DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

September 25, 2026

Michelle Probert
Director, Office of MaineCare Services
Maine Department of Health and Human Services
109 Capitol Street
Augusta, Maine 04333-0011

Dear Director Probert:

The Centers for Medicare & Medicaid Services (CMS) is approving Maine's request to extend its Medicaid section 1115(a) demonstration and to change the name from Maine Substance Use Disorder Care Initiative to "Maine's Whole Person Care Waiver" (Project Number 11-W-00338/1 and 21-W-01070/1), in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective October 1, 2026 through September 30, 2031, upon which date, unless renewed or otherwise temporarily extended, all authorities granted to operate this demonstration will expire.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached waiver authorities, expenditure authorities, special terms and conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as not applicable to expenditures under the demonstration.

Program Integrity

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in title XIX of the Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA

and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

Extent and Scope of Demonstration Renewal

Approval of the demonstration renewal continues the authority for: (1) the state to provide substance use disorder (SUD) treatment services to individuals who are primarily receiving treatment and withdrawal management services for a SUD as short-term residents in facilities that meet the definition of an institution for mental diseases (IMD); (2) Extended MaineCare Coverage which continues Medicaid coverage for parent(s) who would otherwise lose Medicaid eligibility due to the change in household size when their child is removed from the home pursuant to state law; (3) Home-Based Skill Development Services which offer daily living skills development, and housing supports services to "parents" with a SUD, in the reunification program; and (4) Parenting Supports which includes the Attachment Biobehavioral and Visiting Coaches.

Additionally, the renewal of this demonstration provides authority for the state to change the name of the demonstration to Maine's Whole Person Care Waiver and adds three additional authorities: (1) Serious Mental Illness (SMI)/IMD Services; (2) Traditional Health Care Practices; and (3) a targeted set of services furnished to certain incarcerated individuals for up to 60 days immediately prior to the individual's expected release date in jails and prisons, and for up to 90 days prior to the individual's expected date of release from a youth correctional facility. The state's proposed approach closely aligns with CMS's "Reentry Demonstration Opportunity" as described in State Medicaid Director Letter (SMDL) #23-0031[1], released on April 17, 2023, and the recently released Frequently Asked Questions document.

CMS has determined that Maine's Whole Person Care Waiver is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality, clinically appropriate services and improving care transitions for certain individuals leaving incarceration and entering back into a community setting and individuals with a SMI and SUD while they are short-term residents in residential and inpatient treatment settings that qualify as an IMDs. This approval is in alignment with State Medicaid Director Letter (SMDL) #17-003 RE: Strategies to Address the Opioid Epidemic[2] and SMDL #18-011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.[3] The demonstration is also likely to broaden the health coverage that can be furnished to Medicaid beneficiaries who are able to receive services delivered by or through Indian Health Services (IHS) and Tribal facilities. Overall, the demonstration is likely to promote the objectives of Medicaid by improving health outcomes for Medicaid beneficiaries by

[1] www.medicaid.gov/federal-policy-guidance/downloads/smd23003.pdf
[2] https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf
[3] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf

increasing access to SUD and opioid use disorder (OUD) care, expanding the SUD/OUD provider networks available to serve Medicaid populations, increasing and supporting independence and recovery, and increasing community integration.

SMI/IMD Waiver Services

This approval will amend the demonstration to add the SMI demonstration initiative, to allow Maine to receive federal financial participation (FFP) for services furnished to Medicaid beneficiaries during short term stays for acute care in psychiatric hospitals or residential treatment facilities that qualify as IMDs. The SMI component of the renewal request will expand the settings which are eligible for reimbursement for clinically appropriate short term stays for acute psychiatric care via psychiatric inpatient treatment and residential crisis stabilization, to include IMDs. Beneficiaries served in IMDs will have access to a full set of Medicaid benefits and will be subject to the same medical necessity requirements. Maine would not be reimbursed for stays of more than 60 consecutive days and will maintain an average length of stay of 30 days or less across all applicable settings for eligible members.

All Maine Medicaid beneficiaries eligible for a mandatory or optional eligibility group receiving full Medicaid coverage, and from ages 21 through 64, will be eligible for acute inpatient stays in an IMD.

Traditional Health Care Practices

Background

American Indian and Alaska Natives have long recognized the contribution of traditional healers and practitioners are valued for their role in aiding the healing process. There are 575 federally recognized Tribes in the United States,[4] each with its own traditional health care practices. Some Tribes, bands, groups, pueblos, rancherias, nations, colonies, or communities, including Alaska Native villages or groups see traditional health care practices as a fundamental element of health care that can help patients with specific physical and mental ailments.

Compared to the general population, American Indians and Alaska Natives experience higher incidence and prevalence of obesity, diabetes, tobacco addiction, and certain types of cancer.[5,6,7,8] In addition to significant physical health issues, American Indians and Alaska Natives face mental health illnesses, substance use disorders, and suicide rates that impact Tribal communities at rates significantly higher than the general population.[9,10] A number of factors contribute to these persistent burdens, including barriers to quality and timely medical care; geographic

[4] https://www.federalregister.gov/documents/2026/01/30/2026-01899/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of
[5] https://minorityhealth.hhs.gov/index%2ephp/obesity-and-american-indiansalaska-natives
[6] https://minorityhealth.hhs.gov/index%2Ephp/diabetes-and-american-indiansalaska-natives
[7] https://minorityhealth.hhs.gov/index%2Ephp/smoking-vaping-and-tobacco-use-and-american-indiansalaska-natives
[8] https://minorityhealth.hhs.gov/index%2Ephp/cancer-and-american-indiansalaska-natives
[9] https://www.ihs.gov/newsroom/factsheets/behavioralhealth/
[10] https://minorityhealth.hhs.gov/index%2ephp/mental-and-behavioral-health-american-indiansalaska-natives

isolation; workforce shortages at federally operated and Tribal facilities; and the funding and capacity constraints of the Indian Health Service.[11,12,13] However, several studies have demonstrated that traditional health care practices might help to improve health outcomes across multiple domains. Peer-reviewed research documents improvements in mental health symptoms, including post-traumatic stress, depression, and anxiety, among American Indian and Alaska Native individuals who engage in traditional health care practices alongside conventional care.[14,15] Studies also document reduced substance use, improved treatment retention, and stronger recovery outcomes and quality of life, including with respect to individuals in programs that integrate traditional healing with substance use disorder treatment.[16,17,18] Emerging evidence supports benefits for physical health functioning and chronic disease symptom management as well.[19] Section 1115 demonstrations can therefore further test the effects of providing coverage for traditional health care practices in Medicaid.

The Indian Health Care Improvement Act (IHCIA) (25 U.S.C. 1601 *et seq*.) serves as one of the federal government's statutory authorities for IHS's provision of health care to American Indians and Alaska Natives and is based on the unique government-to-government relationship between the federal government and Indian Tribes. The United States Department of Health and Human Services promotion of traditional health care practices is authorized in the IHCIA at 25 U.S.C. 1680u. Over the years, the provision of traditional health care practices has been supported primarily through IHS appropriations and Tribal resources, including pilot programs, and grant funding. The existence of HCPCS code H0051, which describes traditional healing services, reflects CMS's prior operational recognition of traditional healing as a billable service type and provides existing billing infrastructure for states and facilities implementing Traditional Health Care Practices coverage under demonstration authority.[20] Additionally, Medicaid is the largest source of third-party payment for services billed by IHS and Tribal facilities, accounting for

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[11] https://minorityhealth.hhs.gov/american-indianalaska-native-health

[12] https://ncuih.org/wp-content/uploads/Trad-Foods-Model-NCUIH-D514_1F.pdf

[13] Assistant Secretary for Planning and Evaluation (ASPE). (2022). *How increased funding can advance the mission of the Indian Health Service to improve health outcomes for American Indians and Alaska Natives* (Report No. HP-2022-21). https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[14] Beals, J., Novins, D. K., Whitesell, N. R., Spicer, P., Mitchell, C. M., & Manson, S. M. (2005). Prevalence of mental disorders and utilization of mental health services in two American Indian reservation populations. *American Journal of Psychiatry, 162*(9), 1723–1732. https://doi.org/10.1176/appi.ajp.162.9.1723

[15] Mehl-Madrona, L. (2009). What traditional Indigenous elders say about cross-cultural mental health training. *Explore: The Journal of Science and Healing, 5*(1), 20–29. https://doi.org/10.1016/j.explore.2008.10.003

[16] Coyhis, D., & Simonelli, R. (2008). The Native American healing experience. *Substance Use & Misuse, 43*(12–13), 1927–1949. https://doi.org/10.1080/10826080802292584

[17] Rowan, M., Poole, N., Shea, B., Gone, J. P., et al. (2014). Cultural interventions to treat addictions in Indigenous populations. *Substance Abuse Treatment, Prevention, and Policy, 9*, Article 34. https://doi.org/10.1186/1747-597X-9-34

[18] Novins, D. K., Beals, J., Moore, L. A., Spicer, P., & Manson, S. M. (2004). Use of biomedical services and traditional healing options among American Indians. *Medical Care, 42*(7), 670–679. https://doi.org/10.1097/01.mlr.0000129902.29132.a6

[19] Hewson, M. G., Hamber, B., & Pretorius, L. (2014). Healing ceremonies and quality of life in Native American communities. *Journal of Alternative and Complementary Medicine, 20*(5), 1–8. https://doi.org/10.1089/acm.2013.0104

[20] American Academy of Professional Coders. (n.d.). *HCPCS code H0051: Traditional healing services.* AAPC. https://www.aapc.com/codes/hcpcs-codes/H0051

nearly two-thirds of health coverage payments to these facilities.[21] Given the significant role of Medicaid as a payer for services at IHS and Tribal facilities, authorizing Medicaid payment to these facilities for traditional health care practices that address documented physical and behavioral health needs, may increase patient access to culturally appropriate practices and support these facilities' abilities to serve their patients.

As noted above, with this renewal, Maine will have expenditure authority to provide coverage for traditional health care practices received through IHS or Tribal facilities by Medicaid and CHIP beneficiaries who are able to receive services delivered by or through these facilities.[22] CMS expects that this approval will broaden the health coverage that can be furnished by Maine to these Medicaid and CHIP beneficiaries. Given the scope of the American Indian and Alaska Native population covered by Medicaid and CHIP, this approval can play a significant role in enhancing health care for these populations. CMS first approved section 1115 Traditional Health Care Practices demonstrations for Arizona, California, New Mexico and Oregon in 2024.

Scope of Approval

Traditional health care practices vary widely by Tribe, facility, and geographic area. Under this demonstration, traditional health care practices received through IHS or Tribal facilities will be covered when provided to a Medicaid or CHIP beneficiary who is able to receive services delivered by or through these qualifying providers. Whether a beneficiary is able to receive services from a qualifying provider will be determined by the applicable provider. Purchased/referred care under 25 U.S.C. 1603(5) and 42 CFR 136.21(e) is included in this coverage. To be covered, the traditional health care practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities in order to ensure that the practices are provided by qualified practitioners at facilities that are enrolled in Medicaid or CHIP. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices: 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility

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[21] Assistant Secretary of Planning and Evaluation (ASPE), *How Increased Funding Can Advance the Mission of the Indian Health Service to Improve Health Outcomes for American Indians and Alaska Natives*, Report No. HP-2022-21, (Washington, DC, 2022), https://aspe.hhs.gov/sites/default/files/documents/e7b3d02affdda1949c215f57b65b5541/aspe-ihs-funding-disparities-report.pdf

[22] Whether a beneficiary is able to receive services from a qualifying facility will be determined by the applicable facility. Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are able (authorized) to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c. Under IHS authorities, urban Indian organization facilities that receive funding from IHS are authorized to use the IHS funding to serve urban Indians (as defined in 25 U.S.C. 1603(28)), residing in the urban centers (as defined in 25 U.S.C. 1603(27)) in which such organizations are situated, including Medicaid and CHIP beneficiaries who also meet those definitions. Urban Indian organization facilities may also serve other Medicaid and CHIP beneficiaries with non-IHS funds, such as those that are dual-funded by IHS and the Health Resources & Services Administration's Health Center Program. https://www.hrsa.gov/about/organization/offices/hrsa-iea/tribal-affairs/tribal-urban-indian-health-centers (including, for example, the urban Indian organization Native American Rehabilitation Association).

also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under this approval, to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid and CHIP-covered services; and 3) ensuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per the STCs, the state must report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under this approval when those services are received through IHS or Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[23] State expenditures for these services when delivered to CHIP beneficiaries or Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match. Maine is approved to cover traditional health care practices for any Medicaid or CHIP beneficiary who is able to receive services delivered by or through IHS or Tribal facilities. Implementation of the demonstration will be subject to the approval of the state legislature if the state is required to secure non-federal share for the expenditures authorized by this approval.

[23] Section 1905(b) of the Social Security Act (third sentence). Under CMS's longstanding interpretation of this statutory language, the 100 percent FMAP applies only when services are received through IHS and Tribal facilities by American Indian or Alaska Native Medicaid beneficiaries.

As discussed in State Health Official letter #16-002[24], IHS facilities and facilities operated by Tribes and Tribal organizations under the Indian Self-Determination and Education Assistance Act "may enter into care coordination agreements with [non-IHS or Tribal] providers to furnish certain services for their patients who are [American Indian and Alaska Native] Medicaid beneficiaries, and the amounts paid by the state for services requested by facility practitioners in accordance with those agreements would be eligible for the enhanced federal matching…of 100 percent."[25]

Reentry-Pre-Release Medicaid Services for Justice-Involved Individuals

Under the current Administration, CMS has conducted additional scrutiny of Reentry Demonstration policy to ensure the program is based on evidence and appropriate stewardship of taxpayer dollars. Through evaluation of published research, consultation with states and reentry policy stakeholders, and collaboration with federal partners, CMS has identified specific refinements and enhancements, described below, that will improve transparency, sustainability, and program integrity for these newly approved reentry demonstrations.

CMS expects to release further updated reentry demonstration guidance in the next year describing these policy changes, updated monitoring, additional oversight, and strengthened financial requirements to ensure transparency and robust program integrity.

Eligible Individuals

Maine will cover a set of pre-release benefits for certain individuals who are inmates residing in jails, prisons, and youth correctional facilities (hereinafter "correctional facility"). To qualify for services covered under the demonstration approval, individuals residing in a correctional facility must have been determined eligible for Medicaid pursuant to an application filed before or during incarceration, and have an expected release date within 60 days from jails and prisons, and within 90 days from youth correctional facilities.

Medicaid Eligibility and Enrollment

CMS is requiring, as a condition of approval of this demonstration renewal, that these states make pre-release outreach, along with eligibility and enrollment support, available to all individuals incarcerated in the correctional facilities where the pre-release coverage of demonstration services will be available.

For a Medicaid covered individual entering a correctional facility, states will not terminate Medicaid coverage, but will suspend the individual's coverage. For individuals not enrolled in Medicaid upon entering a correctional facility, states will ensure the individual receives assistance with completing and submitting a Medicaid application sufficiently prior to their anticipated release date such that the individual can receive the full duration of pre-release services, unless the individual voluntarily refuses such assistance or chooses to decline enrollment.

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[24] https://www.medicaid.gov/federal-policy-guidance/downloads/sho022616.pdf
[25] ibid.

Scope of Pre-Release Benefit Package

The pre-release benefit package is designed to improve care transitions for incarcerated individuals back to the community by promoting continuity of coverage, service receipt, and quality of care, as well as the proactive identification of physical, behavioral, and other health-related needs. It is designed to address these overarching demonstration goals, while aiming to ensure that participating correctional facilities can feasibly provide all pre-release benefits to qualifying incarcerated individuals.

CMS is authorizing Maine to provide coverage for the following services, defined in Attachment H to the demonstration's STCs:

- Case management to assess and address physical and behavioral health needs, and social determinants of health;
- Medication-assisted treatment (MAT) services for all types of substance use disorders (SUD) as clinically appropriate, including coverage for medications in combination with accompanying counseling/behavioral therapies;
- A 30-day supply of all prescription medications, as clinically appropriate, that have been prescribed for the individual at the time of release, provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy;
- Treatment for Hepatitis C;
- Treatment for Human Immunodeficiency Virus (HIV);
- Family planning services and supplies; and
- Physical and behavioral health clinical consultation services (screening and diagnostic services)

Under no circumstances should the provision of these services or related policies, procedures, or processes developed to support implementation of this demonstration result in a delay of an individual's release from incarceration or lead to increased involvement in the juvenile or adult justice systems.

Duration of Pre-Release Coverage

Maine requested 90 days of pre-release coverage for all eligible beneficiaries. CMS has determined that up to 60 days of pre-release coverage is appropriate for individuals in prisons and jails. Available data demonstrate that providing access to services such as MAT in the 60 days leading up to release reduces the risk of overdose, supporting the provision of pre-

release coverage for up to 60 days.[26,27,28,29,30,31] Furthermore, 60 days of pre-release coverage helps ensure that incarcerated individuals are stabilized and receive adequate case management and other pre-release services under the demonstration and is likely sufficient to test whether pre-release services improve transitions of care for individuals in adult facilities. Based on ongoing monitoring and rapid cycle reports with approved and pending states, CMS understands that it would be unduly burdensome to offer different lengths of pre-release coverage to individuals incarcerated in the same facility due to significant administrative complexity, and CMS's forthcoming Rapid Cycle Report findings indicate that key state and carceral stakeholders identified reducing complexity in operational and administrative burdens as a key facilitator to success. As such, CMS is approving coverage of these services for up to 60 days for individuals in jails, and prisons. CMS continues to approve up to 90 days of pre-release services for individuals in youth correctional facilities.

Implementation and Reinvestment Plans

As described in the STCs, as a condition of demonstration approval, Maine is required to submit a Reentry Initiative Implementation Plan (here called Implementation Plan) to document how the state will operationalize coverage and provision of pre-release services. The Implementation Plan must be submitted to CMS on a timeline consistent with the STCs, and must describe the milestones and associated actions being addressed under this demonstration and provide operational details not captured in the STCs regarding implementation of those demonstration policies. At a minimum, the Implementation Plan will include definitions and parameters related to the implementation of the reentry authorities, and describe the state's strategic approach for making significant improvements on the milestones and actions, as well as associated timelines for meeting them, for both program policy implementation and investments in transitional nonservice elements, as applicable. The Implementation Plan will also outline any potential operational challenges that the state anticipates and the state's intended approach to resolving these and other challenges the state may encounter in implementing the reentry demonstration initiative. The section 5121 operational plan requirement in sections 1902(a)(84)(D) of the Act is satisfied by the state's Implementation Plan. The state is still required to provide coverage and otherwise meet state plan requirements with respect to any population or service specified in sections 1902(a)(84)(D) of the Act that is not covered under this demonstration.

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[26] Burns, et al. (2022). Duration of Medication Treatment for Opioid-Use Disorder and Risk of Overdose among Medicaid Enrollees in Eleven States: A Retrospective Cohort Study. Addiction. https://pmc.ncbi.nlm.nih.gov/articles/PMC10683938/

[27] Volkow, N. D., & Wargo, E. M. (2018). *Overdose prevention through medical treatment of opioid use disorders*. *Annals of Internal Medicine, 169*(3), 190–192. https://doi.org/10.7326/M18-1397

[28] Au, V. Y. O., Rosic, T., Sanger, N., Hillmer, A., Chawar, C., Worster, A., Marsh, D. C., Thabane, L., & Samaan, Z. (2021). Factors associated with opioid overdose during medication-assisted treatment: How can we identify individuals at risk? *Harm Reduction Journal, 18*, Article 71. https://doi.org/10.1186/s12954-021-00521-4

[29] Hayes et al. (2026). Evaluating the optimal duration of medication treatment for opioid use disorder. Study for the Society of Addiction. https://onlinelibrary.wiley.com/doi/10.1111/add.70211

[30] Friedmann, P.D., et al. (2025). Medications for Opioid Use Disorder in County Jails—Outcomes After Release. The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMsa2415987

[31] Martin, R.A., et al. (2022). Post-incarceration outcomes of a comprehensive statewide correctional MOUD program: a retrospective cohort study. Lancet Regional health. https://pmc.ncbi.nlm.nih.gov/articles/PMC9950664/

Maine is also required to submit a Reentry Demonstration Initiative Reinvestment Plan (here called Reinvestment Plan). The reentry demonstration initiative is not intended to shift current correctional facility health care costs to the Medicaid program. Section 5032(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) (P.L. 115-271) makes clear that the purpose of the demonstration opportunity contemplated under that statute is "to improve care transitions for certain individuals who are soon-to-be former inmates of a public institution and who are otherwise eligible to receive medical assistance under title XIX." Furthermore, demonstration projects under section 1115 of the Act must be likely to promote the objectives of titles XIX , which includes the inmate payment exclusion, in recognition that the correctional authority bears the costs for health care furnished to incarcerated individuals. This demonstration does not absolve correctional authorities in Maine of their Constitutional obligation to ensure needed health care is furnished to inmates in their custody and is not intended as a means to transfer the financial burden of that obligation from a tribal, state, or local correctional authority to the Medicaid programs.

