, e-mail, and Internet traffic to improve service levels, enforce this policy, and prevent unauthorized access to State systems.

5. These rules may be amended as necessary by State policies and procedures or by updated DHS policies.

6. Employees needing further clarification regarding the technical aspects of this policy may contact the Director of Technology Services, DHS (287-3864). For questions regarding the policy and its implementation, employees may contact the Director of Human Resources, DHS (287-2567).

V. DEFINITIONS

State Automation Equipment: State automation and related communications equipment may include, but are not limited to: Computer workstations, computer terminals, laptop, notebook and hand-held computers, voice mail, computer networks, printers, copiers, telephones, fax machines, modems, fax modems, wireless modems, e-mail, local and wide area networks, Internet, and Intranet.

Public Records: Public records include e-mail messages and attachments, information obtained from the Internet, and other electronic transmittals that have been created, received, or stored on State of Maine automation equipment (1 MRSA §401–410).

Public Disclosure: All public records are subject to administrative review, inspection by the public, and discover requests as part of legal proceedings in accordance with (1 MRSA §402). Incidental personal use records may be subject to disclosure if stored on Department IT equipment.

Incidental Use: The use of State automation equipment for personal use must be infrequent and using only small amounts of an employee's personal time either inside or outside the regular work day. Occasional use during an employee's 15-minute break would be considered incidental. Regular use, use for a period longer than 20 minutes or any use that interferes with or slows the completion of the Department's business would not be considered incidental. Only occasional and brief use is considered incidental. Solicitations of any nature are not permitted.

VI. DISTRIBUTION

Current employees shall, following the appropriate posting, receive a copy of this policy.

New employees shall receive a copy of this policy upon hire.

Each employee shall sign a statement, confirming that his/her copy of this policy has been received and read. (Refer to Attachment.)

Said statement (Attachment) shall be filed in employee's personnel folder.

VII. ATTACHMENTS

Employee Use of State Automation Equipment Acknowledgement Form

Kevin W. Concannon
Signature of Commissioner

September 1, 2001
Effective Date

December 8, 2001
Date of Revision

KWC
Commissioner's Initials

State Seal

Privacy Policy for the Official Website of the State of Maine

Individuals who visit the State of Maine website are important to us. Because visitors to our website are important, we do not capture personal information about them without their permission. We endeavor to collect only the minimum amount of information needed to meet the purposes for which the website was created.

Public Disclosure

All information collected on the State of Maine website will be treated the same as any written communication and is subject to the confidentiality and public disclosure provisions of 1 MRSA Chapter 13.

PRIVACY STATEMENT

Visitors to the State of Maine Website

We may collect some or all of the following information about visitors who view or download information from our websites:

Information	Definition
Date	Date the visit occurred.
Time	Time the visit occurred.
Client IP	Unique Internet Protocol (IP) address of the website visitor. The IP address recorded is normally that of the visitor's Internet service provider, e.g., aol.com if the visitor connects from an America Online account.
Server IP	Unique Internet Protocol (IP) address of the State of Maine web server accessed.
HTTP Status	Hyper Text Transfer Protocol (HTTP) error code. E.g., "404 Requested Page Not Found."
HTTP Request	Identifies the web page or file requested by the website visitor.

URL	
Bytes Sent	Amount of data sent from the web server to website visitor during that connection.
Bytes Received	Amount of data sent from website visitor to the web server.
User Agent	Type of web browser or other client software that made request to the web server.
Referrer	Uniform Resource Locator (URL) that referred to the requested file.
Protocol Version	Version of HTTP used by the visitor's web browser software.

The information we collect is used to improve the content of our web services and help us understand how people are using our services. We analyze our website logs to continually improve the value of the materials available on our site. The information in our website logs is not personally identifiable, and we make no attempt to link it with the individuals that browse our website.

Some of this statistical information, such as a running count of the number of visitors, may be displayed on the website or shared with other state governments to aid in the provision of better service to the public.

Personally Identifiable Information

"Personally identifiable information" is information about a person that is readily identifiable to that specific individual. It includes, for example, an individual's name, street address, e-mail address, or phone number.

Personally identifiable information will not be collected unless you voluntarily send an e-mail message, fill out and send an online form, or fill out personal information and send in a survey. Your choice not to participate in these activities will not impair your ability to access certain information or obtain a service online.

Unless specifically protected under state law, any information provided may be inspected by the public or disclosed in a legal proceeding.

E-mail Senders

E-mail messages, sent to any Maine State Government address, will be treated the same as any other written communication. They may be subject to public inspection or legal disclosure and may be saved for a period of time before they are destroyed. E-mail or other information requests sent to the state website may be maintained in order to respond to the request, forward that request to the appropriate agency, or to provide the web designer with valuable customer feedback to assist in improving the site. E-mail addresses

obtained as a result of a request to the state site will not be sold or given to private companies for marketing purposes.

Electronic Form Filers

Any other information provided by a visitor at the request of an agency of Maine State Government, such as the completion and electronic filing of a form, will be considered to be voluntarily provided by the visitor and will be treated in the same manner as information provided in written form or in person during a visit to the agency. Information provided may be subject to public inspection and legal disclosure and may be saved for a period of time before it is destroyed. It may be shared with another state agency for appropriate action.

