1115 Waiver Application: Substance Use Disorder Care Initiative
Department of Health and Human Services
State of Maine

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I. Introduction

The Office of MaineCare Services (OMS) within the Maine Department of Health and Human Services (DHHS) is the single state agency that administers Maine's Medicaid program, known as MaineCare. Maine's population is approximately 1.3 million with 43.1 people per square mile,[1] which is indicative of the spread of the State's population among its vast rural areas. Maine expends $3 billion annually in its Medicaid program, and covers approximately 292,000 individuals with enrollment projected to reach about 313,000 after full implementation of Maine's recent Medicaid expansion. Currently, 23% of Maine's population is covered by Medicaid or the Children's Health Insurance Program (CHIP). Maine's rurality, health issues, and infrastructure limitations result in challenges to the State's Substance Use Disorder (SUD) service delivery systems which has been strained by the impact of the opioid epidemic in northern New England.

DHHS has participated in various internal and external inquiries regarding accessibility and quality of Medicaid-covered services in recent months that are highly relevant to this waiver submission. This ranged from external reviews of the full service delivery system informed by key informant interviews and review of publicly available data, efforts to map service capacity using administrative data on licensed and unlicensed SUD treatment provides, to internal assessments for various federal grant applications that involved compiling both high-level and detailed data for the SUD system and priority subpopulations in Maine (these are described in detail in Table 1 below). As a result of one of the funding applications, OMS was awarded over 2 million dollars through the Section 1003 Demonstration Project to Increase Substance Use Provider Capacity through a federal cooperative agreement with the Centers for Medicare and Medicaid Services (CMS) after a thorough assessment of MaineCare members' SUD-related needs and the capacity of our treatment and recovery system. These findings and initiatives, in conjunction with other relevant studies of the behavioral health system as a whole, provide a solid basis for taking action to address the accessibility, adequacy, and quality of Maine's SUD service delivery system.

In addition to requesting the authority to provide MaineCare reimbursement for adults in Institutions of Mental Disease (IMDs) as part of a comprehensive effort to improve the SUD service delivery system, this waiver proposes four pilot interventions focused on MaineCare-enrolled parents with SUD who are involved with or at-risk of involvement with Child Protective Services (CPS). These pilots include community-based skill development, parenting interventions, and MaineCare eligibility changes intended to address coverage and service delivery gaps that impact the health and well-being of this target population and their families.

This waiver application builds on existing state efforts, many of which have been accelerated in recent months. Notably:

- Governor Mills' first two Executive Orders were to implemented Medicaid Expansion and to "Implement Immediate Response to Maine's Opioid Epidemic." The latter order highlighted the impact of the opioid epidemic and prioritized the need for reducing stigma, expanding access to evidence-based treatment and recovery supports, securing non-tax-based resources to further State goals, and improving connections to timely care and community resources.
- Medication Assisted Treatment (MAT) coverage is robust under MaineCare, with Methadone and office-based buprenorphine available in a variety of settings.
- Building upon the Behavioral Health Home and Health Home programs and the integrated team-based approach to care, Maine introduced Opioid Health Homes in 2017 to improve the quality and availability of integrated MAT services statewide. This program currently serves nearly 1,500

[1] US Census retrieved from https://www.census.gov/quickfacts/fact/dashboard/me/PST045218

MaineCare members with OUD monthly, with utilization increasing monthly due to increasing provider capacity and increased Medicaid eligibility.

- ❖ DHHS is collaborating with the Department of Corrections and county jails to ensure inmates complete Medicaid applications in a timely manner to support safe and effective transitions to community-based SUD treatment upon release.

Maine continues to seek ways to both innovate and refine service delivery and service administration to increase access to and quality of care. Therefore, Maine is now seeking an 1115 Demonstration Waiver from the United Stated Department of Health and Human Services, CMS to support comprehensive SUD services with a focus on care transitions, integration of physical and behavioral health, and supports for parents with SUD.