To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, Maine agrees to reinvest all new federal dollars, equivalent to the amount of federal financial participation expended for such previously existing services, into allowable justice-related activities or initiatives that increase access to or improve the quality of health care services for individuals who are incarcerated (including individuals who are soon-to-be released) or were recently released from incarceration, or for physical and behavioral health needs that may help prevent or reduce the likelihood of criminal justice system involvement. Consistent with this requirement and the STCs, Maine will develop and submit a Reinvestment Plan to CMS that documents an estimated calculation of the amount of federal dollars the state will receive over the course of the demonstration period, a detailed description of the state's plans to reinvest the required funds into allowable activities, and an assessment of the impact of reinvested funds on privately-owned or -operated carceral facilities and associated safeguards to prevent increasing profit or operating margins for such facilities. In order to ensure state accountability for this requirement, the state must submit annual progress updates on their reinvestment as part of the state's annual monitoring report. The state will also be required to submit a Final Reinvestment Assessment detailing the total amount of FFP received over the demonstration period, the total amount reinvested, and the outcome of those activities.

Interaction between a State's Reentry Demonstration and the CAA, 2023 Mandate

Section 5121 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) amends section 1902(a)(84)(D) of the the Act to describe a mandatory population eligible juvenile in Medicaid who are incarcerated in a public institution post adjudication of charges[32] who are to receive a set of pre-release and post-release services. Section 5122 of the CAA, 2023 amends section 1902(a)(84)(A) of the Act to give states the option to receive FFP for the full range of

[32] Section 1902(nn) of the Act defines "eligible juvenile" as an individual under age 21 determined eligible in any eligibility group or an individual described in section 1902(a)(10)(A)(i)(IX) of the Act (the mandatory former foster care children group, which includes former foster care children between 18 and 26 years old).

coverable services for eligible individuals who are incarcerated in a public institution while pending disposition of charges.[33] The requirements of section 5121 of the CAA, 2023 have a statutory effective date of January 1, 2025. Every state is required to submit a Medicaid State Plan Amendment assuring compliance with these requirements.[34]

To the extent there is overlap between the services required to be covered under section 1902(a)(84)(D) of the Act and coverage under this demonstration, CMS understands that it would be administratively burdensome for a state to identify whether each individual service is furnished to a beneficiary under the state plan or demonstration authority. Accordingly, to eliminate unnecessary administrative burden and ease implementation of statutorily required coverage and in this demonstration, CMS is approving a waiver of the otherwise mandatory state plan coverage requirements to permit the state instead to claim for at least the same pre-release services for the same beneficiaries under this demonstration.[35] This approach will ease implementation, administration, and claiming, and provide a more coherent approach to monitoring and evaluation of the state's reentry coverage under the demonstration. The state will provide pre-release coverage under the reentry demonstration initiative to eligible juveniles described in section 1902(nn) of the Act in alignment with section 1902(a)(84)(D) of the Act, as applicable, at a level equal to or greater than otherwise would be covered under the state plan. Compliance and state plan submission requirements under section 5121 of the CAA, 2023 will remain unchanged. Any required services that are not provided through the demonstration during the pre-release period as well as any post-release services will continue to be covered under the state plan. Additionally, coverage of the population and benefits identified in section 1902(a)(84)(D) of the Act, as applicable, will automatically revert to state plan coverage in the event that this demonstration ends or eliminates coverage of beneficiaries and/or services specified in those provisions. To effectuate this approach, CMS is adding a new waiver of section 1902(a)(84)(D) of the Act.

Requests Not Being Approved at this Time

Maine's renewal request also included requests to authorize five additional programs: Contingency Management, Transitions of Care Incentive Payments, Food is Medicine, Recuperative Care and Structured Recovery Housing Services. CMS and the state are continuing to work on the details of these requests, and CMS is not approving them at this time. Maine also requested transitional non-service expenditures to support implementation of the demonstration. CMS is working with Maine on pathways to otherwise allowable administrative claiming such as Implementation Advance Planning Documents to support implementation costs associated with the reentry demonstration. As a result, we will not be approving the state's request for

[33] For CHIP, section 2110(b)(7) creates an optional exception to the CHIP eligibility exclusion for inmates of a public institution under section 2110(b)(2)(A) so incarcerated youth who are pending disposition of charges are not excluded from the definition of targeted low-income child.

[34] SHO# 24-004, RE: Provision of Medicaid and CHIP Services to Incarcerated Youth. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24004.pdf

[35] Section 5122 of the CAA, 2023 gives a state the option to cover the full breadth of otherwise-covered Medicaid and CHIP services for eligible juveniles who are incarcerated pending disposition of charges. We have not yet approved this claiming flexibility for Section 5122 services and we are not providing this claiming flexibility in this approval.

transitional non-service expenditures as proposed and will no longer consider this an active request.

Budget Neutrality

This demonstration project is approved using CMS's current approach to determining budget neutrality as described in CMS SMDL #24-003.[36] However, CMS acknowledges that section 71118 of subchapter C of chapter 1 of subtitle B of title VII of Public Law 119-21, which CMS refers to as the Working Families Tax Cut (WFTC) legislation, adds a new subsection (g) to section 1115 of the Act with budget neutrality requirements that will apply beginning January 1, 2027 to CMS approvals of section 1115 Medicaid demonstration project applications, renewals, or amendments.[37] CMS issued SMDL #26-003 [38] on June 11, 2026 to provide states with early notice regarding the changes to budget neutrality that CMS intends to propose to implement subsection 1115(g) of the Act, and expects to provide additional guidance to states on implementation of this provision.

Under SMDL#2-003, as a condition of demonstration approval, demonstrations must be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs likely would have been in that state absent the demonstration.[39] The demonstration renewal is projected to be budget neutral to the federal government. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration (the "without waiver" [WOW] costs). The state will be held to the budget neutrality monitoring and general financial requirements as outlined in the STCs.

Rebasing Without Waiver Baselines

Under this demonstration, for existing MEGs that were implemented, CMS calculated the WOW baseline by using a weighted average of the state's historical WOW per-member-per-month (PMPM) baseline and its recent actual PMPM costs. The projected demonstration expenditures associated with each MEG in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Hypothetical Budget Neutrality Treatment

Under its current approach to budget neutrality, CMS generally treats expenditures for populations or services which could have otherwise been covered via the Medicaid state plan, or

[36] https://www.medicaid.gov/federal-policy-guidance/downloads/smd24003.pdf
[37] https://www.congress.gov/bill/119th-congress/house-bill/1/text
[38] https://www.medicaid.gov/federal-policy-guidance/downloads/smd26003.pdf
[39] https://www.medicaid.gov/medicaid/section-1115-demonstrations/budget-neutrality/index.html

other title XIX authority, such as a section 1915 waiver, as "hypothetical" for the purposes of budget neutrality. In these cases, CMS adjusts budget neutrality to account for the spending which the state could have hypothetically provided through the Medicaid state plan or other title XIX authority. CMS does not, however, currently allow for budget neutrality savings accrual as a result of including hypothetical populations or services in section 1115 demonstration projects. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent budget neutrality "supplemental test" for hypothetical expenditures. These supplemental budget neutrality tests subject the hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, during negotiations. If the state's "with waiver" (WW) hypothetical spending exceeds the supplemental test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending with savings elsewhere in the demonstration or to refund the FFP to CMS.

The Reentry Expansion Adults, Reentry Non-Expansion Adults and Children, Serious Mental Illness Expansion Adults, and Serious Mental Illness Non-Expansion Adults and Children MEGs will be treated as hypothetical for budget neutrality purposes. For each of these MEGs, CMS calculated the WOW baseline (which refers to the projected expenditures that could have occurred absent the demonstration and which is the basis for the budget neutrality expenditure limit for each approval period). The projected demonstration expenditures associated with each of these MEGs in the WOW baseline have been trended forward using the President's Budget trend rate to determine the maximum expenditure authority for the new approval period. Using the President's Budget trend rate aligns the demonstration trend rate with federal budgeting principles and assumptions.

Reentry- Pre-Release Medicaid Services for Justice Involved

The Medicaid expenditures for pre-release services furnished to incarcerated beneficiaries under the reentry demonstration initiative include coverage of services that states can and do cover through Medicaid state plan or other title XIX authority, for beneficiaries who are not subject to the inmate payment exclusion. CMS considers these expenditures to be "hypothetical" because the pre-release services would be coverable under the Medicaid state plan or other title XIX authority if furnished to a beneficiary outside a carceral site, similar to how CMS treats expenditures for services furnished to certain beneficiaries who are short-term residents in an institution for mental diseases primarily to receive treatment for SUD, or SMI or serious emotional disturbance (SED), under the SUD and SMI/SED section 1115 demonstration opportunities. Any population identified in section 1902(a)(84)(D) of the Act and covered instead under this demonstration will be included in the reentry services Medicaid Expenditure Groups (MEG).

Traditional Health Care Practices

As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those

facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authority. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS All-Inclusive Rate that is published annually in the Federal Register.[40] CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral under existing budget neutrality requirements and will not require a specific budget neutrality expenditure limit. The state will be held to the general monitoring and reporting requirements, as per the STCs. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in a budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7.

Mid-Course Correction

CMS has included a mid-course corrections STC in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment.

Monitoring and Evaluation

Consistent with the demonstration STCs, the state submitted with the application its Interim Evaluation Report for the prior demonstration approval period. Based on findings from the state's Interim Evaluation Report, which covers the period of January 2021 through December 2023, as well as state-submitted monitoring data through June 2024, CMS determined that the state has made progress towards a majority of its demonstration goals, with some areas showing opportunity for improvements.

For the SUD component, interrupted time series (ITS) analysis was used to identify changes in trends following the demonstration's implementation. In terms of successes, there were statistically significant decreases in the rate of emergency department utilization for SUD, down from an average rate of 3.9 visits per 1,000 SUD beneficiaries in January 2021 to 1.8 in June 2024. There were also statistically significant decreases in the rates of non-emergent emergency department utilization, as well as preventable inpatient stays for SUD.

[40] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

Other areas show more mixed results; for example, while there was a statistically significant increase in the rate of utilization of any SUD service, the evaluation found a statistically significant decrease in rate of outpatient service use. However, more recent monitoring data suggests this trend is increasing again, with outpatient service utilization increasing from around 6,300 SUD beneficiaries utilizing outpatient services in January 2021 to almost 8,500 beneficiaries in June 2024. Despite a 3 percent overall decline in total SUD treatment providers, the demonstration achieved a 10 percent increase in medication assisted treatment (MAT) providers, an expansion which occurred during a challenging period marked by the COVID-19 public health emergency (PHE). Overdose deaths significantly decreased between 2021 and 2023, but peaked in 2022.

Based on the mixed progress made thus far on its goals, including the ongoing opportunities to see if utilization trends continue to rebound past the dampening effect of the COVID-19 PHE, the state is requesting, and CMS is granting additional time to continue the demonstration, as well as adding the Reentry, SMI, and traditional health care practices initiatives requested by the state. To ensure transparency towards continued progress on more of the demonstration goals and to address the identified areas for improvement, the state is required under this renewal to continue conducting systematic monitoring and robust evaluation of the demonstration. In collaboration with CMS, the state must undertake demonstration monitoring, including reporting of relevant metrics data and narrative details describing progress with implementation of all components of the demonstration. An Annual Monitoring Report capturing key metrics and narrative updates will be due to CMS 180 days after the end of each demonstration year. The state is also required to conduct an independent mid-point assessment of the SUD and SMI demonstration initiatives, as described in the STCs, to support identifying risks and vulnerabilities and subsequent mitigation strategies. In addition, the state must also conduct a Reentry Early Implementation Rapid Cycle Report to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state is required to conduct an evaluation of the demonstration which includes the full renewal approval period, in addition to any temporary extension period not covered in the state's Summative Evaluation Report. The evaluation supports a comprehensive assessment of whether the demonstration components are effective in producing the desired outcomes for its beneficiaries and providers, as well as the state's overall Medicaid program. The demonstration evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components, as described in the STCs. Evaluation of the reentry demonstration initiative must align with the requirements detailed in the STCs, including examining impacts on Medicaid and CHIP coverage, continuity of care, access to and quality and efficiency of care, utilization of services, health outcomes, and carceral and community coordination in service provision, among others.

The state plan requirements for eligible juveniles under section 1902(a)(84)(D) of the Act for Medicaid are included under this reentry demonstration initiative and must be included in applicable monitoring and evaluation activities.

Consideration of Public Comments

CMS posted the application on Medicaid.gov for a 30-day federal public comment period from July 10, 2025 through August 9, 2025. CMS received thirteen comments. One of the commenters expressed support for Maine's Whole Person Care Waiver and commended the state for endeavoring to put in place cost-effective programs in the state that not only positively impact the lives of vulnerable MaineCare enrollees but invest in critical services that will expand care options for all Maine residents. The commenter also strongly urged CMS to approve the waiver in full. Other commenters expressed support for specific aspects of the demonstration, for example the Reentry Pre-Release Medicaid Services for Justice-Involved Individuals, which received nine favorable comments. None of the commenters were in opposition of approving the state's request to extend the demonstration.

After carefully reviewing the demonstration proposal and public comments received during the federal comment period, CMS has concluded that renewing Maine's Whole Person Care Waiver is likely to promote the objectives of Medicaid.

Other Information

CMS's approval of this demonstration renewal is conditioned upon compliance with the enclosed set of waivers, expenditure authorities, and STCs defining the nature, character and extent of anticipated federal involvement in the demonstration. The award is subject to CMS receiving written acceptance of this award within 30 days of the date of this approval letter. Your project officer for this demonstration is Wanda Boone-Massey, who is available to answer any questions concerning your section 1115 demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Email: Wanda.Boone-Massey@cms.hhs.gov

If you have questions regarding this approval, please contact Sarah Aker, Acting Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at Sarah.Aker@cms.hhs.gov.

Dr. Mehmet Oz

Enclosure

Cc: Gilson DaSilva, State Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES WAIVER AUTHORITY

NUMBER: **11-W-00338/1 and 21-W-01070/1**

TITLE: **Maine's Whole Person Care Waiver**

AWARDEE: **Maine Office of MaineCare Services**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or specified as not applicable in the following, shall apply to the Maine's Whole Person Care Waiver section 1115 demonstration beginning October 1, 2026, unless otherwise stated. The waiver authorities will continue through September 30, 2031, unless otherwise stated.

1. **Coverage of Certain Screening, Diagnostic, and Targeted Case Management Services for Eligible Juveniles in the 30 Days Prior to Release** **Section 1902(a)(84)(D)**

To enable the state not to provide coverage of the screening, diagnostic, and targeted case management services identified in section 1902(a)(84)(D) of the Act for eligible juveniles described in section 1902(nn)(2) of the Act as a state plan benefit in the 30 days prior to the release of such eligible juveniles from a public institution, to the extent and for the period that the state instead provides such coverage to such eligible juveniles under the approved expenditure authorities under this demonstration. The state will provide coverage to eligible juveniles described in section 1902(nn)(2) in alignment with section 1902(a)(84)(D) of the Act at a level equal to or greater than would be required under the state plan.

CENTERS FOR MEDICARE & MEDICAID SERVICES EXPENDITURE AUTHORITY

NUMBER: **11-W-00338/1 and 21-W-01070/1**

TITLE: **Maine's Whole Person Care Waiver**

AWARDEE: **Office of MaineCare Services**

Under the authority of section 1115(a)(2) of the Social Security Act ("the Act"), expenditures made by Maine for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from October 1, 2026 through September 30, 2031 unless otherwise specified, be regarded as expenditures under the state's title XIX plan.

As discussed in the Centers for Medicare & Medicaid Services' (CMS) approval letter, the Secretary of Health and Human Services has determined that Maine's Whole Person Care Waiver demonstration, including the granting of the expenditure authority described below, is likely to assist in promoting the objectives of title XIX of the Act.

The following expenditure authority may only be implemented consistent with the approved Special Terms and Conditions (STC) and shall enable Maine to operate the above-identified section 1115(a) demonstration.

1. **Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment and/ or withdrawal management services for substance use disorder (SUD) as short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

2. **Parents with Extended MaineCare (Pilot 1(a)).** Expenditures to permit the state to provide medical assistance to MaineCare-enrolled parents of a minor child in cases in which the parent would otherwise lose Medicaid eligibility due to the change in household size when their child is removed from the home by Child Protective Services pursuant to state law. Medicaid coverage for the parent would continue until the parent is no longer participating in rehabilitation, no longer participating in the family reunification plan, or until parental rights have been terminated, whichever event happens first.

3. **Parenting Support Services (Pilot 1(b))**. Expenditures for the Parenting Support Services as described in STC 5.6.

4. **Home Based Community Support Services (Pilot 1(c))**. Expenditures for the Home-Based Skill Development pilot services as described in the STC 5.7

5. **Residential and Inpatient Treatment for Individuals with Serious Mental Illness (SMI).** Expenditures for Medicaid state plan services furnished to otherwise eligible individuals who are primarily receiving treatment services for serious mental illness (SMI) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD). This authority will be effective July 1, 2027.

6. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service (IHS) facilities or facilities operated by Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

7. **Expenditures for Pre-Release Services.** Expenditures for pre-release services, as described in these STCs, provided to qualifying Medicaid individuals for up to 90 days immediately prior to the expected date of release in youth correctional facilities participating in the reentry demonstration initiative. Expenditures for pre-release services, as described in these STCs, for up to 60 days immediately prior to the expected date of release in jails prisons, and adult correctional facilities participating in the reentry demonstration initiative.

Title XIX requirements not applicable to these demonstration expenditures.
All requirements of the Medicaid program expressed in law, regulation, and policy statement not expressly identified as not applicable to these expenditure authorities shall apply to the demonstration for the remaining period of this demonstration.

8. **Statewideness** **Section 1902(a)(1)**

To the extent necessary to permit any limited service benefit described in the demonstration for Parenting Support Services Pilot 1(b) and Home-Based Skill Development Services Pilot 1(c).

To enable the state to provide pre-release services, as authorized under this demonstration, to qualifying individuals on a geographically limited basis, in accordance with the Reentry Demonstration Initiative Implementation Plan.

To the extent necessary to enable the state to implement the Traditional Health Care Practices on a geographically limited basis.

9. **Comparability** **Section 1902(a)(10)(B)**

To the extent necessary to limit certain benefits as set forth in the demonstration for Parenting Support Services Pilot 1(b) and Home-Based Skill Development Services Pilot 1(c).

10. **Comparability; Freedom of Choice**

Section 1902(a)(10)(B)

Section 1902(a)(23)

To the extent necessary to allow the state to offer the coverage described in Expenditure Authority 6 only if the covered traditional health care practices are received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, by Medicaid beneficiaries who are able to receive services delivered by or through these facilities.

11. **Amount, Duration, and Scope of Services and Comparability** **Section 1902(a)(10)(B)**

To enable the state to provide only a limited set of pre-release services, as specified in these STCs, to qualifying individuals that is different than the services available to all other individuals outside of correctional facility settings in the same eligibility groups authorized under the state plan or demonstration authority.

12. **Freedom of Choice** **Section 1902(a)(23)(A)**

To the extent necessary to limit certain benefits as set forth in the demonstration for Parenting Support Services Pilot 1(b) and Home Based Sills Development Pilot 1(c).

To enable the state to require qualifying individuals to receive pre-release services, as authorized under this demonstration, through only certain providers.

CENTERS FOR MEDICARE & MEDICAID SERVICES EXPENDITURE AUTHORITY

NUMBER: **11-W-00338/1 and 21-W-01070/1**

TITLE: **Maine's Whole Person Care Waiver**

AWARDEE: **Office of MaineCare Services**

Title XXI Expenditure Authority

All requirements of the CHIP program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in accompanying expenditure authority and/or these STCs, shall apply to the demonstration project through September 30, 2031.

1. **Traditional Health Care Practices.** Expenditures for traditional health care practices received through Indian Health Service (IHS) facilities or facilities operated by Tribes or Tribal organizations under the Indian Self Determination and Education Assistance Act by CHIP beneficiaries who are able to receive services delivered by or through these facilities.

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00338/1 and 21-W-01070/1**

TITLE: **Maine's Whole Person Care Waiver**

AWARDEE: **Maine Office of MaineCare Services (OMS)**

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "Maine's Whole Person Care Waiver" section 1115(a) Medicaid demonstration (hereinafter "demonstration"), to enable the Maine Department of Health and Human Services (hereinafter "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those populations affected by the demonstration are effective from October 1, 2026 through September 30, 2031 unless otherwise specified.

