Janet T. Mills
GOVERNOR

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

June 27, 2025

The Hon. Robert F. Kennedy Jr., Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Kennedy:

Please find enclosed, Maine's request to renew our Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381).

With this renewal, Maine seeks to broaden the focus of the currently approved SUD Care Initiative to improve access to behavioral health services, improve health outcomes during transitions from institutions and carceral settings, and develop infrastructure to support health-related social needs for high-risk Medicaid members. With the expansion of intent, Maine seeks to rename this demonstration to "Maine's Whole Person Care Waiver."

Prior to submitting this demonstration extension request, Maine sought feedback from the public as well as the four federally recognized tribes in Maine. A summary of the external engagement process as well as comments received is enclosed.

Thank you for considering this application. We greatly appreciate your partnership in this effort.

Sincerely,

[redacted]

Janet T. Mills
Governor
State of Maine

MaineCare 1115 Demonstration
Whole Person Care
Waiver Application

Amended submission to CMS on

July 9, 2025

Office of MaineCare Services

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Section I: Program Objectives and Vision

Introduction

The Office of MaineCare Services (OMS) within the Maine Department of Health and Human Services (DHHS) is the single state agency responsible for administering the state's Medicaid program, known as MaineCare. Maine's population is approximately 1.3 million, with 43.1 people per square mile, which demonstrates that the State's population is spread widely among its vast rural areas.[1][2] Maine spends over $4.5 billion annually on its Medicaid program. As of January 2025, the Total Medicaid and Children's Health Insurance Program (CHIP) enrollment in Maine was 342,837.

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that broadens the focus of the current approved SUD Care Initiative by strengthening the behavioral health continuum of care, improving transitions from institutions to the community, and improving health outcomes through addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

Historical Summary of the Medicaid Reform Demonstration: 2020-2024

The Maine SUD Care Initiative Section 1115(a) demonstration was approved on December 22, 2020, and became effective on January 1, 2021, through December 31, 2025. Maine's SUD Implementation Plan was approved by CMS on July 26, 2021, with the SUD Monitoring Protocol approved by CMS on March 30, 2022. The goals of this demonstration were to:

Improve access to and quality of treatment for MaineCare members with SUD by:

1. Increasing rates of identification, initiation, and treatment engagement. Increasing adherence to and retention in treatment, especially in community settings.
2. Reducing overdose deaths.
3. Reducing utilization of emergency departments (ED) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
4. Decreasing readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
5. Improving access to care for physical health conditions among beneficiaries.

Accomplishments toward Demonstration Goals

During the demonstration period, Maine made significant progress toward achieving these goals through activities outlined in the implementation plan. These efforts, along with others, represent

[1] https://www.census.gov/library/stories/state-by-state/maine-population-change-between-census-decade.html

[2] https://worldpopulationreview.com/states/maine

the SUD response in Maine and highlight key DHHS activities that advance the specific objectives of the 1115 waiver. They do not comprise an exhaustive list of activities currently underway or planned within the DHHS' SUD response. During the first demonstration period, Maine worked closely with partners across DHHS and communities to ensure a strategic and coordinated state response to enhance the Maine SUD treatment system, including collaboration with the provider community to remove barriers to SUD treatment services. The status of agreed-upon activities related to the implementation plan is included in Appendix 1.

Milestone 1 Activity Highlights

Maine offers comprehensive SUD benefits through the Medicaid State Plan and the Alternative Benefit Plan for expansion group members. For this milestone, Maine enhanced existing Medicaid rules, payment models, and coverage policies to improve access to SUD screening and treatment in the following areas:

- **Early Intervention:** Effective July 1, 2023, DHHS added requirements under its value-based purchasing initiative for primary care health homes to provide screening, brief intervention, and referral to treatment for SUD.
- **Outpatient services:** DHHS clarified through rulemaking that partial hospitalization services are approved outpatient services for psychiatric and non-psychiatric hospitals, effective October 24, 2022. These services may be offered by Acute Care Non-Critical Access Hospitals, hospital-based clinics, or a distinct part of the Acute Care Non-Critical Access Hospital if allowed by the Hospital's license. The adopted rule also allows Certified Intervention Peer Support to be part of the multi-disciplinary team that provides Outpatient Partial Hospitalization Services.
- **Intensive outpatient (IOP) services:** DHHS procured an independent rate study for its SUD treatment services. The study resulted in enhanced IOP rates approved by the Maine Legislature, effective January 2022. The new rates represent an 89% increase for IOP services.
- **Medication-Assisted Treatment (MAT):** DHHS updated the Medicaid State Plan to reflect CMS requirements related to the mandatory coverage of MAT for opioid use disorder (OUD). Maine already had coverage for MAT before 2020, but the state plan was expanded to include it. SPA #21-0003 Medication-Assisted Treatment was approved on November 11, 2021, with an effective date retroactive to October 1, 2020.

As part of the SUD Implementation plan, Maine continued its support for MAT induction in ED, including training on implementation of rapid induction and warm handoffs to community-based treatment. At the outset of the demonstration, 23 of Maine's EDs offered induction for MAT. By the end of demonstration year two (2022), the number of EDs offering induction had increased to 26, with 24/7 MAT services available, and one offering MAT when prescribers are available. Five EDs do not offer MAT inductions. In calendar year (CY) 2023, 14 process improvement and training sessions were provided across 12 sites in Maine.

- **Residential treatment, including medically supervised withdrawal management:** DHHS updated the Private Non-Medical Institution (PNMI) rules to remove potentially stigmatizing language from policy and eliminate single admission limits from Clinically Managed Low-Intensity Services and Clinically Managed Population-Specific High-Intensity Residential Programs. Allowable days per admission were increased in Clinically Managed Residential Services from 30 to 45 days in Residential Rehabilitation Type I facilities and from 45 to 60 days in Residential Rehabilitation Type II facilities. The rules also provided for increased reimbursement rates for SUD residential treatment services. PNMI rules were effective November 1, 2021.

The State of Maine issued two funding opportunities for eligible behavioral health providers in demonstration year two. The first award was for $4 million to support the capital costs necessary to increase residential treatment capacity for SUD. The second award was for $2 million to support start-up costs. In May of demonstration year three (2023), a third award of $2.5 million was made available to support both capital and start-up costs. As a result of these actions, an additional 171 residential treatment beds for SUD treatment will become available.

Milestone 2 Activity Highlights

- As part of MaineCare's administrative rules for SUD PNMI treatment guidelines and references were updated to reflect the third edition of the American Society of Addiction Medicine (ASAM) criteria and guidance. The PNMI rule changes were effective in November 2021.
- Maine also partnered with the Co-Occurring Collaborative to offer ASAM assessment and a level of care training for providers. Fifteen ASAM/SUD-related training courses were provided during the demonstration year one. In demonstration year two, forty training courses were provided; in demonstration year three, seventy-seven separate training courses were provided.
- In addition, DHHS updated the Opioid Health Home administrative rules to require ASAM criteria to assess patient placement and as treatment guidelines. The ASAM criteria are used to determine eligibility for Opioid Health Home services and to assist in treatment planning and referral to other appropriate levels of care, including residential placement for SUD treatment. Updated Opioid Health Home rules were effective August 21, 2022.
- As part of MaineCare's value-based model for primary care providers, Tier II practices must offer MAT services in alignment with ASAM guidelines for an appropriate level of care. Tier II primary care practices must also have a cooperative referral process with specialty behavioral health providers, including a mechanism for co-management MAT provision as needed, or be co-located with a MAT provider. Tier II practices are paid an enhanced rate under the PCPlus program. These changes were memorialized in the State Plan through an amendment (SPA 22-0002) approved in April 2022, effective July 1, 2022.
- DHHS, in collaboration with its Behavioral Health Administrative Service Organization (ASO), developed a Utilization Management (UM) system that requires residential SUD

providers to submit admission information to the ASO, including the ASAM assessment for placement purposes. Maine began working with the ASO during the first year of the demonstration, and the original target date for implementation (March 2022) was delayed due to staffing and the impact of the PHE until July 1, 2023. The independent review process occurs within 10 days of admission and every 30 days thereafter. The 30-day UM review includes additional information on best practices for movement between levels of care. The UM process does not result in a client being discharged from care. Discharges may only occur when a transition to a lower level of care is appropriate, immediately available, and acceptable to the member.

Milestone 3 Activity Highlights

- MaineCare enrolled providers meet the standards of care outlined in the updated PNMI rules, effective November 2021, to include alignment with the most current ASAM level of care guidelines.
- Compliance Reviews
  a. Several units within DHHS are responsible for overseeing residential treatment providers across the SUD system of care. There has been a DHHS-wide effort, including OMS, the Division of Licensing and Certification, the Office of Behavioral Health (OBH), and the Office of Children and Family Services (OCFS), to ensure compliance with ASAM standards.
  b. The new UM process implemented on July 1, 2023, includes a feedback loop to all state oversight entities involved with the facility. If concerning trends are identified, the ASO will provide information to the responsible unit(s) for follow-up.
  c. OBH and OCFS assumed oversight of adult and youth SUD residential treatment programs in July 2021 and November 2021, respectively. Oversight activities include onsite reviews for all MaineCare-enrolled providers.
  d. DHHS rules related to services offered in SUD PNMIs were updated, effective November 1, 2021, to include alignment with ASAM criteria and the provision of MAT (or the facilitation of MAT off-site if the service is not offered onsite).

Milestone 4 Activity Highlights

The following are accomplishments and progress:

- Produced assessments of SUD provider capacity, including recovery support, barriers to capacity, and strategies to address gaps (e.g., eligibility, workforce, etc.). In collaboration with the SUPPORT for ME grant, DHHS contracted with the University of Maine to assess the continuum of care. The SUPPORT for ME SUD Prevalence and Treatment Capacity Assessment was completed in February of 2022 and provided information on the sociodemographic and geographic distribution of SUD prevalence in Maine. In addition, a claims-based analysis included a Capacity Analysis, which examined the current statewide capacity to address SUD by examining current SUD treatment and recovery infrastructure,

service utilization patterns, and geographic distribution of services and usage throughout the state to identify gaps in treatment and recovery capacity. Maine is currently collaborating with the University of Southern Maine to integrate data from various sources, enhancing understanding of access and gaps.

- Evaluated MaineCare rates and rate setting system. Completed. Results drove rate improvements, as highlighted in Milestone 1.
- Deployed a service locator tool to assist healthcare providers, consumers, and other stakeholders in searching for local BH providers and assessing the number of providers accepting new patients. The online tool was launched for providers in September 2022 and for the public in July 2023. Maine continues to work with the vendor to build out the listing of providers and services on the site.
- Funded SUD-specific telehealth services: DHHS worked with the Northeast Telehealth Resource Center (NETRC) to develop and launch the TeleSUD Treatment and Recovery Services Toolkit. This online resource addresses the unique needs of TeleSUD, including treatment considerations, recovery services, and Maine-specific TeleSUD policy and reimbursement. Continuing education credits are available for providers who complete the toolkit series. During the first three years of the demonstration, 102 providers completed the SUPPORT for ME TeleSUD Toolkit. Additionally, the NETRC offers one-on-one technical assistance and virtual and in-person training sessions to providers and healthcare organizations.
- Established an incentive for primary care providers to offer MAT services in alignment with ASAM guidelines: Completed. See the associated action in Milestone 2 highlights.
- Developing policy and rates to expand eligibility criteria for Opioid Health Home services to include individuals diagnosed with any SUD, including stimulant use disorder. DHHS is currently exploring the feasibility of adding an ambulatory withdrawal management component in the expanded Opioid Health Home model, with an expected effective date of mid-2025.
- Reviewed all MAT policies for policy and utilization management restrictions that may impact access to evidence-based and low-barrier care. The MaineCare Policy, clinical advisory boards, and Pharmacy Units conduct ongoing monitoring of policy concerns and UM trends.
- Conducted an 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. Feedback from survey respondents suggests that finding and accessing treatment for SUD is a challenge for young people who often do not know what services are available in their community and experience stigma in reaching out for help. Proposed action steps include:
- Piloted a Maine Youth & Young Adult Screening, Brief Intervention and Referral to Treatment (MY-SBIRT) initiative in 4 schools, including school-based health centers and institutions of higher education.

Milestone 5 Activity Highlights

- DHHS partnered with the University of Maine to develop a community naloxone saturation algorithm. DHHS expanded the purchase of naloxone by 36% between SFY2022 and SFY2023 to support its public health effort to saturate communities with the opioid overdose reversal agent.
- During demonstration year three, Maine continued its work with Emergency Medical Services (EMS) across the state through an EMS Ambassador train-the-trainer program conducted in June of 2023. Seven personnel were trained to work with local EMS agencies in their region to increase awareness of the science of addiction, address compassion fatigue, reduce the stigma associated with SUD, and increase buy-in for the Maine Naloxone Leave Behind Program. Additionally, staff participated in a Naloxone Saturation Policy Academy with nine other states, held in Bethesda, Maryland, in July 2023.
- Lastly, MaineCare received authority from the Maine Legislature in April 2023 to issue Standing Orders for over-the-counter (OTC) medications and vaccines, which include the FDA-approved OTC nasal spray naloxone.
- Maine law currently allows pharmacists to issue prescriptions for all forms of naloxone. In September of 2023, MaineCare authorized a standing order for licensed pharmacists to create single-use prescriptions for OTC naloxone two-dose nasal spray kits with no cost-sharing requirements.

Vision and Goals for 1115 Demonstration Renewal

The vision for DHHS' Whole Person Care Waiver is for Mainers, both individuals and communities, to have the opportunity to thrive. State, county, and community providers will provide accessible, high-quality physical and behavioral healthcare. Specifically, under this Demonstration, DHHS aims to maximize access to high-quality behavioral health services and improve health outcomes for Medicaid enrollees during transitions, as well as for other targeted populations, such as those with nutrition-sensitive conditions or those who would benefit from traditional healing practices. DHHS also aims to develop and maintain adequate infrastructure and system capacity, in partnership with community providers, to support these goals and related initiatives.

Maine is prepared to build on early successes and lessons learned from the existing SUD waiver to continue this progress over the next five-year 1115 demonstration period while implementing select new targeted initiatives in line with Maine's overarching demonstration goals below. Section II maps these overall demonstration goals to specific waiver request goals. This framework guides strategies and the implementation of waiver activities. The following are the overarching demonstration goals:

1. Maximize access to high-quality behavioral health services at the appropriate level of care.

2. Improve health outcomes during transitions and for other targeted populations, such as those with nutrition-sensitive conditions or those who would benefit from traditional healing practices.
3. Develop and maintain adequate infrastructure and system capacity in partnership with community providers, to support these goals and related initiatives.

DHHS maintains a deep commitment to the quality of the services provided through MaineCare and, as such, seeks to phase in elements of this waiver over time. As described in this application, a timeline has been developed to phase in aspects of this waiver, ensuring adequate resources are available to implement each initiative. By proposing a phased-in approach, DHHS aims to ensure that each element of the waiver successfully achieves its objectives in supporting Maine in moving towards a high-quality, comprehensive health system.

Rename from Maine Substance Use Disorder Care Initiative

In this request, the State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine SUD Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. To appropriately reflect the updated program design that broadens the focus of the existing Section 1115(a) waiver demonstration, "Maine SUD Care Initiative," to enable a whole-person approach to care under which Mainers have the opportunity to thrive, Maine proposes that the waiver name be changed to: "**Maine's Whole Person Care Waiver**."

Section II: Continuing Demonstration Features and Changes Requested to the Demonstration:

Demonstration Opportunity Goals:

As Maine continues to enhance its current comprehensive health system, the three overarching demonstration goals are mapped below to the goals for each proposed component. Objectives in each section will drive the achievement of these goals. Table 2 below maps each objective to goals:

Table 2: Crosswalk of Primary Goals with Waiver Goals

Maine Primary goals	Waiver Opportunity Goals
Goal 1: Maximize access to high-quality behavioral health at the appropriate level of care.	SUD Goal 1: Increased identification, initiation, and engagement rates in treatment for OUD and other SUDs.
	SUD Goal 2: Increased access to and retention in treatment for OUD and other SUDs.
	SUD Goal 3: Reductions in overdose deaths, particularly those due to opioids.
	SUD Goal 4: Reduced utilization of EDs and inpatient hospital settings for OUD and other SUD treatments where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Table 2: Crosswalk of Primary Goals with Waiver Goals	
Maine Primary goals	**Waiver Opportunity Goals**
	SUD Goal 6: Improved access to care for physical health conditions among beneficiaries with OUD and other SUDs.
	Serious Mental Illness (SMI)/IMD Goal 1: Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.
	SMI/IMD Goal 3: Improved access to community-based services to address the chronic mental healthcare needs of beneficiaries with SMI, including through increased integration of primary and behavioral healthcare.
	Re-Entry Goal 7: Reduce the number of ED visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral healthcare
Goal 2: Promote successful transitions to the community and improved health outcomes for other targeted populations, such as those with nutrition-sensitive conditions or who would benefit from traditional healing practices.	SUD Goal 5: Fewer readmissions to the same or higher level of care, where readmissions are preventable or medically inappropriate for OUD and other SUDs
	SMI/IMD Goal 2: Reduce preventable psychiatric readmissions to acute care hospitals and residential settings
	SMI/IMD Goal 4: Improved care coordination, especially continuity of care in the community following acute care episodes in hospitals and residential treatment facilities.
	Re-Entry Goal 1: Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings before release
	Re-Entry Goal 2: Improve access to services before release and improve transitions and continuity of care into the community upon release and during reentry
	Re-Entry Goal 6: Reduce all-cause deaths in the near-term post-release.
	Re-Entry Goal 8: Provide intervention for specific behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs to reduce overdose and overdose-related death in the near-term post-release.
	HRSN Goal 1: Improve health outcomes for people experiencing homelessness and who are transitioning into the community.
	HRSN Goal 2: Improve health outcomes for individuals and families with nutrition-sensitive conditions through coordinated, enhanced collaborations with existing federal, state, and local food benefit programs and nutrition prescription and counseling services.

Table 2: Crosswalk of Primary Goals with Waiver Goals	
Maine Primary goals	**Waiver Opportunity Goals**
	HRSN Goal 3: Decrease hospital length of stay for people who are experiencing homelessness and are transitioning into the community by implementing a recuperative care pilot.
	Traditional Healing Services: Improve health outcomes for Native Americans by increasing utilization and access, reducing stigma, and providing more culturally responsive treatment options.
Goal 3: Develop and maintain adequate infrastructure and system capacity in partnership with community providers to support the previously identified goals and related initiatives.	SMI/IMD Goal 5: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
	Re-Entry Goal 3: Improve coordination and communication between correctional systems, Medicaid/Child Health Insurance Program (CHIP) systems, and community-based providers.
	Re-Entry Goal 4: Increase additional investments in healthcare and related services to improve the quality of care for beneficiaries in carceral settings and the community to maximize successful reentry post-release.
	Re-Entry Goal 5: Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN.

Maine's overarching goal for its 1115 demonstration renewal is to create a whole-person approach to care under which Mainers have the opportunity to thrive. The proposed authorities reflect Maine's commitment to addressing both behavioral and physical health, as well as identifying and addressing social drivers of health. The 1115 demonstration renewal will advance this goal through the following specific objectives and related initiatives.

Summary of Section 1115 Demonstration Requests

Table 3 provides an overview of the current Section 1115 demonstration initiatives that Maine is renewing and new demonstration proposals. As Maine works with CMS to advance its The Whole Person Care Waiver Section 1115 demonstration, as well as the federal approval vehicles required, may change. In the table below, each demonstration goal is mapped to objectives, approach, and status:

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
Goal 1: Maximize	Objective 1: Sustain and improve the SUD continuum	SUD IMD Exclusion Waiver Services Initiative	Continuing

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
access to quality behavioral health services and improve coverage of a broader continuum of treatment for individuals with SMI/SUD.	of care	Pilot 1a: Maintenance of Medicaid Coverage	Continuing
		Pilot 1b: Parenting Support Services	Continuing
		Pilot 1c: Home-Based Skill Development Services	Continuing
		Pilot 1d: Contingency Management (CM)	New
	Objective 2: Improve and align the service delivery for individuals living with SMI with best practices.	SMI/SED Waiver Services Initiative	New
Goal 2: Promote successful transitions to the community and improved health outcomes for other targeted populations, such as those with nutrition-sensitive conditions or who would benefit from traditional healing practices.	Objective 3: Improve the continuity of care during transitions by building and strengthening relationships with community-based organizations.	Pilot 3: Transition of Care Incentive	New
	Objective 4: Improve the continuity of coverage and access to needed care by leveraging re-entry initiatives, including pre-release services for justice-involved individuals	Pre-Release Medicaid Services for Justice-Involved Individuals Initiative	New
	Objective 5: Establish HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5a: Food is Medicine	New
	Objective 5: Establish HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5b: Recuperative Care	New
		Pilot 5c: Structured Recovery Housing Programs	New

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
	Objective 6: Improve health outcomes for Native Americans by increasing utilization and access, reducing stigma, and providing more culturally responsive treatment options.	Traditional Healing Therapies for Native Americans	New
	Objective 4: Improve the continuity of coverage and access to needed care by leveraging re-entry initiatives, including pre-release services for justice-involved individuals	Pre-Release Medicaid Services for Justice-Involved Individuals Initiative	New
Goal 3: Develop and maintain adequate infrastructure and system capacity in partnership with community providers to support the previously identified goals and related initiatives.	Objective 5: Establish health-related HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5a: Food is Medicine	New
	Objective 5: Establish health-related HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5b: Recuperative Care	New

Objective 1: Sustain and Improve the SUD Continuum of Care

Maine requests an extension of the currently approved Maine SUD Care Initiative, which authorizes Maine to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid State Plan provided to members residing in IMDs for short-term stays primarily to receive SUD treatment and sustain approved and promising pilots.

Initiative: Extend Current SUD Waiver Services and Successful Pilots

Request

Maine requests an extension of the currently approved Maine SUD Care Initiative, which authorizes FFP for services as described in the Maine Medicaid State Plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current demonstration allows Maine to obtain Medicaid reimbursement for individuals receiving short-term substance use disorder (SUD) treatment in an inpatient mental health disorder (IMD) facility. Under the demonstration, Maine is required to aim for a statewide average length of stay of 30 days in residential treatment settings to ensure that short-term residential treatment stays are maintained. The current SUD expenditure authority expires on December 31, 2025. The DHHS submitted an amendment of the current 1115 Waiver SUD Care Initiative Demonstration to address the budget neutrality overages that Maine experienced in Years 2 and 3 of the demonstration on January 9, 2025.[3] Maine also requests an extension to the following approved pilots:

SUD IMD Waiver

Continuation of approval of Maine's current SUD IMD 1115 waiver supports efforts to increase the capacity and flexibility of states' Medicaid programs to provide necessary services to those facing serious substance use challenges. This flexibility supports Maine's efforts to help address the substance use crisis by providing expanded access to treatment options in these specialized facilities.

Benefits

Provides reimbursement for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SUD by IMDs.

Pilot 1a: Maintenance of Medicaid Coverage (Formerly Pilot 1 Maintenance of Medicaid Coverage)

Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.

Benefits

The expanded MaineCare coverage provides full Medicaid benefits and will continue as the beneficiary was previously receiving, with the goal of family reunification. MaineCare coverage continues 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.

Pilot 1b: Parenting Support Services (Formerly Pilot 2 Parenting Support Services)

Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.

[3] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-sud-pa-01162025.pdf

Eligible parents will receive services concentrating on increasing caregiver knowledge of child development, increasing caregiver nurturance, improving parenting practices, strengthening parent-child attachment, meeting the child's health-related and safety needs, and growing child behavioral and biological regulation while decreasing caregiver behaviors that could be frightening or overwhelming for their child. Members eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with Child Protective Services (CPS) and whose services have been recommended by a physician or other licensed healing arts practitioner.

Under this pilot, Parenting Support Services includes two programs:

A. Program 1: Attachment Biobehavioral Catch-up (ABC)
B. Program 2: Visiting Coaches

A. Program 1 - 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 two age groups: infants (6-24 months of age) and toddlers (24-48 months of age). Recommendations for ABC are made by a physician or licensed practitioner of the healing arts.

Provider Qualifications

1. Provider Qualifications for ABC:
    a) Parent coaches meet the following qualifications:
        i. Be a bachelor's level mental health professional; or
        ii. Be a certified Behavioral Health Professional (BHP)
        iii. Pass a screening by the ABC Developers, who are Doctorate-level professionals independently licensed as child psychologists.
        iv. Receive a year of supervision from the ABC Developers; and
        v. Complete the requisite training as prescribed by the model, which includes the following topics:
            1. Background and evidence base of ABC
            2. Overview of primary targets of ABC
            3. Overview of model and session outline/goals
            4. Coding "In the moment" comments
            5. Review of technology
            6. Practice sessions
            7. Advanced Comments and Sensitivity Assessment

2. Parent Coach Supervisors meet the following qualifications:
    a) Complete one year of supervision by ABC developers; and
    b) At a minimum, have either a Licensed Clinical Social Worker (LCSW), a Licensed Master of Social Work-clinical conditional (LMSW-CC), a Licensed Clinical Professional Counselor (LCPC), or a Licensed Clinical Professional Counselor-conditional (LCPC-C).

Benefits

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

B. Program 2 - Visit Coaching:

Visit Coaching is a program designed for families involved with the Office of Child and Family Services, who have children of any age placed in foster care and are working toward reunification. Licensed social workers make recommendations for visiting coaches. Visit coaching is a strength-based therapeutic intervention that occurs between the coach and the family during the reunification process. This program will augment existing activities and funding available to support family reunification as specified in Maine's Title IV-E plan.

Provider Qualifications

1. Provider Qualifications for Visit Coaches:
    a) Visit Coaches meet the following qualifications:
        i. Have a bachelor's degree as well as experience in human services
        ii. Have previous documented experience working with children and families
        iii. Complete requisite training, including mandated reporter training, and training in de-escalation techniques
        iv. First Aid and CPR certification
        v. Receive Family Time Coaching training

    b) Visit Coaches Supervisors (VCSs) meet the following qualifications:
        i. Meet the qualifications of the VCWs; and
        ii. 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); Licensed Clinical Professional Counselor-conditional (LCPC-C).

Benefits

Component Services of Visit Coaching include:

1. Counseling to prepare for visits, giving feedback on visits, and improving communication with foster parents.
2. Treatment Planning: A needs list is created by the parent and the coach based on the child's specific needs.
3. Psychoeducation: Coaches model and assist the parents on how to engage with their children through play and other developmentally age-appropriate activities. Parents are provided with 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 parents and their child (ren) in the home, engaging with the entire family throughout the visit.

Pilot 1c: Home-Based Skill Development Services (Formerly Pilot 3 Home-Based Skill Development Services)

Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential for independent living, thereby avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot is a MaineCare-enrolled parent with a SUD who is involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Provider Qualifications

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). Supervision is provided by a licensed clinician practicing within their scope of licensure in Maine.

Benefits

Daily Living Skills Development Services include:

1. Psychosocial Rehabilitation to restore and maintain functioning
2. Social skills training in appropriate community services; and
3. Development of positive personal support networks.

Initiative: Expand Access to Evidence-Based Treatment for Stimulant Use Disorder

Pilot 1d: Contingency Management

Request

Maine is seeking new waiver authority under Section 1115 to claim FFP for the provision of CM services described below. Maine is seeking to implement this demonstration feature on January 1, 2028, following approval by CMS and updates to eligibility systems and technical infrastructure.

Background

CM is increasingly necessary in Maine to effectively combat rising SUDs, particularly amid escalating rates of stimulant use disorders (STUD). Most concerningly, stimulants have increased involvement in drug deaths, especially when combined with illicit fentanyl. The number of deaths related to methamphetamines doubled between 2019 and 2020, with the number of deaths involving cocaine making up 23% of all drug deaths in Maine.[4] Additionally, since 2019, Maine has experienced a 215% increase in methamphetamine seizures in Maine, indicating that the drug is now moving into mainstream drug use.[5] CM is the most effective

[4] Sorg, Marcella. n.d. "MAINE DRUG DEATH REPORT for 2020." https://mainedrugdata.org/wp-content/uploads/2021/06/2020_Annual_ME_Drug_Death_Rpt_Final.pdf.

[5] Sauschuck, Michael, and Roy Mckinney. n.d. "ANNUAL REPORT 2021 a STATEWIDE DRUG TASK FORCE." https://www.maine.gov/dps/sites/maine.gov.dps/files/inline-files/2021AnnualReport.pdf.

treatment option for STUDs. CM has three decades of research demonstrating its long-term efficacy for treating a variety of SUDs, including stimulant, opioid, cannabis, alcohol, and tobacco use disorders, as well as concurrent SUDs.[6][7] In studies comparing CM with other psychosocial interventions for SUD (e.g., cognitive behavioral therapy, motivational enhancement therapy), CM produced significantly higher abstinence rates over the course of treatment, higher retention in treatment, and higher abstinence self-efficacy.[8]

CM using operant conditioning as the conceptual framework has proven to be one of the most effective behavioral interventions for the treatment of SUDs, with decades of research indicating its ability to increase substance non-use and SUD treatment adherence.[9] Rewarding desired behaviors encourages individuals to remain abstinent and engage in recovery-oriented activities. The Veterans Affairs (VA) health system has embraced CM as a critical means of addressing SUD with impressive results. As of 2023, over 100 VA Medical Centers offer CM for various SUDs, with a negative drug screening success rate of 92.6 percent for the target substance during the intervention period.[10] Implementing CM improves retention rates and sustained abstinence, as shown in a 2021 meta-analysis of the long-term efficacy of CM treatments. CM participants were 1.22 times as likely to maintain non-use of substances at the one-year mark compared to those receiving therapies or treatments without motivational incentives.[11] Thus, CM should be a significant tool in Maine's interventions with STUD.

Maine's proposed CM pilot reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The pilot will provide motivational incentives to advance treatment or non-use of substances, as evidenced by negative point-of-care drug tests. Maine will provide guidance on the frequency of reassessments for eligibility.

As previously noted, Maine will determine any CM motivational incentives' size, nature, and distribution and will issue guidance, procedures, and protocols that all eligible CM providers shall strictly adhere to, including limitations on motivational incentive payments during CM treatment episodes. In determining the size, nature, and distribution of motivational incentives, Maine will ensure that neither the Federal anti-kickback statute (42 U.S.C. 1320a-7b(b), "AKS") nor the civil monetary penalty provision prohibiting inducements to beneficiaries (42 U.S.C. 1320a-7a(a)(5), "Beneficiary Inducements CMP") is implicated.

To further ensure the integrity of CM and mitigate the risk of fraud, waste, or abuse associated with the motivational incentive, Maine intends to:

- Monitor motivational incentives to ensure safeguards against fraud and abuse. Safeguards will be detailed and issued as guidance to eligible providers before implementation, and

[6] Lussier JP, Heil SH, Mongeon JA, Badger GJ, Higgins ST. A meta-analysis of voucher-based reinforcement therapy for substance use disorders. Addiction. 2006; 101(2): 192-203. doi: 10.1111/j.1360-0443.2006.01311.x. PubMed PMID: 16445548.

[7] De Crescenzo F, Ciabattini M, D'Alo GL, De Giorgi R, Del Giovane C, Cassar C, et al. Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis. PLoS Med. 2018; 15(12): e1002715. Epub 20181226. doi: 10.1371/journal.pmed.1002715. PubMed PMID: 30586362; PubMed Central PMCID: PMC6306153.

[8] Rawson RA, McCann MJ, Flammino F, Shoptaw S, Miotto K, Reiber C, et al. A comparison of contingency management and cognitive-behavioral approaches for stimulant-dependent individuals. Addiction. 2006; 101(2): 267-74. doi: 10.1111/j.1360-0443.2006.01312.x. PubMed PMID: 16445555

[9] McPherson, Sterling M., Sara Parent, Andre Miguel, Michael McDonell, and John M. Roll. "Contingency Management Is a Powerful Clinical Tool for Treating Substance Use Research Evidence and New Practice Guidelines for Use." Psychiatric Times 39, no. 9 (2022). https://www.psychiatrictimes.com/view/contingency-management-is-a-powerful-clinical-tool-for-treating-substance-use-research-evidence-and-new-practice-guidelines-for-use

[10] Dominick DePhilippis et al., "History and Current Status of Contingency Management Programs in the Department of Veterans Affairs," Preventive Medicine 176 (September 17, 2023): 107704, https://doi.org/10.1016/j.ypmed.2023.107704.

[11] Meredith K Ginley et al., "Long-term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence From Illicit Substance Use up to 1 Year Following Treatment: A Meta-analysis.," Journal of Consulting and Clinical Psychology 89, no. 1 (January 1, 2021): 58–71, https://doi.org/10.1037/ccp0000552.

- Provide guidance that includes instructions on calculating and generating motivational incentives.

Maine CM pilot will be offered, along with other MaineCare covered therapeutic interventions, as appropriate for SUD treatment, such as cognitive behavioral therapy, which meets the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and 42 CFR 440.130(d). While Maine will issue guidance strongly encouraging motivational incentives to be provided in concert with other SUD treatments, Maine's CM pilot will not require participation in other SUD treatments as an eligibility requirement for participating in CM. Motivational incentive value shall be excluded from participating MaineCare members' modified adjusted gross income (MAGI)-based eligibility determinations and shall not exceed $750 per person per year.

Eligibility

Qualifying MaineCare members must:

- Be Medicaid members who are diagnosed with STUD (e.g., methamphetamine, cocaine, similar drugs) based on a completed ASAM criteria assessment (or another comparable, nationally recognized SUD assessment based on evidence-based clinical treatment guidelines)
    - The presence of additional substance disorders and/or diagnoses shall not disqualify an individual from receiving CM;
- Not be enrolled in another CM program for SUD; and
- Receive services from an eligible provider that offers CM in accordance with the State laws, policies, procedures, and guidance.

Maine will provide guidance on the frequency of reassessments for eligibility.

Eligible CM Providers and Qualifying Practitioners:

CM providers that opt into and are approved by Maine to participate in the pilot and meet the conditions outlined below.

Eligible CM providers must:

- Be certified as a Certified Community Behavioral Health Clinic to provide MaineCare services in the state as substance use service providers; Maine will explore the possibility of expansion of CM beyond CCBHCs during the five-year implementation timeframe.
- Require the staff providing or overseeing CM to participate in CM-specific training developed and offered by the state of Maine and/or a designated contractor(s).
- Undergo a readiness review by DHHS and/or a designated contractor(s) to ensure that they are capable of offering CM in accordance with Maine's standards, which will be detailed in written guidance.
- Participate in ongoing training and technical assistance as requested or identified by Maine and/or a designated contractor(s) through ongoing monitoring to meet Maine's standards.
- Shall comply with any billing and data reporting requirements established by Maine to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

Benefits

Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM incentive payment will be capped at $750 per person per year for each participating member.

Objective 2: Improve and Align the Service Delivery for Individuals Living with SMI with Best Practices

This opportunity is designed to establish a more effective and comprehensive mental healthcare system for individuals with SMI. First and foremost, it aims to improve access to comprehensive mental health services, ensuring that individuals can receive care in community settings rather than being confined to institutions. It promotes community integration by supporting initiatives that help individuals transition from institutional care to more independent living arrangements. Additionally, the waiver seeks to improve care coordination by fostering the integration of mental and physical health services, addressing co-occurring SUD and mental health conditions more effectively. Notably, the waiver empowers individuals by providing resources and support that encourage active participation in their treatment and recovery path.

Initiative: SMI/IMD Waiver Services

Request

Maine is seeking new waiver authority under Section 1115 SMI to meet its goals of improving the delivery of services for individuals with SMI across the continuum of care. Maine seeks expenditure authority to stabilize individuals who require care in IMDs on a short-term basis and ensure they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. Some individuals living with SMI may require short-term stays in IMDs to support their ability to flourish in their communities.

In this SMI/IMD request, Maine seeks FFP to allow MaineCare the authority to pay for services for individuals receiving inpatient care in an IMD. Specifically, Maine seeks to provide reimbursement for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SMI. These services encompass short-term stays for up to 60 days in public, private, and out-of-state IMDs for Medicaid enrollees living with mental health needs. Within Maine, this demonstration feature would operate statewide and include the following facilities: two private facilities, Spring Harbor Hospital and Acadia Hospital, and one public facility, Dorothea Dix Psychiatric Center. If necessary, Maine will identify and include a limited number of IMDs from out of state to ensure sufficient access to specialized intensive mental health services, given Maine's designated rurality.

Maine is not requesting the authority to receive FFP for Medicaid services provided in Qualified Residential Treatment Programs with more than 16 beds.

Background

The current model, which disallows Medicaid compensation for IMD care for adults 21-64, is not financially sustainable for Maine and requires Maine to direct more limited state funding to support the institutional level of care rather than community-based care. Maine is pursuing the waiver to ensure financial sustainability across the entire mental health continuum for years to come. Additionally, allowing IMDs to bill MaineCare for individual claims will provide greater transparency and opportunity for quality improvement. These claims provide additional details that our MaineCare office can use to track quality measures.

This request will provide Maine with a pathway and allow the state to shift funds to improve mental health services for individuals with SMI. This request supports Maine in improving access to a broader range of community-based mental health services, thereby fostering the integration of physical and mental healthcare and the development of a comprehensive continuum of behavioral healthcare. Reducing reliance on institutionalization promotes a shift toward supportive, community-oriented treatment options, ultimately enhancing the quality of care. The flexibility granted by this authority enables the development of tailored solutions to address specific population needs cost-effectively, thereby preventing more severe health issues that require costly interventions.

Eligibility

Eligible individuals would be those between the ages of 21-64 with an SMI.

Maine is not requesting the authority to receive FFP for Medicaid services provided in Qualified Residential Treatment Programs with more than 16 beds.

Benefits

Provides reimbursement for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SMI by IMDs.

Overview of Current Initiatives to Improve Behavioral Health System of Care

Maine has made significant improvements in the behavioral health system through state and collaborative initiatives with behavioral health providers, implementing effective, efficient, and evidence-based solutions. Maine's DHHS is comprised of the following offices and divisions that oversee and administer critical behavioral health programs and services for Maine:

- **Children's Behavioral Health Services (CBHS):** Responsible for the oversight of behavioral health services for children and youth up to age 21 and their families. CBHS collaborates with local agencies to administer the Mental Health Block Grant (MHBG) for children's and family mental health services.

- **OBH:** Serves as the State Mental Health Authority (SMHA) and the Single State Authority (SSA) responsible for the development, implementation, and evaluation of adult mental health and substance use services. OBH administers the Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and MHBG.

- **Office of Aging and Disability Services (OADS):** Oversees and approves providers offering MaineCare-covered waiver services for people living with Intellectual or Developmental Disabilities (IDD) and brain injury. OADS also manages a team of state-hired crisis intervention staff to provide crisis prevention and intervention services 24

hours a day, seven days a week, to assist individuals and providers with stabilization and support for adults with IDD or brain injury.

- **OMS:** State Medicaid Agency, and the major payor of behavioral health services for people living in Maine, covering over 30% of the total population of Maine.

Behavioral health services in Maine are funded through four primary sources – MaineCare, through Maine's Medicaid State Plan or approved waivers; the federal SAPTBG and Community MHBG, the state general funds, and commercial payors. MHBG and SAPTBG contract with appropriately licensed behavioral health providers to deliver behavioral health services to uninsured individuals. OBH contracts services for adults include Assertive Community Treatment (ACT), community integration, medication management for psychiatric and SUDs, mobile crisis response, residential, as well as intensive outpatient services and residential care for uninsured people living with SUD. CBHS contracts services for children and youth include family respite, homeless youth services, family and peer support, children's crisis residential, transitional living programs, and programs for first-episode psychosis. OMS contracts with Opioid Health Home providers for uninsured individuals and administers the Medicaid Health Home models.

Providing an important foundation to achieve the goals of this renewal request, OMS covers a continuum of behavioral health services in the state's Medicaid program ranging from early intervention services to crisis intervention, outpatient treatment, residential treatment, inpatient treatment, and recovery services for individuals with behavioral health needs as detailed in Table 4 below. Treatment options include outpatient and inpatient services, as well as community-based programs designed to support individuals with SMI. Legislative efforts in Maine aim to enhance mental healthcare by increasing funding and resources and addressing the urgent need for comprehensive care.[12] Additionally, efforts are underway to improve crisis services, including mobile crisis teams, stabilization units, and Certified Community Behavioral Health Clinics (CCBHCs), to provide immediate support and reduce reliance on inpatient care. The following services are part of MaineCare's service delivery system.[13]

Table 4. Continuum of MaineCare State Plan SMI Services

Service	Brief Description
Targeted Case Management	Services include assessment, planning, referral, and related activities, as well as monitoring and follow-up activities for children with behavioral health disorders.
Behavioral Health Homes	Comprehensive care management and health promotion are provided by a multi-disciplinary team of behavioral health and medical providers to support eligible adults and children with SMI/SED.
Community Integration Services	Biopsychosocial assessment, treatment planning, and care coordination to restore independent community living. Available to adults.
Outpatient Services (Comprehensive Assessment, Therapy, and	Comprehensive assessment, individual and group therapy for children and adults with mental health and co-occurring

[12] Maine Legislature. (2021): https://legislature.maine.gov

[13] Specific eligibility criteria apply to each service. Please review the MaineCare Benefits Manual for a full description of services and eligibility requirements.

Service	Brief Description
Counseling Services)	disorders.
Intensive Outpatient	IOPs for SUD and mental health issues. IOPs are a type of treatment that can help people balance recovery with their daily lives. Services are provided at an agency office and consist of intensive and structured substance use treatment three to four days a week. Intensive outpatient programs are typically three or four weeks in duration.
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.
Family Psychoeducation Treatment	Services are evidence-based, provided via single-family session or multi-family groups. Clinical elements include engagement sessions, psychoeducational workshops, and ongoing treatment sessions that focus on addressing problems that interfere with treatment and rehabilitation.
Mental Health Skills Training and Development Services	Includes personal supervision and therapeutic support to restore and improve the members' skills and abilities essential to independent living. Services reorient members to time, place, and circumstance. Available to adults.
Enhanced Family Treatment	Structured, consistent, strengths-based therapeutic services between a licensed clinician and the youth and family for treating the youth's behavioral health needs. Interventions include behavior modification and family therapy. Services utilize various evidence-based practices, including Multi-Systemic Therapy, Multi-Systemic Therapy for Problem Sexualized Behaviors, and Functional Family Therapy. Available to children.
Community Rehabilitation Services	Individualized combination of community integration, daily living supports, and skills development services available 24 hours per day, 7 days a week. Available to adults.
Assertive Community Treatment (ACT)	Evidence-based intensive integrative services delivered through a multidisciplinary team, available 24 hours a day, 7 days a week. Available to adults and children.
Crisis Services	Immediate crisis-oriented therapeutic intervention services to members with a serious problem of disturbed thought, behavior, mood, or social relationships. Services are oriented toward the amelioration and stabilization of these acute emotional disturbances. Crisis services include mobile units and short-term residential placement. Available to adults and children.
Residential Habilitation for Children	Services that offer individually tailored supports assisting with the acquisition, retention, or improvement in skills related to living in the community. Services include assessment, adaptive skill development, community inclusion crisis support, transportation, educational supports, social and leisure skill development, planning, therapy, psychiatric consultation, and medication management. Available to children.
Partial Hospitalization Services	Partial Hospitalization Services are supervised rehabilitative-

Service	Brief Description
	oriented services by a mental health clinician lasting more than two hours but less than twelve hours each day in a psychiatric hospital that provide a combination of evaluative, diagnostic, treatment and rehabilitative services to persons with psychiatric problems.
Psychiatric Residential Treatment Facility Services	Comprehensive mental health treatment and/or SUD treatment to children and adolescents who, due to mental illness, SUD, or SED, meet level of care requirements for a PRTF.
Inpatient Psychiatric Services	Inpatient Services in this Section means services furnished in a psychiatric hospital for patients who have been admitted to the hospital for 24-hour-a-day acute psychiatric care.

Demographic Overview

Maine is comprised of vast rural areas with a relatively small population. According to the Health Resources and Services Administration (HRSA), each of Maine's counties has medically underserved areas, both in non-rural and rural areas. Moreover, Maine holds 70 federal Mental Health Professional Shortage Area (MH-HPSA) designations. According to the HRSA, 399,337 Mainers reside in a designated MH-HPSA, with the state meeting only 19.7% of the needs regarding an adequate number of behavioral health practitioners.[14]

According to the 2022 State of Mental Health in America Report from Mental Health America (MHA), Maine ranks 37th among the 50 states (plus DC) in terms of adult mental health. Exceeding the national average of 19.9%, 22.1% of Maine adults reported having any mental illness, which ranks 35th out of 50 states. SMI is a significant concern in Maine, affecting approximately 4.6% of the adult population, which aligns with national trends indicating that around 5.1% of adults experience SMI.[15] Over 12% of this population reported being uninsured, ranking 37 of 50 states, and over a quarter reported not receiving the care they needed in the past year (ranking 33 of 50 states).[16] Among these adults, a greater share in Maine had Medicaid (25.7%) than the national share (21.6%).[17] With specific regard to Medicaid enrollment, 42% of adults enrolled in MaineCare have at least one mental health condition.[18]

Assessment of Current Availability of Mental Health Services

As of 2024, Maine's mental health inpatient care system is characterized by both challenges and advancements. While the state has both public and private facilities providing acute psychiatric care, many of these institutions face high demand and limited bed availability, often leading to extended waits in EDs for admissions. Despite efforts to improve access to mental health services, challenges persist, especially in rural areas where resources can be limited.[19] Specifically, individuals with SMI often encounter barriers such as stigma, a lack of integrated care, and difficulties in accessing appropriate treatment, with over 60% of those with SMI not

[14] Kaiser Family Foundation: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[15] National Institute of Mental Health. (2021): https://www.nimh.nih.gov/health/statistics/mental-illness

[16] Mental Health America: https://mhanational.org/sites/default/files/2022%20State%20of%20Mental%20Health%20in%20America.pdf

[17] Kaiser Family Foundation: https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/maine/

[18] https://www.samhsa.gov/data/report/behavioral-health-barometer-maine-volume-6

[19] Maine Department of Health and Human Services. (2020): https://www.maine.gov/dhhs/mentalhealth/index.html

receiving adequate care.[20]

In 2023, Maine DHHS was awarded a $1 million, one-year SAMHSA Certified Community Behavioral Health Clinic (CCBHC) Planning Grant. The planning grant will help Maine DHHS expand current state-funded efforts to design and implement a CCBHC model. In March 2025, the state launched the first three CCBHC programs, with two additional programs set to start in July 2025. The CCBHC model provides states with the tools necessary to support a comprehensive array of mental health and substance use treatment services, offering expanded care while enhancing access to crisis services and coordinated care throughout the behavioral health system.

Maine completed an assessment of the availability of mental health services (Attachment 7) using the CMS-provided template to understand the current prevalence of members with SMI and provider participation in Medicaid across psychiatrists, other practitioners licensed to treat mental illness, and other specialty mental health providers.

The assessment reveals significant variability in access to mental health services across Maine's counties, both in terms of availability and type of facilities. Some counties have fewer hospitals but a higher number of Federally Qualified Health Centers (FQHCs) or Look-Alike (LAL) facilities, indicating uneven distribution of resources. Institutions for Mental Diseases (IMDs) are located in only three of Maine's 16 counties, while five counties have acute care hospitals with psychiatric units, and three counties have standalone psychiatric hospitals. Intensive Outpatient Programs (IOPs) are available in 12 counties. While all counties have prescribers and licensed practitioners who can treat mental health conditions, their distribution and availability vary. Importantly, every county has access to mobile crisis services and FQHC/LAL facilities that offer behavioral health services, providing a baseline of support across the state despite regional disparities.

Applying Evidence-Based Programs

The DHHS has prioritized the implementation of evidence-based practices to improve outcomes and meet the needs of people with SMI within Maine, particularly in their communities. The DHHS is committed to continuing its investment in strengthening the use of evidence-based practices during the course of its SMI waiver initiative. This has included various levels of support for Maine providers to do this work in a supported and sustainable way. Primarily through regular training opportunities (many of which are fully funded by the Office of Behavioral Health), consultation with national experts for fidelity support, development of state-level centers of excellence, and compiling these resources on online platforms for easy access. Lastly, a critical piece has been ensuring coverage of many evidence-based practices in MaineCare coverage. Below are specific examples:

- DHHS worked with a vendor to establish a CCBHC site (Maine CCBHC Resources and Evidence-Based Practices Information | CCSME), which hosts a plethora of information on trainings and other resources to support CCBHCs in delivering evidence-based practices in home and community-based settings for individuals with a range of behavioral health needs required or allowed under the Maine CCBHC model.
- DHHS launched a High-Fidelity Wraparound (HFW) Center of Excellence (COE). The Maine COE is responsible for training staff throughout Maine, facilitators, peer support

[20] Substance Abuse and Mental Health Services Administration (SAMHSA). (2021): https://www.samhsa.gov

specialists, supervisors, and coaches, are trained in the HFW philosophies, principles, and practices; and providing ongoing opportunities to enhance their skills and competencies; to support implementation of the HFW, Program to Encourage Active, Rewarding Lives (PEARLS), and Peer Connect models as intended with fidelity and high quality.

- Maine contracts with The Center for Evidence-Based Practices (CEBP) at Case Western Reserve University for expert consultation and technical assistance related to ACT service delivery, as well as to conduct external, third-party DACTS Fidelity Reviews on a semi-annual basis.

Progress & Performance Reporting

Maine will ensure that progress is measurable and regularly monitored for achieving the stated goals, objectives, milestones, and activities. Additionally, Maine will incorporate data that ensures CMS can monitor budget neutrality. Maine will work with CMS to develop monitoring protocols that capture specific data elements, concepts, information, and timelines to track the state's progress. Based on monitoring protocols, progress and performance reports will include timelines and key data points to ensure that reporting includes key indicators on progress towards goals; Maine will include a common set of measures in alignment with CMS requirements and will also agree to include additional measures and measure concepts that are specifically appropriate to Maine's demonstration parameters. The monitoring protocols will be sufficient to allow a mid-point assessment between years two and three of the demonstration, which will confirm that Maine is making sufficient progress toward meeting the milestones and performance targets, as well as budget neutrality.

Implementation Plan

Maine chooses to submit its Implementation Plan as a post-award protocol, using CMS's template within 90 days of the Demonstration approval. The Implementation Plan will commit to specific timeframes and activities to meet each of the identified Milestones above by the end of the second year of Implementation. The implementation plan's first activity, per CMS guidance, is to ensure that all participating IMDs are licensed and accredited and that community-based alternatives are available throughout the state under Maine's financing plan. The Implementation Plan will include an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams.

Maine's Implementation Plan will also include a Health Information Technology Plan (HIT Plan) describing Maine's ability to employ health IT, including opportunities to use Maine's Health Information Exchange, HealthInfoNet, Electronic Health Records, and internal dashboards and provider portals to meet the SMI/IMD goals. Included in this plan will be the current state assessment of electronic care plan sharing, care coordination, and integration of behavioral and physical health with timelines and activities to most effectively leverage Maine's HIT ecosystems and support evidence-based practices.

Milestones to Achieve the SMI/IMD Demonstration Goals

Maine commits to meeting the following milestones as critical steps to achieving the SMI/IMD goals during the demonstration.

1. Ensuring Quality of Care in Psychiatric Hospitals and Residential Settings
2. Improving Care Coordination and Transitions to Community-Based Care
3. Increasing Access to a Continuum of Care, Including Crisis Stabilization Services

4. Earlier Identification and Engagement in Treatment, Including Through Increased Integration

SMI/IMD Demonstration Financing

Budget Neutrality

Maine estimated projected spending for the five-year demonstration period based on the programmatic detail described earlier in this application. Maine is projecting that this demonstration will be budget neutral.

Budget Neutrality analyses are included under Section IV: demonstration Financing and Budget Neutrality.

Ongoing Maintenance of Effort

In this request, Maine commits to ongoing Maintenance of Effort (MOE) on funding outpatient community-based mental health services, as per the CMS guidelines. To this end, Maine will maintain state appropriations and local funding for outpatient community-based mental health services for Medicaid beneficiaries throughout the demonstration, ensuring that the level of investment remains consistent from the beginning to the end of the demonstration.

Maine Medicaid Calendar Year 2022 Expenditures on Community-Based Mental Health Services, From Maine Quality Forum Annual Behavioral Health Spending Report for 2024

Category	Federal	State-General Funds	Local/County funds	Total
Expansion	$214,674,918	$23,852,769	N/A	$238,527,686
Standard	$289,212,835	$177,259,479	N/A	$466,472,314
Total MaineCare	**$503,887,752**	**$201,112,248**	**N/A**	**$705,000,000**

Objective 3: Improve the continuity of care during transitions by building and strengthening relationships with community-based organizations.

By promoting clear communication, continuity of care, and patient education, these transitions lead to improved health outcomes, such as better management of chronic conditions, reduced hospital readmissions, and fewer complications. Effective transitions also enhance patient safety by minimizing medication errors and ensuring timely follow-up care, particularly for individuals with complex health needs.

Pilot 3: Transitions of Care Incentive Payment

Request

Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment for providers who render services to members within 7 days of release from institutions, including hospitals,

Intermediate Care Facilities for Individuals with Intellectual Disabilities (IMDs), and carceral settings such as jails, prisons, and youth correctional centers, to improve the continuity of care. The incentive payment will be an additional $236.77 per eligible claim.

Background

The risk of death following release from hospitals, IMDs, or carceral settings is a significant concern, as individuals are vulnerable to a variety of health-related outcomes, including overdose, suicide, and other health complications. Several key factors contribute to the increased risk of death during this transition, particularly in the immediate period after discharge. A meta-analysis demonstrated a three to eightfold increased risk of drug-related death in the first 2 weeks after release from prison.[21] Transitions from behavioral health facilities also reflect similar risks, where the suicide rate for the first week after discharge for patients with identified suicide risk history is 300 times higher than the general population's[22] and is greatest in the first few days after discharge.[23] The period after discharge from substance use treatment is a vulnerable time for individuals. Continued medical, psychological, and social support is crucial to reduce these risks.

A well-managed transition also addresses the psychological aspect of care—patients who feel informed and supported during transitions are more likely to engage with their care, reducing stress and improving their sense of control. Furthermore, quality transitions reduce unnecessary costs by preventing readmissions, reducing duplication of services, and improving individual well-being by preventing avoidable health crises. Effective transitions contribute to more coordinated, efficient, and patient-centered care, resulting in improved health outcomes and a more resilient and sustainable healthcare system.

Specific goals of the incentive pilot include:

- Reduce All-Cause Death
- Reduce ED visits
- Reduce Hospitalizations
- Have people with lived experience shape the initiatives

Maine will enhance the continuity of care during these transitions by fostering and strengthening relationships with community-based organizations, including substance use and mental health organizations, Federally Qualified Health Centers (FQHCs), sober living homes, and local housing authorities.

Eligibility

Community-based providers will be eligible for reimbursement if the service meets the following requirements:

- Provide an eligible service to a MaineCare member within seven days of the member's release from prison, jail, psychiatric inpatient, or residential setting
    - AND

21 Merrall EL, Kariminia A, Binswanger IA, Hobbs MS, Farrell M, Marsden J, Hutchinson SJ, Bird SM. Meta-analysis of drug-related deaths soon after release from prison. Addiction. 2010 Sep;105(9) https://pmc.ncbi.nlm.nih.gov/articles/PMC2955973/

22 Chung D, Hadzi-Pavlovic D, Wang M, et alMeta-analysis of suicide rates in the first week and the first month after psychiatric hospitalization BMJ Open 2019 https://bmjopen.bmj.com/content/9/3/e023883

23 Riblet N, Shiner B, Watts BV, Mills P, Rusch B, Hemphill RR. Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports. J Nerv Ment Dis. 2017 Jun;205(6):436-442. https://pubmed.ncbi.nlm.nih.gov/28511191/

- Submit a claim to MaineCare for an eligible service that include:
    - Primary Care Services
    - Dental Services
    - SUD Services
    - Mental Health Services
    - Social Worker/Case Management Services

The following services will not be eligible for the incentive payments:

- Ambulance services
- Pharmacy services
- Institutional services (inpatient hospital, ICF-IDD, nursing facilities)
- Non-Emergency Transportation

Benefits

Qualifying providers who render a qualifying service to a MaineCare member within seven days of the member's release from prison, jail, psychiatric inpatient, or residential setting will receive an incentive payment of $236.77.

Objective 4: Improve the Continuity of Coverage and Access to Needed Care by Leveraging Re-entry Initiatives, Including Pre-Release Services for Justice-Involved Individuals

Initiative: Pre-Release Medicaid Services for Justice-Involved Individuals

Request

Maine requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity-building funding to support the system transformation necessary to implement the reentry waiver.

Background

Maine's reentry waiver aims to address the healthcare needs of justice-impacted individuals. Persons involved with the justice system are subject to significant behavioral and physical health disparities compared to the general U.S. population. This spans many areas of health, including greater prevalence of chronic medical conditions (e.g., high blood pressure, asthma), infectious diseases (e.g., Tuberculosis rates are four times higher; hepatitis is over eight times higher, and HIV/AIDS is two to seven times higher), and much larger needs related to behavioral health issues.[24] Data from the U.S. Department of Justice and the National Institute on Drug Abuse shows, respectively, that 58.1% of the United States' incarcerated population had a mental health disorder, and 65% had a SUD (compared to just 11% and 9% for the general population,

[24] US Department of Justice (2015). Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-12. Retrieved from: https://bjs.ojp.gov/content/pub/pdf/mpsfpji1112.pdf.

respectively).[25, 26]

Approximately 3,500 people are incarcerated at any given time in Maine in prisons, jails, and the juvenile facility.[27] Over 30,000 people are released from jails annually. Maine has an incarceration rate of 272 per 100,000 people, far below the national average rate of 642 per 100,000 people.[27] According to Maine DOC, 72% of women who are incarcerated in Maine's state facilities are there on drug-related charges, 90% of them have multiple adverse childhood experiences, and 78% are mothers.[28] As of 2022, 61% of the total Maine Department of Corrections (MDOC) population had a SUD diagnosis, and 40% received medication for a SUD.[29]

Access to healthcare services, particularly for mental health and substance use treatment, is associated with a lower risk of recidivism. The Bureau of Justice Statistics reports that addressing these health needs before release significantly reduces the likelihood of reoffending.[30] The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that initiating treatment for substance use and mental health disorders during incarceration and ensuring it continues post-release helps reduce relapse rates.[31] This aligns with evidence-based practices that support early treatment initiation.[31] Research published in the American Journal of Public Health shows that starting MAT before release can reduce overdose risks, particularly in the first two weeks post-release, a critical period for preventing fatalities.[32,33]

With the nuances of the justice-involved population in Maine, the re-entry waiver will focus efforts on substance use treatment, mental health, infectious diseases like HIV and Hepatitis C, and case management to connect this population with needed services to improve care coordination and to address HRSN for the vulnerable period post-release from carceral settings.

Eligibility

Maine aims to implement this initiative in all 21 prisons, jails, and juvenile facilities. Over the demonstration period, Maine will phase in correctional facilities based on readiness. To be eligible for these services, a member must meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010. All adults and youth who are incarcerated in a participating correctional setting and are enrolled in Medicaid will be eligible to access pre-release services. Services will be available to individuals both pre- and post-adjudication. Maine estimates that approximately 54,528 individuals will receive pre-release services under this demonstration.

Maine is developing a county-informed approach for correctional facilities to participate in this demonstration. Due to each county's unique characteristics and resources, Maine will work with each county and regional jail to develop a plan for services rendered by a carceral healthcare

[25] US Department of Justice (2006). Mental Health Problems of Prison and Jail Inmates. Retrieved from: https://bjs.ojp.gov/content/pub/pdf/mhppji.pdf.
[26] US National Institute of Drug Abuse (2020). Criminal Justice DrugFact. Retrieved from: https://nida.nih.gov/download/23025/criminal-https://bjs.ojp.gov/content/pub/pdf/mhppji.pdfjusticedrugfacts.pdf?v=25dde14276b2fa252318f2c573407966
[27] https://www.prisonpolicy.org/profiles/ME.html
[28] https://legislature.maine.gov/doc/3517#:~:text=According%20to%20Maine%20DOC%2C%2072,capita%20rate%20in%20New%20England.
[29] https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/MDOC%20MSUD%20Year%20Three%20Report%20%282022%29.pdf
[30] People with Mental Health Conditions in Corrections | National Institute of Corrections, https://nicic.gov/resources/resources-topics-and-roles/topics/people-mental-health-conditions-corrections
[31] Substance Abuse & Mental Health Services Administration, Medication Assisted Treatment (MAT) in the Criminal Justice System: Brief Guidance to the States, https://store.samhsa.gov/sites/default/files/pep19-matbriefcjs_0.pdf
[32] Substance Abuse & Mental Health Services Administration, *Use of Medication-Assisted Treatment for Opioid Use Disorder in Criminal Justice Settings*, https://store.samhsa.gov/sites/default/files/treatment-criminal-justice-pep19-matusecjs.pdf
[33] https://www.ncchc.org/wp-content/uploads/From_the_General_Public_to_Americas_Jails_-_MAT_Saves_Lives-_Indivior.pdf

provider, an in-reach provider, or a combination of both. All willing and qualified providers can enroll to provide pre-release services. Pre-release services will be billed through a fee-for-service delivery system. Correctional providers at each jail and prison will be required to enroll in MaineCare.

Dual-Track Implementation will consist of the following:
Track 1: Department of Corrections/State Prisons: Initiate reentry pilot within a state prison. Longcreek is Maine's only juvenile justice facility and is a part of the Department of Corrections. Longcreek will be included as a part of the reentry initiative. After finalizing and implementing MaineCare eligibility and enrollment processes, as well as provider enrollment procedures, the reentry initiative will be implemented in a phased approach to other state prison facilities, based on the readiness assessment.

- **Track 2:** County Jails: Pilot the reentry initiative in one jail. Once short-stay planning, MaineCare eligibility, and enrollment processes are finalized, the reentry initiative will be implemented in a phased approach to other county and regional jails based on a readiness assessment.

Benefits
Maine proposes covering the following services, as required in CMS guidance, for the pre-release population:

- **Case management** to address health and social needs, under which care teams will establish client relationships, conduct a needs assessment, develop a person-centered care plan, and make appropriate linkages and referrals to post-release care and supports. Case management is a component of various sections of MaineCare policy and involves multidisciplinary teams, including Peer Supports and Community Health Workers.
- **Medication-assisted treatment (MAT)** for SUD, including medication in combination with counseling/behavioral therapies, as clinically appropriate.
- **Physical and behavioral health clinical consultation services** for eligible youth
- **At a Minimum, a 30-day Supply of Prescription Medication** in hand upon release, consistent with Medicaid State Plan coverage.

Additionally, Maine proposes covering the following optional services as clinically appropriate, consistent with Medicaid State Plan Coverage, and phased in over time as facility readiness allows:

- **Physical and behavioral health clinical consultation services** (e.g., practitioner office visits for physical, behavioral health, and dental screening and diagnostic services) that are intended to support the creation of a comprehensive, robust, and successful reentry plan, such as clinical screenings and pre-release consultations with community-based providers.
- **HIV and Hepatitis C care.** This includes provider evaluations, laboratory studies, and medications to treat these infectious illnesses.
- **Family Planning Services and Supplies.** These services may include contraception, sexually transmitted infection (STI) screenings, and counseling services.

These additional services aim to create a comprehensive support system for individuals reentering the community, addressing their immediate health needs and concerns. This comprehensive approach will improve health outcomes, reduce recidivism, and promote well-being as individuals reintegrate into the community.

Capacity Building Funds
To support cross-system implementation efforts for this initiative, Maine is requesting a total of $15 million in computable capacity-building funds, which include both the state and federal shares. Capacity-building funds and the level of funding are dependent upon sufficient state and county appropriations. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including, but not limited to, conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications necessary to implement this initiative across participating correctional settings.

Objective 5: Establish HRSN benefits, including Food is Medicine and Recuperative Care

HRSN Pilot 5a: Proposed Food is Medicine

Request
Maine is requesting expenditure authority for federal matching funds to start Food is Medicine pilot programs. Pilots may include the following: food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.

Background
Food is Medicine (FIM) refers to a range of programs, services, and interventions that address the interconnection between nutrition and health outcomes, encompassing areas such as food access and tailored food assistance (e.g., medically tailored meals, vouchers for produce, etc.).

Poor nutrition is the leading cause of chronic illness and death across the entire U.S. Food insecurity, characterized by limited or uncertain access to adequate food, is strongly linked to various negative health outcomes. These include increased risks of chronic diseases like diabetes, heart disease, and hypertension, as well as poor mental health, impaired physical development in children, and higher rates of hospitalization.[34]

A variety of independent FIM-aligned programs are offered in Maine through public and private agencies. However, in isolation, these services do not provide the full scope of FIM programming. Massachusetts' 1115 waiver supported FIM initiatives demonstrated significant improvements in health outcomes, leading to a reduction in hospitalizations and emergency department utilization.[35]

Eligibility

[34] https://www.cdc.gov/nchs/products/databriefs/db465.htm#:~:text=In%202021%2C%2033.8%20million%20people,in%20families%20experiencing%20food%20insecurity.

[35] Medicaid Nutrition Supports Associated With Reductions In Hospitalizations And ED Visits In Massachusetts, 2020–23 | Health Affairs

Maine aims to implement the Food is Medicine initiatives through pilot projects. Eligible individuals include those enrolled in MaineCare, who are identified as being food insecure and meet one of the following criteria:

- Have a chronic health condition such as diabetes, cancer, HIV, etc.
- Have a behavioral health condition (defined as behaviors that affect mental and physical well-being, encompassing mental health and SUD).
- Pregnant and postpartum individuals up to 6 months postpartum.

Benefits

- Case Management services to access food/nutrition services, such as:
    - Outreach and education
    - Linkage to other state and federal benefit programs (application assistance)
- Nutrition counseling and instruction tailored to health risk or nutrition-sensitive health conditions, such as:
    - Guidance on selecting healthy food
    - Healthy meal preparation
- Home-delivered meals or pantry stocking, tailored to health risk and eligibility criteria, or certain nutrition-sensitive health conditions and/or specifically for children or pregnant individuals (includes medically tailored meals) – up to 3 meals/day for up to 6 months
- Nutrition prescriptions tailored to health risks or certain nutrition-sensitive conditions – up to 3 meals/day for up to 6 months
    - Fruit and Veggie Rx.
    - Protein boxes
    - Food pharmacies
    - Healthy food vouchers
- Grocery provisions for high-risk individuals to avoid unnecessary admissions or institutionalization – up to 3 meals/day for up to 6 months

HRSN Pilot 5b: Recuperative Care

Request

Maine is requesting expenditure authority for federal matching funds to cover recuperative care, inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. Maine proposes a recuperative care pilot with three sites.

Background

People experiencing homelessness have a higher burden of chronic illnesses than the general population and have a more challenging time recovering from illness when they are hospitalized. This is in large part due to inadequate housing or a lack of housing as a significant barrier to healing from illness, as people experiencing homelessness may be discharged to a shelter or the streets. As a result, they incur more costly care. On average, individuals experiencing homelessness spend 4.1 more days in the hospital, are twice as likely to be readmitted, are six times as likely to go to the ER within 30 days of the last time they went to the ER, and cost

$4,000 more per day than their housed counterparts.[36]

In Maine, the number of people experiencing homelessness has nearly tripled in the past three years.[37] With emergency homeless shelters at capacity, the number of people experiencing unsheltered homelessness has also steadily increased. The increased rate of homelessness has occurred alongside the existing opioid crisis. Record rates of overdose deaths have disproportionately impacted Maine.[38] Additionally, Maine has the highest rate of Hepatitis C in the country and is experiencing an increase in HIV incidence among people who inject drugs and are experiencing homelessness.[39] [40] This syndemic of homelessness, injection drug use, hepatitis C, and HIV is driving a high disease burden and poor health outcomes.

Recuperative Care programs fill the gap that exists between a shelter and an acute hospital stay. Many members cannot recover from their illness on the streets but are not sick enough to be in a hospital. Recuperative Care programs provide the essentials, such as a safe place to sleep and adequate nutrition, while also offering necessary clinical care and social support. Recuperative Care programs offer a range of medical supports and interventions, including care coordination and case management, medication management, nursing oversight, and referrals to medical care, including behavioral health and substance use disorder (SUD) services. A systematic review showed that recuperative care decreased 90-day readmissions for homeless individuals and reduced the hospital length of stay.[41]

Eligibility

Maine aims to implement the recuperative care initiative through pilot projects. Eligible individuals include those who are:

- enrolled in MaineCare,
- experiencing homelessness, and
- having an acute medical or psychiatric condition.

Benefits

Recuperative care includes:

- **Case management and care coordination**
- **Medical Care**
- **Personal Care Services**: room and board, including three meals per day, access to a bed 24-7, and staff to provide wellness checks

HRSN Pilot 5c: Structured Recovery Housing Services (Previously submitted as Pilot services administered by structured recovery housing programs)

Request

[36] National Healthcare for the Homeless Council. (2011). Clinical Recommendations for the Medical Respite Setting. Nashville, TN: Edgington, S. (Ed.). Available from www.nhchc.org.

[37] https://mainehousing.org/docs/default-source/housing-reports/2024-point-in-time-report.pdf

[38] https://mainedrugdata.org/wp-content/uploads/2023/07/GOPIF_OpioidReport_2023.pdf

[39] https://www.cdc.gov/hepatitis/statistics/2021surveillance/hepatitis-c/figure-3.3.htm

[40] https://www.maine.gov/dhhs/mecdc/infectious-disease/epi/hiv-cluster.shtml

[41] Doran, Kelly M. & Ragins, Kyle T. & Gross, Cary P. & Zerger, Suzanne. "Medical Respite Programs for Homeless Patients: A Systematic Review." Journal of Healthcare for the Poor and Underserved, vol. 24 no. 2, 2013, pp. 499-524. Project MUSE, doi:10.1353/hpu.2013.0053.

Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences. They address the specific health determinants of eligible enrollees to improve health outcomes and lower healthcare costs.

Background

Substantive data indicate that housing plays a vital role in successful long-term recovery for individuals recovering from SUD. Stable housing is a necessary component to achieving health and long-term recovery from mental illness and SUD.[42] SAMHSA delineates the four dimensions that support individuals in recovery, with one dimension of recovery support being to have a "home, a stable and safe place to live."[43] Individuals transitioning from a recovery residence might need support in obtaining stable housing. Transitions are a high-risk period for relapse, and this pilot seeks to reduce the stress of not having stable housing or being at risk of not having such housing that could lead an individual recovering from SUD to return to drug-seeking behaviors, drug use, and/or relapse.

Eligibility

As a pilot program, this work will only be eligible for individuals who meet all the following criteria:

- Is a parent;
- Has a SUD;
- Is a resident of an eligible recovery residence;
- Is engaged in SUD treatment;
- Has an open CPS case or is at risk of such a case being opened; and
- Has been assessed to have a relevant risk-factor(s) and applicable social service needs using a validated screening tool.

And residences that meet the following criteria:

- Approved by MaineCare;
- Demonstrated success managing performance-based contracts;
- Accepts and welcomes the inclusion of members receiving MAT;
- Willing and able to move toward value-based payments;
- Certified as a level 4 facility by the Maine Association of Recovery Residences, utilizing the National Alliance of Recovery Residences quality standards and code of ethics;
- Agrees to develop, contract with, and manage a network of pilot providers to deliver services, including community-based organizations (CBOs), social service agencies and healthcare providers; and,
- Be responsible for authorizing all pilot services to eligible enrollees within State and CMS guidelines.

Benefits

Structured Recovery Housing Services fall into two categories: housing transition and pre-tenancy services, and housing and tenancy sustaining services. The services Maine intends to

[42] https://library.samhsa.gov/sites/default/files/sma13-4734.pdf

[43] https://library.samhsa.gov/sites/default/files/pep12-recdef.pdf

include are described below.