II. Description

The primary purpose of this waiver is to provide reimbursement for clinically appropriate services that are otherwise approved under the Maine Medicaid State Plan, delivered to individuals aged 21-65 with SUD[2] by IMDs, with the goal of testing whether this improves access to and the affordability of care for people with complex SUD needs. IMDs are defined by CMS as any "hospital, nursing facility, or other institution of more than sixteen beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease, including medical attention, nursing care, and related services."[3] Current Medicaid statue does not allow Federal Financial Participation (FFP) for care or services for any adult who has not attained 65 years of age and who is a patient in an IMD. This restriction is known as Medicaid's IMD exclusion.[4]

With this funding stream available, it is expected that additional SUD residential treatment facilities will begin providing these services or expand their current services to the extent that they will qualify as an IMD (e.g., residential treatment facilities may expand capacity to above sixteen beds),[5] when allowable under state law and in accordance with any State requirements. Reimbursement for these services would fill a gap and improve coordination with MaineCare's existing array of community-based services available to individuals otherwise eligible for MaineCare and provide access to evidence-based services at different levels of intensity across a continuum of care, based on individual needs and goals. Maine is committed to maintaining support for community-based SUD treatment options and is pursuing this option in order to assure that appropriate treatment options are accessible across the continuum.

This waiver will also focus efforts on MaineCare-enrolled parents with SUD who are involved with or at-risk of involvement with CPS. In fiscal year 2019, 51 percent of children entering into State custody came from a family with a SUD. The waiver would assess both health outcomes for the family, consistent with the goals of the Medicaid program, as well as its impact on the child welfare system in the State.

Assessment of population needs

[2] Substance Abuse and Mental Health Services Administration (SAMHSA) has defined "adults with a serious mental illness" as persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one of more major life activities (e.g. activities of daily living, instrumental activities of daily living, functioning in social, family, and vocational/educational contexts).

[3] Section 1905(i) of the Social Security Act

[4] 1905(a) (29) (B) of the Social Security Act

[5] This demonstration opportunity does not extend to coverage of room and board payments, nursing facilities that qualify as IMDs, services provided in settings that do not qualify for the Inpatient Psychiatric Services for Individuals Under Age 21 benefit, or services provided in settings where beneficiaries are residing involuntarily in the facility by operation of criminal law.

Maine, like many other states across the nation, has challenges with SUD. The number of emergency medical services responses related to overdoses of drug/medication increased by 62% from 2013-2017 and increased 43% related to alcohol in the same time period.[6] In 2017, Maine's rate of drug overdose deaths was 29.9, nearly double the national rate of 14.9.[7] OUD has continued to grow, having a dramatic effect on Maine people, where opioids contributed to over 85% of overdose deaths in 2017.[8] Of additional concern, in 2016, the rate of infants with Neonatal Abstinence Syndrome (NAS) in Maine was nearly five times the national average (33.1 per 1,000 babies born vs. 6.8)[9]. While OUD remains at the forefront of many state and federal efforts, alcohol use disorder is steadfast as the most prevalent form of SUD in Maine.

Additionally, with Medicaid Expansion underway, the opportunity to reevaluate MaineCare SUD services becomes vital as 62,000 more Mainers are expected to come into Medicaid-coverage through expansion. Expansion of Medicaid benefits from one in five to nearly one in four Maine residents means that many individuals who were previously unable to access SUD treatment will now be able to access SUD treatment services if there are enough willing and able providers offering care in appropriately distributed locations, and if individuals with SUD and those who support them are knowledgeable about the availability of those services and are willing and able to access them. Initial analyses of the Medicaid expansion population suggest that SUD will be a main driver of health care needs and health care costs for this population. Amongst expansion enrollees with claims between July 1, 2018 and July 31, 2019, almost 20% had a diagnosis of SUD the most prevalent diagnosis for a chronic condition. By comparison, 14% of MaineCare's comparable non-expansion population with claims, non-expansion parents and 19- and 20-year old members, had a SUD diagnosis. Expansion enrollees have so far also been utilizing inpatient care at a substantially higher rate than this non-expansion comparison population, with SUD as their most common diagnosis.