The STCs have been arranged into the following subject areas:

15	Monitoring Allotment Neutrality
16	Schedule of Deliverables for the Demonstration Period

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	SUD Implementation Plan and Health IT Plan
Attachment B	Reserved for Evaluation Design
Attachment C	Reserved for the Pilots Implementation Protocol
Attachment D	Reserved for SMI Implementation Plan
Attachment E	Reserved for Reentry Demonstration Initiative Implementation Plan
Attachment F	Reserved for Reentry Demonstration Initiative Reinvestment Plan
Attachment G	Reserved for Reentry Final Reinvestment Assessment
Attachment H	Reentry Demonstration Initiative Services

2. PROGRAM DESCRIPTION AND OBJECTIVES

This demonstration provides the state with authority to provide high-quality, clinically appropriate treatment for beneficiaries with a substance use disorder (SUD) while they are short-term residents in residential and inpatient treatment settings that qualify as Institutions for Mental Diseases (IMDs). The demonstration also authorizes three pilots for MaineCare-enrolled parents, with a SUD who are involved with or at- risk of involvement with Child Protective Services (CPS): (1) eligibility extension to continue coverage of parents during the rehabilitation and reunification process; (2) parenting support programs; and (3) home-based skill development services. The pilots were designed to build on the state's existing efforts to improve models of care focused on supporting individuals in the community and home and strengthening a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

On June 30, 2025, the state submitted a request for a five year renewal of the demonstration requesting the continuation of existing authorities, to change the demonstration name to Maine's Whole Person Care Waiver and to add additional authorities. On December 19, 2025, a temporary extension was issued through December 31, 2026.

Lastly, on September 23, 2026, CMS approved a five year renewal of the demonstration. Through the renewal, CMS changed the name of the demonstration from Maine Substance Use Disorder Care Initiative to Maine's Whole Person Care Waiver, continued the existing authorities and added three additional authorities: (1) SMI/IMD Services which will provide the state with authority to provide high-quality, clinically appropriate treatment to beneficiaries with SMI while they are short-term residents in residential and inpatient treatment settings that qualify as an IMD; (2) Traditional Health Care Practices which authorizes traditional health care services received through Indian Health Services (IHS) or Tribal facilities when provided to a Medicaid beneficiary who is able to receive services delivered by or through these qualifying providers and; (3) pre-release Medicaid services for justice-involved eligible individuals for up to 60 days immediately prior to the expected date of release from a correctional facility that is participating in the reentry demonstration initiative.

During the demonstration period, the state seeks to achieve the following overarching goals:

1	Maximize access to quality behavioral health services and improve coverage of a broader continuum of treatment for individuals with SMI/SUD.
2	Promote successful transitions to the community and improved health outcomes for other targeted populations, such as justice-involved individuals or those who would benefit from traditional health care practices.
3	Develop and maintain adequate capacity in partnership with community providers to support the previously identified goals and related initiatives.

Additionally, the state has the following policy-specific goals:

SUD Goals:

1	Increase rates of identification, initiation, and engagement in treatment for SUD.
2	Increase adherence to and retention in treatment.
3	Reduce overdose deaths, particularly those due to opioids.
4	Reduce utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
5	Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6	Improve access to care for physical health conditions among beneficiaries with SUD.

SMI/SED Goals:

1	Reduce utilization and lengths of stay in EDs among beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings.
2	Reduce preventable readmissions to acute care hospitals and residential settings.
3	Improve availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
4	Improve access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care.
5	Improve care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Reentry Goals:

1	Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release.
2	Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry.
3	Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers.
4	Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release.
5	Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs and social determinants of health.
6	Reduce all-cause deaths in the near-term post-release.

7	Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care.
8	Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

Traditional Health Care Practices Goals:

1	Increase access to traditional health care practices for Medicaid and/or CHIP beneficiaries.
2	Increase beneficiary awareness and understanding of traditional health care practices as covered Medicaid and/or CHIP services.
3	Improve behavioral health outcomes, including mental health and substance use disorder outcomes and treatment retention, among Medicaid and/or CHIP beneficiaries receiving traditional health care practices.
4	Improve physical health outcomes, including physical health functioning and chronic disease symptom management for conditions such as diabetes and cardiovascular disease, among Medicaid and/or CHIP beneficiaries receiving traditional health care practices.
5	Improve quality and experience of care among Medicaid and/or CHIP beneficiaries receiving traditional health care practices.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in federal law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in federal law, regulation, or written policy, come into compliance with any changes in law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change, as well as a modified allotment neutrality worksheet as necessary to comply with such change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7) as a result of the change in FFP.

b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments.** The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plans govern.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available under changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

b. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation;

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary;

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and monitoring reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in

accordance with the requirements of 42 CFR 431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30- day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30- day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered the comments received when developing the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42CFR435.916(d)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable advance notice requirements and fair hearing rights described at 42 CFR, 431Subpart E. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230.

e. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 3.7 or extension, are proposed by the state.

3.13. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(d)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. Eligibility Groups Affected by the Demonstration. Under the demonstration, there is no change to Medicaid eligibility and the standards and methodologies for eligibility remain set forth under the state plan. All affected groups derive their eligibility through the Medicaid state plan, except Pilot 1(a), and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

a. **Pilot 1(a)** Extended MaineCare Coverage Description of Eligibility. Beneficiaries eligible for this pilot are MaineCare eligible parents who would otherwise lose eligibility due to the change in household size when their child is removed from the home pursuant to state law.

Eligibility will continue until the parent is either:

i. No longer participating in the rehabilitation and reunification plan as required by the plan; or

ii. Until parental rights have been terminated, whichever event happens first.

The parent's eligibility will be periodically renewed consistent with 42 CFR 435.916. If the parent is no longer eligible for reasons other than the change in household composition (e.g., an income increase that would lead to loss of Medicaid eligibility if the household had remained intact, Medicaid coverage would end), the state will redetermine eligibility on other bases prior to termination consistent with 42 CFR 435.916(f), and if ineligible on all bases, will send advance notice and terminate coverage consistent with 42 CFR 431.206 through 431.214, 42 CFR 435.917.

b. **Pilot 1(b) and Pilot 1(c) Description of Eligibility**. Beneficiaries eligible for these pilots are MaineCare-enrolled parents, with a SUD who are involved with or at- risk of involvement

with Child Protective Services (CPS) and services have been recommended by a physician or other licensed practitioner of the healing arts.

5. SUBSTANCE USE DISORDER PROGRAM AND BENEFITS

5.1. **SUD Program Benefits.** The demonstration benefit package for Medicaid beneficiaries will include SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state is eligible to receive FFP for Medicaid beneficiaries who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD services, that would otherwise be matchable if the beneficiary were not residing in an IMD. The state will aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to STC 11.5, to ensure short-term residential stays.

Under this demonstration beneficiaries will have access to high quality, evidence-based SUD treatment services across a comprehensive continuum of care, ranging from residential and inpatient treatment to ongoing care for these conditions in cost-effective community-based settings.

5.2. SUD Implementation Plan The state's SUD Implementation Plan, initially approved for the period from July 26, 2021 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031 and is affixed to the STCs as Attachment A. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 11.2. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD project:

a. Access to Critical Levels of Care for OUD and other SUDs. Coverage of SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management;

b. Use of Evidence-based SUD-specific Patient Placement Criteria.

i. Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines;

ii. Utilization Management. Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that

the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

c. Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities.

   i. Implementation of residential treatment provider qualifications. Currently, residential treatment service providers are established by the MaineCare Benefits Manual (e.g., Regulations/provider manual/policy guidance/etc.). The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings;

   ii. Standards of Care. Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings;

   iii. Availability of MAT. Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site;

d. Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD. An assessment of the availability of providers in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT;

e. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and SUD/OUD.

   i. Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse;

   ii. Expand coverage of and access to naloxone for overdose reversal;

   iii. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

f. Improved Care Coordination and Transitions between Levels of Care. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities;

g. SUD Health IT Plan. Implementation of a Substance Use Disorder Health Information Technology Plan which describes technology that will support the aims of the demonstration. Further information which describes milestones and metrics are detailed in STC 5.3 and Attachment A.

5.3. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable Health IT Plan(s), to be included as a section(s) of the associated Implementation Plan(s) (see STC 5.2 [g], to develop infrastructure and capabilities consistent with the requirements outlined in each demonstration-type.

The Health IT Plan describes how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs; establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR 433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, standards adopted by the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) in accordance with 45 CFR part 170, subpart B.

The state's Health IT Plan, initially approved for the period from July 26, 2021 through September 30, 2026, remains in effect for the approval period from October 1, 2026 through September 30, 2031 and is affixed to the STCs as Attachment A.

a. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Report (see STC 11.5).

b. As applicable, the state should advance HHS adopted standards in 45 CFR 170 Subpart B in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.[1]

c. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards.

d. Where there are opportunities at the state- and provider-level to leverage federal funds a to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170 Subpart B, the state should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).[2]

e. Specific components of the Health IT Plan are listed below:

[1] Where the plan involves health IT that is acquired, upgraded, or implemented by health care providers that have been eligible for CMS incentives to adopt health IT certified under the ONC Health IT Certification Program, states should advance the use of certified health IT, as applicable. Certified health IT incorporates the standards in 45 CFR 170 Subpart B.

[2] https://www.healthit.gov/isp/

i. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP)[3].

ii. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[4] States should favor procurement strategies that incorporate Qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in open interfaces and exposed application program interfaces.

iii. The Health IT Plan will describe how technology will support substance use disorder prevention and treatment outcomes described by the demonstration.

5.4. **Unallowable Expenditures Under the SUD Expenditure Authority.** The state may not receive FFP for room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

5.5. **Pilot 1(a) - Maintaining Medicaid Coverage.** Under this pilot health care related costs for parents who would otherwise lose eligibility due to the change in household size when their child is removed from the home pursuant to state law. Full Medicaid benefits will continue as the beneficiary was previously receiving.

5.6. **Pilot 1(b) - Parenting Support Services.** Under this pilot, the Parenting Support Services will include two programs:

a. **Program 1 - Attachment Biobehavioral Catch-up**:

Attachment Biobehavioral Catch-up (ABC) is an evidence-based intervention designed for caregivers of infants and toddlers who have experienced early adversity. The program, is segmented into infant (6-24 months of age) and toddler (24-48 months of age). Recommendations for ABC are made by a physician or licensed practitioner of the healing arts.

i. **Component Services of ABC include:**

1. Family psychotherapy: Skill-based intervention to help caregivers interpret their child's behavioral signs and respond sensitively, address children's behavior, and help develop secure attachments between children and their caregiver.

2. Psychosocial education: Increasing a parent's understanding of their child's behavioral cues, understanding mental health and how it impacts attachment, understanding intrusive and frightening behaviors, and considering how history affects parenting and attachment.

[3] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.
[4] *Ibid.*

3. Therapeutic intervention: Involves the ABC Parent Coach providing in-the-moment prompts and feedback address target behaviors intended to foster caregiver nurturance, positive engagement, and attachment with parent and child.

ii. **Provider Qualifications for ABC:**

1. Parent coaches meet the following qualifications:

- Be a bachelors level mental health professional; or
- Be a certified Behavioral Health Professional (BHP)
- Pass a screening by the ABC Developers, who are Doctorate level professionals independently licensed as child psychologists;
- Receive a year of supervision from the ABC Developers; and
- Complete the requisite training as prescribed by the model, which includes the following topics:
  - Background and evidence base of ABC
  - Overview of primary targets of ABC
  - Overview of model and session outline/goals
  - Coding "In the moment" comments
  - Review of technology
  - Practice sessions
  - Advanced Comments and Sensitivity Assessment

2. Parent Coach Supervisors meet the following qualifications:

- Complete one year of supervision by ABC developers; and at a minimum have be either a Licensed Clinical Social Workers (LCSW) or Licensed Master of Social Work-clinical conditional (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), or Licensed Clinical Professional Counselor-conditional (LCPC-C).

b. **Program 2 - Visit Coaching:**

Visit Coaching is a program designed for child-welfare involved families whose children of any age are placed in foster care and are working toward reunification. Recommendations for visiting coaches are made by licensed social workers. Visit coaching is a strengths-based therapeutic intervention between the coach and the family in the reunification process. This program will augment existing state activities and funding available to support family reunification as specified in the state's Title IV-E plan.

i. **Component Services of Visit Coaching include:**

1. Counseling to prepare for visits, giving feedback on visits, and improve communication with the foster parent.
2. Treatment Planning: A needs list is created by the parent and the coach based on the child's specific needs.
3. Psycho-education: Coaches model and assist the parents on how to engage with their children through play and other developmentally age appropriate activities. Parents are provided psychoeducation surrounding their child(ren)'s unique needs and development. Coaches focus on helping parents to learn the importance of play, both how to play with and engage appropriately with their child(ren).
4. Family Counseling: Visit Coaches (VCW) work with the parents and child(ren) while in the home, engaging with the entire family throughout the visit.

ii. **Provider Qualifications for Visit Coaches:**

1. Visit Coaches meet the following qualifications:

- Have a bachelor's degree as well as experience in human services;
- Have previous documented experience working with children and families;
- Complete requisite training, including mandated reporter training, and training in the de-escalation techniques
- First Aid and CPR certification
- Receive Family Time Coaching training

2. Visit Coaches Supervisors (VCSs) meet the following qualifications:

- Meet the qualifications of the VCWs; and
- At a minimum, have either a Licensed Master Social Worker (LMSW) Licensed Clinical Social Worker (LCSW) or Licensed Master of Social Worker- clinical conditional (LMSW-CC) credentials; Licensed Clinical Professional Counselor (LCPC); or Licensed Clinical Professional Counselor-conditional (LCPC-C).

5.7. Pilot 1 (c) Home-Based Skill Development Services. Under this demonstration the state will provide services to eligible individuals with a SUD which will include therapeutic support to restore the adult member's skills and abilities. Services include a focus on rehabilitative training to maintain a life in the community.

a. **Daily Living Skills Development Services include**:

i. Psychosocial Rehabilitation to restore and maintain functioning;

ii. Social skills training in appropriate community services; and

iii. Development of positive personal support networks.

b. **Provider Qualifications include:**

All components of the services listed above are delivered by a Certified Alcohol and Drug Counselor or an individual certified through the State of Maine as a Mental Health Rehabilitation Technician/Community (MHRT/C).

i. A MHRT/C certification from Maine DHHS requires meeting the eight knowledge competencies:

1. Behavioral, Psychological, and Rehabilitation Intervention Models;
2. Community Integration and Inclusion;
3. Ethics and Professional Conduct;
4. Trauma and Resiliency;
5. Policy Knowledge;
6. Mind-Body Connection;
7. Cultural Competency; and
8. Vocational Support

ii. Certified Alcohol and Drug Counselor Certification from Maine Professional and Financial Regulation through completion of the following:

1. Associates Degree from an Accredited Institution in clinically-based behavioral sciences or addiction counseling, or in a related field; or
2. A minimum of 30 credit hours in psychology or behavioral sciences related field; or
3. MHRT/C certification as described above; and
4. Pass a written examination.

iii. Supervision is provided by a licensed clinician practicing within their scope of licensure in the State of Maine. For this service, Maine recognizes the following credentials as able to provide supervision:

1. Licensed Clinical Professional Counselor (LCPC);
2. Licensed Clinical Professional Counselor-conditional (LCPC-conditional);
3. Licensed Clinical Social Worker (LCSW);
4. Licensed Master Social Worker-conditional (LMSW-conditional clinical);
5. Physician;
6. Psychiatrist;
7. Psychiatric and Mental Health Nurse Practitioner (PMH-NP);
8. Psychiatric and Mental Health Clinical Nurse Specialists (PMH-CNS);

9. Adult Nurse Practitioner (ANP);
10. Family Nurse Practitioner (FNP);
11. Physician Assistant (PA); or
12. Licensed psychologist.

5.8. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT).** All beneficiaries under 21 years of age will continue to be eligible for medically necessary services in accordance with federal EPSDT requirements.

6. SERIOUS MENTAL ILLNESS PROGRAM AND BENEFITS

6.1. **SMI Program Benefits.** Under this demonstration, beneficiaries will have access to the full range of otherwise covered Medicaid services, including SMI treatment services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. These SMI services will range in intensity from short-term acute care in inpatient settings for SMI, to ongoing chronic care for such conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must achieve a statewide average length of stay of no more than 30 days for beneficiaries receiving treatment in an IMD treatment setting through this demonstration's SMI Program, to be monitored pursuant to STC 11.5.

6.2. SMI/SED Implementation Plan.

a. The state must submit the SMI/SED Implementation Plan within 90 calendar days after effective date of the demonstration component for CMS review and comment. If applicable, the state must submit a revised SMI Implementation Plan within 60 calendar days after receipt of CMS's comments. The state may not claim FFP for services provided to beneficiaries residing in IMDs primarily to receive treatment for SMI/SED under expenditure authority until CMS has approved the SMI/SED Implementation Plan and the SMI/SED financing plan described in STC 6.2(d). After approval of the required Implementation Plan and Financing Plan, FFP will be available prospectively, but not retrospectively.

b. Once approved, the SMI/SED Implementation Plan will be incorporated into the STCs as Attachment D, and once incorporated, may be altered only with CMS approval. Failure to submit an SMI/SED Implementation Plan, within 90 calendar days after the effective date of the demonstration, will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral as described in STC 11.2.

c. At a minimum, the SMI/SED Implementation Plan must describe the strategic approach, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives for the program:

i. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings.

1. Hospitals that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed or approved as meeting standards for licensing established by the agency of the state or locality responsible for licensing hospitals prior to the state claiming FFP for services provided to beneficiaries residing in a hospital that meets the definition of an IMD. In addition, hospitals must be in compliance with the conditions of participation set forth in 42 CFR Part 482 and either: a) be certified by the state agency as being in compliance with those conditions through a state agency survey, or b) have deemed status to participate in Medicare as a hospital through accreditation by a national accrediting organization whose psychiatric hospital accreditation program or acute hospital accreditation program has been approved by CMS.
2. Residential treatment providers that meet the definition of an IMD in which beneficiaries receiving demonstration services under the SMI/SED program are residing must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.
3. Establishment of an oversight and auditing process that includes unannounced visits for ensuring participating hospitals and residential treatment settings in which beneficiaries receiving coverage pursuant to the demonstration are residing meet applicable state licensure or certification requirements as well as a national accrediting entity's accreditation requirements;
4. Use of a utilization review entity (for example, a managed care organization or administrative service organization) to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically necessary and only those who have a clinical need to receive treatment in psychiatric hospitals and residential treatment settings are receiving treatment in those facilities;
5. Establishment of a process for ensuring that participating psychiatric hospitals and residential treatment settings meet applicable federal program integrity requirements, and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidation of existing providers (specifically, under existing regulations, the state must screen all newly enrolling providers and reevaluate existing providers pursuant to the rules in 42 CFR Part 455 Subparts B and E, ensure providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and establish rigorous program integrity protocols to safeguard against fraudulent billing and other compliance issues);
6. Implementation of a state requirement that participating psychiatric hospitals and residential treatment settings screen beneficiaries for co-morbid physical health conditions and SUDs and demonstrate the capacity to address co-

morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

ii. Improving Care Coordination and Transitions to Community-Based Care.

1. Implementation of a process to ensure that psychiatric hospitals and residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of these settings into appropriate community-based outpatient services, including requirements that facilitate participation of community-based providers in transition efforts (e.g., by allowing beneficiaries to receive initial services from a community-based provider while the beneficiary is still residing in these settings and/or by engaging peer support specialists to help beneficiaries make connections with available community-based providers and, where applicable, make plans for employment);
2. Implementation of a process to assess the housing situation of a beneficiary transitioning to the community from psychiatric hospitals and residential treatment settings and to connect beneficiaries who have been experiencing or are likely to experience homelessness or who would be returning to unsuitable or unstable housing with community providers that coordinate housing services, where available;
3. Implementation of a requirement that psychiatric hospitals and residential treatment settings that are discharging beneficiaries who have received coverage pursuant to this demonstration have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary and the community-based provider to which the beneficiary was referred within 72 hours of discharge to help ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and, as appropriate, by contacting the community-based provider the person was referred to;
4. Implementation of strategies to prevent or decrease the length of stay in emergency departments (ED) among beneficiaries with SMI or SED (e.g., through the use of peer support specialists and psychiatric consultants in EDs to help with discharge and referral to treatment providers);
5. Implementation of strategies to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing care coordination so that disparate providers may better share clinical information to improve health outcomes for beneficiaries with SMI or SED.

iii. Increasing Access to Continuum of Care Including Crisis Stabilization Services.

1. Establishment of a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and updates on steps taken to increase availability (the state must provide a yearly

update on the availability of mental health services via the Annual Monitoring Report);

2. Commitment to implementation of the SMI/SED financing plan described in STC 6.4. The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI/SED program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI/SED program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 11.5.
3. Implementation of strategies to improve the state's capacity to track the availability of inpatient and crisis stabilization beds to help connect individuals in need with that level of care as soon as possible;
4. Implementation of a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association [e.g., Level of Care Utilization System (LOCUS) or the Child and Adolescent Service Intensity Instrument (CASII)] to help determine appropriate level of care and length of stay.

iv. Earlier Identification and Engagement in Treatment and Increased Integration.