Housing Transition and Pre-Tenancy Services support individuals as they initially transition out of higher LOC settings into home and community-based settings. These services include:

- Conducting a tenant screening and housing assessment
- Developing an individual stabilization plan
- Assisting with the housing search process and application process
- Covering one-time move-in expenses, such as a security deposit, first month's rent, and/or move-in costs
- Assisting in arranging the details of the move
- Developing a housing support crisis plan that identifies resources for eviction prevention, short-term, and/or long-term rental assistance in the event that housing is jeopardized
- Initially conducting as-needed in-home sessions with the member to link and help ensure the receipt of services and resources necessary to support housing stability

Housing and Tenancy Sustaining Services help individuals maintain tenancy in their housing arrangements as they continue recovery. These services include:

- Education and training on the roles, rights, and responsibilities of both tenant and landlord
- Coaching on developing and maintaining important relationships with landlords and/or property managers with the intent of promoting sustained and successful tenancy
- Assistance in resolving disputes with landlords and/or neighbors to reduce eviction risk or other adverse actions
- Providing advocacy and links to available community resources to prevent eviction when housing is or is at risk of becoming jeopardized
- Provision of ongoing training on good tenancy practices and lease compliance

Members eligible for Supported Housing services may receive one or more of the services detailed above under the waiver program.

Capacity Building Funds

To support the implementation of the HRSN initiatives, Maine is requesting a total of $5 million in computable capacity-building funds. Capacity-building funds and the level of funding are dependent upon sufficient state appropriations. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including community-based providers. This funding will support planning and implementation activities, including, but not limited to, conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications necessary to implement these initiatives.

Traditional Healing Therapies for Native Americans

Request

Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services

delivered by or through these facilities. Maine is collaborating with the Wabanaki Nations to refine and finalize the details of the request, including the eligible services, benefits, and types of providers.

Background

The World Health Organization describes traditional healing therapies as the "sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."[44] Native Americans have long recognized the contribution of traditional healers and practitioners who are valued for their role in aiding the healing process. There are 574 federally recognized Tribes in the United States, each with its own traditional healing therapies. The four federally recognized tribes in Maine are the Houlton Band of Maliseet Indians, Mi'kmaq Nation, Penobscot Nation, and Passamaquoddy Tribe. These tribes are collectively known as the Wabanaki. Each of these four federally recognized tribes, consisting of five tribal communities, maintains its own government, cultural centers, and schools, and manages its respective land and resources. The Passamaquoddy Tribe, Penobscot Nation, and the Houlton Band of Maliseet Indians have their own Health Centers, and Mi'kmaq Nations have a service unit through Indian Health Services.

Under an 1115 waiver, states can cover services not typically covered by Medicaid, including traditional healing therapies for Native Americans. Medicaid coverage of traditional healing therapies for substance use treatment has the potential to improve outcomes for individuals, including those in the Wabanaki Nations. It offers a holistic, personalized, and culturally relevant approach to treatment, which can increase engagement, reduce stigma, and provide more culturally responsive options for recovery. Considering emerging evidence supporting the effectiveness of these services as part of a whole-person approach, the State plans to collaborate with our Tribal partners on developing a pilot for traditional healing therapies under the 1115 waiver authority.

Eligibility

To receive coverage for traditional healing therapies under this component of the demonstration, a beneficiary must meet the following criteria:

- Is a Medicaid or CHIP beneficiary, and
- Is able to receive services delivered by or through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10

Benefits

To be covered, the traditional healing therapies must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10) to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid and CHIP. The qualifying facility is expected to make the following determinations and to provide documentation of these determinations to DHHS, upon request.

[44] Traditional, Complementary and Integrative Medicine

Each qualifying facility is responsible for determining that each practitioner, provider, or staff member employed by or contracted with the facility to provide traditional healing therapies 1) is qualified to provide such services to the facility's patients; and 2) has the necessary experience and appropriate training. The qualifying facility is also expected to: 1) establish its methods for determining whether its employees or contractors are qualified to provide traditional healing therapies 2) bill Medicaid or CHIP for traditional healing therapies furnished only by employees or contractors who are qualified to provide them, and 3) provide documentation to DHHS about these activities upon request.

Maine is collaborating with the Wabanaki Nations to develop and refine the specific services to be provided as part of traditional healing therapies.

Section III: Benefits, Eligibility, Delivery System, and Cost Sharing

Benefits

Maine is continuing to request an enhanced set of benefits for the Pilots as described in Section II.

Other changes to benefits proposed in the renewal are described in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration) above, and include:

- Reauthorizing the existing list of Pilot services
- Contingency Management services
- Targeted pre-release services for justice-involved individuals in the 90 days prior to release
- HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services
- Traditional Healing Therapies
- Expenditure authority for services provided to Medicaid enrollees on short-term stays in IMDs

Enrollment Limits

There are no enrollment limits for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility

DHHS proposes to implement the initiatives across all "full benefit" eligibility groups. Processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status will be provided in the implementation plans. Currently, for people enrolled in Medicaid and in a carceral setting, their Medicaid is suspended. For people who are not enrolled in Medicaid prior to incarceration, process improvements to streamline Medicaid determinations will be included in the implementation plan.

Table 5: Full Benefit Medicaid Beneficiaries Eligible for services under this demonstration providing they meet criteria as described in Section II

GROUP NAME	CITATIONS	FPL
Under 19 yrs of age	42 CFR §435.118; 1902(a)(10)(A)(i)(III), (IV), (VI), and (VIII); 1902(a)(10)(A)(ii) (IV) and (IX); 1931(b) and (d)	305%
Age 19 and 20	42 CFR § 1396a(a)(10)(A)(i)(VIII)	305%
Parents and Other Caretakers	42 CFR §435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d)	105%
Pregnant Women	42 CFR §435.116; 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV) and (IX); 1931(b) and (d); 1920; MAGI SPA S28	214%
Expansion Adults	1902(a)(10)(C)	138%
Former Foster Care Children	42 CFR §435.150; 1902(a)(10)(A)(i)(IX)	No income or asset test
Federally Non-Qualified Pregnant People	1902(l)(1)(A)	213%
Aged, Blind, or Disabled	1902(a)(10)(A)(ii)	100%
Specified Low-Income Medicare Beneficiaries	42 CFR §435.150;1902(a)(10)(E)(iii)	170%
Working with a Disabling Condition	1905(s)	250%

Delivery System

All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing

There are no changes to cost sharing proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Section IV: Demonstration Enrollment, Expenditures, and Budget Neutrality

This section describes the historical and expected enrollment impact, historical and expected financial expenditures, and budget neutrality considerations associated with the proposed demonstration renewal initiatives.

Enrollment

Table 6 provides historical data on Member Months and estimated Person Count for Maine's SUD Care Initiative 1115 demonstration populations from January 1, 2021, to December 31, 2023.

Table 6. Historical Member Months and Person Count

		Historical Member Months, Person Count, PMPM and Total Expenditures			
		DY1	DY2	DY3	DY4
		1/1/2021 - 12/31/2021	1/1/2022 - 12/31/2022	1/1/2023 - 12/31/2023	1/1/2024 – 12/31/2024
SUD IMD Services					
Non-Expansion Adults and Children	Member Months	0	57	189	449
	Person Count	0	20	95	259
	PMPM	$5,230.00	$6,961.75	$4,817.74	$5,529.49
	Total Expenditures	$0	$396,820	$910,553	$2,482,740
Expansion Adults	Member Months	0	199	961	1,999
	Person Count	0	71	358	822
	PMPM	$4,765.00	$6,311.90	$5,675.72	$6,456.05
	Total Expenditures	$0	$1,256,069	$5,454,368	$12,905,648
Maintenance of Medicaid Coverage					
Parents with Extended MaineCare	Member Months	0	0	1,056	2,785
	Person Count	0	0	389	544
	PMPM	$0.00	$0.00	$886.90	$1,056.35
	Total Expenditures	$0	$0	$936,571	$2,941,928

Table 7 provides the estimated enrollment for the five years of the 1115 demonstration renewal from January 1, 2026, to December 31, 2030.

Table 7. Projected Member Months and Person Count Under Renewal

		Projected Member Months, Person Count, PMPM and Total Expenditures Under Renewal					
		DY5	DY6	DY7	DY8	DY9	DY10
		1/1/2025 - 12/31/2025	1/1/2026 - 12/31/2026	1/1/2027 - 12/31/2027	1/1/2028 - 12/31/2028	1/1/2029 - 12/31/2029	1/1/2030 - 12/31/2030
SUD IMD Services							
Non-Expansion	Member Months	481	529	556	572	589	601

Adults and Children	Person Count	309	340	357	368	379	386
	PMPM	$6,528.00	$6,854.40	$7,197.12	$7,556.98	$7,934.82	$8,331.57
	Total Expenditures	$3,139,968	$3,626,663	$3,998,396	$4,324,265	$4,676,693	$5,008,738
Expansion Adults	Member Months	1,782	1,871	1,927	1,966	2,005	2,045
	Person Count	920	966	995	1,015	1,035	1,056
	PMPM	$7,432.00	$7,803.60	$8,193.78	$8,603.47	$9,033.64	$9,485.32
	Total Expenditures	$13,243,824	$14,601,316	$15,791,323	$16,912,507	$18,113,295	$19,399,339
Maintenance of Medicaid Coverage							
Parents with Extended MaineCare	Member Months	2,849	2,849	2,849	2,849	2,849	2,849
	Person Count	579	579	579	579	579	579
	PMPM	$1,219.00	$1,279.95	$1,343.95	$1,411.14	$1,481.70	$1,555.79
	Total Expenditures	$3,472,931	$3,646,578	$3,828,906	$4,020,352	$4,221,369	$4,432,438
Parenting Support Services							
Attachment Biobehavioral Catch-up	Member Months	0	150	300	450	525	600
	Person Count	0	50	100	150	175	200
	PMPM	$0	$427.90	$449.30	$471.76	$495.35	$520.12
	Total Expenditures	$0	$64,185	$134,789	$212,292	$260,058	$312,069
Visit Coaching	Member Months	0	120	240	300	360	400
	Person Count	0	30	60	75	90	100
	PMPM	$0	$1,538.00	$1,614.90	$1,695.65	$1,780.43	$1,869.45
	Total Expenditures	$0	$184,560	$387,576	$508,694	$640,954	$747,779
Home-Based Skill Development	Member Months	0	550	1,100	1,650	1,925	2,200
	Person Count	0	50	100	150	175	200
	PMPM	$0	$804.00	$844.20	$886.41	$930.73	$977.27
	Total Expenditures	$0	$442,200	$928,620	$1,462,577	$1,791,656	$2,149,987

Table 8 provides a summary of the estimated number of individuals affected by CM Initiative Impacts.

Table 8. Estimated Number of Individuals Affected by CM Initiative Impacts

		Estimated Number of Individuals Affected by CM				
		DY6	**DY7**	**DY8**	**DY9**	**DY10**
Members with Stimulant Use Disorder	Person Count	93	217	340	495	619
	PMPY	$628.95	$660.40	$693.42	$728.09	$764.49
	Total Expenditures	$58,398	$143,075	$236,074	$360,549	$473,221

Table 9 provides a summary of the estimated number of individuals affected by SMI IMD Initiative Impacts.

Table 9. Estimated Number of Individuals Affected by SMI IMD Initiative Impacts

		Estimated Number of Individuals Affected by SMI IMD				
		DY6	DY7	DY8	DY9	DY10
Non-Expansion Adults	Member Months	1,934	9,672	9672	9672	9672
	Person Count	161	806	806	806	806
	PMPM	$3,514	$3,689	$3,874	$4,068	$4,271
	Total Expenditures	$6,796.843	$35,683,387	$37,467,556	$41,307,980	$160,596,700
Expansion Adults	Member Months	2741	13,704	13,704	13,704	13,704
	Person Count	228	1,142	1,142	1,142	1,142
	PMPM	$3,739	$3,926	$4,122	$4,328	$4,545
	Total Expenditures	$10,247,559	$53,799,686	$59,314,154	$62,279,861	$244,130,930

Table 10 provides a summary of the estimated number of individuals affected by Transitions of Care Incentive Payment

Table 10. Estimated Number of Individuals Affected by Transitions of Care Incentive Payment

		Estimated Number of Individuals Affected by Transitions of Care Incentive Payment				
		DY6	DY7	DY8	DY9	DY10
Transitions of Care Incentive Payment	Member Months	215,016	225,767	237,055	248,908	261,354
	Person Count	20,605	21,635	22,717	23,853	25,045
	PMPM	$33.28	$33.28	$33.28	$33.28	$33.28
	Total Expenditures	$7,155,492	$7,513,267	$7,888,930	$8,283,376	$8,697,545

Justice-involved individuals are not included in the Medicaid Eligibility Group projections noted above. Table 11 provides a summary of the estimated number of individuals who will receive pre-release services under this demonstration.

Table 11. Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative

		Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative				
		DY6	DY7	DY8	DY9	DY10
	Member Months	461	6,263	12,035	17,285	22,535
	Person Count	154	5,588	11,012	16,262	21,512

Justice-Involved Individuals	PMPM	$2,039	$2,141	$2,248	$2,361	$2,479
	Total Expenditures	$939,089	$13,410,098	$27,056,838	$40,802,666	$55,855,434

Table 12 provides a summary of the estimated number of individuals affected by Health-Related Social Needs Pilots

Table 12. Estimated Number of Individuals Affected by Health-Related Social Needs Pilots

		Estimated Number of Individuals Affected by Food Is Medicine Pilot				
		DY6	**DY7**	**DY8**	**DY9**	**DY10**
Food Is Medicine Pilot	Member Months	2400	4800	7200	9600	120,00
	Person Count	200	400	600	800	1000
	PMPM	$416.66	$416.66	$416.66	$416.66	$416.66
	Total Expenditures	$1,000,000.00	$2,000,000.00	$3,000,000.00	$4,000,000.00	$5,000,000.00
		Estimated Number of Individuals Affected by Recuperative Care Pilot				
		DY6	**DY7**	**DY8**	**DY9**	**DY10**
Recuperative Care	Member Months	78	189	284	340	540
	Person Count	78	189	284	340	540
	PMPM	$23,141	$25,070	$26,277	$27,655	$20,315
	Total Expenditures	$1,805,009	$4,738,149	$7,462,585	$9,402,857	$10,970,000
		Estimated Number of Individuals Affected by Certified Recovery Residence Pilot				
		DY6	**DY7**	**DY8**	**DY9**	**DY10**
Certified Recovery Residence	Member Months	96	240	360	432	480
	Person Count	8	20	30	36	40
	PMPM	$604	$634	$666	$699	$734
	Total Expenditures	$57,960	$152,145	$239,628	$301,932	$352,254

Table 13 provides a summary of the estimated number of individuals affected by Traditional Healing Services Pilot

Table 13. Estimated Number of Individuals Affected by Traditional Healing Services Pilot

		Estimated Number of Individuals Affected by Traditional Healing Services				
		DY6	**DY7**	**DY8**	**DY9**	**DY10**
Traditional Healing Services	Member Months	1,188	2,388	3,576	4,776	5,964
	Person Count	99	199	298	398	497
	PMPM	$760	$760	$760	$760	$760
	Total Expenditures	$902,880	$1,814,880	$2,717,760	$3,629,760	$4,532,640

Expenditures

Table 14 provides historical data on the total expenditures for Maine SUD Care Initiative demonstration services and populations from January 1, 2021, to December 31, 2023.

Table 14. Historical Total Computable Expenditures

	Historical Total Computable Expenditures		
	DY1	DY2	DY3
Historical Expenditures	**1/1/2021 - 12/31/2021**	**1/1/2022 - 12/31/2022**	**1/1/2023 - 12/31/2023**
SUD IMD Services			
Non-Expansion Adults and Children	0	$396,820	$910,553
Expansion Adults	0	$1,256,069	$5,454,368
Maintenance of Medicaid Coverage			
Parents with Extended MaineCare	0	0	$936,571

Table 15 provides the projected expenditure under the demonstration renewal. These projections consider estimated prospective trends and projected expenditures for new initiatives as outlined in this document

Table 15. Projected Total Computable Expenditures

	Projected Total Computable Expenditures						
	DY4	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver Expenditures	**1/1/2024 - 12/31/2024**	**1/1/2025 - 12/31/2025**	**1/1/2026 - 12/31/2026**	**1/1/2027 - 12/31/2027**	**1/1/2028 - 12/31/2028**	**1/1/2029 - 12/31/2029**	**1/1/2030 - 12/31/2030**
SUD IMD Services							
Non-Expansion Adults and Children	$2,488,928	$3,139,968	$3,626,663	$3,998,396	$4,324,265	$4,676,693	$5,008,738
Expansion Adults	$11,204,496	$13,243,824	$14,601,316	$15,791,323	$16,912,507	$18,113,295	$19,399,339
Maintenance of Medicaid Coverage							
Parents with Extended MaineCare	$1,476,247	$3,472,931	$3,646,578	$3,828,906	$4,020,352	$4,221,369	$4,432,438
Parenting Support Services							
Attachment Biobehavioral Catch-up	0	0	$64,185	$134,789	$212,292	$260,058	$312,069
Visit Coaching	0	0	$184,560	$387,576	$508,694	$640,954	$747,779
Home-Based Skill Development Services							
Home-Based Skill Development Services	0	0	$442,200	$928,620	$1,462,577	$1,791,656	$2,149,987
Contingency Management							

CM	0	0	$58,398	$143,075	$236,074	$360,549	$473,221
SMI / IMD Services							
Non-Expansion Adults	0	0	$ 6,796,843	$ 35,683,387	$ 37,467,556	$ 39,340,934	$ 41,307,980
Expansion Adults	0	0	$ 10,247,559	$ 53,799,686	$ 56,489,670	$ 59,314,154	$ 62,279,861
Transitions of Care Incentive Payment							
	Projected Total Computable Expenditures						
	DY4	**DY5**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**
With Waiver Expenditures	**1/1/2024 - 12/31/2024**	**1/1/2025 - 12/31/2025**	**1/1/2026 - 12/31/2026**	**1/1/2027 - 12/31/2027**	**1/1/2028 - 12/31/2028**	**1/1/2029 - 12/31/2029**	**1/1/2030 - 12/31/2030**
Transitions of Care Incentive Payment	0	0	$7,155,492	$7,513,267	$7,888,930	$8,283,376	$8,697,545
Pre-Release Medicaid Services for Justice-Involved Individuals							
Non-Expansion Adults and Children	0	0	$187,818	$2,682,020	$5,411,368	$8,160,533	$11,171,087
Expansion Adults	0	0	$751,271	$10,728,079	$21,645,470	$32,642,132	$44,684,347
Pre-Release* Capacity Building	0	0	$3,000,000	$5,000,000	$3,000,000	$2,000,000	$2,000,000
HRSN Pilots							
Food Is Medicine	0	0	$1,000,000	$2,000,000	$3,000,000	$4,000,000	$5,000,000
Recuperative Care	0	0	$1,805,009	$4,738,149	$7,462,585	$9,402,857	$10,970,000
Certified Recovery Residence	0	0	$57,960	$152,145	$239,682	$301,932	$352,254
HRSN* Capacity Building	0	0	$500,000	$2,000,000	$1,000,000	$1,000,000	$500,000
Traditional Healing Therapies for Native Americans*							
	0	0	$902,880	$1,814,880	$2,717,760	$3,629,760	$4,532,640

* These are the proposed budget neutrality cap and Maine requests flexibility on the timing of actual payments.
**The total computable expenditures for traditional healing therapies for Native Americans are under development with tribal partners and are expected to be budget-neutral and not more costly than similar services delivered by other clinicians.

Budget Neutrality

From CMS consultation and a review of similar waiver requests, Maine believes most expenditures incurred under the waiver of expenditure authority contained within this proposal are likely considered "hypothetical expenditures."[45] For these hypothetical expenditures, CMS adjusts the budget neutrality test to treat them as if they were approved Medicaid State Plan

services. Therefore, these expenditures do not necessitate savings to offset their costs. DHHS commits to reporting all expenditures consistent with the special terms and conditions for the demonstration.

To ensure this application meets the requirements of §42 CFR 431.412, financial data

45 Per CMS guidance, this is defined as "the expenditure would have been eligible to receive FFP elsewhere in the Medicaid program."

demonstrating Maine's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration, are included below. This includes a financial analysis of changes to the demonstration requested by Maine.

The DHHS has requested an adjustment to the budget neutrality of the current 1115 Waiver SUD Care Initiative Demonstration to address the budget neutrality overages that Maine has experienced in Years 2 and 3 of the demonstration.

The first adjustment was for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SUD by IMDs. DHHS did not have historical data to base the projection of costs associated with coverage for the Expansion Adults population when developing the original budget neutrality costs. As a result, annual utilization for this population is much higher than in Calendar Year 2019, as Maine has seen increased enrollment for this population. The demonstration showed a deficit in actual expenditures for IMD beneficiaries of $336,425 in demonstration year two and $363,055 in demonstration year three when measured against the hypothetical limits. Cumulatively, actual expenditures exceeded the limit by $699,480. Below in Table 14 is a summary of actual expenses and waiver limits for IMD beneficiaries.

Table 16. Summary of Expenses and Waiver Limits

Medicaid enrollees with SUD in short-term IMD	DY1	DY2	DY3	DY4
With Waiver (Actual)				
Non-Expansion Adults and Children	0	$396,820	$910,553	$2,482,740
Expansion Adults	0	$1,256,069	$5,454,368	$12,905,648
Total Expenditures (Actual)	0	$1,652,889	$6,364,921	$15,388,388
Without Waiver Limit	0	$1,316,464	$6,001,866	$13,989,413
SURPLUS (DEFICIT)	0	($336,425)	($363,055)	($1,398,975)

IMD Beneficiaries	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver (Projected)						
Non-Expansion Adults and Children	$3,139,968	$3,290,686	$3,448,639	$3,614,174	$3,787,654	$3,969,462

Expansion Adults	$13,243,824	$13,879,528	$14,545,745	$15,243,941	$15,975,650	$16,742,481
Total Expenditures (Projected)	$16,383,792	$17,170,241	$17,994,384	$18,858,115	$19,763,304	$20,711,943

The second adjustment is to Pilot 1 Extended MaineCare Coverage. Individuals 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 under state law. The project's initial Per Member Per Month (PMPM) estimate was based on actual data for 2021. While expenditures were below limits in Years 1-3, subsequent rate increases and more costly than anticipated utilization require an amendment to these Without Waiver PMPM values.

The demonstration showed a surplus in expenditure authority for the four pilot projects. The first of three pilots was implemented in demonstration year three, and actual expenditures were below the annual limit. A summary of actual expenditures and waiver limits for the pilot projects is provided in Table 17, below:

Table 17. Expenditures and Waiver Limits for Pilot Projects

Pilot Projects	**DY1**	**DY2**	**DY3**	**DY4**
With Waiver (Actual)				
Parents with Extended MaineCare	0	0	$936,571	$2,941,928
Parents Receiving Home-Based Skills Development Services	0	0	0	0
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	0	0	0	0
Parents Receiving Visit Coaching	0	0	0	0
Total Expenditures (Actual)	**0**	0	$936,571	$2,941,928
Without Waiver Limit	**0**	0	$978,912	$2,715,375
SURPLUS (DEFICIT)	**0**	0	$42,342	($226,553)

Pilot Projects	**DY5**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**
With Waiver (Projected)						
Parents with Extended MaineCare	$3,472,931	$3,639,632	$3,814,334	$3,997,422	$4,189,298	$4,390,385
Parents Receiving Home-Based Skills Development Services	0	$1,768,800	$1,853,702	$1,942,680	$2,035,929	$2,133,653
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	0	$256,740	$269,064	$281,979	$295,514	$309,698

Parents Receiving Visit Coaching	0	$615,200	$644,730	$675,677	$708,109	$742,098
Total Expenditures (Projected)	$3,472,931	$6,280,372	$6,581,830	$6,897,757	$7,228,850	$7,575,834

Table 18 shows the requested budget neutrality treatment across initiatives in the renewal. Maine will continue to work with CMS to confirm and finalize budget neutrality during the demonstration negotiation and approval process.

Table 18. Budget Neutrality (BN)

Waiver Initiative	Per Capita or Aggregate	Proposed Budget Neutrality Treatment
SUD IMD Exclusion Initiative	Per Capita	Hypothetical
Pilot 1a Maintenance of Medicaid Coverage	Per Capita	Hypothetical
Pilot 1b Parenting Support Services	Aggregate	Hypothetical
Pilot 1c Home-Based Skill Development Services	Aggregate	Hypothetical
Pilot 1d CM	Aggregate	Main Budget Neutrality Test
SMI IMD Waiver Initiative	Per Capita	Hypothetical
Pilot 3 Transitions of Care Incentive Payment	Aggregate	Main Budget Neutrality Test
Justice Involved Pre-Release Services	Per Capita	Hypothetical
Justice Involved Pre-Release Capacity Building	Aggregate	Hypothetical
Pilot 5a Food is Medicine	Aggregate	Capped Hypothetical
Pilot 5b Recuperative Care	Aggregate	Capped Hypothetical
Pilot 4c Structured recovery housing programs	Aggregate	Capped Hypothetical
HRSN Capacity Building	Aggregate	Capped Hypothetical
Traditional Healing Therapies for Native Americans	Propose to be excluded from Budget Neutrality, consistent with other states.	

Section V: Waiver and Expenditure Authorities

Summary of Changes to Section 1115 Demonstration Application

Table 19. Summary of Changes to Section 1115 Demonstration Application

Initiatives for which Maine Seeks to Renew without Modification
SUD IMD Exclusion Initiative
Pilot 1a Maintenance of Medicaid Coverage
Pilot 1b Parenting Support Services
Pilot 1c Home-Based Skill Development Services
Initiatives for which Maine Requests New Section 1115 Demonstration Authority
Pilot 1d CM
SMI IMD Waiver Initiative
Pilot 3 Transitions of Care Incentive Payment
Pre-Release MaineCare Services for Justice-Involved Individuals Initiative
Pilot 5a Food is Medicine
Pilot 5b Recuperative Care
Pilot 4c Structured recovery housing programs
Traditional Healing Therapies for Native Americans

Waiver and Expenditure Authorities

Under the authority of Section 1115(a) of the Act, the following waivers and expenditure authorities shall enable Maine to implement the Whole Person Care demonstration from January 1, 2026, to December 31, 2030. To the extent that CMS advises Maine that additional authorities are necessary to implement the programmatic vision and operational details described above, Maine is requesting such waiver or expenditure authority as applicable. Maine's negotiations with the federal government, as well as State legislative/budget changes, could lead to refinements in these lists, and Maine will work with CMS to identify and add any other waiver and/or expenditure authorities needed to authorize the requested waiver initiatives.

Table 20. Waiver Authorities

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
Waiver Authorities		
	To enable the state to provide Parenting Supports as a pilot and on a geographically limited basis.	Currently Approved

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
Statewideness: Section 1902(a)(1)	To enable the state to provide Home-Based Skills Services as a pilot and on a geographically limited basis.	Currently Approved
	To the extent necessary to enable the state to implement the Food is Medicine pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the recuperative care pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the Structured recovery housing pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the healing therapies for Native Americans pilot in geographically limited areas of the state.	Not currently approved
	To the extent necessary to enable the state to implement the CM pilot in geographically limited areas of the state.	Not currently approved
	To enable the state to provide pre-release services to qualifying beneficiaries on a facility-limited basis, as outlined in this application	Not currently approved
Freedom of Choice: Section 1902(a)(23)(A)	To enable the state to provide Parenting Support Services as a pilot through only certain providers.	Currently approved
	To enable the state to provide Home Based Skills Services as a pilot through only certain providers.	Currently approved
	To enable the state to provide CM as a pilot through only certain providers.	Not currently approved

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
	To enable the state to require qualifying beneficiaries to receive pre-release services, as described in this application, through only certain providers.	Not currently approved
	To enable the state to provide healing therapies for Native Americans as a pilot through only certain providers.	Not currently approved
Amount, Duration, and Scope of Services: Section 1902(a)(10)(B) **Comparability:** Section 1902(a)(17)	To the extent necessary to enable the state to provide Parenting Support Services that are not otherwise available to all beneficiaries in the same eligibility group.	Currently approved
	To the extent necessary to enable the state to provide Home Based Skills Services that are not otherwise available to all beneficiaries in the same eligibility group.	Currently approved
	To the extent necessary to enable the state to provide CM services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To enable the state to provide only a limited set of pre-release services to qualifying beneficiaries, as described in this application, that is different than the services available to all other enrollees outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration	Not currently approved
	To the extent necessary to enable the state to provide Food is Medicine services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to provide recuperative care services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
	To the extent necessary to enable the state to provide structured recovery housing services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to offer coverage of traditional healing therapies that are not otherwise available to all members in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to offer coverage of CM services that are not otherwise available to all members in the same eligibility group	Not currently approved
Coverage for 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.	Not currently approved

Table 21. Expenditure Authorities

Expenditure Authorities
IMD Waiver Services

Expenditure Authorities		
SUD IMD Waiver Initiative	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.	Currently approved
SMI IMD Waiver Initiative	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment services for MH who are short-term residents in facilities that meet the definition of an IMD.	Not currently approved
SUD Pilots		
Pilot 1a. Maintenance of Medicaid Coverage	Expenditures for continued benefits for individuals who have been determined eligible for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility determination.	Currently approved
Pilot 1b. Parenting Support Services	Expenditures to provide Parenting Support Pilot services for individuals who meet the eligibility criteria and in accordance with this application.	Currently approved
Pilot 1c. Home-Based Skill Development Services	Expenditures to provide Home-Based Skill Development Services Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Currently approved
Pilot 1d. CM	Expenditures to provide CM Pilot services for individuals who meet the eligibility criteria in accordance with this application.	Not currently approved

Expenditure Authorities		
Transitions of Care Incentive Payment		
Pilot 3: Transitions of Care Incentive Payment	Expenditures for the Transitions of Care Incentive Payment	Not currently approved
Coverage for Justice-Involved Reentry		
Initiative 4 Expenditures Related to Pre-Release Services Expenditures Related to Pre-Release Services Initiative	Expenditures for pre-release services provided to qualifying demonstration beneficiaries who would be eligible for Medicaid, if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.	Not currently approved
Expenditures Related to Pre-Release Services Capacity Building Funding	Expenditures for capacity building funding to support implementation of the Justice-Involved Reentry Initiative.	Not currently approved
HRSN Pilots		
Pilot 5a: Food is Medicine	Expenditures to provide Food is Medicine Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Pilot 5b: Recuperative Care Pilot	Expenditures to provide Recuperative Care Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Pilot 5c: Structured Recovery Housing Services	Expenditures to provide Recovery Housing Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Expenditures Related to HRSN Capacity Building	Expenditures for capacity building funding to support the implementation of HRSN pilots.	Not currently approved

Expenditure Authorities		
Traditional Healing Therapies for Native Americans		
Traditional Healing Therapies for Native Americans	Expenditures for traditional healthcare practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Healthcare Improvement Act by Children's Health Insurance Program beneficiaries who are able to receive services delivered by or through these facilities	Not currently approved

Section VI: Demonstration Evaluation

External Quality Review Organization Reports

MaineCare is delivered directly through Provider Agreements in Fee-for-Service (FFS) and value-based payment models. As described in the Evaluation section below, Maine leverages partnership agreements to conduct evaluations and assessments when required. For example, the Pacific Health Policy Group is a current independent evaluation partner. There are no Medicaid Managed Care Organizations (MCOs) operating through MaineCare, and Maine does not contract directly with an External Quality Review Organization (EQRO).

At the DHHS level, engagement with the Provider Relations teams in OMS supports compliance with regulations and ensures effective connection and support of billing and claims management; finance and benefits management staff perform quality assurance to ensure accuracy of claims processing, billing, and eligibility. The DHHS Office of Program Integrity provides oversight and quality assurance monitoring.

In addition, the Maine Quality Forum submits an annual report on behavioral healthcare spending in Maine to the Joint Standing Committee on Health Coverage, Insurance, and Financial Services and the Commissioner of the DHHS. The 2024 Annual Behavioral Healthcare Spending Report for MaineCare[46] emphasizes a commitment to improving the quality of behavioral health services. The report highlights that while significant resources are dedicated to behavioral healthcare, accounting for approximately 33% of MaineCare's total expenditure, the focus remains on enhancing care delivery through data-driven strategies. This includes increasing access to services, improving care coordination, and monitoring outcomes to ensure that individuals receive the right care at the right time. It underscores Maine's efforts to create a more integrated, comprehensive behavioral health system that promotes both short-term and long-term health improvements for individuals served by MaineCare.

[46]https://mhdo.maine.gov/_mqfdocs/MQF%20Annual%20BH%20Spending%20Report_240311.pdf

Evaluation Findings to Date

The Pacific Health Policy Group, Maine's independent evaluator for the Maine SUD Care Initiative Section 1115(a) Demonstration completed the Mid-Point Assessment. They examined the progress of planned enhancements expected as part of the CMS-approved Implementation Plan and the State's performance per CMS-defined metrics, as outlined in its SUD Monitoring Protocol. Implementation Plan and Monitoring Protocol metrics were examined for the first two and one-half years of the Demonstration (January 1, 2021 – June 30, 2023).

Results from the assessment found that overall, Maine has completed the expected activities and is making progress in all areas of the SUD Implementation Plan. Activities identified in the SUD Implementation Plan have been completed or are progressing as anticipated. In addition, the majority of critical performance metrics moved in the expected direction between the baseline and midpoint. Activities related to the SUD IT Plan have been completed or are progressing as expected. Maine reported program expenditures under the Demonstration beginning in Year 2 of the Demonstration. (There were no Medicaid-enrolled IMD providers in Year 1.) Actual Medicaid expenditures on behalf of IMD beneficiaries exceeded the budget neutrality limits in both years. Maine submitted a Budget Neutrality Amendment to CMS on January 9, 2025.

Table 22 below provides an overview of SUD Mid-Point Assessment findings.

Table 22. SUD Mid-Point Assessment Findings

SUD Mid-Point Assessment Overview		
CMS Milestone	**Risk**	**Key Findings**
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs	**Low**	✓ All 7 related activities in the SUD Implementation Plan have been completed, and Maine continues to build residential capacity ✓ Performance moved in the expected direction for 6 of the 7 critical metrics ✓ Performance moved in the expected direction for all 3 of the other metrics related to access
Milestone #2: Use of Evidence- Based, SUD-Specific Patient Placement Criteria	**Low**	✓ All 7 related activities in the SUD Implementation Plan have been completed ✓ Performance for the 2 critical metrics is undetermined (single data point available)
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	**Low**	✓ All 8 related activities in the SUD Implementation Plan have been completed or are progressing with ongoing activities ✓ There are no critical metrics for this milestone
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD	**Low**	✓ All 10 activities in the SUD Implementation Plan have been completed or are progressing with ongoing activities ✓ Performance for the 2 critical metrics did not move in the expected direction; provider capacity

SUD Mid-Point Assessment Overview		
CMS Milestone	**Risk**	**Key Findings**
		is expected to increase, but remained consistent
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	**Low**	✓ All 4 activities in the SUD Implementation Plan have been completed or are progressing with ongoing activities ✓ Performance for 3 of the 4 critical metrics moved in the expected direction; overdose deaths for Medicaid members increased between the baseline and the midpoint
Milestone #6: Improved Care Coordination and Transitions between Levels of Care	**Low**	✓ All 9 activities in the SUD Implementation Plan have been completed or are progressing with ongoing activities ✓ Performance for 5 of the 7 critical metrics moved in the expected direction; follow-up after ED visits for mental health declined between the baseline and midpoint
SUD IT Plan	**Low**	✓ All activities in the SUD IT Plan have been completed or are ongoing activities
Budget Neutrality	**Medium**	✓ Expenditures under the Demonstration exceed the budget neutrality limits; continued monitoring may be warranted

The Pacific Health Policy Group, DHHS's independent evaluator, completed the draft interim evaluation (Attachment 1) in accordance with the demonstration special terms and conditions (STCs) and the evaluation design approved by CMS on February 23, 2022.

The evaluation of the Demonstration provides a comprehensive look at its effectiveness in addressing several key outcomes related to SUD treatment. Across the board, the Demonstration has shown strong positive results, with consistent support for its ability to maintain or improve various aspects of care and outcomes.

First, in terms of identification, initiation, and engagement in treatment for SUD, the Demonstration has been moderately successful and is making meaningful progress in getting individuals into treatment and keeping them engaged. This is an important foundation, as successful engagement is crucial for long-term recovery.

The Demonstration has been shown particular success members ages 18 and older eligible for opioid health homes with pharmacotherapy for OUD who have at least 180 days of continuous treatment. The data shows it is clear that the program is highly successful in maintaining individuals in treatment once they are enrolled. This speaks to the program's strength in creating supportive environments that encourage continued participation, which is vital for sustained recovery.

Another area of success is the reduction of opioid prescribing patterns that could potentially lead to misuse or OUD. This outcome is significant given the ongoing opioid crisis and the need for effective strategies to address opioid-related harm.

Table 23. Evaluation Results

Measure	Analytic Approach	Improve or Maintain	Statistical Significance
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.			
3.1.1. Percentage of members ages 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more	Logistic Regression	Yes	-
Hypotheses 2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.			
3.2.1. Percentage of members ages 18 and older eligible for AC participation with concurrent use of prescription opioids and benzodiazepines	Comparison Strategy	Yes	↑
Hypothesis 3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.			
3.3.1. The rate of opioid overdose deaths per 1,000 Medicaid members	Proportional T-test	Yes	↓
3.3.2. The total number of PMP users during the twelve-month measurement period		Inconclusive*	
3.3.3. The total number of PMP inquiries performed during the twelve-month measurement period		Yes	↑

** 2023 user data represents six months of prescriber information*

Overall, the evaluation highlights the Demonstration's effectiveness across all evaluated areas, with particularly strong results in improving adherence to treatment, reducing hospital visits and readmissions, curbing opioid misuse, and improving access to comprehensive care. These findings suggest that the program is making a meaningful impact on the lives of individuals with SUD, helping to improve treatment outcomes and overall health while reducing the burden on the healthcare system.

Table 24. Evaluation Questions

Evaluation Question	Measures Maintaining or Improving Performance	Interim Finding

Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?	67% (8/12)	Supported
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	100% (1/1)	Supported
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	80% (4/5)	Supported
Evaluation Question 4. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?	100% (4/4)	Supported
Evaluation Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	100% (1/1)	Supported
Evaluation Question 6. Does the Demonstration maintain or improve access to care for physical health conditions?	100% (1/1)	Supported

Hypotheses and Evaluation Approach

Through this demonstration, DHHS intends to evaluate several hypotheses. Hypotheses focus primarily on access to various levels of care, service utilization, quality of care, care transitions, spillover effects of a more efficient service delivery system, and associated costs. DHHS plans to use evaluation results from the demonstration to inform strategic decisions on how to improve existing and new State Plan services, including the potential use of alternative payment models in the future to support this work.

Current Evaluation Approach

Maine does not propose any changes to the currently approved evaluation design for the SUD IMD portion of the demonstration. Continuation of the current plan will permit additional study of outcomes over an extended period. Table 25 outlines the hypotheses, research questions, and analytic approach that will continue to be studied during the extension.

Table 25. Hypotheses, Research Questions, and Analytical Approach for current activities

SUD IMD Waiver Services		
Evaluation Question	**Hypothesis**	**Approach**
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?	1. The Demonstration will maintain or increase utilization of SUD treatment services	ITS
	2. The Demonstration will maintain or increase SUD provider	
SUD IMD Waiver Services		
Evaluation Question	**Hypothesis**	**Approach**
a. How does service	availability	

utilization vary by member characteristics (e.g., age, aid category code)? b. How does utilization vary by service type?	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence	
	4. The Demonstration will maintain or increase initiation and engagement in treatment	
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for OHH enrollees	PSM (OHH)
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage	ITS
	2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for ACO attributed members	PSM (ACO)
	3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population	ITS
4. Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by member characteristics (e.g., age, aid category code) code? b. How does utilization vary by geographic characteristics (e.g., rural v. urban)? c. How does utilization vary when MAT induction in the ED is offered?	1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD	ITS; Pre/Post for MAT (4c)
	2. The Demonstration will contain or reduce preventable inpatient admissions	ITS
5. Does the Demonstration contain or reduce readmissions to the same	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.	PSM (OHH and BHH); ITS for PQI #92
SUD IMD Waiver Services		
Evaluation Question	**Hypothesis**	**Approach**
or higher levels of care?		

6. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for Health Home enrollees	PSM (OHH and BHH)
	2. The Demonstration will maintain or increase access to care for physical health conditions for TCM program enrollees	PSM (TCM)
Pilot 1a. Maintenance of Medicaid Coverage		
Evaluation Question	**Hypothesis**	**Approach**
1. Does Pilot 1a maintain or improve access to SUD and mental health treatment for Medicaid members whose children were removed from the home?	1. Members who participate in Pilot 1a will maintain or increase utilization of community-based SUD and/or MH treatment services.	One pre/one post observation point with t-test
2. Does Pilot 1a maintain or improve retention in treatment services?	1. Members who participate in Pilot 1a will maintain or improve retention in treatment.	
3. Does Pilot 1a support family reunification?	1. The number of children who are reunified with their parents will increase for parents who participate in Pilot 1a.	
	2. Children who were returned to the home will be maintained in the home setting for at least nine (9) months after reunification.	
Pilot 1b. Parenting Support Services		
Evaluation Question	**Hypothesis**	**Approach**
1. Does the ABC pilot result in improved family stability (e.g., children remaining in the family home)?	1. Children whose caregivers participate in ABC services will be maintained in the home for at least nine months following program completion.	PSM w/t-test (one observation point)
2. Does the ABC pilot improve access to primary or preventive care for children whose parents complete the program?	1. Children whose caregivers participate in ABC services will increase the number of well child visits during the measurement period	PSM w/t-test (one observation point)
3. Does the visit coaching pilot result in family reunification when a child(ren) has been	1. The number of children who are reunified with their caregivers will increase for parents who complete Visit Coaching services	PSM w/t-test (one observation point)

SUD IMD Waiver Services		
Evaluation Question	**Hypothesis**	**Approach**
removed from the home pursuant to Maine law		
	2. Children who were returned to the home will not re-enter the program in the nine (9) months after the completion of Pilot Project services	PSM w/t-test (one observation point)
4. Are members satisfied with the services they received from the visit coaching program?	1. Members who participate in Visit Coaching will report improved satisfaction with the vendor and service model	Descriptive
Pilot 1c. Home-Based Skill Development Services		
Evaluation Question	**Hypothesis**	**Approach**
1. Does Pilot 1c support community living and avoid more intensive residential, hospital or ED services for parents who have an SUD and their child(ren)	1. Inpatient admissions for SUD will be controlled or reduced for participants in Pilot 1c	PSM w/t-test (one observation point)
	2. Use of residential SUD treatment will decrease for participants in Pilot 1c	PSM w/t-test (one observation point)
	3. Out of home placements for children of participants in Pilot 1c will be decrease	ANOVA; w/t-test (one observation point)
	4. The number of children who are reunified with their caregivers will increase	PSM w/t-test (one observation point)
2. Do parent/caregivers who participate in Pilot 1c have lower ED use for SUD?	1. Visits to the ED for SUD will be controlled or reduced for participants in Pilot 1c	PSM w/t-test (one observation point)

Projected Evaluation Activities

DHHS intends to evaluate several hypotheses related to the added program and pilots to the demonstration (see Table 23). Hypotheses focus primarily on access to various levels of care, service utilization, quality of care, care transitions, spillover effects of a more efficient service delivery system, and associated costs. The evaluation of the additional programs and pilots added to the 1115 waiver will be developed following waiver approval, and Maine acknowledges this must be approved by CMS. Additionally, Maine will comply with all required reporting requirements throughout the demonstration period, as mandated by CMS. When possible, proposed measures will be selected from nationally recognized sources and national measure sets. Maine understands and appreciates that there are CMS-defined measures to utilize for ongoing monitoring and evaluation, including measures adapted from the Adult Core Set. Data sources may include administrative data (e.g., licensing information), Medicaid claims data, stakeholder surveys/interviews/focus groups, and provider-supplied data. DHHS will also seek to align measures in this demonstration with existing quality improvement initiatives within the state, when relevant, to support focused system transformation and reduce administrative burden.

Table 26. Hypotheses to Test

CM Pilot		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. The rate of ED visits will decrease among beneficiaries participating in the CM Pilot.	1. Examine rates of ED visits for beneficiaries participating in CM Pilot compared with rates prior to the Pilot.	Claims data.
2. The rate of negative drug screens (stimulant-free biological tests) will increase among beneficiaries living with STUD who participate in the CM Pilot.	2. Examine rates of positive and negative drug screens among beneficiaries living with STUD, and who are participating in the pilot.	Data from CM vendor.
SMI IMD		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. The Demonstration will increase access to outpatient mental health services.	1. Examine the utilization rate of outpatient behavioral health services.	Medicaid Claims Data
2. The Demonstration will reduce hospitalization rates for individuals with SMI.	2. Examine the rate of psychiatric hospitalizations for decreased utilization for waiver participants	Hospital Discharge Data Claims Data
3. There will be a measurable reduction in preventable readmissions with the implementation of improved coordination of care, as well as incentives for timely care following a hospitalization.	3. Examine Medicaid expenditure on inpatient care for reduced preventable readmissions for members who receive services in an IMD under this waiver	Medicaid Claims Data State Medicaid Reports
4. The Demonstration will improve coordination of care for individuals with SMI.	4. Examine follow-ups that are completed within 72 hours following discharge from an IMD for improvement	Claims Data
Pilot 3 Transitions of Care Incentive Payment		
Hypotheses	***Evaluation Approach***	***Data Sources***

1. The number of ED visits will decrease among beneficiaries released from prison, jail, psychiatric inpatient, or residential setting.	1. Examine rates of ED visits for beneficiaries who have follow-up with 7 days or release compared to those who exceed the 7-day follow-up period.	Claims data
Pre-Release Medicaid Services for Justice-Involved Individuals		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. Implementation of pre-release services will result in increased collaboration between stakeholders, identification of unaddressed medical and HRSN prior to release, gradual expansion of access to pre-release services for justice-involved individuals, and improved insights into healthcare delivery for this population.	1. Use a mixed-methods process evaluation approach to examine the implementation of pre-release services, including the identification of eligible individuals, unaddressed medical and HRSN, and provision of Medicaid-covered services in the pre-release setting.	Qualitative interviews of stakeholders review of guidance, workflows, and other documents to examine various aspects of implementation; and examination of health plan reports to assess progress of implementation.
2. The demonstration will result in increases in Medicaid enrollment and service utilization among individuals who re-enter the community after a period of incarceration	1. Difference-in-differences model 2. Subgroup analyses	Claims data
3. The demonstration will result in reductions in preventable readmissions to acute care hospitals and residential settings.	1. Difference-in-difference model to examine to what extent does the demonstration result in improved availability of intensive outpatient services and partial hospitalization?	Claims data
4. The demonstration will result in fewer ED visits, fewer inpatient hospitalizations, and shorter lengths of stay	1. Difference-in-differences model	Claims data

5. The demonstration will result in increases in Medicaid enrollment among individuals who re-enter the community after a period of incarceration who have access to treatment services and reduce the rate of overdoses, suicides, and all causes of deaths among those released from incarceration at 12-month, 24- month, and 36-month intervals	1. Difference-in-differences model	Encounter data, specific outcome metrics of interest Claims data
Pilot 5a: Food is Medicine		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. Implementation of nutrition supports will result in increased collaboration between stakeholders, gradual expansion of access to nutrition services for qualifying individuals, and improved infrastructure for the provision of nutrition support services.	1. Use a mixed-methods process evaluation approach to examine the implementation of nutrition support programs including the identification of individuals with food insecurity, referral mechanisms to existing non-Medicaid nutrition programs, and provision of Medicaid-covered nutrition supports to qualifying individuals.	Qualitative interviews of stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation.
2. Nutrition support services will result in reductions in food insecurity and improved disease management for participating individuals.	2. Assess the impact of each nutrition supports program on targeted outcomes. Examine related and proximal health outcomes (e.g., diabetes control).	Encounter data and to capture utilization metrics and other qualitative data. Additional data may be collected at target delivery locations if feasible.
Pilot 5b: Recuperative Care Pilot		
Hypotheses	***Evaluation Approach***	***Data Sources***

1. Members experiencing homelessness post-hospital discharge will have reduced hospital readmissions after utilizing Recuperative Care Services.	1. Members receiving recuperative care services will have reduced hospital readmissions annually and in comparison to a similar population in the four years preceding this benefit.	Administrative claims data
Pilot 5C: Structured Recovery Housing Services		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. Members receiving Structured Recovery Housing Services will increase access to and utilization of necessary behavioral and physical health services.	1. Members receiving Structured Recovery Housing Services will have greater utilization of behavioral and physical health services annually and in comparison to a similar population in the four years preceding this benefit	Administrative claims data
Traditional Healing Therapies for Native Americans		
Hypotheses	***Evaluation Approach***	***Data Sources***
1. Coverage of traditional healing therapies will increase access to and utilization of traditional healing therapies	1. Members receiving traditional healing therapies will have greater utilization of these health services annually, and in comparison to a similar population in the four years preceding this benefit	Administrative claims data

Section VII: Stakeholder Engagement and Public Notification Process

In accordance with 42 CFR section 431.408, Maine conducted a thirty (30) day public notice and comment process from March 21, 2025 through April 22, 2025. Maine DHHS hosted two public workshops on April 3, 2025 (telephonic and virtual) and April 10, 2025 (in-person). Maine certifies that it provided public notice of the application on the State's Medicaid website and posted the full public notice and information for public workshops on this waiver online, along with the proposed waiver application, which can be found at http://www.maine.gov/dhhs/oms/rules/index.shtml. DHHS will also post a summary of public

comments received, once available, at http://www.maine.gov/dhhs/oms/rules/index.shtml. Maine certifies that the public notice was posted and available at all major newspapers, as reflected in Table 27, below. Newspaper proofs are included in Attachment 4.

Table 27. Demonstration Newspaper Postings

Newspaper	Posted
Lewiston Sun Journal	March 21, 2025
Bangor Daily News	March 21, 2025
Portland Press Herald	March 21, 2025
Kennebec Journal	March 21, 2025
Waterville Sentinel	March 21, 2025

Maine certifies that it convened two official public hearings more than twenty days prior to submitting the demonstration application to CMS. Specifically, Maine held the following hearings:

- **First Public Hearing**
  April 3, 2025, 11:30am
  Virtual telephonic and web conference

- **Second Public Hearing**
  April 10, 2025, 9:00 AM
  Location: 109 Capitol St, Augusta, Maine 04330
  Room A&B First Floor

The total number of attendees at the hearings was over 40 individuals. The slide decks used for the public hearings can be found on MaineCare's website:
http://www.maine.gov/dhhs/oms/rules/index.shtml

Maine certifies that it used an electronic mailing list to provide notice of the proposed demonstration renewal request to the groups listed below. A copy of this email notice can be found in Attachment 4.

The electronic mailing was sent to the Interested Parties list, which includes everyone subscribed to the Maine.gov Listserv under the Policy and State Plan Amendment and the State & Federal Policy subscriptions.

Section VIII: Responses to Public Comments

Summary of Public Comments

OMS within the DHHS held a public comment period from March 21, 2025, through April 22, 2025, regarding the **1115 Whole Person Care Waiver.** As part of the public comment period, MaineCare held a virtual/telephonic public forum on April 3, 2025, and an in-person public forum on April 10, 2025, to present the application for Maine's 1115 Demonstration Whole Person Care Waiver and allow time for public comments. In addition, DHHS discussed the

application during the virtual March 4, 2025, MaineCare Advisory Council meeting. Following the public hearing, DHHS accepted written public comments on the Waiver application through April 22, 2025.

DHHS received 16 comments during hearings and 12 comments via email. All comments were supportive; one comment offered support conditional on the approach to funding current IMD beds, only if the funds freed up did not include *new* beds. Commenters agreed with the overall vision and goals of the Whole Person Care Waiver demonstration application and urged DHHS to work with CMS to obtain approval of Maine's requests as soon as possible. Commentors also identified key aspects of implementation and operations that would facilitate success, including examples of best practices. Commentors brought forth many lived experiences describing challenges for those living with serious mental illness, brain injuries, and SUD in their families and communities. These experiences are both moving and extremely valuable in improving care for Mainers, and we plan to continue engaging with providers and the public, utilizing their lived experiences and expertise in developing the waiver implementation plan. The State appreciates these comments and looks forward to continuing to engage with community partners to improve the health and wellbeing of Mainers.

Attachment 5 includes a summary of public comments received by the waiver objective as well as DHHS's response.

The written public comments, comment summary of written and presented at public comment sessions, and DHHS response are available on the 1115 demonstration page of the State's Medicaid website: http://www.maine.gov/dhhs/oms/rules/index.shtml

The most recent post-award forum, as required under the Special Terms and Conditions and 42 CFR § 431.420, was held on May 28, 2024, to allow the public an opportunity to comment on the progress of the demonstration. No comments were received. The next post award public forum will be held August 20, 2025.

Section IX: Responses to Tribal Consultation

Maine certifies that it conducted Tribal consultation according to the consultation process outlined in its approved state plan and DHHS processes. DHHS provided notice to each of Maine's tribes on March 21, 2025, and additional information will be found in Attachment 6:

- Houlton Band of Maliseet Indians, www.maliseets.net
- Mi'kmaq Nation, www.micmac-nsn.gov
- Passamaquoddy Tribe at Indian Township (Motahkomikuk), www.passamaquoddy.com
- Passamaquoddy Tribe at Pleasant Point (Sipayik), www.wabanaki.com
- Penobscot Nation, www.penobscotnation.org

Additionally included was the Wabanaki Public Health District and the Wabanaki Public Health and Wellness organization, which provides services to all Maine tribes.

Maine certifies that it conducted Tribal consultation according to the consultation process outlined in its approved state plan and DHHS protocols. DHHS met virtually and in person with tribal consultation including monthly Tribal Health Directors' meetings and Tribal Behavioral Health meeting as the application was being developed and continues to meet tribal health center leaders to gather recommendations and to support implementation planning. Three tribal site visits occurred to explore aspects of the application.

There was significant enthusiasm for pursuing the waiver to support traditional healing therapies. During a site visit to a tribal health center, we heard concerns about the exchange of funding for spiritual practices. They said it was worth exploring the possibilities of the waiver for traditional healing therapies but cautioned that we need to proceed with care and look to the Wabanaki Nations to lead the design of implementation. We discussed how each tribe in Maine is unique and that each tribe may require or need different services. One commentator also highlighted the challenge of identifying and contracting with traditional healers. Below is a list of the Tribal engagement:

October 3 Tribal Health Directors' Meeting
December 12 Tribal Behavioral Health Meeting
April 24 site visit to Penobscot Nation Indian Health Center
May 29 site visit Houlton Band of Maliseet Indians Health and Wellness Center
June 11 site visit to Wabanaki Public Health and Wellness

Demonstration Contact

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Demonstration Administration

Attachment 1 - Activities to Accomplish Milestones
Attachment 2 – Interim Evaluation Report
Attachment 3 – Budget Neutrality
Attachment 4 – Public Notice
Attachment 5 – Responses to Public Comment
Attachment 6 – Tribal Consultation & Responses to Tribal Consultation
Attachment 7 – Assessment of the Availability of Mental Health Services

Attachment 1 - Activities to Accomplish Milestones

Required Activities	Actions	Status
Milestone #1: Access to Critical Levels of Care for OUD and Other SUDs		
Early Intervention	Incorporate Screening Brief Intervention and Referral to Treatment (SBIRT) into primary care payment model	Completed
Coverage of Outpatient	Clarify rules for coverage of partial hospitalization as outpatient care	Completed
	Continued provider support for Medications for OUD in EDs and introduced additional incentives for this work.	Completed
Coverage of Intensive Outpatient Programs (IOP)	Complete rate study for IOP programs	Completed
Coverage of MAT	Revise administrative rules to add MAT as a mandatory benefit in the Medicaid state plan	Completed
Coverage of Intensive Levels of Care in residential and inpatient settings, including withdrawal management	Complete rate study and updated rates for residential programs	Completed
	Revise administrative rules and coverage limits for residential levels of care.	Completed
Milestone #2: Use of Evidence-Based, SUD-Specific Placement Criteria		
Assessment of treatment needs with multidimensional evidence-based assessment tool	Update administrative rules for residential SUD treatment providers to reference the most recent ASAM version.	Completed
	Amend Opioid Health Home rules to require level of care assessments	Completed
	Establish incentives in primary care value-based payment model, including the use of a cooperative referral model for MAT	Completed
	Develop and implement provider training related to the use of ASAM criteria at all levels of care.	Completed
	Develop service locator tools for consumers and providers	Completed
UM approach that ensures beneficiaries have access at the appropriate level of care	Develop a post-utilization review process, including the submission of ASAM placement assessments	Completed

Required Activities	Actions	Status
UM approach that ensures interventions are appropriate for the diagnosis and level of care	Enhance review of placements across the continuum of care	Completed
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities		
Nationally recognized program standards for residential treatment providers (e.g., ASAM)	Amend administrative rules for residential SUD treatment providers to reference the most recent ASAM version.	Completed
	Develop provider training and guidance	Completed
Implement a process for compliance reviews for residential programs	Improve and coordinate processes across departments responsible for residential program oversight	Completed
	Expand OBH oversight to all Medicaid-enrolled facilities	Completed
	Enhance OCFS residential oversight processes	Completed
	Initiate TA and quality improvement activities for adolescent programs by OCFS	Ongoing
Require residential programs to offer MAT onsite or facilitate access offsite	Amend administrative rules 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.	Completed
	Assess policies and operational practices that could be improved to support MAT and integration of care, including the solicitation of provider feedback	Ongoing
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD		
Complete Assessment of Availability	Assess provider capacity and gaps across system of care	Completed
	Conduct rate study for SUD services at all levels of care	Completed
	Deploy a service locator tool, including assessment of providers accepting new patients	Ongoing

Required Activities	Actions	Status
	Fund telehealth capacity for SUD treatment	Completed
	Establish incentives for primary care providers to offer MAT	Completed
	Demonstration approval to expand residential continuum of care to IMD providers	Completed
	Amend Opioid Health Home rules to improve access	Completed
	Pilot mobile MAT services	Completed
	Review MaineCare policies that may create barriers to access and amend (if needed)	Ongoing
	Assess gaps and barriers to treatment for youth	Completed
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD		
Implementation of opioid prescribing guidelines and other interventions to prevent prescription drug abuse	Assess concurrent use of opioids and benzodiazepines in MaineCare's Accountable Care Organizations	Completed
	Enhance the State's Prescription Monitoring Program	Completed
Expand coverage and access to Naloxone	Implement standing orders for naloxone	Completed
Implement strategies to increase utilization and improve functionality of the prescription drug monitoring program	See Section 5 Information Technology Plan	Ongoing
Milestone #6: Improved Care Coordination and Transitions between Levels of Care		
Ensure residential and inpatient facilities link clients with community-based services following stays	Assess transition of care policies	Ongoing
	Develop performance monitoring and incentive strategies to support quality improvement related to follow-up care	Ongoing
	Solicit input through provider and stakeholder surveys/focus groups	Ongoing
	Amend administrative rules for residential facilities to clarify discharge planning requirements	Completed

Required Activities	Actions	Status
Policies to ensure care coordination for physical and mental health conditions	Share results of Maine Health Access Foundation Site Self-Assessments and discuss opportunities to improve	Completed
	Integrate pay for performance provisions in the Opioid Health Home model to support access to ambulatory/preventive care	Completed
	Convene provider work group regarding transitions of care and integration	Ongoing
	Assess opportunities to expand Opioid Health Home and Targeted Case Management programs to more members	Completed
	Amend administrative rules to clarify coordination of care requirements	Completed

Attachment 2 – Interim Evaluation Report

PHPG

THE PACIFIC HEALTH POLICY GROUP

MaineCare Substance Use Disorder Care Initiative Section 1115 Medicaid Demonstration

(Project # 11-W-00381)

Draft Interim Evaluation Report

(January 1, 2021 - December 31, 2023)

Submitted to CMS December 17, 2024

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ACROYNMS AND ABREVITATIONS

Acronym	Description
ABD	Aged, Blind, Disabled
ANOVA	Analysis of Variance
AOD	Alcohol and Other Drug
ASAM	American Society of Addiction Medicine
BN	Budget Neutrality
CEM	Coarsened Exact Matching
CMS	Centers for Medicare and Medicaid Services
CY	Calendar Year
DCG	Diagnostic Cost Group
DHHS	Maine Department of Health and Human Services
DY	Demonstration Year
ED	Emergency Department
FFS	Fee-for-Service
FPL	Federal Poverty Level
HCPCS	Healthcare Common Procedure Coding System
HRSN	Health Related Social Needs
HEDIS	Healthcare Effectiveness Data and Information Set
IET	Initiation and Engagement in Treatment
IMD	Institution for Mental Diseases
IP	Inpatient
ITS	Interrupted Time Series
LOCUS	Level of Care Utilization System
LTC	Long Term Care
MaineMOM	Maine Maternal Opioid Misuse Model
MAT	Medication Assisted Treatment
MMIS	Medicaid Management Information System
MOUD	Medication for Opioid Use Disorder
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OMS	Office of MaineCare Services
OUD	Opioid Use Disorder
PCP	Primary Care Provider
PDMP	Prescription Drug Monitoring Program
PHE	Public Health Emergency
PHPG	Pacific Health Policy Group
PMPM	Per Member Per Month
SAMHSA	Substance Abuse and Mental Health Services Administration
SDOH	Social Determinants of Health
SFY	State Fiscal Year
STC	Special Terms and Conditions
SUD	Substance Use Disorder

.EXECUTIVE SUMMARY

The Maine Substance Use Disorder Care Initiative Section 1115(a) Demonstration was approved on December 22, 2020, effective January 1, 2021 through December 31, 2025. The 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 evaluation design was approved by the Centers for Medicare and Medicaid Service (CMS) on February 23, 2022.

Results for CY2017-CY2020 were used to establish the baseline trends for assessing change during the Demonstration period for Interrupted Time Series (ITS) analyses. Evaluation measures studied using the ITS design were examined quarterly. The ITS assumes stationarity in the data and includes the assumption that absent the Demonstration, results would have continued on the same trajectory as the pre-Demonstration quarters. The ITS examined whether there was: (1) no effect; (2) only an immediate effect; (3) only a sustained long-term effect; or (4) both an immediate and a sustained long-term effect. When data did not meet criteria for ITS analysis, a regression or test of proportionality was employed to assess the significance of change from the baseline.

To examine the impact of the Opioid and Behavioral Health Home (HH) and Accountable Community (AC) enhancements expected under the Demonstration, a comparison group strategy using Coarsened Exact Matching (CEM) was employed. Specifically, members receiving services under each initiative were matched to a comparison group of members eligible for, but not receiving HH or AC services. The interim evaluation examines outcomes for these measures during CY2021 – CY2023.

Due to the quasi-experimental nature of the design and the limitations identified below, the evaluation results cannot be attributed to causal inference. The findings may suggest an association or correlation with various aspects of the Demonstration. However, suggesting causation or analyses of counterfactuals may not be appropriate when describing results. Data and design limitations include:

- Lack of True Experimental Control Groups: However, as described above, the evaluation employs a comparison strategy to study some delivery system enhancements. In addition, the use of an ITS design to examine trends over time helps to mitigate this limitation.

- Use of Administrative Data: The evaluation may be limited by its reliance on payment files, claims and diagnostic codes to identify members with SUD. This type of limitation is inherent in claims-based analysis, however the potential for missing data is random. There is no reason to believe that any given Demonstration group is more or less likely to have missing data.

- Medicaid Enrollment/Disenrollment: Medicaid enrollment changes on an annual basis related to eligibility. The use of an ITS design to examine trends over time helps mitigate this phenomenon.

- Pre-Existing IMD services: SUD IMD treatment facilities are statewide providers that had been delivering care to Medicaid enrollees prior to the implementation of the SUD Demonstration. The Demonstration allows the State to continue services that had been in place, albeit with a new funding partner and additional capacity. Independent variables expected to result in

change throughout the Demonstration are based on delivery system enhancements and quality improvement strategies and not new IMD expenditure authorities.

The interim evaluation findings should be interpreted with caution. The Demonstration start date coincided with the ongoing novel coronavirus Public Health Emergency (PHE) in CY 2021. CY 2023 results are considered preliminary, pending six-month claims run out for the final quarter. Results will be updated in the summative evaluation report.

A summary of findings for each evaluation question is presented below. For measures studied using the aggregate ITS approach, hypotheses were deemed supported when the sustained effect of the Demonstration showed no statistically significant change (performance was maintained) regardless of direction or showed a statistically significant improvement in trend. For measures studied using an alternative approach (e.g., logistic regression and two sample tests), hypotheses were deemed supported when preliminary 2023 results showed no change (performance was maintained across years) or showed a statistically significant improvement in performance.

Evaluation Question One - Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?

Four hypotheses were examined relating to utilization of treatment services and engagement in treatment.

1. The Demonstration will maintain or increase utilization of SUD treatment services.
2. The Demonstration will maintain or increase SUD provider availability.
3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.
4. The Demonstration will maintain or increase initiation and engagement in treatment.

These hypotheses theorized that the Demonstration would maintain or improve performance. Of the twelve measures studied, six maintained performance, two improved and four declined, providing support for most of the hypotheses studied.

The percentage of Medicaid members engaging in any type of SUD treatment has been increasing over time. The Demonstration period was associated with a statistically significant decline in outpatient treatment, although not statistically significant there was an increase in medication assisted treatment (MAT). Utilization of intensive outpatient/partial hospitalization showed little change. While not statistically significant, utilization of inpatient/residential and withdrawal management/detox services showed an increase in trend.

The total number of SUD treatment providers billing Medicaid declined by approximately three percent. However, providers billing MAT increased by nearly 10 percent.

There were no statistically significant changes in the percentage of members initiating and engaging in SUD treatment. Follow-up after members visited the ED for SUD-related diagnosis declined during the Demonstration period. The evaluator is working with OMS to determine if the measure is impacted by a potential data gap resulting from the increased use of Opioid Health Home services.

Evaluation Questions Two - Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?

This question examined whether members receiving Opioid Health Home (OHH) services showed stronger performance than a comparison group for continuity of pharmacotherapy (i.e., having 180 days of continuous medication assisted treatment for Opioid Use Disorder (OUD)). In each year studied members engaged with an OHH had higher scores than the comparison group.

Evaluation Question Three - Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?

Three hypotheses were examined relating to opioid prescribing patterns and overdose deaths.

1. The Demonstration will contain or reduce the use of opioids at a high dosage.
2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.
3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.

Three of the five measures studied under evaluation question three maintained or improved performance during the Demonstration.

The percentage of members receiving opioids at a high dosage remained stable throughout the baseline and Demonstration period. In CY2020-21 performance was 22 percent which fell slightly to 21 percent in CY2022-23 (low rates are preferred). Members receiving AC services had lower rates than a comparison group on a measure of concurrent use of opioids and benzodiazepines (low rates are preferred). The rate of opioid-related overdose deaths in the Medicaid population began to decline in CY2023.

The number of providers using the Prescription Monitoring Program (PMP) declined, while the number of inquiries has increased year over year. It is likely that the decline over baseline was due to a purging of inactive user accounts from the PMP system and data availability at the time of the study.

Evaluation Question Four - Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?

Two hypotheses were examined relative to ED and inpatient use.

1. The Demonstration will contain or reduce the rate of ED visits for individuals with a SUD.
2. The Demonstration will contain or reduce inpatient admissions.

The total number of ED visits for SUD showed a statistically significant decline during the Demonstration as did inpatient stays. Non-emergent ED visits and inpatient discharges related to chronic conditions (e.g., asthma, chronic obstructive pulmonary disease, diabetes, heart failure and hypertension) also declined, although the change was not statistically significant. All four of the measures studied maintained or improved performance.

Evaluation Question Five - Does the Demonstration contain or reduce readmissions to the same or higher levels of care?

Two measures were examined for this question: unplanned readmissions for any cause and readmissions for SUD treatment to the same or higher level of care. Members receiving Health Home services (OHH and BHH) showed the same or fewer readmissions for SUD treatment than the comparison group. However, the differences were not statistically significant. The trend in readmissions for any cause did not change during the Demonstration period. Both measures studied maintained performance levels.

Evaluation Question Six - Does the Demonstration maintain or improve access to care for physical health conditions?

In each year studied members who received Health Home services (OHH and BHH) had more ambulatory and preventive care visits than the comparison group. The differences also were statistically significant in each year.

Findings Summary

The evaluation found that the Demonstration maintained or improved performance across each of the areas (evaluation questions) studied. As described above, twenty of the 25 analyzed measures (76 percent) supported their hypotheses. Twelve of the twenty maintained pre-Demonstration trends, while eight showed improvements. Maintaining pre-Demonstration levels of performance related to SUD treatment during the pandemic should be considered a success under the Demonstration.

Statistically significant declines in performance were documented for five measures, four of which were likely impacted by provider availability during the PHE and one of which was caused by issues related to data availability. The inclusion of final 2023 data, along with the remaining Demonstration years (and subsequent renewal period) will offer valuable information for understanding utilization and engagement, absent the effect of the PHE. A summary of findings by evaluation question and hypothesis is provided below.

Summary of Interim Findings			
Evaluation Question and Hypotheses	Number of Measures		
	Maintained	Improved	Declined
Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?			
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services.	4	1	1
Hypothesis 2. The Demonstration will maintain or increase SUD provider availability.		1	1
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.			2
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in treatment.	2		
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?			
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for OHH enrollees.		1	

Summary of Interim Findings			
Evaluation Question and Hypotheses	Number of Measures		
	Maintained	Improved	Declined
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?			
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.	1		
Hypothesis 2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.	1		
Hypothesis 3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.		2	1
Evaluation Question 4. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?			
Hypothesis 1. The Demonstration will contain or reduce the rate of ED visits for individuals with a SUD.	1	1	
Hypothesis 2. The Demonstration will contain or reduce inpatient admissions.	1	1	
Evaluation Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?			
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care	2		
Evaluation Question 6. Does the Demonstration maintain or improve access to care for physical health conditions?			
Hypothesis 1. The Demonstration will maintain or increase access to care for physical health conditions for Health Home enrollees (OHH and BHH).		1	

Exploratory Expenditure Analysis

Total expenditures were examined for physical and SUD-related categories of services with breakouts for SUD-IMD and other residential treatment services. Cost drivers including ED and inpatient use, pharmacy, outpatient and LTC also were assessed.

Immediately following the start of the Demonstration there was a decline in the total cost of care and SUD-related expenditures. The sustained effect of the Demonstration period showed a statistically significant increase in all categories, apart from physical health care. A generalized linear model was used to examine the impact of member characteristics on the data (i.e., age, gender, aid category, and geography). The generalized linear model showed that older members and members residing in rural counties were associated with fewer expenditures, while women and expansion group members were associated with more SUD-related expenditures.

There were no statistically significant sustained changes in expenditures for inpatient, emergency department or pharmacy services. Expenditures for outpatient care (non-ED) and long term care did show increases in expenditures during the Demonstration period.

GENERAL BACKGROUND INFORMATION

The Maine Substance Use Disorder Care Initiative Section 1115(a) Demonstration was approved on December 22, 2020, effective January 1, 2021 through December 31, 2025. The 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 evaluation design was approved by the Centers for Medicare and Medicaid Services (CMS) on February 23, 2022.

The Maine Department of Health and Human Services (DHHS) is the umbrella agency responsible for oversight of Maine's public health, behavioral health, Medicaid, and other human service programs. The Office of MaineCare Services (OMS) within the DHHS is the Single State Agency that administers Maine's Medicaid program, known as MaineCare. Medicaid programs supporting treatment and recovery services for persons with a SUD are jointly operated by the Office of Behavioral Health (OBH), Office of Child and Family Services [both within DHHS] and OMS.

MaineCare utilizes American Society of Addiction Medicine (ASAM) criteria and other mental health/SUD screening and assessment tools to support treatment and level of care decisions. MaineCare covers all ASAM levels of care, including Medication Assisted Treatment (MAT) and recovery supports. In addition, Emergency Departments (EDs) offer rapid induction of MAT. The State also has worked aggressively to control overprescribing of opioids through its Prescription Monitoring Program (PMP) by revising prescribing guidelines, promoting alternative treatments to pain management, and offering provider education.

Maine offers a comprehensive SUD benefits package through the Medicaid State Plan. In April 2018, DHHS received CMS approval to extend comprehensive SUD benefits to the expansion group members in the Alternative Benefit Plan.

Over the last ten years, DHHS has focused on delivery system reforms to support primary care, population health, and chronic disease management. This work is designed to move MaineCare away from a payment system that rewards volume to one focused on high-quality care, accountability, and appropriate use of health care. The MaineCare Value-Based Purchasing (VBP) strategy includes the Accountable Communities and Health Home Programs. Three Health Home models have been developed: Primary Care, Opioid Use Treatment and Behavioral Health.