Overview of current efforts and SUD system assessments

Maine has aimed to address SUD and the opioid epidemic through various mechanisms; these efforts are evolving rapidly under the Mills Administration and position Maine well to design and implement a plan to meet the goals and milestones of this 1115 waiver opportunity. In recent years, DHHS has deployed resources to improve syndromic surveillance, created seven peer recovery centers statewide, piloted and supported training on rapid access programs in hospital emergency departments, improved care transitions and eligibility connections for individuals upon release from incarceration, promoted clinical screening and referral for pregnant women with SUD through the SnuggleME guidelines, integrated MAT into child protective case work, developed a Medicaid opioid health home program to improve access to and quality of Office-based Opioid Treatment (OBOT), and several other interventions.

In 2019, the Governor created a Prevention and Recovery Cabinet, and appointed a Director of Opioid Response who is leading additional efforts statewide. Maine's recent Section 1003 Demonstration Project award provides additional resources to support remaining SUD treatment assessment needs and includes specific activities, such as a rate study of residential treatment facilities, which will help maximize the

[6] Public Consulting Group, Inc. "Substance Use Trends in Maine, State Epidemiological Profile 2018.": Retrieved from https://www.maineseow.com/Documents/2018/SEOW%20EpiProfile%202018%20with%20sub%20state%20data%2011302018.pdf.

[7] Kaiser Family Foundation. "Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted)." Retrieved from https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22All%20Drug%20Overdose%20Death%20Rate%

[8] Sorg, Marcela, PhD. University of Maine Margaret Chase Smith Policy Center. "Maine drug death report January – September, 2018." Retrieved from http://www.maine.gov/tools/whatsnew/attach.php?id=1065628&an=1

[9] Maine Centers for Disease Control and Prevention, Maine Maternal and Child Health Block Grant Annual Report. Healthcare Cost and Utilization Project State Inpatient Database

impact of our SUD treatment system capacity, and funding for a treatment locator to assist with appropriate and timely access to treatment.

Table 1 highlights the assessment component of recent initiatives which have informed the development of this waiver. These assessments also provide OMS with base elements to include in the implementation plan, which will be developed submitted after waiver approval. Many of these initiatives have or will be shared publicly as part of a broader stakeholder engagement effort.

Table 1. Recent SUD Service Delivery System Assessments

Initiative (Timeline)	Main Findings/Activities	Next Steps
Pew Charitable Trust (Summer-Fall 2019/ Completed)	Pew relied on publicly available data and data shared by the Maine DHHS to create a series of maps that depict the behavioral health provider community across the State, including providers of MAT, the capacity of licensed behavioral health agencies, and recovery residences. Pew also conducted a review of approaches that other states have used to map the capacity of behavioral health treatment providers and connect patients with appropriate care.	Develop a website to share main findings with the public. Procure a treatment locator tool.
SUPPORT ACT (Award period 9/30/2019-3/29/2021)	Initial assessment of SUD and OUD among MaineCare population, capacity qualification and willingness of Medicaid-enrolled providers to provide SUD treatment and/or recovery services, gaps in Medicaid-covered SUD treatment and recovery services, barriers to SUD treatment and recovery services, reimbursement and administrative barriers to service provision, and provider training needs. Initials plans for overcoming gaps and barriers and increasing provider SUD treatment and recovery service capacity including securing a treatment locator tool, supporting telehealth adoption, providing workflow technical assistance to OBOT providers.	Complete comprehensive assessment of SUD and OUD among MaineCare population. Implement plans for overcoming gaps and barriers and increasing provider SUD treatment and recovery service capacity. Assess the level and amount of physical, social, and behavioral health coordination.
Maternal Opioid Misuse Model Application (1/1/2020 – 12/31/2024, if awarded)	OMS worked collaboratively across DHHS to assess OUD-related prenatal and maternity care needs and opportunities for service delivery system improvements. If awarded, this funding would support the development and implementation of a state-wide integrated care delivery system for pregnant/parenting women with OUD and their infants that will be sustained by Medicaid reimbursement for covered services.	Awaiting funding decision
Leveraging Medicaid to Address Opioid and Substance Use Disorder in Maine: Ten State Policy Options from Expedited Review	In early 2019, the Urban Institute produced an expedited review of the SUD delivery system in Maine which highlighted opportunities for improved service delivery.	Maine will continue to incorporate these findings into future initiatives.