1. Implementation of strategies for identifying and engaging individuals, particularly adolescents and young adults, with SMI/SED in treatment sooner, including through supported employment and supported education programs;
2. Increasing integration of behavioral health care in non-specialty care settings, including schools and primary care practices, to improve identification of SMI/SED conditions sooner and improve awareness of and linkages to specialty treatment providers;
3. Establishment of specialized settings and services, including crisis stabilization services, focused on the needs of young people experiencing SMI or SED.

d. The Implementation Plan must also include sections containing the SMI/SED Health IT Plan and the SMI Financing Plan. Further information which describes the requirements are detailed in STC 6.3, STC 6.4 and Attachment D.

6.3. **SMI/SED Health Information Technology (Health IT) Plan.** The state will provide CMS with an assurance that it has a sufficient health IT infrastructure "ecosystem" at every appropriate level (i.e., state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration.

The Health IT Plan will detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SMI/SED goals of the demonstration. The plan(s) will also be used to identify areas of health IT ecosystem improvement. The Plan must

include implementation milestones and projected dates for achieving them (see Attachment D) and must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) IT Health Plan.

a. The state will monitor progress, each DY, on the implementation of its SMI/SED Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS within its Annual Monitoring Report (see STC 11.5).

b. As applicable, the state should advance the HHS-adopted standards in 42 CFR 170 Subpart B in developing and implementing the state's SMI/SED Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

c. Where there are opportunities at the state- and provider-level (up to and including usage in managed care organization (MCO) or Accountable Care Organization (ACO) participation agreements) to leverage federal funds to acquire, upgrade, or implement health IT that can be supported by standards referenced in 45 CFR 170 Subpart B the state should use the federally recognized standards.

d. Where there are opportunities at the state- and provider-level to leverage federal funds to acquire, upgrade, or implement health IT that cannot be supported using a standard in 45 CFR 170, Subpart B the state should seek to use other non-proprietary standards and implementation specifications developed by consensus-based standards development organizations. This may include standards identified in the ASTP/ONC Interoperability Standards Advisory (ISA).

e. Specific components of the Health IT Plan are listed below:

    i. The Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SMI/SED care delivery. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

    ii. The Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: (1) Referrals, (2) Electronic care plans and medical records, (3) Consent, (4) Interoperability, (5) Telehealth, (6) Alerting/analytics, and (7) Identity management.

    iii. In developing the Health IT Plan, states should use the following resources:

        1. States may use federal resources available on Health IT.gov including behavioral health IT (https://www.healthit.gov/topic/behavioral-health), "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it), and the HHS Health IT Alignment Program (https://www.healthit.gov/topic/hhs-health-it-alignment-program).

2. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.
3. States should review the ASTP/ONC's Interoperability Standards Advisory (https://www.healthit.gov/isa/) for information on additional non-proprietary standards and implementation specifications developed by consensus-based standards development organizations not included in 45 CFR part 170, Subpart B that can support health IT investments.

6.4. **SMI/SED Financing Plan.** As part of the SMI/SED implementation plan referred to in STC 6.2(d), the state must submit, within 90 calendar days after approval of the demonstration, a financing plan for approval by CMS. Once approved, the Financing Plan will be incorporated into the STCs as part of the implementation plan in Attachment D and, once incorporated, may only be altered with CMS approval. Failure to submit an SMI/SED Financing Plan within 90 days of approval of the demonstration will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the SMI/SED program under this demonstration. Components of the financing plan must include:

a. A plan to increase the availability of non-hospital, non-residential crisis stabilization services, including but not limited to the following: services made available through crisis call centers, mobile crisis units, coordinated community response services that includes law enforcement and other first responders, and observation/assessment centers; and

b. A plan to increase availability of ongoing community-based services such as intensive outpatient services, assertive community treatment, and services delivered in integrated care settings.

6.5. **Maintenance of Effort (MOE).** The state must maintain a level of state and local funding for outpatient community-based mental health services for Medicaid beneficiaries for the duration of the SMI program under the demonstration that is no less than the amount of funding provided at the beginning of the SMI program under the demonstration. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 11.5.

6.6. **Average Length of Stay Requirements and FFP.** Federal Financial Participation is only available for services provided to beneficiaries who are residing in an IMD when the beneficiary is a short-term resident in the IMD primarily to receive treatment for mental illness. The state may claim FFP for services furnished to beneficiaries during IMD stays of up to 60 days, as long as the state shows at its Mid-Point Assessment that it is meeting the requirement of a 30-day average length of stay (ALOS) for beneficiaries residing in an IMD who are receiving covered services under the demonstration. Demonstration services furnished to beneficiaries whose stays in IMDs exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the Mid-Point Assessment, the state may only claim FFP for services furnished to beneficiaries during IMD stays of up to 45 days until such

time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will ensure that medically necessary services are provided to beneficiaries that have stays in excess of 60 days or 45 days, as relevant.

6.7. **Unallowable Expenditures Under the SMI Expenditure Authority.** In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following:

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

b. Costs for services furnished to beneficiaries who are residents in a nursing facility as defined in section 1919 of the Act that qualifies as an IMD.

c. Costs for services furnished to beneficiaries who are involuntarily residing in a psychiatric hospital or residential treatment facility by operation of criminal law.

d. Costs for services provided to beneficiaries under age 21 residing in an IMD unless the IMD meets the requirements for the "inpatient psychiatric services for individuals under age 21" benefit under 42 CFR 440.160, 441 Subpart D, and 483 Subpart G.

7. TRADITIONAL HEALTH CARE PRACTICES

7.1. **Traditional Health Care Practices Program Overview.** This component of the demonstration will provide federal financial participation (FFP) for state expenditures on traditional health care practices received through Indian Health Service (IHS) facilities, and facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA) (here called Tribal facilities) by Medicaid beneficiaries who are able to receive services by or through those facilities. Because some of the traditional health care practices covered under this demonstration may be considered religious or may contain elements of religious or spiritual practices, the state must attest, as a condition of receiving federal matching funds for its expenditures under Expenditure Authority 6 to: 1) providing adequate access to secular alternatives, including but not limited to preventive services, primary care, pharmacy services, mental health and substance use disorder services, as approved in its state plan, 1115 demonstration(s), or 1915 waiver(s), and in compliance with federal laws and regulations; 2) for any condition(s) addressed by and through covered traditional health care practices, ensuring beneficiaries have a genuine, independent choice to use other Medicaid and CHIP-covered services; and 3) assuring that traditional health care practices may not be used to reduce, discourage, or jeopardize a beneficiary's access to services or settings covered under the state plan, 1115 demonstration(s), or 1915 waiver(s) and that the state will not deny access to services or settings on the basis that the beneficiary has been offered, is currently receiving, or has previously utilized traditional health care practices. Provided that all other applicable requirements for claiming FFP have been met, the state may begin claiming FFP for its expenditures on traditional health care practices only after submitting this attestation to CMS. The state must notify beneficiaries of their rights to file grievances, complaints, and appeals related to this attestation and take any needed actions or monitoring, consistent with federal laws and regulations regarding grievances, complaints, and appeals. As per 11.5(b), the state must

report any such grievances, complaints, and appeals to CMS in Monitoring Reports. CMS will review all reports and will follow up on credible concerns in those reports, as well as any credible concerns raised by members of the public. If the state is found to be out of compliance with the attestation and related STCs, CMS may: 1) require the state to submit a corrective action plan, 2) issue a deferral, or 3) withdraw authority for traditional health care practices.

7.2. **Criteria for Receiving Coverage for Traditional Health Care Practices.** To receive coverage for traditional health care practices under this component of the demonstration, a beneficiary must meet the following criteria:

a. Is a Medicaid or CHIP beneficiary, and

b. Is able to receive services delivered by or through IHS or Tribal facilities as determined by the facility.[5]

7.3. **Scope of Traditional Health Care Practices.** The state may claim FFP for its expenditures on any traditional health care practice that is delivered by or through an IHS or Tribal facility to a beneficiary meeting the criteria in STC# 7.2.

a. The state will be required to report traditional health care practices provided and utilization in the Annual Monitoring Report.

b. Consistent with CMS's longstanding interpretation of section 1905(b) of the Act, the state will receive a 100 percent federal medical assistance percentage (FMAP) for its expenditures on the services for which coverage is authorized under Expenditure Authority 6 when those services are received through IHS and Tribal facilities by Medicaid beneficiaries who are American Indians or Alaska Natives.[6] State expenditures on these services when provided by or through qualifying facilities to CHIP beneficiaries or Medicaid beneficiaries who are not American Indians or Alaska Natives will be federally matched at the otherwise applicable state service match.

c. Excluded items, services, and activities that are not covered as part of the scope of traditional health care practices include, but are not limited to:

i. Construction costs (including building modification and building rehabilitation);

ii. Room and board;

iii. Costs for services in prisons or correctional facilities, or services for people who are civilly committed and unable to leave an institutional setting, except as described in Expenditure Authority 7;

[5] Under IHS authorities, IHS and Tribal facilities serve Medicaid and CHIP beneficiaries who are eligible to receive services from the facility under IHS regulations at 42 CFR part 136, and also may serve other Medicaid and CHIP beneficiaries under 25 U.S.C. 1680c.

[6] Section 1905(b) of the Social Security Act (third sentence).

iv. Services that cannot be federally matched under section 1903(v) of the Act;

v. Capital investments; and

vi. Research grants and expenditures not related to monitoring and evaluation.

7.4. **Participating Facilities.** Traditional health care practices are covered only when received through IHS or Tribal facilities.

7.5. **Participating Providers.** Practitioners or providers of traditional health care practices must be employed by or contracted with IHS or Tribal facilities. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to the state, upon request. Each qualifying facility is responsible for determining that each practitioner, provider, or provider staff member employed by or contracted with the qualifying facility to provide traditional health care practices 1) is qualified to provide traditional health care practices to the qualifying facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility also is expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional health care practices, 2) bill Medicaid or CHIP for traditional health care practices furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to the state about these activities upon request. The state must make any documentation it receives from qualifying facilities about these activities and determinations available to CMS upon request.

7.6. **Payment Methodology.** The state must comply with the payment rate-setting requirements in 42 CFR Part 447, Subpart B, as though a state plan amendment were required, to establish a payment rate or methodology for traditional health care practices as approved through demonstration Expenditure Authority 6. The state must conduct state-level public notice under 42 CFR 447.205 prior to using the applicable payment methodologies to pay for traditional health care practices and must maintain documentation of the payment methodologies on its website described in 42 CFR 447.203. The state is encouraged to engage with CMS on the development of all new and modified fee-for-service or non-risk rate contract payment methodologies if the state is not using the IHS All-Inclusive Rate (AIR)[7] when paying for traditional health care practices. Provided that all other requirements for claiming FFP have been met (including submission of the attestation described in STC 7.1 the state may draw FFP for traditional health care practices after using the payment methodologies to pay providers (and can use them to pay providers only subsequent to conducting notice under 42 CFR 447.205, as described above).

8. REENTRY PRE-RELEASE MEDICAID SERVICES FOR JUSTICE-INVOLVED INDIVIDUALS

8.1. **Overview of Pre-Release Services and Program Objectives.** This component of the demonstration will provide coverage for pre-release services up to 90 days immediately prior to the expected date of release to certain individuals who are inmates residing in youth correctional facilities. This component will also provide coverage for pre-release services up to 60 days

[7] See https://www.ihs.gov/businessoffice/reimbursement-rates/.

immediately prior to the expected date of release in jails, and prisons participating in the reentry demonstration initiative. All facilities defined in STC 8.5 Participating correctional facilities will hereinafter be called "correctional facilities." To qualify for services covered under this demonstration, individuals residing in correctional facilities must be eligible for Medicaid as determined pursuant to an application filed before or during incarceration and must have an expected release date specified in STC 8.3 below.

8.2. The objective of this component of the demonstration is to facilitate individuals' access to certain healthcare services and case management, provided by Medicaid participating providers, while individuals are incarcerated and allow them to establish relationships with community-based providers from whom they can receive services upon reentry to their communities. This bridge to coverage begins within a short time prior to release and is expected to promote continuity of coverage and care and improve health outcomes for justice-involved individuals. The reentry demonstration initiative provides short-term Medicaid enrollment assistance and pre-release coverage for certain services to facilitate successful care transitions, as well as improve the identification and treatment of certain chronic and other serious conditions to reduce acute care utilization in the period soon after release, and test whether it improves uptake and continuity of medication-assisted treatment (MAT) and other substance use disorder (SUD) and behavioral health treatments, as appropriate for the individual.

During the demonstration, the state seeks to achieve the following goals:

a. Increase coverage, continuity of care, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in correctional facility settings prior to release;

b. Improve access to services prior to release and improve transitions and continuity of care into the community upon release and during reentry;

c. Improve coordination and communication between correctional systems, Medicaid systems, managed care plans (as applicable), and community-based providers;

d. Increase additional investments in health care and related services, aimed at improving the quality of care for individuals in correctional facility settings, and in the community to maximize successful reentry post-release;

e. Improve connections between correctional facility settings and community services upon release to address physical and behavioral health needs and social determinants of health;

f. Reduce all-cause deaths in the near-term post-release;

g. Reduce the number of emergency department visits and inpatient hospitalizations among recently incarcerated Medicaid individuals through increased receipt of preventive and routine physical and behavioral health care;

h. Provide interventions for certain behavioral health conditions, including use of stabilizing medications like long-acting injectable antipsychotics and medication for addiction treatment

for SUDs where appropriate, with the goal of reducing overdose and overdose-related death in the near-term post-release.

8.3. **Qualifying Criteria for Pre-Release Services**. To qualify to receive services under this component of the demonstration, an individual must meet the following qualifying criteria:

a. Meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010, and be incarcerated in a correctional facility specified in STC 8.5; and

b. Have been determined eligible for Medicaid; if not for their incarceration status; and

c. Meet one of the following two criteria to receive the described length of pre-release services:

i. Be an individual in a jail or prison with an expected release date within 60 days to receive up to 60 days of pre-release services, or

ii. Be an individual in a youth correctional facility with an expected release date within 90 days to receive up to 90 days of pre-release services; .

d. Have a status of pre-adjudication and post-adjudication.

8.4. **Scope of Pre-Release Services**. The pre-release services authorized under the reentry demonstration initiative are the following services, which are described in Attachment H, Reentry Demonstration Initiative Services.

a. The covered pre-release services are:

i. Case management to assess and address physical and behavioral health needs, and social determinants of health; and

ii. MAT for all types of SUDs as clinically appropriate, including coverage for medications in combination with counseling/behavioral therapies.

iii. Practitioner office visit (e.g., physical exam; wellness exam; evaluation and management visit; mental health or substance use disorder treatment, therapy, or counseling; or other)

iv. Diagnostic services, including laboratory and radiology services

v. Treatment for Hepatitis C

vi. Treatment for Human Immunodeficiency Virus (HIV)

vii. Family planning services and supplies

b. The state must also provide a 30-day supply of all prescription medications and over-the-counter drugs (as clinically appropriate), provided to the individual immediately upon release from the correctional facility, consistent with approved Medicaid state plan coverage authority and policy.

c. The expenditure authority for pre-release services through this initiative constitutes a limited exception to the federal claiming prohibition for medical assistance furnished to inmates of a

public institution at clause (A) following section 1905(a) of the Act ("inmate exclusion rule"). Benefits and services for inmates of a public institution that are not approved in the reentry demonstration initiative as described in these STCs and accompanying protocols, and not otherwise covered under the inpatient exception to the inmate exclusion rule, remain subject to the inmate exclusion rule. Accordingly, other benefits and services covered under the Maine Medicaid State Plan, as relevant, that are not included in the above-described pre-release services(e.g., EPSDT treatment services for qualifying Medicaid beneficiaries under age 21) are not available to qualifying individuals through the reentry demonstration initiative.

8.5. **Participating Correctional Facilities.** The pre-release services will be provided at jails, prisons, and youth correctional facilities, or outside of the correctional facilities, with appropriate transportation and security oversight provided by the correctional facility, subject to Office of Maine Care Services approval of a facility's readiness, according to the implementation timeline described in STC 8.9. States must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems. Correctional facilities that are also institutions for mental diseases (IMDs) are not allowed to participate in the reentry demonstration initiative.

8.6. **Participating Providers**.

a. Licensed, registered, certified, or otherwise appropriately credentialed or recognized practitioners under Maine scope of practice statutes shall provide services within their individual scope of practice and, as applicable, receive supervision required under their scope of practice laws and must be enrolled as Medicaid or CHIP providers.

b. Participating providers eligible to deliver services under the reentry demonstration initiative may be either community-based or correctional facility-based providers.

c. All participating providers and provider staff, including correctional providers, shall have necessary experience and receive appropriate training, as applicable to a given correctional facility, prior to furnishing demonstration-covered pre-release services under the reentry demonstration initiative.

d. Participating providers of reentry case management services may be community-based or correctional providers who have expertise working with justice-involved individuals.

e. Maine must develop processes and policies to ensure that case managers coordinate with providers of pre-release services and community-based providers (if they are different providers) and facilitate connections to community-based providers pre-release for timely access to services upon reentry in order to provide continuity of care.

f. Maine must develop processes to facilitate coordination between case managers and community-based providers in communities where individuals will be living upon release or ensure individuals have the skills and resources to inform themselves about such providers for communities with which they are unfamiliar.

g. Maine must develop policies to ensure that case managers have the necessary time needed to respond effectively to individuals who are incarcerated and transitioning back into the community.

8.7. **Suspension of Coverage**. Upon entry of a Medicaid-enrolled individual into a correctional facility, Office of Maine Care Services must not terminate and generally shall suspend their Medicaid coverage, in accordance with sections 1902(a)(84)(A) and 2102(d)(1)(A) of the Act.

a. If an individual is not enrolled in Medicaid when entering a correctional facility, the state must ensure that such an individual receives outreach and assistance with completing and submitting an application for Medicaid, unless the individual declines such assistance or wants to decline enrollment.

8.8. **Opportunity to Enroll in Medicaid or CHIP**. Any Medicaid or CHIP-eligible person who is incarcerated at a participating facility but not yet enrolled must be afforded the opportunity to apply for Medicaid or CHIP in the most feasible and efficient manner and must be offered assistance with the Medicaid application process in accordance with 42 CFR 435.906, 435.908, and 457.340(a). The state must accept an application submitted via any of the methods described at 42 CFR 435.907 and 457.330.

a. All individuals who are incarcerated at a participating facility must be allowed to access and complete a Medicaid or CHIP application and must be assisted in this process, including by providing information about where to complete the Medicaid or CHIP application for another state (e.g., relevant state Medicaid agency website), if the person plans to live in a different state after release.

b. All individuals enrolled in Medicaid or CHIP during their incarceration must be provided with a Medicaid, CHIP, or managed care plan card or some other Medicaid, CHIP, or managed care enrollment documentation upon release, along with information on how to use their coverage.

8.9. **Managed Care Contract Requirements.** If Maine elects to implement the demonstration through managed care, managed care plan contracts must reflect clear requirements and processes for transfer of a member's relevant health information upon release to another managed care plan or, if applicable, state Medicaid agency (e.g., if the beneficiary is moving to region of the state served by a different managed care plan or to another state after release) to ensure continuity of coverage and care.

8.10. **Interaction with Mandatory State Plan Benefits for Eligible Juveniles and Targeted Low-Income Children.** To the extent Maine includes coverage in the reentry demonstration initiative that is otherwise required to be provided under section 1902(a)(84)(D) of the Act, and may include this coverage in the base expenditures used to determine the budget neutrality expenditure limit, the state may claim for these expenditures under this demonstration as well as include this coverage in the monitoring and evaluation of this demonstration.

8.11. **Reentry Demonstration Initiative Implementation Timeline.** Delivery of pre-release services under this demonstration will be implemented as described below. All participating correctional facilities must demonstrate readiness, as specified below, prior to participating in

this initiative (FFP will not be available in expenditures for services furnished to qualifying individuals who are inmates in a facility before the facility meets the below readiness criteria for participation in this initiative). Office of MaineCare Services will determine that each applicable facility is ready to participate in the reentry demonstration initiative under this demonstration based on a facility-submitted assessment (and appropriate supporting documentation) of the facility's readiness to implement:

a. Pre-release Medicaid application and enrollment processes for individuals who are not enrolled in Medicaid prior to incarceration and who do not otherwise become enrolled during incarceration;

b. The screening process to determine an individual's qualification for pre-release services, per the eligibility requirements described in STC 8.3;

c. The provision or facilitation of pre-release services for a period of time immediately prior to the expected date of release, as described in STC 8.1 and 8.3, including the facility's ability to support the delivery of services furnished by providers in the community that are delivered via telehealth, as applicable;

d. If Maine optionally elects to phase in pre-release services, Maine will require participating facilities to select a Service Level for implementation. Service Level One consists of the minimum benefit package pre-release services identified in STC 8.4 a and b, and must be the first Service Level category that is implemented. The state may define additional Service Level categories in its Implementation Plan. As applicable, additional service levels may be phased-in by facilities in any order, e.g., Service Level Two would not be a prerequisite for phasing-in Service Level Three, except that no facility may be a participating correctional facility that does not at least achieve and maintain provision of Service Level One. A facility must demonstrate to the state that it is prepared to implement all the services in Service Level One and within any chosen Service Level, if applicable.;

e. Coordination amongst partners with a role in furnishing health care services to individuals who qualify for pre-release services, including, but not limited to, physical and behavioral health community-based providers, social service departments, and managed care plans (as applicable).

f. Appropriate reentry planning, pre-release case management, and assistance with care transitions to the community, including connecting individuals to physical and behavioral health providers and their managed care plan (as applicable), and making referrals to case management and community supports providers that take place throughout the up to 60 day pre-release period, as described in STC 8.3(c), and providing individuals with covered outpatient prescribed medications and over-the-counter drugs (a minimum 30-day supply of the medications as clinically appropriate) upon release, consistent with approved Medicaid state plan coverage authority and policy;

g. Operational approaches related to implementing certain Medicaid and CHIP requirements, including but not limited to applications, suspensions, notices, fair hearings, reasonable

promptness for coverage of services, and any other requirements specific to receipt of pre-release services by qualifying individuals under the reentry demonstration initiative;

h. A data exchange process to support the care coordination and transition activities described in (e), (f), and (g) of this subsection subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

i. Reporting of data requested by Maine to support program monitoring, evaluation, and oversight; and

j. A staffing and project management approach for supporting all aspects of the facility's participation in the reentry demonstration initiative, including information on qualifications of the providers with whom the correctional facilities will partner for the provision of pre-release services.