DHHS engages in continuous quality improvement to assess provider availability, quality of care, and potential gaps in the SUD system. DHHS promotes integrated and holistic approaches to care by supporting the Health Home programs and Accountable Communities that address comorbid physical and behavioral health conditions, as well as psychosocial needs of the individual.

At the time of its request to CMS for Demonstration approval, Maine, like many other states across the nation, was experiencing growing challenges with SUD. Under the Demonstration, the State has the authority to receive federal financial participation (FFP) for services as described in the Maine Medicaid State Plan when provided to beneficiaries residing in IMDs for short-term stays primarily to receive SUD treatment, including but not limited to:

- Inpatient Treatment;

- Residential Treatment;
- Medically Monitored Withdrawal Management; and
- Medication-Assisted Treatment.

The provision of SUD treatment in IMD settings allows the State to fill gaps in the current system and supports access to evidence-based services at various levels of intensity across a continuum of care, based on individual needs and goals. DHHS expects additional SUD residential treatment facilities to offer services and existing providers to expand their current service capacity.

During the first year of the Demonstration, the State and CMS finalized the SUD Implementation Plan; CMS approval was obtained on July 26, 2021. The State began receiving FFP for IMD services provided in DY2.

A. DEMONSTRATION GOALS

DHHS is committed to maintaining support for community-based SUD treatment options and sought the authority approved under this Demonstration to better ensure that appropriate treatment options are accessible across the continuum. Maine's goals align with the CMS goals for SUD Demonstrations nationally and include:

1) Increased rates of identification, initiation, and engagement in treatment for SUD;
2) Increased adherence to, and retention in, treatment;
3) Reductions in overdose deaths, particularly those due to opioids;
4) Reduced 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; and
6) Improved access to care for physical health conditions among beneficiaries with an SUD.

B. POPULATIONS IMPACTED BY THE DEMONSTRATION

Under the Demonstration, there is no change to Medicaid eligibility; standards and methodologies for eligibility remain as set forth under the State Plan. All Medicaid members who have an SUD are eligible for participation in the Demonstration, based on clinical need.

.EVALUATION QUESTIONS AND HYPOTHESES

MaineCare offers access to a broad range of SUD and Opioid Use Disorder (OUD) services across the continuum of care. While the Demonstration authorized Medicaid coverage of SUD residential treatment provided in IMD settings, no new service categories were proposed. However, DHHS has engaged in a variety of activities that are designed to improve access, increase engagement and retention in treatment, promote the integration of physical and behavioral health care, and improve opioid prescribing patterns across the delivery system.

A. LOGIC MODEL AND QUANTIFIABLE TARGETS

DHHS supports increased rates of identification, initiation, and engagement in treatment (Goal 1) and adherence to and retention to treatment (Goal 2) through: improving access to short-term residential treatment in an IMD; improving the alignment of assessment tools, utilization management (UM), and treatment plans with ASAM guidelines; creating training resources, tools and performance incentives for SUD screening in community-based settings; expanding access to MAT in EDs, residential, and community-based settings; and implementing a Service Locator Tool for providers, members, and other stakeholders.

DHHS supports improved opioid prescribing patterns through a continued focus on provider education and training. DHHS initiated a provider outreach campaign in 2021 to share advances in the PMP, including Electronic Health Record (EHR) integration and PMP alerting analytics.

DHHS promoted access to care for physical health conditions among beneficiaries with SUD (Goal 6) by revising Opioid Health Home expectations and offering additional provider training to improve transitions of care and care integration. This included the creation of performance incentives for the integration of physical and behavioral health care.

In total, these activities are expected to result in reduced overdose deaths, particularly those due to opioids (Goal 3); reduced utilization of emergency departments and inpatient hospital settings for treatment, where the utilization is preventable (Goal 4); and fewer readmissions to the same or higher level of care (Goal 5).

The SUD Demonstration's logic model is provided on the following page, offering a visual depiction of the Demonstration activities and the expected impact on CMS Demonstration goals.

Moderating Factors

- Expanded interstate data-sharing in the PDMP for up to 15 additional states and US Territories and the Canadian border province of New Brunswick
- Rate setting study and review of options to support improved capacity
- Potential enhancements to Naloxone distribution

Key Actions

- Obtain Medicaid approval for SUD treatment in IMD settings
- Create training materials, tools and incentives for SUD screening
- Expand access to MAT in ED, residential, and community-based settings
- Implement a Service Locator Tool

- Align assessment tools, UM, and treatment plans with ASAM guidelines

- Develop provider education, outreach and incentives for improved opioid prescribing patterns

- Revise OHH model to improve transitions of care and care integration
- Create incentives for the integration of physical and behavioral health care

Short-Term Outcomes

- Increase access to SUD treatment
- Increase SUD provider availability

- Increase identification, initiation, and engagement in SUD treatment (Goal #1)
- Increase adherence to, and retention in, SUD treatment (Goal #2)

- Increase use of PMP (number of users and inquiries)
- Contain or reduce the use of opioids at high doses
- Contain or reduce concurrent use of opioids and benzodiazepines

- Increase follow-up after discharge from ED, inpatient and residential settings
- Increase access to physical health care (Goal #6)

Long-Term Outcomes

- Reductions in overdose deaths, particularly those due to opioids (Goal #3)

- Reduce utilization of the ED and inpatient hospital settings where the utilization is preventable or medically inappropriate (Goal #4)

- Fewer readmissions to the same or higher level of care, where the readmission is preventable or medically inappropriate (Goal #5)

Contextual Variables

- Expanding MAT induction in the ED may impact the number of ED visits for SUD
- Multiple opioid response strategies occurring concurrently with the demonstration may impact results
- The pandemic may impact utilization of SUD treatment services and/or impact the prevalence of opioid-related overdoses
- Provider/workforce capacity may impact availability of services

B. EVALUATION QUESTIONS AND HYPOTHESES

The evaluation design considered six primary evaluation questions, with five subsidiary questions and twelve hypotheses. In addition, two exploratory questions are examined. In some cases, the hypothesis considers the impact of Demonstration activities on specific SUD programs, such as enrollees served by Accountable Communities, Behavioral Health Homes, or Opioid Health Homes. The table below provides an overview of the evaluation questions and hypotheses.

SUD Evaluation Question	Hypothesis
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does utilization vary by member characteristics (e.g., age, aid category code)? b. How does utilization vary by service type?	1. The Demonstration will maintain or increase utilization of SUD treatment services.
	2. The Demonstration will maintain or increase SUD provider availability.
	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.
	4. The Demonstration will maintain or increase initiation and engagement in treatment.
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for OHH enrollees.
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage.
	2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.
	3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.
4. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by member characteristics (e.g., age, aid category code)? b. How does utilization vary by geographic characteristics (e.g., rural v. urban)? c. How does utilization vary when MAT induction in the ED is offered?	1. The Demonstration will contain or reduce the rate of ED visits for individuals with a SUD.
	2. The Demonstration will contain or reduce inpatient admissions.
5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care
6. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for Health Home enrollees (OHH and BHH).
7. How does the cost of SUD services change over time?	N/A Exploratory
8. What are the cost drivers?	N/A Exploratory

C. ALIGNMENT WITH TITLE XIX MEDICAID PROGRAM OBJECTIVES

CMS has determined that the Maine Substance Use Disorder Care Initiative Demonstration is likely to promote the objectives of the Medicaid program, and that the expenditure authority sought is necessary and appropriate to carry out the Demonstration. The evaluation aligns with the objectives of Title XIX through evaluation questions one, two, four, and five, as outlined in the table below.

Title XIX Objective	MaineCare Evaluation Question
The Demonstration will assist Maine in increasing the identification, initiation, and engagement of Medicaid beneficiaries diagnosed with SUD.	**1.** Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? **a.** How does utilization vary by member characteristics (e.g., age, aid category code)? **b.** How does utilization vary by service type?
The Demonstration will assist Maine in increasing beneficiary adherence to, and retention in, SUD treatment programs.	2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?
The Demonstration will assist Maine in reducing medically inappropriate or preventable utilization of emergency departments and inpatient hospital settings through improved access to a continuum of care services.	**4.** Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD? **a.** How does utilization vary by member characteristics (e.g., age, aid category code)? **b.** How does utilization vary by geographic characteristics (e.g., rural v. urban)? **c.** How does utilization vary when MAT induction in the ED is offered?
	5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?

.METHODOLOGY

The Demonstration evaluation used quasi-experimental techniques to measure change over time and differential statistics to describe the population and findings. A detailed description of the methodology and analytic approach is provided below.

A. EVALUATION DESIGN

Interrupted Time Series (ITS) was used for most of the evaluation questions studied. Four evaluation questions (2,3,5, and 6) related to MaineCare's Accountable Communities (AC) and Health Home models were examined using Coarsened Exact Matching (CEM) with a t-test to support the comparison strategy.

- Accountable Communities: The performance framework for AC includes incentives for decreasing the number of members, without a cancer diagnosis, who receive concurrent prescriptions for opioids and benzodiazepines. Evaluation question three examined whether performance for AC-enrolled members is significantly different than a comparison group of members who are eligible but not engaged with an AC.

- Opioid Health Homes: MaineCare created enhanced incentives for Opioid Health Homes related to improvements in the continuity of pharmacotherapy. Evaluation question two examined whether performance for OHH-enrolled members is significantly different than a comparison group of members who are eligible but not engaged with an OHH.

- Opioid and Behavioral Health Homes: MaineCare enhanced requirements and incentives related to transitions of care and integration with physical health. Evaluation questions five and six examined whether performance is significantly different than a comparison group of members who are eligible but not engaged in those programs.

Matching was used to control for potential variances in demographic and delivery system characteristics between the treatment and comparison groups. (See subsection B below for a description of groups and subsection F for a description of statistical models.) Most remaining evaluation questions and hypotheses were studied using an ITS methodology, t-tests, and/or logistic regression. Results were calculated quarterly in the four years before the Demonstration effective date to identify trends. Following Demonstration implementation, quarterly results were studied against the baseline.

B. TARGET AND COMPARISON POPULATIONS

The study group consisted of all full benefit Medicaid enrollees with an SUD diagnosis listed in one of the following HEDIS® value sets:

- Alcohol Abuse and Dependence
- Opioid Abuse and Dependence
- Other Drug Abuse and Dependence

The evaluation included Demonstration enrollees with 12 months of continuous enrollment during the measurement period who met the criteria for the hypothesis and measure under study. The evaluation did not employ random, representative, or other sampling methods.

Several hypotheses were studied using a within-subjects comparison strategy using CEM as previously described. Enrollment reports for each initiative studied were provided to the evaluator by OMS using the eligibility guidelines summarized below:

Accountable Community Eligibility: Accountable Community (AC) members are full benefit Medicaid beneficiaries. Members may be eligible for AC services if the Member has six months of continuous MaineCare eligibility or nine months of non-continuous MaineCare eligibility during the relevant 12-month period of data, and if the Members meet one of the following requirements:

a. Member has received Primary Care Health Home or Primary Care Plus Services during the appropriate look-back period; OR
b. Member has at least one visit with a Primary Care Provider during the appropriate look-back period; OR
c. Member has three (3) or more Emergency Department (ED) visits during the appropriate look-back period.

Opioid Health Home Eligibility: Individuals with an OUD are eligible for Opioid Health Home services. Members must meet both of the following criteria:

1. Have a SUD-OUD (as outlined in the Diagnostic and Statistical Manual of Mental Disorders [5th ed. DSM–5]) diagnosis within the last twelve months; AND
2. Have or be at risk of having a second chronic condition:
   a. A mental health condition
   b. An additional substance use disorder (other than opioid use disorder)
   c. Tobacco use
   d. Diabetes
   e. Heart disease
   f. Overweight or obese as evidenced by a body mass index over 25
   g. Chronic Obstructive Pulmonary Disease (COPD)
   h. Hypertension
   i. Hyperlipidemia
   j. Developmental and intellectual disorders
   k. Circulatory congenital abnormalities
   l. Asthma
   m. Acquired brain injury
   n. Seizure disorder

3. Members shall be assessed by the OHH providers for high-risk behaviors and other risk factors that may contribute to chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current substance use other than opioids; and family health issues.

Behavioral Health Home Eligibility: Adults with a Serious and Persistent Mental Illness (SPMI) are eligible for Behavioral Health Home services. Both of the following criteria must be met:

1. Members must have a primary mental health diagnosis under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, except that the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:
    a. Delirium, dementia, amnestic, and other cognitive disorders;
    b. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
    c. Substance abuse or dependence;
    d. Intellectual disability;
    e. Adjustment disorders;
    f. Z-codes; or
    g. Antisocial personality disorder; AND

2. Members must have a LOCUS score, as determined by staff certified for LOCUS assessment by DHHS, of seventeen (17) (Level III) or greater. The LOCUS assessment must be administered annually and documented in the members' records.

C. EVALUATION PERIOD

The SUD Demonstration was approved on December 22, 2020, effective January 1, 2021 through December 31, 2025. The State began drawing Medicaid FFP for IMD services in DY2, following CMS approval of its SUD Implementation Plan. Results for CY2017-CY2020 were used to establish the baseline trends for assessing change during the Demonstration period for the ITS analysis. The comparison strategy using CEM for AC and Health Home participants presented in this Interim Evaluation Report examines outcomes for CY2021 – CY2023. Results should be considered preliminary, pending a full six-month runout of claims for the final quarter of 2023.

D. EVALUATION MEASURES

An overview of each evaluation question, hypothesis, and measure is outlined in Section VI Results. Attachment A provides a listing of measures from the approved evaluation design by goal area and hypothesis, including any changes made during the implementation of the evaluation due to data availability or integrity.

Where measures are referenced from the SUD Monitoring Protocol (MP), the CMS Technical Specifications Manual v 4 was used as guidance for diagnostic and CPT code value sets, index events and other specifications. The metric number is included as reference. One measure, the rate of non-emergent ED visits per 1,000 member months, was developed by OMS. The list of qualifying diagnosis codes and other criteria is included in Attachment B.

E. DATA SOURCES, CLEANING AND VALIDATION

The evaluation used administrative data collected by DHHS. The primary source of data was the Medicaid Management Information System (MMIS). MMIS data was augmented by information from the State of Maine Center for Disease Control's Data, Research and Vital Statistics database and the Prescription Monitoring program (PMP) reporting system. Data sources are described in the table below.

Data Source	Description
Medicaid Management Information System (MMIS)	Medicaid payment information and claims data submitted to the State by providers used to support HEDIS and HEDIS-like performance, Medication Assisted Treatment, service utilization, and cost metrics for all enrollees
State Medicaid Eligibility and Enrollment files	Eligibility and enrollment detail for Medicaid beneficiaries used to determine enrollee aid category and stratify data into sub-groups, when applicable
State Medicaid Provider Enrollment Files	Provider enrollment type and specialty designation
Prescription Monitoring Program (PMP)	Collects, monitors, and analyzes electronically transmitted data on all dispensed Schedule II, III, and IV controlled substances. Data on each prescription includes the prescribed drug, the recipient, the health care provider who wrote the prescription, and the pharmacy that dispensed the prescription
Data, Research and Vital Statistics (DVRS)	Public health birth, death, and other vital records used to track overdose deaths attributed to Maine residents

The SUD evaluator held ad hoc meetings with State subject matter experts to discuss data and any anomalies found in the data. In addition, the evaluator inventoried changes in program operations or policy, if any, that may have occurred to explain changes in the data.

The evaluator received a standardized Medicaid claims extract monthly. Claims extracts were validated and prepared by the State's fiscal agent, Gainwell, based on date of payment. The evaluator performed a data audit process to identify any problems or inconsistencies with the data received. This included comparisons to previous raw claims extracts and sample trends. No anomalies were found during the production of the interim evaluation findings. Recipient eligibility segments may change over time. In examining utilization of service and results by aid category, the evaluator assigned aid categories as of January 1 of each year.

The Data, Research and Vital Statistics (DVRS) database is maintained by the public health department of the Maine Center for Disease Control. This system serves as the authority for birth, death, and other vital records in Maine. Death records are recorded with the cause of death and are used to track overdose deaths attributed to Maine residents. The MMIS links with the Vital Statistics database as part of its program integrity process to ensure Medicaid members who have died are removed from the eligibility system. OMS staff matched deaths attributed to opioid and other drug overdose to Medicaid eligibility data to calculate the number and rate of overdose deaths among Medicaid beneficiaries. (Note that cause of death data may lag up to one year or more.)

The Prescription Monitoring Program (PMP) is supported through a contract with Appriss Health. The vendor's software platform is used to host the PMP. Data is monitored for accuracy within the proprietary vendor system. The evaluator extracted evaluation data from annual reports prepared for the legislature.

F. ANALYTIC METHODS

Data analysis consisted of both exploratory and descriptive strategies and incorporated univariate, bi-variate, and multi-variate techniques. Analyses were performed to systematically apply statistical and/or logical techniques to describe, summarize, and compare data within the State and across time.

Descriptive statistics were used to describe the basic features of the data and what they depict, and to provide simple summaries about the sample and the measures. They also were used to provide summaries about the participants and their outcomes. An exploratory data analysis is used to compare many variables in the search for organized patterns. Data were analyzed as rates, proportions, frequencies, and measures of central tendency (e.g., mean, median, mode).

As appropriate, analysis methods included Logistic and Linear Regressions, Analysis of Variance (ANOVA), T-test, and Coarsened Exact Matching with t-test. These tests were used for comparing sample and population means against each other; this can be the same population across time or within the same time but for populations receiving different treatments, or for one group that does not receive treatment while others do.

T-tests and ANOVA are appropriate when granular (patient-level) data is not available, but population-level means and standard deviations are, the outcome variable is continuous, and the objective is to determine whether the mean of a certain outcome variable of interest is significantly different between two or more groups. T-tests allow for comparison of means between two groups where the outcome variable is continuous whereas ANOVA allows this to be done for more than two groups. Where the outcome variable was binary, logistic regression was used.

The traditionally accepted significance level ($p \leq 0.05$) was used for all comparisons. The design did not employ multiple t-tests involving the same set of data; thus, the Bonferroni correction was not applied.

INTERRUPTED TIME SERIES

Evaluation measures studied using an interrupted time series (ITS) design were examined quarterly. The ITS assumes stationarity in the data and includes the assumption that absent the Demonstration, results would have continued on the same trajectory as the pre-Demonstration quarters.

The evaluator determined that the data included enough observations (pre and post) and reflected a stationary time series (i.e., the statistical properties of the time series did not change over time – in this case in the pre-Demonstration data subset and the post Demonstration data subset). In addition, the data preserved enough non-zero values and variation to allow for time series analysis. The ITS examined whether there was: (1) no effect; (2) only an immediate effect; (3) only a sustained long-term effect; or (4) both an immediate and a sustained long-term effect. To model the time series, the evaluator used the following equation:

$$YY = \beta\beta_0 + \beta\beta_1 TTTTTTTT + \beta\beta_2 DD + \beta\beta_3 PP + \varepsilon\varepsilon$$

where Y is the outcome variable or metric of interest, *Time* indicates the quarter since the beginning of the observational period (i.e., 1, 2, …), D is an indicator variable (takes on either value 0 or 1) that indicates whether this period is before or after the Demonstration, and P denotes the period or quarter since the Demonstration started (i.e., 0's until the Demonstration effective date then 1, 2, …).

A description of the ITS variables and how results may be interpreted is provided below.

<table>
<tr><th>ITS Model Variable</th><th>Description</th><th>Interpretation</th></tr>
<tr><td>General Trend (Time)</td><td>The impact of time overall (pre and post Demonstration) on the outcome variable</td><td rowspan="3">If the general trend is improving and significant and:
The immediate or sustained effects are not significant and:
Moving in the desired direction, then the trend is not interrupted by the Demonstration period or start date (e.g., it was already moving in the desired direction)
Not moving in the desired direction, then the general trend overcame any negative effects associated with the Demonstration period or start date
The immediate or sustained effects are significant and:
Moving in the desired direction, then the Demonstration period or start date are associated with improvement
Not moving in the desired direction, then the Demonstration period or start date are associated with a decline in performance
If the immediate and sustained effects are moving in opposite directions and:
The immediate effect is in the desired direction and the sustained effect is not, then there was an immediate desirable effect, however, over time the improvement was diminished
The immediate effect is not in desired direction and the sustained effect is, then start date is associated with a decline in performance which then improved during the Demonstration period</td></tr>
<tr><td>Immediate Effect of Demonstration Start</td><td>The immediate impact of the Demonstration start date (difference in the quarters immediately before and after the start date)</td></tr>
<tr><td>Sustained Effect (Time since demo start)</td><td>The trend seen after the start of the Demonstration through the last observation point</td></tr>
<tr><td>Counterfactual</td><td colspan="2">This is the projected trend assuming pre-demonstration performance continued absent the Demonstration</td></tr>
</table>

The design relies on measures that by nature include participants with attributes that are highly correlated. For example, many measures focus on specific diagnosis, medications, age bands or treatment conditions. The inclusion and exclusion criteria for each measure limits the variability of beneficiary characteristics that are observed in the data. In addition, as measure specificity increases (e.g., members with opioid prescriptions over 90 morphine milligram equivalents (MME)), sample size decreases, limiting the conclusions that may be drawn from an analysis of member characteristics.

However, Evaluation Questions #1 *(Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?)* and #4 *(Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?)* focus on broader population trends.

As part of the interrupted time series analysis, and based on the viability of the sample size, the evaluator controlled for demographic characteristics (age, gender, geography, and aid category code) using the following equation:

$$YY_{tt} = \beta\beta_0 + \beta\beta_1 TT_{tt} + \beta\beta_2 DD_{tt} + \beta\beta_3 PP_{tt} + \beta\beta_4 DD_{AAAAAA} + \beta\beta_5 DD_{AAAAGGGGAAGG} + \beta\beta_6 DD_{AAAAAAAAAAAAAAAAAAAAAAA} + \beta\beta_7 DD_{AAAAAAGGAAAAAAAAGG} + \beta\beta_8 DD_{UUGGAAAAGGGGUUGGAAUU} + \varepsilon\varepsilon$$

These variables are defined as:

- T_t (time since beginning of data collection)
- D_t (a dummy variable indicating if the current period is pre-intervention (D_t =0) or post-intervention (D_t =1))
- P_t (time since Demonstration start date, takes on 0 for periods before Demonstration start date)
- D_{AGE}, D_{GENDER}, $D_{URBANRURAL}$, (demographic and geography variables)
- $D_{AidExpansion}$, $D_{AidNonABD}$ (dummy variables for the member's aid category code where Aged Blind Disabled (ABD) is represented by 0 on both Expansion and non-ABD)

Generalized linear models with both demographic and time series variables (time, time since Demonstration, dummy variable for pre/post Demonstration) were used to help isolate the impact of the Demonstration. The covariates explain some of the variation in the metrics of interest and thus reflect a more accurate importance of the temporal variables relating to the Demonstration date. As with all regressions, there is always the risk of confounding factors that cannot be measured or entered into the regression model having explanatory power over the variation in the outcome variable.

IMPACT OF THE NOVEL CORONAVIRUS PUBLIC HEALTH EMERGENCY

Given the unique circumstances of the PHE in 2020, the evaluator assessed whether CY2020 data should be included in the interrupted time series analysis. The analysis was performed using data collected during CY2020 as part of the baseline period 2017-2020. No noticeable anomalies in the trend lines were observed.

For measures relying on logistic regression for assessment of annual results against a baseline, the evaluator tested whether 2020 was significantly different from 2019. When this was the case, 2019 was used as the baseline year; otherwise, 2020 was used. The detailed findings for each measure identify when 2019 was used as the base year.

COARSENED EXACT MATCHING

Coarsened Exact Matching (CEM) was used for evaluating AC and non-AC comparison groups, as well as Health Home enrollees and non-enrollees. CEM is intended to reduce confounding variables associated with the observational data by "coarsening" data (e.g., using age ranges rather than specific ages) to find exact matches more quickly between comparison and treatment groups. This allows the evaluator to create balanced subsets of comparison and treatment data in order to attribute more of the differences in the metrics of interest across these two groups to their treatment (or lack thereof in the case of the comparison group) and not to one of the demographic factors which could also explain some or all of the differences between the groups' outcomes.

The covariates included gender, age, geography, health status, and aid category code (enumerated below). Health status was defined as the IBM Watson risk level identified through a member's assignment to a Diagnostic Cost Group (DCG) in the OMS decision support system. The evaluator performed a separate analysis for each year of the Demonstration; thus, the year was also entered as a covariate. Geography was characterized as "Urban" and "Rural" using Maine county classifications of Metropolitan Statistical Areas as illustrated below.

Geographic Category	Maine County (Recipient Place of Residence)
Urban	Cumberland, York, Sagadahoc, Androscoggin, Penobscot, Kennebec
Rural	Aroostook, Oxford, Hancock, Somerset, Knox, Waldo, Lincoln, Washington, Franklin, Piscataquis

The aid category which determines how a member qualified for Medicaid was one-hot encoded to become the following binary variables: expansion; ABD; Non-ABD. After matching, the evaluator compared the two groups on the demographic factors to determine if there were statistically significant differences in any of those factors.

Balance tables are provided in Attachment D. The tables provide CEM data, both pre- and post-matching. The post-matching data presents characteristics of the beneficiaries included in the related t-test analysis. Age is shown in years (e.g., 39.5 years of age). Other variables are binary, with the results expressed as a value between 0 and 1. For example, the urban/rural variable classifies members residing in rural areas as "1" and urban areas as "0". The reported value signifies the percent of members with the characteristic designated with a "1" (e.g., an urban/rural value of 0.255 indicates that 25.5 percent of the members reside in a rural area).

LOGISTIC REGRESSION

In some instances, measures could not be studied using the ITS approach. When the outcome of interest was binary, a logistic regression was performed against the baseline year. The evaluator denoted 0 as 'no' and 1 as 'yes' and estimated the log odds (or logit) which is 'l=ln(p/1-p)' where 'ln' denotes natural log or log base e. The logistic regression was:

$$ll = llll\frac{pp}{1-pp} = \beta\beta_0 + \beta\beta_1(yyTTyyyy) + \varepsilon\varepsilon$$

which was solved algebraically for p to yield:

$$pp = \frac{1}{1 + TT^{-(\beta\beta 0 + \beta\beta 1(yyyyAAyy) + \varepsilon\varepsilon)}}$$

SUD EXPENDITURE ANALYSIS

In addition to hypotheses testing, the evaluation explored changes in total Medicaid expenditures for members served in an SUD IMD. Cost of care measures not associated with a hypothesis were examined using an ITS design to estimate different linear effects in the pre-Demonstration (CY2017-CY2020) and post-Demonstration periods (CY2021-2025). The evaluator examined each cost measure separately.

$$CCCCCCCC_{tt} = \beta\beta_0 + \beta\beta_1 TTTTTTTT + \beta\beta_2 DD + \beta\beta_3 PP + \varepsilon\varepsilon$$

where Y is the outcome variable or metric of interest, *Time* indicates the quarter since the beginning of the observational period (i.e., 1, 2, …), D is an indicator variable (takes on either value 0 or 1) that indicates whether this period is before or after the Demonstration, and P denotes the period or quarter since the Demonstration started (i.e., 0's until the Demonstration effective date then 1, 2, …). Additionally, the evaluator used a generalized linear model to control demographic variables that may contribute to cost.

$$CCCCCCCC_{tt} = \beta\beta_0 + \beta\beta_1 TT_{tt} + \beta\beta_2 DD_{tt} + \beta\beta_3 PP_{tt} + \beta\beta_4 DD_{AAAAAA} + \beta\beta_5 DD_{AAAAGGGGAAGG} + \beta\beta_6 DD_{AAAAAAAAAAAAAAAAAAAAAA} + \beta\beta_7 DD_{AAAAAAGGAAAAAAAAGG} + \beta\beta_8 DD_{UUGGAAAAGGGGUUGGAAUU} + \varepsilon\varepsilon$$

These variables are defined as:

- T_t (time since beginning of data collection)
- D_t (a dummy variable indicating if the current time period is pre-intervention (D_t =0) or post-intervention (D_t =1))
- P_t (time since Demonstration start date, takes on 0 for periods before Demonstration start date)
- D_{AGE}, D_{GENDER}, $D_{URBANRURAL,}$ (demographic and geography variables)
- $D_{AidExpansion}$, $D_{AidNonABD}$ (dummy variables for the member's aid category code where ABD is represented by 0 on both Expansion and non-ABD)

ISOLATION FROM OTHER SUD-RELATED INITIATIVES

The evaluation design contemplated isolating the effect of an initiative funded by CMS outside of the Demonstration. MaineMOM involves providing integrated care management, social service supports, and MAT for Medicaid members who are pregnant and postpartum. However, MaineMom enrollments represented only 30 of the 106,733 members included in DY1, 113 of the 124,040 members in DY2 and 98 of the 143,154 members in DY3. Individuals enrolled in MaineMOM services therefore were not removed from the results. No other SUD initiatives involving Medicaid members outside of the Demonstration were identified.

METHODOLOGICAL LIMITATIONS

Due to the quasi-experimental nature of the design and the limitations identified below, the evaluation results cannot be attributed to causal inference. The findings may suggest an association or correlation with various aspects of the Demonstration. However, suggesting causation may not be appropriate when describing results. Data and design limitations are outlined below.

A. DESIGN LIMITATIONS

Lack of True Experimental Control Groups: IMD facilities serve residents from across the State. Thus, regional control or comparison groups are not available. In addition, residential placement decisions are based on nationally recognized ASAM level of care guidelines; thus, individuals admitted to a residential SUD program have a clinically different profile and level of care need than those who are not admitted. These clinical differences eliminate the possibility of a matched sample of IMD enrollees who receive services versus those who did not. Lastly, all Medicaid enrollees who meet SUD criteria are eligible for the Demonstration. However, the evaluation does employ a comparison strategy to study delivery system enhancements relative to their impact on AC and Health Home enrollees.

B. DATA LIMITATIONS

Use of Administrative Data: The evaluation may be limited by its reliance on payment files, claims and diagnostic codes to identify the beneficiary population with SUD. These codes may not capture all participants, especially if the impact or severity of the SUD is not evident on the initial assessment. For example, an ED visit for a broken arm due to inebriation may not be coded as SUD-related if the member does not present as inebriated, the ED provider has not ascertained causation, or the member fails to disclose the cause. This type of limitation is inherent in claims-based analysis. However, the potential for missing data is random and there is no reason to believe that any given Demonstration group is more or less likely to have missing data.

Medicaid Enrollment/Disenrollment: Medicaid enrollment changes on an annual basis related to eligibility. For example, someone may be attributed to a study cohort in year one, disenroll in year two and re-enroll in year three. In response to the novel coronavirus public health emergency, the State suspended Medicaid terminations resulting in increased enrollment for CY2020 and CY2021. In addition, as innovations such as Medicaid ACOs or Health Homes expand their membership or focus, membership in any potential comparison group decreases over time.

C. SPECIAL METHODOLOGICAL CONSIDERATIONS

SUD IMD treatment facilities are existing statewide providers that had been delivering care to Medicaid enrollees prior to the implementation of the SUD Demonstration. The Demonstration allows the State to continue services that have been in place, albeit with a new funding partner. Independent variables expected to result in change throughout the Demonstration are based on delivery system enhancements and quality improvement strategies and not new IMD expenditure authorities.

.RESULTS

Results for each hypothesis and measure are presented by evaluation question. Measure descriptions, analytics and statistical details are provided for each finding. Unless otherwise noted, the data source for all measures was Medicaid claims. Results for measures examined using the ITS approach were assessed using the variables in the table below.

ITS Model Variable	Description
General Trend (Time)	The impact of time overall (pre and post Demonstration) on the outcome variable
Immediate Effect of Demonstration Start	The immediate impact of the Demonstration start date (difference in the quarters immediately before and after the start date)
Sustained Effect (Time since demo start)	The trend seen after the start of the Demonstration through the last observation point
Counterfactual	This is the projected trend assuming pre-demonstration performance continued absent the Demonstration

A. SUD EVALUATION QUESTION ONE

Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?

Evaluation question one includes two subsidiary questions:

a. How does service utilization vary by age and aid category code?
b. How does utilization vary by service type?

Four hypotheses were examined under evaluation question one:

1. The Demonstration will maintain or increase utilization of SUD treatment services.
2. The Demonstration will maintain or increase SUD provider availability.
3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.
4. The Demonstration will maintain or increase initiation and engagement in treatment.

The measures examined under ***hypothesis one*** are outlined below. The analytic methods and findings for each measure are outlined on the following pages.

1.1.1. Percentage of Medicaid members receiving any SUD treatment service
1.1.2. Percentage of members with SUD receiving SUD outpatient treatment services)
1.1.3. Percentage of members receiving with SUD receiving intensive outpatient (IOP) treatment and partial hospitalization (PH) services
1.1.4. Percentage of members with SUD receiving residential and inpatient treatment services
1.1.5. Percentage of members with SUD receiving withdrawal management services
1.1.6. Percentage of members with SUD receiving medication-assisted treatment (MAT)

Measure 1.1.1 - Percentage of Medicaid members receiving any SUD treatment service

Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

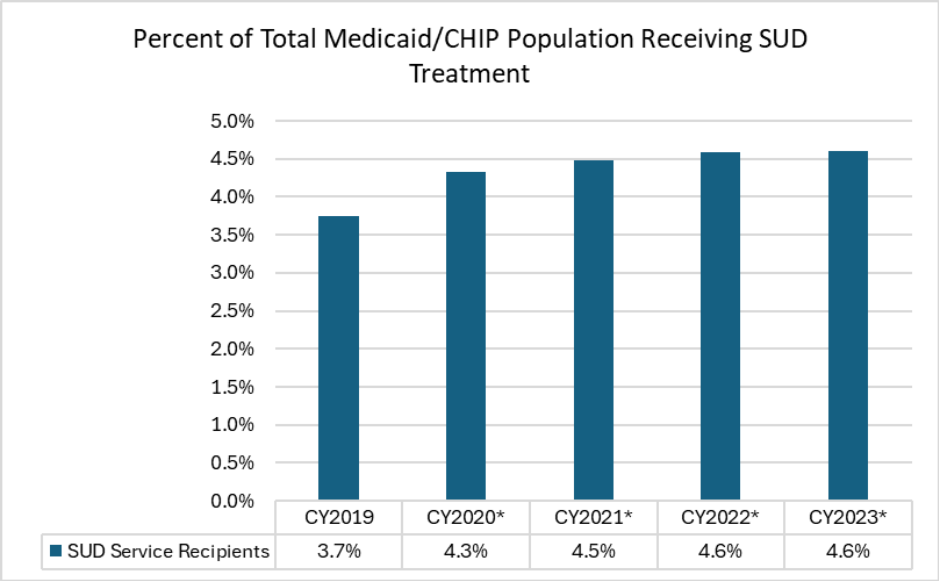
Measure Description: The numerator includes the number of Medicaid members with a claim for any type of SUD treatment services during the 12-month measurement period. The denominator includes the number of Medicaid/CHIP enrollments for each year studied.

Data Source and Time Period: MMIS paid claims CY2019-2023

Analytical Approach: Logistic Regression with t-test; Demonstration Year results (CY2021-23) were examined using 2019 as the baseline year.

Findings: In 2019, Maine substantially expanded Medicaid eligibility for adults under the Affordable Care Act. The percentage of Medicaid/CHIP enrollees receiving any type of SUD treatment was 3.7 percent. In 2020 the percentage increased to 4.3 and continued to increase, to 4.5 percent in 2021 and to 4.6 percent both in 2022 and 2023.

The change over baseline was statistically significant in each year of the Demonstration.



**Statistically significant change over baseline*

Measure 1.1.2 Percentage of members with a SUD diagnosis receiving SUD outpatient treatment services

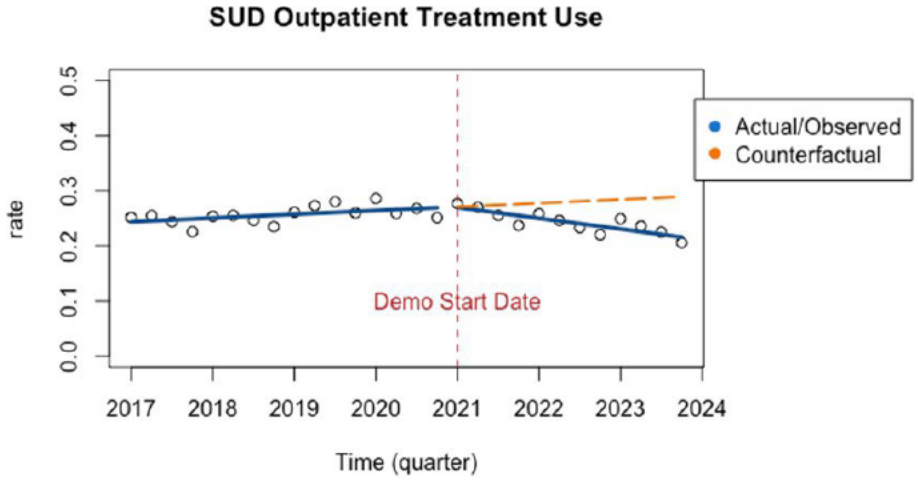
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

Measure Description: The denominator includes all enrollees with an SUD diagnosis. The numerator includes members with an SUD diagnosis who had a claim for SUD outpatient treatment during the measuring period (quarter).

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed a statistically significant increase over time. There was no statistically significant effect in utilization immediately following the Demonstration start date. The sustained effect showed a statistically significant decline in outpatient treatment use during the first years of the Demonstration.



Outpatient ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.01	0.003	p<0.05
Immediate Effect of Demonstration Start	0.01	0.01	None
Sustained Effect (Time since demo start)	-0.01	0.001	p<0.01
Constant	-13.36	5.66	p<0.05

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that utilization is explained in part by the Demonstration period (immediate and sustained impact) as well as the demographic variables studied. Older members tend to use more outpatient services, as do women, expansion group members, non-ABD group members and those living in rural counties. Although coefficients are small, all temporal and individual factors showed statistically significant explanatory power.

Outpatient GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.006	(0.001)	p<0.01
Immediate Effect of Demonstration Start	0.005	(0.002)	p<0.01
Sustained Effect	-0.006	(0.0003)	p<0.01
Age	0.001	(0.00004)	p<0.01
Gender (Female)	0.021	(0.001)	p<0.01
Expansion Group	0.017	(0.001)	p<0.01
Non-ABD	0.017	(0.001)	p<0.01
Rural	0.007	(0.001)	p<0.01
Constant	-11.491	(1.358)	p<0.01

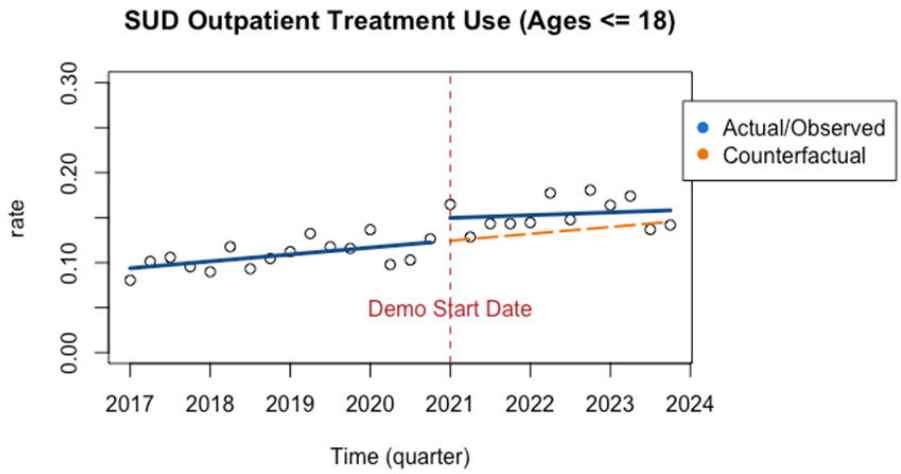
Age

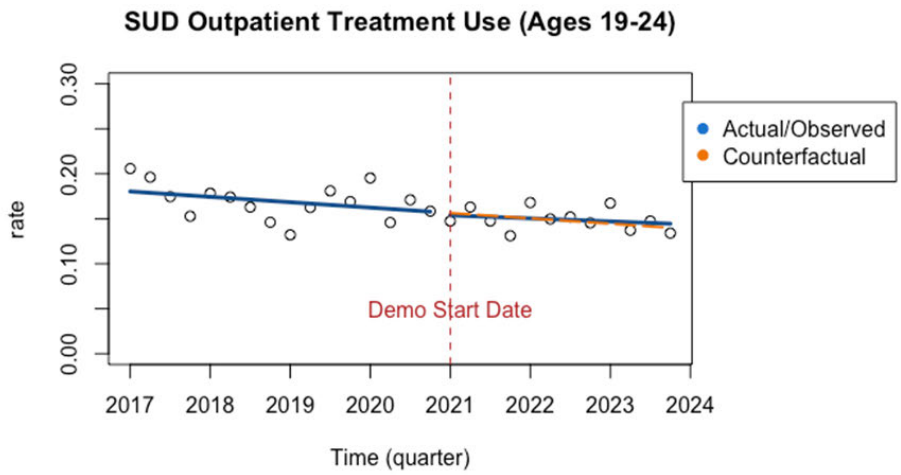
The general trend in utilization by age showed a statistically significant increase in use of outpatient treatment for members 18 and under, including immediately after the Demonstration started. There was no sustained increase in utilization for members 18 and under. There was no statistically significant effect for members ages 19-24.

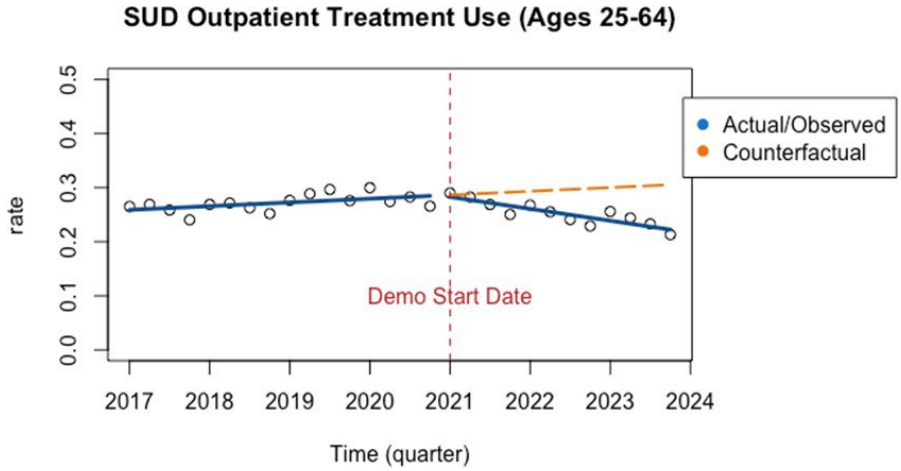
Members 25-64 showed a statistically significant general trend for increased use; however, there was a statistically significant sustained decrease in utilization for this age group. Members ages 65 and older showed a statistically significant increase in outpatient use immediately following the Demonstration start date.

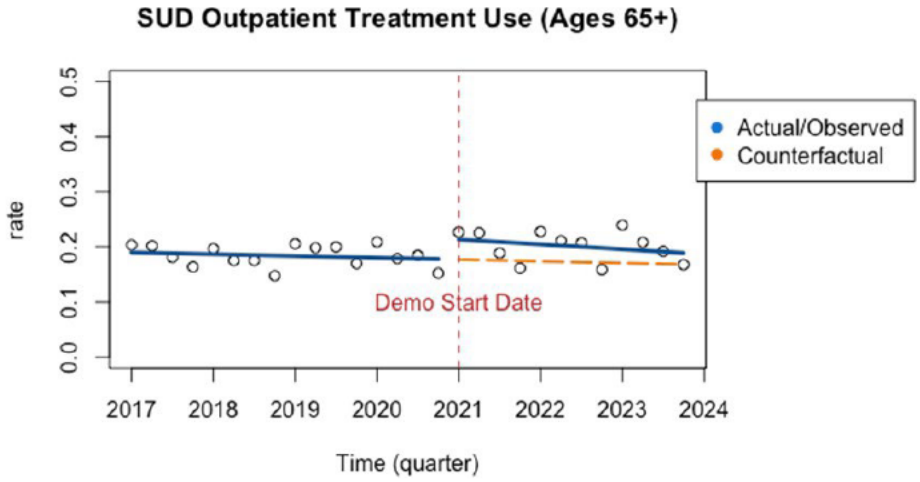
Outpatient ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	0.01** (0.003)	-0.01 (0.004)	0.01** (0.003)	-0.003 (0.01)
Immediate Effect of Demonstration Start (Standard Error)	0.03** (0.01)	-0.003 (0.01)	0.004 (0.01)	0.04** (0.02)
Sustained Effect (Standard Error)	-0.001 (0.002)	0.001 (0.002)	-0.01*** (0.001)	-0.001 (0.02)
Constant (Standard Error)	-15.32*** (6.73)	12.24 (7.32)	-13.61** (5.52)	6.70 (10.16)

**p<0.05; ***p<0.01


SUD Outpatient Treatment Use (Ages <= 18)
rate
0.00
0.10
0.20
0.30
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual


SUD Outpatient Treatment Use (Ages 19-24)
rate
0.00
0.10
0.20
0.30
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual


SUD Outpatient Treatment Use (Ages 25-64)
rate
0.0
0.1
0.2
0.3
0.4
0.5
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

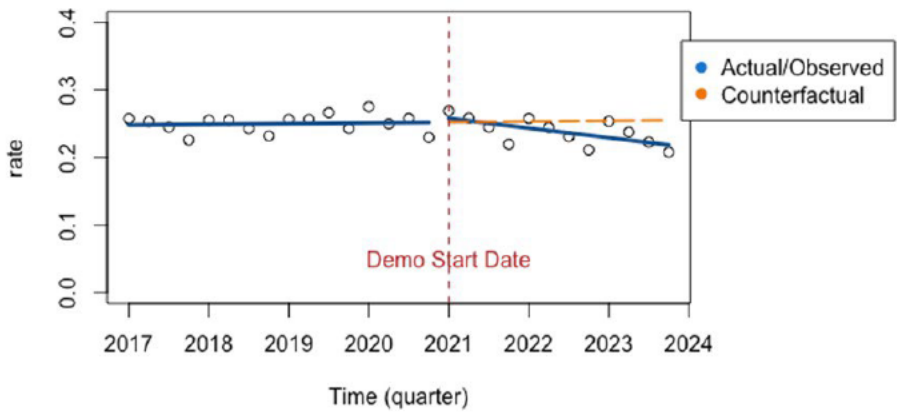


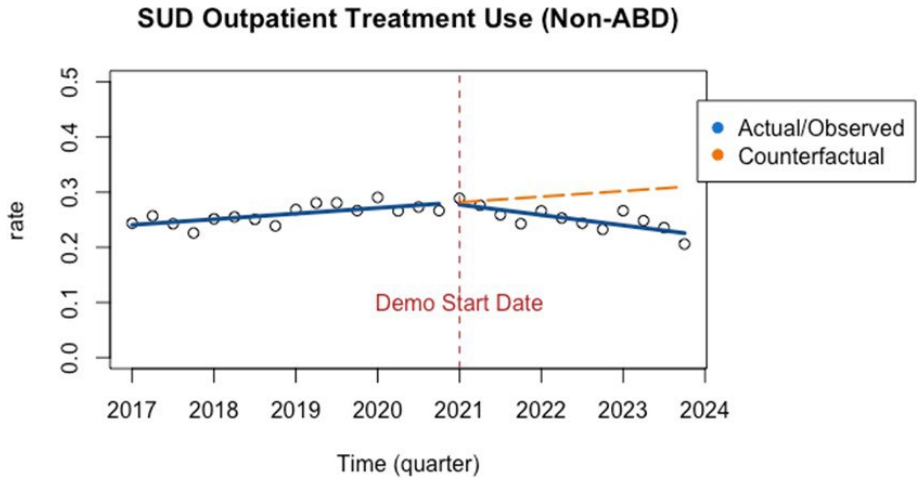
Aid Category

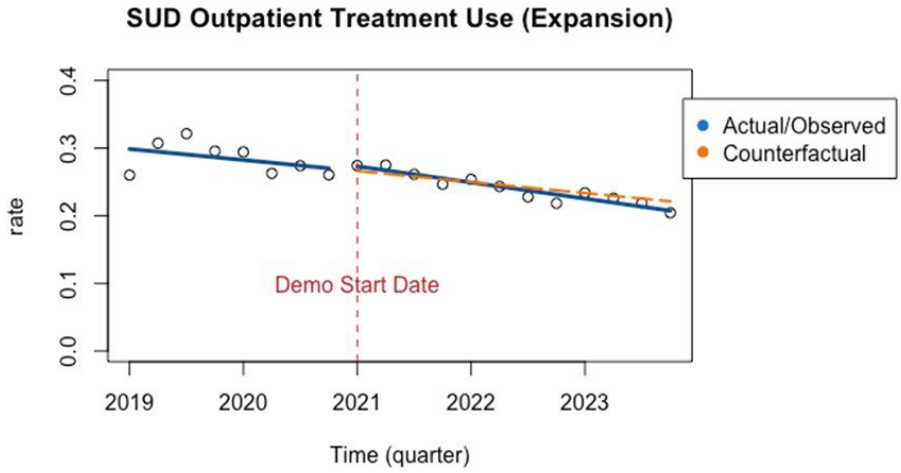
An analysis of utilization by aid category showed increased use associated with members in the non-ABD group, a statistically significant decline in utilization was sustained during the Demonstration for this group and members in the ABD group. There were no significant changes in trend for the expansion group.

Outpatient ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	0.001 (0.003)	0.01*** (0.003)	-0.02 (0.01)
Immediate Effect of Demonstration Start (Standard Error)	0.01 (0.01)	0.003 (0.01)	0.01 (0.01)
Sustained Effect (Standard Error)	-0.004** (0.001)	-0.01*** (0.001)	-0.002 (0.003)
Constant (Standard Error)	-1.87 (6.40)	-20.38*** (5.97)	33.18 (19.05)

**p<0.05; ***p<0.01




SUD Outpatient Treatment Use (Non-ABD)
rate
0.0
0.1
0.2
0.3
0.4
0.5
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual


SUD Outpatient Treatment Use (Expansion)
rate
0.0
0.1
0.2
0.3
0.4
2019
2020
2021
2022
2023
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

Measure 1.1.3 Percentage of members with a SUD diagnosis receiving intensive outpatient (IOP) treatment and partial hospitalization (PH) services.

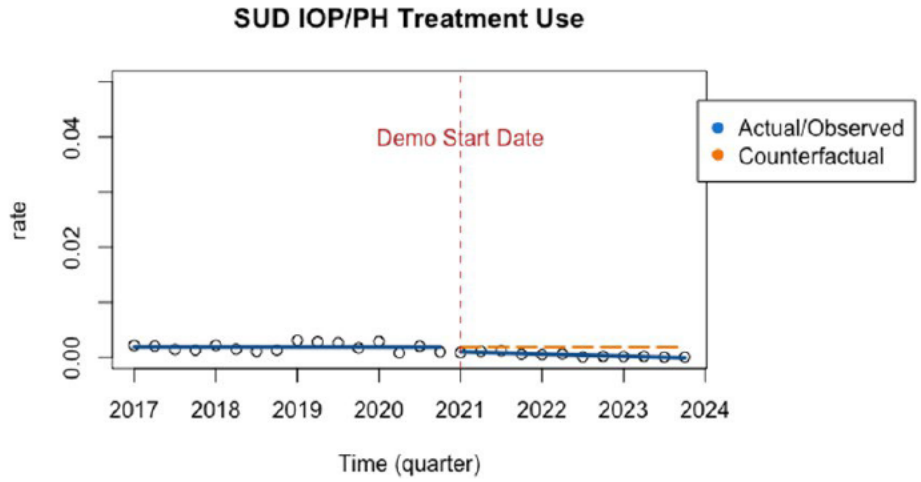
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

Measure Description: The denominator includes all enrollees with an SUD diagnosis. The numerator includes members with a claim for intensive outpatient treatment (IOP) or partial hospitalization (PH) during the measuring period (quarter).

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: An interrupted time series showed no statistically significant change in trends after the start of the Demonstration.



IOP/PH ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.0000	0.0001	None
Immediate Effect of Demonstration Start	-0.001	0.0005	None
Sustained Effect	-0.0001	0.0001	None
Constant	0.02	0.26	None

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that a decrease in utilization is explained by the Demonstration period, as well as several demographic variables studied. Older members and members in rural counties used fewer IOP/PH services. Women and expansion group members used more IOP/PH services. Although coefficients are small, these individual factors showed statistically significant explanatory power.

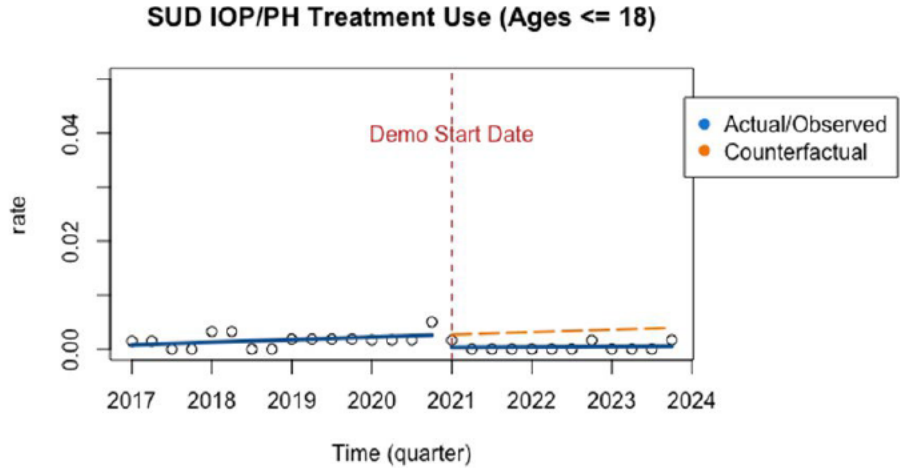
IOP/PH GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.0001	(0.0001)	p<0.05
Immediate Effect of Demonstration Start	-0.001	(0.0002)	p<0.01
Sustained Effect	-0.0001	(0.00002)	p<0.01
Age	-0.00002	(0.00000)	p<0.01
Gender (Female)	0.001	(0.0001)	p<0.01
Expansion Group	0.001	(0.0001)	p<0.01
Non-ABD	-0.00004	(0.0001)	None
Rural	-0.001	(0.0001)	p<0.01
Constant	0.223	(0.106)	p<0.05

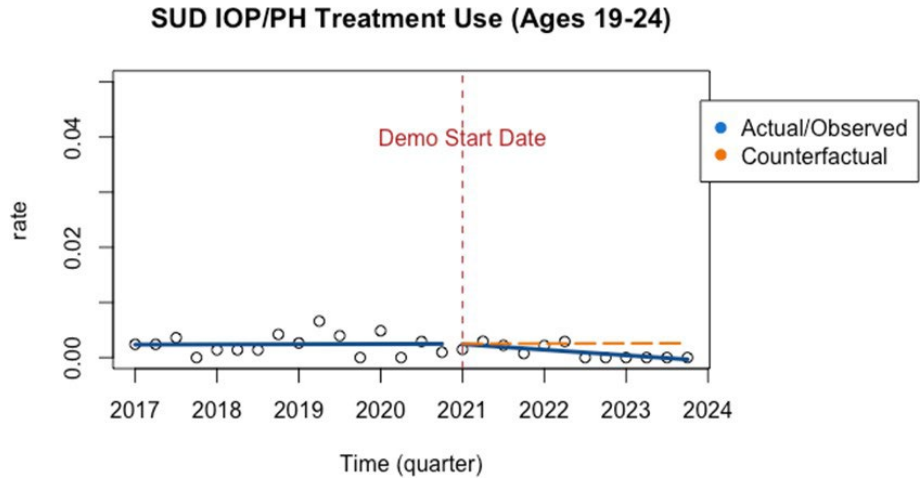
Age

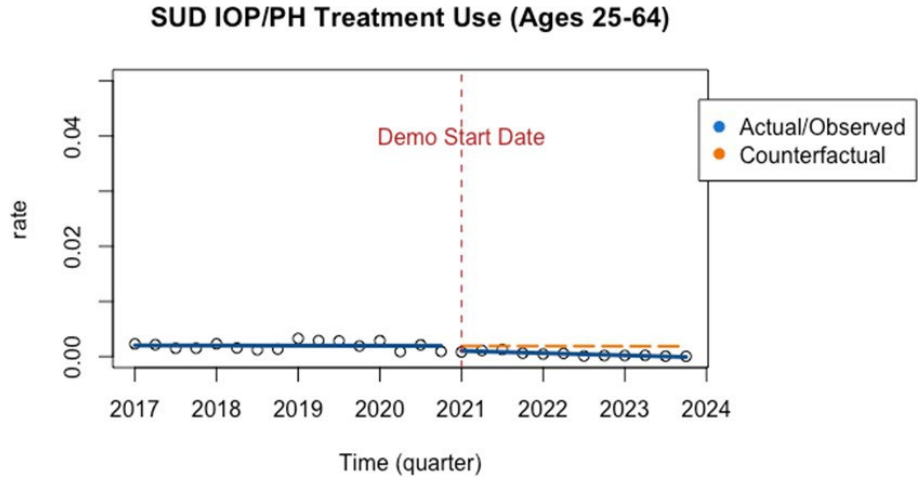
In an analysis of IOP/PH use by age, members 18 and under had a statistically significant decline in use immediately after the Demonstration started. There were no other statistically significant effects related to IOP/PH use and age.

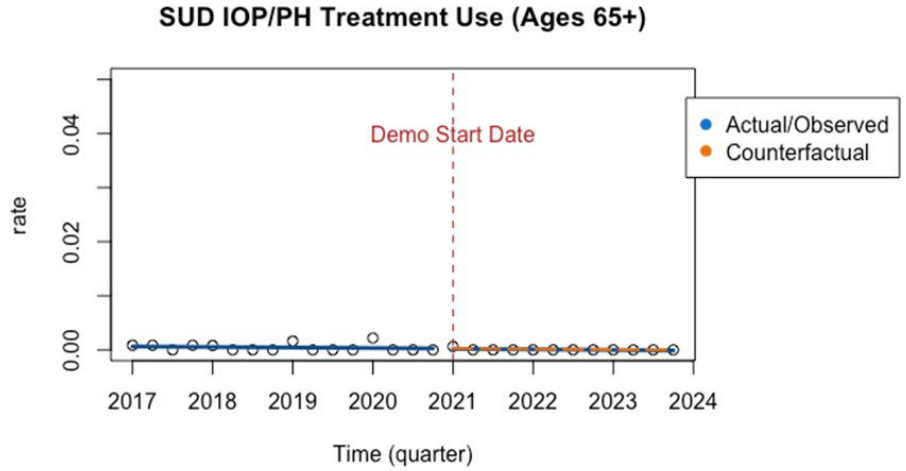
IOP/PH ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	0.0005 (0.0002)	0.0000 (0.0003)	-0.0000 (0.0001)	-0.0001 (0.0001)
Immediate Effect of Demonstration Start (Standard Error)	-0.002** (0.001)	0.0002 (0.001)	-0.001 (0.0005)	-0.0001 (0.0004)
Sustained Effect (Standard Error)	-0.0001 (0.0001)	-0.0003 (0.0002)	-0.0001 (0.0001)	-0.0000 (0.0001)
Constant (Standard Error)	-0.95 (0.48)	-0.07 (0.70)	0.05 (0.26)	0.19 (0.24)

**p<0.05; ***p<0.01




SUD IOP/PH Treatment Use (Ages 19-24)
Demo Start Date
Actual/Observed
Counterfactual
rate
0.00
0.02
0.04
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)


SUD IOP/PH Treatment Use (Ages 25-64)
Demo Start Date
Actual/Observed
Counterfactual
rate
0.00
0.02
0.04
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)

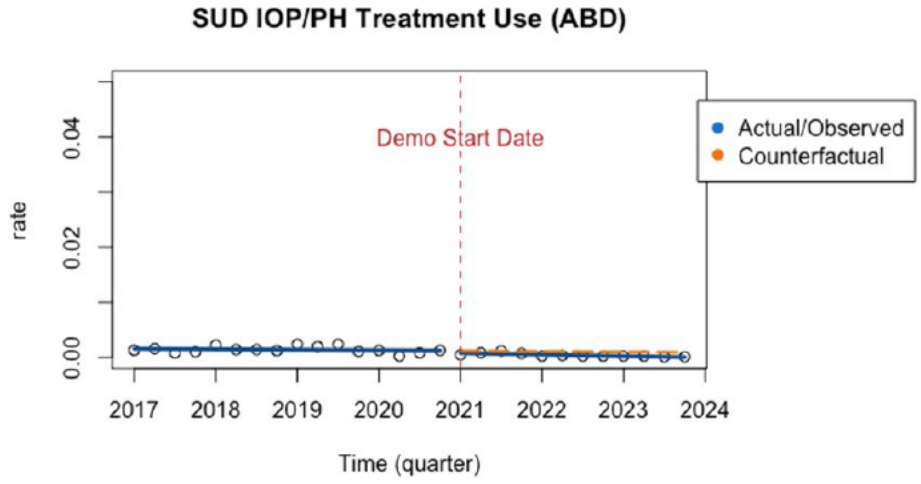

SUD IOP/PH Treatment Use (Ages 65+)
Demo Start Date
Actual/Observed
Counterfactual
rate
0.00
0.02
0.04
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)

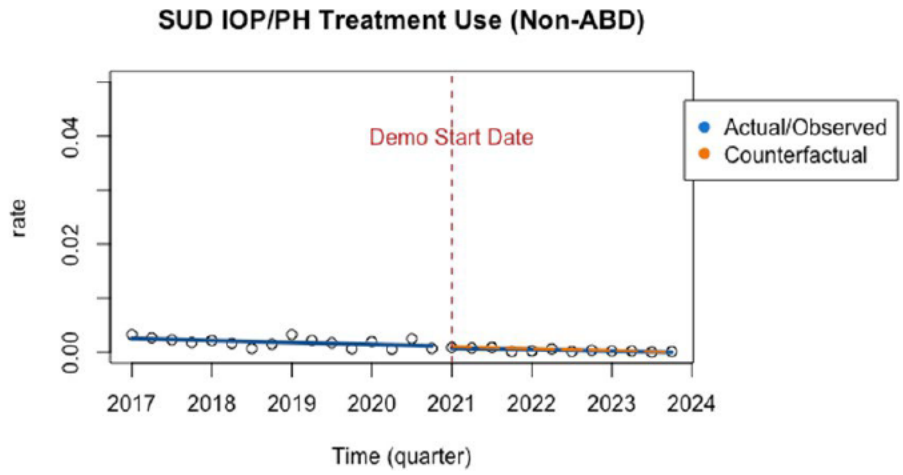
Aid Category

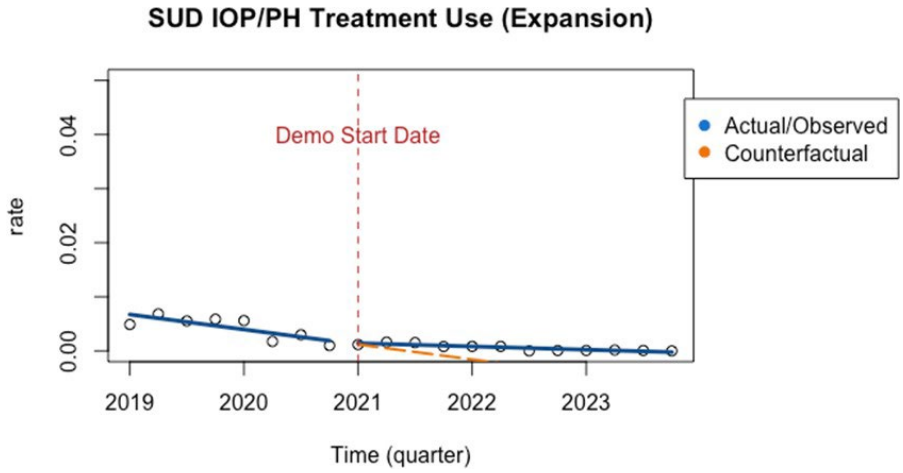
An analysis of utilization of IOP/PH services by aid category showed a general trend of decreased utilization associated with members in the non-ABD and expansion groups. There was no statistically significant effect immediately following the Demonstration. However, during the Demonstration period, the sustained effect showed a statistically significant increase in use for the expansion group.

IOP/PH ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General (Time) (Standard Error)	-0.0001 (0.0001)	-0.0004** (0.0001)	-0.003*** (0.001)
Immediate Effect of Demonstration Start (Standard Error)	-0.0004 (0.0004)	-0.0003 (0.0005)	-0.0003 (0.001)
Sustained Effect (Standard Error)	-0.0000(0.0000)	0.0000 (0.0001)	0.001*** (0.0002)
Constant (Standard Error)	0.19 (0.22)	0.74** (0.27)	5.60*** (1.10)

**p<0.05; ***p<0.01






SUD IOP/PH Treatment Use (Expansion)
Demo Start Date
Actual/Observed
Counterfactual
rate
0.00
0.02
0.04
2019
2020
2021
2022
2023
Time (quarter)

Measure 1.1.4 Percentage of members with a SUD diagnosis receiving residential and inpatient treatment services.

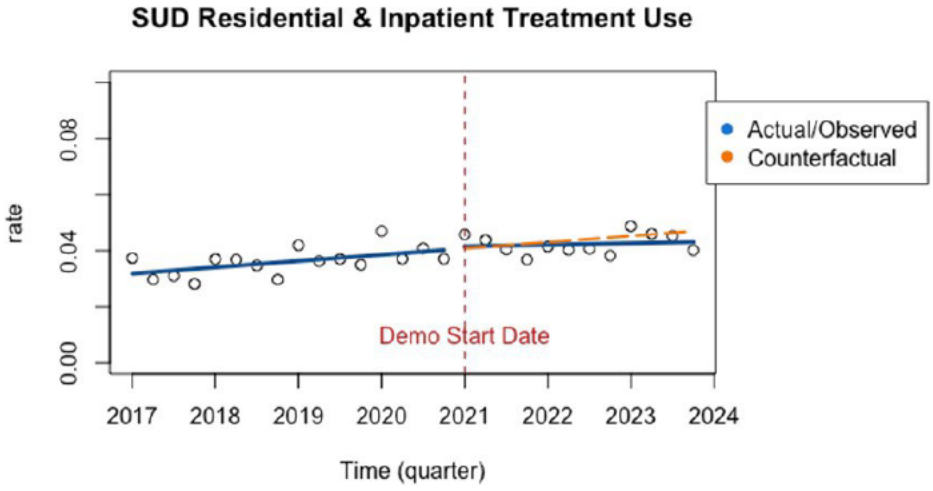
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

Measure Description: The denominator includes all enrollees with an SUD diagnosis. The numerator includes members with an SUD diagnosis who had a claim for SUD residential or inpatient treatment during the measuring period (quarter).

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed a statistically significant increase in SUD residential and inpatient treatment use. There were no statistically significant changes in trend during the first years of the Demonstration.



Inpatient/Res ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.002	(0.001)	p<0.05
Immediate Effect of Demonstration Start	0.001	(0.003)	None
Sustained Effect	-0.0004	(0.0004)	None
Constant	-4.49	(1.76)	p<0.05

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that time was not a statistically significant factor for explaining the decreased utilization of residential and inpatient services. Older members, non-ABD group members, and those in rural counties tended to use less residential and inpatient treatment, while women and expansion group members

tended to use more. Although coefficients are small, the individual factors noted showed statistically significant explanatory power.

Inpatient/Res GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.0002	0.0003	None
Immediate Effect of Demonstration Start	-0.001	0.001	None
Sustained Effect	0.0002	0.0001	None
Age	-0.0001	0.00002	p<0.01
Gender (Female)	0.003	0.0005	p<0.01
Expansion Group	0.017	0.001	p<0.01
Non-ABD	-0.010	0.001	p<0.01
Rural	-0.014	0.001	p<0.01
Constant	0.494	0.611	None

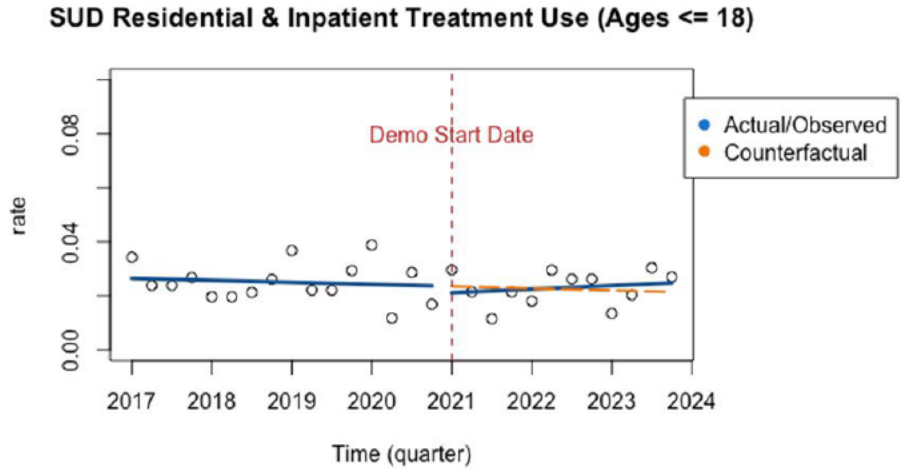
Age

An analysis of SUD residential and inpatient treatment by age showed a statistically significant decrease in the general trend for members ages 19-24 and an increase in use for the 25-64 age group.

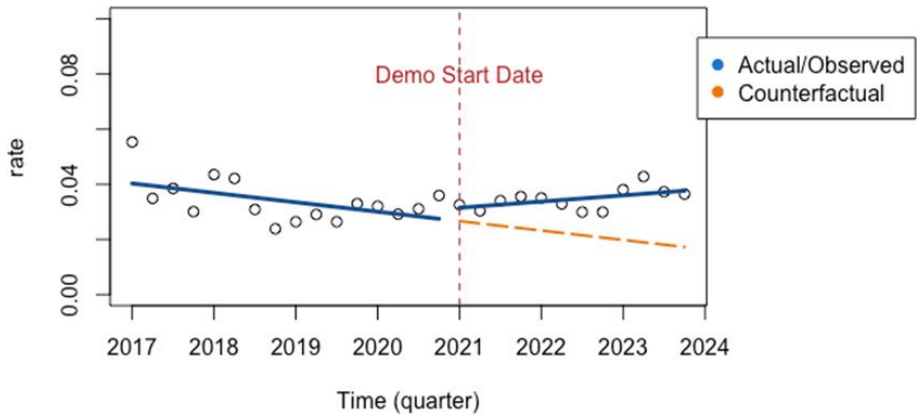
There was a statistically significant sustained increase in utilization for members ages 19-24 during the Demonstration period. There were no other statistically significant trends.