CMS's Medicaid Innovation Accelerator Program (IAP): Maternal and Infant Health Initiative (MIHI) Value-Based Payment (VBP)	The goal of this collaborative project with the Maine Center for Disease Control and Prevention was to increase the proportion of mothers covered by MaineCare who are screened, and if positively screened, receive MAT during pregnancy for an OUD.	DHHS has numerous efforts underway to address maternal and infant health of which this project has informed efforts and built additional strength of inter-agency partnerships.

Overview of treatment system

MaineCare utilizes the American Society of Addiction Medicine's (ASAM) criteria, among other assessments like the Level of Care Utilization System (LOCUS) and Adults Needs and Strengths Assessment (ANSA), to assess and support treatment and level of care decisions. MaineCare covers various forms of MAT and recovery supports (see Table 2). The State has also worked aggressively to control overprescribing of opioids through a robust Prescription Monitoring Program (PMP), revising prescribing guidelines, promoting alternative treatments to pain management, and offering provider education. Currently, MaineCare provides reimbursement for the following SUD services:[10]

Table 2. MaineCare State Plan SUD Services

Service	Brief Description
Community-based Services	
Targeted Case Management	Services consist of assessment, planning, referral and related activities, and monitoring and follow-up activities for individuals with a diagnosed SUD who are currently seeking treatment and are either pregnant, living with minor children, or an intravenous drug user.
Outpatient Services (Comprehensive Assessment, Therapy and Counseling Services)	Comprehensive assessment, individual and group therapy for children and adults with mental health and co-occurring disorders.
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.
Medication Assisted Treatment	Treatment for SUD that includes the use of methadone delivered in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) regulations. Services include assessment, planning, counseling, drug use disorder testing, and medication administration. Also includes MAT services that are delivered in an office-based setting, (e.g. OBOT or a certified Opioid Treatment Program (OTP).
Opioid Health Homes	Integrated MAT services, including office visits with a MAT prescriber, prescription medication for OUD, OUD counseling, comprehensive care management/care coordination/health promotion, urine drug screening, and peer recovery support services provided through a bundled rate.
Intensive Outpatient Services	Intensive and structured service of alcohol and drug assessment, diagnosis, and treatment services in a non-residential setting for members who meet ASAM criteria level II.1 or II.5. Services include co-occurring mental health and SUD. Available to adults and children.
Residential	
Clinically Managed Low Intensity Residential Services	Services delivered according to ASAM level 3.1, including scheduled therapeutic and rehabilitative treatment designed to enable the member to sustain a substance free lifestyle in an unsupervised community situation. Available to adults.

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

Clinically Managed Population-Specific High Intensity Residential Programs	Services delivered according to ASAM level 3.3, Category II, including scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling. Available to adults.
Clinically Managed Residential Services	Services delivered according to ASAM level 3.5, including therapeutic treatment and planning consisting of assessment, diagnostic, and counseling services. Available to adults and children.
Medically Monitored Inpatient Programs	Services delivered according to ASAM level 3.7, including a planned structured regimen of 24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. Services provide immediate diagnosis and care to members having acute physical problems related to substance use disorder. Available to adults and children.
Inpatient	
Psychiatric Residential Treatment Facility (PRTF) Services	Comprehensive mental health treatment and/or SUD treatment to children and adolescents who, due to mental illness, SUD, or Serious Emotional Disturbance (SED), meet level of care requirements for a PRTF.