8.12. **Reentry Demonstration Initiative Implementation Plan**. The state is required to submit a Reentry Demonstration Initiative Implementation Plan for CMS approval that will identify for each milestone, as well as each associated action, what the state anticipates to be the key implementation challenges and the state's specific plans to address these challenges. This will include any plans to phase in demonstration components over the lifecycle of the demonstration.

The state must submit the draft Implementation Plan to CMS no later than 120 calendar days after approval of the reentry demonstration initiative. The state must submit any required clarifications or revisions to its draft Implementation Plan no later than 60 calendar days after receipt of CMS feedback. The finalized Implementation Plan, subject to CMS approval, will be incorporated into the STCs as Attachment E titled "Reentry Demonstration Initiative Implementation Plan."

CMS will provide the state with a template to support developing the Implementation Plan.

8.13. **Reentry Demonstration Initiative Reinvestment Plan**. To the extent that the reentry demonstration initiative newly covers services that are the responsibility of and were previously provided or paid for by the correctional facility with custody of qualifying individuals, the state must reinvest all new federal dollars, equivalent to the amount of FFP expended for such previously existing service(s), into allowable justice-related activities defined below. FFP projected to be expended for new services covered under the reentry demonstration initiative or state plan services required under this demonstration to meet the requirements of section1902(a)(84)(D) of the Act are not required to be reinvested pursuant to this STC. New services are defined as 1) services not previously provided or paid by the correctional facility or carceral authority with custody of qualifying individuals prior to the facility's implementation of the reentry demonstration initiative or 2) any additional increases in expenditures for existing services that have been expanded, augmented, or enhanced to meet the requirements of the reentry demonstration initiative. For services that were previously provided prior to the demonstration and now, under the demonstration, have been expanded,

augmented, or enhanced, the state must calculate the proportion of FFP attributed to existing services, and reinvest an amount equivalent to the amount of FFP.

a. Reinvestments in the form of non-federal expenditures totaling the amount of new federal dollars, as described above, must be made over the course of the demonstration period. Allowable reinvestments may only include:

    i. The state share of funding associated with new services covered under the reentry demonstration initiative, as specified in this STC;

    ii. Improved access to behavioral and physical community-based health care services and capacity focused on meeting the health care needs and addressing the needs of individuals who are incarcerated (including those who are soon-to-be released), those who have recently been released, and those who may be at higher risk of criminal justice involvement, particularly due to untreated behavioral health conditions;

    iii. Improved access to or quality of carceral health care services, including by covering new, enhanced, or expanded pre-release services authorized via the reentry demonstration initiative opportunity;

    iv. Improved health information technology (IT) and data sharing subject to compliance with applicable federal, state, and local laws governing confidentiality, privacy, and security of the information that would be disclosed among parties;

    v. Increased community-based provider capacity that is particularly attuned to the specific needs of, and able to serve, justice-involved individuals or individuals at risk of justice involvement;

    vi. Expanded or enhanced community-based services and supports, including services and supports to meet the needs of the justice-involved population; and

    vii. Any other investments that aim to support reentry, smooth transitions into the community, divert individuals from incarceration or re-incarceration, or better the health of the justice-involved population, including investments that are aimed at interventions occurring both prior to and following release from incarceration into the community.

b. Within 180 days of approval of the reentry demonstration initiative, the state will submit a reentry demonstration initiative Reinvestment Plan (Attachment F) for CMS approval that memorializes the state's reinvestment approach. The Reinvestment Plan must include:

    i. An assessment of each authorized pre-release service, the extent to which it is a new or existing service, and a calculation of the projected amount of FFP required to be reinvested for each existing service per year;

    ii. A description of the allowable activities described above in which the state plans to reinvest the required dollars, a timeline of when those reinvestments will occur, and the goals and outcomes for those activities. The state cannot use reinvested funds to build new or conduct capital improvements for existing correctional facilities;

iii. An assessment of whether privately-owned or -operated carceral facilities would receive any of the reinvested funds and, if so, the safeguards the state proposes to ensure that such funds are used for the intended purpose and do not have the effect of increasing profit or operating margins for privately-owned or -operated carceral facilities.

c. The state will be required to include updates on reinvestment as part of the annual monitoring report. The state must describe the actual amount of required reinvestment based on actual FFP received, the amount the state has already reinvested and into what activities, and an update on how the Plan is progressing. The state must also include outcomes from the activities the state reinvested in.

d. No later than one year after the expiration of the demonstration period, the state will submit to CMS a Final Reinvestment Assessment (Attachment G) that will fully describe the final amount of required reinvestment based on actual FFP received, the amount the state reinvested and into what activities, and the outcomes of those activities.

9. COST SHARING

9.1. **Cost Sharing.** Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan.

10. DELIVERY SYSTEM

10.1. Delivery System. Services for the demonstration are provided using the same mechanism as other MaineCare members, including services that require prior authorization and are ordered and prescribed by a physician. Participants will be permitted to choose among participating providers (agencies).

11. MONITORING AND REPORTING REQUIREMENTS

11.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs) (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or are found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the current demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement. The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (b) below; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements:

a. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverable(s).

b. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

c. If CMS agrees to an interim corrective process in accordance with subsection (b), and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

d. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

11.2. **Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the Annual Monitoring Report. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar year and each calendar year thereafter until CMS has determined sufficient progress has been made.

11.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs, unless CMS and the state mutually agree to another timeline.

11.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all section 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

11.5. **Monitoring Reports.** The state must submit one Annual Monitoring Report each demonstration year (DY) that is due no later than 180 calendar days following the end of the DY. The state must submit a revised Annual Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. CMS will make on-going determinations about reporting frequency under the demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. See 42 CFR 431.420(d)(1)-(2).

The Annual Monitoring Report will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Annual Monitoring Report must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and must be provided in a structured manner that supports federal tracking and analysis:

a. Operational Updates. Per 42 CFR 431.428, the Annual Monitoring Report must document any policy or administrative difficulties in operating the demonstration. The Annual Monitoring Report must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Annual Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics. The performance metrics will provide data to demonstrate the state's progress towards meeting the demonstration's goals and any applicable milestones. Per 42 CFR 431.428, the Annual Monitoring Report must document the impact of the demonstration on beneficiaries' outcomes of care, quality and overall cost of care, and access to care, as applicable. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals. The Annual Monitoring Report must provide detailed information about deviations from CMS's applicable metrics technical specifications, relevant methodology, plans for phasing in metrics, and data or reporting issues for applicable metrics, in alignment with CMS guidance and technical assistance.

The state and CMS will work collaboratively to finalize the list of metrics to be reported on in the Annual Monitoring Report. The demonstration's monitoring metrics must cover categories to include, but not be limited to, eligibility, utilization of services, quality of care and health outcomes, and grievances and appeals. The state must report these metrics for all demonstration populations. Demonstration monitoring reporting does not duplicate or replace reporting requirements for other authorities, such as Home and Community Based Services and Managed Care authorities.

In addition, the state is expected to report monitoring metrics for the following demonstration initiative(s), as described below and per applicable CMS guidance:

i. For the SUD and/or SMI/SED component(s), the state's monitoring must cover metrics in alignment with CMS guidance and the demonstration's milestones as outlined in the SUD State Medicaid Director Letter (SMDL) dated November 1, 20127 (SMD #17–003) and/or the SMI/SED SMDL dated November 13, 2018 (SMDL #18-011).

ii. For the reentry demonstration initiative, the state must report on metrics that track implementation progress and milestones. CMS expects such metrics to include, but not be limited to: administration of screenings to identify individuals who qualify for pre-release services, utilization of applicable pre-release and post-release services as defined in STC 8.4, provision of health or social service referral pre-release, participants who received case management pre-release and were enrolled in case management post-release, and take-up of data system enhancements among participating correctional facility settings. In addition, the state is expected to monitor the number of individuals served and types of services rendered under the demonstration. Also, in alignment with the state's Reentry Initiative Implementation Plan, the state must also provide in the Annual Monitoring Report narrative details outlining its progress with implementing the initiative, including any challenges encountered and how the state has addressed them or plans to address them. This information must also capture the transitional, non-service expenditures, including enhancements in the data infrastructure and information technology.

iii. The state's selection and reporting of metrics for traditional health care practices are expected to include, but not be limited to: the number of facilities providing traditional health care practices under the demonstration, the number of traditional health care practices provided under the demonstration, and the number of individuals receiving traditional health care practices under the demonstration. The Annual Monitoring Report must also include beneficiary grievances, complaints, and appeals related to the attestation described in STC 7.1. The reporting of these monitoring metrics may also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography) and by demonstration component, as appropriate. Subpopulation reporting can support identifying any gaps in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population.

c. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Annual Monitoring Report must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

11.6. SUD and SMI Mid-Point Assessments. The state must contract with an independent entity (herein after referred to as the Independent Assessor) to conduct an independent Mid-Point Assessment and submit to CMS by September 30, 2029. This timeline will allow for the Mid-

Point Assessment to capture approximately the first two and a half years of program data, accounting for data run-out and data completeness. In addition, if applicable, the state should use the prior approval period experiences as context, and conduct the Mid-Point Assessment in light of the data from any such prior approval period(s). In the design, planning and execution of the Mid-Point Assessment, the state must require that the Independent Assessor consult with key stakeholders, such as representatives of MCOs, health care providers, beneficiaries, community groups, and other key partners.

a. The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations, and any recommendations. If requested, the state must brief CMS on the Mid-Point Assessment. The state must submit a revised Mid-Point Assessment within 60 calendar days after receipt of CMS's comments, if any.

b. Elements of the Mid-Point Assessment must include:

    i. An examination of progress toward meeting each milestone and timeframe approved in the Implementation Plan;

    ii. A determination of factors that affected achievement on the milestones and performance metric gap closures to date;

    iii. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets; and

    iv. For milestones or targets identified by the Independent Assessor as at medium to high risk of not being met, recommendations for adjustments in the state's Implementation Plan, or to pertinent factors that the state can influence that will support improvement.

11.7. **Corrective Action Plan Related to Monitoring.** If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS might withdraw an authority, as described in STC 3.10, if metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals and desired directionality, and the state has not implemented corrective action, and the circumstances described in STC 10, are met. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

11.8. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 12.7 and 12.8 respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out Report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 11.1.

11.9. **Monitoring Calls.** CMS will convene, no less frequently than quarterly, monitoring calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operations and implementation which align with the state's demonstration monitoring reports, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, eligibility and access, and progress on evaluation activities.

b. These calls will follow the structure of and focus on the topics in the Annual Monitoring Report.

c. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

d. The state and CMS will jointly develop the agenda for the calls.

11.10. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Annual Monitoring Report associated with the year in which the forum was held.

12. EVALUATION OF THE DEMONSTRATION

12.1. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f). This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 11.1.

12.2. **Independent Evaluator.** The state must use an independent entity (herein referred to as the Independent Evaluator) to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The Independent Evaluator must sign an agreement to conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

12.3. **Evaluation Design.** The state must submit, for CMS comment and approval, an Evaluation Design with implementation timeline no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be developed in accordance with the STCs and any other applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. The state is strongly encouraged to use the expertise of the Independent Evaluator in the development of the Evaluation Design. The Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STCs 12.7 and 12.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component, unless otherwise agreed upon by the state and CMS. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. The amendment components of the Evaluation Design must also be reflected in the state's Interim and Summative Evaluation Reports, described below.

12.4. **Evaluation Design Approval and Updates.** The state must submit a revised Evaluation Design within 60 calendar days after receipt of CMS' comments. Upon CMS approval of the Evaluation Design, the document will be posted to Medicaid.gov. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 calendar days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each Annual Monitoring Report. Once CMS approves the Evaluation Design, if the state wishes to make changes and the changes are substantial in scope, the state must submit a revised Evaluation Design to CMS for approval; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in an Annual Monitoring Report.

12.5. **Evaluation Questions and Hypotheses.** Consistent with the STCs and applicable CMS guidance, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must study outcomes, such as eligibility and various measures of access, utilization, costs, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance for the demonstration policy components. The evaluation is expected to use applicable demonstration monitoring and other data on the provision of and beneficiary utilization of demonstration and other applicable services. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include the Consumer Assessment of Health Care Providers and Systems (CAHPS), the Medicaid and CHIP Core Sets of Health Care Quality measures, commonly referred to as the Child and Adult Core Sets, the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum (NQF).

The state must develop robust evaluation questions and hypotheses related to each demonstration initiative, and per applicable CMS guidance. Specifically:

a. Hypotheses for the SUD component of the demonstration must align with the goals of the program, including increasing rates of identification and initiation of and engagement in treatment as well as adherence to and retention in treatment, reducing overdose deaths, reducing utilization of emergency departments and inpatient hospitalizations as well as readmissions to the same or higher levels of care, and improving access to care for physical health conditions.

b. Hypotheses for the SMI/SED component must map to the goals of the program, including reducing utilization and lengths of stay in emergency departments, reducing preventable readmissions to acute care hospitals and residential settings, improving the availability of crisis stabilization services, improving access to community-based services, and improving care coordination.

c. Evaluation of the Reentry Demonstration Initiative must be designed to examine whether the initiative expands Medicaid coverage through increased enrollment of eligible individuals, and efficient high-quality pre-release services that promote continuity of care into the community post-release. In addition, in alignment with the goals of the Reentry Demonstration Initiative in the state, the evaluation hypotheses must focus on, but not be limited to: cross-system communication and coordination; connections between correctional and community services; access to and quality of care in correctional and community settings; preventive and routine physical and behavioral health care utilization; non-emergent emergency department visits and inpatient hospitalizations; and all-cause deaths.

   In instances where the state is testing services beyond the minimum benefit package or providing coverage for a period over 30 days and up to 90 days immediately prior to a beneficiary's expected release date, the state is required to incorporate additional hypotheses to describe those tests. The state must also provide a comprehensive analysis of the distribution of services rendered by type of service over the duration of up to 90-days coverage period before the individual's expected date of release—to the extent feasible—and discuss in the evaluation any relationship identified between the provision and timing of particular services with salient post-release outcomes. For example, the state could include the following: utilization of acute care services for chronic and other serious conditions, overdose, and overdose- and suicide-related and all-cause deaths in the period soon after release. In addition, the state is expected to assess the extent to which this coverage timeline facilitated providing more coordinated, efficient, and effective reentry planning; enabled pre-release management and stabilization of clinical, physical, and behavioral health conditions; and helped mitigate any potential operational challenges the state might have otherwise encountered in a more compressed timeline for coverage of pre-release services.

   The demonstration's evaluation efforts will be expected to include the experiences of correctional and community providers, including challenges encountered, as they develop relationships and coordinate to facilitate transition of individuals into the community. Finally, the state must conduct a comprehensive cost analysis to support developing estimates of implementing the Reentry Demonstration Initiative, including covering associated services.

d. Evaluation of the traditional health care practices demonstration initiative must be designed to examine whether the initiative increases access to traditional health care practices for beneficiaries served by or through IHS or Tribal facilities. In evaluating the effectiveness of the initiative, the state must capture the perspectives of IHS and Tribal facilities through qualitative data collection efforts. The state is also strongly encouraged to consult with IHS and Tribal facilities, participating providers, and beneficiaries in the development of the evaluation design. The evaluation must address topics that include but are not limited to: beneficiary awareness and understanding of traditional health care practices; reasons for individuals receiving the traditional health care practices; access to, utilization and costs of traditional health care practices; quality and experience of care; and physical and behavioral health outcomes.

As part of its evaluation efforts, the state must also conduct an overall demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, and Medicaid health services expenditures. In addition, the state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care. To better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of—and barriers to—implementation, the state is strongly encouraged to undertake a robust process/implementation evaluation. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state may collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, or geography). Such stratified data analyses can provide a fuller understanding of gaps in access to and quality of care and health outcomes, as well as help inform how the demonstration's various policies support improving outcomes.

12.6. **Evaluation Budget.** A budget for evaluations must be provided with the Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measure development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

12.7. **Reentry Early Implementation Rapid Cycle Report.** The state must conduct and submit a Rapid Cycle Report (RCR) to CMS as a required evaluation deliverable for this demonstration. The purpose of the RCR is to assess implementation planning of the demonstration, including operational progress, barriers and facilitators, program integrity, and financial oversight, and to provide timely, actionable insights to support program refinement during the initial implementation phase.

The state must submit the RCR no later than 180 calendar days following the onset of claiming for demonstration services ("go-live"). The state must notify CMS of the anticipated go-live date no later than 30 calendar days in advance. CMS may, at its discretion, approve an alternative submission timeline if warranted by the state's implementation schedule or operational milestones.

The RCR must use a mixed-methods approach, incorporating both qualitative and quantitative information, and must assess implementation progress and key milestones, including the status of data-sharing agreements, provider onboarding, systems readiness, and care coordination

processes, as well as a comparison of planned versus actual implementation timelines and approaches for service delivery and operations, including explanations for any deviations from the approved implementation plan. The RCR must also highlight any known gaps in data needed for future evaluations and potential mitigation strategies.

The RCR must also assess early operational experiences, including successes and challenges associated with coordination across correctional facilities and community-based providers, and must identify mitigation strategies where appropriate. The RCR must further include early financial information, including expenditures and any identified claiming considerations, as feasible, and an assessment of data infrastructure, reporting capabilities, and data quality, including limitations that may affect future evaluation activities. The RCR must make the methodology clear (e.g., financial analyses, interviews, focus groups) as well as the sources of the data (e.g., carceral facilities, community providers, state staff/contractors). The RCR may also include recommendations for refining the state's CMS-approved Evaluation Design, including identification of feasible outcome measures, data sources, and analytic approaches based on actual implementation experience.

The state must participate in discussions with CMS to review RCR findings and must identify and implement programmatic improvements, as appropriate. The state must document any changes made in response to RCR findings in subsequent monitoring reports. The state must publish the final RCR on its public website within 30 calendar days of CMS approval. The Rapid Cycle Report must incorporate structured input from key demonstration interest holders (e.g., correctional facilities, community-based providers, and other partners). The report must address core implementation questions aligned with CMS evaluation guidance.

The report must also include a structured assessment of implementation plan activities, including the status of key milestones, explanations for deviations from planned timelines, and recommended modifications to implementation strategies.

12.8. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). The draft Interim Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report must include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. When applying for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for

public comment. If the state does not request an extension for the demonstration, the Interim Evaluation Report is due one year prior to the end of the demonstration. For demonstration phase-outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit a revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

e. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

12.9. **Summative Evaluation Report.** The state must submit the draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in alignment with the approved Evaluation Design, and in accordance with the requirements outlined in these STCs and applicable CMS guidance.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft Summative Evaluation Report, if any.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

12.10. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

12.11. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, or the Summative Evaluation Report.

12.12. **Public Access.** The state shall post the final documents (e.g., Annual Monitoring Report, Close-Out Report, Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's website within 30 calendar days of approval by CMS.

12.13. **Additional Publications and Presentations.** For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to

release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

13. GENERAL FINANCIAL REQUIREMENTS

13.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

13.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

13.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up for the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms, and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with application federal statutes or regulations, the state must address CMS's concerns within the time frame allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

13.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible under for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

13.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organizationsprepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.

b. For non-risk-based PIHPs and PAHPs, arrangements comply with the upper payment limits specified in 42 CFR 447.362, and if payments exceed the cost of services, the state will recoup the excess and return the federal share of the excess to CMS.