Inpatient/Res ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	-0.001 (0.002)	-0.003** (0.001)	0.003*** (0.001)	-0.001 (0.001)
Immediate Effect of Demonstration Start (Standard Error)	-0.003 (0.01)	0.003 (0.005)	0.001 (0.003)	0.002 (0.005)
Sustained Effect (Standard Error)	0.001 (0.001)	0.001** (0.001)	0.001 (0.0004)	-0.0005 (0.001)
Constant (Standard Error)	1.56 (3.09)	6.93** (2.54)	-5.60*** (1.79)	2.81 (2.59)

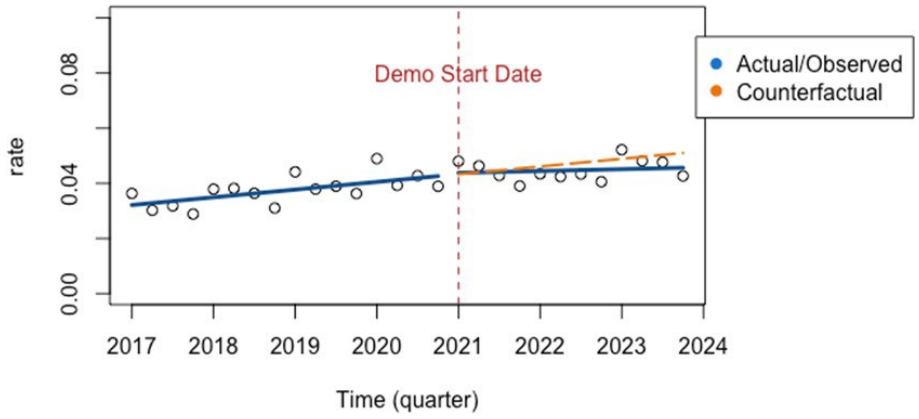
**p<0.05; ***p<0.01



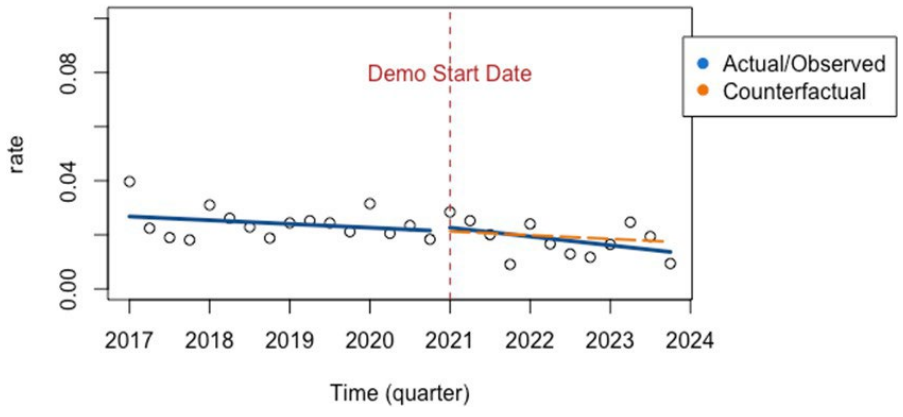
SUD Residential & Inpatient Treatment Use (Ages 19-24)



SUD Residential & Inpatient Treatment Use (Ages 25-64)



SUD Residential & Inpatient Treatment Use (Ages 65+)



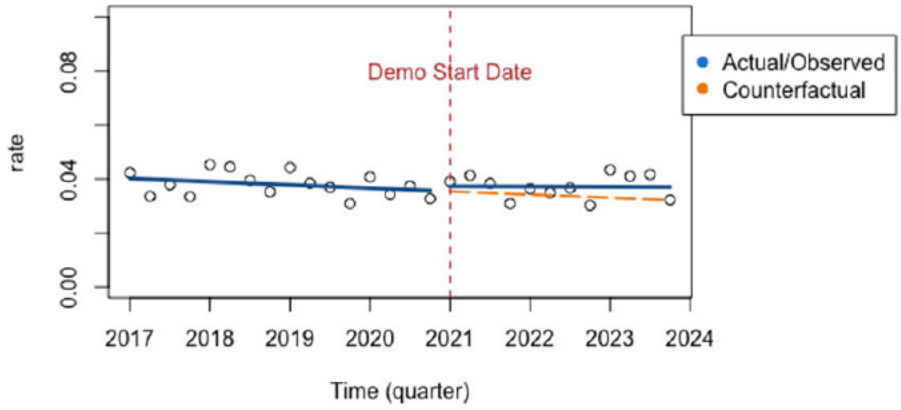
Aid Category

Utilization of SUD residential and inpatient treatment by aid category showed no statistically significant changes in trend.

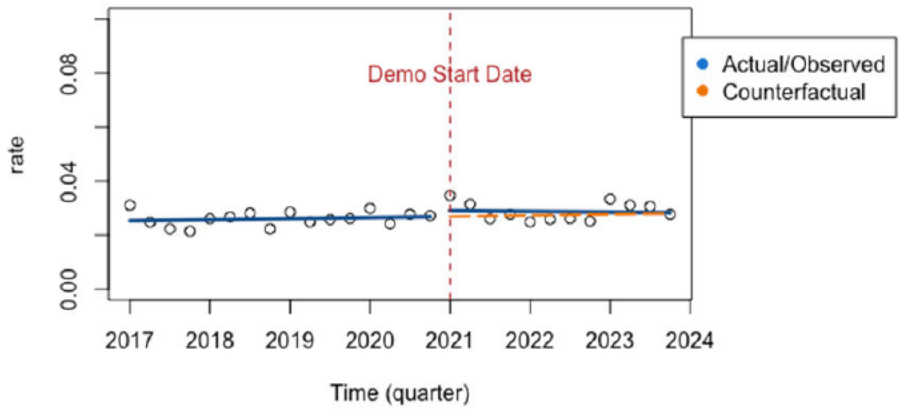
Inpatient/Res ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	-0.001 (0.001)	0.0004 (0.001)	-0.004 (0.003)
Immediate Effect of Demonstration Start (Standard Error)	0.002 (0.004)	0.002 (0.002)	-0.002 (0.005)
Sustained Effect (Standard Error)	0.0003 (0.0004)	-0.0002 (0.0003)	0.001 (0.001)
Constant (Standard Error)	2.42 (1.97)	-0.80 (1.37)	9.06 (6.69)

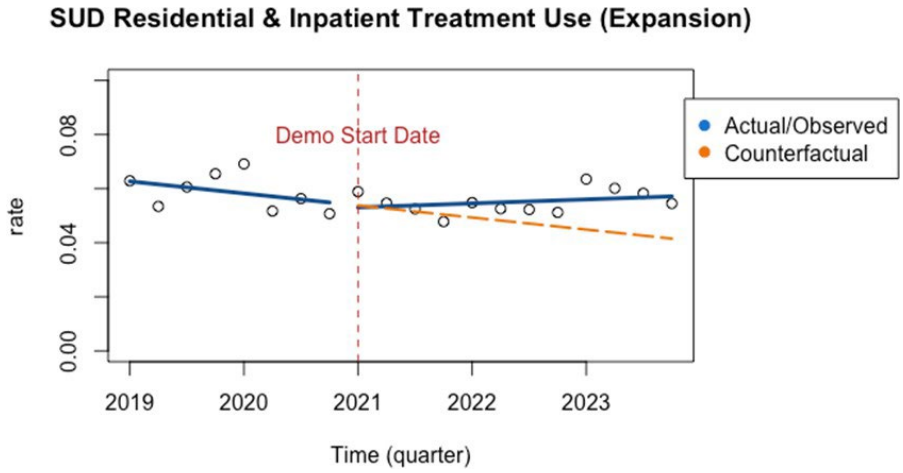
**p<0.05; ***p<0.01

SUD Residential & Inpatient Treatment Use (ABD)



SUD Residential & Inpatient Treatment Use (Non-ABD)




SUD Residential & Inpatient Treatment Use (Expansion)
Demo Start Date
Actual/Observed
Counterfactual
rate
0.00
0.04
0.08
2019
2020
2021
2022
2023
Time (quarter)

Measure 1.1.5 Percentage of members with a SUD diagnosis receiving withdrawal management services.

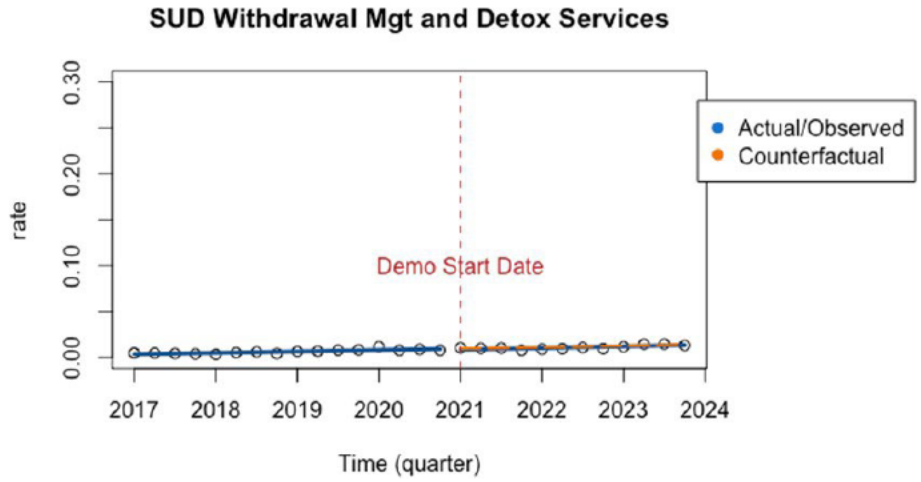
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

Measure Description: The denominator includes all enrollees with an SUD diagnosis. The numerator includes members with an SUD diagnosis who had a claim for withdrawal management services during the measuring period (quarter).

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed a slight yet statistically significant increase in the use of withdrawal management and detox services. There was no statistically significant change in trend during the first years of the Demonstration.



Withdrawal Mgt/Detox ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.002	0.0003	p<0.01
Immediate Effect of Demonstration Start	-0.001	0.001	None
Sustained Effect	0.0001	0.0001	None
Constant	-3.07	0.64	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that the decline in utilization is explained by the start of the Demonstration, while an increase was sustained during the Demonstration period. Older members tend to use fewer services, as do women, non-ABD group members, and those living in rural counties. Expansion group members tend

to use more withdrawal management/detox services. Although coefficients are small, all individual factors showed statistically significant explanatory power.

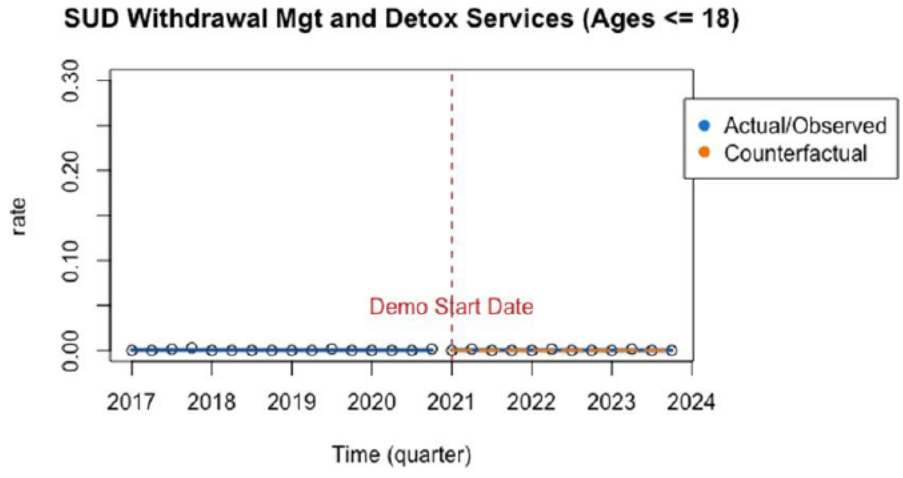
Withdrawal Mgt/Detox ITS GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.0004	0.0001	p<0.01
Immediate Effect of Demonstration Start	-0.002	0.0005	p<0.01
Sustained Effect	0.0003	0.0001	p<0.01
Age	-0.00005	0.00001	p<0.01
Gender (Female)	-0.003	0.0002	p<0.01
Expansion Group	0.009	0.0003	p<0.01
Non-ABD	-0.002	0.0003	p<0.01
Rural	-0.007	0.0002	p<0.01
Constant	-0.770	0.294	p<0.01

Age

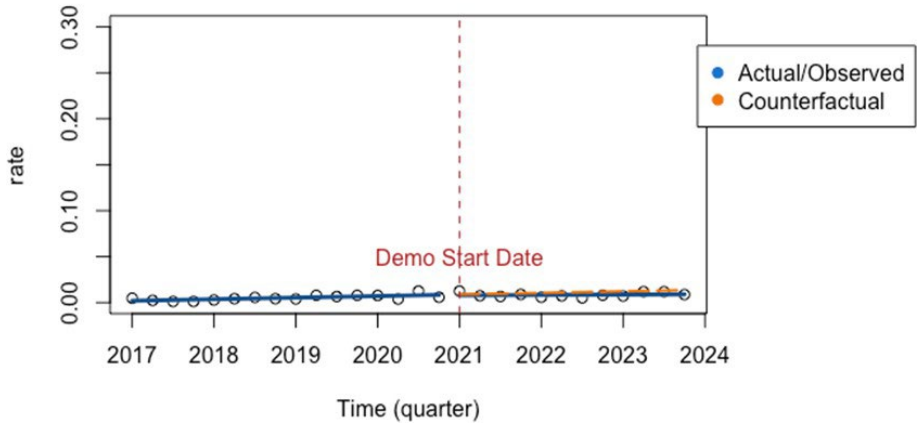
Members in the 19-24 and 25-64 age group showed a statistically significant general trend for increased utilization of withdrawal management and detox services. There were no statistically significant changes in trend associated with the Demonstration period or start date.

Withdrawal Mgt/Detox ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	-0.0001 (0.0002)	0.002*** (0.001)	0.002*** (0.0003)	-0.0001 (0.0003)
Immediate Effect of Demonstration Start (Standard Error)	0.0001 (0.001)	-0.001 (0.002)	-0.001 (0.001)	-0.001 (0.001)
Sustained Effect (Standard Error)	-0.0000 (0.0001)	-0.0003 (0.0002)	0.0001 (0.0002)	0.0002 (0.0001)
Constant (Standard Error)	0.10 (0.39)	-3.45*** (1.03)	-3.30*** (0.68)	0.27 (0.57)

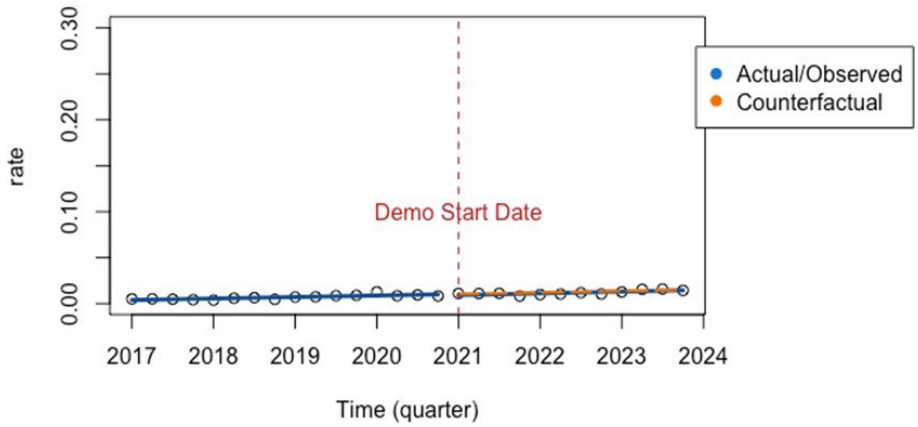
**p<0.05; ***p<0.01



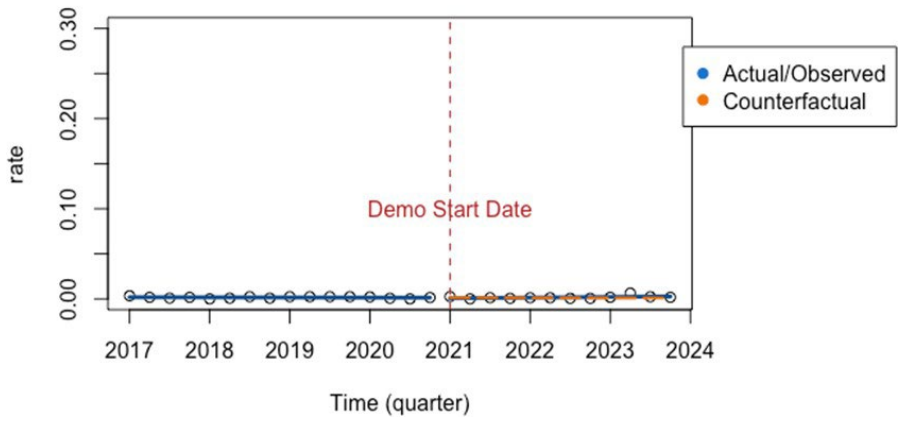
SUD Withdrawal Mgt and Detox Services (Ages 19-24)



SUD Withdrawal Mgt and Detox Services (Ages 25-64)



SUD Withdrawal Mgt and Detox Services (Ages 65+)

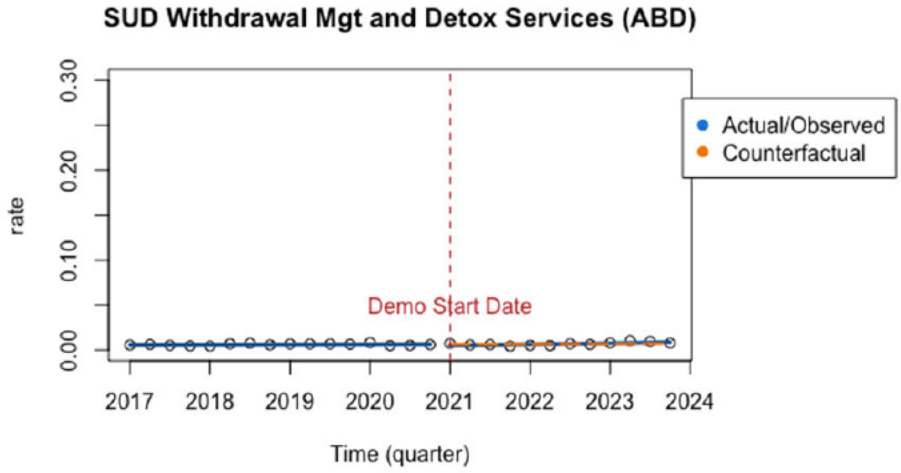


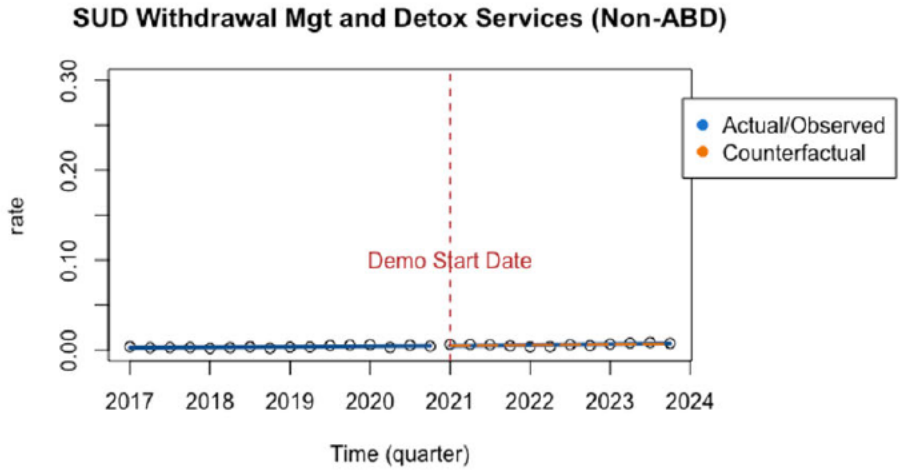
Aid Category

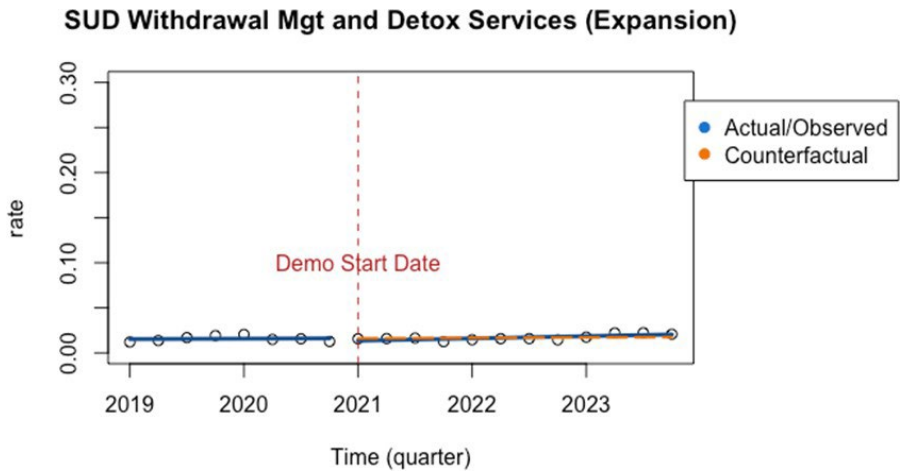
There was a slight increase in the general trend for members in the non-ABD group. Members in the ABD group showed a slight increase in use during the Demonstration period. There were no other statistically significant changes in trend.

Withdrawal Mgt/Detox ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	0.0002 (0.0003)	0.001** (0.0003)	0.0005 (0.002)
Immediate Effect of Demonstration Start (Standard Error)	-0.002 (0.001)	-0.0003 (0.001)	-0.003 (0.002)
Sustained Effect (Standard Error)	0.0003** (0.0001)	0.0001 (0.0001)	0.001 (0.0005)
Constant (Standard Error)	-0.43 (0.57)	-1.27** (0.52)	-0.90 (3.35)

**p<0.05; ***p<0.01






SUD Withdrawal Mgt and Detox Services (Expansion)
rate
0.00
0.10
0.20
0.30
Demo Start Date
Actual/Observed
Counterfactual
2019
2020
2021
2022
2023
Time (quarter)

Measure 1.1.6 Percentage of members with a SUD diagnosis receiving medication-assisted treatment.

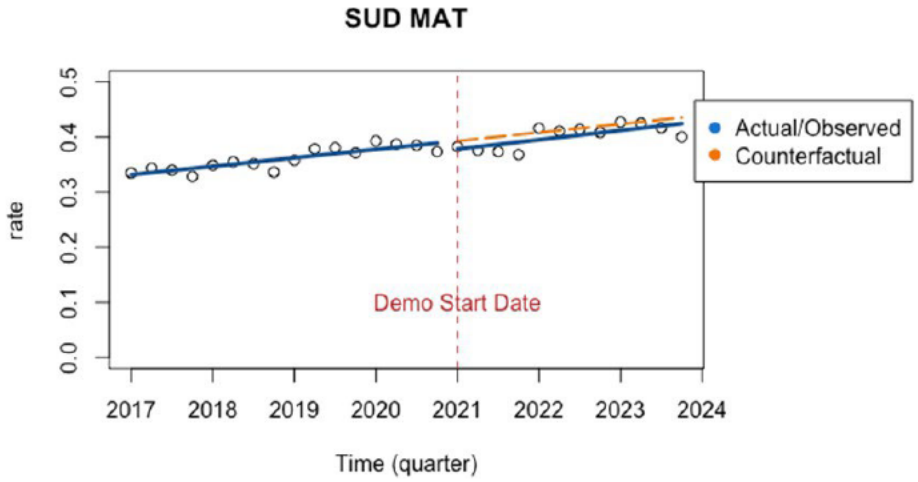
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 1.	The Demonstration will maintain or increase utilization of SUD treatment services.

Measure Description: The denominator includes all enrollees with an SUD diagnosis. The numerator includes members with an SUD diagnosis who had a claim for Medication Assisted Treatment (MAT) during the measuring period (quarter) from any of the following HEDIS MY 2020 Value Sets and Medications Lists: AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medication Lists; Opioid Use Disorder Treatment Medication Lists.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed a statistically significant increase in the use of MAT for SUD. There were no significant changes in trend during the first years of the Demonstration.



MAT ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.02	0.003	p<0.01
Immediate Effect of Demonstration Start	-0.01	0.01	None
Sustained Effect	0.0004	0.001	None
Constant	-30.64	5.65	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that increased utilization was negatively impacted at the start of the Demonstration. However, increased use of MAT was sustained during the Demonstration period. Older members tend to use less MAT services, while women, expansion group, non-ABD group members and those living in rural

counties used more MAT services. Although coefficients are small, all temporal and individual factors showed statistically significant explanatory power.

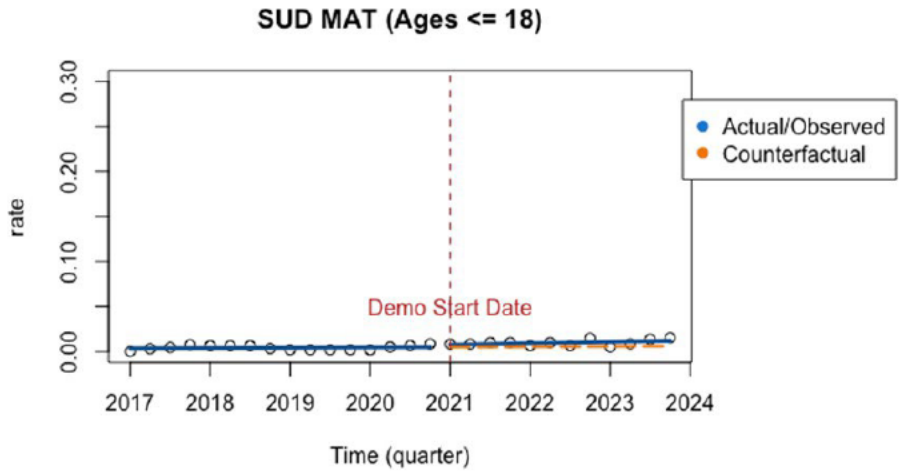
MAT GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.006	0.001	p<0.01
Immediate Effect of Demonstration Start	-0.024	0.002	p<0.01
Sustained Effect	0.003	0.0003	p<0.01
Age	-0.004	0.00005	p<0.01
Gender (Female)	0.080	0.001	p<0.01
Expansion Group	0.119	0.002	p<0.01
Non-ABD	0.067	0.002	p<0.01
Rural	0.003	0.001	p<0.01
Constant	-11.856	1.497	p<0.01

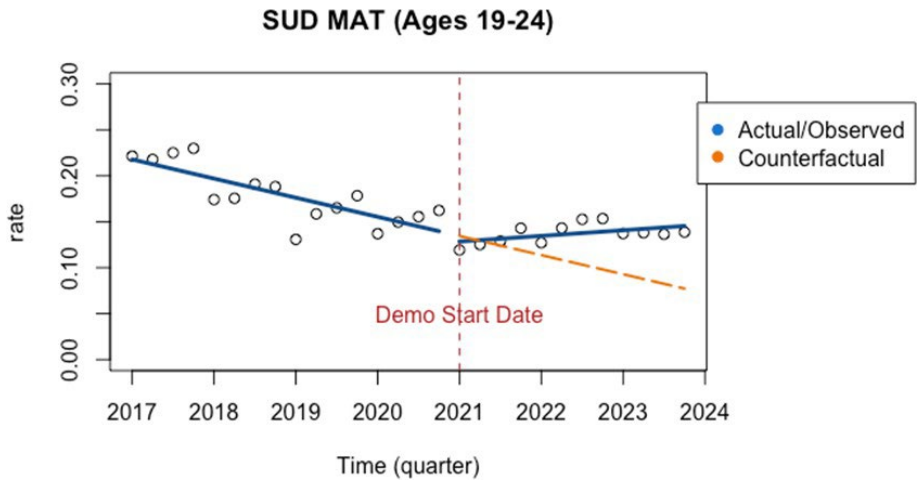
Age

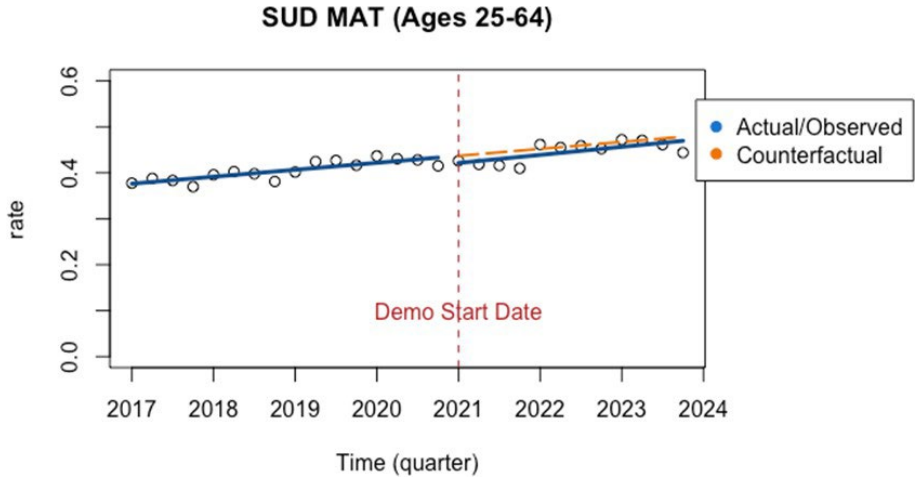
An analysis of utilization by age showed a general increase in use of MAT in all groups 19 and older. The trend showed a statistically significant and sustained increase after the Demonstration in the 19-24 age group.

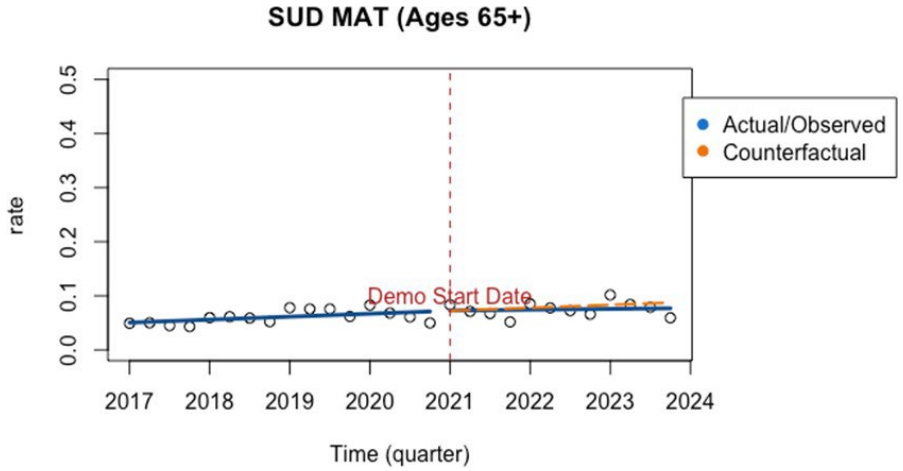
MAT ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	0.0003 (0.001)	-0.02*** (0.004)	0.02*** (0.003)	0.01 (0.003)
Immediate Effect of Demonstration Start (Standard Error)	0.002 (0.002)	-0.01 (0.01)	-0.02 (0.01)	0.001 (0.01)
Sustained Effect (Standard Error)	0.0003 (0.0003)	0.01*** (0.002)	0.001 (0.001)	-0.001 (0.001)
Constant (Standard Error)	-0.69 (1.25)	42.21*** (7.11)	-30.17*** (6.04)	-10.96 (5.34)

**p<0.05; ***p<0.01




SUD MAT (Ages 19-24)
rate
0.00
0.10
0.20
0.30
Actual/Observed
Counterfactual
Demo Start Date
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)


SUD MAT (Ages 25-64)
rate
0.0
0.2
0.4
0.6
Actual/Observed
Counterfactual
Demo Start Date
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)

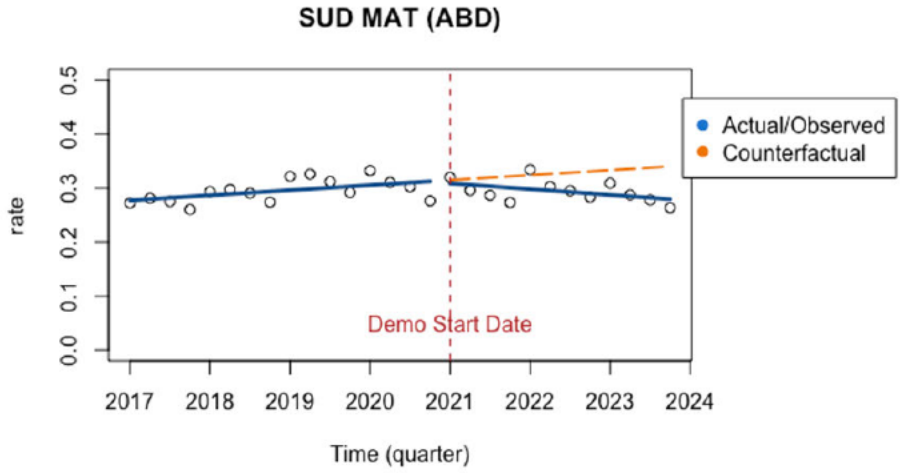

SUD MAT (Ages 65+)
rate
0.0
0.1
0.2
0.3
0.4
0.5
Actual/Observed
Counterfactual
Demo Start Date
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)

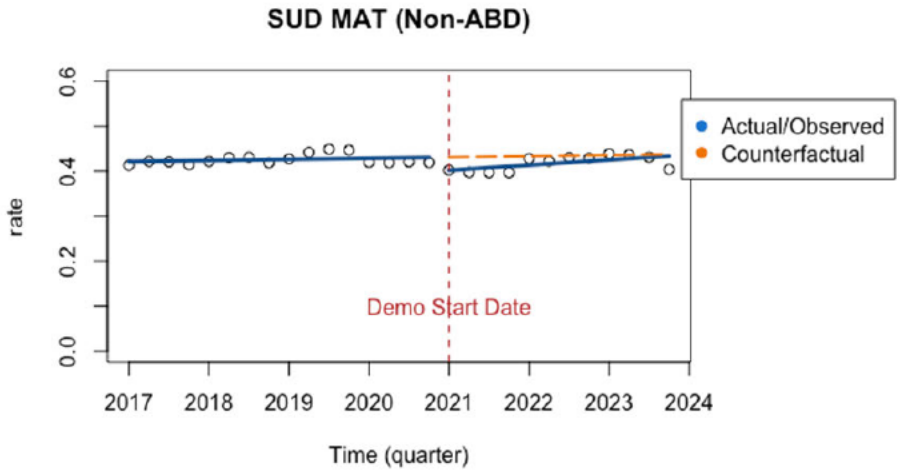
Aid Category

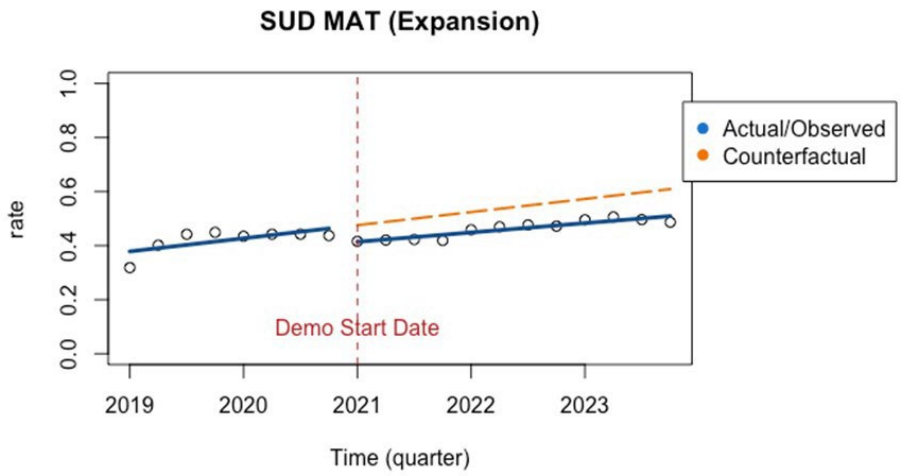
The general trend by aid category showed a decrease in MAT services for ABD and expansion groups. There was a statistically significant decrease in MAT use for the non-ABD and expansion groups immediately following the Demonstration and a sustained decrease for the ABD group.

MAT ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	0.01** (0.004)	0.002 (0.003)	0.05*** (0.01)
Immediate Effect of Demonstration Start (Standard Error)	-0.001 (0.01)	-0.03*** (0.01)	-0.06** (0.02)
Sustained Effect (Standard Error)	-0.005** (0.002)	0.002 (0.001)	-0.003 (0.004)
Constant (Standard Error)	-18.56** (8.16)	-4.50 (5.45)	-97.61*** (29.61)

**p<0.05; ***p<0.01






SUD MAT (Expansion)
rate
0.0
0.2
0.4
0.6
0.8
1.0
2019
2020
2021
2022
2023
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

Measures studied under ***hypothesis two***, the Demonstration will maintain or increase SUD provider availability, are summarized below. There are no subsidiary analyses associated with evaluation question one, hypothesis two.

1.2.1. Percentage change in the number of Medicaid SUD billing providers each year
1.2.2. Percentage change in the number of Medicaid providers billing MAT treatment services

Measure 1.2.1 Percentage change in the number of providers enrolled in Medicaid and billing SUD services.

Measure 1.2.2 Percentage change in the number of providers enrolled in Medicaid and billing MAT services.

Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 2.	The Demonstration will maintain or increase SUD provider availability.

Measure Description: The number of Medicaid SUD providers billing for treatment services, including MAT was obtained from OMS monitoring protocol metric results reported to CMS for each year of the Demonstration. MAT was defined using HEDIS MY 2020 Value Sets and Medications Lists: AOD Medication Treatment Value Set; Alcohol Use Disorder Treatment Medication Lists; Opioid Use Disorder Treatment Medication Lists.

Data Source and Time Period: Medicaid claims SUD Monitoring Protocol reports.

Analytical Approach: A 2-sample test for equality of proportions with continuity correction for the absolute change over time.

Findings: The total number of SUD treatment providers billing for services decreased by 3.61 percent in 2023. However, providers billing MAT increased by 9.68 percent. Approximately 39 percent of Medicaid enrolled SUD treatment providers billed for MAT.

Medicaid SUD Treatment Providers Billing for Services					
Year	Total	Percent Change	Total MAT	Percent Change	% MAT
2021	6,559	-	2,241	-	34.17%
2022	6,561	0.03%	2,242	0.04%	34.17%
2023	6,322	-3.61%*	2,458	9.68%*	38.88%

**Statistically significant rate of change over baseline*

Measures studied under ***hypothesis three***, the Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence, are listed below. There are no subsidiary analyses associated with evaluation question one, hypothesis three.

1.3.2. Percentage of ED visits for Alcohol and Other Drug (AOD) abuse or dependence for which the member received follow-up within 7-days of discharge

1.3.2. Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30-days of discharge

Measure 1.3.1 Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7-days of discharge.

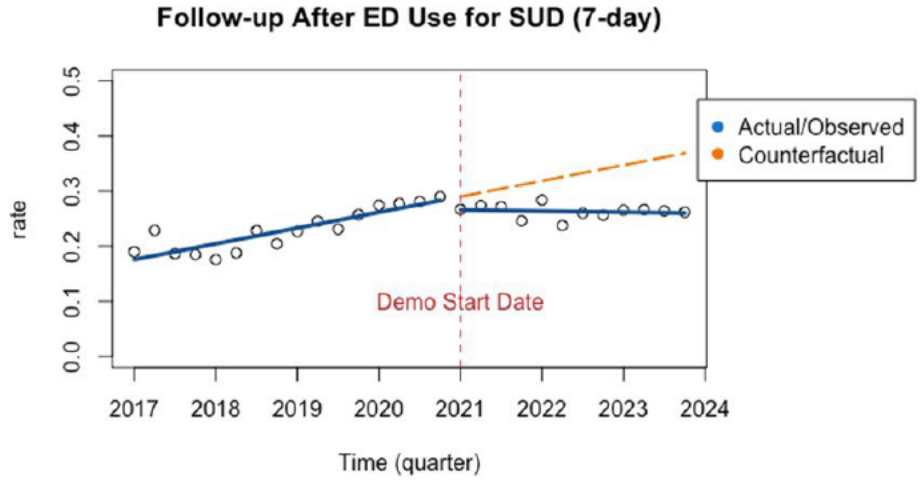
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 3.	The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.

Measure Description: The denominator included the number of ED visits with a principal diagnosis of SUD abuse or dependence for members 18 and older. The numerator included the number of visits with a follow-up with an outpatient provider within 7 days of the ED visit.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model controlling for member demographics.

Findings: The general trend showed a statistically significant increase in follow-up after the ED within 7 days. A statistically significant decrease was associated with the first years of the Demonstration period.



7-Day Follow-up ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.03	0.004	p<0.01
Immediate Effect of Demonstration Start	-0.02	0.01	None
Sustained Effect	-0.01	0.002	p<0.01
Constant	-57.39	7.31	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that the decline in follow-up after the ED for SUD is explained by temporal factors (Demonstration start date and period). Older members tend to have less follow-up, while women and expansion group members engaged in more follow-up. Members in rural counties and in non-ABD

groups tended to engage in follow-up less. Although coefficients are small, all temporal and individual factors showed statistically significant explanatory power.

7-Day Follow-up GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.023	0.003	p<0.01
Immediate Effect of Demonstration Start	-0.022	0.010	p<0.05
Sustained Effect	-0.006	0.001	p<0.01
Age	-0.002	0.0002	p<0.01
Gender (Female)	0.032	0.005	p<0.01
Expansion Group	0.030	0.007	p<0.01
Non-ABD	-0.026	0.007	p<0.01
Rural	-0.012	0.006	None
Constant	-46.163	6.471	p<0.01

Measure 1.3.2 Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30 days of discharge.

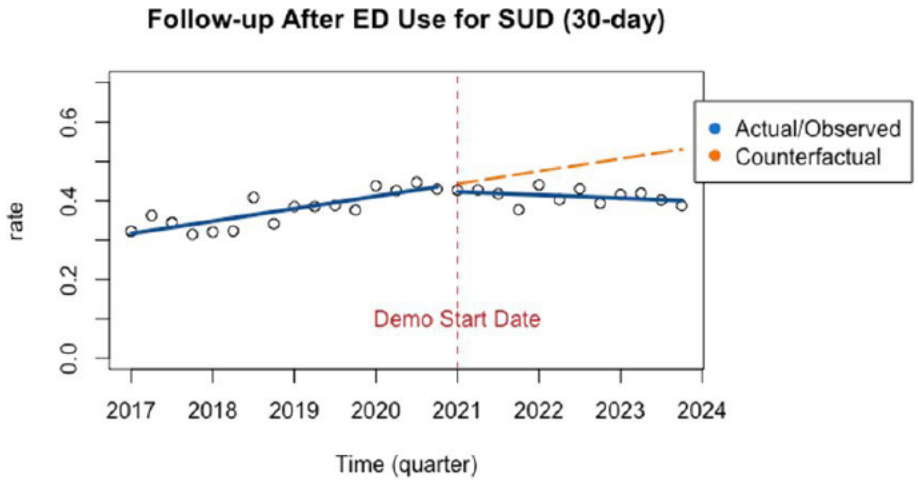
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 3.	The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence.

Measure Description: The denominator included the number of ED visits with a principal diagnosis of SUD abuse or dependence for members 18 and older. The numerator included the number of visits with a follow-up with an outpatient provider within 30 days of the ED visit.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model controlling for member demographics.

Findings: There was a statistically significant trend for increased follow-up after the ED for SUD within 30 days. A sustained decrease was statistically significant during the first years of the Demonstration period.



30-Day Follow-up ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance level
General Trend (Time)	0.03	0.005	p<0.01
Immediate Effect of Demonstration Start	-0.01	0.02	None
Sustained Effect	-0.01	0.002	p<0.01
Constant	-63.64	10.00	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that the decline in the 30-day follow-up rate after ED use for SUD is explained by temporal factors associated with the Demonstration period. Older members and non-ABD group members tend to

engage in follow-up less. Women and expansion group members tend to engage in follow-up after the ED more often. Although coefficients are small, these factors showed statistically significant explanatory power.

30-Day Follow-up GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.025	0.004	p<0.01
Immediate Effect of Demonstration Start	-0.018	0.011	None
Sustained Effect	-0.008	0.002	p<0.01
Age	-0.002	0.002	p<0.01
Gender (Female)	0.052	0.006	p<0.01
Expansion Group	0.047	0.008	p<0.01
Non-ABD	-0.031	0.008	p<0.01
Rural	-0.012	0.007	None
Constant	-49.319	7.330	p<0.01

Measures studied under ***hypothesis four***, the Demonstration will maintain or increase initiation and engagement in treatment, are listed below. There are no subsidiary analyses associated with evaluation question one, hypothesis four.

1.4.1. Percentage of members ages 18 and older with a new episode of AOD abuse or dependence who initiate in SUD treatment
1.4.2. Percentage of members with a new episode of alcohol and other drug abuse or dependence who engage in SUD treatment

Measure 1.4.1 Percentage of members ages 18 and older with a new episode of AOD abuse or dependence who initiate in SUD treatment.

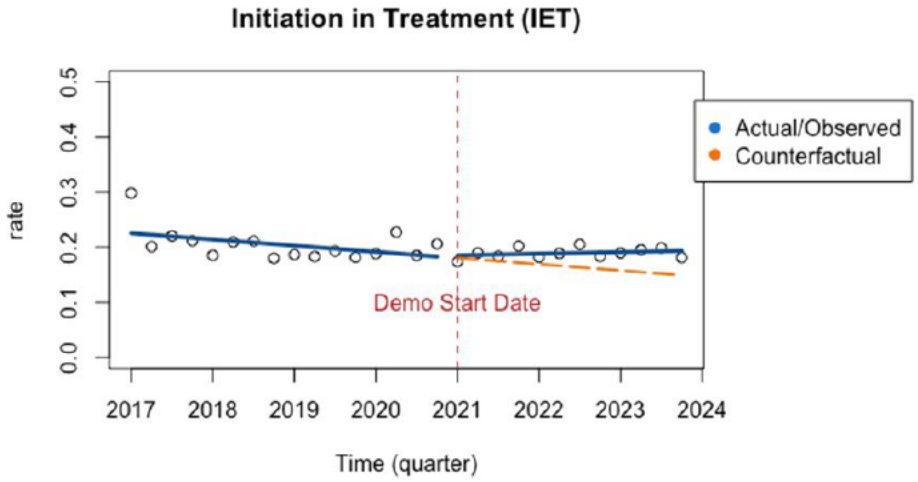
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 4.	Demonstration will maintain or increase initiation and engagement in treatment.

Measure Description: The denominator includes the number of members 18 and older with at least one AOD abuse or dependence diagnoses. The numerator includes the number of members who initiate treatment within 14 days of diagnosis.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model controlling for member demographics.

Findings: The general trend showed a statistically significant decline in members initiating treatment. Increases were observed during the Demonstration period. However, the change was not statistically significant.



Initiation ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.01	0.005	P<0.05
Immediate Effect of Demonstration Start	0.002	0.02	None
Sustained Effect	0.004	0.002	None
Constant	22.90	9.36	P<0.05

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that a general decline in initiation in treatment was reversed during the first few years of the Demonstration. Older members and those in rural counties tend to initiate less. Women and

expansion group members tend to initiate in treatment more often. Although coefficients are small, these factors showed statistically significant explanatory power.

Initiation GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.030	0.002	p<0.01
Immediate Effect of Demonstration Start	0.005	0.006	None
Sustained Effect	0.009	0.001	p<0.01
Age	-0.0003	0.0001	p<0.01
Gender (Female)	0.007	0.003	p<0.05
Expansion Group	0.069	0.004	p<0.01
Non-ABD	-0.007	0.004	None
Rural	-0.021	0.003	p<0.01
Constant	60.802	3.687	p<0.01

Measure 1.4.2 Percentage of members with a new episode of alcohol and other drug abuse or dependence who engage in SUD treatment.

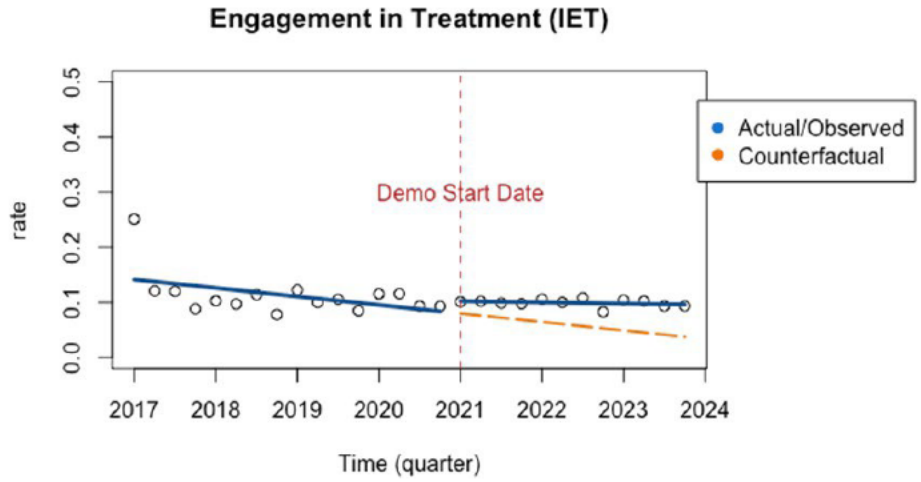
Question 1.	Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?
Hypothesis 4.	Demonstration will maintain or increase initiation and engagement in treatment.

Measure Description: The denominator includes the number of members 18 and older with at least one AOD abuse or dependence diagnosis who initiated treatment within 14 days of diagnosis. The numerator includes the number of members who received two or more services for AOD abuse or dependence within 34 days of the initiation visit.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model controlling for member demographics.

Findings: Overall engagement in treatment was trending downward. There was an increase in engagement during the Demonstration. However, neither the immediate nor sustained effect of the increase were statistically significant in the aggregate ITS model.



Engagement ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.02	0.01	p<0.05
Immediate Effect of Demonstration Start	0.02	0.02	None
Sustained Effect	0.003	0.003	None
Constant	31.19	12.23	p<0.05

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a general trend of fewer members engaging in SUD treatment. However, the Demonstration start date, and first few years show a statistically significant effect and sustained trend for improvements in the number of members engaging in treatment. Older members tend to engage in

SUD treatment less. Women, non-ABD, and expansion group members tend to engage in treatment more often. Although coefficients are small, these factors showed statistically significant explanatory power.

Engagement GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.038	0.001	p<0.01
Immediate Effect of Demonstration Start	0.025	0.005	p<0.01
Sustained Effect	0.009	0.001	p<0.01
Age	-0.001	0.0001	p<0.01
Gender (Female)	0.012	0.003	p<0.01
Expansion Group	0.074	0.003	p<0.01
Non-ABD	0.018	0.003	p<0.01
Rural	-0.004	0.003	None
Constant	77.562	2.920	p<0.01

A summary of the ITS aggregate findings related to evaluation question one is presented below.

Measure	Interrupted Time Series (Statistically Significant Trends)		
	General Trend	Immediate Effect	Sustained Effect
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services			
1.1.1. Members receiving SUD outpatient treatment	↑	-	↓
1.1.2. Members receiving IOP/PH	-	-	-
1.1.3. Members receiving residential and inpatient	↑	-	-
1.1.4. Members receiving withdrawal mgt/detox	↑	-	-
1.1.5. Members receiving MAT	↑	-	-
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visits for alcohol and other drug abuse			
1.3.1. ED visits for AOD abuse or dependence with follow-up within 7-days of discharge	↑	-	↓
1.3.2. ED visits for AOD abuse or dependence with follow-up within 30-days of discharge	↑	-	↓
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in SUD treatment			
1.4.1. Members ages 18 and older who initiate in SUD treatment	↓	-	-
1.4.2. Members who initiate treatment and engage in SUD treatment	↓	-	-

Notes

- No statistically significant change in trend

↑Statistically significant increase in trend

↓Statistically significant decrease in trend

A summary of the Generalized Linear Model Results (i.e., how individual factors contribute to the variation in the data) related to evaluation question one is presented below.

Measure	General Trend	Immediate Effect	Sustained Effect	Age (Older)	Gender (Female)	Expansion Group	Non-ABD	Rural Counties
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services								
1.1.2. Members receiving SUD outpatient treatment	↑	↑	↓	↑	↑	↑	↑	↑
1.1.3. Members receiving IOP/PH	↓	↓	↓	↓	↑	↑	-	↓
1.1.4. Members receiving residential and inpatient	-	-	-	↓	↑	↑	↓	↓
1.1.5. Members receiving withdrawal mgt/detox	↑	↓	↑	↓	↓	↑	↓	↓
1.1.6. Members receiving MAT	↑	↓	↑	↓	↑	↑	↑	↑
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visits for alcohol and other drug abuse								
1.3.1. ED visits for AOD with follow-up within 7-days	↑	↓	↓	↓	↑	↑	↓	-
1.3.2. ED visits for AOD with follow-up within 30-days	↑	-	↓	↓	↑	↑	↓	-
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in SUD treatment								
1.4.1. Members ages 18 and older who initiate in SUD treatment	↓	-	↑	↓	↑	↑	-	↓
1.4.2. Members who initiate treatment and engage in SUD treatment	↓	↑	↑	↓	↑	↑	↑	-

Notes:

- No statistically significant explanatory power

↑Statistically significant explanatory power

↓Statistically significant explanatory power

B. SUD EVALUATION QUESTION TWO

Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?

This evaluation question has one hypothesis: The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for Opioid Health Home members. The measure studied is outlined below. There are no subsidiary analyses associated with evaluation question two, hypothesis one.

2.1.1. Percentage of OHH eligible members ages 18 and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment

Measure 2.1.1 Percentage of members ages 18 and older eligible for opioid health homes with pharmacotherapy for OUD who have at least 180 days of continuous treatment

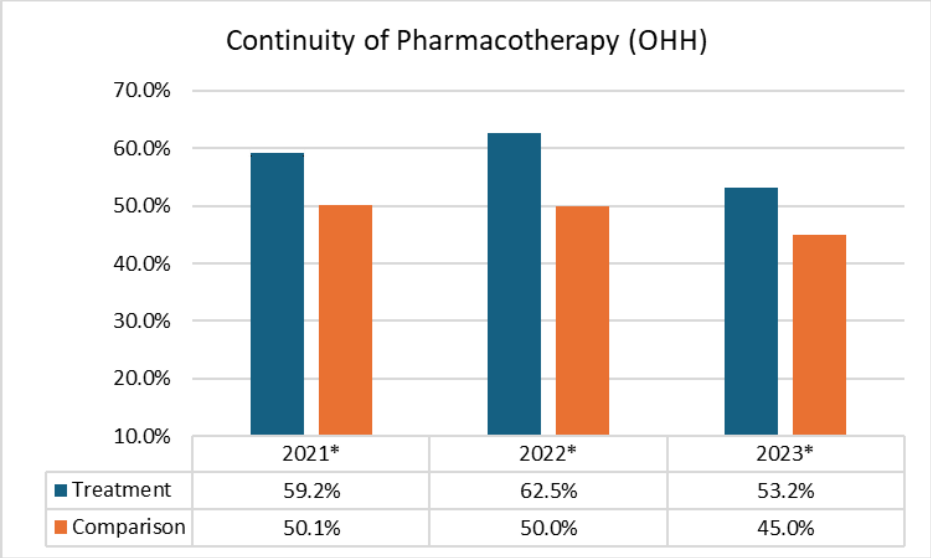
Question 2.	Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?
Hypothesis 1.	The Demonstration will maintain or increase continuity of pharmacotherapy for OUD.

Measure Description: The denominator includes the number of OHH members 18 and older with an OUD who have at least one claim for an OUD medication. The numerator includes the number of OHH members with an OUD who had at least 180 days of continuous pharmacotherapy.

Data Source and Time Period: MMIS paid claims 2017-2023; OMS Health Home enrollment reports.

Analytical Approach: Comparison group strategy using Coarsened Exact Matching for members with an OUD, not receiving OHH services.

Findings: In each of the years studied, the treatment group (members receiving OHH services) showed a statistically significant improvement over the comparison group. In 2021, 59.2 percent of OHH members had 180 days of continuous treatment with 62.5 percent in 2022 and 53.2 percent in 2023. Comparison group scores were 50.1 percent, 50.0 percent, and 45.0 percent, respectively.



A summary of results for evaluation question two is provided below.

Measure	Analytic Approach	Treatment Group Maintain/Improve	Statistically Significant
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for Opioid Health Home members.			
2.1.1. OHH members who have at least 180 days of continuous OUD treatment	Comparison Strategy	Yes	Yes

C. SUD EVALUATION QUESTION THREE

Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?

Evaluation question three has three hypotheses:

1. The Demonstration will contain or reduce the use of opioids at a high dosage.
2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for ACO attributed members.
3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.

Measures studied under ***hypothesis one*** are listed below. There are no subsidiary analyses associated with evaluation question three.

3.1.1. Percentage of members ages 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more

Measure 3.1.1 Percentage of members ages 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more.

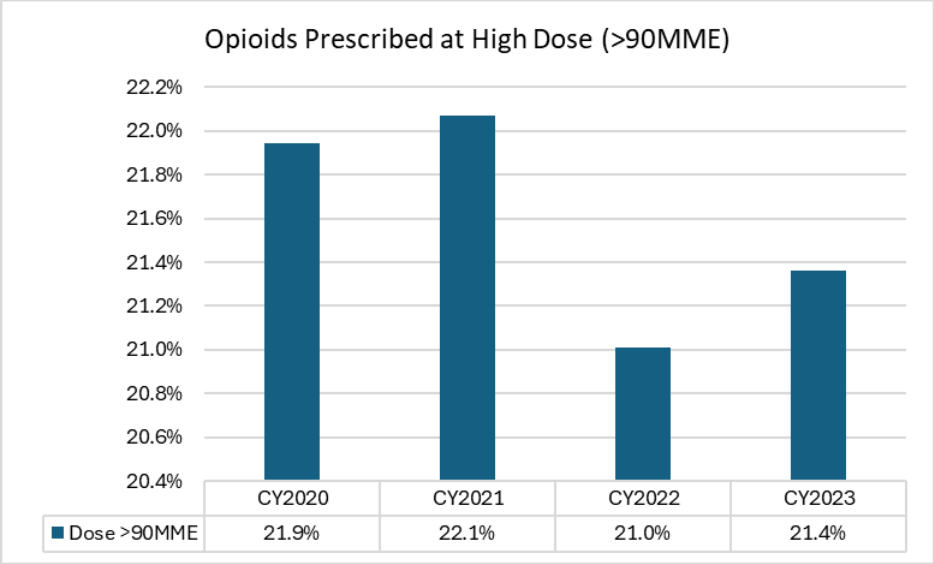
Question 3.	Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?
Hypothesis 1.	The Demonstration will contain or reduce the use of opioids at a high dosage.

Measure Description: The denominator includes the number of members with two or more claims for opioid medications on different dates with a cumulative supply of 15 or more days. The numerator includes the number of members with an average daily dosage greater than or equal to 90 MME.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Logic regression with t-test. Demonstration Year results (CY2021-23) were examined using 2020 as the baseline. To assess the potential impact of the PHE on data, the evaluator tested the means for 2019 and 2020. The evaluator found no statistically significant difference between 2019 and 2020 results.

Findings: In 2020 the percentage of members with SUD prescribed opioids at a high dose was 21.9 percent. The number rose slightly in 2021 to 22.1 percent before declining to 21 percent in 2022 and 21.4 percent in 2023 (lower rates are preferred). The change over baseline was not statistically significant any year of the Demonstration.



Hypothesis two, the Demonstration will maintain or increase continuity of pharmacotherapy for OUD for members eligible for the Accountable Community program, was examined with one measure, listed below. There are no subsidiary analyses associated with evaluation question three, hypothesis two.

3.2.1. Percentage of members aged 18 and older with concurrent use of prescription opioids and benzodiazepines

Measure 3.2.1 Percentage of members ages 18 and older with concurrent use of prescription opioids and benzodiazepines

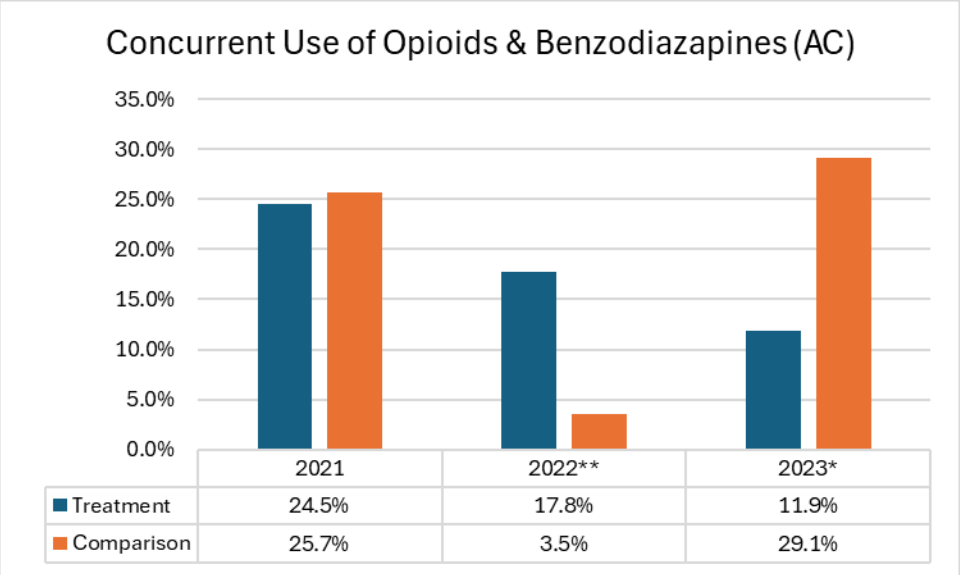
Question 3.	Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?
Hypothesis 2.	The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for Accountable Community (AC) attributed members.

Measure Description: The denominator includes the number of AC members with two or more claims for opioid medications on different dates of service and with a cumulative day supply of 15 or more days. The numerator includes the number of AC members with two or more claims for any benzodiazepine and concurrent use of opioids for 30 or more consecutive days.

Data Source and Time Period: MMIS paid claims 2017-2023; OMS Accountable Community enrollment reports.

Analytical Approach: Comparison group strategy using Coarsened Exact Matching for members not receiving AC services.

Findings: Lower scores are preferred. In 2021 there was no statistically significant difference in performance in the AC group (24.5 percent) versus comparison group (257 percent). Members receiving AC services performed better than the control group in 2023 (11.9 percent versus 29.1 percent, respectively). In 2022 the comparison sample was fewer than 50 members, causing a considerable fluctuation in findings and inconclusive results.



	2021	2022**	2023*
Treatment	24.5%	17.8%	11.9%
Comparison	25.7%	3.5%	29.1%

**Statistically significant difference*
***Comparison sample was small causing extreme fluctuations in results*

Evaluation question three, ***hypothesis three*** suggests the Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population. There are no subsidiary analyses associated with evaluation question three, hypothesis three. A summary of the measures examined is provided below.

3.3.1. The rate of opioid overdose deaths per 1,000 Medicaid members
3.3.2. The total number of PMP users during the twelve-month measurement period
3.3.3. The total number of PMP inquires performed during the twelve-month measurement period

Measure 3.3.1 The rate of opioid overdose deaths per 1,000 Medicaid members

Question 3.	Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?
Hypothesis 3.	The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.

Measure Description: The denominator includes members enrolled in Medicaid for at least one month during the measurement period or 30 days prior to the beginning of the measurement period. The numerator includes the total number of overdose deaths. For opioid related deaths, the denominator is the number of members with an OUD and the numerator is the number of overdose deaths for that group.

Data Source and Time Period: CY2020 (Baseline) – CY2023 (Demonstration Year 2) results reported by OMS to CMS as part of the SUD Monitoring Protocol metrics.

Analytical Approach: A 2-sample test for equality of proportions with continuity correction comparing overdose deaths per Medicaid member.

Findings: Overdose deaths per 1,000 Medicaid members rose from 1.14 at baseline to 1.34 in CY2022. Overdose deaths related to members with an OUD also rose from 8.13 at baseline to 9.64 in CY2022. In CY2023 both rates declined to 1.03 for overdose deaths and 6.89 per 1,000 for members with an OUD. Change over baseline was statistically significant in each year for both metrics.

Overdose Death Rate per 1,000 Members		
Year	All Members	Members with OUD
CY2021	1.14	8.13
CY2022	1.34*	9.64*
CY2023	1.03*	6.89*

**Statistically significant change over baseline*

Measure 3.3.2 The total number of PMP users during the twelve-month measurement period.

Measure 3.3.3 The total number of PMP inquiries performed during the twelve-month measurement period.

Question 3.	Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?
Hypothesis 3.	The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.

Measure(s) Description: Each measure is a count from the Maine Prescription Monitoring System of registered users and the number of inquiries made in each 12-month period.

Data Source and Time Period: Maine Prescription Monitoring System Annual Report to the Legislature 2020 – 2023.

Analytical Approach: A 2-sample test for equality of proportions with continuity correction

Findings: The total number of PMP inquiries has been increasing in each year of the Demonstration. CY2020 had 1,837,295 inquires while CY2023 had 2,876,518 inquires. The number of dispensers has also been steadily increasing with 1,970 at baseline and 2,174 in CY2023. The number of prescribers has decreased over time, at the time of reporting only six months of data was available on the number of prescribers for CY2023. The rate of change was significantly different year over year.

	PMP Users				Inquiries	
Year	Prescribers	Dispensers	Total Users	Percent Change	Total # Inquires	Percent Change
Baseline	13,732	1,970	15,702	-	1,837,295	-
CY2021	13,571	1,867	15,438	-1.68%	1,847,726	0.57%
CY2022	12,106	2,030	14,136	-9.97%*	2,474,768	34.70%*
CY2023	8,266**	2,174	10,440	-32.37%*	2,876,518	55.68%*

**Statistically significant change over baseline; **6-months of data*

A summary of results for evaluation question three is presented below.

Measure	Analytic Approach	Improve or Maintain	Statistical Significance
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.			
3.1.1. Percentage of members ages 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more	Logistic Regression	Yes	-
Hypotheses 2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.			
3.2.1. Percentage of members ages 18 and older eligible for AC participation with concurrent use of prescription opioids and benzodiazepines	Comparison Strategy	Yes	↑
Hypothesis 3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.			
3.3.1. The rate of opioid overdose deaths per 1,000 Medicaid members	Proportional T-test	Yes	↓
3.3.2. The total number of PMP users during the twelve-month measurement period		Inconclusive*	
3.3.3. The total number of PMP inquires performed during the twelve-month measurement period		Yes	↑

** 2023 user data represents six months of prescriber information*

D. SUD EVALUATION QUESTION FOUR

Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?

Evaluation question four includes two subsidiary questions:

a. How does utilization vary by age, aid category code?
b. How does utilization vary by geographic characteristics (e.g., rural v. urban)?

There are two hypotheses:

1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD.
2. The Demonstration will contain or reduce preventable inpatient admissions.

Measures examined under ***hypothesis one*** are outlined below.

4.1.1. Total number of ED visits for SUD per 1,000 members
4.1.2. The rate of non-emergent ED visits per 1,000 member months

Measure 4.1.1 Total number of ED visits for SUD per 1,000 members

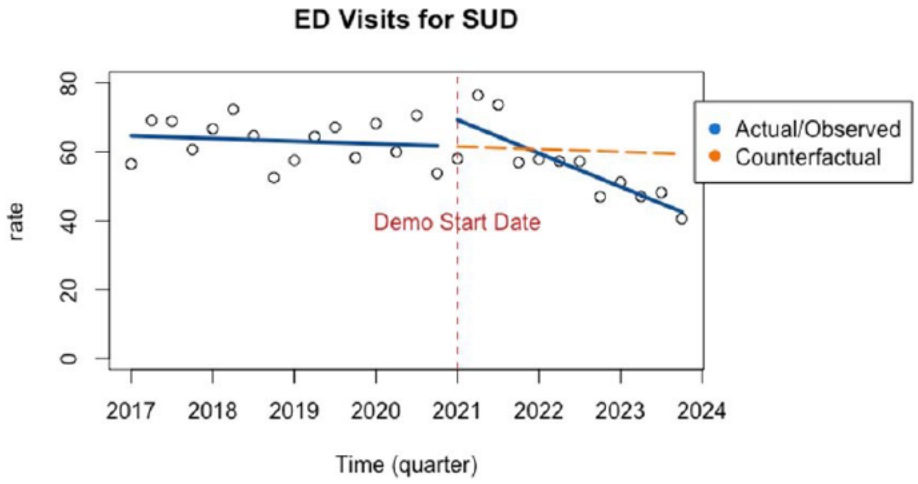
Question 4.	Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?
Hypothesis 1.	The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD.

Measure Description: The denominator represents the number of members with an SUD who had an ED visit during the measurement period. The numerator includes the number of ED visits with SUD as the primary diagnosis.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for members demographics.

Findings: ED visits for SUD showed a statistically significant sustained decline during the first years of the Demonstration.



ED for SUD ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.78	1.37	None
Immediate Effect of Demonstration Start	9.97	4.91	None
Sustained Effect	-2.23	0.63	p<0.01
Constant	1,637.38	2,763.36	None

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a general trend of declining ED use for SUD. There was an increase in ED use for SUD associated with the Demonstration's start and a sustained decline in use after that date. Women, older members, non-ABD group members and members in rural counties have fewer visits to the ED for SUD.

Expansion group members tend to have more visits to the ED for SUD. All temporal and demographic factors showed statistically significant explanatory power.

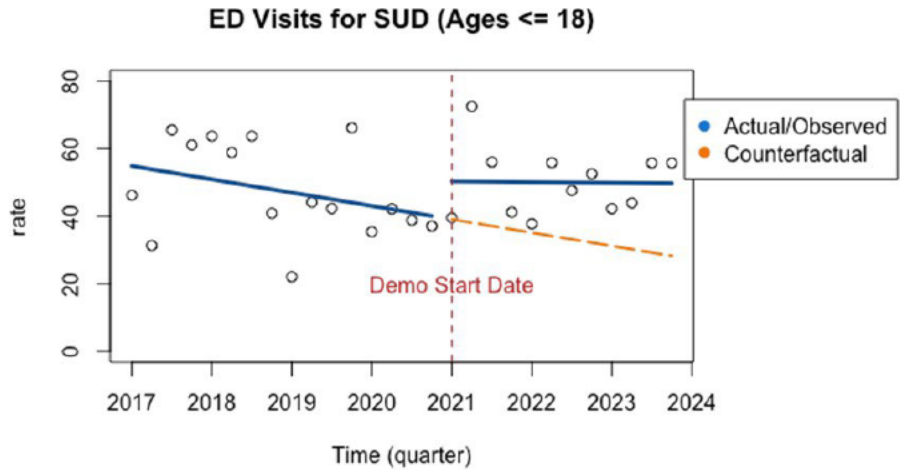
ED for SUD GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-3.054	0.596	p<0.01
Immediate Effect of Demonstration Start	8.629	1.867	p<0.01
Sustained Effect	-1.617	0.240	p<0.01
Age	-0.097	0.039	p<0.05
Gender (Female)	-20.053	0.964	p<0.01
Expansion Group	7.412	1.317	p<0.01
Non-ABD	-23.750	1.222	p<0.01
Rural	-36.856	0.994	p<0.01
Constant	6,264.726	1,202.756	p<0.01

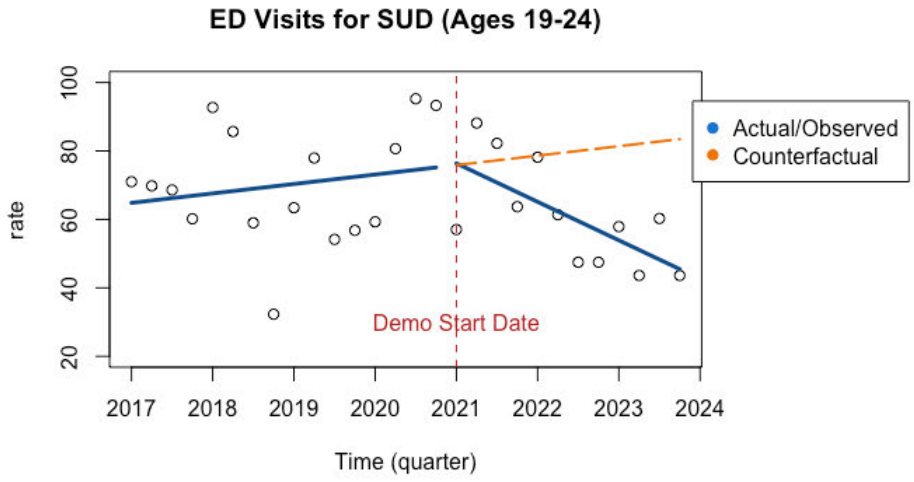
Age

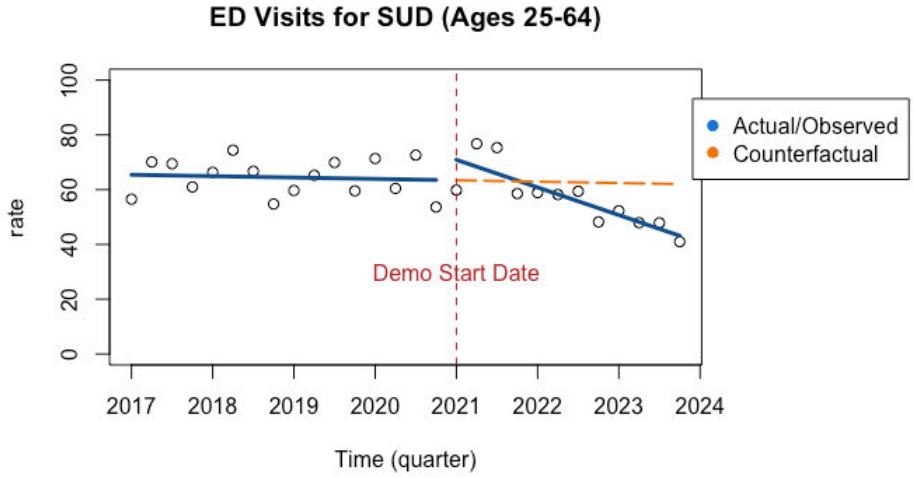
In general, members 65 and older use the ED for SUD less frequently. The was also a statistically significant sustained trend for fewer ED visits for SUD for members in the 19-24 and 25-64 age groups.