Through the demonstration period, the State will be revisiting potential gaps in services whether it be a coverage or supply gap, strengths and opportunities for improvement within programs/services with a strong focus on evidence-based treatment, assessments, and successful transitions of care. Specifically, MaineCare seeks to better understand the impact of low-supply and utilization of residential treatment services for high-acuity SUD needs, gaps in recovery support service coverage, and highly-prescriptive counseling requirements within MAT services. Unlocking some of the resources the state now spends on inpatient care not otherwise qualifying for federal matching payments could help support such a model. Additionally, the funds could support evidence-based prevention for people at risk of SUD. Lastly, DHHS is focused on holistic approaches to care by supporting programs which address comorbid physical and mental health conditions, as well as psychosocial needs of the individual. As such, an important component of the evaluation of this demonstration will focus on the impact of improved SUD service delivery on broader indicators of success (e.g., employment and housing).

Through this application process and in response to public comment, Maine has identified four pilots to impact the service delivery system for MaineCare-enrolled parents, specifically those parents with SUD who are involved with or at-risk of involvement with Child Protective Services (CPS). The four pilots include:

1) Home-based skill development services;
2) Parenting support programs;
3) Pilot services administered by structured recovery housing programs; and,
4) Eligibility expansion to continue coverage of parents during the rehabilitation and reunification process.

These pilots are based off of assessment of gaps in services and supports within MaineCare that OMS seeks to evaluate for effectiveness in advancing the goals of the Medicaid program. The design and

presentation of these pilots in the waiver application are modeled after recently approved pilot programs by North Carolina[11] and Illinois[12].

Home-based Skill Development Services

Home-based skill development services are services Maine has historically covered via State Plan and Waiver authority for our members with SMI[13] and members with intellectual disabilities who meet institutional level of care,[14] respectively. While these members may display extreme deficits in their ability to function independently in their environment, their challenges are not unique. Parents with SUD may have similar challenges surrounding self-care, daily living skills, personal adjustment, socialization, relationship development, use of community resources, and adaptive skills necessary to reside in community settings. As such, Maine is planning to pilot this service for eligible members with SUD. This service will assist members to develop the skills necessary for living in the community and aid in their recovery process through daily living skills development, community integration, and housing supports. Members receiving these services will gain assistance in recovery through a multitude of strategies aimed at preventing use of more intensive interventions, developing social opportunities and natural support systems, and increasing self-advocacy. The service will be delivered at an intensity and duration determined to be clinically appropriate to address the individual's needs. Services will be conducted by community Mental Health Rehabilitation Technicians (MHRT/C) professionals certified within the State of Maine with a minimum education level of Associate Degree in an approved human services field. The MHRT/C will be supervised by a Certified Clinical Supervisor (CCS), who is a licensed mental health professional qualified to deliver alcohol and drug counseling services or a Licensed Alcohol and Drug Counselor (LADC) with additional training in clinical supervision. SAMHSA recognizes the importance of delivering responsive and flexible services to members in recovery in their chosen community,[15] and Maine is planning to achieve these goals through strengthening its service delivery system. Upon approval of this waiver, Maine will work to identify qualified providers to begin contracting for services. Maine will choose an appropriate area to begin this pilot program with the goal of expanding access throughout the five-year duration of this waiver, dependent on service outcomes. If successful, OMS will consider which authority will be appropriate to continue service provision: a State Plan Amendment, 1915(i) Home and Community-Based Services State Plan Amendment, or 1915(c) waiver to support statewide implementation of this service.