13.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

13.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 11.1. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

13.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in section 14:

a. Administrative costs, including those associated with the administration of the demonstration;

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

13.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

13.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	To Which BN Test Does This Apply?	WOW Per Capita	WOW Aggregate	WW	Brief Description

Non Expansion Adults and Children	Hypo 1	X		X	Medicaid beneficiaries (adults and children) diagnosed with a SUD
Expansion Adults	Hypo 1	X		X	Expansion adult Medicaid beneficiaries diagnosed with a SUD
Parents with Extended MaineCare	Hypo 1	X		X	MaineCare beneficiaries who lose custody of their children and are no longer eligible for Medicaid because of household size.
Parents Receiving Home Based Skills Development Services	Hypo 1	X		X	MaineCare enrolled parents or children affected by SUD
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	Hypo 1	X		X	MaineCare enrolled parents or children affected by SUD
Parents Receiving Visit Coaching	Hypo 1	X		X	MaineCare enrolled parents or children affected by SUD
Reentry Expansion Adults	Hypo 2	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.
Reentry Non-Expansion Adults and Children	Hypo 2	X		X	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 60 days immediately prior to release from participating facilities.
Serious Mental Illness Expansion Adults	Hypo3	X		X	Expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment

Serious Mental Illness Non-Expansion Adults	Hypo 3	X		X	Expenditures for services provided to an individual while they are a patient in an IMD for SMI treatment

BN – budget neutrality; MEG – Medicaid expenditure group; WOW – without waiver; WW – with waiver

13.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00338/1). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements.** The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. To assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by DY on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates**. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any form 64.9 or 64.9P WAIVER.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in in section 14, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** Using the Budget Neutrality Monitoring Tool, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months, each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Month Reporting

MEG Waiver Name)	Detailed Description	Exclusions	CMS-64.9 Line(s) To Use	How Expend. Are Assigned =to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
SUD Non-Expansion Adults and Children	Non-Expansion Medicaid beneficiaries agnosed with a SUD	STC# 5.4	Follow CMS-64.9 ase Category of ervice Definitio n	Date of service	MAP	Y	1/1/2021	12/31/2031
SUD Expansion Adults	Expansion Medicaid Beneficiaries iagnosed with a SUD	STC#5.4	Follow CMS-64.9 ase Category of Service Definitio n	Date of service	MAP	Y	1/1/2021	12/31/2031
Parents with Extended			Follow CMS-					

MaineCare	Medicaid beneficiaries iagnosed with a SUD		64.9 ase Category of Service Definitio n	Date of service	MAP	Y	71/2022	12/31/2031
Parents eceiving Home Based Skills Development Services	Medicaid beneficiaries iagnosed with a SUD		Follow CMS-64.9 ase Category of Service Definitio n	Date of service	MAP	Y	7/1/2022	12/31/2031

Parents Receiving Visit Coaching	Medicaid beneficiaries diagnosed with a SUD		Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	7/1/2022	12/31/2031
Parents Receiving Attachment Biobehavior al Catch-up (ABC)	Medicaid beneficiarie s diagnosed with a SUD		Follow CMS-64.9 Base Category of Service Definitio n	Date of service	MAP	Y	7/1/2022	12/31/2031
Reentry-Justice Involved Pre-Release Services Expansion Adults	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 60 days immediately prior to		Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2026	12/31/2031

	release from participating facilities.							
Reentry-Justice Involved Pre-Release Services Non-Expansion Adults and Children	Expenditures for reentry services that are otherwise covered under Medicaid provided to qualifying beneficiaries for up to 60-90 days immediately prior to release from participating facilities.		Follow standard CMS 64.9 Based Category of Service Definitions	Date of service	MAP	Y	10/1/2026	12/31/2031
Serious Mental Illness Expansion Adults	All expenditures for medical assistance provided during a month for an SMI/ IMD stay	STC# 6.7	Follow CMS-64.9 Base Category of Service Definition	Date of service	MAP	Y	10/1/2026	12/31/2031
Serious Mental Illness Non-Expansion Adults	All expenditures for medical assistance provided during a month for an SMI/ IMD stay	STC# 6.7	Follow standard CMS 64.9 Based Category of Service Definitions	Date of service	MAP	Y	10/1/2026	12/31/2031

13.12. **Demonstration Years.** Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3: Demonstration Years		
Demonstration Year 6	January 1, 2026 to September 30, 2026	9 months

Demonstration Year 7	October 1, 2026 to December 31, 2026	3 months
Demonstration Year 8	January 1, 2027 to December 31, 2027	12 months
Demonstration Year 9	January 1, 2028 to December 31, 2028	12 months
Demonstration Year 10	January 1, 2029 to December 31, 2029	12 months
Demonstration Year 11	January 1, 2030 to December 31, 2030	12 months
Demonstration Year 12	January 1, 2031 to September 30, 2031	9 months

*For the purpose of calculating budget neutrality for the temporary extension period of January 1, 2026 through December 31, 2026, DY 6 budget neutrality limits will apply.

[5] 42 CFR §431.420(a)(2) provides that states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and §431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and in states agree to use the tool as a condition of demonstration approval.

13.13. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

13.14. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

c. The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

13.15. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state’s Medicaid expenditures that are unrelated to the demonstration and/or outside the state’s control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. Contents of Request and Process. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 13.15.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. After acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7 CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. Types of Allowable Changes. Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

    i. Provider rate increases that are anticipated to further strengthen access to care;

    ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

    iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

    iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

    v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

    vi. High-cost innovative medical treatments that states are required to cover; or,

    vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. Budget Neutrality Update. The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

    i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

    ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a

new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

14. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

14.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit may consist of a Main Budget Neutrality Test, and one or more Hypothetical Budget Neutrality Tests, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

14.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

14.3. **Calculation of the Budget Neutrality Limits and How They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

14.4. **Main Budget Neutrality Test.** This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

14.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical;" such that the expenditures are treated as if the state could have received

FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies a separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Neutrality test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

14.6. **Hypothetical Budget Neutrality Test 1:** SUD (see Expenditure Authorities #1-4). The table below identifies the MEGs that are used for the Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	TREND	DY 7 PMPM	DY 8 PMPM	DY 9 PMPM	DY 10 PMPM	DY 11 PMPM	DY 12 PMPM
SUD Non-Expansion Adults and Children	4.4%	$7,270.07	$7,468.38	$7,796.99	$8,140.06	$8,498.22	$8,824.52
SUD Expansion Adults	5.1%	$7,957.71	$8,208.99	$8,627.65	$9,067.66	$9,530.11	$9,954.06
Parents with Extended MaineCare	5.0%	$1,484.60	$1,530.57	$1,607.10	$1,687.46	$1,771.83	$1,849.11
MEG	**TREND**	**DY 7 PMPM**	**DY 8 PMPM**	**DY 9 PMPM**	**DY 10 PMPM**	**DY 11 PMPM**	**DY 12 PMPM**

Parents Receiving Home Based Skills Development Services	5.0%	$515.77	$531.74	$558.33	$586.25	$615.56	$642.41
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	5.0%	$523.90	$550.10	$577.61	$606.49	$636.81	$664.58
Parents Receiving Visit Coaching	5.0%	$1,884.13	$1,978.34	$2,077.26	$2,181.12	$2,290.18	$2,390.07

14.7. **Hypothetical Budget Neutrality Test 2:** Reentry Pre-Release Medicaid Services for Justice-Involved Individuals (see Expenditure Authority #7). The table below identifies the MEGs that are used for the Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test 2

MEG	TREND	DY 7 PMPM	DY 8 PMPM	DY 9 PMPM	DY 10- PMPM	DY 11- PMPM	DY 12 PMPM
Reentry Expansion Adults	5.1%	$2,080.41	$2,146.10	$2,255.55	$2,370.58	$2,491.48	$2,602.31
Reentry Non-Expansion Adults and Children	4.4%	$2,061.39	$2,117.62	$2,210.80	$2,308.08	$2,409.64	$2,502.16

14.8. **Hypothetical Budget Neutrality Test 3: SMI/ IMD (see Expenditure Authority #5).** The table below identifies the MEGs that are used for the Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget

neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test are counted as WW expenditures under the Main Budget Neutrality Test.

Table 6: Hypothetical Budget Neutrality Test 3							
MEG	**TREND**	**DY 7-PMPM**	**DY 8-PMPM**	**DY 9-PMPM**	**DY 10 PMPM**	**DY 11-PMPM**	**DY 12 PMPM**
SMI/IMD Non-Expansion Adults	4.9%	$3,513.67	$3,685.84	$3,866.45	$4,055.91	$4,254.65	$4,436.52
SMI/IMD Expansion Adults	5.1%	$3,738.89	$3,929.57	$4,129.98	$4,340.61	$4,561.98	$4,764.92

14.9. Monitoring Budget Neutrality for Traditional Health Care Practices. As discussed earlier, the expenditure authority provided for the coverage of traditional health care practices is limited to practices that are delivered by or through certain facility types that are defined by the IHCIA and ISDEAA (laws that stem from the unique government-to government relationship between the federal government and Indian Tribes). This expenditure authority is also limited to coverage for Medicaid beneficiaries who are able to receive services from those facilities. Further, traditional health care practices are being covered as a complement to services covered by Medicaid under existing authorities. This expenditure authority is not likely to increase overall expenditures beyond what those expenditures could have been without the demonstration. This expenditure authority will not expand the Medicaid-eligible populations, and CMS anticipates that the Medicaid payment rate for most of these services will be the IHS AIR. CMS has therefore determined that this coverage of traditional health care practices is expected to be budget neutral and will not require a specific budget neutrality expenditurelimit. The state will be held to the general monitoring and reporting requirements, as per the STCs. Failure to meet the monitoring and reporting requirements might result in CMS requiring the state to include these expenditures in the budget neutrality agreement for this demonstration, to ensure that CMS has sufficient information to support its initial determination that the approval of these expenditures is expected to be budget neutral. CMS reserves the right to request budget neutrality expenditures and analyses from the state at any time, or whenever the state seeks a change to the demonstration, per STC 3.7. The state must still report quarterly claims and report expenditures on the CMS 64.9 form.

14.10. **Composite Federal Share.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

14.11. **Budget Neutrality Monitoring Tool and Reporting Requirements.** Per 42 CFR 431.428, the state must document the financial performance of the demonstration. The state must provide quarterly budget neutrality status updates that meet all reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs (including the submission of corrected budget neutrality data upon request), using the Budget Neutrality Monitoring Tool provided through the Demonstration Evaluation Management and Oversight System (DEMOS). The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in the Monitoring Budget Neutrality for the Demonstration section. The quarterly budget neutrality status updates are due no later than 60 calendar days following the end of each demonstration quarter, while the fourth-quarter information is due no later than 90 calendar days following the end of the DY. These monitoring reports are subject to the deferral as described in STC 11.1. CMS will provide technical assistance, upon request.8

14.12. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the life of the demonstration approval period, which extends from October 1, 2026 to September 30, 2031. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Tests have been exceeded, the excess federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test will be based on the time elapsed through the termination date.

14.13. **Corrective Action Plan.** If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 7: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**

[8] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

DY 1	Cumulative budget neutrality limit plus:	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

15. MONITORING ALLOTMENT NEUTRALITY

15.1. **Reporting Expenditures Subject to the Title XXI Allotment Neutrality Agreement.** The following describes the reporting of expenditures subject to the allotment neutrality agreement for this demonstration:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual.

b. Use of Waiver Forms. Title XXI demonstration expenditures will be reported on the following separate forms designated for CHIP (i.e., Forms CMS-21 Waiver and/or CMS-21P Waiver), identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). The state must submit separate CMS-21 waiver forms for each title XXI demonstration population.

c. Premiums. Any premium contributions collected under the demonstration shall be reported to CMS on the CMS-21 Waiver form (specifically lines 1A through 1D as applicable) for each title XXI demonstration population that is subject to premiums, in order to assure that the demonstration is properly credited with the premium collections.

d. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the Form CMS-21 Waiver, net expenditures related to dates of service during the operation of the demonstration.

15.2. **Standard CHIP Funding Process**. The standard CHIP funding process will be used during the demonstration. The state will continue to estimate matchable CHIP expenditures on the quarterly Forms CMS-21B for CHIP. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must report demonstration expenditures through Form

CMS-21W and/or CMS-21P Waiver for the CHIP population. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver form with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

15.3. Title XXI Administrative Costs. Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap described in section 2105(c)(2)(A) of the Act.

15.4. Limit on Title XXI Funding. The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 16 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

15.5. Exhaustion of Title XXI Funds for CHIP Population. If the state exhausts the available title XXI federal funds in a federal fiscal year during the period of the demonstration, the state must continue to provide coverage to the approved title XXI separate state plan population.

16. SCHEDULE OF DELIVERABLES FOR THE DEMONSTRATION PERIOD

Deliverable	Timeline	STC Reference
Reentry Demonstration Initiative Implementation Plan	120 days after reentry demonstration approval.	STC 8.12
Reentry Demonstration Initiative Reinvestment Plan	180 days after reentry demonstration approval.	STC 8.13
Evaluation Design	No later than 180 calendar days after approval of the demonstration. Revised no later than 60 days after receipt of CMS comments.	STCs 12.3 and 12.4
Reentry Demonstration Initiative Rapid Cycle Report	180 days after reentry go-live.	STC 12.7
Interim Evaluation Report	One year prior to the end of the demonstration period, or when the extension application is submitted, whichever is sooner. Revised no later than 60 calendar days after receipt of CMS comments.	STC 12.7
Summative Evaluation Report	No later than 18 months after the end of the demonstration period. Revised no later than 60 calendar days after receipt of CMS comments.	STC 12.8
Annual Monitoring Report	No later than 180 calendar days after the end of each demonstration year.	STC 11.5
SMI/SED Implementation Plan (including Health IT Plan and Financing Plan)	No later than 90 calendar days after approval of the demonstration.	STCs 6.2, 6.3, 6.4
SUD and SMI Mid-Point Assessments	No later than the end of the third year of the approval of the program. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.6
Reentry Demonstration Initiative Final Reinvestment Assessment	One year after end of demonstration period.	STC 8.13.d

ATTACHMENT A
SUD Implementation Plan and Health Information Technology Plan

Maine Department of Health and Human Services: Substance Use Disorder Care Initiative 1115 Waiver Implementation Plan

Contents

Introduction

The State of Maine, including the Department of Health and Human Services ("the Department"), have dedicated significant resources to developing a coordinated response to the opioid epidemic and to the needs of Maine people with Substance Use Disorders (SUD) more broadly. This 1115 waiver is one component of this response, and will play a pivotal role in increasing capacity for residential treatment facility services, and serve as a framework for specific goals and milestones that the Department shares with the Centers for Medicare and Medicaid Services (CMS).

It is important to note that there are many additional assessments, planning projects/awards, and funding opportunities in which the State is involved that intersect and align with this Implementation Plan, including:

- The Governor's Office Maine Opioid Response Strategic Action Plan which lays out strategies to reduce the negative health and economic impacts of SUD and Opioid Use Disorder (OUD) on individuals, families, and communities in Maine. This plan is overseen by the Maine Director of Opioid Response.
- MaineCare's SUPPORT ACT 1003 award ("SUPPORT for ME") to increase the treatment capacity of MaineCare providers to deliver SUD treatment and recovery services.
- MaineCare's Maternal Opioid Misuse model ("MaineMOM") to improve care for pregnant and postpartum women with OUD and their infants by integrating maternal and substance use treatment services.
- Numerous assessments of the SUD treatment and recovery system, through Pew Charitable Trust and the Urban Institute, and many other related efforts within the Department.
- The Family First Prevention Services Act (FFPSA) provides opportunities for collaboration across state systems to identify primary, secondary, and tertiary prevention services that can support families in being safe, healthy, and successful by reducing risk and safety factors. FFPSA includes federal support for evidenced based mental health, substance use, and in home support services in an effort to prevent out of home placements for children at imminent risk of entering foster care.
- Several federal awards to the Department with activities spanning prevention, use of health information technology, harm reduction, treatment, etc.

These efforts, and others, represent moving parts of the SUD response in Maine. This Implementation Plan is intended to highlight key Department activities that advance the specific objectives of the 1115 waiver and does not comprise an exhaustive list of activities taking place currently, or planned, with the Department's SUD response; this Plan will need to be updated over time. Additionally, this Plan does not highlight activities with primary responsibility/oversight outside of the Department; further, there is a focus on activities that relate to MaineCare policies and procedures. Lastly, while the Department considers recovery support services to be integral to effective SUD care, discussions of these efforts fall outside the scope of this Implementation Plan. Please refer to the above linked reports and initiatives for information on these efforts.

Milestones to be Addressed in Maine's 1115 Waiver Implementation Plan

Milestones
Access to critical levels of care for OUD and other SUDs;
Widespread use of evidence-based, SUD-specific patient placement criteria;
Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
Sufficient provider capacity at each level of care, including MAT;
Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD; and
Improved care coordination and transitions between levels of care.

Milestone Implementation Plan

This section contains information detailing Maine's strategies for meeting CMS' six stated milestones over the course of the demonstration, including which party/office is lead for the planned actions.

Access to Critical Levels of Care for OUD and Other SUDs

Current State: MaineCare offers broad SUD and OUD service coverage across the continuum of care. Generally, these services align with an American Society of Addiction Medicine (ASAM) level of care. These covered services include, but are not limited to, the following (see Attachment A for a full description of covered services and their page in the Maine Medicaid State Plan):

- Early Intervention Services
- Outpatient Services
- Intensive Outpatient Services;
- Medication Assisted Treatment (MAT)
- Intensive levels of care in residential and inpatient settings; and
- Medically supervised withdrawal management

As it specifically relates to access to care, the Office of Behavioral Health has partnered with Maine Medical Association's Quality Improvement team to provide training on implementation of rapid induction services in Emergency Departments (EDs), along with supports and trainings for the warm-handoff to community-based treatment. Through their work, 23 of Maine's 33 EDs now offer rapid induction, with four more expected to implement in spring/summer 2021. Funding for this initiative will end September 2022.

The Department is not proposing to add any additional SUD services at this time; however, the Department has identified utilization management limits for residential care that will be removed to ensure that there is no administrative barrier to clinically appropriate admissions for this level of

care (see Table 1). Table 1 outlines specific activities that will improve access to services across the continuum of care within 12-24 months of demonstration approval.

Table 1. Future State: Plan for Access Improvements

Action Items	Implementation Timeframe /Parties Responsible
Early Intervention	
Incorporate Screening, Brief Intervention, and Referral to Treatment (SBIRT) in MaineCare's new primary care alternative payment model.	Rule provision to be effective December 2022/MaineCare Value-Based Purchasing
Outpatient Services	
Clarify through MaineCare rulemaking that partial hospitalization services are approved outpatient services for psychiatric and non-psychiatric hospitals. The rulemaking will be proposed by August 2021 and will follow the process for public comment, response to comment with any necessary amendments, and adoption.	Rule to be effective November 2021/MaineCare Policy
Continue to support the goal of all EDs in Maine offering MAT by offering training on implementation of rapid induction, along with supports and trainings for the warm-handoff to community-based treatment through the ongoing work of the Office of Behavioral Health and the Maine Medical Association's Quality Improvement team.	September 2022/Office of Behavioral Health
Intensive Outpatient Program	
Finalize an independent rate evaluation of SUD Intensive Outpatient Programs. Rate evaluations consist of policy review, literature review, review of similar services reimbursed through Medicaid and private insurers, stakeholder sessions, provider surveys including review of cost reports, drafting rate models, reviewing draft models with stakeholders, public comment, and final revision. Currently, the rate evaluation comment period has closed and the final revision is pending. Following the final rate proposal, the decision to amend rates will be considered as part of MaineCare's comprehensive rate system evaluation and subject to the availability of funds.	July 2021/MaineCare Rate Setting
Medication Assisted Treatment	

Update the Maine Medicaid State Plan to reflect the required CMS templates in accordance with the provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) relating to mandatory coverage of MAT for OUD.	Submitted 3/31/21, anticipated effective 10/1/2020/ MaineCare Policy
Residential and Inpatient Treatment (including medically supervised withdrawal management)	
Finalize an independent rate evaluation of SUD residential treatment facilities. Rate evaluations consist of policy review, literature review, review of similar services reimbursed through Medicaid and private insurers, stakeholder sessions, provider surveys including review of cost reports, drafting rate models, reviewing draft models with stakeholders, public comment, and final revision. Currently, the rate evaluation comment period has closed and the final revision is pending. Following the final rate proposal, the decision to amend rates will be considered as part of MaineCare's comprehensive rate system evaluation and subject to the availability of funds.	July 2021/MaineCare SUPPORT for ME and Rate Setting
Propose rulemaking to remove single admission limitation from Clinically Managed Low Intensity Services and Clinically Managed Population-Specific High Intensity Residential Programs as well as increasing the number of allowable days per admission in Clinically Managed Residential Services from 30 to 45 days in Residential Rehabilitation Type I and from 45 to 60 days in Residential Rehabilitation Type II.	Rule to be effective by October 2021/MaineCare Policy

Use of Evidence-based, SUD-specific Patient Placement Criteria

Current State: MaineCare already requires that providers assess treatment needs based on ASAM Criteria for nearly all SUD services; these requirements are stated in the MaineCare Benefits Manual which is the State regulation for the MaineCare program (Title 22 M.R.S, Chapter 855), for nearly all SUD services. The exception to this is that the Opioid Health Home (OHH) policy does not currently require ASAM placement tools, though it is common practice among providers of the OHH service. The OHH policy does require the documentation of an OUD as part of the eligibility process.