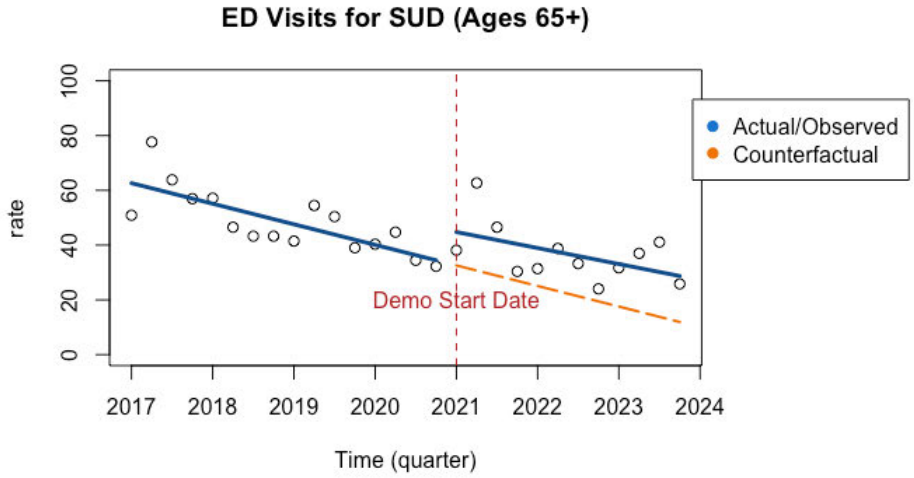
ED for SUD ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	-3.95 (2.67)	2.76 (3.29)	-0.50 (1.41)	-7.51*** (1.82)
Immediate Effect of Demonstration Start (Standard Error)	10.35 (9.57)	4.01 (11.83)	9.89 (5.06)	11.77 (6.55)
Sustained Effect (Standard Error)	0.93 (1.22)	-3.50** (1.51)	-2.40*** (0.65)	0.42 (0.84)
Constant (Standard Error)	8,017.22 (5,382.32)	-5,500.84 (6,651.72)	1,079.08 (2,845.25)	15,212.63*** (3,681.06)

**p<0.05; ***p<0.01




ED Visits for SUD (Ages 19-24)
rate
20
40
60
80
100
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual


ED Visits for SUD (Ages 25-64)
rate
0
20
40
60
80
100
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

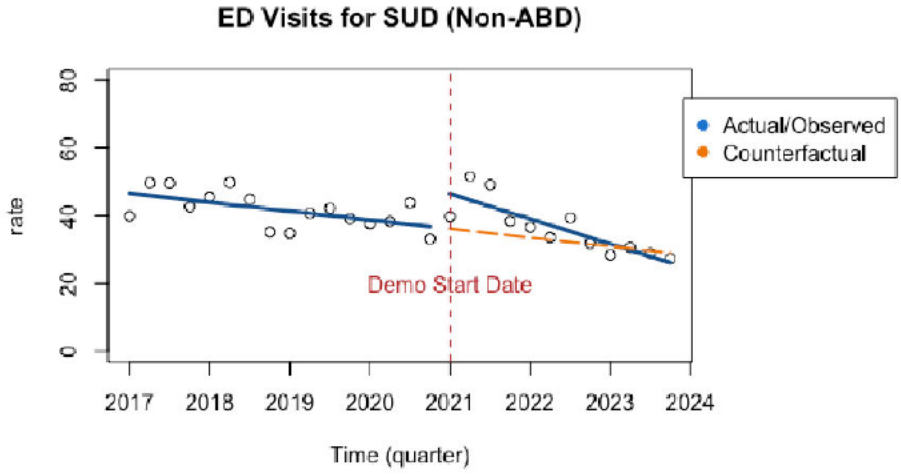

ED Visits for SUD (Ages 65+)
rate
0
20
40
60
80
100
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

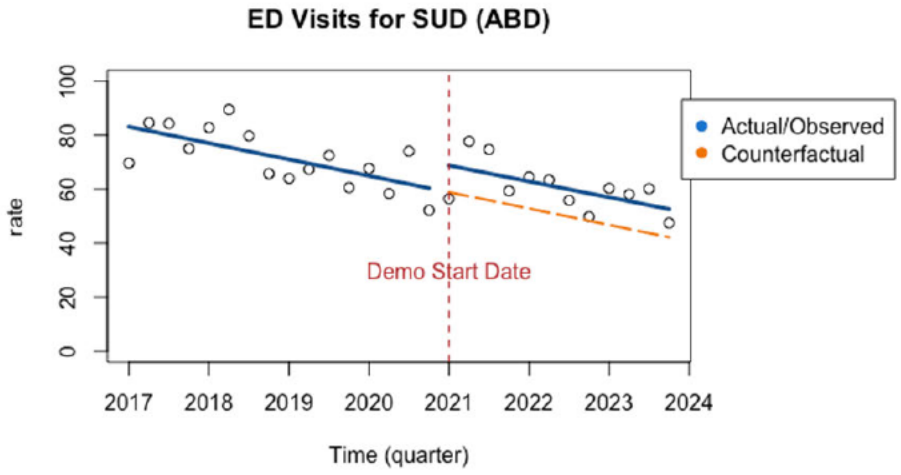
Aid Category

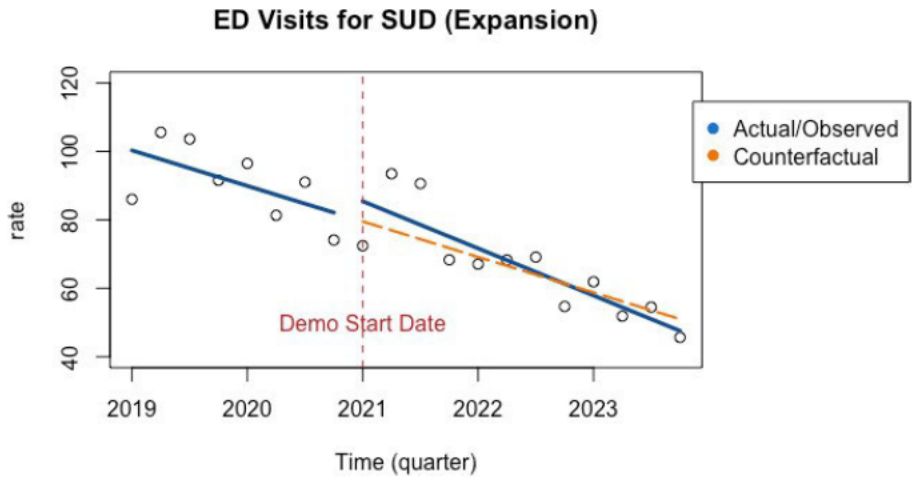
An analysis of utilization by aid category showed statistically significant general trend for fewer ED visits for SUD in the ABD and non-ABD groups. Immediately following the start of the Demonstration members in the non-ABD group had more frequent visits to the ED for SUD before a decline was sustained during the first few years of the Demonstration.

ED for SUD ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	-6.06*** (1.67)	-2.61** (0.96)	-10.38 (5.20)
Immediate Effect of Demonstration Start (Standard Error)	9.83 (6.01)	11.50*** (3.46)	6.75 (7.52)
Sustained Effect (Standard Error)	0.04 (0.77)	-1.20** (0.44)	-0.85 (1.48)
Constant (Standard Error)	12,302.05*** (3,379.85)	5,305.59** (1,943.46)	21,066.30 (10,510.49)

**p<0.05; ***p<0.01





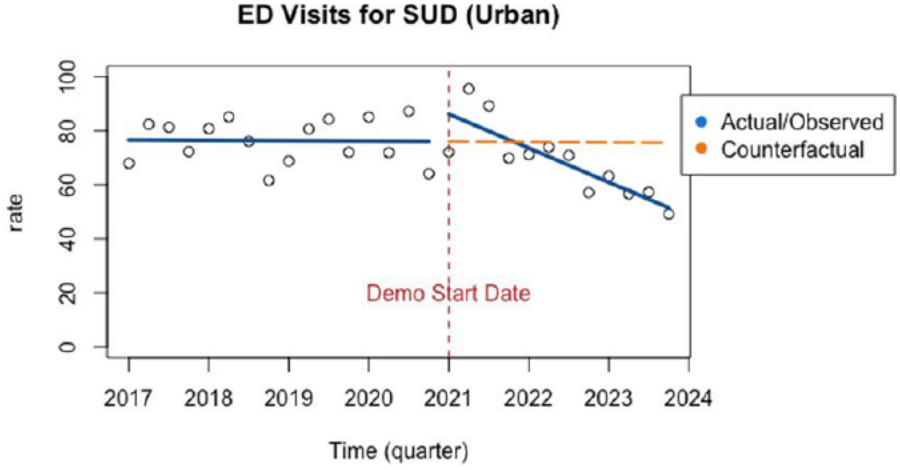


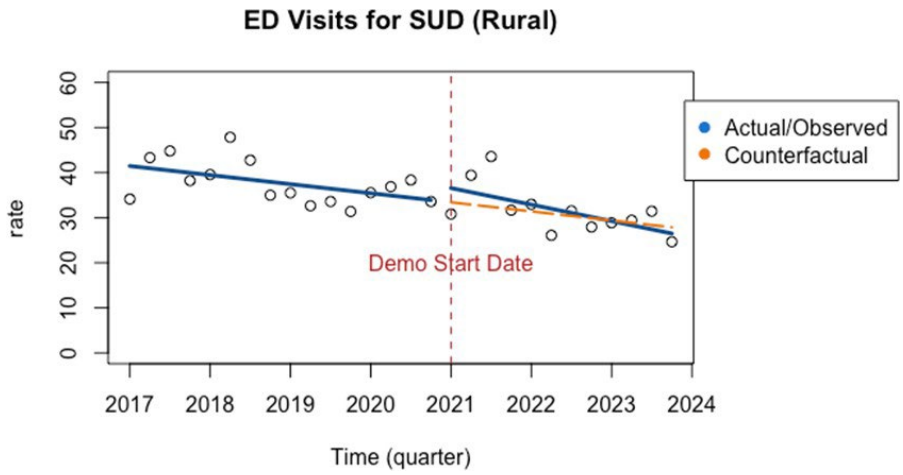
Urban/Rural

In general, members living in rural counties used the ED for SUD less frequently. There were no immediate or sustained effects of the Demonstration period for members in rural counties. Immediately following the start of the Demonstration members in urban counties showed a statistically significant increase in use of the ED for SUD followed by a statistically significant sustained decrease in use for the first few years of the Demonstration.

ED for SUD ITS Model (Urban/Rural)	Urban	Rural
General Trend (Time) (Standard Error)	-0.16 (1.76)	-2.01** (0.94)
Immediate Effect of Demonstration Start (Standard Error)	13.31** (6.30)	3.57 (3.37)
Sustained Effect (Standard Error)	-3.12*** (0.81)	-0.41 (0.43)
Constant (Standard Error)	408.18 (3,544.64)	4,105.12** (1,893.95)

**p<0.05; ***p<0.01




ED Visits for SUD (Rural)
rate
0
10
20
30
40
50
60
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

Measure 4.1.2 The rate of non-emergent ED visits per 1,000 member months

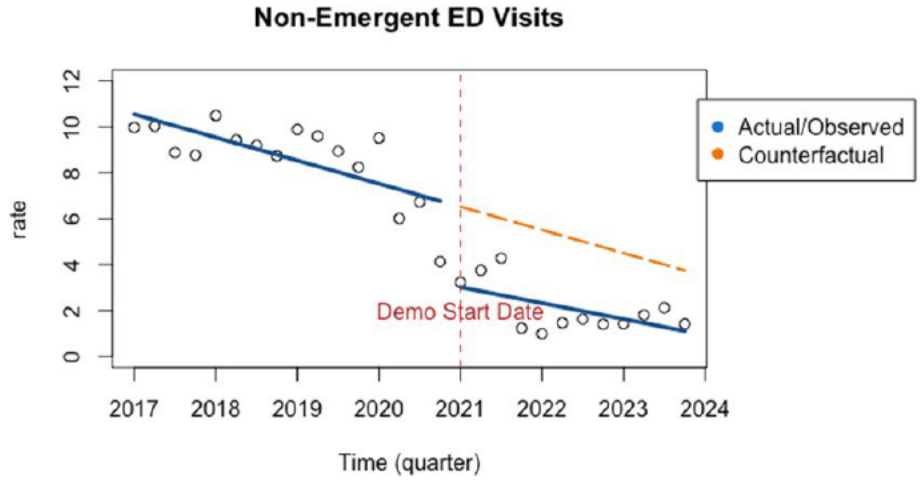
Question 4.	Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?
Hypothesis 1.	The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD.

Measure Description: The denominator represents the number of members with an SUD who had an ED visit during the measurement period. The numerator includes the number of ED visits with a diagnosis identified as non-emergent (see Appendix B) as the primary diagnosis.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for members demographics.

Findings: Non-emergent ED visits showed a declining trend. There was a statistically significant decline immediately following the start of the Demonstration.



Non-Emergent ED ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-1.01	0.24	p<0.01
Immediate Effect of Demonstration Start	-3.58	0.86	p<0.01
Sustained Effect	0.08	0.11	None
Constant	2,042.66	485.87	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a general trend of declining non-emergent ED use with an immediate decline immediately following the start of the Demonstration. Older members, those in rural counties and those in the non-ABD and expansion group had fewer non-emergent ED visits. Women had more non-emergent ED visits. All temporal and demographic factors showed statistically significant explanatory power.

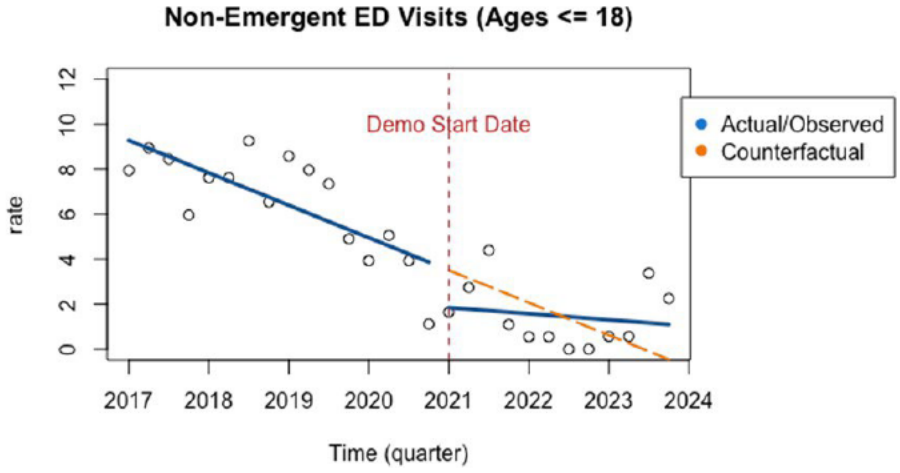
Non-Emergent ED GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-1.085	0.077	p<0.01
Immediate Effect of Demonstration Start	-3.434	0.241	p<0.01
Sustained Effect	0.113	0.031	p<0.01
Age	-0.011	0.005	p<0.05
Gender (Female)	1.167	0.124	p<0.01
Expansion Group	-0.744	0.170	p<0.01
Non-ABD	-2.424	0.158	p<0.01
Rural	-1.726	0.128	p<0.01
Constant	2,200.198	155.205	p<0.01

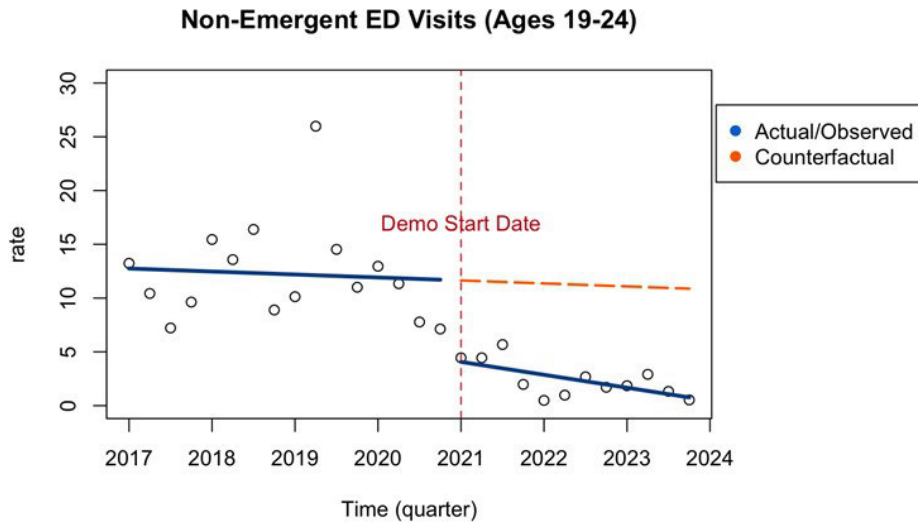
Age

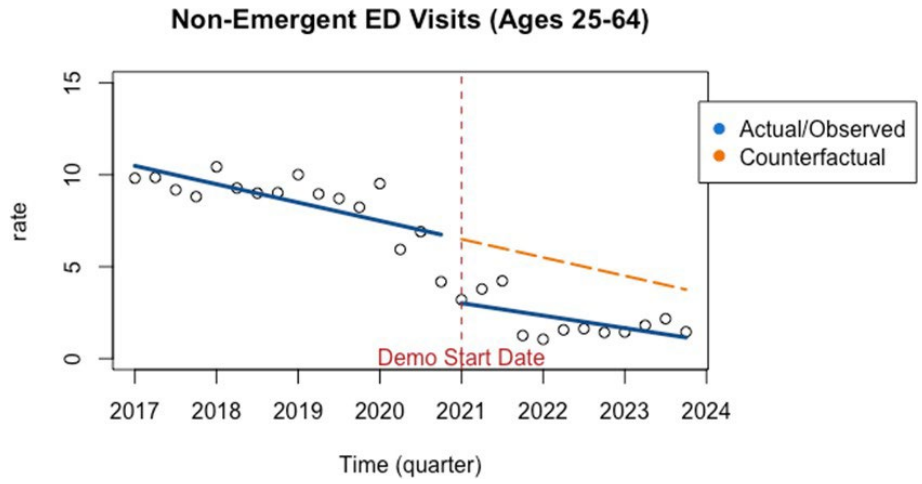
Utilization by age showed a general decline in non-emergent ED use for all age groups, apart from the 19–24-year-olds. The start of the Demonstration was associated with an immediate decline in all age groups, apart from those 18 and under. The sustained effect was not statistically significant.

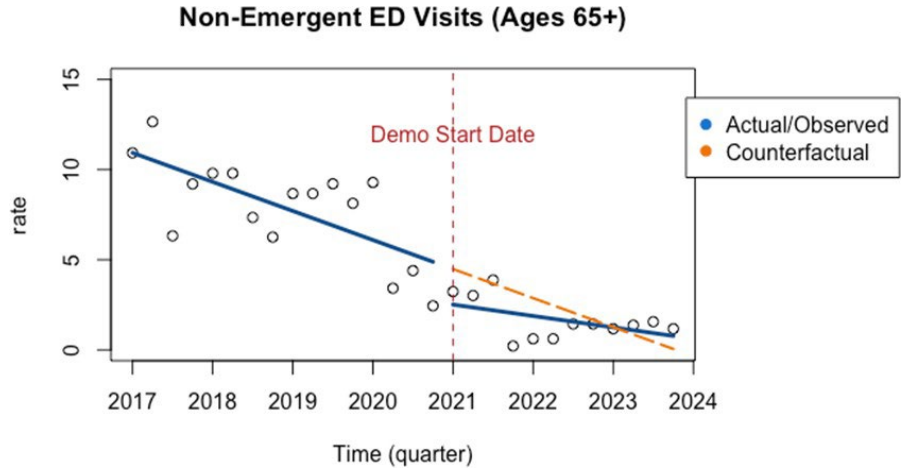
Non-Emergent ED ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	-1.44*** (0.32)	-0.28 (0.82)	-1.00*** (0.23)	-1.61*** (0.37)
Immediate Effect of Demonstration Start (Standard Error)	-1.95 (1.16)	-7.34** (2.93)	-3.56*** (0.83)	-2.22 (1.32)
Sustained Effect (Standard Error)	0.29 (0.15)	-0.23 (0.38)	0.08 (0.11)	0.25 (0.17)
Constant (Standard Error)	2,918.53*** (653.76)	572.75 (1,649.45)	2,021.34*** (466.30)	3,261.88*** (739.97)

**p<0.05; ***p<0.01




Non-Emergent ED Visits (Ages 19-24)
rate
0
5
10
15
20
25
30
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual


Non-Emergent ED Visits (Ages 25-64)
rate
0
5
10
15
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

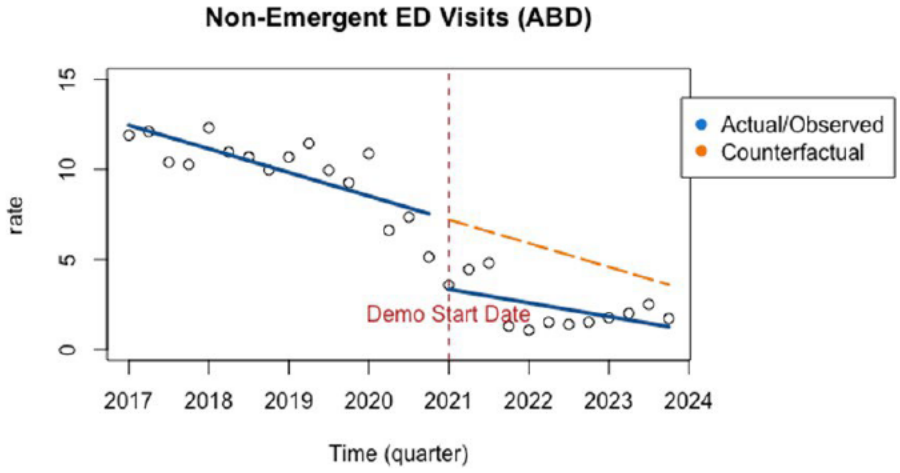

Non-Emergent ED Visits (Ages 65+)
rate
0
5
10
15
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

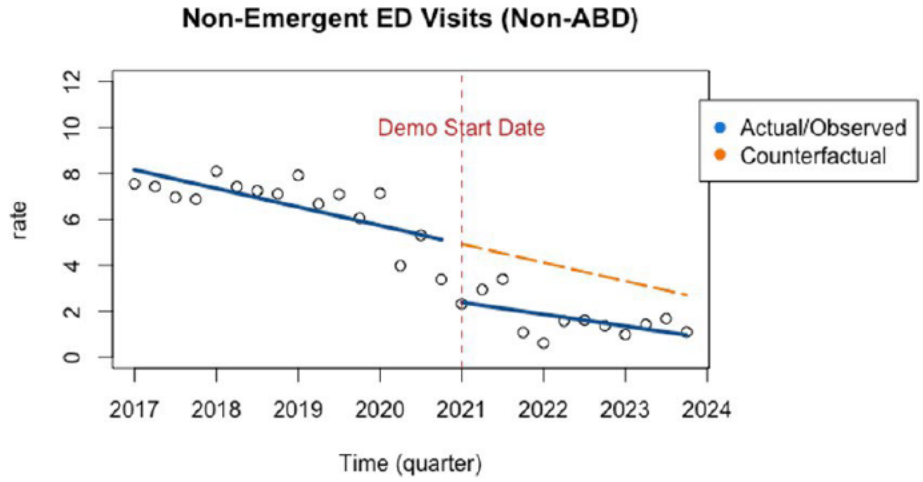
Aid Category

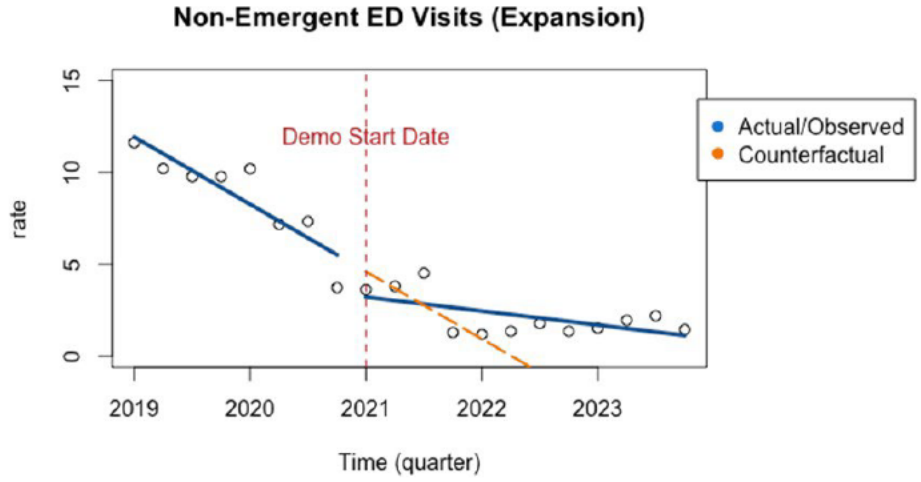
An analysis of non-emergent ED use by aid category showed statistically significant decreases for all eligibility groups in the general trend, with an immediate effect associated with the start of the Demonstration. Non-emergent ED use showed a statistically significant sustained increase for members in the expansion group during the first few years of the Demonstration.

Non-Emergent ED ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	-1.31*** (0.27)	-0.81*** (0.19)	-3.67*** (0.66)
Immediate Effect of Demonstration Start (Standard Error)	-4.01*** (0.97)	-2.62*** (0.68)	-2.11** (0.96)
Sustained Effect (Standard Error)	0.14 (0.12)	0.07 (0.09)	0.73*** (0.19)
Constant (Standard Error)	2,658.10*** (545.47)	1,636.77*** (379.62)	7,414.56*** (1,335.05)

**p<0.05; ***p<0.01





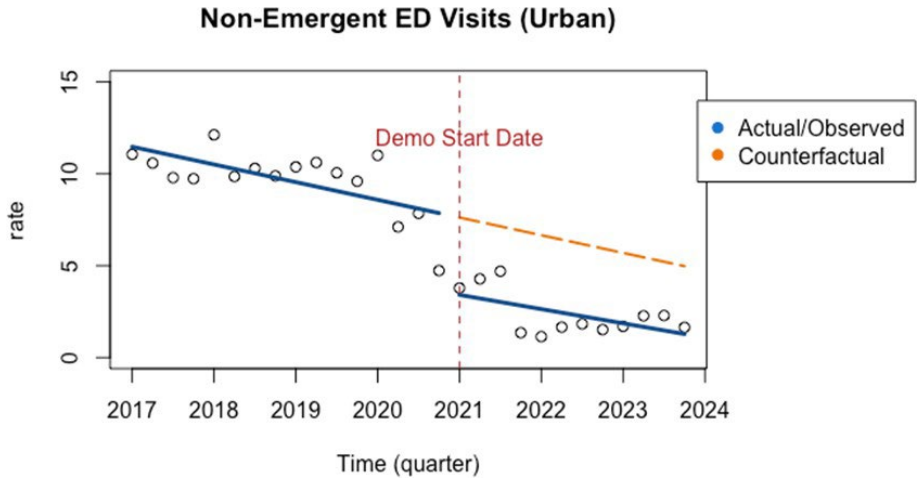


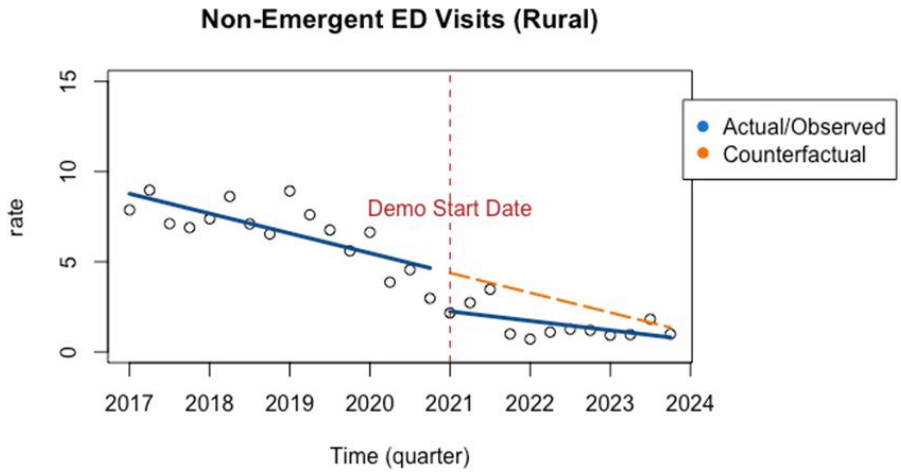
Urban/Rural

In examining general trends for urban and rural counites, all members showed a statistically significant trend for fewer non-emergent ED visits with an immediate effect of the Demonstration's start date.

Non-Emergent ED ITS Model (Urban/Rural)	Urban	Rural
General Trend (Time) (Standard Error)	-0.96*** (0.27)	-1.10*** (0.22)
Immediate Effect of Demonstration Start (Standard Error)	-4.26*** (0.98)	-2.28*** (0.79)
Sustained Effect (Standard Error)	0.05 (0.13)	0.14 (0.10)
Constant (Standard Error)	1,952.44*** (550.14)	2,224.70*** (442.36)

**p<0.05; ***p<0.01


Non-Emergent ED Visits (Urban)
rate
0
5
10
15
Demo Start Date
Actual/Observed
Counterfactual
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)


Non-Emergent ED Visits (Rural)
rate
0
5
10
15
Demo Start Date
Actual/Observed
Counterfactual
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)

Evaluation question four, ***hypothesis two*** suggests the Demonstration will contain or reduce preventable inpatient admissions. Measures examined under this hypothesis are outlined below.

4.2.1. Total number of inpatient stays for SUD per 1,000 members
4.2.2. Prevention Quality Chronic Composite

Measure 4.2.1 Total number of inpatient stays for SUD per 1,000 members

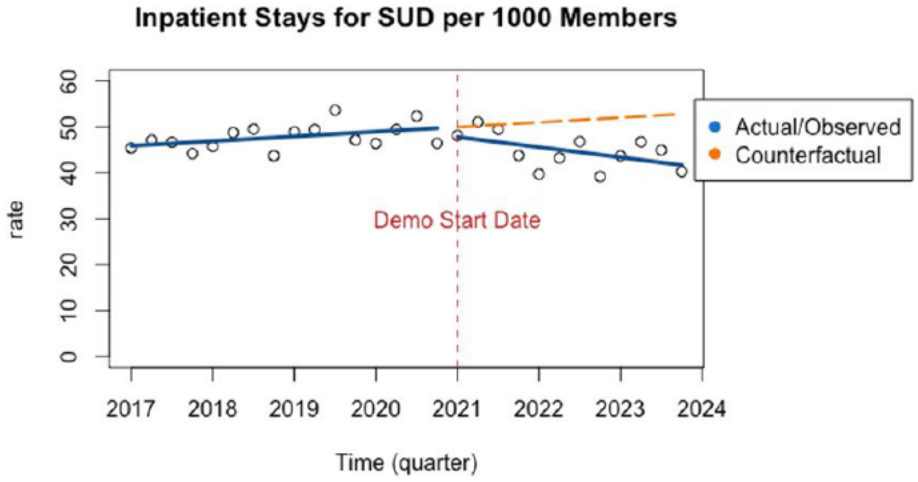
Question 4.	Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?
Hypothesis 1.	The Demonstration will contain or reduce the rate of preventable inpatient admissions.

Measure Description: The denominator represents the number of members with an SUD who had an inpatient discharge during the measurement period. The numerator includes the number of inpatient discharges with a primary diagnosis code of SUD.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for members demographics.

Findings: The Demonstration period was associated with a statistically significant sustained decline in inpatient stays for SUD.



Inpatient ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	1.02	0.64	None
Immediate Effect of Demonstration Start	-1.35	2.29	None
Sustained Effect	-0.81	0.29	p<0.05
Constant	-2,012.35	1,287.52	None

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a statistically significant sustained trend with fewer inpatient stays for SUD during the Demonstration period. Women, expansion group, non-ABD groups and members in rural counties had fewer hospitalization for SUD. Older members were associated with more inpatient stays for SUD. These temporal and demographic factors showed statistically significant explanatory power.

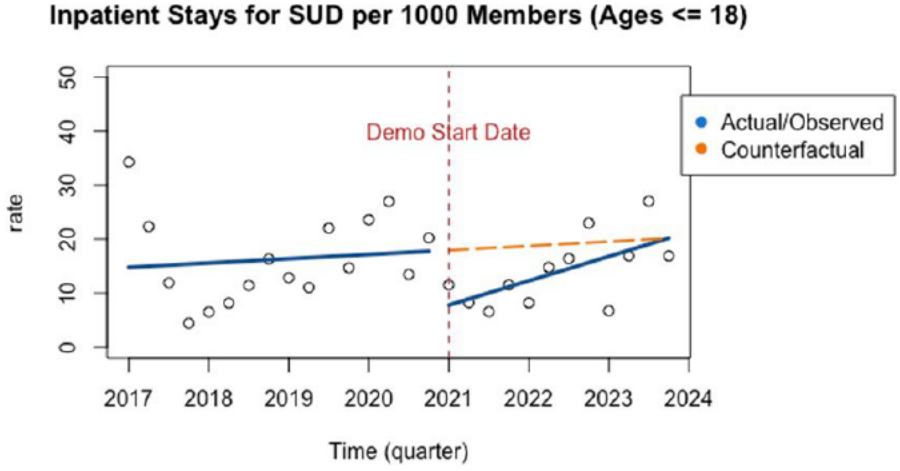
Inpatient GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.310	0.455	None
Immediate Effect of Demonstration Start	-0.156	1.427	None
Sustained Effect	-0.693	0.184	p<0.01
Age	1.857	0.030	p<0.01
Gender (Female)	-6.269	0.736	p<0.01
Expansion Group	-2.091	1.007	p<0.05
Non-ABD	-18.932	0.934	p<0.01
Rural	-16.075	0.759	p<0.01
Constant	-640.508	919.169	None

Age

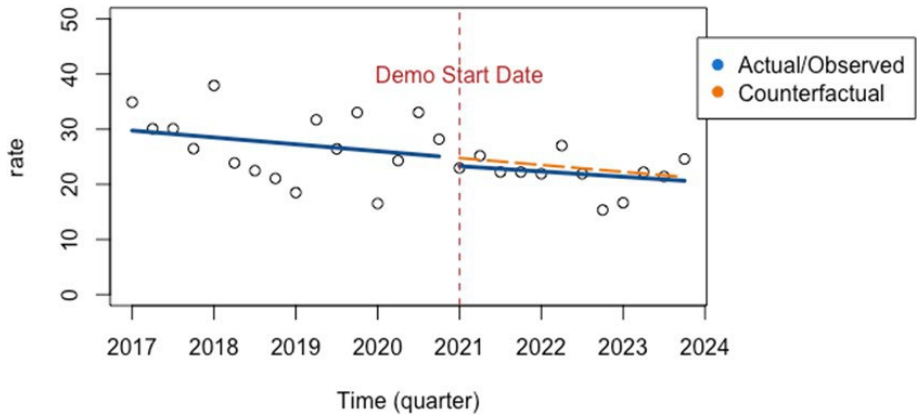
An analysis of inpatient stays for SUD showed a general trend of increased stays in the 25-64 and 65 and older age groups. There was a statistically significant sustained decline in use during the first few years of the Demonstration for members aged 25-64.

Inpatient ITS Model (Age)	Ages ≤18	Ages 19-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	0.79 (1.56)	-1.25 (1.11)	2.41*** (0.69)	-11.86*** (2.21)
Immediate Effect of Demonstration Start (Standard Error)	-11.09 (5.59)	-1.54 (3.97)	-0.66 (2.47)	3.04 (7.92)
Sustained Effect (Standard Error)	0.93 (0.72)	0.07 (0.51)	-1.09*** (0.32)	-0.13 (1.01)
Constant (Standard Error)	-1,574.79 (3,142.10)	2,544.65 (2,234.89)	-4,827.02*** (1,390.29)	24,121.44*** (4,452.46)

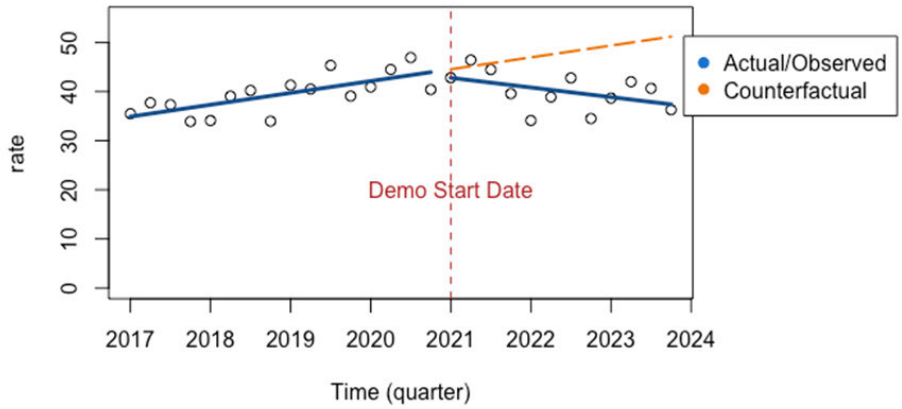
**p<0.05; ***p<0.01



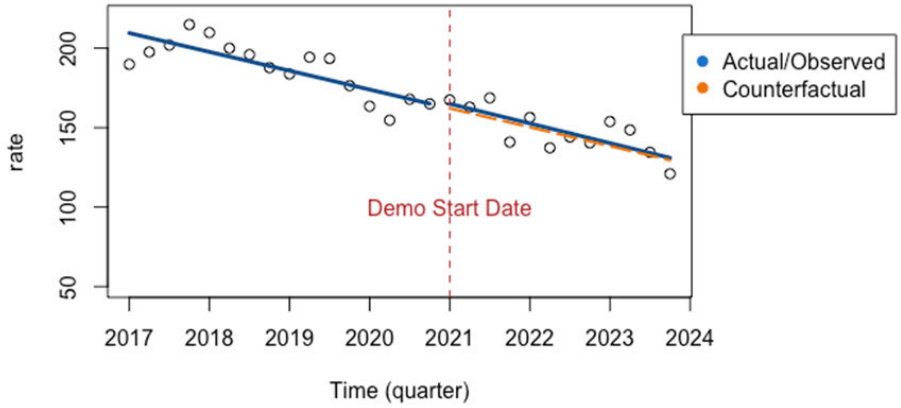
Inpatient Stays for SUD per 1000 Members (Ages 19-24)



Inpatient Stays for SUD per 1000 Members (Ages 25-64)



Inpatient Stays for SUD per 1000 Members (Ages 65+)

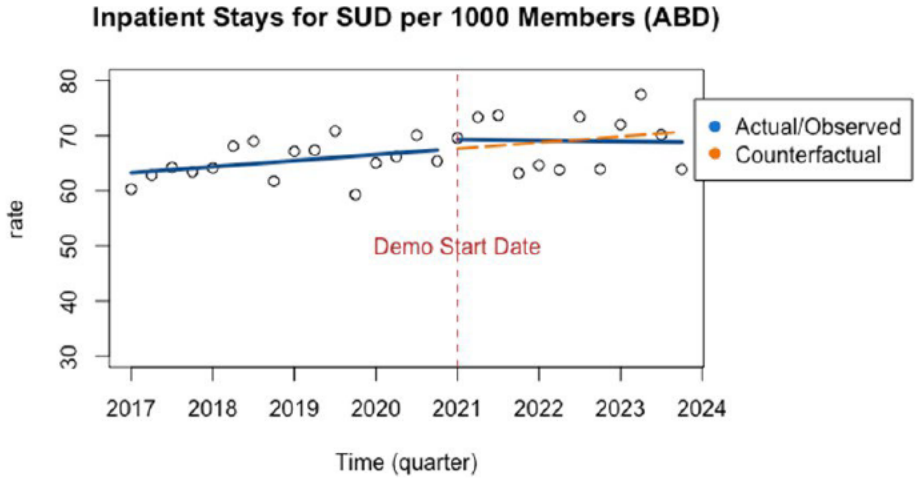


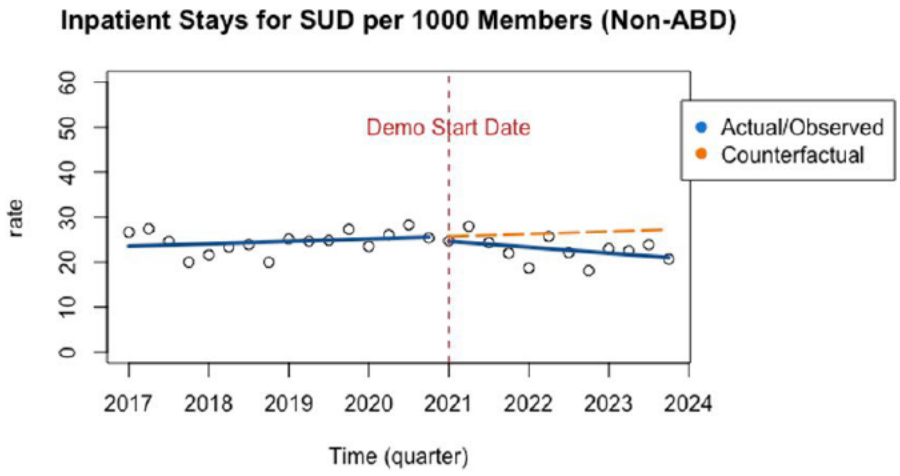
Aid Category

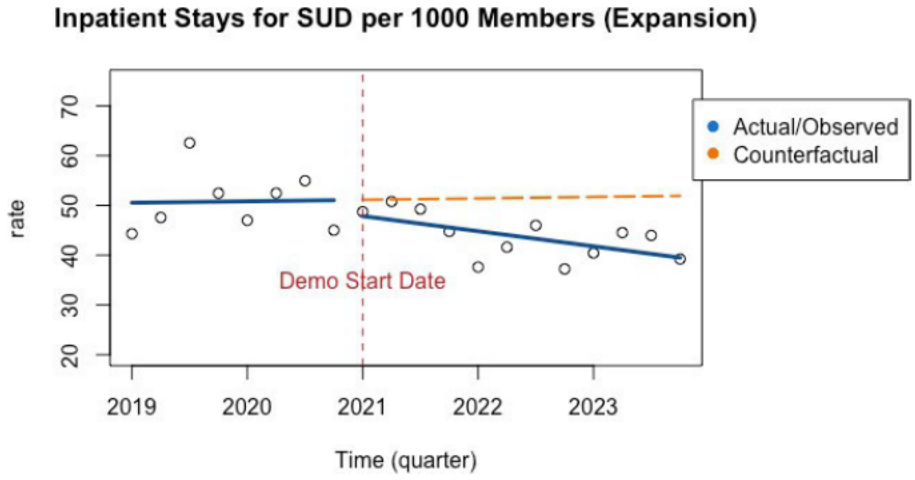
There were no statistically significant changes in trend based on Medicaid eligibility group.

Inpatient ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	1.10 (0.91)	0.55 (0.55)	0.29 (3.11)
Immediate Effect of Demonstration Start (Standard Error)	2.01 (3.25)	-0.63 (1.98)	-2.44 (4.49)
Sustained Effect (Standard Error)	-0.32 (0.42)	-0.47 (0.25)	-0.83 (0.88)
Constant (Standard Error)	-2,155.47 (1,828.40)	-1,090.55 (1,115.83)	-538.35 (6,281.84)

**p<0.05; ***p<0.01





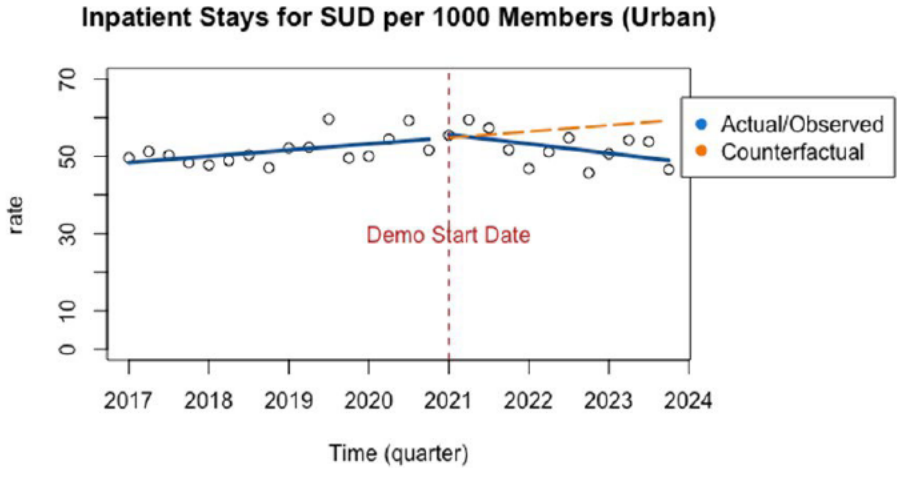


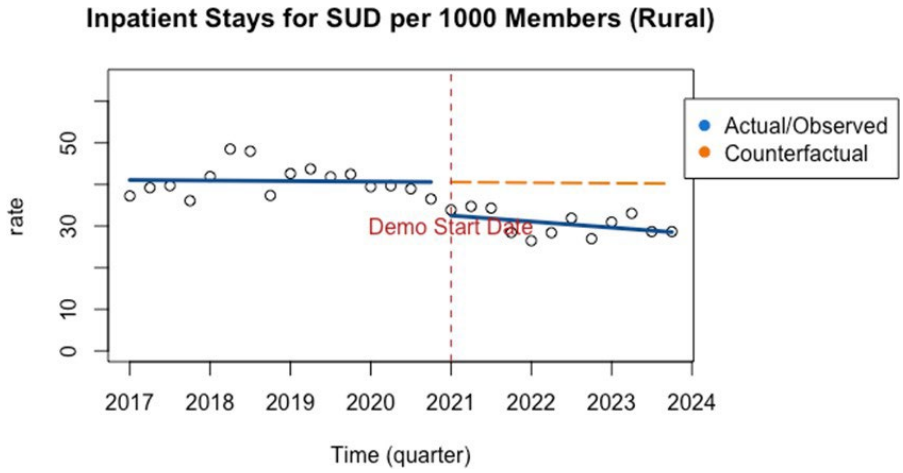
Urban/Rural

Members in urban counties showed a general trend of more inpatient stays for SUD with a sustain declined associated with the first few years of the Demonstration. Members in rural counties showed a decline in inpatient stays for SUD immediately following the start of the Demonstration.

Inpatient ITS Model (Urban/Rural)	Urban	Rural
General Trend (Time) (Standard Error)	1.61** (0.77)	-0.13 (0.74)
Immediate Effect of Demonstration Start (Standard Error)	1.87 (2.76)	-7.70*** (2.67)
Sustained Effect (Standard Error)	-1.02*** (0.35)	-0.33 (0.34)
Constant (Standard Error)	-3,199.83 (1,551.93)	297.22 (1,498.83)

**p<0.05; ***p<0.01




Inpatient Stays for SUD per 1000 Members (Rural)
rate
0
10
30
50
2017
2018
2019
2020
2021
2022
2023
2024
Time (quarter)
Demo Start Date
Actual/Observed
Counterfactual

Measure 4.2.2 Prevention Quality Chronic Composite (PQI #92)

Question 4. *Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD?*

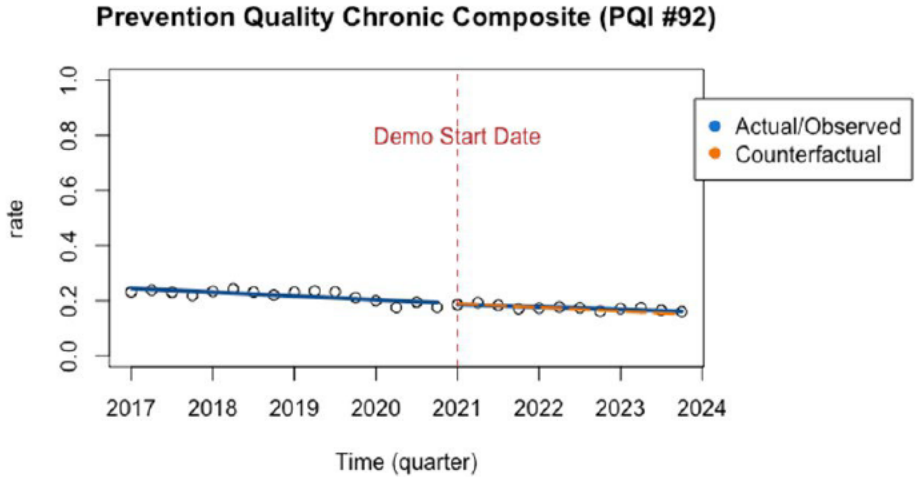
Hypothesis 1. *The Demonstration will contain or reduce the rate of preventable inpatient admissions.*

Measure Description: The denominator includes discharges for members 18 years and older with an SUD. The numerator includes discharges for one of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for members demographics.

Findings: The general trend showed a statistically significant decline in discharges for the chronic conditions studied. There were no other effects associated with the Demonstration period.



PQI #92 ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.01	(0.002)	p<0.01
Immediate Effect of Demonstration Start	-0.004	(0.01	None
Sustained Effect	0.001	(0.001)	None
Constant	28.16	(5.05)	p<0.01

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a statistically significant decline in discharges for the chronic conditions studied in the general trend and through the Demonstration period. Women and members in the expansion and non-ABD groups tended to have fewer discharges for the chronic conditions studied. There was a slight

increase immediately following the start of the Demonstration. Older members were associated with more discharges related to the chronic conditions studied. These temporal and demographic factors showed statistically significant explanatory power. There was no statistically significant change related to urban/rural characteristics.

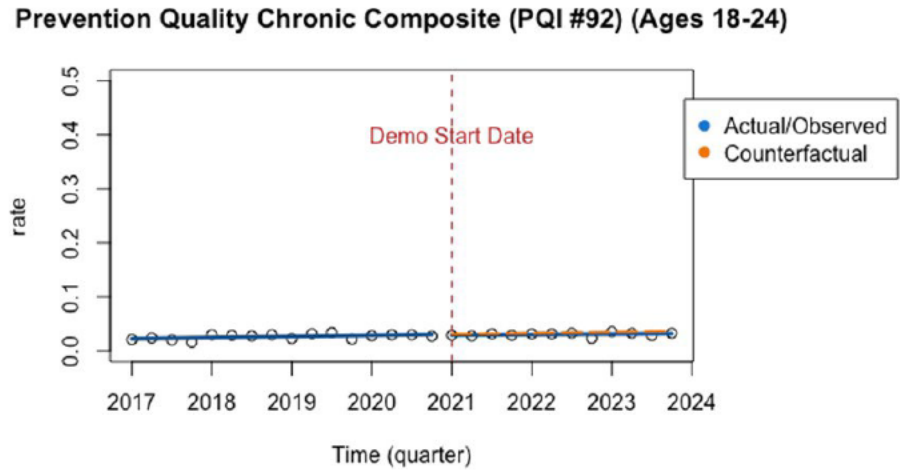
PQI #92 GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.009	(0.001)	p<0.01
Immediate Effect of Demonstration Start	0.011	0.002	p<0.01
Sustained Effect	-0.001	0.0002	p<0.05
Age	0.011	0.00004	p<0.01
Gender (Female)	-0.013	0.001	p<0.01
Expansion Group	-0.067	0.001	p<0.01
Non-ABD	-0.062	0.001	p<0.01
Rural	0.001	0.001	None
Constant	17.082	1.154	p<0.01

Age

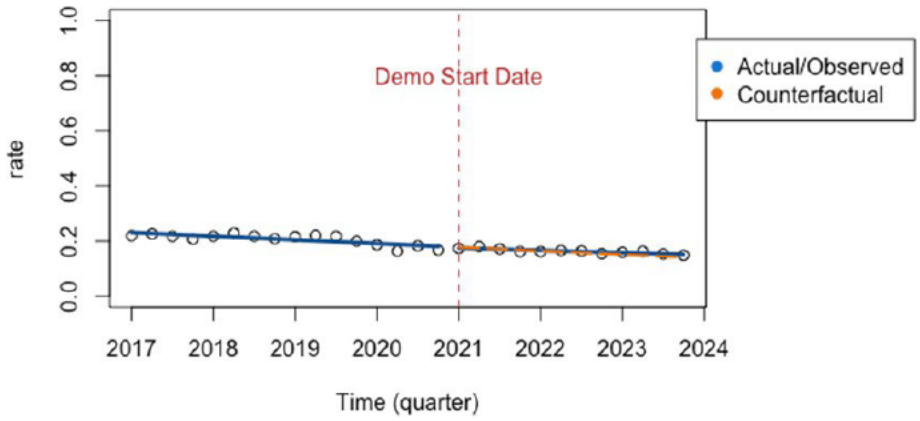
An analysis of discharges by age showed a general trend of decreased stays for members 25-64 and over age 65 and a slight increase for members in the 18-24 age group. There was no statistically significant impact on trends associated with the Demonstration period.

PQI #92 ITS Model (Age)	Ages 18-24	Ages 25-64	Ages 65+
General Trend (Time) (Standard Error)	0.002** (0.001)	-0.01*** (0.002)	-0.03*** (0.01)
Immediate Effect of Demonstration Start (Standard Error)	-0.001 (0.003)	-0.004 (0.01)	0.04 (0.02)
Sustained Effect (Standard Error)	-0.0003 (0.0004)	0.001 (0.001)	-0.002 (0.003)
Constant (Standard Error)	-4.26** (1.75)	27.17*** (4.60)	51.38*** (12.72)

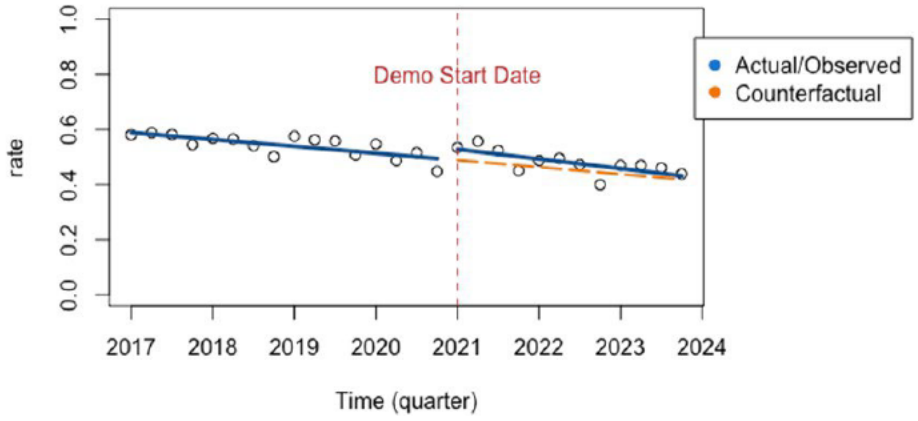
**p<0.05; ***p<0.01



Prevention Quality Chronic Composite (PQI #92) (Ages 25-64)



Prevention Quality Chronic Composite (PQI #92) (Ages 65+)



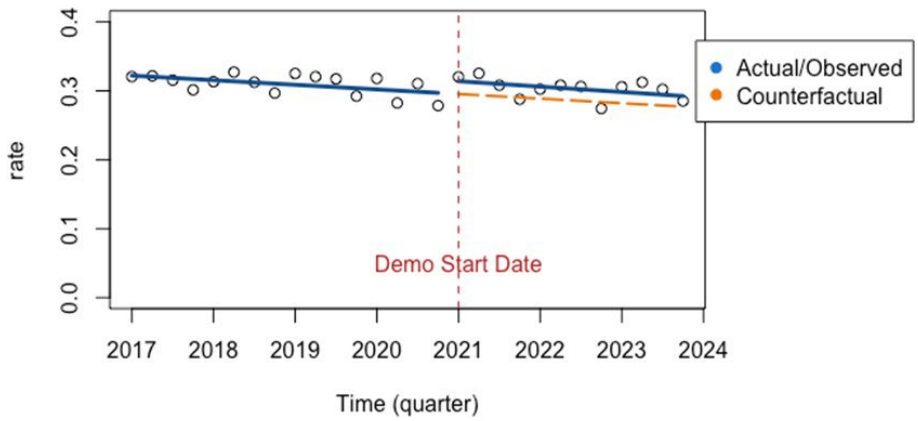
Aid Category

An analysis of discharges by eligibility group showed a statistically significant trend for fewer discharges for the chronic conditions studied in the ABD and expansion groups. During the Demonstration there a statistically significant sustained decrease in discharges within the non-ABD group and a slight increase in discharges within the expansion group.

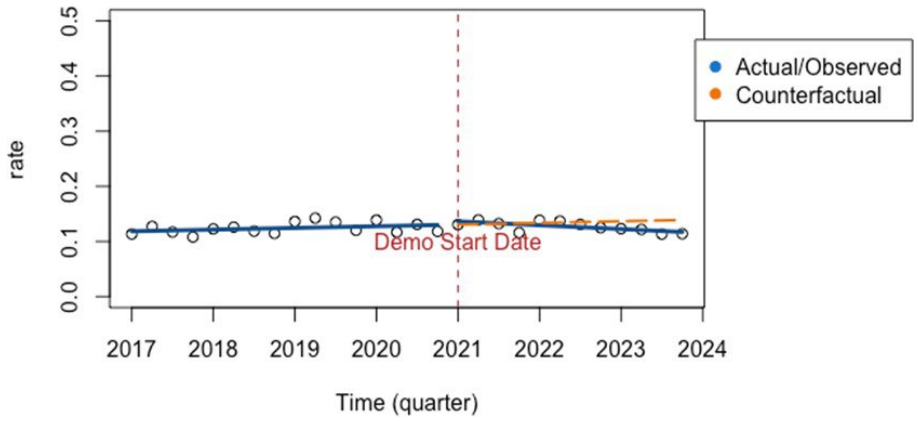
PQI #92 ITS Model (Aid Category)	ABD	Non-ABD	Expansion
General Trend (Time) (Standard Error)	-0.01** (0.003)	0.003 (0.002)	-0.03*** (0.01)
Immediate Effect of Demonstration Start (Standard Error)	0.02 (0.01)	0.01 (0.01)	0.01 (0.01)
Sustained Effect (Standard Error)	-0.0003 (0.001)	-0.003*** (0.001)	0.01*** (0.002)
Constant (Standard Error)	13.80** (5.79)	-5.99 (3.84)	52.42*** (12.95)

**p<0.05; ***p<0.01

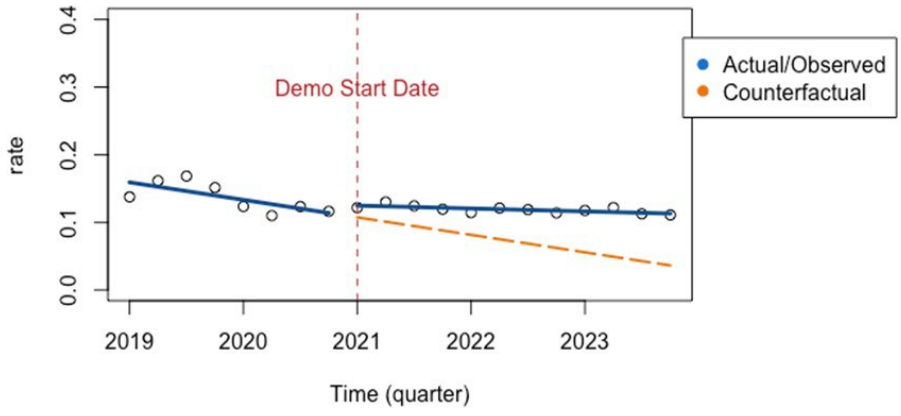
Prevention Quality Chronic Composite (PQI #92) (ABD)



Prevention Quality Chronic Composite (PQI #92) (Non-ABD)



Prevention Quality Chronic Composite (PQI #92) (Expansion)



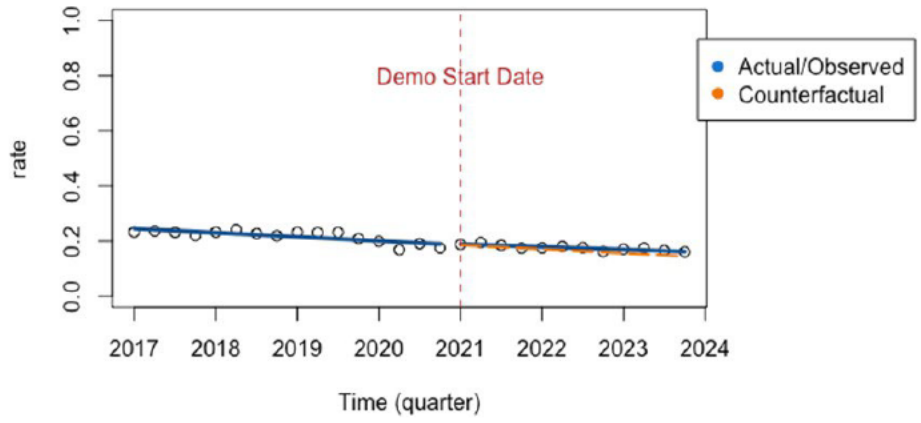
Urban/Rural

In examining general trends for members living in urban and rural counites, there was a statistically significant decrease in the general trend for discharges for chronic conditions. There were no significant changes in trend associated with the Demonstration period.

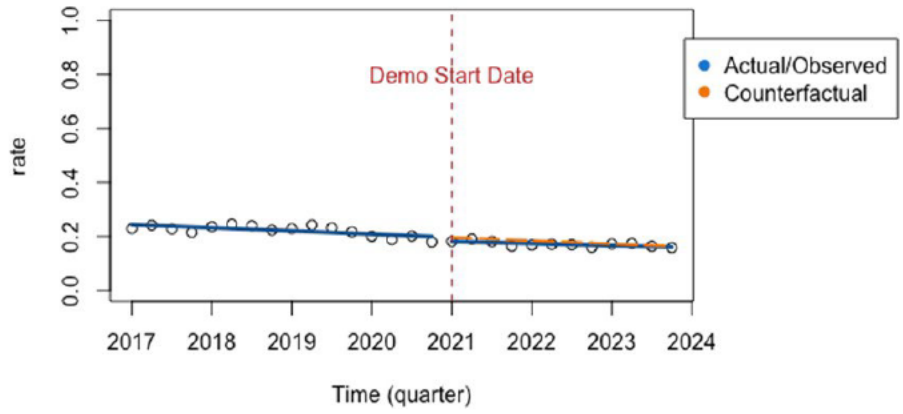
PQI #92 ITS Model (Urban/Rural)	Urban	Rural
General Trend (Time) (Standard Error)	-0.01*** (0.003)	-0.01*** (0.003)
Immediate Effect of Demonstration Start (Standard Error)	0.002 (0.01)	-0.02 (0.01)
Sustained Effect (Standard Error)	0.001 (0.001)	0.001 (0.001)
Constant (Standard Error)	30.20*** (5.08)	24.18*** (5.31)

**p<0.05; ***p<0.01

Prevention Quality Chronic Composite (PQI #92) (Urban)



Prevention Quality Chronic Composite (PQI #92) (Rural)



A summary of the ITS aggregate analysis trends related to evaluation question four are presented below.

Measure‡	General Trend	Immediate Effect	Sustained Effect
Hypothesis 1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD			
4.1.1. Total number of ED visits for SUD per 1,000 members	-	-	↓
4.1.2. The rate of non-emergent ED visits per 1,000 member months	↓	↓	-
Hypotheses 2. The Demonstration will contain or reduce preventable inpatient admissions			
4.2.1. Total number of inpatient stays for SUD per 1,000 members	-	-	↓
4.2.2. Prevention Quality Chronic Composite (PQI #92)	↓	-	-

Notes:
‡Fewer visits (↓) are preferred
*Logistic regression or 2-sided t-test used
- No statistically significant trend
↑Statistically significant increase in trend
↓Statistically significant decrease in trend

A summary of the Generalized Linear Model Results (i.e., how individual factors contribute to the variation in the data) related to evaluation question four, is presented below.

Measure‡	General Trend	Immediate Effect	Sustained Effect	Age (Older)	Gender (Female)	Expansion Group	Non-ABD	Rural Counties
Hypothesis 1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD								
4.1.1. ED visits for SUD	↓	↑	↓	↓	↓	↑	↓	↓
4.1.1. Non-emergent ED visits	↓	↓	↑	↓	↑	↓	↓	↓
Hypotheses 2. The Demonstration will contain or reduce preventable inpatient admissions								
4.2.1. Inpatient stays for SUD	↓	↑	↓	↑	↓	↓	↓	↓
4.2.2. PQI #92	↓	↑	↓	↑	↓	↓	↓	-

Notes:
‡Fewer visits (↓) are preferred
- No statistically significant trend
↑Statistically significant explanatory power
↓Statistically significant explanatory power

E. SUD EVALUATION QUESTION FIVE

Does the Demonstration contain or reduce readmissions to the same or higher levels of care?

Evaluation question five has one hypothesis: The Demonstration will contain or reduce readmissions to the same or higher levels of care. Measures examined are outlined below. There are no subsidiary analyses associated with evaluation question five, hypothesis one.

5.1.1. Percentage of readmissions to the same or higher level of residential care
5.1.2. The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis

Measure 5.1.1 Percentage of readmissions to the same or higher level of residential care

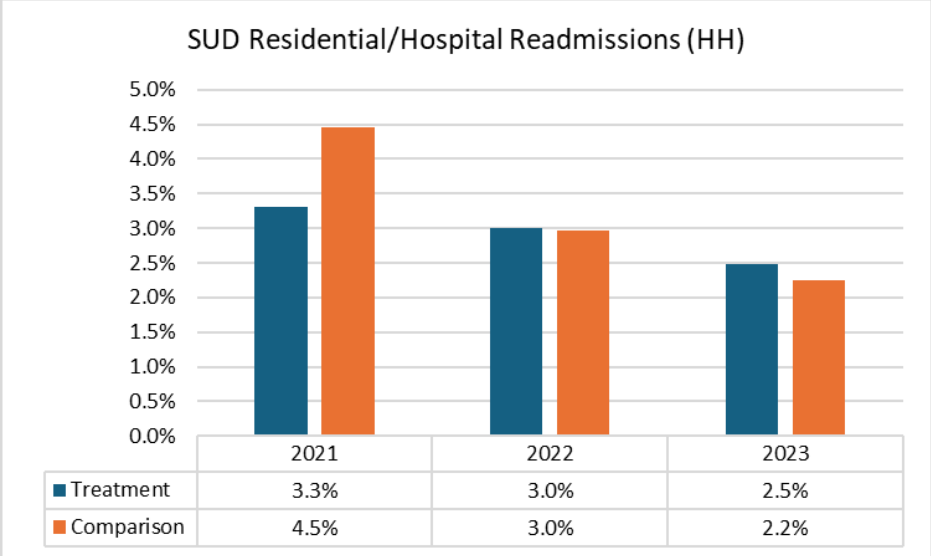
Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.

Measure Description: The denominator includes members receiving Health Home services who were discharged from residential or inpatient treatment for SUD. The numerator includes those members who were readmitted to SUD residential or inpatient within 30 days of discharge.

Data Source and Time Period: MMIS paid claims 2017-2023; OMS Opioid and Behavioral Health Home enrollment files.

Analytical Approach: Comparison group strategy using Coarsened Exact Matching for members not receiving Opioid or Behavioral Health Home services.

Findings: Members receiving Opioid and Behavioral Health Home services had fewer readmissions for SUD treatment than the control group. However, the differences were not statistically significant in any year of the Demonstration.



Measure 5.1.2 The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis

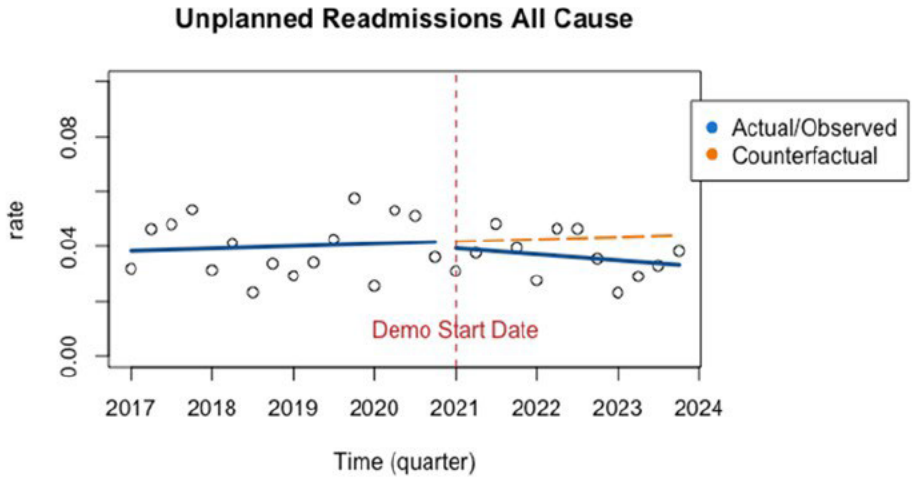
Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.

Measure Description: The denominator includes the number of inpatient dischargers for members with an SUD. The numerator includes the number of unplanned acute readmission for any diagnosis within 30 days after discharge.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: An interrupted time series showed no statistically significant effect of time or the Demonstration period on the trend.



Readmissions ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.001	(0.002)	None
Immediate Effect of Demonstration Start	-0.002	0.01	None
Sustained Effect	-0.001	0.001	None
Constant	-1.71	4.35	None

A generalized linear model (GLM) was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show a statistically significant increase in unplanned readmissions for older members and fewer readmissions for members in non-ABD groups. No other temporal or demographic variable had a statistically significant explanatory effect on the trend.

Readmissions GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.0004	0.002	None
Immediate Effect of Demonstration Start	-0.001	0.004	None
Sustained Effect	-0.001	0.001	None
Age	0.001	0.0001	p<0.01
Gender (Female)	-0.0004	0.002	None
Expansion Group	0.003	0.003	None
Non-ABD	-0.007	0.003	p<0.05
Rural	-0.0001	0.003	None
Constant	-0.826	3.090	None

A summary of the ITS aggregate analysis trends related to evaluation question five are presented below.

Measure	General Trend	Immediate Effect	Sustained Effect
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.			
5.1.2. The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis*	-	-	-

Notes:
*Lower rates are preferred
- No statistically significant trend
↑Statistically significant increase in trend
↓Statistically significant decrease in trend

A summary of the Generalized Linear Model Results (i.e., how individual factors contribute to the variation in the data) related to evaluation question five, is presented below.

Measure	General Trend	Immediate Effect	Sustained Effect	Age (Older)	Gender (Female)	Expansion Group	Non-ABD	Rural Counties
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.								
5.1.2. The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis*	-	-	-	↑	-	-	↓	-

Notes:
*Lower rates are preferred
- No statistically significant trend
↑Statistically significant explanatory power
↓Statistically significant explanatory power

F. SUD EVALUATION QUESTION SIX

Does the Demonstration maintain or improve access to care for physical health conditions?

Evaluation question six has one hypothesis, the Demonstration will maintain or increase access to care for physical health conditions for Health Home enrollees. There are no subsidiary analyses associated with the evaluation question. The hypothesis was examined using the following measure:

1.2.1. Percentage of members with a SUD who had an ambulatory or preventive health care visit

Measure 6.1.1 Percentage of members with a SUD who had an ambulatory or preventive health care visit.