Parenting support programs

A key element of Maine's future SUD delivery system includes developing and bolstering services aimed at family stability and permanency. MaineCare's State Plan Authority and treatment services available via Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) offer considerable flexibility to assure children have access to medically necessary services designed to ameliorate defects and physical and mental illness and conditions. Under State Plan Authority, MaineCare is planning to add three medically necessary parenting services designed to assist with a child's symptoms of their diagnosis (the Positive Parenting Program (Triple P), Parent-Child Interaction Therapy, and the Incredible Years) for youth with disruptive behavior health disorders. Understanding the importance of early childhood development,

[11] Centers for Medicare and Medicaid Services. "North Carolina's Medicaid Reform Demonstration." Retrieved from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=38522

[12] Centers for Medicare and Medicaid Services. "Illinois Behavioral Health Transformation." Retrieved from https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=40098

[13] Daily Living Supports, Section 17 Community Support Services, MaineCare Benefits Manual; retrieved from http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s017.docx

[14] Home Support-Quarter Hour, Section 21, Home and Community Benefits for Members with Intellectual Disabilities or Autism Spectrum Disorder, MaineCare Benefits Manual; retrieved from http://www.maine.gov/sos/cec/rules/10/ch101.htm

[15] The Substance Abuse and Mental Health Services Administration. "Recovery and Recovery Support." , Retrieved from https://www.samhsa.gov/find-help/recovery

Maine wishes to take this a step further to provide a package of services to families and expecting families that are geared toward promoting caregiver nurturance, strengthened attachment, reciprocity in relationships, and healthy child development while enhancing family support and promoting supportive relationships.

The Family First Prevention Services Act (FFPSA), passed in 2018, allows states to access Title IV-E funds and federal match on services designed to target at-risk families with the goal of helping them stay together. The FFPSA allows states to use Title IV-E money on "time-limited" services aimed at preventing the use of foster care. The FFPSA has strict guidelines to use "well-supported" services, as described in the California Evidence-based Clearinghouse for Child Welfare (CEBC).[16] To help assure services utilized have a high level of evidence, the FFPSA has created its own Clearinghouse,[17] to guide states on appropriate services eligible for IV-E funds. Maine's demonstration application aligns well with the FFPSA in that it aims to promote use of evidence-based services to target at-risk families. Through this demonstration, Maine plans to compliment, and not duplicate efforts guided through the FFPSA. The FFPSA's clearinghouse lists a number of services; however, the list is not yet exhaustive, so Maine intends to pilot programs approved and pending approval by the FFPSA once the demonstration period is over, providing ongoing fiscal support for an established service system for eligible children and families.

Maine's plan through this waiver is to support Medicaid eligible families involved with CPS or at risk of CPS involvement by offering evidence-based services for families affected by SUD. For this demonstration, Maine has looked to pilot services that have a high relevance to child welfare, as rated through the CEBC. Programs with a high rating are ones that were designed or are commonly used to meet the needs of children, youth, and families receiving child welfare services.[18] Using this criterion, Maine will initially focus on two services to support children and families: Attachment Biobehavioral Catch-up (ABC) and Visit Coaching. These services focus 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 increasing child behavioral and biological regulation, while decreasing caregiver behaviors that could be frightening or overwhelming for their child (e.g. tickling roughly, being intrusive with toys, harshly grabbing).[19] While some home visiting services are offered now through non-Medicaid dollars, the State expects that by introducing Medicaid funding for these services, the services may become more widely available and better integrated into comprehensive treatment planning of Medicaid services for at-risk families. By building access to these services, Maine expects to see improvement in child and parent health outcomes and a decrease in child welfare involvement over time.