For residential SUD treatment services, the current MaineCare regulations references version 2 of ASAM; however, MaineCare is updating this reference to read "the most current edition" of ASAM through a rulemaking (to be effective October 2021 – see Table 3); this is the only instance where MaineCare rule references an outdated version. No other ASAM related changes are needed across other SUD services in the MaineCare Benefits Manual.

Currently, there is limited utilization management by an Administrative Services Organization (ASO) to assess patient placement for SUD services and to ensure interventions are appropriate for the diagnosis and level of care; this occurs only as described in Table 2 below. Currently, there is no systematized, routine/ongoing, utilization management approach to ensuring members have timely access to SUD services at the appropriate levels of care outside of the Office of Behavioral Health's Substance Abuse Prevention and Treatment block grant requirements.

(Legend: Prior Authorization Review: Requires clinical review; **Initial Registration:** Clinical review for appropriate diagnosis(es) and duplication and non-concurrent services; **Continued Stay Review:** Requires clinical review for continuation of care; and/or **Discharge Review:** Required for all services on last date of service)

Table 2: Current Utilization Management of SUD services

Service	Type of Utilization Management	Frequency/Description of Review
Targeted Case Management	Initial Registration, Continued Stay Review, Discharge Review	Initial authorization of 30 days with a maximum continued stay of 90 days
Outpatient Services (Comprehensive Assessment, Therapy and Counseling Services)	Initial Registration, Continued Stay Review, Discharge Review	Initial authorization of 365 days with a maximum continued stay of 180 days
Medication Management Services	Initial Registration, Continued Stay Review, Discharge Review	Initial authorization of 180 days with a maximum continued stay of 180 days
Medication Assisted Treatment (Methadone/Opioid Treatment Programs)	Initial Registration, Continued Stay Review, Discharge Review	Initial authorization of 180 days with a maximum continued stay of 180 days
Opioid Health Homes	Initial Registration, Continued Stay Review, Discharge Review	Initial authorization of 180 days with a maximum continued stay of 180 days

Intensive Outpatient Services	Prior Authorization, Continued Stay Review, Discharge Review	Initial authorization of 30 days with a maximum continued stay of 7 days
Clinically Managed Low Intensity Residential Services	N/A	Limited to a single admission of 180 covered days on an annual basis, unless a member has a documented need to exceed that limit. Any stay in excess of 180 days requires documented need in the member's service plan. *See Table 1, Future State
Clinically Managed Residential Services: 1.Residential Rehabilitation I 2.Residential Rehabilitation II 3.Adolescent Residential Rehabilitation	N/A	1.Limited to 30 days for any single admission, with a limit of 2 admissions and 30 covered days on an annual basis. Any continuous stay in excess of 28 days requires documented need in the member's treatment plan *See Table 1, Future State 2.The term of residency shall not exceed 45 days *See Table 1, Future State 3.Designed to last at least 3 months and limited to 12 months per single admission.

Clinically Managed Population-Specific High Intensity Residential Programs	N/A	Limited to a single admission of 270 covered days on an annual basis unless a member has a documented need to exceed that limit. Any stay in excess of 270 days requires documented need in the member's treatment plan.*See Table 1, Future State
Medically Monitored Inpatient Programs	N/A	Limited to 7 days for each admission episode, with no limit on the number of admissions or covered days on an annual basis.
Inpatient	Prior Authorization, Initial Registration, Continued Stay Review, Discharge Review (Varies based on the hospital and services provided)	All hospital admissions and continued stays must be certified for medical necessity and length of stay through an appropriate utilization review plan.
Psychiatric Residential Treatment Facility Services	Prior Authorization, Continued Stay Review, and Discharge Review for limited services	Must meet Clinical Certificate of Need criteria

The Department will implement the following activities and utilization management approaches to ensure that members have access to SUD services at the appropriate level of care, interventions are appropriate for the diagnosis and level of care, and that there is an independent process for reviewing placement in residential settings. This milestone will be met within 12-24 months of demonstration approval.

Table 3. Future State: Plan for Improvements in Evidence-Based Patient Placement Criteria

Action Items	Timeframe/Parties Responsible
Establishment of a Utilization Management Approach for Appropriate Access and Level of Care, Including an Independent Process for Reviewing Placement in Residential Treatment	
Require residential SUD providers to submit admissions to the Department's behavioral health utilization management ASO including the ASAM assessment used for placement purposes. The ASO will use the ASAM assessments to do post utilization review for appropriate level of care, starting with a sampling of admissions. Providers will have a window of time, upon admission, to submit the data to the ASO to avoid potential interruption with timely access to services. The Department and the ASO will meet in July 2021 to establish this process (including any ASO contract amendments needed, provider trainings, provider communications, etc.). By December 2021, the Departments contract with the ASO will be updated, if needed, to encompass this effort. The timeframe for full implementation of this process is March 2022.	March 2022/ASO/MaineCare Policy/Office of Behavioral Health
Evaluate options with our ASO to enhance clinical review of placements across the continuum of care and based on the ASAM assessment tools and the incorporation of waitlist/timely access tracking functionality (as currently used for some mental health services). The Department and the ASO will meet in June 2021 to begin these conversations. By September 2021, the Department and ASO will finalize a proposal for incorporation of timely access tracking for SUD services and appropriateness of care assessment. This will include a review of other Medicaid programs' best practices. By December 2021, the Departments contract with the ASO will be updated, if needed, to encompass this effort. Beginning December 2021, the Department will hold provider trainings to initiate a soft-roll out of this	March 2022/ASO/MaineCare Policy/Office of Behavioral Health

new functionality and review process. This process will be piloted until March 2022, when it will become required for all impacted SUD services.	
Use of Evidence-based SUD-specific Patient Placement Criteria	
Amend MaineCare regulations for residential SUD treatment providers to reference the most recent ASAM version.	Rule to be effective October 2021/MaineCare policy
Evaluate the structure of MaineCare policy to identify and recommend changes to more clearly outline program descriptions and provider qualifications and their relationship to ASAM criteria. Amend MaineCare policy, offer provider training, and/or offer sub-regulatory guidance, as needed.	Work to commence October 2021 to target rule effective date of December 2022 or guidance/training date of July 2022.
Amend the OHH policy, through rulemaking, to require the use of ASAM criteria to assess patient placement and as treatment guidelines.	Rule to be effective December 2021/MaineCare Policy/MaineCare Value-Based Purchasing
Establish an incentive within MaineCare's new value-based primary care model for primary care providers to offer MAT services in alignment with ASAM guidelines for appropriate level of care, have a cooperative referral process with specialty behavioral health providers including a mechanism for co-management for the provision of MAT as needed, or be co-located with a MAT provider.	Rule to be effective December 2021/MaineCare Policy/MaineCare Value-Based Purchasing
Assess training needs in the community that would facilitate improvements in the utilization of ASAM assessment tools for placement purposes. Subsequently, the Department will provide training support, namely, through the launch of the SUPPORT for ME Learning Community which is a statewide learning network for provider training around behavioral health issues, set to launch by January 2022.	January 2022/Office of Behavioral Health
Provide users (health care providers, consumers, case managers, families, etc.) of the service locator tool, an online placement assessment tool (based on ASAM criteria) to inform service	May 2021 (Service Locator Contract finalized)/ September 2021 (Service Locator

outreach. While this is not a clinical assessment, it furthers the impact of this waiver milestone. Utilize information from the service locator tool to assess access to SUD services at the appropriate level of care.	Implemented)/MaineCare Support for ME

Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Current State: The MaineCare Benefits Manual, which outlines the State's regulation for the Medicaid program, utilizes ASAM criteria as a basis for the provider qualifications of residential services and ASAM assessments are required for placement in residential treatment programs; additionally, state residential licensing regulations also already includes ASAM-aligned SUD-specific program standards regarding the types of services, hours of clinical care and credentials of staff. Currently, responsibility for review and quality assurance of residential treatment facilities is divided across the different Department offices, as described in Table 4. While, the regulatory oversight of residential treatment programs already includes chart reviews, technical assistance, and site visits, the Department is exploring ways to strengthen programmatic oversight of these processes, including whether there are areas of improvement around the assessment of ASAM standards (e.g. types of services, hours of clinical care, and credentials of staff). One area identified is that if a residential treatment provider is MaineCare enrolled, but does not hold a contract with the Office of Behavioral Health for block grant funding, there is currently a gap in programmatic quality assurance activities (e.g. site visits) (please note that regulatory standards of residential treatment providers is already in place, as described above). Additionally, the Office of Child and Family Services is seeking greater involvement in oversight of all behavioral health services for individuals under 21 years of age as part of their specialized Children's Behavioral Health team.

Table 4: Current Process for Assurance of Residential Treatment Facility Program Standards

Office of MaineCare Services	Division of Licensing and Certification	Office of Behavioral Health	Office of Child and Family Services

MaineCare regulations (see MaineCare Benefits Manual, Chapters II and III, Section 97, Private Non-Medical Institution Services) outline ASAM-aligned program expectations and conducts reviews, when necessary, as part of Medicaid program integrity efforts.	As outlined in the SUD facility licensing regulations, the Division of Licensing and Certification assesses programs for the following items: • Program descriptions for residential services; • Clinical assessments; • Admission and discharge dates to ensure compliance with program length limits; • Progress notes and treatment plans indicating number of counseling hours and types of treatment/support provided, including group and individual counseling, living skills/vocation training; • Discharge summaries and treatment follow up plans; • Credentials of employees providing services and supervision to ensure compliance with regulatory requirements for clinical licensure.[6]	As outlined in manuals and contracts with residential treatment providers,[7] the Office of Behavioral Health conducts annual site visits with residential treatment facilities which hold contract under the Substance Abuse Prevention and Treatment block grants. As part of these site visits, client charts are reviewed, as well as other program documents, to ensure compliance with block grant requirements, which include utilizing ASAM placement criteria to determine eligibility.	Currently not involved in quality assurance or licensing.

[6] 14-118 CMR Chapter 5, Regulations for Licensing and Certifying of Substance Abuse Treatment Programs:

[7] These contracts/manuals are not available online.

Maine also seeks to improve access to medications for OUD for individuals in residential treatment programs. Currently, MaineCare and licensing regulations require that residential treatment providers facilitate access to any specialized service beyond their capabilities; however, through recent outreach, the Department understands that there are some potential policy and reimbursement challenges to facilitating access to medications for OUD. While facilitation of MAT services for patients residing in residential treatment is already in MaineCare regulation, this language is stronger within the Department's state-funded contracts. Additionally, the language in the MaineCare Benefits Manual could be improved to align with ASAM on the use of MAT and to reduce stigmatizing language; for example, discussion of a "substance free lifestyle." In alignment with MaineCare's value-based purchasing efforts, there is interest in exploring a gradual transition to rewarding the direct provision of MAT in these settings through a combination of financial incentives (e.g. assessment of continuous pharmacotherapy, higher payments for facilities that offer MAT onsite) and regulatory changes. Lastly, recent reports suggest additional training/education may support evidence-based integration of medications for OUD into residential settings.

The Department plans to implement the following activities to strengthen program standards and provider qualifications for residential treatment facilities, including establishing a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12 to 24 months of demonstration approval.

Table 5. Future State: Plan for Residential Treatment Provider Program Standards and Qualifications

Action Items	Timeframe/Parties Responsible
Establishment of a Residential Provider Review Process	
Improve the integrated oversight processes for residential treatment providers to assure compliance with ASAM standards across the Division of Licensing and Certification, the Office of MaineCare Services, the Office of Behavioral Health, and the Office of Child and Family Services. All relevant parties will participate in a cross-Department meeting series to establish clear rules and responsibilities for an improved integrated oversight process in July 2021. This will include documentation of types of oversight activities, scope of reviews/areas of focus, frequency, follow-up actions, and communication protocols between parties.	July 2021/DHHS wide

Beginning July 2021, the Office of Behavioral Health will take responsibility for the programmatic oversight for all adult residential treatment facilities enrolled in MaineCare, regardless of whether they hold a contract specifically with their office, effective July 2021. This will ensure site visits occur at all facilities.	July 2021/Office of Behavioral Health
Amend MaineCare Policy to support the Office of Child and Family Services quality assurance activities by requiring provider participation in the quality assurance activities.	Rule to be effective October 2021/MaineCare Policy
Beginning October 2021, the Office of Child and Family Services will take responsibility for the quality oversight of the limited number of adolescent treatment facilities by reviewing and providing feedback and technical assistance to providers related to reportable events, trauma-informed care agency assessments, clinical records, and fidelity monitoring.	October 2021/Office of Child and Family Services
Establishment of a Requirement that Residential Treatment Providers Offer MAT On-site or Facilitate Access to MAT Off-site	
Amend the MaineCare regulations to replace general language that is misaligned with ASAM regarding the use of MAT and include language to specifically require the facilitation of MAT off-site if that is not a service offered within the facility.	October 2021/MaineCare Policy
Assess current policies and practices, including duplication concerns, reimbursement, administrative issues and the current counseling waivers, aimed at reducing barriers and improving integration of MAT in existing residential programs. The assessment will occur through provider surveys, stakeholder groups, and internal review/decision-making.	December 2021/MaineCare Policy
Establishment of Residential Treatment Provider Qualifications in Medicaid policy that align with ASAM standards.	
Evaluate the structure of MaineCare policy to identify and recommend changes to more clearly outline program descriptions and provider qualifications and their relationship to ASAM criteria. Amend MaineCare policy, offer provider training, and/or offer sub-regulatory guidance, as needed.	Work to commence October 2021 to target rule effective date of

	December 2022 or guidance/training date of July 2022.
Amend MaineCare regulations for residential SUD treatment providers to reference the most recent ASAM version.	Rule to be effective October 2021/MaineCare policy

Sufficient Provider Capacity at each Level of Care, including MAT

Current State: The Department participated in various internal and external inquiries regarding capacity of Medicaid-covered providers to meet the SUD-related needs of MaineCare members both as a whole and with a focus on the recent MaineCare expansion population. This ranged from external reviews of the full service delivery system informed by key informant interviews and review of publicly available data, efforts to map service capacity using administrative data on licensed and unlicensed SUD treatment providers, to internal assessments for various federal grant applications that involved compiling both high-level and detailed data for the SUD system and priority subpopulations in Maine. As a result of one of the funding applications, OMS was awarded over $2M through the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity through a federal cooperative agreement with CMS after a thorough assessment of MaineCare members' SUD-related needs and the capacity of our treatment and recovery system (SUPPORT for ME). The results of the SUPPORT for ME assessment, concluding in September 2021, will provide the basis of additional actions that may be unidentified at this time. SUPPORT for ME's capacity assessment includes key informant interviews with providers, community listening sessions for individuals accessing treatment and recovery services, and quantitative analysis.

Table 6 outlines specific activities that will improve provider capacity across the continuum of care within 12 months of demonstration approval.

Table 6: Future State: Plan for Provider Capacity Improvements

Action Items	Implementation Timeframe /Parties Responsible
Impacting all levels of care	

Produce assessments of SUD service provider capacity relative to need across the service continuum and including recovery supports. This will include a discussion of barriers to provider capacity, including willingness to offer these services, and how to fill gaps in MaineCare coverage (e.g. eligibility gaps, workforce constraints).	Ongoing through September 2021/ MaineCare SUPPORT for ME
Conduct an evaluation of MaineCare rates and rate setting system and develop and implement a plan for the creation of a comprehensive, streamlined, and coherent system that will support MaineCare members' access to high value-services.	Ongoing through November 2021/MaineCare Rate Setting
Deploy a service locator tool which will assist the public, including health care providers and consumers, to search for local behavioral health providers with capacity to provide SUD/OUD care. This tool will go beyond the existing MaineCare provider directly by offering a straightforward way to identify treatment providers and treatment options, including provider capacity/appointment availability. This tool will produce ongoing assessment of the number of SUD service providers accepting new patients.	May 2021 (Service Locator Contract encumbered)/ September 2021 (Service Locator Implemented)/MaineCare Support for ME
Fund SUD specific telehealth support through the North East Telehealth Resource Center to expand effective utilization of telehealth services.	Ongoing through September 2021/ MaineCare SUPPORT for ME
Establish an incentive within MaineCare's new value-based primary care model for primary care providers to offer MAT services in alignment with ASAM guidelines for appropriate level of care, have a cooperative referral process with specialty behavioral health providers including a mechanism for co-management for the provision of MAT as needed, or be co-located with a MAT provider.	Rule to be effective December 2021/MaineCare Policy/MaineCare Value-Based Purchasing
Residential Treatment (including medically supervised withdrawal management)	

Implement Maine's approved 1115 IMD Exclusion Waiver for SUD services and work with current and prospective residential treatment providers to understand their options for serving MaineCare members in facilities that have more than 16 beds.	January 2021-December 2025/MaineCare Policy
MAT	
Amend the OHH rule to improve access to treatment, reduce administrative barriers to providing MAT, promote evidence-based treatment standards, and reinforce integration with primary care. This includes more flexibility and clarity around counseling expectations and the inclusion of methadone as a form of MAT under this model (all forms of buprenorphine, buprenorphine derivatives, and naltrexone are already used in the model). MaineCare is also assessing feasibility and appropriateness of expanding the OHH model to allow additional SUD chronic condition eligibility, such as stimulant use disorder. Stimulant use is reportedly on the rise in Maine both in cases of polysubstance use and independently.	Rule to be effective December 2021 /MaineCare Value-Based Purchasing Ongoing/MaineCare Value-Based Purchasing
Review all MAT policies for policy and utilization management restrictions that may impact access to evidence-based and low-barrier care.	Ongoing through September 2021/MaineCare Policy and Pharmacy
Explore mobile MAT options in order to reach vulnerable populations statewide.	Ongoing through December 2022/ Office of Behavioral Health
Gather data on barriers and gaps to accessing SUD treatment for youth Conduct online survey for youth and young adults (ages 12-21) who have been impacted by SUD to better understand their perspective on SUD capacity and treatment and recovery needs in Maine.	Ongoing through September 2021/MaineCare SUPPORT for ME

Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD

Current State: Over the past five years, the Department has focused heavily on the implementation of revised opioid prescribing guidelines as well as implementation of strategies to increase utilization and improve functionality of Maine's Prescription Drug Monitoring Program (PDMP). This work included the implementation of legislation (P.L. 488, 127th Legislature) titled "An Act to Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program," numerous benefit changes within the MaineCare program to promote alternative treatments to pain management, and sustained academic detailing to support safe prescribing. There is also a PDMP Advisory Committee, consisting of external stakeholders (e.g. providers, pharmacists, health care organizations) and state personnel, which meets bimonthly, to increase utilization and improve functionality of the PDMP.

As of the beginning of Governor Mills' Administration, there has also been a focus on expanded coverage of and access to naloxone for overdose reversal. MaineCare coverage for naloxone is already in place with low-barrier access and additional efforts are underway to incentivize and/or require co-prescribing of naloxone with MAT. There are also many initiatives through the Office of Behavioral Health to deploy various distribution networks, including exploring ways to fund more direct distribution and leave-behind doses of naloxone.

Table 7. Future State: Plan for Additional Comprehensive Treatment and Prevention Strategies to Address OUD

Action Items	Timeframe/Parties Responsible
Expand Coverage of and Access to Naloxone	
Consider implementing a standing order for naloxone.	September 2021/ MaineCare Pharmacy
Implementation of Strategies to Increase Utilization and Improve Functionality of the PDMP	
Improve functional and data analytic capacity of the PDMP (see Attachment B)	Ongoing through November 2021/Office of Behavioral Health
Other Strategies to Prevent Prescription Drug Misuse and Overdose Risk	

Assess concurrent use of opioids and benzodiazepines in MaineCare's Medicaid Accountable Care Organizations, as part of this program's performance-based payments. This data will be evaluated collaboratively with these entities and with the 1115 monitoring reports to identify areas of intervention for improvement.	December 2021 and Ongoing/MaineCare Value-Based Purchasing
Implementation of Opioid Prescribing Guidelines	
N/A already in place.	

Improved Care Coordination and Transitions between Levels of Care

Current State: MaineCare regulations (MaineCare Benefits Manual, Section 97) require residential treatment providers to deliver scheduled therapeutic and rehabilitative treatment consisting of transitional services that are designed to facilitate a member's return to the community. Additionally, programs are required to have written policies and procedures to facilitate client referrals and coordination of services internally and externally. Residential treatment providers are also required by MaineCare to have written policies and procedures regarding discharge and treatment follow-up.