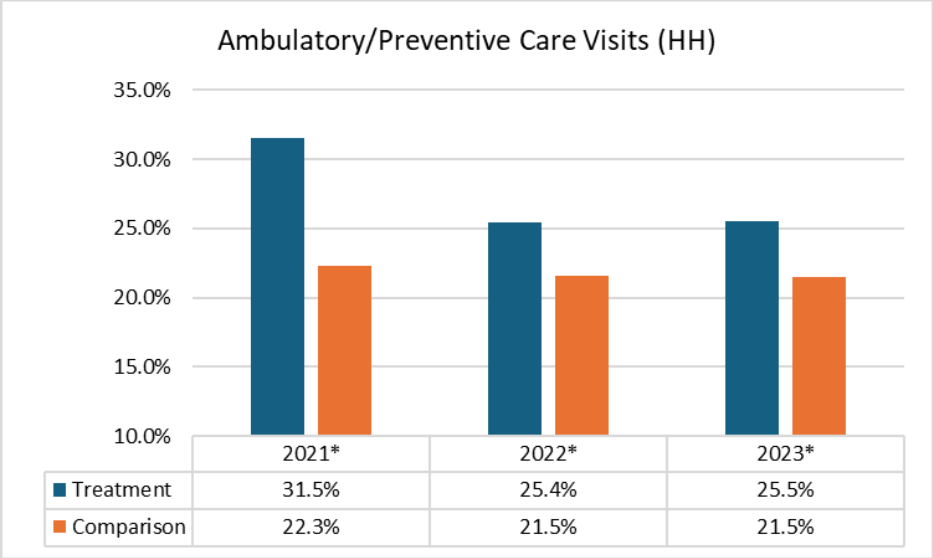
Question 6.	Does the Demonstration maintain or improve access to care for physical health conditions?
Hypothesis 1.	The Demonstration will maintain or increase access to care for physical health conditions for health home enrollees.

Measure Description: The denominator includes the number of members receiving Health Home services with an SUD diagnosis. The numerator includes the number who had one or more visits for ambulatory or preventive care during the measurement year.

Data Source and Time Period: MMIS paid claims 2017-2023; OMS Opioid and Behavioral Health Home enrollment reports.

Analytical Approach: Comparison group strategy using Coarsened Exact Matching for members not receiving Opioid or Behavioral Health Home services.

Findings: In each of the years studied, members who received Opioid and Behavioral Health Home services had more ambulatory and preventive health care visits than the comparison group. In 2021, 2022 and 2023 the treatment group had 31.5 percent, 25.4 percent, and 25.5 percent, respectively. The comparison group results were 22.3 percent in 2021 and 21.5 percent in both 2022 and 2023. Differences between the treatment and comparison group were statistically significant in each year studied.



G. SUD EVALUATION QUESTION SEVEN

How does the cost of care change over time?

Evaluation question seven is an exploratory analysis to examine how expenditures change over time. There are no subsidiary analyses associated with evaluation question seven. A summary of the measures examined is provided below.

7.1.1. Per member per month (PMPM) Medicaid cost for members with an SUD during the measurement year

7.1.2 Per member per month (PMPM) cost of SUD-Related treatment for members with an SUD during the measurement year

7.1.3 Per member per month (PMPM) cost of physical health care for members with an SUD during the measurement year

Measure 7.1.1 Per member per month (PMPM) Medicaid cost for individuals who have an SUD.

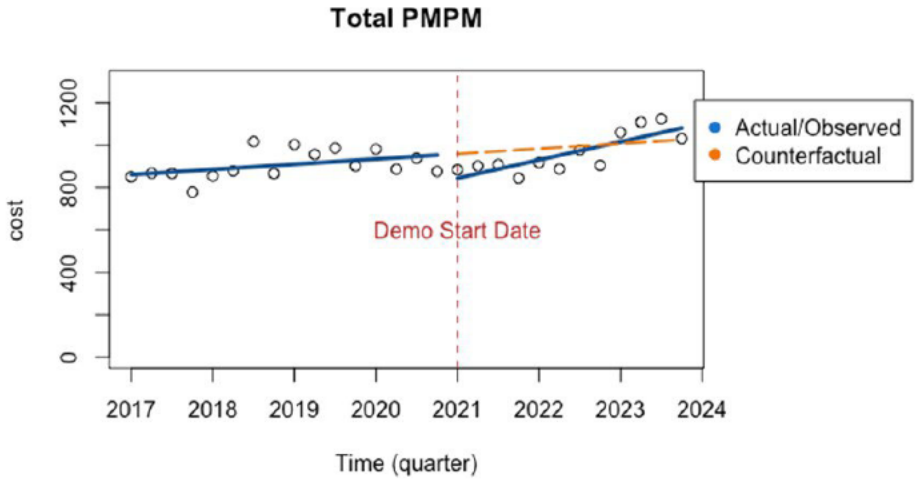
Question 7. How does the cost of care change over time?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made (physical and SUD-related health care) divided the total number of member months for members with an SUD.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The interrupted time series showed a decline in total expenditures immediately following the start date of the Demonstration. There was a statistically significant sustained increase in total expenditures during the first few years of the Demonstration.



Total $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	24.49	13.04	None
Immediate Effect of Demonstration Start	-130.05	46.81	p<0.05
Sustained Effect	15.37	5.99	p<0.05
Constant	-48,530.87	26,321.75	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show that both temporal and individual factors have statistically significant explanatory power. The general trend over time showed an increase in total expenditures, the start date of the Demonstration was associated with a decrease, while the sustained effect showed increased Medicaid expenditures during the first years of the Demonstration. Older members, women, members in non-ABD and expansion groups, and members living in rural counties had lower expenditures.

Total $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	42.828	(5.410)	p<0.01
Immediate Effect of Demonstration Start	-99.622	16.956	p<0.01
Sustained Effect	13.665	2.182	p<0.01
Age	-2.916	0.351	p<0.01
Gender (Female)	-29.270	8.750	p<0.01
Expansion Group	-497.383	11.962	p<0.01
Non-ABD	-720.920	11.095	p<0.01
Rural	-260.669	9.022	p<0.01
Constant	-84,992.290	10,921.800	p<0.01

Measure 7.1.2 Per member per month (PMPM) cost of SUD-Related treatment for individuals who have an SUD.

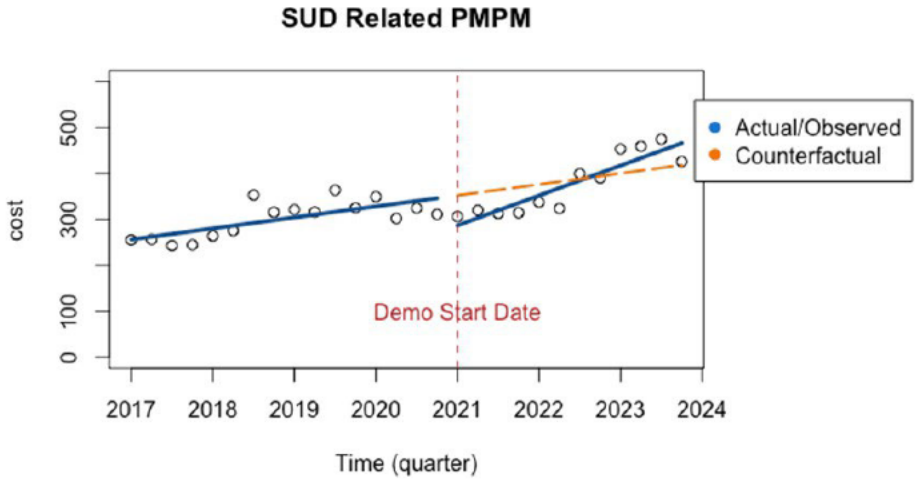
Question 7. How does the cost of care change over time?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for SUD-related health care with breakouts for SUD-IMD and SUD-other treatment for members with an SUD divided the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed an increase in SUD-related expenditures over time. The immediate effect of the Demonstration was associated with a decrease in SUD-related expenditures. The sustained effect showed an increase in SUD-related expenditures in the first few years of the Demonstration.



SUD $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	23.99	6.17	p<0.01
Immediate Effect of Demonstration Start	-75.66	22.16	p<0.01
Sustained Effect	10.29	2.83	p<0.01
Constant	-48,134.61	12,456.91	p<0.01

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

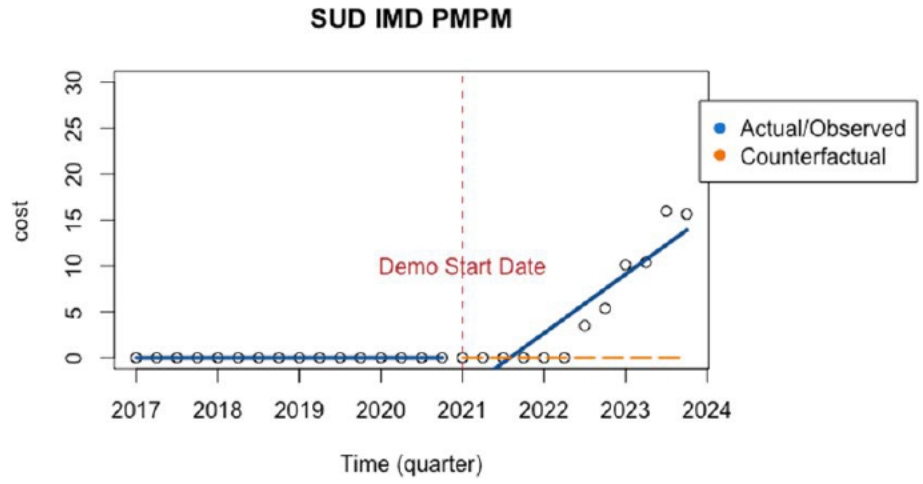
Results show that both temporal and individual factors have statistically significant explanatory power. The general trend over time showed an increase in SUD-related expenditures, the start date of the Demonstration was associated with a decrease, while the sustained effect showed an increase in SUD-related expenditures during the first years of the Demonstration. Older members, members in non-ABD

groups, and members living in rural counties had lower expenditures. Women and members in the expansion population had more SUD-related expenditures.

SUD $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	8.001	2.056	p<0.01
Immediate Effect of Demonstration Start	-80.882	6.445	p<0.01
Sustained Effect	14.458	0.830	p<0.01
Age	-0.471	0.133	p<0.01
Gender (Female)	10.310	3.326	p<0.01
Expansion Group	104.211	4.546	p<0.01
Non-ABD	-61.348	4.217	p<0.01
Rural	-97.294	3.429	p<0.01
Constant	-15,795.720	4,151.287	p<0.01

SUD-IMD PMPM

There were no SUD-IMD Medicaid expenditures prior to the Demonstration. The ITS showed an immediate and sustained increase in expenditures during the Demonstration period.



SUD IMD $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.00	0.38	None
Immediate Effect of Demonstration Start	-5.34	1.36	p<0.01
Sustained Effect	1.60	0.17	p<0.01
Constant	0.00	765.29	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

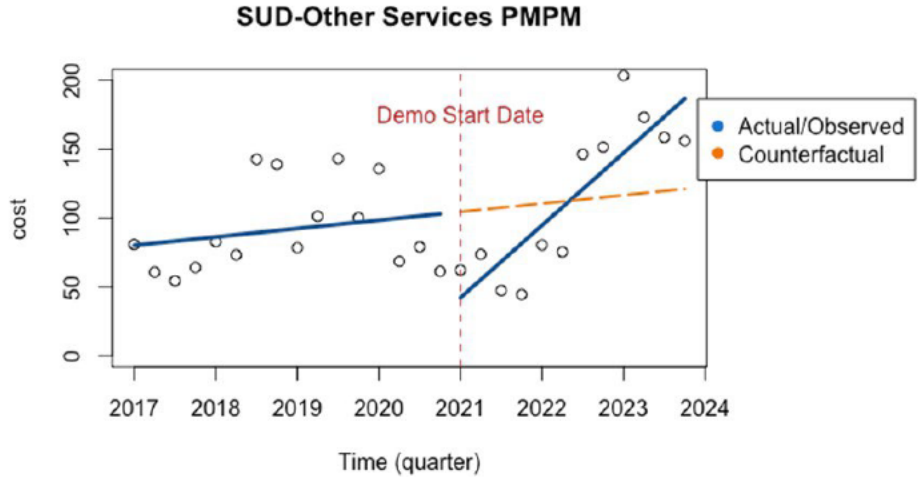
Results show both temporal and individual factors have statistically significant explanatory power. The general trend and Demonstration period showed an increase in SUD-IMD expenditures. Women and

members living in rural counties had lower SUD-IMD expenditures. Expansion group members had higher SUD-IMD expenditures.

SUD IMD $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.570	0.159	p<0.01
Immediate Effect of Demonstration Start	-5.870	0.499	p<0.01
Sustained Effect	1.751	0.064	p<0.01
Age	-0.015	0.010	None
Gender (Female)	-3.871	0.258	p<0.01
Expansion Group	4.535	0.352	p<0.01
Non-ABD	0.094	0.327	None
Rural	-2.857	0.266	p<0.01
Constant	1,153.826	321.537	p<0.01

Other SUD-Related PMPM

The PMPM for other SUD services showed a statistically significant decrease associated with the start of the Demonstration and a sustained increase over the first few years of the Demonstration.



SUD Other $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	6.07	6.78	None
Immediate Effect of Demonstration Start	-73.97	24.34	p<0.01
Sustained Effect	11.62	3.12	p<0.01
Constant	-12,160.88	13,687.82	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results show expenditures on other SUD treatment services increasing over time. Older members, women, members of non-ABD and expansion groups, and members living in rural counties tended to have fewer SUD treatment expenditures.

SUD Other $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	34.827	4.877	p<0.01
Immediate Effect of Demonstration Start	-18.740	15.285	None
Sustained Effect	-0.793	1.967	None
Age	-2.446	0.316	p<0.01
Gender (Female)	-39.579	7.887	p<0.01
Expansion Group	-601.593	10.783	p<0.01
Non-ABD	-659.572	10.001	p<0.01
Rural	-163.375	8.133	p<0.01
Constant	-69,196.570	9,845.442	p<0.01

Measure 7.1.3 Per member per month (PMPM) cost of physical health care for individuals who have an SUD.

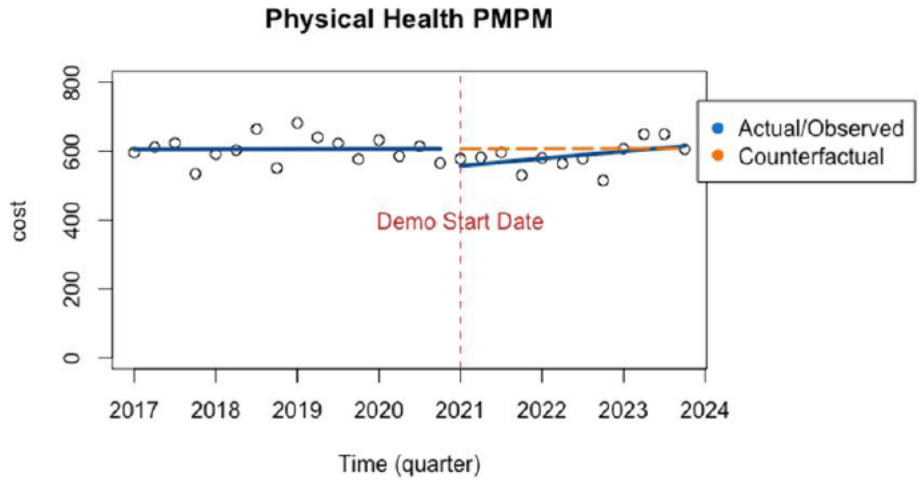
Question 7. How does the cost of care change over time?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for physical health care for members with an SUD divided the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: There were no statistically significant trends related to expenditures for physical health care.



Physical Health $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.50	8.53	None
Immediate Effect of Demonstration Start	-54.39	30.63	None
Sustained Effect	5.08	3.92	None
Constant	-396.26	17,223.35	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Results showed a statistically significant increase in physical health related expenditures over time. Older members, women, expansion group, non-ABD groups and members living in rural counties all showed statistically significant explanatory power for lower physical health related expenditures.

Physical Health $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	34.827	4.877	p<0.01
Immediate Effect of Demonstration Start	-18.740	15.285	None
Sustained Effect	-0.793	1.967	None
Age	-2.446	0.316	p<0.01
Gender (Female)	-39.579	7.887	p<0.01
Expansion Group	-601.593	10.783	p<0.01
Non-ABD	-659.572	10.001	p<0.01
Rural	-163.375	8.133	p<0.01
Constant	-69,196.570	9,845.442	p<0.01

A summary of the ITS trends in the aggregate analyses related to evaluation question seven is provided below.

Measure	General Trend	Immediate Effect	Sustained Effect
Expenditure Analyses – Total Cost			
7.1.1. Total PMPM	-	↓	↑
7.1.2(a) SUD PMPM	↑	↓	↑
7.1.2(b) SUD IMD PMPM	-	↓	↑
7.1.2(c) SUD Other PMPM	-	↓	↑
7.1.3. Physical Health PMPM	-	-	-

Notes:
- No statistically significant trend
↑Statistically significant increase in trend
↓Statistically significant decrease in trend

A summary of the Generalized Linear Model Results (i.e., how individual factors contribute to the variation in the data) related to evaluation question seven, is presented below.

Measure	General Trend	Immediate Effect	Sustained Effect	Age (Older)	Gender (Female)	Expansion Group	Non-ABD	Rural Counties
Expenditure Analyses – Total Cost								
7.1.1. Total PMPM	↑	↓	↑	↓	↓	↓	↓	↓
7.1.2(a) SUD PMPM	↑	↓	↑	↓	↑	↑	↓	↓
7.1.2(b) SUD IMD PMPM	↓	↓	↑	-	↓	↑	-	↓
7.1.2(c) SUD Other PMPM	↑	-	-	↓	↓	↓	↓	↓
7.1.3. Physical Health PMPM	↑	-	-	↓	↓	↓	↓	↓

Notes:
- No statistically significant trend
↑Statistically significant explanatory power
↓Statistically significant explanatory power

H. SUD EVALUATION QUESTION EIGHT

What are the cost drivers?

Evaluation question eight includes an exploratory analysis to examine cost drivers for expenditures related to SUD. A summary of the measures examined under evaluation question eight is provided below.

8.1.1. Per member per month (PMPM) cost of outpatient (non-ED) for members with an SUD during the measurement year
8.1.2 Per member per month (PMPM) cost of pharmacy for members with an SUD during the measurement year
8.1.3 Per member per month (PMPM) cost of outpatient ED for members with an SUD during the measurement year
8.1.4 Per member per month (PMPM) cost of inpatient care for members with an SUD during the measurement year
8.1.5 Per member per month (PMPM) cost of Long-term care for members with an SUD during the measurement year

Measure 8.1.1 Per member per month (PMPM) cost of outpatient (non-ED) for individuals who have an SUD.

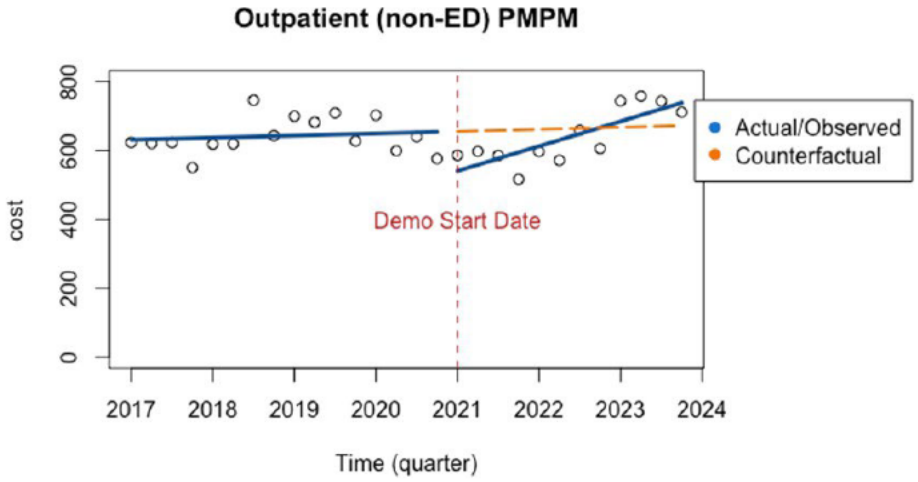
Question 8. What are the cost drivers?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for outpatient care (non-ED) for members with an SUD divided the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: There was a statistically significant decrease in expenditures for outpatient services associated with the start of the Demonstration. The first few years of the Demonstration were associated with an increase in outpatient service expenditures.



Outpatient $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	6.07	11.32	None
Immediate Effect of Demonstration Start	-131.40	40.63	p<0.01
Sustained Effect	16.48	5.20	p<0.01
Constant	-11,620.77	22,847.17	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

The generalized linear model shows a statistically significant increase in outpatient expenditures over time. Older members, women, expansion group, non-ABD groups and members living in rural counties all showed statistically significant explanatory power for fewer outpatient expenditures.

Outpatient $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	34.827	4.877	p<0.01
Immediate Effect of Demonstration Start	-18.740	15.285	None
Sustained Effect	-0.793	1.967	None
Age	-2.446	0.316	p<0.01
Gender (Female)	-39.579	7.887	p<0.01
Expansion Group	-601.593	10.783	p<0.01
Non-ABD	-659.572	10.001	p<0.01
Rural	-163.375	8.133	p<0.01
Constant	-69,196.570	9,845.442	p<0.01

Measure 8.1.2 Per member per month (PMPM) cost of pharmacy for individuals who have an SUD.

Question 8. What are the cost drivers?

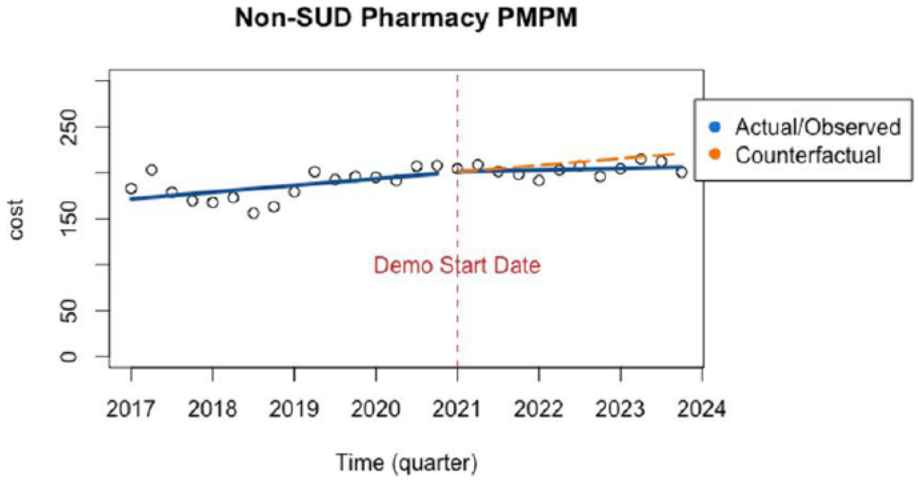
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for pharmacy services for members with an SUD divided the total number of member months with breakouts for non-SUD and SUD-related pharmacy expenditures.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: Non-SUD-related pharmacy expenditures showed a statistically significant increase over time.



Non-SUD Pharmacy $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	7.31	2.55	p<0.01
Immediate Effect of Demonstration Start	1.60	9.16	None
Sustained Effect	-1.37	1.17	None
Constant	-14,581.49	5,150.28	p<0.01

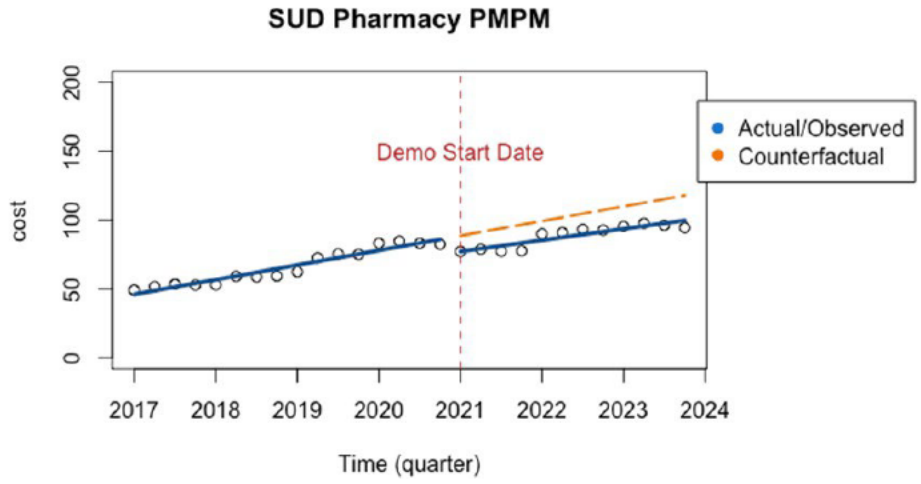
A generalized linear model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Non-SUD related pharmacy expenditures showed a statistically significant increase over time. Older members, members in the non-ABD, and expansion group members showed less non-SUD related pharmacy expenditures. Women and members living in rural counties had more non-SUD pharmacy expenditures.

Non-SUD Pharmacy $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	5.557	1.528	p<0.01
Immediate Effect of Demonstration Start	1.143	4.789	None
Sustained Effect	-0.593	0.616	None
Age	-0.319	0.099	p<0.01
Gender (Female)	40.738	2.471	p<0.01
Expansion Group	-19.154	3.378	p<0.01
Non-ABD	-101.695	3.134	p<0.01
Rural	6.118	2.548	p<0.05
Constant	-11,001.420	3,084.703	p<0.01

SUD-Related Pharmacy PMPM

SUD-related pharmacy expenditures showed a general increase in trend over time. There was a decrease in expenditures associated with the start date of the Demonstration, the sustained effect was not statistically significant.



SUD-Pharmacy $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	10.64	0.77	p<0.01
Immediate Effect of Demonstration Start	-10.83	2.78	p<0.01
Sustained Effect	-0.61	0.36	None
Constant	-21,414.92	1,563.52	p<0.01

A generalized linear model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

SUD-related pharmacy expenditures showed a statistically significant increase over time. There was a decrease associated with the start date of the Demonstration and a sustained increase during the first few years of the Demonstration period. Older members had fewer SUD-related pharmacy expenditures. Women, expansion group and non-ABD group members, and members living in rural counties had more SUD-related pharmacy expenditures.

SUD-Pharmacy $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	6.127	0.295	p<0.01
Immediate Effect of Demonstration Start	-15.026	0.926	p<0.01
Sustained Effect	0.393	0.119	p<0.01
Age	-0.703	0.019	p<0.01
Gender (Female)	16.049	0.478	p<0.01
Expansion Group	58.817	0.653	p<0.01
Non-ABD	38.473	0.606	p<0.01
Rural	9.211	0.492	p<0.05
Constant	-12,306.390	596.155	p<0.01

Measure 8.1.3 Per member per month (PMPM) cost of outpatient ED for individuals who have an SUD.

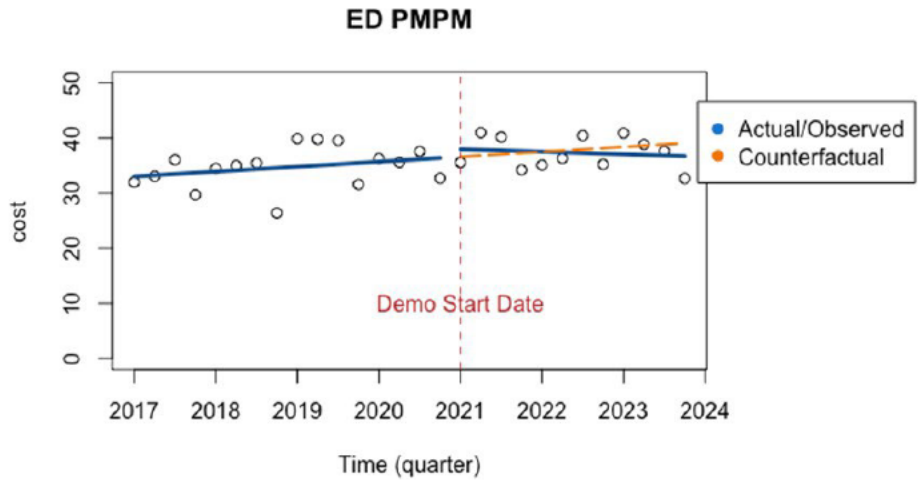
Question 8. What are the cost drivers?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for ED services for members with an SUD divided the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: There were no statistically significant trends related to expenditures on ED use.



ED $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	0.90	0.74	None
Immediate Effect of Demonstration Start	1.73	2.67	None
Sustained Effect	-0.34	0.34	None
Constant	-1,774.59	1,498.43	None

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

Temporal factors provided no explanatory power for ED expenditures. Older members, members in the expansion and non-ABD groups, and members living in rural counties showed fewer ED expenditures. Women had more ED expenditures.

ED $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	0.065	0.281	None
Immediate Effect of Demonstration Start	1.404	0.882	None
Sustained Effect	-0.050	0.113	None
Age	-0.419	0.018	p<0.01
Gender (Female)	1.289	0.455	p<0.01
Expansion Group	-0.462	0.622	None
Non-ABD	-16.956	0.577	p<0.01
Rural	-15.537	0.469	p<0.01
Constant	-66.473	567.907	None

Measure 8.1.4 Per member per month (PMPM) cost of inpatient care for individuals who have an SUD.

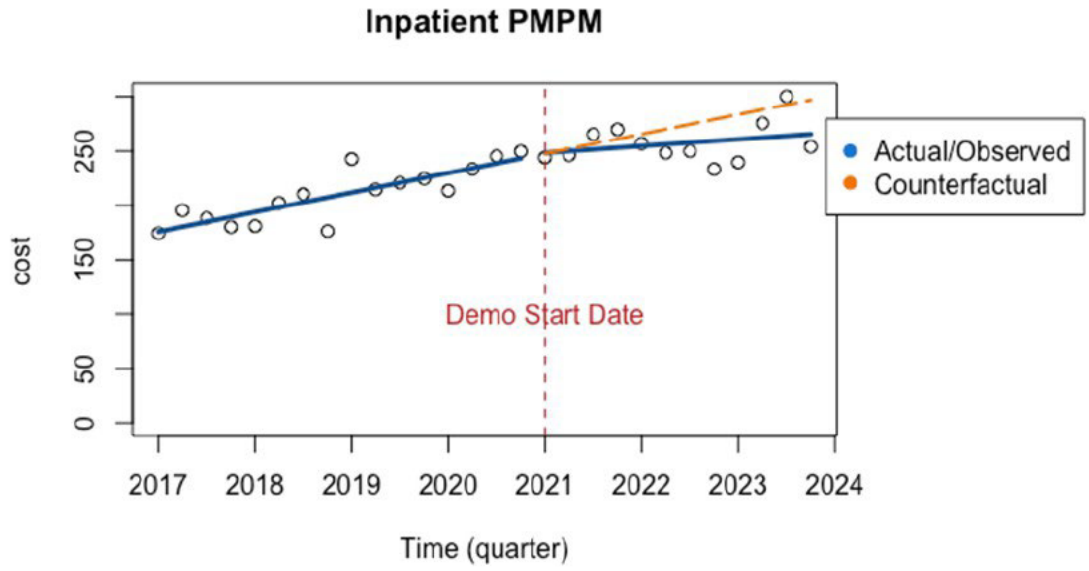
Question 8. What are the cost drivers?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for inpatient care for members with an SUD divided the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend was increasing for inpatient expenditures. There was no immediate or sustained effect of the Demonstration on the trend.



Inpatient $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	17.92	3.48	p<0.01
Immediate Effect of Demonstration Start	3.65	12.50	None
Sustained Effect	-2.93	1.60	None
Constant	-35,973.73	7,030.49	p<0.01

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

The general trend showed an increase in expenditures over time. There was no immediate or sustained effect of the Demonstration. Older members had explanatory power for increased inpatient expenditures. Women, non-ABD groups, and members living in rural counties were associated with fewer inpatient expenditures.

Inpatient $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	11.955	4.203	p<0.01
Immediate Effect of Demonstration Start	3.603	13.173	None
Sustained Effect	-1.308	1.696	None
Age	2.640	0.273	p<0.01
Gender (Female)	-23.319	6.798	p<0.01
Expansion Group	-1.600	9.293	None
Non-ABD	-123.916	8.620	p<0.01
Rural	-58.638	7.010	p<0.01
Constant	-23,959.740	8,485.375	p<0.01

Measure 8.1.5 Per member per month (PMPM) cost of Long-term care for individuals who have an SUD.

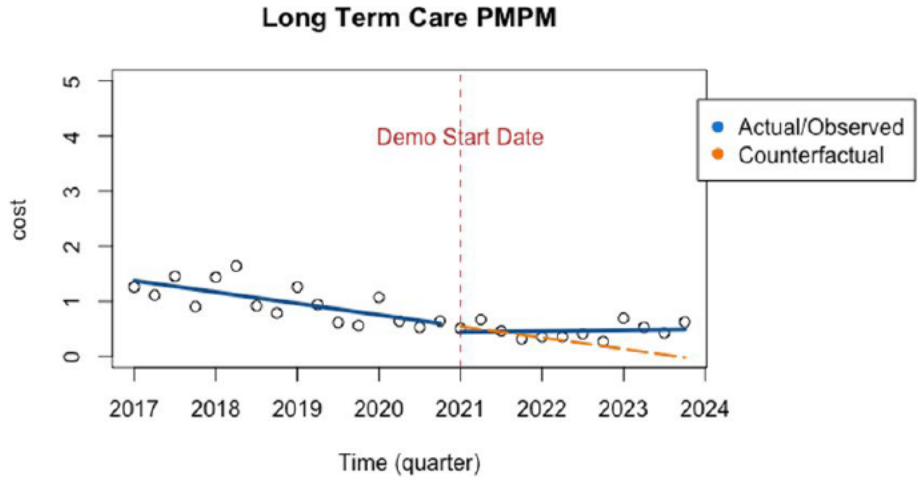
Question 8. What are the cost drivers?
Hypothesis 1. N/A

Measure Description: The sum of all Medicaid payments made for long-term care services for members with an SUD divided by the total number of member months.

Data Source and Time Period: MMIS paid claims 2017-2023.

Analytical Approach: Interrupted Time Series; Generalized Linear Model to control for member demographics.

Findings: The general trend showed a decline in LTC expenditures. The Demonstration period showed a statistically significant sustained increase in LTC expenditures.



LTC $ ITS Model (Aggregate)	Coefficient Estimate	Standard Error	Significance Level
General Trend (Time)	-0.21	0.05	p<0.01
Immediate Effect of Demonstration Start	-0.16	0.17	None
Sustained Effect	0.06	0.02	p<0.05
Constant	417.57	96.07	p<0.01

A generalized linear (GLM) model was used to control for member demographics. Coefficient estimates are presented on the following page. The generalized linear model allows us to explain the variation in utilization attributable to individual demographic factors as well as temporal factors such as the Demonstration start date.

The general trend showed a decline in LTC expenditures. The Demonstration period showed a statistically significant and sustained increase in LTC expenditures. Older members had more LTC expenditures. Expansion and non-ABD groups and members living in rural counties had less LTC expenditures.

LTC $ GLM - Variable	Coefficient Estimate	Standard Error	Significance Level
Quarter (Time)	-0.166	0.052	p<0.01
Immediate Effect of Demonstration Start	-0.098	0.164	None
Sustained Effect	0.048	0.021	p<0.05
Age	0.040	0.003	p<0.01
Gender (Female)	-0.051	0.084	None
Expansion Group	-0.749	0.115	p<0.01
Non-ABD	-0.988	0.107	p<0.01
Rural	-0.444	0.087	p<0.01
Constant	334.786	105.339	p<0.01

A summary of the ITS trends in the aggregate analyses related to evaluation question eight is presented below.

Measure	General Trend	Immediate Effect	Sustained Effect
Expenditure Analyses –Cost Drivers			
8.1.1. Outpatient (non-ED) PMPM	-	↓	↑
8.1.2. (a)Non-SUD Pharmacy PMPM	↑	-	-
8.1.2. (b)SUD Pharmacy PMPM	↑	↓	-
8.1.3 ED PMPM	-	-	-
8.1.4 Inpatient PMPM	↑	-	-
8.1.5 LTC PMPM	↓	-	↑

Notes:
- No statistically significant trend
↑Statistically significant increase in trend
↓Statistically significant decrease in trend

A summary of the Generalized Linear Model Results (i.e., how individual factors contribute to the variation in the data) related to evaluation question eight, is presented below.

Measure	General Trend	Immediate Effect	Sustained Effect	Age (Older)	Gender (Female)	Expansion Group	Non-ABD	Rural Counties
Expenditure Analyses – Cost Drivers								
8.1.1. Outpatient (non-ED) PMPM	↑	-	-	↓	↓	↓	↓	↓
8.1.2(a) SUD Pharmacy PMPM	↑	-	-	↓	↑	↓	↓	↑
8.1.2(b) Non-SUD Pharmacy PMPM	↑	↓	↑	↓	↑	↑	↑	↑
8.1.3 ED PMPM	-	-	-	↓	↑	↓	↓	↓
8.1.4 Inpatient PMPM	↑	-	-	↑	↓	-	↓	↓
8.1.5 LTC PMPM	↓	-	↑	↑	-	↓	↓	↓

Notes:
- No statistically significant trend
↑Statistically significant explanatory power
↓Statistically significant explanatory power

CONCLUSIONS

Trends were examined for 2017-2020 as part of the pre-Demonstration period and 2021-2023 as part of the Demonstration. The interim evaluation findings should be interpreted with caution. The Demonstration start date coincided with the ongoing novel coronavirus PHE (CY2021). 2023 results are considered preliminary, pending a six month claims runout for the final quarter. Results will be updated in the summative evaluation report.

A summary of findings for each evaluation question is presented below. For measures studied using the aggregate ITS approach, hypotheses were deemed supported when:

- The sustained effect of the Demonstration showed no statistically significant change (performance was maintained), regardless of direction, or showed a statistically significant improvement in trend.

For measures studied using an alternative approach (e.g., logistic regression and two sample tests) hypotheses were deemed supported when:

- Preliminary 2023 results showed no change (performance was maintained across years) or showed a statistically significant improvement in performance.

Evaluation Question One

Overall, the percentage of Medicaid members receiving any type of SUD treatment has been increasing over time. The general trend for members receiving outpatient treatment was increasing prior to the Demonstration. A decline in utilization was seen during the first few years of the Demonstration (coinciding with the PHE). Trends for other service types (IOP/PH, inpatient/residential, withdrawal mgt/detox, and MAT) did not yield statistically significant change under the Demonstration. Utilization in three service categories – residential/inpatient services, withdrawal management/detox, and MAT – showed a statistically significant increase as part of the general trend; although no statistically significant change occurred during the Demonstration for these services, increases were maintained. **Hypothesis one, *The Demonstration will maintain or increase utilization of SUD treatment services,* was supported, with five of the six measures maintaining or improving.**

The overall number of Medicaid enrolled providers billing SUD treatment services declined by approximately three percent. However, providers billing MAT increased by nearly 10 percent. **Hypothesis two, *The Demonstration will maintain or increase SUD provider availability*, was partially supported, with one of two measures improving**.

Follow-up after ED visits for alcohol and other drug abuse showed a statistically significant decline during the Demonstration period for both 30 day and 7-day follow-up measures. Women and expansion group members tended to engage in follow-up more often. The evaluator is working with OMS to determine if the measure is impacted by a potential data gap resulting from the increased use of Opioid Health Home services. **Hypothesis three, *The Demonstration will maintain or increase follow-up after ED visits for alcohol and other drug use*, was not supported by the interim results**.

There was no statistically significant change in Members initiating and engaging in treatment under the Demonstration. Women and expansion group members tended to initiate and engage in treatment more often. **Hypothesis four, *The Demonstration will maintain or increase initiation and engagement in SUD treatment,* was supported with two of two measures maintaining pre-Demonstration results.**

It is likely that the results related to the utilization of services and follow-up after the ED were impacted by the PHE. Final results for Demonstration as well as the next five-year study period will help to determine whether declines in service utilization under the PHE are reversed.

Hypothesis/Measure	Analytic Approach	Hypothesis Supported	Statistical Significance
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services			
1.1.1. Members receiving any SUD treatment service	Logistic Regression	Yes	↑
1.1.2. Members receiving SUD outpatient treatment	ITS	No	↓
1.1.3. Members receiving IOP/PH	ITS	Yes	-
1.1.4. Members receiving residential and inpatient	ITS	Yes	-*
1.1.5. Members receiving withdrawal mgt/detox	ITS	Yes	-*
1.1.6. Members receiving MAT	ITS	Yes	-*
Hypotheses 2. The Demonstration will maintain or increase SUD provider availability			
1.2.1 Medicaid SUD treatment providers	T-test	No	↓
1.2.2 Medicaid providers billing MAT	T-test	Yes	↑
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visits for alcohol and other drug use			
1.3.1. ED visits for AOD abuse or dependence with follow-up within 7-days of discharge	ITS	No	↓
1.3.2. ED visits for AOD abuse or dependence with follow-up within 30-days of discharge	ITS	No	↓
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in SUD treatment			
1.4.1. Members ages 18 and older who initiate in SUD treatment	ITS	Yes	-
1.4.1. Members who initiate treatment and engage in SUD treatment	ITS	Yes	-

- No statistically significant change in trend or performance (performance maintained)
-*The general trend shows a statistically significant increase in utilization
↑Statistically significant increase in sustained trend or performance
↓Statistically significant decrease in sustained trend or performance

Evaluation Question Two

In each year studied members who received services from an Opioid Health Home showed stronger performance for continuity of pharmacotherapy (180 days of continuous treatment). **Hypothesis one, *The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for Opioid Health Home members*, was supported.**

Measure	Analytic Approach	Hypothesis Supported	Statistically Significant
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for Opioid Health Home members.			
2.1.1. OHH members who have at least 180 days of continuous OUD treatment	Comparison Strategy	Yes	Yes

Evaluation Question Three

There was no statistically significant change in the percent of members receiving opioids at a high dose during the Demonstration. ***Hypothesis one, The Demonstration will contain or reduce the use of opioids at a high dosage,*** **was supported with the measure maintaining performance.**

In 2023, members who received Accountable Community services showed better results (i.e., lower rates) for the concurrent use of prescription opioids and benzodiazepines. **Hypothesis two, *The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC-attributed members*, was supported.**

Overdose deaths in the Medicaid population began to decline in 2023 as did opioid-related overdose death. Data on the number of PMP users shows a decline over the baseline period; however, the user count for 2023 represented six months of data. In addition, PMP staff report that inactive users were removed from the system and contributed to the change in total prescribers registered in the PMP. The number of inquiries under the prescription monitoring program (PMP) has been steadily increasing in each year of the Demonstration. **Hypothesis three, *The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population* was not supported, with two of the three measures showing a decline in performance.**

Measure	Analytic Approach	Hypothesis Supported	Statistical Significance
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage.			
3.1.2. Percentage of members ages 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more	Logistic Regression	Yes	-
Hypotheses 2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for AC attributed members.			
3.2.2. Percentage of members ages 18 and older eligible for AC participation with concurrent use of prescription opioids and benzodiazepines	Comparison Strategy	Yes	↓*
Hypothesis 3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population.			
3.3.4. The rate of opioid overdose deaths per 1,000 Medicaid members	Proportional T-Test	Yes	↓
3.3.5. The total number of PMP users during the twelve-month measurement period		No	↓**
3.3.6. The total number of PMP inquires performed during the twelve-month measurement period		Yes	↑

**Lower rates are preferred*

***2023 data on prescribers was only available for 6 months of the year*

Evaluation Question Four

The total number of ED visits for SUD showed a statistically significant decline during the Demonstration period. Non-emergent ED visits showed a statistically significant decline immediately following the start of the Demonstration; the sustained change was not significant. **Hypothesis one, *The Demonstration will contain or reduce the rate of preventable ED visits for individuals with SUD*, was supported with two of two measures maintaining or improving performance.**

The total number of inpatient stays showed a statistically significant decline during the Demonstration period. The PQI (i.e., the number of discharges for chronic conditions) showed a decline, the change was not statistically significant. **Hypothesis two, *The Demonstration will contain or reduce preventable inpatient admissions,* was supported, with both measures maintaining or improving performance.**

Continued study is warranted to ensure that the decline in ED and Inpatient use is sustained in the coming years and not due to members avoiding the ED or hospital during the PHE.

Hypothesis/Measure	Analytic Approach	Hypothesis Supported	Statistical Significance
Hypothesis 1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD			
4.1.1. Total number of ED visits for SUD per 1,000 members	ITS	Yes	Yes
4.1.1. The rate of non-emergent ED visits per 1,000 member months	ITS	Yes	-*
Hypotheses 2. The Demonstration will contain or reduce preventable inpatient admissions			
4.2.1. Total number of inpatient stays for SUD per 1,000 members	ITS	Yes	Yes
4.2.2. Prevention Quality Chronic Composite (PQI #92)	ITS	Yes	-*

- No statistically significant change in trend or performance (maintained)
-*The general trend shows a statistically significant improvement in performance

Evaluation Question Five

In each year studied, members who received Health Home services showed the same or fewer readmissions for SUD treatment than the comparison group. The differences were not statistically significant in any year. The trend for unplanned readmissions for all causes did not change during the Demonstration period. **Hypothesis one, *The Demonstration will contain or reduce readmissions to the same of higher levels of care*, was supported, with two of the two measures maintaining performance.**

Hypothesis/Measure	Analytic Approach	Hypothesis Supported	Statistical Significance
Hypothesis 1. The Demonstration will contain or reduce the readmissions to the same or higher levels of care			
5.1.1. Percentage of readmission to the same or higher level of residential care	Comparison Strategy	Yes	-
5.1.2. The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis	ITS	Yes	-

Evaluation Question Six

In each year studied members who received Health Home services showed more visits for ambulatory and preventive care than those in the comparison group. **Hypothesis one, *The Demonstration will maintain or increase access to care for physical health conditions for health home enrollees*, was supported**

Hypothesis/Measure‡	Analytic Approach	Hypothesis Supported	Statistical Significance
Hypothesis 1. Demonstration will maintain or increase access to care for physical health conditions for health home enrollees			
6.1.1. Percentage of members with a SUD who had an ambulatory or preventive health care visit	Comparison Strategy	Yes	Yes

Exploratory Expenditure Analysis (Evaluation Questions 7-8)

Immediately following the start of the Demonstration there was a decline in the total cost of care and SUD-related expenditures. The sustained effect of the Demonstration period showed a statistically significant increase in all categories, apart from physical health care.

The generalized linear model showed that older members and members residing in rural counties had fewer expenditures in every category. Expansion group members showed statistically significant explanatory power for increased SUD IMD related expenditures. Women and expansion group members had statistically significant explanatory power for increased SUD-related expenditures.

There were no statistically significant sustained changes in expenditures for inpatient, ED or pharmacy services during the Demonstration period. Both outpatient care (non-ED) and LTC services did show increases in expenditures during the Demonstration period.

Interim Conclusion

When 50 percent or more of the measures studied maintained or improved performance, the evaluation question was considered supported.

Evaluation Question	Measures Maintaining or Improving Performance	Interim Finding
Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD?	67% (8/12)	Supported
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	100% (1/1)	Supported
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	80% (4/5)	Supported
Evaluation Question 4. Does the Demonstration contain or reduce ED visits and inpatient hospitalizations for individuals with a SUD?	100% (4/4)	Supported
Evaluation Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	100% (1/1)	Supported
Evaluation Question 6. Does the Demonstration maintain or improve access to care for physical health conditions?	100% (1/1)	Supported

.INTERPRETATIONS, AND POLICY IMPLICATIONS AND INTERACTIONS WITH OTHER STATE INITIATIVES

In advance of its application to CMS for the SUD-IMD Demonstration authority in 2019, the State of Maine had been engaged in extensive assessment of the SUD treatment system. The DHHS sponsored both internal and independent external reviews of capacity, success and barriers to treatment. These discussions and reviews were followed by: the implementation of Medicaid expansion (effective July 1, 2018); expanded coverage of MAT, with methadone and office-based buprenorphine available in a variety of settings including in the ED; and building on the existing Behavioral Health Home model by adding the Opioid Health Home program in 2017.

Seeking authority for the reimbursement of services provided for adults in IMDs was one part of a comprehensive effort to improve the SUD service delivery system. Supporting SUD residential treatment at every level of the American Society for Addition Medicine (ASAM) continuum of care allowed the State to fill gaps in capacity that had been identified in the Medicaid delivery system.

During the first year of the Demonstration the State completed a rate study and subsequently increased rates for intensive outpatient treatment in DY2. In DY2 and DY3, the State also issued several behavioral health funding opportunities to increase residential treatment for SUD.

The first award was for $4 million to support the capital costs necessary to increase residential treatment for (SUD) capacity. The second award was for $2 million to support start-up costs. A third award of $2.5 million was made available to support both capital and start-up costs. As a result, 64 beds opened at the end of 2023 and 108 new beds are expected by the end 2024, for a cumulative total of 172 new treatment beds for SUD by the end of the Demonstration.

As part of the SUD Implementation plan, the State continued its support for MAT induction EDs (e.g., training on implementation of rapid induction, warm-hand offs to community-based treatment). At the outset of the Demonstration, 23 of Maine's EDs offered induction for MAT. By the end of DY2, the number of EDs offering induction had increased to 26 offering services MAT 24/7 and one offering MAT when prescribers are available. Five EDs do not offer MAT induction.

A treatment locator tool to assist with appropriate and timely access to SUD treatment was launched in 2023. OMS added requirements under its value-based purchasing initiative for Primary Care Health Homes to provide screening, brief intervention, and referral to treatment for SUD/OUD, effective July 1, 2023.

This long-term and sustained focus on the SUD treatment needs and delivery system provided a strong foundation for improvements under the Demonstration. While increases in utilization were not immediately observed, the maintenance of performance and improvement in several areas should be seen as a success considering the overlap of the PHE during the Demonstration period.

.LESSONS LEARNED AND RECOMMENDATIONS

Maintaining pre-Demonstration utilization levels for SUD treatment during the pandemic should be considered a success under the Demonstration. Statistically significant declines in performance were evident for six measures, four of which were likely impacted by provider availability during the PHE and two of which were caused by issues related to data availability.

Under evaluation question one, declines were seen in four measures related to access: utilization of outpatient treatment; the number of Medicaid enrolled SUD treatment providers; and follow-up after visiting the ED for SUD (within 7 and 30 days). The decreases in each of these areas coincide with the PHE. In addition, the evaluator is working with OMS to determine if the measure is impacted by a potential data gap resulting from the increased use of Opioid Health Home services. Modifications to the measure specifications or in the analytic approach such as controlling for OHH participation may be considered for the summative evaluation.

Under evaluation three, declines were seen in the number of PMP users. The change in the number of PMP users was caused, in part, by the removal of inactive accounts from the monitoring system and the availability of only six months of data for prescribers in 2023. PMP inquiries continued to increase year over year. The overall death rate as well as opioid-related deaths in the Medicaid population began to decline in 2023.

Prior to and during the Demonstration period, the State of Maine made sustained and long-term investments in SUD treatment and recovery system. This focus on sustaining the full continuum of care provided a strong foundation and likely contributed to maintaining pre-Demonstration trends during the PHE.

Finalizing 2023 results, the inclusion of 2024 data and additional years under the renewed Demonstration will be important to understand if utilization and engagement in treatment show further improvements.

ATTACHMENTS

A. EVALUATION MEASURES AND CHANGES

Original Measure Name (Steward Reference)	Data Source	Analytic Approach	Interim Report Changes
Evaluation Question 1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? **a. How does service utilization vary by age and aid category code?** **b. How does utilization vary by service type?**			
Hypothesis 1. The Demonstration will maintain or increase utilization of SUD treatment services			
Percentage of members receiving any SUD treatment service (SUD MP #6 modified)	Claims	ITS; T-test	None
Percentage of members receiving SUD outpatient treatment services (SUD MP #8 modified)	Claims	ITS; T-test	None
Percentage of members receiving intensive outpatient (IOP) treatment and partial hospitalization (PH) services (SUD MP #9 modified)	Claims	ITS; T-test	None
Percentage of members receiving residential and inpatient treatment services (SUD MP #10 modified)	Claims	ITS; T-test	None
Percentage of members receiving withdrawal management services (SUD MP #11 modified)	Claims	ITS; T-test	None
Percentage of members receiving medication-assisted treatment (MAT) (SUD MP #12 modified)	Claims	ITS; T-test	None
Hypothesis 2. The Demonstration will maintain or increase SUD provider availability			
Percentage of licensed SUD providers enrolled in Medicaid	Medicaid Enrollment Files; State Licensing Records	ITS; T-test	Detailed information on the number of licensed providers statewide was not available. Data reported for SUD MP Metric 13 (Number of Medicaid providers billing SUD treatment) was used. Data collection for SUD MP #13 and 14 began in 2021, therefore there were insufficient observations for ITS; t-test was used in place of an ITS analysis
Percentage of providers enrolled in Medicaid and qualified to deliver MAT services (SUD MP #14 modified)	Medicaid Enrollment Files	ITS; T-test	Data collection for SUD MP #14 began in 2021, therefore there were insufficient observations for ITS; t-test was used in place of an ITS analysis
Hypothesis 3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug (AOD) dependence			
Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 7-days of discharge (SUD MP #17(1))	Claims	ITS; T-test	None
Percentage of ED visits for AOD abuse or dependence for which the member received follow-up within 30-days of discharge (SUD MP #17(1))	Claims	ITS; T-test	None
Hypothesis 4. The Demonstration will maintain or increase initiation and engagement in treatment			
Percentage of members ages 18 and older with a new episode of AOD abuse or dependence who initiate in SUD treatment (SUD MP #15a)	Claims	ITS; T-test	None

Original Measure Name (Steward Reference)	Data Source	Analytic Approach	Interim Report Changes
Percentage of members with a new episode of alcohol and other drug abuse or dependence who engage in SUD treatment (SUD MP #15b)	Claims	ITS; T-test	None
Evaluation Question 2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?			
Hypothesis 1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for OHH enrollees			
Percentage of members ages 18 and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment (SUD MP #22)	Claims	PSM/CEM w/T-test (OHH)	None
Evaluation Question 3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?			
Hypothesis 1. The Demonstration will contain or reduce the use of opioids at a high dosage			
Percentage of members aged 18 and older who receive prescriptions for opioids with an average daily dose greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more (SUD MP #18)	Claims; PMP	ITS; T-test	Quarterly analysis does not allow for adherence to the technical specifications (e.g., the index event must occur 90 days before the end of the measurement period). ITS analysis was replaced with logistic regression for Demonstration years 2021 – 2025.
Hypothesis 2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for ACO attributed members			
Percentage of members aged 18 and older with concurrent use of prescription opioids and benzodiazepines (SUD MP #21)	Claims; PMP	PSM/CEM w/T-test (ACO)	None
Hypothesis 3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population			
The rate of opioid overdose deaths per 1,000 Medicaid members (SUD MP #27 OUD subgroup)	Eligibility Files; Data, Research and Vital Statistics (DVRS)	ITS; T-test	Data collection for SUD MP #27 began in 2021; test of proportionality was used in place of an ITS analysis
The total number of PMP users during the twelve-month measurement period	PMP	T-test (% change)	None
The total number of PMP inquires performed during the twelve-month measurement period	PMP	T-test (% change)	
Evaluation Question 4. Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD? **a. How does utilization vary by age, aid category code?** **b. How does utilization vary by geographic characteristics (e.g., rural v. urban)?** **c. How does utilization vary when MAT induction in the ED is offered?**			
Hypothesis 1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD			

Original Measure Name (Steward Reference)	Data Source	Analytic Approach	Interim Report Changes
Total number of ED visits for SUD per 1,000 members (SUD MP #23)	Claims	ITS; Pre/Post MAT; T-test test	Start dates for MAT providers in the ED were not recorded; pre/post subsidiary analysis of MAT in the ED could not be performed.
The rate of non-emergent ED visits per 1,000 member months (OMS Non-emergent ED use)	Claims	ITS; T-test	None
Hypothesis 2. The Demonstration will contain or reduce preventable inpatient admissions			
Total number of inpatient stays for SUD per 1,000 members (SUD MP #24)	Claims	ITS; T-test	None
Prevention Quality Chronic Composite (PQI #92)	Claims	ITS; T-test	None
Evaluation Question 5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?			
Hypothesis 1. The Demonstration will contain or reduce readmissions to the same or higher levels of care			
Percentage of readmission to the same or higher level of residential care (SUD MP #25 modified)	Claims	PSM/CEM w/T-test (HH)	None
The rate of adult acute inpatient and observation stays that were followed by an unplanned acute readmission for any diagnosis (HEDIS – PCR)	Claims	ITS; T-test	None
Evaluation Question 6. Does the Demonstration maintain or improve access to care for physical health conditions?			
Hypothesis 1. The Demonstration will maintain or increase access to care for physical health conditions for health home enrollees			
Percentage of members with a SUD who had an ambulatory or preventive health care visit (SUD MP #32)	Claims	PSM/CEM w/T-test (HH	None
Percentage of members with a SUD who had an ambulatory or preventive health care visit (SUD MP #32)	Claims	PSM/CEM w/T-test (TCM)	A comparison group of members who are eligible for TCM and did not receive a service was not identifiable. In addition, service use is declining as members enter the Opioid and Behavioral Health Home programs. Measure was removed from the study.
Evaluation Question 7. How does the cost of SUD services change over time?			
Hypothesis: N/A Exploratory			
Per member per month (PMPM) Medicaid cost for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of SUD-Related treatment for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of physical health care for members with an SUD during the measurement year	Claims	ITS	None
Evaluation Question 8. What are the cost drivers?			
Hypothesis: N/A Exploratory			

Original Measure Name (Steward Reference)	Data Source	Analytic Approach	Interim Report Changes
Per member per month (PMPM) cost of outpatient (non-ED) for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of pharmacy for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of outpatient ED for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of inpatient care for members with an SUD during the measurement year	Claims	ITS	None
Per member per month (PMPM) cost of Long-term care for members with an SUD during the measurement year	Claims	ITS	None

B. NON-EMERGENT ED USE

OMS maintains the specifications for non-emergent ED use as described below.

Non-Emergent ED Use	
Denominator	Any outpatient claims with the following: CPT Code: 99281,99282,99283,99284,99285 or Revenue Code: 0450,0451,0452,0456,0459,0981 or ED Procedure CPT Code with a Place of Service of 23
Numerator	Claims with a primary diagnosis code listed in Table 1 below (non-emergent)

Table 1. Non-Emergent Diagnosis Code List	
Code	Description
B97.10	Unspecified enterovirus as the cause of diseases classified elsewhere
B97.89	Other viral agents as the cause of diseases classified elsewhere
F41.1	Generalized anxiety disorder
F41.9	Anxiety disorder, unspecified
G44.1	Vascular headache, not elsewhere classified
G93.3	Post viral fatigue syndrome
H10.30	Unspecified acute conjunctivitis, unspecified eye
H10.31	Unspecified acute conjunctivitis, right eye
H10.32	Unspecified acute conjunctivitis, left eye
H10.33	Unspecified acute conjunctivitis, bilateral
H10.9	Unspecified conjunctivitis
H60.00	Abscess of external ear, unspecified ear
H60.01	Abscess of the right external ear
H60.02	Abscess of the left external ear
H60.03	Abscess of external ear, bilateral
H60.10	Cellulitis of external ear, unspecified ear
H60.11	Cellulitis of right external ear
H60.12	Cellulitis of left external ear
H60.13	Cellulitis of external ear, bilateral
H60.311	Diffuse otitis externa, right ear
H60.312	Diffuse otitis externa, left ear
H60.313	Diffuse otitis externa, bilateral
H60.319	Diffuse otitis externa, unspecified ear
H60.321	Hemorrhagic otitis externa, right ear
H60.322	Hemorrhagic otitis externa, left ear
H60.323	Hemorrhagic otitis externa, bilateral
H60.329	Hemorrhagic otitis externa, unspecified ear
H60.391	Other infective otitis externa, right ear
H60.392	Other infective otitis externa, left ear
H60.393	Other infective otitis externa, bilateral
H60.399	Other infective otitis externa, unspecified ear
H65.00	Acute serous otitis media, unspecified ear

Table 1. Non-Emergent Diagnosis Code List	
Code	Description
H65.01	Acute serous otitis media, right ear
H65.02	Acute serous otitis media, left ear
H65.03	Acute serous otitis media, bilateral
H65.04	Acute serous otitis media, recurrent, right ear
H65.05	Acute serous otitis media, recurrent, left ear
H65.06	Acute serous otitis media, recurrent, bilateral
H65.07	Acute serous otitis media, recurrent, unspecified ear
H65.90	Unspecified nonsuppurative otitis media, unspecified ear
H65.91	Unspecified nonsuppurative otitis media, right ear
H65.92	Unspecified nonsuppurative otitis media, left ear
H65.93	Unspecified nonsuppurative otitis media, bilateral
H66.001	Acute suppurative otitis media without spontaneous rupture of ear drum, right ear
H66.002	Acute suppurative otitis media without spontaneous rupture of ear drum, left ear
H66.003	Acute suppurative otitis media without spontaneous rupture of ear drum, bilateral
H66.004	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear
H66.005	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, left ear
H66.006	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral
H66.007	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, unspecified ear
H66.009	Acute suppurative otitis media without spontaneous rupture of ear drum, unspecified ear
H66.90	Otitis media, unspecified, unspecified ear
H66.91	Otitis media, unspecified, right ear
H66.92	Otitis media, unspecified, left ear
H66.93	Otitis media, unspecified, bilateral
J01.90	Acute sinusitis, unspecified
J01.91	Acute recurrent sinusitis, unspecified
J02.0	Streptococcal pharyngitis
J02.8	Acute pharyngitis due to other specified organisms
J02.9	Acute pharyngitis, unspecified
J03.00	Acute streptococcal tonsillitis, unspecified
J03.01	Acute recurrent streptococcal tonsillitis
J06.9	Acute upper respiratory infection, unspecified
J20.0	Acute bronchitis due to Mycoplasma pneumoniae
J20.1	Acute bronchitis due to Hemophilus influenzae
J20.2	Acute bronchitis due to streptococcus
J20.3	Acute bronchitis due to coxsackievirus
J20.4	Acute bronchitis due to parainfluenza virus
J20.5	Acute bronchitis due to respiratory syncytial virus
J20.6	Acute bronchitis due to rhinovirus
J20.7	Acute bronchitis due to echovirus

Table 1. Non-Emergent Diagnosis Code List	
Code	Description
J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J32.9	Chronic sinusitis, unspecified
J40	Bronchitis, not specified as acute or chronic
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J44.9	Chronic obstructive pulmonary disease, unspecified
J45.20	Mild intermittent asthma, uncomplicated
J45.21	Mild intermittent asthma with (acute) exacerbation
J45.30	Mild persistent asthma, uncomplicated
J45.31	Mild persistent asthma with (acute) exacerbation
J45.40	Moderate persistent asthma, uncomplicated
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.50	Severe persistent asthma, uncomplicated
J45.51	Severe persistent asthma with (acute) exacerbation
J45.901	Unspecified asthma with (acute) exacerbation
J45.909	Unspecified asthma, uncomplicated
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.998	Other asthma
L20.0	Besnier's prurigo
L20.81	Atopic neurodermatitis
L20.82	Flexural eczema
L20.84	Intrinsic (allergic) eczema
L20.89	Other atopic dermatitis
L20.9	Atopic dermatitis, unspecified
L22	Diaper dermatitis
L23.7	Allergic contact dermatitis due to plants, except food
L23.9	Allergic contact dermatitis, unspecified cause
L24.7	Irritant contact dermatitis due to plants, except food
L24.9	Irritant contact dermatitis, unspecified cause
L25.5	Unspecified contact dermatitis due to plants, except food
L25.9	Unspecified contact dermatitis, unspecified cause
L30.0	Nummular dermatitis
L30.2	Cutaneous autosensitization
L30.8	Other specified dermatitis
L30.9	Dermatitis, unspecified
M25.50	Pain in unspecified joint
M25.512	Pain in left shoulder
M25.519	Pain in unspecified shoulder
M25.521	Pain in right elbow
M25.522	Pain in left elbow
M25.529	Pain in unspecified elbow
M25.531	Pain in right wrist
M25.532	Pain in left wrist

Table 1. Non-Emergent Diagnosis Code List	
Code	Description
M25.539	Pain in unspecified wrist
M25.551	Pain in right hip
M25.552	Pain in left hip
M25.559	Pain in unspecified hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M25.569	Pain in unspecified knee
M25.571	Pain in right ankle and joints of right foot
M25.572	Pain in left ankle and joints of left foot
M25.579	Pain in unspecified ankle and joints of unspecified foot
M54.5	Low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M60.80	Other myositis, unspecified site
M60.811	Other myositis, right shoulder
M60.812	Other myositis, left shoulder
M60.819	Other myositis, unspecified shoulder
M60.821	Other myositis, right upper arm
M60.822	Other myositis, left upper arm
M60.829	Other myositis, unspecified upper arm
M60.831	Other myositis, right forearm
M60.832	Other myositis, left forearm
M60.839	Other myositis, unspecified forearm
M60.841	Other myositis, right hand
M60.842	Other myositis, left hand
M60.849	Other myositis, unspecified hand
M60.851	Other myositis, right thigh
M60.852	Other myositis, left thigh
M60.859	Other myositis, unspecified thigh
M60.861	Other myositis, right lower leg
M60.862	Other myositis, left lower leg
M60.869	Other myositis, unspecified lower leg
M60.871	Other myositis, right ankle and foot
M60.872	Other myositis, left ankle and foot
M60.879	Other myositis, unspecified ankle and foot
M60.88	Other myositis, other site
M60.89	Other myositis, multiple sites
M60.9	Myositis, unspecified
M79.1	Myalgia
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.603	Pain in arm, unspecified
M79.604	Pain in right leg
M79.605	Pain in left leg

Table 1. Non-Emergent Diagnosis Code List	
Code	Description
M79.606	Pain in leg, unspecified
M79.609	Pain in unspecified limb
M79.621	Pain in right upper arm
M79.622	Pain in left upper arm
M79.629	Pain in unspecified upper arm
M79.631	Pain in right forearm
M79.632	Pain in left forearm
M79.639	Pain in unspecified forearm
M79.641	Pain in right hand
M79.642	Pain in left hand
M79.643	Pain in unspecified hand
M79.644	Pain in right finger(s)
M79.645	Pain in left finger(s)
M79.646	Pain in unspecified finger(s)
M79.651	Pain in right thigh
M79.652	Pain in left thigh
M79.659	Pain in unspecified thigh
M79.661	Pain in right lower leg
M79.662	Pain in left lower leg
M79.669	Pain in unspecified lower leg
M79.671	Pain in right foot
M79.672	Pain in left foot
M79.673	Pain in unspecified foot
M79.674	Pain in right toe(s)
M79.675	Pain in left toe(s)
M79.676	Pain in unspecified toe(s)
M79.7	Fibromyalgia
R05	Cough
R21	Rash and other nonspecific skin eruption
R51	Headache
R53.0	Neoplastic (malignant) related fatigue
R53.1	Weakness
R53.81	Other malaise

C. INDEPENDENT EVALUATOR

DHHS partnered with the New England States Consortium Systems Organization (NESCSO) to conduct a procurement for this project. NESCSO issued a Request for Proposals (RFP) on October 2, 2020, on behalf of the State. One RFP was released for all evaluation activities (evaluation design development and implementation) and the production of required CMS reports. Bidders were given the option of working with a subcontractor on the design or implementation components of the procurement. The successful bidder demonstrated, at a minimum, the following qualifications:

- The extent to which the evaluator can meet the RFP's minimum requirements, including an assurance that the firm does not have a conflict of interest in designing and performing the SUD evaluation;
- The extent to which the evaluator has sufficient capacity to conduct the proposed evaluation, in terms of technical experience and the size/scale of the evaluation;
- The evaluator's prior experience with similar evaluations;
- Past references; and
- Value (i.e., the evaluator's capacity to conduct the proposed evaluation, with consideration given to those that offer higher quality at a lower cost).

Four proposals were received, and Pacific Health Policy Group has been retained by NESCSO to develop the SUD Demonstration Evaluation Design and implement the final evaluation activities in compliance with CMS requirements, including no conflict of interest.

D. COARSENED EXACT MATCHING BALANCE TABLES

After matching, the evaluator compared the two groups to determine if there were statistically significant differences in any of the demographic factors used as covariates and compare it to the demographic differences before matching.

Ideally, the evaluator should not find such differences, thereby attributing greater explanatory power to the variation in the metrics of interest to the member's association with the comparison or the treatment group.

The tables provide CEM data, both pre- and post-matching. The post-matching data presents characteristics of the beneficiaries included in the related t-test analysis. Age is shown in years (e.g., 39.5 years of age). Other variables are binary, with the results expressed as a value between 0 and 1. For example, the urban/rural variable classifies members residing in rural areas as "1" and urban areas as "0". The reported value signifies the percent of members with the characteristic designated with a "1" (e.g., an urban/rural value of 0.255 indicates that 25.5 percent of the members reside in a rural area).

Balance tables for each of the measures below, examined using the Coarsened Exact Matching, are presented on the following pages.