Surveys

Surveys will be used for the purpose stated. If personally identifiable information is collected it may be subject to public inspection and legal disclosure and may be saved for a period of time before it is destroyed.

InforME Subscribers

The Information Resource of Maine collects, retains and utilizes personal information about its customers only when they volunteer to subscribe to InforME. The information is used to administer subscriber accounts and to provide products, services and other opportunities requested by InforME subscribers. Records containing personal information about InforME subscribers are confidential and may only be released with the express written permission of the subscriber pursuant to the provisions of 1 MRSA Chapter 14.

Cookies

In order to better serve you, the user, we use cookies for certain types of online transactions.

Cookies are small text files that a web server may ask your web browser to store, and to send back to the web server when needed. Cookies may be used to store a transaction identifier or other information a user may provide. We use cookies in the following ways:

- **Complex transactions**: Cookies are used to store and retrieve unique transaction identifiers or other server-generated or user-provided information in complex, multi-page web applications. This allows us to distinguish between different users, and to use information provided at one stage of an application at a later time (for instance, items placed in a 'shopping cart' might need to be displayed on a later 'check-out' screen). When we use cookies in this way, the cookie is stored on your web browser only temporarily; the cookie is destroyed at the end of the transaction or at the end of the browser session.

- **Customized Services**: Cookies may also be used to automatically identify a particular user to the system, in order to provide a customized service, such as a personalized web page. In this case, a cookie containing a unique user identifier will be permanently stored on your web browser. We do not store sensitive information in such cookies; only a unique user identifier or generic preference values are stored. Personal information you give us for processing a transaction or using one of our personalization features, may be stored on our secure web server.

We do not use cookies in order to track your visit to our website.

The "help" portion of the toolbar on most browsers will tell you how to prevent your browser from accepting new cookies or how to disable cookies altogether. However, cookies allow you to take full advantage of many of the Information Resource of Maine's eGovernment services, and we recommend that you set your web browser to accept cookies.

If you have further questions about cookies, the Computer Incident Advisory Capacity unit that monitors computer problems for the U.S. Department of Energy issued a study on March 12, 1998 of the risks of cookies to users, titled Information Bulletin I-034: Internet Cookies.

You can refuse the cookies or delete the cookie file from your computer by using any of the widely available methods.

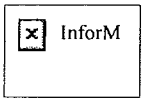
Disclaimer

Neither the State of Maine, nor any agency, officer, or employee of the State of Maine warrants the accuracy, reliability or timeliness of any information published on the State of Maine website, nor endorses any products or services linked from this system, and shall not be held liable for any losses caused by reliance on the accuracy, reliability or timeliness of such information. Portions of the information may be incorrect or not current. Any person or entity that relies on any information obtained from this system does so at his or her own risk.

Various websites may be linked through the State of Maine website. Visitors to those sites are advised to check the privacy statements of those sites and be cautious about providing personally identifiable information without a clear understanding of how the information will be used. This Privacy Statement does not apply to non-Maine State Government websites linked to the State of Maine website.

Contact Information

To offer comments about the State of Maine website or about information presented in this Privacy Statement, contact webmaster@informe.org.



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Title 5: ADMINISTRATIVE PROCEDURES AND SERVICES

Part 17: STATUS OF WOMEN (HEADING: P&SL 1975, c. 147, Pt. G, @1 (new))

Chapter 372: STATE CIVIL SERVICE SYSTEM (HEADING: PL 1985, c. 785, Pt. B, @38 (new))

Subchapter 2: EMPLOYEE POLICIES, PRACTICES AND RESTRICTIONS (HEADING: PL 1985, c. 785, Pt. B, @38 (new))

Article 3: EMPLOYEE BENEFITS, RECORDS AND TRAINING (HEADING: PL 1985, c. 785, Pt. B, @38 (new))

§7070. Personnel records

Every appointment, transfer, promotion, demotion, dismissal, vacancy, change of salary rate, leave of absence, absence from duty and other temporary or permanent change in status of employees in both the classified service and the unclassified service of the Executive and Legislative Departments shall be reported to the director at such time, in such form and together with such supportive or pertinent information as he shall by rule prescribe. [1985, c. 785, Pt. B, §38 (new).]

The director shall maintain a perpetual roster of all officers and employees in the classified and unclassified services, showing for each person such data as he and the board deem pertinent. [1985, c. 785, Pt. B, §38 (new).]

Records of the Bureau of Human Resources shall be public records and open to inspection of the public during regular office hours at reasonable times and in accordance with the procedure as the director may provide. [1985, c. 785, Pt. B, §38 (new).]

The following records shall be confidential and not open to public inspection, and shall not be "public records," as defined in Title 1, section 402, subsection 3: [1985, c. 785, Pt. B, §38 (new).]

1. Papers relating to applications, examinations or evaluations of applicants. Except as provided in this subsection, applications, resumes, letters and notes of reference, working papers, research materials, records, examinations and any other documents or records and the information they contain, solicited or prepared either by the applicant or the State for use in the examination or evaluation of applicants for positions as state employees.