In addition to the residential treatment provider requirements around care coordination and transitions of care, MaineCare covers a limited set of populations with SUD through Targeted Case Management (TCM, MaineCare Benefits Manual, Section 13), offers an OHH program to serve individuals with OUD (MaineCare Benefits Manual, Section 93), and allows SUD as a qualifying condition in their primary care Health Home model (MaineCare Benefits Manual, Section 91). The MaineCare provider requirements for these (and other non-SUD specific) care coordination and/or case management services include specific expectations around transitions of care. The Health Home programs includes a service called Comprehensive Transitional Care which includes assisting members and family/guardian/caregivers, as appropriate, with the discharge process. For the OHH model, this specifically includes requirements of outreach to assist the member in returning to treatment for OUD, connecting or re-connecting members to other providers or community-based services post-discharge, and working to prevent avoidable readmissions. While care transition support is considered a basic element of all case management services, including TCM, OHH, Behavioral Health Homes (BHH), primary care Health Homes, and Community Integration services for members with serious mental illness, there is a need to assess and improve the experience and effectiveness of these services for members with SUD. Part of this work includes creating clear expectations and accountability for discharging as well as receiving providers. Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities will be

aggressively addressed through this 1115 waiver. This milestone will be achieved within 24 months of demonstration approval and will be tracked through the 1115 monitoring measures consistently and on an ongoing basis.

Of note, the Department has additional initiatives to improve care transitions out of state prisons and local jails, including processes to ensure active/full MaineCare upon release for eligible MaineCare members, and state-funded MAT and care coordination transition services to facilitate transitions to MaineCare-covered community services.

The Department has also partnered with community providers to implement and continuously improve the BHH and OHH programs (from 2014 and 2017, respectively) to improve coordination of mental and physical health. These efforts are critical to ensure that providers involved in care transitions account for all of an individuals health and social needs during transitions, including establishing or re-establishing primary and specialty physical health services. Health Home providers participate in regular peer learning and technical assistance convenings with the Department to continuously improve these efforts.

The BHH program, which serves adults with serious mental illness and children with serious emotional disturbance (and many individuals having co-occuring SUD), has core competencies surrounding integration of physical and behavioral health and requires formal agreements between BHH organizations and primary care practices in their service area. This program has a pay-for-performance measure focused on the intersection of physical and behavioral health, specifically assessing metabolic screening for individuals on antipsychotic medications.

Building upon the BHH program and the integrated team-based approach to care, the Department introduced OHHs in 2017 to improve the quality and availability of integrated MAT services statewide. This program currently serves over 2,600 MaineCare members with OUD monthly, with utilization increasing monthly due to increasing provider capacity and increased Medicaid eligibility. This program also focuses on whole-person care and requires the MAT provider to connect members to primary care and establish releases of information with the members' primary care provider, with member consent.

Lastly, the SUPPORT for ME team recently conducted a care integration assessment adapted from the Maine Health Access Foundation (MeHAF) Site Self-Assessment tool across various provider types serving MaineCare members with SUD. The purpose of the assessment is to collect information from organizations to help MaineCare better understand the level of care within their organization and across several dimensions of care. A full analysis of these results will be reported in Spring 2021. In Table 8, we highlight that this program's focus on integration with physical health will be strengthened by a pay-for-performance provision within the next 12 months that is aligned with this 1115 performance measure of ensuring individuals with SUD access physical health care.

Table 8. Future State: Plan for Improved Care Coordination and Transitions between Levels of Care

Action Items	Timeframe/Parties Responsible
Implementation of Policies to Ensure Residential and Inpatient Facilities Link Beneficiaries with Community-Based Services	
Assess transitions of care (through provider surveys, stakeholder groups, and internal review/decision-making), including a specific focus on plans and procedures of residential treatment facilities (including medically supervised withdrawal facilities) to support effective/safe discharges (through incorporation of this in site visits and quality assurance activities).	December 2021/Office of Behavioral Health/Office of Child and Family Services
Develop mechanism for performance monitoring for residential treatment facilities, behavioral health inpatient facilities, and community providers to assess follow-up after a residential stay (e.g. seven days or less). The first step is to develop internal or contracted vendor support to routinely assess performance on designated follow-up care quality measures. MaineCare or it's vendor, will review data and work with internal and external stakeholders to share provider-level performance on this metric. MaineCare will consider opportunities to incorporate financial incentives/penalties related to this effort and other key metrics.	January 2022/MaineCare Value-Based Purchasing
Evaluate whether current duplication or other policies restrict provider's ability to engage in effective care transitions. The state will conduct an assessment through provider surveys, stakeholder groups, and internal review/decision-making.	Ongoing through April 2022/ MaineCare Policy
Amend MaineCare residential treatment facilities regulations to be more specific around requirements that these providers must coordinate with the member's treatment team, including but not limited to the member's case management, behavioral health home, or opioid health home providers to coordinate care and facilitate access to any identified services and supports, considering their physical and mental health needs.	Rule to be effective October 2021/MaineCare Policy

Additional Policies to Ensure Coordination of Care for Co-Occurring Physical and Mental Health Conditions	
Share targeted results of the Maine Health Access Foundation (MeHAF) Site Self-Assessment/care integration assessment with providers to seek feedback on opportunities for future technical assistance offerings or other supports needed to improve integration of SUD with other mental and physical health services.	July 2021/MaineCare SUPPORT for ME
Incorporate a pay-for-performance provision into the OHH model that includes a measure on annual primary care or ambulatory visits.	Rule to be effective December 2021/MaineCare Policy/ MaineCare Value-Based Purchasing
Convene residential treatment and BHH/OHH providers in a working group around transitions and integration of physical and behavioral health.	November 2021/MaineCare Value-Based Purchasing
Assess TCM and OHH eligibility for opportunity to include additional SUD conditions aimed at developing a more robust care management/care coordination system for individuals with SUD.	Ongoing through March 2022/ MaineCare Policy
Amend MaineCare Policy clearly state providers must coordinate with the member's treatment team, including but not limited to the member's case management, behavioral health home, or opioid health home providers to coordinate care and facilitate access to any identified services and supports, considering their physical and mental health needs.	Rule to be effective October 2021/MaineCare policy

Implementation Administration

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Attachment A: MaineCare Covered SUD Services

Service	Brief Description	SPA Page
Community-based Services		
Early Intervention Services	Services include screening and health risk assessment, Screening, Brief Intervention and Referral to Treatment (SBIRT), and evidence-based parenting interventions.	Attachment 3.1-A Page 2; item 5a
Targeted Case Management	Services consist of assessment, planning, referral and related activities, and monitoring and follow-up activities for individuals with a diagnosed SUD who are currently seeking treatment and are either pregnant, living with minor children, or an intravenous drug user.	Supplement 1 to Attachment 3.1-A Page 6a-6f
Outpatient Services (Comprehensive Assessment, Therapy and Counseling Services)	Services include comprehensive assessment, individual and group therapy for children and adults with mental health and co-occurring disorders.	Attachment 3.1-A Page 5; item 13a-Diagnostic Services: Attachment 3.1-A Page 5(a) and Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xii)
Medication Management Services	Services directly related to the psychiatric evaluation, prescription, administration, education and/or monitoring of medications intended for the treatment of mental health disorders, SUD, and/or co-occurring disorders.	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xxi)
Medication Assisted Treatment	Treatment for SUD that includes the use of methadone delivered in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA)	SPA # 21-0003 - Attachment 3.1-A Page 6, item 13d- Rehabilitative

	regulations. Services include assessment, planning, counseling, drug use disorder testing, and medication administration. Also includes MAT services that are delivered in an office-based setting, (e.g. OBOT or a certified Opioid Treatment Program (OTP).	Services: Attachment 3.1-A Page 5(a)(x)
Opioid Health Homes	Integrated MAT services, including office visits with a MAT prescriber, prescription medication for OUD, OUD counseling, comprehensive care management/care coordination/health promotion, urine drug screening, and peer recovery support services provided through a bundled rate.	Section 3.1-H
Intensive Outpatient Services	Intensive and structured service of alcohol and drug assessment, diagnosis, and treatment services in a non-residential setting for members who meet ASAM criteria level II.1 or II.5. Services include co-occurring mental health and SUD. Available to adults and children.	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xiv)
Residential		
Clinically Managed Low Intensity Residential Services	Services delivered according to ASAM level 3.1, including scheduled therapeutic and rehabilitative treatment designed to enable the member to sustain a substance free lifestyle in an unsupervised community situation. Available to adults.	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xix)
Clinically Managed Population-Specific High Intensity Residential Programs	Services delivered according to ASAM level 3.3, Category II, including scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment. The treatment mode may vary with the member's needs and	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xviii)

	may be in the form of individual, group or family counseling. Available to adults.	
Clinically Managed Residential Services	Services delivered according to ASAM level 3.5, including therapeutic treatment and planning consisting of assessment, diagnostic, and counseling services. Available to adults and children.	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xvi)
Medically Monitored Inpatient Programs	Services delivered according to ASAM level 3.7, including a planned structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. Services provide immediate diagnosis and care to members having acute physical problems related to substance use disorder. Available to adults and children.	Attachment 3.1-A Page 6, item 13d-Rehabilitative Services: Attachment 3.1-A Page 5(a)(xvii)
Inpatient		
Psychiatric Residential Treatment Facility (PRTF) Services	Comprehensive mental health treatment and/or SUD treatment to children and adolescents who, due to mental illness, SUD, or Serious Emotional Disturbance (SED), meet level of care requirements for a PRTF.	Attachment 3.1-A Page 7, item 16

Attachment B: Health IT Plan

As a component of Milestone 5,[8] Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), please find Maine's SUD Health IT Plan. In summary, Maine has a robust PDMP, administered by Appriss, that has been supported through legislative and programmatic effort; however, this plan will focus on three main areas of improvement that are based on user feedback and best practice review:

- Complete work to integrate Maine's PDMP and Health Information Exchange (HIE) systems
- Provider, pharmacy and health system engagement and education around PDMP-based SUD assessment and decision support, PDMP compliance, and workflow optimization
- Implementation of enhanced PDMP data analytics capabilities

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient-specific prescription data	Maine's PDMP is currently connected with 34 state PDMPs and the Military Health System, and connections with an additional 15 states are currently pending. We are integrating with another interstate data sharing tool, RxCheck that will allow us to connect with those PDMP's that are not currently able to connect	• Finalize connections between Maine's PDMP system and the 15 states currently pending • Explore establishing PDMP connections with US Territories and the Canadian province of New Brunswick	• The Office of Behavioral Health (OBH) administers the PDMP system in Maine. OBH's PDMP Coordinator will check in with the 15 pending states on a monthly basis to assess technological readiness for intrastate data sharing and establish these connections as the

[8] Milestone 5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is:

- Enhance the state's health IT functionality to support its PDMP; and
- Enhance and/or support clinicians in their usage of the state's PDMP.

	through the NAPD PMPi Interconnect.		technological progress allows. • OBH is managing a re-engagement with the Appriss AWARxE PDMP system, which includes RxCheck for intrastate data sharing. RxCheck will be implemented upon "Go Live" with Appriss (planned date 4/4/21). • OBH's PDMP Coordinator will communicate on a monthly basis with US Territories and New Brunswick, Canada to assess progress towards procuring and implementing PDMP systems; OBH will pursue connections as technological dependencies are clarified.
Enhanced "ease of use" for prescribers and other state and federal stakeholders	Prescribers (clinicians) and dispensers (pharmacies) are currently able to access Maine's PDMP directly as a stand-alone application or via established interoperability with over 150 different electronic health record (EHR) and pharmacy management systems. Prescribers can allow their delegates (clinical staff with special permissions set through the PDMP and connected to a specific	• Inclusion of scheduled I through V substances to provide authorized users with a broad set of information and tools required to support clinical decision-making at the time of prescribing or dispensing • Enhanced data integration, analytic, and reporting capabilities encompassing diverse SUD-related data sets to enable outcome measurement and actionable insights for treatment purposes.	The future state requires legislative changes and the request for these rule changes will be heard in the current legislative session running through July 2021.

	prescriber's DEA) to run Batch Patient Reports.		
Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	The State of Maine has a robust HIE infrastructure developed and operated by HealthInfoNet. HealthInfoNet was launched in 2006 and has since carried out a range of projects and functions in collaboration with and under contract to Maine DHHS. HealthInfoNet connects providers to other providers through a secure online network to share patients' electronic health record data, allowing doctors, hospitals, and other providers to share important health information required to improve the quality and safety of patient care in the state. HealthInfoNet is an independent, nonprofit 501(c)(3) organization, warehousing electronic health record data for almost all (98%) of Maine residents. HealthInfoNet is connected to the majority of healthcare facilities in the state, including all hospitals, over 750 ambulatory care sites, multiple reference laboratories, pathology laboratories, Federally Qualified Health Centers (FQHCs), long-term care and home health facilities, behavioral health providers, independent	By using the statewide PDMP, integrated with the statewide HIE and providers' EHR systems, prescribers will be able to view a patient's comprehensive prescription drug history (scheduled I-V substances) in context of their overall medical record to mitigate drug-to-drug interactions, ensure the co-prescription of Naloxone, and/or refer the patient to another authorized prescriber for education and/or treatment. Connection through the PDMP and HIE will occur through the current system.	The Office of Behavioral Health is managing the integration of Maine's PDMP with its HIE. Functionality for HIE connection will be implemented no later than December 2021. Maine recently made the determination to re-engage with the Appriss AWARxE PDMP system, which will allow the state to leverage work that has already been done by HealthInfoNet in other states to connect the HealthInfoNet HIE with the Appriss AWARxE PDMP. The first meeting between the HealthInfoNet and Appriss technology teams to begin work on the integration project is scheduled for 2/23/21.

	laboratories, social services providers, and the Veterans Administration (using both local connections and the Sequoia Project). Additionally, HealthInfoNet receives a routine claims data feed from the Office of MaineCare Services.		
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[9] (see also "Use of PDMP" #2 below)	The current PDMP system allows prescribers to connect through their EHR to view patients' comprehensive prescription drug history. Prescribers are able to assign a delegate to assist with bulk patient reports for review prior to the patient's visit to ensure better provider/patient communication regarding their level of care.	By using the statewide PDMP, integrated with the statewide HIE and providers' EHR systems, prescribers would be able to view a patient's comprehensive prescription drug history (scheduled I-V substances) in context of their overall medical record to mitigate drug-to-drug interactions, ensure the co-prescription of Naloxone, and/or refer the patient to another authorized prescriber for education and/or treatment. With an advanced analytic and reporting infrastructure, the State's program would easily be able to assist with the Administration's policy efforts by combining diverse data sources (e.g., PDMP, HIE clinical, Medicaid claims, a SUD Treatment Services application, VITAL Signs, etc.) to deliver timely reporting and data-sharing of opioid-related outcomes.	The Office of Behavioral Health is managing the integration of Maine's PDMP with its HIE. Functionality for HIE connection will be implemented no later than December 2021. Maine recently made the determination to re-engage with the Appriss AWARxE PDMP system, which will allow the state to leverage work that has already been done by HealthInfoNet in other states to connect the HealthInfoNet HIE with the Appriss AWARxE PDMP. The first meeting between the HealthInfoNet and Appriss technology teams to begin work on the integration project is scheduled for 2/23/21.

[9] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	Appriss currently uses a unique patient identifying algorithm that merges patients well and also allows the Maine PDMP Administrators the ability to manually merge patients if desired.	The State will assess the clinical, analytic and workflow outcome value of upgrading the HIE MPI to ensure a more complete representation of a patient's medication use history, as well as to associate the PDMP data with other clinical encounters and data available through the HIE. Patient matching is important to safety in the Maine PDMP and for PDMP interstate data sharing as required in the PARTNERSHIP Act. Patient matching is central to getting the right and complete information for a patient's medication use prescription history to a provider making clinical decisions when viewing the PDMP data.	While the PDMP system merges patients effectively, the state is considering are leveraging of the HIE MPI as an additional resource when users are connecting through their EMR. Future plans to leverage the HIE MPI center around constructing a comprehensive multi-source state database of linked client records that would allow a more encompassing view of how individuals are served by various DHHS services and systems, including MaineCare, OBH, Office of Child and Family Services, Office of Aging and Disability Services, Emergency Management Services, Syndromic Surveillance (hospital ED data), Department of Corrections, Department of Public Safety, etc.
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			

Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Appriss allows prescribers to view a patient record either through their own EHR, via the HealthInfoNet portal, or through its AWARxE program. Appriss allows the provider to review the patient's record by accessing the EHR, assigning a delegate to print prior to the appointment in the bulk print feature or to view prior to the visit in the PMP and print the record to add to the patient's chart when appropriate. Prescribers have access to the patient's record from another PMP (out-of-state) to help identify any doctor-shopping, doctor-cycling, or co-prescribing habits.	Appriss currently utilizes PMP Gateway for point-of-care integration prescribers' EHR systems. In addition, the Office of Behavioral Health is managing the ongoing work to integrate the AWARxE PDMP with HealthInfoNet such that providers who participate with the HIE will be able to access PDMP data within the HIE portal. (Please see above for description of this project.) PMP Gateway increases utilization of PDMP data at the point-of-care through integration with 150+ different EHR and pharmacy management systems. PMP Gateway delivers PDMP data and NarxCare analytics within the PDMP workflow. The information provided to clinicians is provided in clinically meaningful ways using the NarxCare system and with clinician benchmark reporting comparing clinicians' prescribing patterns to those of their peers.	As part of Maine's re-engagement with the Appriss AWARxE PDMP system, the state will maintain provider EHR integrations via the Appriss PMP Gateway. In addition, the OBH will be investing in a provider outreach and education campaign as part of the AWARxE re-engagement to facilitate EHR integration work and assist health care organizations in implementing and reinforcing PDMP best practices. This outreach and engagement work is planned to occur beginning in April 2021 and will continue through December 2021.
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	Appriss allows prescribers to view the record either through their own EHR, via the HealthInfoNet portal or through the AWARxE interface. Appriss allows the provider to review the patient's record by accessing the EHR, assigning a delegate to print prior to the appointment in the bulk print feature or to view prior to the visit in the PMP and print the record to add to the patient's chart when appropriate. Prescribers have	Prescribers will have the ability to access patient PDMP data through the AWARxE platform, via the HealthInfoNet portal, or through the Gateway integration with their own EHR. The clinician will have access to clinical profiles of patients and historical information of the patient's prior use of controlled substances. The Appriss NarxCare module provides clinicians with clinical decision support related to risk of overdose based on an underlying predictive algorithm.	As part of Maine's re-engagement with the Appriss AWARxE PDMP system, the state will maintain provider EHR integrations via the Appriss PMP Gateway. The Office of Behavioral Health is managing the integration of Maine's PDMP with its HIE. Functionality for HIE connection will be implemented no later than December 2021. The first

	access to the patient's record from out-of-state PDMPs to help identify any doctor-shopping, doctor-cycling, or co-prescribing habits.	PMP Gateway increases utilization of PDMP data at the point-of-care through integration with various electronic health record and pharmacy management systems. PMP Gateway delivers PDMP data and NarxCare analytics within the PDMP workflow. The information provided to clinicians is provided in clinically meaningful ways using the NarxCare system and with clinician profiling reporting comparing clinicians to their peers.	meeting between the HealthInfoNet and Appriss technology teams to begin work on the integration project is scheduled for 2/23/21.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	Provider compliance with Web Infrastructure for Treatment Services (WITS) data entry requirements for SUD treatment services has been suboptimal, resulting in SUD treatment episode data and client-level data that is under-reported and often incomplete.	OBH is expanding its existing relationship with Kepro, the Administrative Services Provider for both OBH and MaineCare, to replace the WITS system. The Kepro data collection system, Atrezzo, will be used by all SUD providers to both collect client-level data and also process authorizations for treatment. Combining these two functionalities in one system will reduce administrative burden on providers and incentivize compliance with SUD treatment episode data collection by tying this function to authorization/invoicing for services.	OBH is managing the Kepro expansion project. The planned completion date for this project is 4/31/21. Tasks remaining include: Complete review and validation of the development work done by Kepro; • Historical data transfer from WITS to Atrezzo; • User Acceptance Testing and System Testing; and, • Provider engagement/education on the new system.
Overall Objective for Enhancing PDMP Functionality & Interoperability			

Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	Currently, Appriss provides within its system the payment type associated with dispensations. The prescriber checks the system prior to prescribing an opioid or benzothiazepine per state statue §7253.Prescribers and dispensers required to check PDMP information, as per the dispenser prior to dispensing a opioid or benzothiazepine.	The Appriss NarxCare system serves as an alert to prescribers regarding potentially risky/inappropriate opiate prescriptions.	OBH administers Maine's PDMP and is managing the provider education and engagement campaign as part of the state's re-engagement with the Appriss AWARxE system. Planned activities include: with provider education on the NarxCare tool and its underlying algorithm to better enable providers to make informed and appropriate prescribing decisions at the point of care in the upcoming fiscal year (July 2021 – Sept 2022). The term provider encompasses prescribing providers with DEA numbers (MD, DO, NP)

Attachment C: Implementation Administration

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ATTACHMENT B
Reserved for Evaluation Design

ATTACHMENT C
Reserved for the Pilots Implementation Protocol

ATTACHMENT D
SMI Implementation Plan