2.1.1 Continuity of Pharmacotherapy (Opioid Health Homes)
3.2.1 Concurrent use of Opioids and Benzodiazepines (Accountable Communities)
5.1.1 Readmissions to the same or higher level of care (Opioid and Behavioral Health Homes)
6.1.1 Ambulatory/Preventive Care Visits (Opioid and Behavioral Health Homes)

Measure 2.1.1 Continuity of Pharmacotherapy (Opioid Health Homes)

2021	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	1559	4638	-	1482	4057	-
Age	38.1039	39.2309	-0.1298	37.8900	37.8654	0.0028
Gender	0.4567	0.4838	-0.0545	0.4636	0.4636	0.0000
Geography	0.3521	0.3057	0.0972	0.3495	0.3495	0.0000
Expansion Group	0.5279	0.4728	0.1103	0.5351	0.5351	0.0000
Non-ABD	0.2425	0.2602	-0.0415	0.2422	0.2422	0.0000
ABD	0.2296	0.2669	-0.0887	0.2227	0.2227	-0.0000
Risk Score	154.6094	165.6628	-0.0486	123.234	125.0174	-0.0078

2022	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	3581	5136	-	3451	4754	-
Age	39.7325	39.5055	0.0254	39.4859	39.4752	0.0012
Gender	0.4957	0.4823	0.0268	0.4938	0.4938	0.0000
Geography	0.3943	0.3246	0.1427	0.3906	0.3906	-0.0000
Expansion Group	0.5635	0.5461	0.0351	0.5703	0.5703	-0.0000
Non-ABD	0.2477	0.2286	0.0443	0.2489	0.2489	0.0000
ABD	0.1888	0.2253	-0.0933	0.1808	0.1808	0.0000
Risk Score	124.9260	158.6515	-0.1655	102.7102	107.4858	-0.0234

2023	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	1265	3017	-	1238	2846	-
Age	40.2356	40.6410	-0.0461	40.1252	40.1142	0.0012
Gender	0.4458	0.4587	-0.0259	0.4435	0.4435	-0.0000
Geography	0.3755	0.3427	0.0677	0.3732	0.3732	0.0000
Expansion Group	0.6253	0.4846	0.2907	0.6300	0.6300	0.0000
Non-ABD	0.1874	0.2844	-0.2487	0.1898	0.1898	0.0000
ABD	0.1874	0.2310	-0.1119	0.1801	0.1801	0.0000
Risk Score	132.1731	163.2907	0.1433	114.0129	121.5099	-0.0345

Measure 3.2.1 Concurrent use of Opioids and Benzodiazepines (Accountable Communities)

2021	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	4065	145	-	1108	132	-
Age	52.8615	55.6345	-0.2442	57.0487	56.5108	0.0474
Gender	0.5279	0.4138	0.2286	0.5099	0.5099	0.0000
Geography	0.3688	0.4414	-0.1505	0.2789	0.2789	0.0000
Expansion Group	0.2197	0.1586	0.1475	0.0812	0.0812	0.0000
Non-ABD	0.1149	0.1241	-0.0290	0.0298	0.0298	0.0000
ABD	0.6654	0.7172	-0.1098	0.8890	0.8890	0.0000
Risk Score	340.2755	308.3517	0.0914	211.4720	211.0988	0.0011

2022	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	3487	89	-	523	68	-
Age	52.3100	55.7079	-0.3050	53.4092	53.8862	-0.0428
Gender	0.5202	0.4607	0.1192	0.4742	0.4742	0.0000
Geography	0.3771	0.4494	-0.1492	0.5086	0.5086	0.0000
Expansion Group	0.2690	0.2921	-0.0522	0.2467	0.2467	0.0000
Non-ABD	0.1302	0.1798	-0.1473	0.1013	0.1013	0.0000
ABD	0.6008	0.5281	0.1485	0.6520	0.6520	0.0000
Risk Score	384.9564	305.6292	0.2061	185.1128	184.7310	0.0010

2023	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	2803	60	-	227	49	-
Age	52.2590	54.5500	-0.2161	55.6828	55.9833	-0.0283
Gender	0.5105	0.5167	-0.0123	0.4361	0.4361	0.0000
Geography	0.3682	0.4333	-0.1351	0.3480	0.3480	0.0000
Expansion Group	0.2922	0.2667	0.0561	0.1145	0.1145	0.0000
Non-ABD	0.1391	0.2167	-0.2240	0.0617	0.0617	0.0000
ABD	0.5687	0.5167	0.1050	0.8238	0.8238	0.0000
Risk Score	435.2255	334.8500	0.2285	178.4185	197.4335	-0.0433

Measure 5.1.1 Readmissions to the same or higher level of care (Opioid and Behavioral Health Homes)

2021	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	1137	1634	-	959	1341	-
Age	40.7282	39.2821	0.1246	40.1376	40.0198	0.0102
Gender	0.4617	0.4920	-0.0608	0.4609	0.4609	0.0000
Geography	0.2735	0.1971	0.1715	0.2096	0.2096	0.0000
Expansion Group	0.4565	0.5000	-0.0874	0.4828	0.4828	0.0000
Non-ABD	0.1856	0.2424	-0.1460	0.1814	0.1814	0.0000
ABD	0.3580	0.2576	0.2092	0.3358	0.3358	0.0000
Risk Score	366.6130	408.5410	-0.1147	291.9896	291.6149	0.0010

2022	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	1293	1538	-	1118	1286	-
Age	41.2351	39.2965	0.1703	40.4946	40.3913	0.0091
Gender	0.4524	0.4525	-0.0002	0.4401	0.4401	0.0000
Geography	0.2560	0.2347	0.0487	0.2227	0.2227	0.0000
Expansion Group	0.5189	0.6138	-0.1898	0.5671	0.5671	0.0000
Non-ABD	0.1748	0.1632	0.0305	0.1583	0.1583	0.0000
ABD	0.3063	0.2230	0.1806	0.2746	0.2746	0.0000
Risk Score	380.1694	392.5631	-0.0298	306.0483	303.0934	0.0071

2023	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	1278	1831	-	1055	1422	-
Age	41.2778	40.2480	0.0933	40.3052	40.3918	-0.0078
Gender	0.4225	0.4315	-0.0181	0.4009	0.4009	0.0000
Geography	0.2285	0.2436	-0.0360	0.2009	0.2009	0.0000
Expansion Group	0.6025	0.5205	0.1676	0.6682	0.6682	0.0000
Non-ABD	0.1174	0.2348	-0.3650	0.1232	0.1232	0.0000
ABD	0.2801	0.2447	0.0789	0.2085	0.2085	0.0000
Risk Score	375.6909	385.1644	-0.0227	274.9583	269.4838	0.0131

Measure 6.1.1 Ambulatory/Preventive Care Visits (Opioid and Behavioral Health Homes)

2021	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	21272	43911	-	21092	43222	-
Age	40.6974	40.5553	0.0116	40.7159	40.7758	-0.0049
Gender	0.5229	0.5118	0.0223	0.5221	0.5221	0.0000
Geography	0.3437	0.3377	0.0128	0.3427	0.3427	0.0000
Expansion Group	0.3631	0.4170	-0.1121	0.3634	0.3634	0.0000
Non-ABD	0.2178	0.3010	-0.2018	0.2170	0.2170	0.0000
ABD	0.4191	0.2820	0.2780	0.4197	0.4197	0.0000
Risk Score	181.3103	145.2403	0.1562	173.1508	154.4696	0.0809

2022	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	26524	45717	-	25988	44499	-
Age	41.3980	41.1072	0.0247	41.3017	41.3046	-0.0002
Gender	0.5129	0.4898	0.0463	0.5139	0.5139	0.0000
Geography	0.3610	0.3484	0.0263	0.3586	0.3586	0.0000
Expansion Group	0.4253	0.4648	-0.0799	0.4293	0.4293	0.0000
Non-ABD	0.2229	0.2785	-0.1337	0.2239	0.2239	0.0000
ABD	0.3518	0.2567	0.1992	0.3468	0.3468	0.0000
Risk Score	173.2190	141.8617	0.1295	155.4702	150.9676	0.0186

2023	Pre-Matching			Post-Matching		
	Treatment	Control	Std. Mean Difference	Treatment	Control	Std. Mean Difference
Sample Size	26560	46314	-	26276	45354	-
Age	41.8267	42.0076	-0.0155	41.7828	41.7972	-0.0012
Gender	0.4893	0.4752	0.0282	0.4882	0.4882	0.0000
Geography	0.3488	0.3611	-0.0259	0.3465	0.3465	0.0000
Expansion Group	0.4700	0.4160	0.1082	0.4708	0.4708	0.0000
Non-ABD	0.1979	0.3263	-0.3224	0.1994	0.1994	0.0000
ABD	0.3321	0.2577	0.1580	0.3297	0.3297	0.0000
Risk Score	172.5589	149.3586	0.0944	162.3649	152.2133	0.0413

Attachment 3 – Budget Neutrality

With Waiver

PB Trend Rate(s) Used:	2019 - 2025	2026 - 2030
Non-Expansion Adults	5.70%	5.00%
Expansion Adults	5.60%	5.00%

Start DY

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) 2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL WW
SUD IMD														
Non-Expansion Adults														
Eligible Member Months	n.a.	n.a.		1,498	1,619	1,750	1,891	2,044	2,209	2,387	2,580	2,788	3,013	
PMPM Cost	5.7%	24	$ 4,681	$ 5,229.68	$ 5,527.77	$ 5,842.85	$ 6,175.89	$ 6,527.92	$ 6,900.01	$ 7,293.31	$ 7,709.03	$ 8,148.44	$ 8,612.90	
Total Expenditure				$ 7,834,062	$ 8,949,460	$ 10,224,988	$ 11,678,608	$ 13,343,068	$ 15,242,122	$ 17,409,131	$ 19,889,297	$ 22,717,851	$ 25,950,668	$ 153,239,253
Expansion Adults														
Eligible Member Months	n.a.	24		2,579	3,536	4,847	6,646	9,111	12,492	17,126	23,480	32,191	44,133	
PMPM Cost	5.6%	24	$ 4,273	$ 4,764.87	$ 6,312.00	$ 6,665.47	$ 7,038.00	$ 7,432.13	$ 7,848.33	$ 8,287.84	$ 8,751.96	$ 9,242.07	$ 9,759.63	
Total Expenditure				$ 12,288,300	$ 22,319,232	$ 32,307,533	$ 46,774,548	$ 67,714,136	$ 98,041,338	$ 141,987,548	$ 205,496,021	$ 297,511,475	$ 430,721,751	$ 1,355,112,182
Pilots														
Parents Receiving Extended MaineCare					June- Dec.									
PMPM Cost	n.a.				$881	$927	$1,159	$1,219	$1,283	$1,349	$1,420	$1,493	$1,571	
Enrollment	5.2%				429	903	950	999	1051	1106	1163	1223	1287	
Total Expenditure					$1,715,049	$10,040,700	$13,206,370	$14,615,542	$16,175,079	$17,901,025	$19,811,135	$21,925,063	$24,264,555	$139,654,517
Eligible Member Months	12				5148	10831	11395	11987	12610	13266	13956	14682	15445	
Parents Receiving Home Based Skills Development Services					June- Dec.									
PMPM Cost	n.a.				$804	$846	$890	$936	$985	$1,036	$1,090	$1,146	$1,206	
Enrollment	5.2%				100	210	221	233	245	258	271	285	300	
Total Expenditure					$884,400	$1,957,538	$2,166,415	$2,397,580	$2,653,412	$2,936,541	$3,249,882	$3,596,658	$3,980,435	$23,822,862
Eligible Member Months	11				1100	2314	2435	2561	2695	2835	2982	3137	3300	
Parents Receiving Attachment Biobehavioral Catch-up (ABC)					June- Dec.									
PMPM Cost	n.a.				$428	$450	$474	$498	$524	$551	$580	$610	$642	
Enrollment	5.2%				100	210	221	233	245	258	271	285	300	
Total Expenditure					$128,370	$284,202	$314,527	$348,088	$385,231	$426,336	$471,828	$522,174	$577,892	$3,458,649
Eligible Member Months	3				300	631	664	699	735	775	813	856	900	
Parents Receiving Visit Coaching					June- Dec.									
PMPM Cost	n.a.				$1,538	$1,618	$1,702	$1,791	$1,884	$1,982	$2,085	$2,193	$2,307	
Enrollment	5.2%				50	105	111	116	122	129	136	143	150	
Total Expenditure					$307,693	$680,844	$753,493	$833,894	$922,874	$1,021,348	$1,130,330	$1,250,941	$1,384,421	$8,285,837
Eligible Member Months	4				200	421	443	466	490	515	542	570	600	
Contingency Management														
Total Expenditure									$58,398	$143,075	$236,074	$360,549	$473,221	$1,271,317
SMI IMD														
Non-Expansion Adults														
Eligible Member Months									1,934	9,672	9,672	9,672	9,672	
PMPM Cost	5.0%								$ 3,514	$ 3,689	$ 3,874	$ 4,068	$ 4,271	
Total Expenditure									$ 6,795,843	$ 35,685,387	$ 37,467,356	$ 39,340,954	$ 41,307,980	$ 160,596,700
Expansion Adults														
Eligible Member Months									2,741	13,704	13,704	13,704	13,704	
PMPM Cost	5.0%								$ 3,739	$ 3,926	$ 4,122	$ 4,328	$ 4,545	
Total Expenditure									$ 10,247,559	$ 53,799,686	$ 56,489,670	$ 59,314,154	$ 62,279,861	$ 242,130,930
Transition of Care Incentive Payments														
Total Expenditure	5.0%								$ 7,155,492	$ 7,513,267	$ 7,888,930	$ 8,283,376	$ 8,697,545	$ 39,538,610
Justice Involved Pre-Release Services														
Non-Expansion Adults & Children														
Eligible Member Months									92	1,253	2,407	3,457	4,507	
PMPM Cost	5.0%								$ 2,039	$ 2,141	$ 2,248	$ 2,361	$ 2,479	
Total Expenditure									$ 187,818	$ 2,682,020	$ 5,411,368	$ 8,160,533	$ 11,171,087	$ 27,612,825
Expansion Adults														
Eligible Member Months									368	5,011	9,628	13,828	18,028	
PMPM Cost	5.0%								$ 2,039	$ 2,141	$ 2,248	$ 2,361	$ 2,479	
Total Expenditure									$ 751,271	$ 10,728,079	$ 21,645,470	$ 32,642,132	$ 44,684,347	$ 110,451,299
HRSN Pilots														
Food is Medicine														
Total Expenditure									$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000	$ 15,000,000
Recuperative Care														
Total Expenditure									$ 1,141,351	$ 2,793,548	$ 4,305,338	$ 5,424,725	$ 6,328,846	$ 19,833,808
Certified Recovery Residence														
Total Expenditure									$ 57,960	$ 152,145	$ 239,628	$ 301,357	$ 352,254	$ 1,103,919
Traditional Healing Therapies														
Traditional Healing Therapies														
Total Expenditure									$ 902,880	$ 1,814,880	$ 2,717,760	$ 3,629,760	$ 4,532,640	$ 13,597,920

Without Waiver

PB Trend Rate(s) Used:	2019 - 2025	2026 - 2030
Non-Expansion Adults	5.70%	5.00%
Expansion Adults	5.60%	5.00%

Start DY

ELIGIBILITY GROUP	PB TREND RATE	MONTHS OF AGING	LAST HISTORIC YEAR	DEMONSTRATION YEARS (DY) 2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	TOTAL WOW
SUD IMD														
Non-Expansion Adults														
Eligible Member Months	n.a.	n.a.		1,498	1,619	1,750	1,891	2,044	2,209	2,387	2,580	2,788	3,013	
PMPM Cost	5.7%	24	$ 4,681	$ 5,229.68	$ 5,527.77	$ 5,842.85	$ 6,175.89	$ 6,527.92	$ 6,900.01	$ 7,293.31	$ 7,709.03	$ 8,148.44	$ 8,612.90	
Total Expenditure				$ 7,834,061	$ 8,949,460	$ 10,224,988	$ 11,678,608	$ 13,343,068	$ 15,242,122	$ 17,409,131	$ 19,889,297	$ 22,717,851	$ 25,950,668	$ 153,239,253
Expansion Adults														
Eligible Member Months	n.a.	24		2,579	3,536	4,847	6,646	9,111	12,492	17,126	23,480	32,191	44,133	
PMPM Cost	5.6%	24	$ 4,273	$ 4,764.87	$ 6,312.00	$ 6,665.47	$ 7,038.00	$ 7,432.13	$ 7,848.33	$ 8,287.84	$ 8,751.96	$ 9,242.07	$ 9,759.63	
Total Expenditure				$ 12,288,600	$ 22,319,232	$ 32,307,533	$ 46,774,548	$ 67,714,136	$ 98,041,338	$ 141,937,548	$ 205,496,021	$ 297,511,475	$ 430,721,751	$ 1,355,112,182
Pilots														
Parents Receiving Extended MaineCare				June- Dec.										
PMPM Cost	n.a.			$881	$927	$1,159	$1,219	$1,283	$1,349	$1,420	$1,493	$1,571		
Enrollment	5.2%			429	903	950	999	1051	1106	1163	1223	1287		
Total Expenditure				$1,715,049	$10,040,700	$13,206,370	$14,615,542	$16,175,079	$17,901,025	$19,811,135	$21,925,063	$24,264,555	$139,654,517	
Eligible Member Months	12			5148	10831	11395	11987	12610	13266	13956	14682	15445		
Parents Receiving Home Based Skills Development Services				June- Dec.										
PMPM Cost	n.a.			$804	$846	$890	$936	$985	$1,036	$1,090	$1,146	$1,206		
Enrollment	5.2%			100	210	221	233	245	258	271	285	300		
Total Expenditure				$884,400	$1,957,538	$2,166,415	$2,397,580	$2,653,412	$2,936,541	$3,249,882	$3,596,658	$3,980,435	$23,822,862	
Eligible Member Months	11			1100	2314	2435	2561	2695	2835	2982	3137	3300		
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PMPM Cost	n.a.			$428	$450	$474	$498	$524	$551	$580	$610	$642		
Enrollment	5.2%			100	210	221	233	245	258	271	285	300		
Total Expenditure				$128,370	$284,202	$314,527	$348,088	$385,231	$426,336	$471,828	$522,174	$577,892	$3,458,649	
Eligible Member Months	3			300	631	664	699	735	773	813	856	900		
Parents Receiving Visit Coaching				June- Dec.										
PMPM Cost	n.a.			$1,538	$1,618	$1,702	$1,791	$1,884	$1,982	$2,085	$2,193	$2,307		
Enrollment	5.2%			50	105	111	116	122	129	136	143	150		
Total Expenditure				$307,693	$680,844	$753,493	$833,894	$922,874	$1,021,348	$1,130,330	$1,250,941	$1,384,421	$8,285,837	
Eligible Member Months	4			200	421	443	466	490	515	542	570	600		
SMI IMD														
Non-Expansion Adults														
Eligible Member Months									1,934	9,672	9,672	9,672	9,672	
PMPM Cost	5.0%								$ 3,514	$ 3,689	$ 3,874	$ 4,068	$ 4,271	
Total Expenditure									$ 6,796,836	$ 35,683,387	$ 37,467,556	$ 39,340,934	$ 41,307,980	$ 160,596,693
Expansion Adults														
Eligible Member Months									2,741	13,704	13,704	13,704	13,704	
PMPM Cost	5.0%								$ 3,739	$ 3,926	$ 4,122	$ 4,328	$ 4,545	
Total Expenditure									$ 10,247,559	$ 53,799,686	$ 56,489,670	$ 59,314,154	$ 62,279,861	$ 242,130,930
Justice Involved Pre-Release Services														
Non-Expansion Adults & Children														
Eligible Member Months									92	1,253	2,407	3,457	4,507	
PMPM Cost	5.0%								$ 2,039	$ 2,141	$ 2,248	$ 2,361	$ 2,479	
Total Expenditure									$ 187,818	$ 2,682,020	$ 5,411,368	$ 8,160,533	$ 11,171,087	$ 27,612,825

Expansion Adults

Eligible Member Months									368	5,011	9,628	13,828	18,028	
PMPM Cost	5.0%								$ 2,039	$ 2,141	$ 2,248	$ 2,361	$ 2,479	
Total Expenditure									$ 751,271	$ 10,728,079	$ 21,645,470	$ 32,642,132	$ 44,684,347	$ 110,451,299

HRSN Pilots

Food is Medicine

Total Expenditure									$ 1,000,000	$ 2,000,000	$ 3,000,000	$ 4,000,000	$ 5,000,000	$ 15,000,000

Recuperative Care

Total Expenditure									$ 1,041,351	$ 2,733,548	$ 4,305,338	$ 5,424,725	$ 6,328,846	$ 19,833,808

Certified Recovery Residence

Total Expenditure									$ 57,960	$ 152,145	$ 239,628	$ 301,932	$ 352,254	$ 1,103,919

Attachment 4 – Public Notice

Full Public Notice: https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/rule-2025-03/Updated_1115_RENEWAL%20FULL%20Public%20Notice.pdf

NOTICE OF MAINECARE 1115 WAIVER RENEWAL APPLICATION

Full Notice of Public Hearing and Public Comment Period

I. AGENCY: Department of Health and Human Services, Office of MaineCare Services

II. PUBLIC HEARINGS: Pursuant to 42 CFR Part 431.408, notice is hereby given that the Department of Health and Human Services ("DHHS") will host two public hearings on the DHHS 1115 waiver application that will be submitted to the Centers for Medicare and Medicaid Services ("CMS").

Table 1. Public Hearings

Hearing 1: Statewide Virtual/Teleconference Hearing	**Hearing 2: Augusta Hearing**
Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EblbXEW5dfillZsMurS4n.1	Date: April 10, 2025 Time: 9:00 AM Location: 109 Capitol St, Augusta, Maine 04330 Room A&B First Floor

III. DESCRIPTION: This waiver seeks to implement the changes below. More information, including the proposed waiver application and the full public notice, can be found at http://www.maine.gov/dhhs/oms/rules/index.shtml. More information about 1115 waivers may be accessed https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/81926

Overview of 1115 waiver application Services

Extension of Current waiver services:
DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026.

State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that broadens the focus of the current approved Maine SUD Care Initiative by strengthening the behavioral health continuum of care, improving transitions from institutions to the community, expand access to traditional healing practices, and improving health outcomes through addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The Department submitted an amendment of the current

1115 Waiver SUD Care Initiative Demonstration to address the budget neutrality overages the State has experienced in Year 2 and Year 3 of the demonstration on January 9 2025[1]. Maine also requests an extension to the following approved pilots:

Pilot 1a: Maintenance of Medicaid Coverage (Formerly Pilot 1 Maintenance of Medicaid Coverage)
Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.

The expanded MaineCare coverage provides full Medicaid benefits will continue as the beneficiary was previously receiving with the goal of family reunification. MaineCare coverage continues 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.

Pilot 1b: Parenting Support Services (Formerly Pilot 2 Parenting Support Services)
Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching. Eligible parents will receive services concentrating on increasing caregiver knowledge of child development, increasing caregiver nurturance, improving parenting practices, strengthening parent-child attachment, meeting the child's health-related and safety needs, and growing child behavioral and biological regulation while decreasing caregiver behaviors that could be frightening or overwhelming for their child. Members eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with Child Protective Services (CPS) and whose services have been recommended by a physician or other licensed healing arts practitioner.
Under this pilot, Parenting Support Services includes two programs:

A. Program 1: Attachment Biobehavioral Catch-up (ABC)
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.

1. Provider Qualifications for ABC:
    a) Parent coaches meet the following qualifications:
        i. Be a bachelors level mental health professional; or
        ii. Be a certified Behavioral Health Professional (BHP)
        iii. Pass a screening by the ABC Developers, who are Doctorate level professionals independently licensed as child psychologists;
        iv. Receive a year of supervision from the ABC Developers; and
        v. Complete the requisite training as prescribed by the model, which includes the following topics:
            1. Background and evidence base of ABC
            2. Overview of primary targets of ABC
            3. Overview of model and session outline/goals
            4. Coding "In the moment" comments
            5. Review of technology
            6. Practice sessions
            7. Advanced Comments and Sensitivity Assessment
2. Parent Coach Supervisors meet the following qualifications:
    a) Complete one year of supervision by ABC developers; and
    b) At a minimum have either a Licensed Clinical Social Worker (LCSW) or Licensed Master of Social Work-clinical conditional (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), or

[1] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-sud-pa-01162025.pdf

Licensed Clinical Professional Counselor-conditional (LCPC-C).

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. 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.

B. Program 2 - Visit Coaching:

Visit Coaching is a program designed for families who are involved with the Office of Child and Family Services and have children of any age who are placed in foster care and are working toward reunification. Recommendations for visiting coaches are made by licensed social workers. Visit coaching is a strength-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.

1. Provider Qualifications for Visit Coaches:
    a) Visit Coaches meet the following qualifications:
        i. Have a bachelor's degree as well as experience in human services;
        ii. Have previous documented experience working with children and families;
        iii. Complete requisite training, including mandated reporter training, and training in the de-escalation techniques
        iv. First Aid and CPR certification
        v. Receive Family Time Coaching training

    b) Visit Coaches Supervisors (VCSs) meet the following qualifications:
        i. Meet the qualifications of the VCWs; and
        ii. 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); Licensed Clinical Professional Counselor-conditional (LCPC-C).

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.

Pilot 1c: Home-Based Skill Development Services (Formerly Pilot 3 Home-Based Skill Development Services)

Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care,

or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.
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). Supervision is provided by a licensed clinician practicing within their scope of licensure in the State of Maine.

Daily Living Skills Development Services include:
1. Psychosocial Rehabilitation to restore and maintain functioning
2. Social skills training in appropriate community services; and
3. Development of positive personal support networks.

Proposed Additional Waiver Services:

Pilot 1d: Contingency Management
Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.

Qualifying MaineCare members must:
- Medicaid members who are diagnosed with STUD (e.g., methamphetamine, cocaine, similar drugs) based on a completed ASAM criteria assessment (or another comparable, nationally recognized SUD assessment based on evidence-based clinical treatment guidelines
    - The presence of additional substance disorders and/or diagnoses shall not disqualify an individual from receiving CM;
- Not be enrolled in another CM program for SUD; and
- Receive services from an eligible provider that offers CM in accordance with the State laws, policies, procedures, and guidance.

Contingency management providers that opt into and are approved by the State to participate in the pilot and meet the conditions outlined below.

Eligible CM providers must:
- Be certified as a Certified Community Behavioral Health Center to provide MaineCare services in the State as substance use service providers;
- Require the staff providing or overseeing CM to participate in CM-specific training developed and offered by the State and/or the State's designated contractor(s);
- Undergo a readiness review by the State and/or the State's designated contractor(s) to ensure that they are capable of offering CM in accordance with the State's standards that will be detailed in the State's guidance;
- Participate in ongoing training and technical assistance as requested or identified by the State and/or the State's designated contractor(s) through ongoing monitoring to meet the State's standards and
- Shall comply with any billing and data reporting requirements established by the State to support research, evaluation, and performance monitoring efforts, including but not limited to satisfactory claims submission, data and quality reporting, and survey participation.

Initiative: SMI/IMD Waiver Services

Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.

In this SMI/IMD request, Maine seeks Federal Financial Participation (FFP) to allow MaineCare the authority to pay for services for individuals receiving inpatient care in an IMD when they might otherwise be excluded due to federal law that prevents coverage for care in such institutions for individuals with SMI. Specifically, Maine seeks to provide reimbursement for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SMI. These services encompass short-term stays for up to 60 days in public, private, and out-of-state IMDs for Medicaid enrollees living with mental health needs. This demonstration feature would operate statewide and include the following types of facilities: 2 private facilities, Spring Harbor Hospital and Acadia Hospital, and one State facility, Dorothea Dix Psychiatric Center.

The State is not requesting the authority to receive FFP for Medicaid services provided to children in Qualified Residential Treatment Programs with more than 16 beds.

A. Budget Neutrality

Maine estimated projected spending for the five-year demonstration period based on the programmatic detail described earlier in this application. The authorities requested in the demonstration period do not represent new spending but instead represent spending that would otherwise be expected under the Maine Medicaid State Plan

Pilot 3: Transitions of Care Incentive Payment

Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

Specific goals of the incentive pilot include:

- Reduce All-Cause Death
- Reduce ED visits
- Reduce Hospitalizations
- Have people with lived experience shape the initiatives

The State will improve the continuity of care during these transitions by building and strengthening relationships with community-based organizations, including substance use and mental health organizations, FQHCs, sober living homes, and local housing authorities.

Community-based providers will be eligible for reimbursement if the service meets the following requirements:

- Provide an eligible service to a MaineCare member within seven days of the member's release from prison, jail, psychiatric inpatient, or residential setting
    - AND
- Submit a claim to MaineCare for an eligible service which include:
    - Primary Care Services
    - Dental Services
    - SUD Services
    - Mental Health Services

- Social Worker/Case Management Services

The following services will not be eligible for the incentive payments:

- Ambulance services
- Pharmacy services
- Institutional services (inpatient hospital, ICF-IDD, nursing facilities)
- Non-Emergency Transportation

Pre-Release Medicaid Services for Justice-Involved Individuals

The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.

With the nuances of the justice-involved population in Maine, the re-entry waiver will focus efforts on substance use treatment, mental health, and case management to connect this population with needed services to improve care coordination and to address HRSN for the vulnerable period post-release from carceral settings. Maine aims to implement this initiative in all 21 prisons, jails, and juvenile facilities. Over the course of the demonstration period, Maine will phase in correctional facilities based on readiness.

To be eligible for these services, a member must meet the definition of an inmate of a public institution, as specified in 42 CFR 435.1010. All adults and youth who are incarcerated in a participating correctional setting and are enrolled in Medicaid will be eligible to access pre-release services. Services will be available to individuals both pre- and post-adjudication. Maine estimates that approximately 70,105 individuals will receive pre-release services under this demonstration.

Maine is developing a County-Informed Approach. Correctional providers at each jail and prison must enroll in MaineCare. Due to each county's unique characteristics and resources, Maine will work with each county and regional jail to develop a plan for services rendered by a carceral healthcare provider, an in-reach provider, or a combination of both. All willing and qualified providers can enroll to provide pre-release services. Pre-release services will be billed through a fee-for-service delivery system.

Dual-Track Implementation will consist of the following:

- Track 1: Department of Corrections/State Prisons: Initiate reentry pilot within a state prison. After finalizing and implementing MaineCare eligibility & enrollment processes and provider enrollment procedures, the reentry initiative will be implemented in a phased approach to other state prison facilities based on the readiness assessment.
- Track 2: County Jails: Pilot the reentry initiative in one jail. Once short-stay planning, MaineCare eligibility and enrollment processes are finalized, the reentryyyMaine proposes covering the following services, as required in CMS guidance, for the pre-release population:
- Case management to address health and social needs: under which providers (such as care managers, peer support specialists, and others) will establish client relationships, conduct a needs assessment, develop a person-centered care plan, and make appropriate linkages and referrals to post-release care and supports.
- Medication-assisted treatment (MAT) for SUD, including medication in combination with counseling/behavioral therapies, as clinically appropriate.
- At a Minimum, a 30-Day Supply of Prescription Medication in hand upon release, consistent with Medicaid State Plan coverage.

Additionally, the state of Maine proposes covering the following optional services as clinically appropriate, consistent with Medicaid State Plan Coverage and phased in over time as facility readiness allows:

- Physical and behavioral health clinical consultation services (e.g., practitioner office visit for physical, behavioral health, and dental screening and diagnostic services). that are intended to support the creation of a comprehensive, robust, and successful reentry plan, such as clinical screening
- Prescribed drugs and medication administration during the pre-release period.
- Services provided by community health workers (CHW) and Peer support
- Family Planning Services and Supplies. These services may include contraception, sexually transmitted infection (STI) screenings, and counseling services.
- Targeted laboratory services for diagnosis and treatment of priority health conditions, including hepatitis C and HIV.

These additional services aim to create a holistic support system for individuals reentering the community and addressing immediate health needs. This comprehensive approach will improve health outcomes, reduce recidivism, and promote well-being as individuals reintegrate into the community.

Capacity Building Funds
To support cross-system implementation efforts for this initiative, Maine is requesting $10 million total computable capacity-building funds. Capacity building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Health Related Social Needs Pilot 5a: Proposed Food is Medicine
Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals. Maine aims to implement the Food is Medicine initiatives through pilot projects. Eligible individuals include those enrolled in MaineCare, are identified as being food insecure, and meet one of the following criteria:

- Have a chronic health condition such as diabetes, cancer, HIV, etc.
- Have a behavioral health condition (defined as behaviors that affect mental and physical well-being, encompassing mental health and SUD).
- Pregnant and post-postpartum individuals up to 6 months post-partum.

Program services:
Case Management services to access food/nutrition services, such as:

- Outreach and education
- Linkage to other state and federal benefit programs (application assistance and application fees)

Nutrition counseling and instruction tailored to health risk or nutrition-sensitive health conditions, such as:

- Guidance on selecting healthy food
- Healthy meal preparation

Home-delivered meals or pantry stocking, tailored to health risk and eligibility criteria, or certain nutrition-sensitive health conditions and/or specifically for children or pregnant individuals (includes medically tailored meals) – up to 3 meals/day for up to 6 months
Nutrition prescriptions tailored to health risks or certain nutrition-sensitive conditions – up to 3 meals/day for up to 6 months

- Fruit and Veggie Rx.
- Protein boxes
- Food pharmacies
- Healthy food vouchers

Grocery provisions for high-risk individuals to avoid unnecessary admissions or institutionalization – up to 3 meals/day for up to 6 months

Health Related Social Needs Pilot 5b: Recuperative Care
Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.

Recuperative Care programs work to fill the gap that exists between a shelter and an acute hospital stay. Many members cannot recover from their illness on the streets but are not sick enough to be in a hospital. Recuperative Care programs provide the necessities like a safe place to sleep and adequate nutrition while providing needed clinical care and social support. Recuperative Care programs provide varying medical supports and interventions, including care coordination/case management, medication management, nursing oversight, and referrals to medical care, including behavioral health and SUD services. A systematic review showed that recuperative care decreased 90-day readmissions for homeless individuals and reduced the hospital length of stay.

Maine aims to implement the recuperative care initiative through pilot projects.
Eligible individuals include individuals:

- enrolled in MaineCare,
- experiencing homelessness, and
- having an acute medical or psychiatric condition.

Recuperative care include:

- Case management and care coordination
- Medical Care
- Personal Care Services: room and board, including three meals per day, access to a bed 24-7, and staff to provide wellness checks

Health Related Social Needs Pilot 5c: Structured Recovery Housing Services (Previously submitted as Pilot services administered by structured recovery housing programs)
Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs.

Eligibility
As a pilot program, this work will only be eligible for individuals who meet all the following criteria:

- Is a parent;
- Has a SUD;
- Is a resident of an eligible recovery residence;
- Is engaged in SUD treatment;
- Has an open CPS case or is at risk of such a case being opened; and
- Has been assessed to have a relevant risk-factor(s) and applicable social service needs using a validated screening tool.

And residences that meet the following criteria:

- Approved by MaineCare;
- Demonstrated success managing performance-based contracts;
- Accepts and welcomes the inclusion of members receiving MAT;

- Willing and able to move toward value-based payments;
- Certified as a level 4 facility by the Maine Association of Recovery Residences, utilizing the National Alliance of Recovery Residences quality standards and code of ethics;
- Agrees to develop, contract with, and manage a network of pilot providers to deliver services, including community-based organizations (CBOs), social service agencies and healthcare providers; and,
- Be responsible for authorizing all pilot services to eligible enrollees within State and CMS guidelines.

Structured Recovery Housing Services fall into two categories: housing transition and pre-tenancy services, and housing and tenancy sustaining services. The services Maine intends to include are described below.

Housing Transition and Pre-Tenancy Services support individuals as they initially transition out of higher LOC settings into home and community-based settings. These services include:

- Conducting a tenant screening and housing assessment
- Developing an individual stabilization plan
- Assisting with the housing search process and application process
- Covering one-time move-in expenses, such as a security deposit, first month's rent, and/or move-in costs
- Assisting in arranging the details of the move
- Developing a housing support crisis plan that identifies resources for eviction prevention, short-term, and/or long-term rental assistance in the event that housing is jeopardized
- Initially conducting as-needed in-home sessions with the member to link and help ensure the receipt of services and resources necessary to support housing stability

Housing and Tenancy Sustaining Services help individuals maintain tenancy in their housing arrangements as they continue recovery. These services include:

- Education and training on the roles, rights, and responsibilities of both tenant and landlord
- Coaching on developing and maintaining important relationships with landlords and/or property managers with the intent of promoting sustained and successful tenancy
- Assistance in resolving disputes with landlords and/or neighbors to reduce eviction risk or other adverse actions
- Providing advocacy and links to available community resources to prevent eviction when housing is or is at risk of becoming jeopardized
- Provision of ongoing training on good tenancy practices and lease compliance

Members eligible for Supported Housing services may receive one or more of the services detailed above under the waiver program.

Health Related Social Needs Capacity Building Funds

To support the implementation of the HRSN initiatives, Maine is requesting $5 million total computable in capacity building funds. Capacity building funds will be available to entities partnering with DHHS to implement the initiative, including community-based providers. This funding will support planning and implementation activities, including but not limited to: conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement these initiatives.

Designated State Health Programs

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will

work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans

Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Under an 1115 waiver, states can cover services not typically covered by Medicaid, including traditional healing therapies for Native Americans. Medicaid coverage of traditional healing services for substance use treatment has the potential to improve outcomes for individuals, including those in the Wabanki Nations in Maine. It offers a holistic, personalized, and culturally relevant approach to treatment, which can increase engagement, reduce stigma, and provide more culturally responsive options for recovery. Considering emerging evidence supporting the effectiveness of these services as part of a comprehensive addiction treatment strategy, the State plans to collaborate with our Tribal partners on developing a pilot for traditional healing therapies under the 1115 waiver authority.

To receive coverage for traditional healthcare practices under this component of the demonstration, a beneficiary must meet the following criteria:

- Is a Medicaid or CHIP beneficiary, and
- Is able to receive services delivered by or through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10

To be covered, the traditional healthcare practices must be provided by practitioners or providers who are employed by or contracted with one of these facilities (which could include an urban Indian organization contracted with an IHS or Tribal facility) to ensure that the practices are provided by culturally appropriate and qualified practitioners at facilities that are enrolled in Medicaid and 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 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 is also 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.

Maine is working with Wabanaki Nations to develop and solidify the specific services to be provided as part of traditional healing practices.

Goals and Objectives

Over the course of the current demonstration period, Maine made significant progress toward achieving set goals through activities within the implementation plan. These efforts and others represent the SUD response in Maine and highlight key Department activities that advance the specific objectives of the 1115 waiver and do not comprise an exhaustive list of activities taking place currently or planned with the Department's SUD response. During the first demonstration period, Maine worked closely with partners across DHHS and

communities to ensure a strategic and coordinated State response to enhance the Maine SUD treatment system, including working with the provider community to remove barriers to SUD treatment services. Status of agreed upon activities related to the implementation plan are included in Table 1.

Table 1 Overview of Activities to Accomplish Milestones		
Required Activities	**Actions**	**Status**
Milestone #1: Access to Critical Levels of Care for Opioid Use Disorder (OUD) and Other SUDs		
Early Intervention	Incorporate Screening Brief Intervention and Referral to Treatment (SBIRT) into primary care payment model	Completed
Coverage of Outpatient	Clarify rules for coverage of partial hospitalization as outpatient care	Completed
	Continued provider support for Medications for Opioid Use Disorder in Emergency Departments (EDs) and introduced additional incentives for this work.	Completed
Coverage of Intensive Outpatient Programs (IOP)	Complete rate study for IOP programs	Completed
Coverage of Medication-Assisted Treatment (MAT)	Revise administrative rules to add medication-assisted treatment (MAT) as a mandatory benefit in the Medicaid state plan	Completed
Coverage of Intensive Levels of Care in residential and inpatient settings, including withdrawal management	Complete rate study and updated rates for residential programs	Completed
	Revise administrative rules and coverage limits for residential levels of care.	Completed
Milestone #2: Use of Evidence-Based, SUD-Specific Placement Criteria		
Assessment of treatment needs with multidimensional evidence-based assessment tool	Update administrative rules for residential substance use disorder treatment providers to reference the most recent American Society of Addiction Medicine (ASAM) version.	Completed
	Amend Opioid Health Home rules to require level of care assessments	Completed
	Establish incentives in primary care value-based payment model, including the use of a cooperative referral model for MAT	Completed

Table 1 Overview of Activities to Accomplish Milestones		
Required Activities	**Actions**	**Status**
	Develop and implement provider training related to the use of ASAM criteria at all levels of care.	Completed
	Develop service locator tools for consumers and providers	Completed
Utilization management (UM) approach that ensures beneficiaries have access at the appropriate level of care	Develop a post-utilization review process, including the submission of ASAM placement assessments	Completed
UM approach that ensures interventions are appropriate for the diagnosis and level of care	Enhance review of placements across the continuum of care	Completed
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities		
Nationally recognized program standards for residential treatment providers (e.g., ASAM)	Amend administrative rules for residential SUD treatment providers to reference the most recent ASAM version.	Completed
	Develop provider training and guidance	Completed
Implement a process for compliance reviews for residential programs	Improve and coordinate processes across departments responsible for residential program oversight	Completed
	Expand Office of Behavioral Health (OBH) oversight to all Medicaid-enrolled facilities	Completed
	Enhance Office of Child and Family Services (OCFS) residential oversight processes	Completed
	Initiate TA and quality improvement activities for adolescent programs by OCFS	Ongoing
Require residential programs to offer MAT onsite or facilitate access offsite	Amend administrative rules 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.	Completed
	Assess policies and operational practices that could be improved to support MAT and integration of care,	Ongoing

Table 1 Overview of Activities to Accomplish Milestones		
Required Activities	**Actions**	**Status**
	including the solicitation of provider feedback	
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment for OUD		
Complete Assessment of Availability	Assess provider capacity and gaps across system of care	Completed
	Conduct rate study for SUD services at all levels of care	Completed
	Deploy a service locator tool, including assessment of providers accepting new patients	Ongoing
	Fund telehealth capacity for SUD treatment	Completed
	Establish incentives for primary care providers to offer MAT	Completed
	Demonstration approval to expand residential continuum of care to Institution for Mental Diseases (IMD) providers	Completed
	Amend Opioid Health Home rules to improve access	Completed
	Pilot mobile MAT services	Completed
	Review MaineCare policies that may create barriers to access and amend (if needed)	Ongoing
	Assess gaps and barriers to treatment for youth	Completed
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD		
Implementation of opioid prescribing guidelines and other interventions to prevent prescription drug abuse	Assess concurrent use of opioids and benzodiazepines in MaineCare's Accountable Care Organizations	Completed
	Enhance the State's Prescription Monitoring Program	Completed
Expand coverage and access to Naloxone	Implement standing orders for naloxone	Completed
Implement strategies to increase utilization and improve functionality of the prescription drug monitoring program	See Section 5 Information Technology Plan	Ongoing

Table 1 Overview of Activities to Accomplish Milestones		
Required Activities	**Actions**	**Status**
Milestone #6: Improved Care Coordination and Transitions between Levels of Care		
Ensure residential and inpatient facilities link clients with community-based services following stays	Assess transition of care policies	Ongoing
	Develop performance monitoring and incentive strategies to support quality improvement related to follow-up care	Ongoing
	Solicit input through provider and stakeholder surveys/focus groups	Ongoing
	Amend administrative rules for residential facilities to clarify discharge planning requirements	Completed
Policies to ensure care coordination for physical and mental health conditions	Share results of Maine Health Access Foundation Site Self-Assessments and discuss opportunities to improve	Completed
	Integrate pay for performance provisions in the Opioid Health Home model to support access to ambulatory/preventive care	Completed
	Convene provider work group regarding transitions of care and integration	Ongoing
	Assess opportunities to expand Opioid Health Home and Targeted Case Management programs to more members	Completed
	Amend administrative rules to clarify coordination of care requirements	Completed

As Maine continues to enhance their current comprehensive health system, the three overarching demonstration goals are mapped below to goals for each proposed component. Objectives in each section will drive the achievement of these goals. Table 2 below maps each objective to goals:

Table 2: Crosswalk of Primary goals with Waiver Goals	
Maine Primary goals	**Waiver Opportunity Goals**
Goal 1: Maximize access to high-quality behavioral health at the appropriate level of care.	SUD Goal 1: Increased identification, initiation, and engagement rates in treatment for OUD and other SUDs.
	SUD Goal 2: Increased access to and retention in treatment for OUD and other SUDs.

Table 2: Crosswalk of Primary goals with Waiver Goals	
Maine Primary goals	**Waiver Opportunity Goals**
	SUD Goal 3: Reductions in overdose deaths, particularly those due to opioids.
	SUD Goal 4: Reduced utilization of EDs and inpatient hospital settings for OUD and other SUD treatments where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.
	SUD Goal 6: Improved access to care for physical health conditions among beneficiaries with OUD and other SUDs.
	SMI/IMD Goal 1: Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI while awaiting mental health treatment in specialized settings.
	SMI/IMD Goal 3: Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI, including through increased integration of primary and behavioral healthcare.
	Re-Entry Goal 7: Reduce the number of ED visits and inpatient hospitalizations among recently incarcerated Medicaid and CHIP individuals through increased receipt of preventive and routine physical and behavioral healthcare
	HRSN Goal 1: Improve health outcomes for people experiencing homelessness.
Goal 2: Promote successful transitions to the community that result in improved health outcomes, reduced health disparities, fewer readmissions, and lower rates of recidivism.	SUD Goal 5: Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs
	SMI/IMD Goal 2: Reduced preventable psychiatric readmissions to acute care hospitals and residential settings
	SMI/IMD Goal 4: Improved care coordination, especially continuity of care in the community following acute care episodes in hospitals and residential treatment facilities.
	Re-Entry Goal 1: Increase coverage, continuity of coverage, and appropriate service uptake through assessment of eligibility and availability of coverage for benefits in carceral settings before release
	Re-Entry Goal 2: Improve access to services before release and improve transitions and continuity of care into the community upon release and during reentry
	Re-Entry Goal 6: Reduce all-cause deaths in the near-term post-release.
	Re-Entry Goal 8: Provide intervention for specific behavioral health conditions and use stabilizing medications like long-acting injectable antipsychotics and medications for addiction treatment for SUDs to reduce overdose and overdose-related death in the near-term post-release.
	HRSN Goal 2: Increase food security of individuals and families through coordinated, enhanced collaborations with existing

Table 2: Crosswalk of Primary goals with Waiver Goals	
Maine Primary goals	**Waiver Opportunity Goals**
Goal 3: Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry and HRSN services.	federal, state, and local food benefit programs and nutrition prescription and counseling services.
	HRSN Goal 3: Decrease hospital length of stay for people who are experiencing homelessness by implementing a recuperative care pilot.
	SMI/IMD Goal 5: Improved availability of crisis stabilization services, including services made available through call centers and mobile crisis units, intensive outpatient services, and services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state.
	Re-Entry Goal 3: Improve coordination and communication between correctional systems, Medicaid systems, and community-based providers.
	Re-Entry Goal 4: Increase additional investments in healthcare and related services to improve the quality of care for beneficiaries in carceral settings and the community to maximize successful reentry post-release.
	Re-Entry Goal 5 Improve connections between carceral settings and community services upon release to address physical health, behavioral health, and HRSN.

Maine's overarching goal for its 1115 demonstration renewal is to create a whole-person approach to care that includes implementing HRSN benefits and supporting transition populations to reduce healthcare disparities in the State. The proposed authorities reflect the State's commitment to addressing behavioral and physical health in addition to identifying and addressing social drivers of health. The 1115 demonstration renewal will advance this goal through the following specific objectives and related initiatives.

Table 3 provides an overview of the current Section 1115 demonstration initiatives that Maine is renewing and new demonstration proposals. As Maine works with CMS to advance its Whole Person Care Waiver Section 1115 demonstration, the federal authorities sought and/or the federal approval vehicles required may change. In the table below, each demonstration goal is mapped to objectives, approach and status:

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
Goal 1: Maximize access to quality behavioral health services and improve	Objective 1: Sustain and improve the SUD continuum of care	SUD IMD Exclusion Waiver Services Initiative	Continuing
		Pilot 1a: Maintenance of Medicaid Coverage	Continuing
		Pilot 1b: Parenting Support Services	Continuing

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
coverage of a broader continuum of treatment for individuals with SMI/SUD.		Pilot 1c: Home-Based Skill Development Services	Continuing
		Pilot 1d: Contingency Management	New
Goal 2: Improve health outcomes during transitions (e.g., justice-involved individuals returning to the community or individuals experiencing or at risk of homelessness) to reduce health disparities and drive sustainable transformation through reentry and health-related HRSN services.	Objective 2: Address ongoing structural challenges with the delivery of services for people living with SMI with proven strategies	SMI/SED Waiver Services Initiative	New
	Objective 3: Improve the continuity of care during transitions by building and strengthening relationships with community-based organizations.	Pilot 3: Transition of Care Incentive	New
	Objective 4: Improve the continuity of coverage and access to needed care by leveraging re-entry initiatives, including pre-release services for justice-involved individuals	Pre-Release Medicaid Services for Justice-Involved Individuals Initiative	New
	Objective 5: Establish HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5a: Food is Medicine	New
		Pilot 5b: Recuperative Care	New
		Pilot 5c: Structured Recovery Housing Programs	New
Goal 3: Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry and HRSN services.	Objective 4: Improve the continuity of coverage and access to needed care by leveraging re-entry initiatives, including pre-release services for justice-involved individuals	Pre-Release Medicaid Services for Justice-Involved Individuals Initiative	New
	Objective 5: Establish health-related HRSN benefits, including Food is Medicine and Recuperative Care	Pilot 5a: Food is Medicine	New
		Pilot 5b: Recuperative Care	New

Table 3: Overview of Programs Included in Demonstration Renewal Request			
Primary goal	**Objective**	**Policy/program name**	**Status**
Other Programs			
Support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building		Designated State Health Programs	New
Improve health outcomes for Native Americans by increasing utilization and access, reducing stigma, and providing more culturally responsive options for SUD recovery		Traditional Healing Therapies for Native Americans	New

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements and Cost sharing

Benefit Coverage

The State is continuing to request an enhanced set of benefits for the Pilots as described in Section II.

Other changes to benefits proposed in the renewal are described in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration) above, and include:

- Reauthorizing the existing list of Pilot services
- Providing CM services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Providing the HRSN pilots: Food is Medicine, Recuperative Care and the Structured Recovery Housing Services

Enrollment Limits

There are no enrollment limits for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements

DHHS proposes to implement the initiatives across all "full benefit" eligibility groups. Processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status will be provided in the implementation plans. Currently, for people enrolled in Medicaid and in a carceral setting, their Medicaid is suspended. For people who are not enrolled in Medicaid prior to incarceration, process improvements to streamline Medicaid determinations will be included in the implementation plan.

Table 5: Full Benefit Medicaid Beneficiaries Eligible for services under this demonstration providing they meet criteria as described in Section II

GROUP NAME	CITATIONS	FPL
3. Under 19 yrs of age	42 CFR §435.118; 1902(a)(10)(A)(i)(III), (IV), (VI), and (VIII); 1902(a)(10)(A)(ii) (IV) and (IX); 1931(b) and (d)	305%
4. Age 19 and 20	42 CFR § 1396a(a)(10)(A)(i)(VIII)	305%

5. Parents and Other Caretakers	42 CFR §435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d)	105%
6. Pregnant Women	42 CFR §435.116; 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV) and (IX); 1931(b) and (d); 1920; MAGI SPA S28	214%
7. Expansion Adults	1902(a)(10)(C)	138%
Former Foster Care Children 8.	42 CFR §435.150; 1902(a)(10)(A)(i)(IX)	No income or asset test
9. Federally Non-Qualified Pregnant People	1902(l)(1)(A)	213%
10. Aged, Blind, or Disabled 11.	1902(a)(10)(A)(ii)	100%
12. Specified Low-Income Medicare Beneficiaries	13. 42 CFR §435.150;1902(a)(10)(E)(iii)	14. 170%
Working with a Disabling Condition	1905(s)	250%

Delivery System

All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing

There are no changes to cost sharing proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures and Budget Neutrality

This section describes the historical and expected enrollment impact, historical and expected financial expenditures, and budget neutrality considerations associated with the proposed demonstration renewal initiatives.

Enrollment

Table 6 provides historical data on Member Months and estimated Person Count for Maine's Substance Use Disorder (SUD) Care Initiative 1115 demonstration populations from January 1, 2021, to December 31, 2023.

Table 6. Historical Member Months, Person Count, PMPM and Total Expenditures

		Historical Member Months, Person Count, PMPM and Total Expenditures			
		DY1	DY2	DY3	DY4
		1/1/2021 - 12/31/2021	1/1/2022 - 12/31/2022	1/1/2023 - 12/31/2023	1/1/2024 – 12/31/2024
SUD IMD Services					
Non-Expansion Adults and Children	Member Months	0	57	189	449
	Person Count	0	20	95	259
	PMPM	$5,230.00	$6,961.75	$4,817.74	$5,529.49

	Total Expenditures	$0	$396,820	$910,553	$2,482,740
Expansion Adults	Member Months	0	199	961	1,999
	Person Count	0	71	358	822
	PMPM	$4,765.00	$6,311.90	$5,675.72	$6,456.05
	Total Expenditures	$0	$1,256,069	$5,454,368	$12,905,648
Maintenance of Medicaid Coverage					
Parents with Extended MaineCare	Member Months	0	0	1,056	2,785
	Person Count	0	0	389	544
	PMPM	$0.00	$0.00	$886.90	$1,056.35
	Total Expenditures	$0	$0	$936,571	$2,941,928

Table 7 provides the estimated enrollment for the five years of the 1115 demonstration renewal from January 1, 2026, to December 31, 2030.

Table 7. Projected Member Months, Person Count, PMPM and Total Expenditures Under Renewal

		Projected Member Months, Person Count, PMPM and Total Expenditures Under Renewal					
		DY5	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**
		1/1/2025 - 12/31/2025	**1/1/2026 - 12/31/2026**	**1/1/2027 - 12/31/2027**	**1/1/2028 - 12/31/2028**	**1/1/2029 - 12/31/2029**	**1/1/2030 - 12/31/2030**
SUD IMD Services							
Non-Expansion Adults and Children	Member Months	481	529	556	572	589	601
	Person Count	309	340	357	368	379	386
	PMPM	$6,528.00	$6,854.40	$7,197.12	$7,556.98	$7,934.82	$8,331.57
	Total Expenditures	$3,139,968	$3,626,663	$3,998,396	$4,324,265	$4,676,693	$5,008,738
Expansion Adults	Member Months	1,782	1,871	1,927	1,966	2,005	2,045
	Person Count	920	966	995	1,015	1,035	1,056
	PMPM	$7,432.00	$7,803.60	$8,193.78	$8,603.47	$9,033.64	$9,485.32
	Total Expenditures	$13,243,824	$14,601,316	$15,791,323	$16,912,507	$18,113,295	$19,399,339
Maintenance of Medicaid Coverage							
Parents with Extended MaineCare	Member Months	2,849	2,849	2,849	2,849	2,849	2,849
	Person Count	579	579	579	579	579	579
	PMPM	$1,219.00	$1,279.95	$1,343.95	$1,411.14	$1,481.70	$1,555.79
	Total Expenditures	$3,472,931	$3,646,578	$3,828,906	$4,020,352	$4,221,369	$4,432,438
Parenting Support Services							
Attachment Biobehavioral Catch-up	Member Months	0	150	300	450	525	600
	Person Count	0	50	100	150	175	200
	PMPM	$0	$427.90	$449.30	$471.76	$495.35	$520.12
	Total Expenditures	$0	$64,185	$134,789	$212,292	$260,058	$312,069
Visit Coaching	Member Months	0	120	240	300	360	400
	Person Count	0	30	60	75	90	100
	PMPM	$0	$1,538.00	$1,614.90	$1,695.65	$1,780.43	$1,869.45

	Total Expenditures	$0	$184,560	$387,576	$508,694	$640,954	$747,779
Home-Based Skill Development	Member Months	0	550	1,100	1,650	1,925	2,200
	Person Count	0	50	100	150	175	200
	PMPM	$0	$804.00	$844.20	$886.41	$930.73	$977.27
	Total Expenditures	$0	$442,200	$928,620	$1,462,577	$1,791,656	$2,149,987

Table 8 provides a summary of the estimated number of individuals affected by Contingency Management Initiative Impacts.

Table 8. Estimated Number of Individuals Affected by Contingency Management Initiative Impacts

		Estimated Number of Individuals Affected by Contingency Management				
		DY6	DY7	DY8	DY9	DY10
Members with Stimulant Use Disorder	Person Count	93	217	340	495	619
	PMPY	$628.95	$660.40	$693.42	$728.09	$764.49
	Total Expenditures	$58,398	$143,075	$236,074	$360,549	$473,221

Table 9 provides a summary of the estimated number of individuals affected by SMI IMD Initiative Impacts.

Table 9. Estimated Number of Individuals Affected by SMI IMD Initiative Impacts

		Estimated Number of Individuals Affected by SMI IMD				
		DY6	DY7	DY8	DY9	DY10
Non-Expansion Adults	Member Months	1,318	6,889	7,204	7,534	7,879
	Person Count	110	574	600	628	657
	PMPM	$12,155.38	$12,763.15	$13,401.31	$14,071.38	$14,774.94
	Total Expenditures	$16,020,796	$87,925,360	$96,543,041	$106,013,747	$116,411,791
Expansion Adults	Member Months	1,746	10,631	12,945	15,763	19,194
	Person Count	146	886	1,079	1,314	1,599
	PMPM	$8,548.17	$8,975.58	$9,424.36	$9,895.58	$10,390.36
	Total Expenditures	$14,925,109	$95,419,400	$121,998,338	$155,983,994	$199,432,507

Justice-involved individuals are not included in the Medicaid Eligibility Group projections noted above. Table 10 provides a summary of the estimated number of individuals who will receive pre-release services under this demonstration.

Table 10. Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative Impacts

		Estimated Number of Individuals Affected by Justice-Involved Reentry Initiative				
		DY6	DY7	DY8	DY9	DY10
Justice-Involved Individuals	Member Months	461	6,263	12,035	17,285	22,535
	Person Count	197	7,184	14,158	20,908	27,658
	PMPM	$1,685.07	$1,769.33	$1,857.79	$1,950.68	$2,048.22

	Total Expenditures	$776,027	$11,081,590	$22,358,732	$33,717,756	$46,156,786

Additionally, the traditional healers initiative could impact the nearly 5,000 enrollees who receive tribal health services annually.

Expenditures

Table 11 provides historical data on the total expenditures for Maine Substance Use Disorder (SUD) Care Initiative demonstration services and populations from January 1, 2021, to December 31, 2023.

Table 11. Historical Total Computable Expenditures

	Historical Total Computable Expenditures			
	DY1	DY2	DY3	DY4
Historical Expenditures	**1/1/2021 - 12/31/2021**	**1/1/2022 - 12/31/2022**	**1/1/2023 - 12/31/2023**	**1/1/2024 – 12/31/2024**
SUD IMD Services				
Non-Expansion Adults and Children	0	$396,820	$910,553	$2,482,740
Expansion Adults	0	$1,256,069	$5,454,368	$12,905,648
Maintenance of Medicaid Coverage				
Parents with Extended MaineCare	0	0	$936,571	

Table 12 provides the projected expenditures under the demonstration renewal. These projections consider estimated prospective trends and projected expenditures for new initiatives as outlined in this document

Table 12. Projected Total Computable Expenditures

	Projected Total Computable Expenditures						
	DY4	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver Expenditures	**1/1/2024 - 12/31/2024**	**1/1/2025 - 12/31/2025**	**1/1/2026 - 12/31/2026**	**1/1/2027 - 12/31/2027**	**1/1/2028 - 12/31/2028**	**1/1/2029 - 12/31/2029**	**1/1/2030 - 12/31/2030**
SUD IMD Services							
Non-Expansion Adults and Children	$2,488,928	$3,139,968	$3,626,663	$3,998,396	$4,324,265	$4,676,693	$5,008,738
Expansion Adults	$11,204,496	$13,243,824	$14,601,316	$15,791,323	$16,912,507	$18,113,295	$19,399,339
Maintenance of Medicaid Coverage							
Parents with Extended MaineCare	$1,476,247	$3,472,931	$3,646,578	$3,828,906	$4,020,352	$4,221,369	$4,432,438
Parenting Support Services							
Attachment Biobehavioral Catch-up	0	0	$64,185	$134,789	$212,292	$260,058	$312,069
Visit Coaching	0	0	$184,560	$387,576	$508,694	$640,954	$747,779
Home-Based Skill Development Services							
Home-Based Skill	0	0	$442,200	$928,620	$1,462,577	$1,791,656	$2,149,987

	Projected Total Computable Expenditures						
	DY4	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver Expenditures	**1/1/2024 - 12/31/2024**	**1/1/2025 - 12/31/2025**	**1/1/2026 - 12/31/2026**	**1/1/2027 - 12/31/2027**	**1/1/2028 - 12/31/2028**	**1/1/2029 - 12/31/2029**	**1/1/2030 - 12/31/2030**
Development Services							
Contingency Management							
Contingency Management	0	0	$58,398	$143,075	$236,074	$360,549	$473,221
SMI / IMD Services							
Non-Expansion Adults	0	0	$16,020,796	$87,925,360	$96,543,041	$106,013,747	$116,411,791
Expansion Adults	0	0	$14,925,109	$95,419,400	$121,998,338	$155,983,994	$199,432,507
Transitions of Care Incentive Payment							
Transitions of Care Incentive Payment	0	0	$7,155,492	$7,513,267	$7,888,930	$8,283,376	$8,697,545
Pre-Release Medicaid Services for Justice-Involved Individuals							
Non-Expansion Adults and Children	0	0	$798,199	$11,398,207	$22,997,553	$34,681,121	$47,475,551
Expansion Adults	0	0	$199,550	$2,849,552	$5,749,388	$8,670,280	$11,868,888
Pre-Release* Capacity Building	0	0	$3,000,000	$5,000,000	$3,000,000	$2,000,000	$2,000,000
Health-Related Social Needs (HRSN) Pilots							
Food Is Medicine	0	0	$1,000,000	$2,000,000	$3,000,000	$4,000,000	$5,000,000
Recuperative Care	0	0	$991,763	$2,479,408	$3,719,112	$4,462,935	$4,958,817
Certified Recovery Residence	0	0	$55,200	$138,000	$207,000	$248,400	$276,000
HRSN* Capacity Building	0	0	$500,000	$2,000,000	$1,000,000	$1,000,000	$500,000
Designated State Health Programs (DSHP)*							
	0	0	$5,800,000	$5,800,000	$5,800,000	$5,800,000	$5,800,000
Traditional Healing Therapies for Native Americans*							
	0	0	$TBD	$TBD	$TBD	$TBD	$TBD

* These are the proposed budget neutrality cap and Maine requests flexibility on the timing of actual payments.

**The total computable expenditures for traditional healing therapies for Native Americans are under development with tribal partners and is expected to be budget neutral and not more costly than similar services delivered by other clinicians.

Budget Neutrality

From CMS consultation and a review of similar waiver requests, Maine believes potential expenditures incurred under the waiver of expenditure authority contained within this proposal are likely considered "hypothetical expenditures."[2] For these hypothetical expenditures, CMS adjusts the budget neutrality test to effectively treat these expenditures as if they were approved Medicaid State Plan services. Therefore, these expenditures do not

[2] Per CMS guidance, this is defined as "the expenditure would have been eligible to receive FFP elsewhere in the Medicaid program."

necessitate savings to offset their costs. DHHS commits to reporting all expenditures consistent with the special terms and conditions for the demonstration.

To ensure this application meets the requirement of §42 CFR 431.412, financial data demonstrating the State's historical and projected expenditures for the requested period of the extension, as well as cumulatively over the lifetime of the demonstration, are included below. This includes a financial analysis of changes to the demonstration requested by the State.

The Department has requested an adjustment to the budget neutrality of the current 1115 Waiver SUD Care Initiative Demonstration to address the budget neutrality overages the State has experienced in Year 2 and Year 3 of the demonstration.

The first adjustment was for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-64 with SUD by IMDs. The State did not have historical data to base the projection of costs associated with coverage for the Expansion Adults population when developing the original budget neutrality costs. As a result, annual utilization for this population is much higher than in Calendar Year 2019, as the State has seen increased enrollment for this population. The demonstration showed a deficit in actual expenditures for IMD beneficiaries of $336,425 in demonstration year two and $363,055 in demonstration year three when measured against the hypothetical limits. Cumulatively, actual expenditures exceeded the limit by $699,480. Below in Table 14 is a summary of actual expenses and waiver limits for IMD beneficiaries.

Table 14. Summary of Expenses and Waiver Limits

IMD Beneficiaries	DY1	DY2	DY3	DY4
With Waiver (Actual)				
Non-Expansion Adults and Children	0	$396,820	$910,553	$2,482,740
Expansion Adults	0	$1,256,069	$5,454,368	$12,905,648
Total Expenditures (Actual)	0	$1,652,889	$6,364,921	$15,388,388
Without Waiver Limit	0	$1,316,464	$6,001,866	$13,989,413
SURPLUS (DEFICIT)	0	($336,425)	($363,055)	($1,398,975)

IMD Beneficiaries	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver (Projected)						
Non-Expansion Adults and Children	$3,139,968	$3,290,686	$3,448,639	$3,614,174	$3,787,654	$3,969,462
Expansion Adults	$13,243,824	$13,879,528	$14,545,745	$15,243,941	$15,975,650	$16,742,481
Total Expenditures (Projected)	$16,383,792	$17,170,241	$17,994,384	$18,858,115	$19,763,304	$20,711,943

The second adjustment is to Pilot 1 Extended MaineCare Coverage. Individuals 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 under state law. This project's initial Per Member Per Month (PMPM) estimate was based on actuals for 2021. While expenditures were below limits in Years 1-3, subsequent rate increases and more costly than anticipated utilization require an amendment to these Without Waiver PMPM values.

The demonstration showed a surplus in expenditure authority for the four pilot projects. The first of three pilots was implemented in demonstration year three, and actual expenditures were below the annual limit. A summary of actual expenditures and waiver limits for the pilot projects is provided in Table 15, below:

Table 15. Expenditures and Waiver Limits for Pilot Projects

Pilot Projects	DY1	DY2	DY3	DY4
With Waiver (Actual)				
Parents with Extended MaineCare	0	0	$936,571	$2,941,928
Parents Receiving Home-Based Skills Development Services	0	0	0	0
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	0	0	0	0
Parents Receiving Visit Coaching	0	0	0	0
Total Expenditures (Actual)	**0**	0	$936,571	$2,941,928
Without Waiver Limit	**0**	0	$978,912	$2,715,375
SURPLUS (DEFICIT)	**0**	0	$42,342	($226,553)

Pilot Projects	DY5	DY6	DY7	DY8	DY9	DY10
With Waiver (Projected)						
Parents with Extended MaineCare	$3,472,931	$3,639,632	$3,814,334	$3,997,422	$4,189,298	$4,390,385
Parents Receiving Home-Based Skills Development Services	0	$1,768,800	$1,853,702	$1,942,680	$2,035,929	$2,133,653
Parents Receiving Attachment Biobehavioral Catch-up (ABC)	0	$256,740	$269,064	$281,979	$295,514	$309,698
Parents Receiving Visit Coaching	0	$615,200	$644,730	$675,677	$708,109	$742,098
Total Expenditures (Projected)	$3,472,931	$6,280,372	$6,581,830	$6,897,757	$7,228,850	$7,575,834

Table 16 shows the requested budget neutrality treatment across initiatives in the renewal. Maine will continue to work with CMS to confirm and finalize budget neutrality during the demonstration negotiation and approval process.

Table 16. Budget Neutrality (BN)

Waiver Initiative	Per Capita or Aggregate	Proposed Budget Neutrality Treatment
SUD IMD Exclusion Initiative	Per Capita	Hypothetical
Pilot 1a Maintenance of Medicaid Coverage	Per Capita	Hypothetical
Pilot 1b Parenting Support Services	Aggregate	Hypothetical
Pilot 1c Home-Based Skill Development Services	Aggregate	Hypothetical
Pilot 1d Contingency Management	Aggregate	Budget Neutral
SMI IMD Waiver Initiative	Per Capita	Hypothetical
Pilot 3 Transitions of Care Incentive Payment	Aggregate	Budget Neutral
Justice Involved Pre-Release Services	Per Capita	Hypothetical
Justice Involved Pre-Release Capacity Building	Aggregate	Hypothetical
Pilot 5a Food is Medicine	Aggregate	Capped Hypothetical
Pilot 5b Recuperative Care	Aggregate	Capped Hypothetical
Pilot 4c Structured recovery housing programs	Aggregate	Capped Hypothetical
HRSN Capacity Building	Aggregate	Capped Hypothetical
Designated State Health Programs (DSHP)	Aggregate	Main BN Test
Traditional Healing Therapies for Native Americans	Propose to be excluded from Budget Neutrality consistent with other states	

IV. HYPOTHESIS & EVALUATION:

Through this demonstration, DHHS intends to evaluate several hypotheses (see Table 3 & 4). Hypotheses focus primarily on access to various levels of care, service utilization, quality of care and care transitions, spillover effects of a more efficient service delivery system, and costs. DHHS plans to use evaluation results from the demonstration to make strategic decisions on how to improve existing and any new State Plan services, including the possibility of utilizing alternative payment models in the future to support this work.

DHHS will conduct a rigorous evaluation of the impact of this waiver on our system of care, health outcomes, and other relevant indicators. The evaluation of this 1115 waiver will include a continuation of the current evaluation of the SUD IMD Waiver services with additional components which will be developed following waiver approval and must be approved by CMS. In addition, the State will comply with all required reporting requirements throughout the demonstration period, as required by CMS.

For new components, when possible, proposed measures will be selected from nationally-recognized sources and national measure sets. Data sources may include administrative data (e.g. licensing information), Medicaid claims data, stakeholder surveys/interviews/focus groups, and provider-supplied data. DHHS will also seek to align measures in this demonstration with existing quality improvement initiatives within the state, when relevant, to support focused system transformation and reduce administrative burden.

Current Evaluation Approach

The State does not propose any changes to the currently approved evaluation design for the SUD IMD portion of the demonstration. Continuation of the current plan will permit additional study of outcomes over an extended period. Table 3 outlines the hypotheses, research questions and analytic approach that will continue to be studied during the extension

Table 3. 1115 Waiver Hypotheses and Current Measures

SUD IMD Waiver Services, *continuing*		
Evaluation Question	**Hypothesis**	**Approach**
1. Does the Demonstration maintain or improve identification, initiation, and engagement in treatment for SUD? a. How does service utilization vary by member characteristics (e.g., age, aid category code)? b. How does utilization vary by service type?	1. The Demonstration will maintain or increase utilization of SUD treatment services	ITS
	2. The Demonstration will maintain or increase SUD provider availability	
	3. The Demonstration will maintain or increase follow-up after ED visit for alcohol or other drug dependence	
	4. The Demonstration will maintain or increase initiation and engagement in treatment	
2. Does the Demonstration maintain or increase adherence to and retention in treatment for alcohol or other drug use?	1. The Demonstration will maintain or increase continuity of pharmacotherapy for OUD for OHH enrollees	PSM (OHH)
3. Does the Demonstration contain or reduce opioid prescribing patterns that may lead to misuse or OUD?	1. The Demonstration will contain or reduce the use of opioids at a high dosage	ITS
	2. The Demonstration will contain or reduce the use of opioids concurrent with benzodiazepines for ACO attributed members	PSM (ACO)
	3. The Demonstration will contain or reduce the rate of overdose deaths due to opioids in the Medicaid population	ITS
4. Does the Demonstration contain or reduce preventable ED visits and inpatient hospitalizations for individuals with a SUD? a. How does utilization vary by member characteristics (e.g., age, aid category code) code? b. How does utilization vary by geographic characteristics (e.g., rural v. urban)? c. How does utilization vary when MAT induction in the ED is offered?	1. The Demonstration will contain or reduce the rate of preventable ED visits for individuals with a SUD	ITS; Pre/Post for MAT (4c)
	2. The Demonstration will contain or reduce preventable inpatient admissions	ITS

SUD IMD Waiver Services, *continuing*		
Evaluation Question	**Hypothesis**	**Approach**
5. Does the Demonstration contain or reduce readmissions to the same or higher levels of care?	1. The Demonstration will contain or reduce readmissions to the same or higher levels of care.	PSM (OHH and BHH); ITS for PQI #92
6. Does the Demonstration maintain or improve access to care for physical health conditions?	1. The Demonstration will maintain or increase access to care for physical health conditions for Health Home enrollees	PSM (OHH and BHH)
	2. The Demonstration will maintain or increase access to care for physical health conditions for TCM program enrollees	PSM (TCM)
Pilot 1a. Maintenance of Medicaid Coverage		
Evaluation Question	**Hypothesis**	**Approach**
1. Does Pilot 1a maintain or improve access to SUD and mental health treatment for Medicaid members whose children were removed from the home?	1. Members who participate in Pilot 1a will maintain or increase utilization of community-based SUD and/or MH treatment services.	One pre/one post observation point with t-test
2. Does Pilot 1a maintain or improve retention in treatment services?	1. Members who participate in Pilot 1a will maintain or improve retention in treatment.	
3. Does Pilot 1a support family reunification?	1. The number of children who are reunified with their parents will increase for parents who participate in Pilot 1a.	
	2. Children who were returned to the home will be maintained in the home setting for at least nine (9) months after reunification.	
Pilot 1b. Parenting Support Services		
Evaluation Question	**Hypothesis**	**Approach**
1. Does the ABC pilot result in improved family stability (e.g., children remaining in the family home)?	1. Children whose caregivers participate in ABC services will be maintained in the home for at least nine months following program completion.	PSM w/t-test (one observation point)
2. Does the ABC pilot improve access to primary or preventive care for children whose parents complete the program?	1. Children whose caregivers participate in ABC services will increase the number of well child visits during the measurement period	PSM w/t-test (one observation point)
3. Does the visit coaching pilot result in family reunification when a child(ren) has been removed from the home pursuant to State law	1. The number of children who are reunified with their caregivers will increase for parents who complete Visit Coaching services	PSM w/t-test (one observation point)
	2. Children who were returned to the home will not re-enter the program in the nine (9) months after the completion of Pilot Project services	PSM w/t-test (one observation point)
4. Are members satisfied with the services they received from the visit coaching program?	1. Members who participate in Visit Coaching will report improved satisfaction with the vendor and service model	Descriptive
Pilot 1c. Home-Based Skill Development Services		
Evaluation Question	**Hypothesis**	**Approach**
1. Does Pilot 1c support community living and avoid more intensive residential, hospital or ED services for parents who have an SUD and their child(ren)	1. Inpatient admissions for SUD will be controlled or reduced for participants in Pilot 1c	PSM w/t-test (one observation point)
	2. Use of residential SUD treatment will decrease for participants in Pilot 1c	PSM w/t-test (one observation point)
	3. Out of home placements for children of participants in Pilot 1c will be decrease	ANOVA; w/t-test (one observation point)
	4. The number of children who are reunified with their caregivers will increase	PSM w/t-test (one observation point)

SUD IMD Waiver Services, *continuing*		
Evaluation Question	**Hypothesis**	**Approach**
2. Do parent/caregivers who participate in Pilot 1c have lower ED use for SUD?	1. Visits to the ED for SUD will be controlled or reduced for participants in Pilot 1c	PSM w/t-test (one observation point)

Projected Evaluation Activities

DHHS intends to evaluate several hypotheses related to the added program and pilots to the demonstration, (see Table 4). Hypotheses focus primarily on access to various levels of care, service utilization, quality of care and care transitions, spillover effects of a more efficient service delivery system, and costs. The evaluation of the additional added programs and pilots to the 1115 waiver will be developed following waiver approval and the state acknowledges this must be approved by CMS. In addition, the State will comply with all required reporting requirements throughout the demonstration period, as required by CMS. When possible, proposed measures will be selected from nationally recognized sources and national measure sets. Maine understands and appreciates that there are CMS-defined measures to utilize for ongoing monitoring and evaluation, including measures adapted from the Adult Core Set. Data sources may include administrative data (e.g. licensing information), Medicaid claims data, stakeholder surveys/interviews/focus groups, and provider-supplied data. DHHS will also seek to align measures in this demonstration with existing quality improvement initiatives within the state, when relevant, to support focused system transformation and reduce administrative burden.