A. Notwithstanding any confidentiality provision other than this subsection, applications, resumes and letters and notes of reference, other than those letters and notes of reference expressly submitted in confidence, pertaining to the applicant hired are public records after the applicant is hired. [1989, c. 402, §1 (new).]

B. Telephone numbers are not public records if they are designated as

"unlisted" or "unpublished" in an application, resume or letter or note of reference. [1989, c. 402, §1 (new).]

C. This subsection does not preclude union representatives from access to personnel records, consistent with subsection 4, which may be necessary for the bargaining agent to carry out its collective bargaining responsibilities. Any records available to union representatives which are otherwise covered by this subsection shall remain confidential and are not open to public inspection; [1989, c. 402, §1 (new).] [1989, c. 402, §1 (rpr).]

2. Personal information. Records containing the following, except they may be examined by the employee to whom they relate when the examination is permitted or required by law:

A. Medical information of any kind, including information pertaining to diagnosis or treatment of mental or emotional disorders; [1985, c. 785, Pt. B, §38 (new).]

B. Performance evaluations and personal references submitted in confidence; [1985, c. 785, Pt. B, §38 (new).]

C. Information pertaining to the credit worthiness of a named employee; [1985, c. 785, Pt. B, §38 (new).]

D. Information pertaining to the personal history, general character or conduct of members of the employee's immediate family; [1997, c. 124, §2 (amd).]

D-1. Personal information pertaining to the employee's race, color, religion, sex, national origin, ancestry, age, physical disability, mental disability and marital status; social security number; home telephone number and home address; and personal employment choices pertaining to elected payroll deductions, deferred compensation, savings plans, pension plans, health insurance and life insurance. When there is a work requirement for public access to personal information under this paragraph that is not otherwise protected by law, that information may be made public. The Director of the Bureau of Human Resources, upon the request of the employing agency, shall make the determination that the release of certain personal information not otherwise protected by law is allowed; and [1997, c. 124, §2 (new).]

E. Except as provided in section 7070-A, complaints, charges or accusations of misconduct, replies to those complaints, charges or accusations and any other information or materials that may result in disciplinary action. If disciplinary action is taken, the final written decision relating to that action is no longer confidential after the decision is completed if it imposes or upholds discipline. If an arbitrator completely overturns or removes disciplinary action from an employee personnel file, the final written decision is public except that the employee's name must be deleted from the final written decision and

kept confidential. If the employee whose name was deleted from the final written decision discloses that the employee is the person who is the subject of the final written decision, the entire final written report, with regard to that employee, is public.
For purposes of this paragraph, "final written decision" means:

(1) The final written administrative decision that is not appealed pursuant to a grievance arbitration procedure; or

(2) If the final written administrative decision is appealed to arbitration, the final written decision of a neutral arbitrator.

A final written administrative decision that is appealed to arbitration is no longer confidential 120 days after a written request for the decision is made to the employer if the final written decision of the neutral arbitrator is not issued and released before the expiration of the 120 days;
[1997, c. 770, §1 (amd).]

This subsection does not preclude union representatives from having access to personnel records, consistent with subsection 4, that may be necessary for the bargaining agent to carry out its collective bargaining responsibilities. Any records available to union representatives that are otherwise covered by this subsection remain confidential and are not open for public inspection;

[1997, c. 770, §1 (amd).]

3. Other information. Other information to which access by the general public is prohibited by law. [1985, c. 785, Pt. B, §38 (new).]

4. Disclosure of certain information for grievance and other proceedings. The Director of Human Resources may release to the Director of Employee Relations specific information designated confidential by this section which has been requested by the Director of Employee Relations to be used in negotiations, mediation, fact-finding, arbitration, grievance proceedings and other proceedings in which the Director of Employee Relations represents the State as defined in this subsection. For the purpose of this subsection, "other proceedings" means unemployment compensation proceedings, workers' compensation proceedings, human rights proceedings and labor relations proceedings.

Confidential information provided under this subsection to the Bureau of Employee Relations shall be governed by the following.

A. The information to be released shall be information only as necessary and directly related to the proceeding as determined by the Director of Human Resources. [1987, c. 673, §1 (new).]

B. The Director of Employee Relations shall specify in writing the confidential information required in the proceedings and the reasons explaining the need for the information, and shall provide a copy of the written request to the employee or employees. [1987, c. 673, §1 (new).]

C. The proceeding for which the confidential information is provided shall be private and not open to the public; or, if the proceeding is open to the public, the confidential information shall not be disclosed except exclusively in the presence of the fact finder, the parties and counsel of record, and the employee who is the subject of the proceeding and provisions are made to ensure that there is no public access to the confidential information. [1987, c. 673, §1 (new).]

The Director of Employee Relations may use this information in grievance proceedings and provide copies to the employee organization that is a party to the proceedings, provided the information is directly related to those proceedings as defined by the applicable collective bargaining agreement. Confidential personnel records in the possession of the Bureau of Employee Relations shall not be open to public inspection and shall not be "public records," as defined in Title 1, section 402, subsection 3.

[1987, c. 673, §1 (new).]

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