Table 4. 1115 Waiver Hypotheses and Potential Measures

Contingency Management Pilot		
Hypotheses	***Evaluation Approach***	***Data Sources***
The number of ED visits will decrease among beneficiaries participating in the CM Pilot.	Examine rates of ED visits for beneficiaries participating in Contingency Management Pilot compared with rates prior to the Pilot.	Claims data.
The rate of negative drug screens (stimulant-free biological tests) will increase among beneficiaries living with STUD who participate in the CM Pilot.	Examine rates of positive and negative drug screens among beneficiaries living with STUD, and who are participating in the pilot.	Data from CM vendor.
SMI/SED IMD		
Hypotheses	Evaluation Approach	Data Sources
The Demonstration will increase access to outpatient mental health services.	Examine utilization rate to outpatient behavioral health services.	- Medicaid Claims Data
The Demonstration will reduce hospitalization rates for individuals with SMI.	- Examine rate of psychiatric hospitalizations for decreased utilization for waiver participants	- Hospital Discharge Data - Claims Data
There will be a measurable reduction in preventable readmissions due to the services and length of stay permissible under this waiver	Examine Medicaid expenditure on inpatient care for reduced preventable readmissions for members who receiving	- Medicaid Claims Data - State Medicaid Reports
The Demonstration will improve coordination of care for individuals with SMI.	Examine follow-ups that are completed within 72 hours following discharge from an IMD for improvement	- Claims Data
Pilot 3 Transitions of Care Incentive Payment		
Hypotheses	***Evaluation Approach***	***Data Sources***
The number of ED visits will decrease among beneficiaries release from prison, jail, psychiatric inpatient, or residential setting.	Examine rates of ED visits for beneficiaries who have follow-up with 7 days or release compared to those who exceed the 7 day follow-up period.	Claims data
Pre-Release Medicaid Services for Justice-Involved Individuals		
Hypotheses	***Evaluation Approach***	***Data Sources***
Implementation of pre- release services will result in increased collaboration between stakeholders, identification of unaddressed medical and HRSN prior to release, gradual expansion of access to pre-release services for justice-involved individuals, and improved insights into healthcare delivery for this population.	Use a mixed-methods process evaluation approach to examine the implementation of pre-release services, including the identification of eligible individuals, unaddressed medical and HRSN, and provision of Medicaid- covered services in the pre-release setting.	Qualitative interviews of stakeholders review of guidance, workflows, and other documents to examine various aspects of implementation; and examination of health plan reports to assess progress of implementation.

Access to pre-release services will result in continuity of targeted health services upon release to the community, resulting in positive impacts on health outcomes.	Examine the post-release utilization of specific targeted health services including but not limited to housing supports, those that address other identified HRSN, and medication refills among individuals receiving pre-release services. Examine related and short term physical and behavioral health outcomes (e.g., stable housing, medication adherence).	Encounter data, specific outcome metrics of interest (e.g., medication possession ratio),
Pilot 5a: Food is Medicine		
Hypotheses	***Evaluation Approach***	***Data Sources***
Implementation of nutrition supports will result in increased collaboration between stakeholders, gradual expansion of access to nutrition services for qualifying individuals, and improved infrastructure for the provision of nutrition support services.	Use a mixed-methods process evaluation approach to examine the implementation of nutrition support programs including the identification of individuals with food insecurity, referral mechanisms to existing non-Medicaid nutrition programs, and provision of Medicaid-covered nutrition supports to qualifying individuals.	Qualitative interviews of stakeholders (e.g., QI health plans, SNAP program, MQD, and providers of nutrition support services); review of guidance, workflows and other documents to examine various aspects of implementation; and examination of QI health plan reports to assess progress of implementation.
Nutrition support services will result in reductions in food insecurity and improved disease management for participating individuals.	Assess the impact of each nutrition supports program on targeted outcomes. Examine related and proximal health outcomes (e.g., diabetes control).	Encounter data and to capture utilization metrics and other qualitative data. Additional data may be collected at target delivery locations if feasible.
Pilot 5b: Recuperative Care Pilot		
Hypotheses	***Evaluation Approach***	***Data Sources***
Members experiencing homelessness post-hospital discharge will have reduced hospital readmissions after utilizing Recuperative Care Services.	Members receiving recuperative care services will have reduced hospital readmissions annually and in comparison to a similar population in the four years preceding this benefit.	Administrative claims data
Pilot 5C: Structured Recovery Housing Services		
Hypotheses	***Evaluation Approach***	***Data Sources***
Members receiving Structured Recovery Housing Services will increase access to and utilization of necessary behavioral and physical health services.	Members receiving Structured Recovery Housing Services will have greater utilization of behavioral and physical health services annually and in comparison to a similar population in the four years preceding this benefit	Administrative claims data
Traditional Healing Therapies for Native Americans		
Hypotheses	***Evaluation Approach***	***Data Sources***
Coverage of traditional healing therapies will increase access to and utilization of traditional health care practices	Members receiving traditional healing therapies will have greater utilization of these health services annually and in comparison, to a similar population in the four years preceding this benefit	Administrative claims data

Waiver and Expenditure Authorities

Under the authority of Section 1115(a) of the Act, the following waivers and expenditure authorities shall enable Maine to implement the Whole Person Care demonstration from January 1, 2026, to December 31, 2030. To the extent that CMS advises the State that additional authorities are necessary to implement the programmatic vision and operational details described above, the State is requesting such waiver or expenditure authority as applicable. Maine's negotiations with the federal government, as well as State legislative/budget changes, could lead to refinements in these lists and Maine will work with CMS to identify and add any other waiver and/or expenditure authorities needed to authorize the requested waiver initiatives.

Table 17. Waiver Authorities

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
Waiver Authorities		
Statewideness: Section 1902(a)(1)	To enable the state to provide Parenting Supports as a pilot and on a geographically limited basis.	Currently Approved
	To enable the state to provide Home Based Skills Services as a pilot and on a geographically limited basis.	Currently Approved
	To the extent necessary to enable the state to implement the Food is Medicine pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the recuperative care pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the Structured recovery housing pilot in geographically limited areas of the state	Not currently approved
	To the extent necessary to enable the state to implement the healing therapies for Native Americans pilot in geographically limited areas of the state.	Not currently approved
	To the extent necessary to enable the state to implement the contingency management pilot in geographically limited areas of the state.	Not currently approved
	To enable the state to provide pre-release services to qualifying beneficiaries on a facility limited basis, as outlined in this application	Not currently approved
	To enable the state to provide Parenting Support Services as a pilot through only certain providers.	Currently approved

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
Freedom of Choice: Section 1902(a)(23)(A)	To enable the state to provide Home Based Skills Services as a pilot through only certain providers.	Currently approved
	To enable the state to provide contingency management as a pilot through only certain providers.	Not currently approved
	To enable the state to require qualifying beneficiaries to receive pre-release services, as described in this application, through only certain providers.	Not currently approved
	To enable the state to provide healing therapies for Native Americans as a pilot through only certain providers.	Not currently approved
Amount, Duration, and Scope of Services: Section 1902(a)(10)(B) **Comparability:** Section 1902(a)(17)	To the extent necessary to enable the state to provide Parenting Support Services that are not otherwise available to all beneficiaries in the same eligibility group.	Currently approved
	To the extent necessary to enable the state to provide Home Based Skills Services that are not otherwise available to all beneficiaries in the same eligibility group.	Currently approved
	To the extent necessary to enable the state to provide contingency management services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To enable the state to provide only a limited set of pre-release services to qualifying beneficiaries, as described in this application, that is different than the services available to all other enrollees outside of carceral settings in the same eligibility groups authorized under the state plan or the demonstration	Not currently approved
	To the extent necessary to enable the state to provide Food is Medicine services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved

Waiver Authority	Use for Waiver Authority	Currently Approved Waiver Authority
	To the extent necessary to enable the state to provide recuperative care services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to provide structured recovery housing services that are not otherwise available to all beneficiaries in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to offer coverage of traditional health care practices that are not otherwise available to all members in the same eligibility group	Not currently approved
	To the extent necessary to enable the state to offer coverage of contingency management services that are not otherwise available to all members in the same eligibility group	Not currently approved
Coverage for 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.	Not currently approved

Table 18. Expenditure Authorities

Expenditure Authorities
IMD Waiver Services

Expenditure Authorities		
SUD IMD Waiver Initiative	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.	Currently approved
SMI IMD Waiver Initiative	Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment services for MH who are short-term residents in facilities that meet the definition of an IMD.	Not currently approved
SUD Pilots		
Pilot 1a. Maintenance of Medicaid Coverage	Expenditures for continued benefits for individuals who have been determined eligible for the applicable continuous eligibility period who would otherwise lose coverage during an eligibility determination.	Currently approved
Pilot 1b. Parenting Support Services	Expenditures to provide Parenting Support Pilot services for individuals who meet the eligibility criteria and in accordance with this application.	Currently approved
Pilot 1c. Home-Based Skill Development Services	Expenditures to provide Home-Based Skill Development Services Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Currently approved
Pilot 1d. Contingency Management	Expenditures to provide Contingency Management Pilot services for individuals who meet the eligibility criteria in accordance with this application.	Not currently approved
Transitions of Care Incentive Payment		

Expenditure Authorities		
Pilot 3: Transitions of Care Incentive Payment	Expenditures for the Transitions of Care Incentive Payment	Not currently approved
Coverage for Justice-Involved Reentry		
Initiative 4 Expenditures Related to Pre-Release Services Expenditures Related to Pre-Release Services Initiative	Expenditures for pre-release services provided to qualifying demonstration beneficiaries who would be eligible for Medicaid, if not for their incarceration status, for up to 90 days immediately prior to the expected date of release from a participating state prison, county jail, or youth correctional facility.	Not currently approved
Expenditures Related to Pre-Release Services Capacity Building Funding	Expenditures for capacity building funding to support implementation of the Justice-Involved Reentry Initiative.	Not currently approved
HRSN Pilots		
Pilot 5a: Food is Medicine	Expenditures to provide Food is Medicine Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Pilot 5b: Recuperative Care Pilot	Expenditures to provide Recuperative Care Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Pilot 5c: Structured Recovery Housing Services	Expenditures to provide Recovery Housing Pilot Services for individuals who meet the eligibility criteria and in accordance with this application.	Not currently approved
Expenditures Related to HRSN Capacity Building	Expenditures for capacity building funding to support implementation of HRSN pilots.	Not currently approved
Designated State Health Programs		
Designated State Health Programs	Expenditures for Designated State Health Programs, as described in this application, which are otherwise fully state-funded, and not otherwise eligible for Medicaid matching funds.	Not currently approved
Traditional Healing Therapies for Native Americans		

Expenditure Authorities		
Traditional Healing Therapies for Native Americans	Expenditures for traditional health care practices received through Indian Health Service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act by Children's Health Insurance Program beneficiaries who are able to receive services delivered by or through these facilities	Not currently approved

V. PUBLIC COMMENT: This notice also serves to open the 30-day public comment period. DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov. The public may review the proposed waiver application at any Maine DHHS office in every Maine County. To find out where the Maine DHHS offices are, call 1-800-452-1926, or visit https://www.maine.gov/dhhs/about/contact/offices.

Comments and questions about the proposed 1115 waiver application can also be submitted by email to: Policy.DHHS@maine.gov or by mail to: Division of Policy/MaineCare Services, 242 State St. 11 State House Station, Augusta, Maine 04333-0011. All comments must be received by 11:59 pm, April 22, 2025.The public may review the proposed waiver application at any Maine DHHS office in every Maine County. To find out where the Maine DHHS offices are, call 1-800-452-1926, or visit https://www.maine.gov/dhhs/about/contact/offices.

Abbreviated Public Notice:

DHHS → Rulemaking → MaineCare Notice of Agency 1115 Waiver Renewal Application, "Maine Substance Use Disorder (SUD) Care Initiative"

MaineCare Notice of Agency 1115 Waiver Renewal Application, "Maine Substance Use Disorder (SUD) Care Initiative"

Date posted: Mar 21, 2025

Attachment(s):

- Maine 1115 Waiver Application Draft
- Updated 1115 Renewal Full Public Notice
- Correction to 1115 Renewal Full Public Notice
- Phone_Number_for_April_3_Call-in

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative"

CONCISE SUMMARY: The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.

- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing Benefit Coverage:

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release

- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearing

Hearing 1: Statewide Virtual/Teleconference Hearing	Hearing 2: Augusta Hearing
Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EblbXEW5dfillZsMurS4n.1 Phone one-tap: • +13126266799,,81403447665# US (Chicago) • +16468769923,,81403447665# US (New York) Webinar ID: 814 0344 7665	Date: April 10, 2025 Time: 9:00 AM Location: 109 Capitol St, Augusta, Maine 04330 Room A&B First Floor

STATUTORY AUTHORITY: 42 CFR §441.304

DEADLINE FOR COMMENTS: Comments must be received by 11:59 pm, April 22, 2025

AGENCY CONTACT PERSON: Courtney Pladsen, Medical Director

AGENCY NAME: MaineCare Services

ADDRESS: 109 Capitol Street

Augusta, Maine 04333-0011

EMAIL courtney.pladsen@maine.gov

Office: MaineCare Services

Comment deadline: Apr 22, 2025

Comments for this rule have been closed.

Newspaper Proofs (Kennebec Journal/Waterville Sentinal use same proof) :

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative

CONCISE SUMMARY: The Department plans to submit a five-year renewal to the Section 21. The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-00338/1), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing

Benefit Coverage

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearings

Hearing 1: Statewide Virtual/Teleconference Hearing

Date: April 3, 2025
Time: 11:30 AM
Location: Virtual & Teleconference link:
https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EblbXEW5dfiIlZsMurS4n.1

Hearing 2: Augusta Hearing

Date: April 10, 2025
Time: 9:00 AM
Location: 109 Capitol St, Augusta, Maine 04330
Room A&B First Floor

STATUTORY AUTHORITY: 42 CFR §441.304

DEADLINE FOR COMMENTS: Comments must be received by 11:59 pm, April 22, 2025

AGENCY CONTACT PERSON: Courtney Pladsen, Medical Director
AGENCY NAME: MaineCare Services
ADDRESS: 109 Capitol Street
Augusta, Maine 04333-0011
EMAIL courtney.pladsen@maine.gov

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative

CONCISE SUMMARY: The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-00338/1), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing

Benefit Coverage

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services.
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release.
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities.
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services.

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025.
For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1 Public Hearings

Hearing 1: Statewide Virtual/Teleconference Hearing Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://mainestate.zoom.us/j/81403447665? pwd=yXRwcDjF0EbIbXEW5dlllZaMurS4n.1	Hearing 2: Augusta Hearing Date: April 10, 2025 Time: 9:00 a.m. Location: 109 Capitol St, Augusta, Maine 04330 Room A&B, First Floor

STATUTORY AUTHORITY: 42 CFR §441.304
DEADLINE FOR COMMENTS: Comments must be received by 11:59 pm, April 22, 2025.
AGENCY CONTACT PERSON: Courtney Pladsen, Medical Director
AGENCY NAME: MaineCare Services
ADDRESS: 109 Capitol Street, SHS # 11
Augusta, Maine 04333-0011
EMAIL courtney.pladsen@maine.gov

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

March 21, 2025

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services
RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application
WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative
CONCISE SUMMARY: The Department plans to submit a five-year renewal to the Section 21, The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-00338/1), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing

Benefit Coverage

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearings

Hearing 1: Statewide Virtual/Teleconference Hearing
Date: April 3, 2025
Time: 11:30 AM
Location: Virtual & Teleconference link:
https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EbIbXEW5dfiIZsMurS4n.1

Hearing 2: Augusta Hearing
Date: April 10, 2025
Time: 9:00 AM
Location: 109 Capitol St, Augusta, Maine 04330
Room A&B First Floor

STATUTORY AUTHORITY:	42 CFR §441.304
DEADLINE FOR COMMENTS:	Comments must be received by 11:59 pm, April 22, 2025
AGENCY CONTACT PERSON:	Courtney Pladsen, Medical Director
AGENCY NAME:	MaineCare Services
ADDRESS:	109 Capitol Street Augusta, Maine 04333-0011
EMAIL	courtney.pladsen@maine.gov

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

TELEPHONE:	207-624-4951 FAX: (207) 287-1864 TTY: 71

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative"

CONCISE SUMMARY: The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in institutions for Mental Diseases (IMD) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-00338/1), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing Benefit Coverage

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for Justice-Involved Individuals in the 90 days prior to release
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program Beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a correctional setting have their Medicaid suspended. Processes improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system.

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearings

Hearing 1: Statewide Virtual/ Teleconference Hearing Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://maine.zoom.us/j/81403447665?pwd=yXRwaDJF0EblbXEW5dfIlZsMurS4n.1	**Hearing 2: Augusta Hearing** Date: April 10, 2025 Time: 9:00 AM Location: 109 Capitol St, Augusta, Maine 04330 Room A&B First Floor

STATUTORY AUTHORITY:	42 CFR §441.304
DEADLINE FOR COMMENTS:	Comments must be received by 11:59 pm, April 22, 2025
AGENCY CONTACT PERSON:	Courtney Pladsen, Medical Director
AGENCY NAME:	MaineCare Services
ADDRESS:	109 Capitol Street Augusta, Maine 04333-0011
TELEPHONE:	courtney.pladsen@maine.gov

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

Public notice dissemination on 3/21/25 included from electronic files. Notice was sent on 3/21/25 to:

- The Office of MaineCare Services Interested Parties (IP) listserv of 224 members
- As an e-bulletin to everyone who is subscribed to Maine.gov Listserv under the Policy and State Plan Amendment and the State & Federal Policy subscriptions
- Posted on Office of MaineCare Services Maine.gov website: https://www.maine.gov/dhhs/about/rulemaking/mainecare-notice-agency-1115-waiver-renewal-application-maine-substance-use-disorder-sud-care-2025-03-18 .

Office of MaineCare Services

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You are subscribed to MaineCare - State & Federal Policy for Maine Department of Health & Human Services. This information has recently been updated, and is now available.

Notice of MaineCare 1115 Waiver Renewal Application, "Maine Substance Use Disorder (SUD) Care Initiative"

Notice of MaineCare 1115 Waiver Renewal Application, "Maine Substance Use Disorder (SUD) Care Initiative"
Mar 21, 2025

The Division of Policy posts all proposed and recently adopted rules on MaineCare's Policy and Rules webpage. This website keeps the proposed rules on file until they are finalized and until the Secretary of State website is updated to reflect the changes. The MaineCare Benefits Manual is available on-line at the Secretary of State's website.

Below, please find a MaineCare Notice of Agency Waiver Renewal Application. You can access the complete details at http://www.maine.gov/dhhs/oms/rules/index.shtml.

Notice of Agency Waiver Renewal

AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative"

CONCISE SUMMARY: The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved

waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD.

Proposed Additional Waiver Services:

- Maine is requesting new waiver authority under Section 1115 to claim FFP for the provision of contingency management (CM) services.
- Maine is requesting new waiver authority under the Section 1115 Serious Mental Illness (SMI) demonstration opportunity. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
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services and related capacity building for the next demonstration period using Designated State Health Program expenditures.

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Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing
Benefit Coverage:

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all “full benefit” eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries’ Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearing

Hearing 1: Statewide Virtual/Teleconference Hearing Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EblbXEW5dfillZsMurS4n.1	**Hearing 2: Augusta Hearing** Date: April 10, 2025 Time: 9:00 AM Location: 109 Capitol St, Augusta, Maine 04330 Room A&B First Floor

STATUTORY AUTHORITY: 42 CFR §441.304

DEADLINE FOR COMMENTS: Comments must be received by 11:59 pm, April 22, 2025

AGENCY CONTACT PERSON: Courtney Pladsen, Medical Director

AGENCY NAME: MaineCare Services

ADDRESS: 109 Capitol Street

Augusta, Maine 04333-0011

EMAIL: courtney.pladsen@maine.gov

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GOVDELIVERY

The Division of Policy posts all proposed and recently adopted rules on MaineCare's Policy and Rules webpage. This website keeps the proposed rules on file until they are finalized and until the Secretary of State website is updated to reflect the changes. The MaineCare Benefits Manual is available on-line at the Secretary of State's website.

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Notice of Agency Waiver Renewal
AGENCY: Department of Health and Human Services (DHHS), Office of MaineCare Services

RULE TITLE OR SUBJECT: 1115 Waiver Renewal Application

WAIVER: Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative"

CONCISE SUMMARY: The state of Maine DHHS seeks a five-year waiver renewal approval period to operate this waiver statewide, with a requested start date of January 1, 2026. The currently approved waiver authorizes the state to receive Federal Financial Participation (FFP) for services described in the Maine Medicaid state plan when provided to members residing in Institutions for Mental Diseases (IMDs) for short-term stays to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025.

DHHS seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing services, and improves health outcomes by addressing Health-Related Social Needs (HRSN). With the expansion of intent, Maine seeks to rename this demonstration to Maine's Whole Person Care Waiver.

General:

- Continuation of approval for eligibility for covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
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care from IMDs on a short-term basis and ensure that they are supported in their transitions to the community.

- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot.
- Maine is requesting waiver authority to extend Medicaid coverage for targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility.
- Maine is requesting expenditure authority for federal matching funds to provide targeted services, including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care, including room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness and pre-procedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost-based Per Member Per Month payments to certified recovery residences.
- Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building, and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program expenditures.
- Maine requests the authority to cover traditional healing therapies received through Indian Health Services or Tribal Organizations as defined by CFR Title 42, Chapter I, Subchapter M, Part 137, Subpart B, § 137.10, for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.
- Capacity Building Funds: To support cross-system implementation efforts for this initiative, Maine is requesting $15 million in total computable capacity-building funds. Capacity-building funds will be available to entities partnering with DHHS to implement the initiative, including correctional facilities. This funding will support planning and implementation activities, including but not limited to conducting stakeholder engagement, hiring and training new staff, strengthening health information technology systems, and establishing new operational workflows, processes, and space modifications needed to implement this initiative across participating correctional settings.

Proposed Benefit Coverage, Enrollment Limits, Eligibility Requirements, and Cost Sharing Benefit Coverage:

The State continues to request an enhanced set of benefits for the currently approved SUD Pilots. Other changes to benefits proposed in the renewal include:

- Providing Contingency Management services
- Providing targeted pre-release services for justice-involved individuals in the 90 days prior to release
- Provide access to traditional healing received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and Children's Health Insurance Program beneficiaries who can receive services delivered by or through these facilities
- Providing the HRSN pilots: Food is Medicine, Recuperative Care, and the Structured Recovery Housing Services

Enrollment Limits: No enrollment limits exist for people who meet the waiver participation requirements in Section II (Continuing Demonstration Features and Changes Requested to the Demonstration).

Eligibility Requirements: DHHS proposes implementing the initiatives across all "full benefit" eligibility groups. The implementation plans will provide processes to streamline the exchange of data to demonstration settings about beneficiaries' Medicaid status. Currently, people enrolled in Medicaid and in a carceral setting have their Medicaid suspended. Process improvements to streamline Medicaid determinations will be included in the implementation plan for people not enrolled in Medicaid prior to incarceration.

Delivery System: All MaineCare members will continue to receive services through the current delivery system

Cost Sharing: No changes to cost sharing are proposed under this demonstration. Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

Demonstration Enrollment, Expenditures, and Budget Neutrality: The renewal application includes budget Cost Neutrality and Derivation of Estimates for the requested extension period.

Please see the accompanying draft application for all proposed changes included in the renewal.

DHHS is accepting comments through 11:59 pm, April 22, 2025. Any interested party may obtain a copy of the waiver application. A printed copy may be obtained by calling Lisa Weaver at (207) 624-4050 or emailing lisa.weaver@maine.gov.
See http://www.maine.gov/dhhs/oms/rules/index.shtml for the full public notice document, waiver application draft, and to submit comments.

Maine DHHS intends to host two public workshops on April 3, 2025 and April 10, 2025. For more information, the public notice and information for public workshops on this waiver are posted online at http://www.maine.gov/dhhs/oms/rules/index.shtml DHHS will also post a finalized draft waiver application online, including a summary of public comments received, once available.

Table 1. Public Hearing

Hearing 1: Statewide Virtual/Teleconference Hearing Date: April 3, 2025 Time: 11:30 AM Location: Virtual & Teleconference link: https://mainestate.zoom.us/j/81403447665?pwd=yXRweDjF0EblbXEW5dfillZsMurS4n.1	Hearing 2: Augusta Hearing Date: April 10, 2025 Time: 9:00 AM Location: 109 Capitol St, Augusta, Maine 04330 Room A&B First Floor

STATUTORY AUTHORITY: 42 CFR §441.304

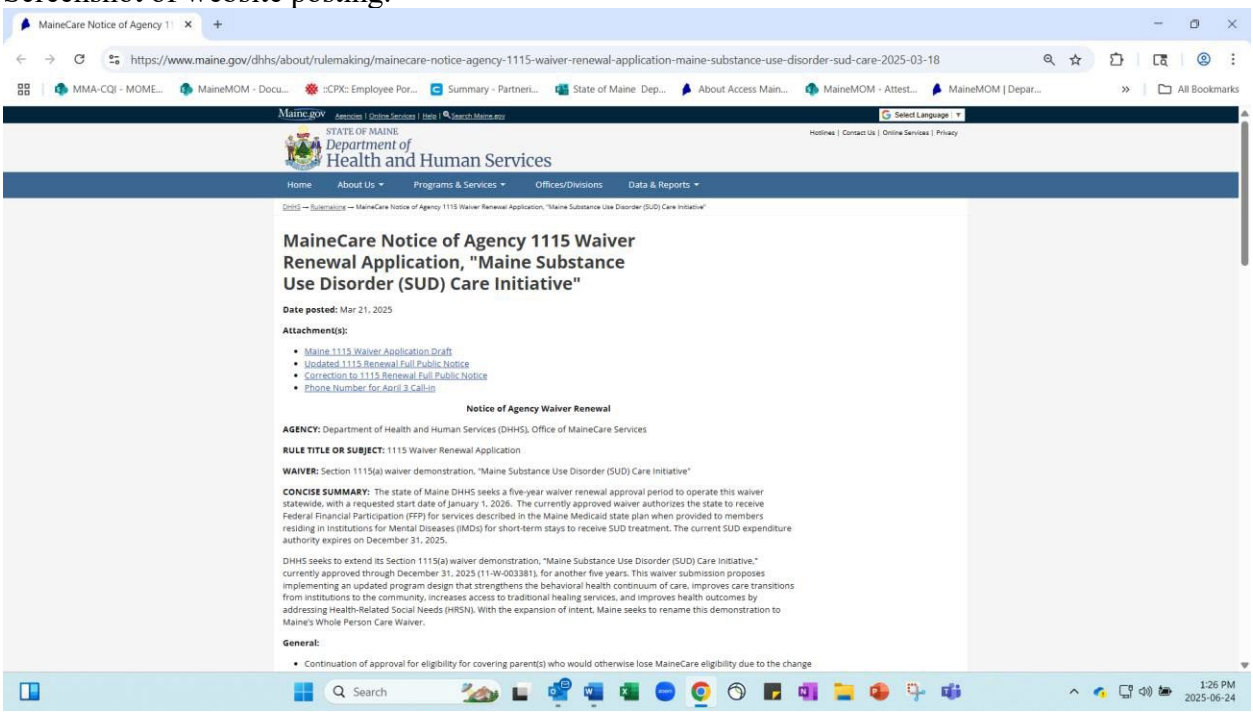
DEADLINE FOR COMMENTS: Comments must be received by 11:59 pm, April 22, 2025
AGENCY CONTACT PERSON: Courtney Pladsen, Medical Director
AGENCY NAME: MaineCare Services
ADDRESS: 109 Capitol Street
Augusta, Maine 04333-0011
EMAIL courtney.pladsen@maine.gov

Update your subscriptions, modify your password or email address, or stop subscriptions at any time on your Subscriber Preferences Page. You will need to use your email address to log in. If you have questions or problems with the subscription service, please visit subscriberhelp.govdelivery.com. This service is provided to you at no charge by Maine Department of Health & Human Services.

Office of MaineCare Services Website posting:

https://www.maine.gov/dhhs/about/rulemaking/mainecare-notice-agency-1115-waiver-renewal-application-maine-substance-use-disorder-sud-care-2025-03-18

Screenshot of website posting:



Attachment 5 – Response to Public Comments

The Office of MaineCare services within the Department of Health and Human Services (The Department) held a public comment period from March 21, 2025, through April 22, 2025, regarding the **1115 Whole Person Care Waiver.** As part of the public comment period, MaineCare held a virtual/telephonic public forum on April 3, 2025, and an in-person public forum on April 10, 2025, to present the application for Maine's 1115 Demonstration Whole Person Care Waiver and allow time for public comments. In addition, the Department discussed the application during the virtual March 4, 2025, MaineCare Advisory Council meeting. Following the public hearing, the Department accepted written public comments on the Waiver application through April 22, 2025.

The Department received 16 Comments during hearings and 12 comments via email. All comments were supportive; one comment offered support conditional on the approach to funding current IMD beds, only if the funds freed up did not include *new* beds.

This appendix summarizes key themes of the public comments received and provides the Department's responses. The Department appreciates the valuable and thoughtful comments submitted and is committed to continuing an open and collaborative process to continue to strengthen Maine's Medicaid program and improve health for all Mainers.

1. Goals of Maine's 1115 Whole Person Care Waiver

Comment summary:
Twenty-eight (28) comments were received in support of the Waiver. Commenters agreed with the overall vision and goals of the Whole Person Care Waiver demonstration application and urged the Department to work with CMS to obtain approval of Maine's requests as soon as possible. Commentors also identified key aspects of implementation and operations that would facilitate success, including examples of best practices. Commentors brought forth many lived experiences describing challenges for those living with serious mental illness, brain injuries, and substance use disorders in their families and communities. These experiences are moving and extremely valuable to improving care for Mainers, and we plan to continue to engage with providers and the public and utilize their lived experiences and expertise in developing the waiver implementation plan.

2. Objective 1: Sustain & Improve the SUD Continuity of Care

***Comment summary*:**
One comment expressly supported the addition of Contingency Management to support MaineCare members living with stimulant use disorder. Stated support also included the use of resources for evidence-based training & education, and a request for sites beyond Certified Community Behavioral Health Centers (CCBHCs) to be eligible to provide Contingency Management (CM)

Response:
Maine appreciates the expressed support of this component of the waiver. Since CCBHCs have an established pathway to implement CM, these sites were identified as the first locations for

implementation. Based upon feedback received, DHHS will modify the application to include the possibility of expansion of CM beyond CCBHCs in subsequent phases. Additionally, Maine CCBHCs are able to establish Designated Collaborating Organizations (DCOs), which is another potential opportunity for the expansion of CM services. A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. CCBHCs must establish formal agreements if they choose to utilize a DCO to serve CCBHC enrolled members. A formal relationship is evidenced by a contract or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. More information about CCBHC requirements is available at https://www.maine.gov/dhhs/oms/providers/value-based-purchasing/ccbhc (see the latest Maine CCBHC Certification Guide).

3. Objective 2: Improve and Align the Service Delivery for Individuals Living with SMI with Best Practices

***Comment Summary*:**

Nineteen (19) comments were in support of this objective. Specific requests included increasing the number of residential treatment programs, often referred to as Private Non-Medical Institutions (PNMIs) in Maine, the addition of at least four more Assertive Community Treatment teams across the state, more intensive case managers, transitional housing units, and more police liaison officers to support keeping people safe in a community setting rather than experience homelessness, be incarcerated, or hospitalized. One comment offered support, conditional on the approach to fund current IMD beds, only if the funds freed up did not include *new* inpatient psychiatric beds. Several comments were made requesting an increase in the number of progressive treatment plans. There was a comment expressing concern about covering out-of-state IMDs. They wanted to ensure this would not lead to more people being sent to out-of-state facilities.

Response:

The Department wants to express our gratitude for the many individuals who attended the public hearings and submitted public comments, sharing their personal stories and expertise. The Department is committed to working with Mainers to improve the continuum of behavioral health services.

As a condition of receiving approval for a waiver of the Institutions of Mental Disease (IMD) exclusion for individuals with SMI, the state will need to meet milestones focused enhancing the quality of care in psychiatric hospitals and residential settings, improving care coordination and transitions to the community, and increasing access to crisis stabilization and community-based services. The state is not seeking to add inpatient psychiatric beds. Instead, the Department is pursuing sustainable funding for inpatient care so that it has the support available to improve care transitions and strengthen community-based services to avoid the need for inpatient psychiatric care.

The Department shares the commitment to improving community-based supports for Mainers with mental health needs. Under the leadership of Governor Mills, the Department has made significant investments over the past six years to strengthen the behavioral health continuum.

Some examples include:

- Supporting Mobile Crisis Teams: $5.3 million for FY25, supplemented by enhanced federal matching funds, to strengthen mobile crisis response through a comprehensive MaineCare payment model.
- Implementing Comprehensive Behavioral Health Centers: $2 million for startup and implementation costs for all organizations participating in the certified community behavioral health clinic demonstration.
- Strengthening the Behavioral Health Workforce: $2.5 million in ongoing funding for providers of medication management to increase recruitment and retention of skilled workers and clinicians.
- Adjusting Payments to Behavioral Health Providers for Inflation: $19.8 million to ensure payments to behavioral health providers keep pace with costs affected by inflation. Increase in Residential Treatment Beds for SUD: 140 new residential treatment beds for substance use disorder were created across the state, an increase of nearly 40 percent, supported by $6 million in funding. Establishing the Options Program statewide, inclusive of hiring 16 behavioral health liaisons (one in each county) to work alongside local emergency services and law enforcement to provide therapeutic interventions, outreach, referrals, and post-overdose follow-up for individuals

Increase the number of PNMIs: Private Non-Medical Institutions are already a Medicaid-covered service for people with severe persistent mental illness. The Department welcomes any new or existing providers to open additional PNMIs. Additionally, OBH provides funding to support individuals who are underinsured or uninsured in accessing this resource.

Assertive Community Treatment (ACT): ACT services are an essential component of the behavioral health continuum and are crucial in providing care that prevents hospitalization. In 2024, the Department released a request for applications to expand ACT services. Subsequently, ACT services have expanded to two additional counties: Oxford and Franklin. ACT services are a MaineCare-covered service, and we welcome any qualified provider to enroll or expand ACT services.

Progressive Treatment Plans: There were comments in support of accessing Progressive Treatment Plans, which are outside the scope of an 1115 waiver. A Maine statute (MRS Title 34-B, §3873-A. PROGRESSIVE TREATMENT PROGRAM) outlines the process for this plan. Additionally, the Department provides financial support to individuals and families who require legal representation in this process.

Out-of-state services: Maine currently does not have any treatment beds for inpatient eating disorder care for adults. The Department currently works with out-of-state IMDs to ensure access to this life-saving care. Due to the IMD exclusion, MaineCare cannot pay for this necessary service. The waiver would ensure access to clinically necessary care out of state if needed.

4. Objective 3: Improve the Continuity of Care During Transitions by Building and Strengthening Relationships with Community-Based Organizations

Comment summary:

Two comments expressed support for this Objective in supporting continuity of care, specifically noting the importance for individuals leaving a correctional setting to receive the support needed to be successful in the community of their choosing.

Response:
No changes to the waiver are required, and the feedback will be incorporated into the development of the implementation plan.

5. **Objective 4: Improve the continuity of Coverage and Access to Needed Care by Leveraging Re-Entry Initiatives, Including Pre-Release Services for Justice-Involved Individuals**

***Comment summary*:**
Three (3) comments specifically supported this objective and encouraged the Department to consider including intensive family-based reentry benefits for this population. Allowing federal match for reentry services will improve health outcomes for formerly incarcerated people and lower healthcare costs. Considering the unique needs of women in carceral settings in the design and operationalization of this benefit is recommended. Comments also included operational and implementation questions, with requests to involve facilities in defining the timelines and approach to implementation. Concerns were also expressed about current resource gaps, particularly funding substance use treatment services in county facilities.

Response:
Thank you for the comments. No change to the 1115 Waiver required.

Many of the concerns or questions raised were related to operational planning that has not yet taken place. The implementation plan will be developed after submitting the application to CMS. The Department is committed to working collaboratively with the County Jails and the Department of Corrections as more detailed implementation and operational decisions are made. Depending on appropriations, the Department plans to use capacity-building funds to support the implementation and system changes required for the reentry initiative implementation within the Jails and the DOC. We will work with the jails to develop an implementation plan that meets their needs.

6. **Objective 5: Establish Health Related Social Needs (HRSN) Benefits, including Food is Medicine, and Recuperative Care**

Comment Summary: Food is Medicine
Eight (8) comments specifically supported HRSN Food is Medicine approaches, noting the unique readiness of Maine communities and local systems for Food is Medicine implementation with active opportunities to work with local and operational best practices. Recommendations also identified specific populations to benefit from Food is Medicine (e.g., those living with cancer, HIV, and pregnant individuals).

Comments also included support for using capacity funding for Maine's funding request to build and sustain HRSN infrastructure, in recognition of the significant impact that HRSN has on individual and community health.

Response:

Thank you for your comments in support of the HRSN and Food is Medicine component of the waiver. No changes are required to the waiver. We will consider the operational recommendations during the implementation planning phase.

Comment Summary Recuperative Care:
Two commenters specifically supported the Department's proposal to provide recuperative care services to eligible members as a complement to other housing-related support offered by the State. The Department was also asked to keep the unique needs of pregnant and postpartum people in mind during the design and roll-out. Recuperative care was also supported to facilitate recovery from medical procedures.

Response:
Thank you for your comments. We recognize the unique needs of people with housing instability who are pregnant or postpartum. No changes to the waiver are required, and we incorporate this feedback into the implementation plan.

7. Objective 6: Traditional Healing Therapies for Native Americans

Comment Summary: Traditional Healing Therapies
One comment specifically supported Traditional Healing Therapies, recommending that the Department consider the unique needs of pregnant and parenting individuals, as well as those seeking reproductive healthcare, when incorporating traditional healing services into preventative services categories.

Response:
Thank you for your comment. The Department is committed to working with the Wabanaki Nations through work groups and tribal consultation to develop an implementation plan that meets the unique needs of each of the tribes. The Department appreciates the expressed support of this component and the unique needs of people who are pregnant and parenting, as well as reproductive healthcare. No changes to the waiver are required.

Attachment 6 – Tribal Notification & Response to Tribal Notification

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Chief Clarissa Sabattis
88 Bell Road
Littleton, ME 04730

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Chief Sabattis:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

- Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.
- Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Chief Edward Peter-Paul
8 Northern Road
Presque Isle, ME 04769

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Chief Peter-Paul:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

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Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Chief William Nicholas
P.O. Box 301
Princeton, ME 04668

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Chief Nicholas:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

- Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.
- Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

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your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Chief Rena Newell
P.O. Box 343
Perry, ME 04667

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Chief Newell:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

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Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Chief Kirk Francis
12 Wabanaki Way
Indian Island, ME 04468

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Chief Francis:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

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Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Michelle Barrows
12 Clover Circle
Houlton, ME 04730

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Barrows:

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Director, Office of MaineCare Services

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Janet T. Mills
Governor

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Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Katie Espling
8 Northern Road
Presque Isle, ME 04769

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Espling:

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- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Carol Francis
P.O. Box 97
Princeton, ME 04668

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Francis:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

- Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.
- Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.
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Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Jesse Bean
P.O. Box 351
Perry, ME 04667

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Jesse Bean:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

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The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

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Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Candy Henderly
23 Wabanaki Way
Indian Island, ME 04468

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Henderly:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

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Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ambassador Zeke Crofton-MacDonald
88 Bell Road
Littleton, ME 04730

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ambassador Crofton-MacDonald:

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Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Vice Chief Joseph Socobasin
P.O. Box 301
Princeton, ME 04668

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Vice Chief Socobasin:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

- Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.
- Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



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March 21, 2025

Vice Chief Pos Bassett
P.O. Box 343
Perry, ME 04667

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Vice Chief Bassett:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

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[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
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Sara Gagné-Holmes
Commissioner



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March 21, 2025

Ambassador Maulian Dana
12 Wabanaki Way
Indian Island, ME 04468

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ambassador Dana:

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[redacted]

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Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
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Sara Gagné-Holmes
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March 21, 2025

Ms. Leona Alvarado
88 Bell Road
Littleton, ME 04730

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Alvarado:

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March 21, 2025

Ms. Lisa Sockabasin
P.O. Box 1356
Bangor, ME 04401

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- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

Should you have any questions about these changes, please contact Courtney Pladsen, Medical Director, Office of MaineCare Services at courtney.pladsen@maine.gov .

Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely,

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Rebecca Petrie
P.O. Box 1356
Bangor, ME 04401

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Petrie:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

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[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Crystal Bore
P.O. Box 351
Perry, ME 04667

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Bore:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

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Sincerely

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Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Theresa Cochran
P.O. Box 1356
Bangor, ME 04401

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Cochran:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

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[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Andrea Hanson
P.O. Box 97
Princeton, ME 04668

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Hanson:

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Please note this communication is also being sent to the tribal health director on file with the Department. If you would like future communications sent to any additional individuals within

your organization, please contact us. Thank you for serving MaineCare members. We look forward to working with you on this and future efforts.

Sincerely

[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Janet T. Mills
Governor

Sara Gagné-Holmes
Commissioner



Maine Department of Health and Human Services
Office of MaineCare Services
11 State House Station
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-2675
TTY: Dial 711 (Maine Relay)

March 21, 2025

Ms. Allison Binney

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

Dear Ms. Binney:

This is a notice of a forthcoming submission from the Department of an 1115 Demonstration Waiver renewal and application for Whole Person Care.

1115 Waiver Renewal Application for Whole Person Care:

The State of Maine seeks to extend its Section 1115(a) waiver demonstration, "Maine Substance Use Disorder (SUD) Care Initiative," currently approved through December 31, 2025 (11-W-003381), for another five years. This waiver submission proposes implementing an updated program design that strengthens the behavioral health continuum of care, improves care transitions from institutions to the community, increases access to traditional healing therapies, and improves health outcomes by addressing Health-Related Social Needs (HRSN). The application includes a request for three new 1115 demonstration opportunities. Overarching 1115 Waiver Demonstration Renewal goals are to:

- Maximize access to high-quality behavioral health services at the appropriate level of care.
- Improve health outcomes during transitions to reduce health disparities.
- Develop and maintain adequate infrastructure and system capacity to deliver MaineCare-reimbursed reentry, HRSN, and traditional healing therapies.

The Department plans to submit the Application in the next 60 days. The Department discussed the proposed change with Maine's five federally recognized tribal health centers during the October 3, 2024, and February 6, 2025, Tribal Health Directors' conference calls, as well as on December 12, 2024, at the Tribal Behavioral Health meeting. The main purpose of this Waiver continuation request is to continue existing activities and additional components, including the following continuations and changes:

The currently approved Maine Substance Use Disorder Care Initiative, authorizes the state to receive Federal Financial Participation (FFP) for services as described in the Maine Medicaid state plan when provided to members residing in IMDs for short-term stays primarily to receive SUD treatment. The current SUD expenditure authority expires on December 31, 2025. The department requests to renew and continue the following existing activities:

- Continuation of approval to expand eligibility to continue covering parent(s) who would otherwise lose MaineCare eligibility due to the change in household size when their child is removed from the home under state law.
- Continuation of approval to offer the Parenting Support Services pilot focusing on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching.
- Continuation of approval to offer daily living skills development, community integration, and housing support services to eligible parents with an SUD. The services include psychosocial rehabilitation to restore the individual's skills and abilities essential to independent living and avoiding crisis intervention, residential care, or hospitalization. A member eligible for this pilot are MaineCare-enrolled parents with a SUD who are involved with or at risk of involvement with CPS and whose services have been recommended by a physician or other licensed practitioners.

Proposed Additional Waiver Services:

- Maine is seeking new waiver authority under Section 1115 to claim Federal Financial Participation (FFP) for the provision of contingency management (CM) services described below. Maine is seeking to implement this demonstration on January 1, 2028, following approval by CMS and eligibility systems and technical infrastructure. Maine's proposal to pilot CM reflects an evidence-based approach that recognizes and reinforces individual positive behavior change consistent with substance non-use or medication/treatment adherence. The CM will be capped at $750 per person, per year for each participating member.
- Maine is seeking new waiver authority under Section 1115 SMI demonstration opportunity and proposes to focus its goals and strategies on SMI/IMD. Maine seeks expenditure authority to stabilize individuals who require care from IMDs on a short-term basis, ensuring that they are supported in their transitions to the community. Maine is committed to establishing a comprehensive, effective continuum of care for individuals with SMI, with strategies to support community-based services to the maximum extent possible. For some individuals living with SMI, short-term stays in IMDs may be required to ensure effective support in accordance with established evidence. The goal is to, wherever possible, support the ability of individuals to flourish in their communities.
- Maine is requesting expenditure authority for federal matching funds to provide a Transitions of Care Incentive Payment pilot. Maine is seeking to implement an incentive payment to providers who render services to members within 7 days of release from institutions, including hospitals, IMDs, and carceral settings, including jails, prisons, and youth correctional centers, to improve the continuum of care. The incentive payment will be an additional $236.77 per eligible claim.

- The state requests waiver authority to extend Medicaid coverage for a set of targeted Medicaid services up to 90 days pre-release for individuals transitioning from jails, prisons, and the youth correctional facility. This waiver will provide healthcare access, including mental health and substance use treatment, to improve re-entry outcomes and support community reintegration. Maine is requesting $15 million in total computable capacity building funding to support service delivery.
- Maine is requesting expenditure authority for federal matching funds to provide a set of targeted services including food pharmacy/fruit and vegetable prescriptions, nutrition counseling/education, case management for nutrition benefits, and medically tailored meals.
- Maine is requesting expenditure authority for federal matching funds to cover recuperative care inclusive of room, board, and onsite clinical services. MaineCare is seeking federal matching funds for recuperative care for members experiencing homelessness for preprocedural and post-hospitalization care for individuals with an acute medical condition. The state proposes a recuperative care pilot with three sites.
- Maine is requesting expenditure authority for federal matching funds to provide bundled and cost based Per Member Per Month (PMPM) payments to certified recovery residences. These programs support parents with SUD who are at risk of or are currently involved with CPS for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs

Designated State Health Programs:

Maine is seeking expenditure authority to support the non-federal share of funding for pre-release services for justice-involved individuals and related capacity building and for HRSN services and related capacity building for the next demonstration period using Designated State Health Program (DSHP) expenditures. Maine is requesting $X million in total computable DSHP funding. Maine is engaging in a cross-divisional review of eligible state health programs and as such, the requested DSHP amount may be subject to change. Maine will work with CMS to finalize the demonstration initiatives that can be supported with DSHP funding, and to develop Special Terms and Conditions (STCs) and DSHP funding and reimbursement protocols for the demonstration period to reflect the demonstration's goals and funding levels

Traditional Healing Therapies for Native Americans:

Maine requests the authority to cover traditional healing therapies received through Indian Health Services, Tribal, or urban Indian organization facilities for Medicaid and CHIP beneficiaries who can receive services delivered by or through these facilities. Maine is working with the Wabanaki Nations to develop and solidify the specifics of the request, including the eligible services, benefits, and provider types.

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[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

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March 21, 2025

Mr. Corey Hinton

Re: Notice of 1115 Waiver Application Whole Person Care Demonstration

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[redacted]

Michelle Probert
Director, Office of MaineCare Services

cc: Courtney Pladsen, Medical Director, MaineCare Services

Attachment 6 Response to Tribal Notification

Response to Tribal Notification

Comment Summary: Traditional Healing Therapies
The Department met virtually and in person with tribal consultation as the application was being developed and continues to meet with tribal health center leaders to gather recommendations and support implementation planning. There was significant enthusiasm for pursuing the waiver to support Traditional Healing therapies. During a site visit to a tribal health center, we heard concerns about the exchange of funding for spiritual practices. They said it was worth exploring the possibilities of the waiver for Traditional Healing Therapies but cautioned that we need to proceed with care and look to the Wabanaki Nations to lead the design of implementation. We discussed how each tribe in Maine is unique and that each tribe may require or need different services. One commentator also highlighted the challenge of identifying and contracting with traditional healers.

Response:
Thank you for your comments. The Department is committed to working with the Wabanaki Nations through work groups and tribal consultation to develop an implementation plan that meets the unique needs of each of the tribes. No changes to the waiver are required.

Attachment 7 – Assessment of the Availability of Mental Health Services

Narrative Description (to be completed at baseline)
1. In the space below, describe the mental health service needs (e.g. prevalence and distribution of SMI/SED) of Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. [Limit responses to 500 words if possible]
Maine faces significant challenges in providing adequate behavioral health services, particularly due to its vast rural geography and relatively small, dispersed population. According to the Health Resources and Services Administration (HRSA), every county in Maine contains medically underserved areas, spanning both rural and nonrural regions. The state has 70 federally designated Mental Health Professional Shortage Areas (MH-HPSAs), with 399,337 residents—nearly a third of the population—living in one of these areas. Per the 2022 State of Mental Health in America Report from Mental Health America (MHA), Maine ranks 37 of 50 states (plus DC) regarding adult mental health. Approximately 22.1% of Maine adults report experiencing any mental illness, exceeding the national average of 19.9%, placing the state 35th in this category. Serious mental illness (SMI) affects 4.6% of the adult population in Maine, closely mirroring the national rate of 5.1%. Access to care remains a pressing concern, with 12.6% of adults with mental illness lacking adequate insurance—ranking Maine 37th—and 25.9% reporting that they did not receive needed mental health care in the past year, ranking the state 33rd. Medicaid plays a critical role in behavioral health access, as 25.7% of adults with mental illness in Maine are enrolled in Medicaid, a higher proportion than the national average of 21.6%. Notably, 42% of adults enrolled in MaineCare, the state's Medicaid program, have at least one diagnosed mental health condition. These figures collectively underscore the urgent need to strengthen Maine's behavioral health workforce and infrastructure to meet the growing demand for services.
2. In the space below, describe the organization of the state's Medicaid behavioral health service delivery system at the beginning of the demonstration. [Limit responses to 500 words if possible]
The State of Maine's Medicaid program, MaineCare, covers a continuum of behavioral health services ranging from early intervention services to crisis intervention, including outpatient treatment, residential treatment, and inpatient treatments for individuals with behavioral health needs. Treatment options include outpatient and inpatient services, as well as community-based programs like assertive community treatment are designed to support individuals with SMI. In Maine there is access to substance use treatment across all ASAM levels but access varies highly by county. Additionally, efforts to implement crisis services, such as mobile crisis teams, crisis stabilization units, and Certified Community Behavioral Health Clinics (CCBHC), are underway to provide immediate support and lessen the reliance on inpatient care.

Narrative Description (to be completed at baseline)
3. In the space below, describe the availability of mental health services for Medicaid beneficiaries with SMI/SED in the state at the beginning of the demonstration. At minimum, explain any variations across the state in the availability of the following: inpatient mental health services; outpatient and community-based services; crisis behavioral health services; and care coordination and care transition planning. [Limit responses to 1000 words if possible]
The assessment reveals significant variability in access to mental health services across Maine's counties, both in terms of availability and type of facilities. Some counties have fewer hospitals but a higher number of Federally Qualified Health Centers (FQHCs) or Look-Alike (LAL) facilities, indicating uneven distribution of resources. Institutions for Mental Diseases (IMDs) are located in only three of Maine's 16 counties, while five counties have acute care hospitals with psychiatric units, and three counties have standalone psychiatric hospitals. Intensive Outpatient Programs (IOPs) are available in 12 counties. While all counties have prescribers and licensed practitioners who can treat mental health conditions, their distribution and availability vary. Importantly, every county has access to mobile crisis services and FQHC/LAL facilities that offer behavioral health services, providing a baseline of support across the state despite regional disparities.
4. In the space below, describe any gaps the state identified in the availability of mental health services or service capacity while completing the Availability Assessment. [Limit responses to 500 words if possible]
Gaps in Maine's behavioral health system include limited bed availability for psychiatric care, a challenge that is particularly pronounced in rural areas where healthcare resources are often scarce. In addition, four counties currently lack Intensive Outpatient Program (IOP) providers, further restricting access to intermediate levels of mental health care for residents in those regions. These gaps highlight the need for targeted resource allocation and service expansion to ensure equitable access to care across all counties.
5. In the space below, describe any gaps in the availability of mental health services or service capacity NOT reflected in the Availability Assessment. [Limit responses to 500 words if possible]

Narrative Description (to be completed at baseline)
As of 2024, Maine's mental health inpatient care system reflects a mix of ongoing challenges and gradual advancements. The state is served by a combination of public and private facilities offering acute psychiatric care; however, these institutions frequently experience high demand and limited bed availability, resulting in prolonged wait times in emergency departments for individuals in need of admission. While efforts to expand access and improve service delivery continue, significant challenges remain—particularly in rural areas where mental health resources are often scarce. Individuals with serious mental illness (SMI) face additional barriers, including stigma, fragmented or insufficiently integrated care, and difficulties accessing appropriate treatment. As a result, over 60% of adults with SMI in Maine are not receiving the care they need, underscoring the urgent need for more comprehensive and coordinated behavioral health services statewide.

State Name	Maine
Date of Assessment	June 2025
Time Period Reflected in Assessment	January 2025-June 2025

Geographic Designation			Beneficiaries											
			Adult					Children			Total			
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of adult Medicaid beneficiaries (18 - 20)	Number of adult Medicaid beneficiaries with SMI (18 - 20)	Number of adult Medicaid beneficiaries (21+)	Number of adult Medicaid beneficiaries with SMI (21+)	Percent with SMI (Adult)	Number of Medicaid beneficiaries (0 - 17)	Number of Medicaid beneficiaries with SED (0 - 17)	Percent with SED (0-17)	Number of Medicaid beneficiaries (Total)	Number of Medicaid beneficiaries with SMI or SED (Total)	Percent with SMI or SED (Total)	Beneficiary Category Notes
County - Cumberland	Urban		3507	326	56165	5835	10%	20502	2520	12%	80174	8681	11%	
County - Aroostook	Rural		1284	132	21701	2161	10%	7770	998	13%	30755	3291	11%	
County - Washington	Rural		642	59	10662	995	9%	4135	465	11%	15439	1519	10%	
County - Penobscot	Urban		2475	274	40401	4761	12%	14744	2321	16%	57620	7356	13%	
County - Kennebec	Rural		1800	221	30205	3963	13%	12313	1870	15%	44318	6054	14%	
County - Knox	Rural		615	71	9458	889	10%	3411	340	10%	13484	1300	10%	
County - Androscoggin	Urban		2133	193	30798	3472	11%	15039	1911	13%	47970	5576	12%	
County - Hancock	Rural		713	61	12248	1187	10%	4528	569	13%	17489	1817	10%	
County - York	Rural		2438	257	38862	3795	10%	15562	2042	13%	56862	6094	11%	
County - Franklin	Rural		471	38	8304	799	10%	3128	410	13%	11903	1247	10%	
County - Waldo	Rural		599	76	10838	1070		4069	510					
County - Oxford	Rural		1066	89	17546	1681		6762	832					
County - Piscataquis	Rural		319	31	5371	495		1924	221					
County - Sagadahoc	Rural		411	64	6526	696		2710	333					
County - Lincoln	Rural		423	35	7700	659		2915	247					
County - Somerset	Rural		1013	103	16819	1766	10%	6219	768	12%	24051	2637	11%	
Total			**19909**	**2030**	**323604**	**34224**	**11%**	**125731**	**16357**	**13%**	**400065**	**45572**	**11%**	

Geographic Designation			Providers														
			Psychiatrists or Other Practitioners Who Are Authorized to Prescribe							Other Practitioners Certified and Licensed to Independently Treat Mental Illness							
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe	Number of Medicaid-Enrolled Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Accepting New Medicaid Patients	Ratio of Medicaid beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Total Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers	Ratio of Medicaid-Enrolled Psychiatrists or Other Prescribers to Medicaid-Enrolled Psychiatrists or Other Prescribers Accepting New Medicaid Patients	Psychiatrists or Other Practitioners Who Are Authorized to Prescribe Category Notes	Number of Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Number of Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Other Practitioners Certified or Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified or Licensed to Independently Treat Mental Illness	Ratio of Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness to Medicaid-Enrolled Other Practitioners Certified and Licensed to Independently Treat Mental Illness Accepting New Patients	Other Practitioner Category Notes
County - Cumberland	Urban		277	277		22.2418773	1	-		2366	2366		2.60397295	1	-		
County - Aroostook	Rural		29	29		79.0689655	1	-		180	180		12.7388889	1	-		
County - Washington	Rural		9	9		117.111111	1	-		91	91		11.5824176	1	-		
County - Penobscot	Urban		114	114		44.1666667	1	-		737	737		6.83175034	1	-		
County - Kennebec	Rural		62	62		67.483871	1	-		536	536		7.80597015	1	-		
County - Knox	Rural		17	17		56.4705882	1	-		190	190		5.05263158	1	-		
County - Androscoggin	Urban		46	46		79.673913	1	-		395	395		9.27848101	1	-		
County - Hancock	Rural		26	26		48	1	-		224	224		5.57142857	1	-		
County - York	Rural		60	60		67.5333333	1	-		861	861		4.70615563	1	-		
County - Franklin	Rural		13	13		64.3846154	1	-		96	96		8.71875	1	-		
County - Waldo	Rural		15	15						170	170						
County - Oxford	Rural		10	10						135	135						
County - Piscataquis	Rural		5	5						38	38						
County - Sagadahoc	Rural		8	8						192	192						
County - Lincoln	Rural		7	7						119	119						
County - Somerset	Rural		11	11		169.909091	1	-		117	117		15.974359	1	-		
Total			**709**	**709**	**0**	**64.2764457**	**1**	-		**6447**	**6447**	**0**	**7.06871413**	**1**	-		

Geographic Designation			Community Mental Health Centers							Intensive Outpatient or Partial Hospitalization Providers						
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of CMHCs	Number of Medicaid-Enrolled CMHCs	Number of Medicaid-Enrolled CMHCs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled CMHCs	Ratio of Total CMHCs to Medicaid Enrolled CMHCs	Ratio of Medicaid-Enrolled CMHCs to Medicaid-Enrolled CMHCs Accepting New Patients	CMHC Category Notes	Number of Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Number of Medicaid-Enrolled Intensive Outpatient/Partial Hospitalization Providers Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Total Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers	Ratio of Medicaid-Enrolled Partial Hospitalization/ Day Treatment Providers to Medicaid-Enrolled Intensive Outpatient/ Partial Hospitalization Providers Accepting New Medicaid Patients	Intensive Outpatient/ Partial Hospitalization Category Notes
County - Cumberland	Urban		0	0	0	-	-	-		14	14		440.0714286	1	-	
County - Aroostook	Rural					-	-	-		2	2		1146.5	1	-	
County - Washington	Rural					-	-	-		2	2		527	1	-	
County - Penobscot	Urban					-	-	-		7	7		719.2857143	1	-	
County - Kennebec	Rural					-	-	-		7	7		597.7142857	1	-	
County - Knox	Rural					-	-	-		1	1		960	1	-	
County - Androscoggin	Urban					-	-	-		11	11		333.1818182	1	-	
County - Hancock	Rural					-	-	-		4	4		312	1	-	
County - York	Rural					-	-	-		7	7		578.8571429	1	-	
County - Franklin	Rural					-	-	-		0	0		-	-	-	
County - Waldo	Rural									1	1					
County - Oxford	Rural									1	1					
County - Piscataquis	Rural									0	0					
County - Sagadahoc	Rural									0	0					
County - Lincoln	Rural									1	1					
County - Somerset	Rural					-	-	-	No CMHC in Maine	0	0		-	-	-	
Total			0	0	0	-	-	-		58	58	0	785.7241379	1	-	

Geographic Designation			Residential Mental Health Treatment Facilities													
			Residential Mental Health Treatment Facilities (Adult)													
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities Accepting New Medicaid Patients (Adult)	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Total Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult)	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) Accepting New Patients	Total Number of Residential Mental Health Treatment Facility Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds (Adult)	Total Number of Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Adult Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Total Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Beds to Medicaid-Enrolled Residential Mental Health Treatment Beds Available to Medicaid Patients	Residential Mental Health Treatment Facility Category Notes (Adult)
County - Cumberland	Urban		21	21		293.3809524	1	-		173	173	35.61271676	0	1	
County - Aroostook	Rural		2	2		1146.5	1	-		17	17	134.8823529	0	1	
County - Washington	Rural		2	2		527	1	-		20	20	52.7	0	1	
County - Penobscot	Urban		25	25		201.4	1	-		139	139	36.22302158	0	1	
County - Kennebec	Rural		28	28		149.4285714	1	-		182	182	22.98901099	0	1	
County - Knox	Rural		5	5		192	1	-		21	21	45.71428571	0	1	
County - Androscoggin	Urban		14	14		261.7857143	1	-		68	68	53.89705882	0	1	
County - Hancock	Rural		2	2		624	1	-		10	10	124.8	0	1	
County - York	Rural		14	14		289.4285714	1	-		96	96	42.20833333	0	1	
County - Franklin	Rural		0	0		-	-	-		0	0	-	-	-	
County - Waldo	Rural		4	4						29	29				
County - Oxford	Rural		6	6						23	23				
County - Piscataquis	Rural		3	3						9	9				
County - Sagadahoc	Rural		2	2						12	12				
County - Lincoln	Rural		0	0						0	0				
County - Somerset	Rural		5	5		373.8	1	-		38	38	49.18421053	0	1	
Total			**133**	**133**	**0**	**272.5864662**	**1**	**-**	**0**	**837**	**837**	**43.31421744**	**0**	**1**	

Geographic Designation			Residential Mental Health Treatment Facilities														
			Psychiatric Residential Treatment Facilities														
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Psychiatric Residential Treatment Facilities (PRTF)	Number of Medicaid-Enrolled PRTFs	Number of Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PTRFs	Ratio of Total PTRFs to Medicaid-Enrolled PRTFs	Medicaid-Enrolled PRTFs to Medicaid-Enrolled PRTFs Accepting New Medicaid Patients	Total Number of PRTF Beds	Number of Medicaid-Enrolled PRTF Beds	Number of Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SED to Medicaid-Enrolled PRTF Beds Available to Medicaid Patients	Ratio of Total Number of PRTF Beds to Medicaid-Enrolled PRTF Beds	Ratio of Medicaid-Enrolled PRTF Beds to Medicaid-Enrolled PRTFs Available to Medicaid Patients	Psychiatric Residential Treatment Facility (Under 21) Category Notes
County - Cumberland	Urban		0	0	0	-	-	-	0	0	0	-	-	-	Maine does not have a currently established PRTF and therefore does not have any data to submit on that point
County - Aroostook	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Washington	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Penobscot	Urban		0	0	0	-	-	-	0	0	0	-	-	-	
County - Kennebec	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Knox	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Androscoggin	Urban		0	0	0	-	-	-	0	0	0	-	-	-	
County - Hancock	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - York	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Franklin	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
County - Waldo	Rural		0	0	0				0	0	0				
County - Oxford	Rural		0	0	0				0	0	0				
County - Piscataquis	Rural		0	0	0				0	0	0				
County - Sagadahoc	Rural		0	0	0				0	0	0				
County - Lincoln	Rural		0	0	0				0	0	0				
County - Somerset	Rural		0	0	0	-	-	-	0	0	0	-	-	-	
Total			**0**	**0**	**0**	**-**	**-**	**-**	**0**	**0**	**0**	**-**	**-**	**-**	

			Psychiatric Hospitals					Psychiatric Units													Psychiatric Beds				
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Psychiatric Hospitals	Psychiatric Hospitals Available to Medicaid	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals Available to Medicaid Patients	Ratio of Psychiatric Hospitals to Psychiatric Hospitals Available to Medicaid Patients	Psychiatric Hospital Category Notes	Number of Psychiatric Units in Acute Care Hospitals	Number of Psychiatric Units in Critical Access Hospitals (CAHs)	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Number of Medicaid-Enrolled Psychiatric Units in CAHs	Number of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Number of Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Medicaid Beneficiaries with SMI/SED to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals	Ratio of Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs	Ratio of Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals to Medicaid-Enrolled Psychiatric Units in Acute Care Hospitals Accepting New Medicaid Patients	Ratio of Medicaid-Enrolled Psychiatric Units in CAHs to Medicaid-Enrolled Psychiatric Units in CAHs Accepting New Medicaid Patients	Psychiatric Unit Category Notes	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units)	Number of Licensed Psychiatric Hospital Beds (Psychiatric Hospital + Psychiatric Units) Available to Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI/SED to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Ratio of Licensed Psychiatric Hospital Beds to Licensed Psychiatric Hospital Beds Available to Medicaid Patients	Psychiatric Beds Category Notes
County - Cumberland	Urban		1	1	6161	1		2	0	2	0			4340.5	-	1	-	-	-		174	174	49.8908046	1	
County - Aroostook	Rural		0	0	-	-		1	0	1	0			3291	-	1	-	-	-		9	9	365.6666667	1	
County - Washington	Rural		0	0	-	-		0	0	0	0			-	-	-	-	-	-		0		-	-	
County - Penobscot	Urban		2	2	2517.5	1		0	0	0	0			-	-	-	-	-	-		200	200	36.78	1	
County - Kennebec	Rural		1	1	4184	1		1	0	1	0			6054	-	1	-	-	-		122	122	49.62295082	1	
County - Knox	Rural		0	0	-	-		1	0	1	0			1300	-	1	-	-	-		18	18	72.22222222	1	
County - Androscoggin	Urban		0	0	-	-		1	0	1	0			5576	-	1	-	-	-		51	51	109.3333333	1	
County - Hancock	Rural		0	0	-	-		0	0	0	0			-	-	-	-	-	-		0	0	-	-	
County - York	Rural		0	0	-	-		0	0	0	0			-	-	-	-	-	-		0	0	-	-	
County - Franklin	Rural		0	0	-	-		0	0	0	0			-	-	-	-	-	-		0	0	-	-	
County - Waldo	Rural		0	0				0	0	0	0										0	0			
County - Oxford	Rural		0	0				0	0	0	0										0	0			
County - Piscataquis	Rural		0	0				0	0	0	0										0	0			
County - Sagadahoc	Rural		0	0				0	0	0	0										0	0			
County - Lincoln	Rural		0	0				0	0	0	0										0	0			
County - Somerset	Rural		0	0	-	-		0	0	0	0			-	-	-	-	-	-		0	0	-	-	
Total			**4**	**4**	**11393**	**1**		**6**	**0**	**6**	**0**	**0**	**0**	**7595.333333**	**-**	**1**	**-**	**-**	**-**		**574**	**574**	**79.39372822**	**1**	

Geographic Designation			Institutions for Mental Diseases									
			Residential Treatment Facilities That Qualify As IMDs							Psychiatric Hospitals That Qualify As IMDs		
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Number of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting Medicaid Patients	Ratio of Medicaid Beneficiaries with SMI (Adult) to Medicaid- Enrolled Residential Mental Health Treatment Facilities that Qualify as IMDs	Ratio of Total Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs	Ratio of Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs to Medicaid-Enrolled Residential Mental Health Treatment Facilities (Adult) that Qualify as IMDs Accepting New Medicaid Patients	Number of Psychiatric Hospitals that Qualify as IMDs	Ratio of Medicaid Beneficiaries with SMI/SED to Psychiatric Hospitals that Qualify as IMDs	Facilities That Qualify As IMDs Category Notes
County - Cumberland	Urban		1	1		6161	1	-	1	8681	
County - Aroostook	Rural		0	0		-	-	-	0	-	
County - Washington	Rural		0	0		-	-	-	0	-	
County - Penobscot	Urban		2	2		2517.5	1	-	2	3678	
County - Kennebec	Rural		1	1		4184	1	-	1	6054	
County - Knox	Rural		0	0		-	-	-	0	-	
County - Androscoggin	Urban		0	0		-	-	-	0	-	
County - Hancock	Rural		0	0		-	-	-	0	-	
County - York	Rural		0	0		-	-	-	0	-	
County - Franklin	Rural		0	0		-	-	-	0	-	
County - Waldo	Rural		0	0					0		two private facilities, Spring Harbor Hospital and Acadia Hospital, and two public facility, Dorothea Dix Psychiatric Center, Riverview
County - Oxford	Rural		0	0					0		
County - Piscataquis	Rural		0	0					0		
County - Sagadahoc	Rural		0	0					0		
County - Lincoln	Rural		0	0					0		
County - Somerset	Rural		0	0		-	-	-	0	-	
Total			**4**	**4**	**0**	**9063.5**	**1**	**-**	**4**	**11393**	

Geographic Designation			Crisis Stabilization Services											Federally Qualified Health Centers		
Geographic designation	Is this geographic designation primarily urban or rural?	Geographic Designation Notes	Number of Crisis Call Centers	Number of Mobile Crisis Units	Number of Crisis Observation/ Assessment Centers	Number of Crisis Stabilization Units	Number of Coordinated Community Crisis Response Teams	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Call Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Mobile Crisis Units	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Observation/ Assessment Centers	Ratio of Medicaid Beneficiaries with SMI/SED to Crisis Stabilization Units	Ratio of Medicaid Beneficiaries with SMI/SED to Coordinated Community Crisis Response Teams	Crisis Stabilization Services Category Notes	Number FQHCs that Offer Behavioral Health Services	Ratio of Medicaid Beneficiaries with SMI/SED to FQHCs that Offer Behavioral Health Services	FQHC Category Notes
County - Cumberland	Urban		1	1	1	2	1	8681	8681	-	4340.5	8681	Mobile Units serve regions with several counties in some cases -- there are 8 statewide; all 8 mobile crisis units have walk-in assessment availability, so 10 if you count that; 5. Number of coordinated community response crisis teams: 3 teams with a total of 47 staff members, i. Teams travel to any counties in Maine as needs arise, these are where they're based	36	241.1388889	Data from Maine FQHCs & LAL download from federal site; includes all FQHC and LAL site locations including clinic, mobile sites; FQHC/LAL organizations have multiple sites listed.
County - Aroostook	Rural		0	1	0	2	1	-	3291	3291	1645.5	3291		25	131.64	
County - Washington	Rural		0	1	0	2	0	-	1519	-	759.5	-		11	138.0909091	
County - Penobscot	Urban		0	1	1	2	1	-	7356	7356	3678	7356		59	124.6779661	
County - Kennebec	Rural		0	1	0	3	1	-	6054	-	2018	6054		10	605.4	
County - Knox	Rural		0	1	0	2	0	-	1300	-	650	-		8	162.5	
County - Androscoggin	Urban		0	1	0	1	1	-	5576	-	5576	5576		14	398.2857143	
County - Hancock	Rural		0	1	0	0	0	-	1817	-	-	-		7	259.5714286	
County - York	Rural		0	1	0	2	1	-	6094	-	3047	6094		4	1523.5	
County - Franklin	Rural		0	1	0	0	0	-	1247	-	-	-		3	415.6666667	
County - Waldo	Rural		0	1	0	0	0							2		
County - Oxford	Rural		0	1	0	1	0							5		
County - Piscataquis	Rural		0	1	0	0	0							10		
County - Sagadahoc	Rural		0	1	0	0	0							1		
County - Lincoln	Rural		0	1	0	0	0							1		
County - Somerset	Rural		0	1	0	0	0	-	-	-	-	-		4	659.25	
Total			**1**	**16**	**1**	**17**	**6**	**45572**	**2848.25**	**-**	**2680.705882**	**7595.333333**		**200**	**227.86**	

Comments on Data Included in Availability Assessment

Completeness of Data	In subsequent years, once the Waiver is accepted, we are able to book time for a data analyst to dive deeper into the Assessment data; this resource was not able to be booked for the current baseline
Medicaid entities Accepting New Patients	Currently we do not have the ability to track the data elements for Medicaid entities Accepting New Patients- this is not availble as a tracking system across the state at this time
Community Mental Heatlh Centers	Maine does not have CMHC
Psychiatric Residential Treatment Facilities	Maine does not have a currently established PRTF and therefore does not have any data to submit on that point
Crisis Call Center	One center serves the entire state
Mobile Crisis Teams	There are eight teams, each covering a district, and some agencies cover multiple districts. The mobile crisis teams cover all 16 counties. All 8 mobile crisis units have walk-in assessment availability
Community Response Teams	Teams travel to anywhere in the Counties as Needs Arise; the Assessment includes their location but they serve all counties
Federally Qualified Health Centers	Data for the Assessment includes both FQHC and Look Alike
Institutions for Mental Diseases	Data for the four IMD in Maine are redundant to the psychiatric hospitals: Spring Harbor, Acadia, Riverview and Dorothea Dix