ABC

Attachment Biobehavioral Catch-up is an evidence-based intervention designed for caregivers of infants and toddlers who have experienced early adversity.[20] The parenting intervention is segmented into infant (6-24 months of age) and toddler (24-48 months of age) and is designed to help caregivers interpret their child's behavioral signs and respond sensitively, enhance children's behavioral and regulatory capabilities, and develop secure attachments between children and their caregivers. Additionally, the

[16] California Department of Social Services' (CDSS') Office of Child Abuse Prevention. " California Evidence-Based Clearinghouse for Child Welfare." Retrieved from https://www.cebc4cw.org/

[17] .S. Department of Health and Human Services "Title IV-E Prevention Services Clearinghouse." Retrieved from https://preventionservices.abtsites.com/program

[18] CDSS. "Child Welfare System Relevance Levels." Retrieved from https://www.cebc4cw.org/registry/how-are-programs-on-the-cebc-reviewed/child-welfare-relevance-levels/

[19] Dozier, M., Roben, C.K.P., Caron, E., Hoye, J., & Bernard, K. Attachment and Biobehavioral Catch-up: An evidence-based intervention for vulnerable infants and their families. *Psychotherapy Research, 2016 (p.3, para. 1);* retrieved from http://www.abcintervention.org/wp-content/uploads/2017/11/2016-Dozier-et-al.pdf

[20] University of Delaware "The Attachment Biobehavioral Catch-Up (ABC) Program." Retrieved from http://www.abcintervention.org/about/

program supports parents to create and maintain a predictable environment to reduce stress and the likelihood of behavioral dysregulation, and the program works to decrease behaviors in parents that could be overwhelming or frightening to a young child. The ABC program consists of ten 1-hour sessions in the member's home environment. Treatment is guided by an implementation manual and incorporates video feedback and homework. The sessions are facilitated by parent coaches who must pass a screening by the developers of the model, and who must complete requisite training as prescribed by the model. Parent coaches receive a year of supervision from the developers. Maine currently has a provider trained in this model servicing one area of the state via grants from the Gorman Foundation. Maine's plan is to utilize funds made available via the 1115 to broaden ABC to multiple areas of the State for MaineCare members.

Expansion of the ABC program will be accomplished by a partnership with a qualified vendor developed through a Request for Proposals (RFP) to implement a "Train-the-Trainer" approach to expand access to services. The State intends to phase expansion of services throughout the period of this waiver in order to maintain fidelity to the program and assure outcome effectiveness. Work will be done to separate the State into geographic regions, using rates of substance exposed infants and population birth to five to determine need and capacity to begin implementation immediately. The implementation plan will focus on the regions with the highest rates of substance exposed infants, phasing in regions with lower rates over the course of a three-year period. The following two years of implementation will devote resources to areas experiencing challenges and will focus on strengthening referral networks throughout the State. Following the five-year waiver period, based on the evaluation results, Maine plans to transfer funding of ABC from the 1115 Waiver Demonstration authority to FFPSA funding, pending approval by the Clearinghouse, for those eligible children and families.

Visit Coaching

Visit Coaching is a program designed for child-welfare involved families whose children of any age are placed in foster care and are working toward reunification. Visit Coaching differs from typical supervised visitation because visits focus on the strengths of the family and the needs of the children.[21] Visit Coaching supports families to make visits fun for their children while meeting their unique needs. The program includes helping parents to articulate their child's needs, preparing parents for their child's reactions, helping parents plan to give their full attention to their child, appreciating parent strengths in responding to their child and coaching them to improve their skills, and helping parents cope with their feelings so they can visit consistently and keep their anger or sadness out of the visit. The program accomplishes these activities through visit plan meetings, pre-visit coaching, coaching during the visit, post-visit debriefing, and partnering to encourage communication between the parent and foster parent. Regular meetings are encouraged to review the child's needs and how the parent is meeting them, and to encourage parent understanding of the importance of the visits and lifestyle changes to address the child's unmet safety needs that brought them into care. Service intensity and duration may vary based on need, but generally is one- to three-hour family visits at least once per week for about three to six months. The program can be implemented by staff who must have training and experience in the model, though no specific educational level is required.

Currently, Maine is piloting Visit Coaching funded through State General Funds through a local Community Action Program (CAP) in a limited urban/suburban area in northern Maine. The current pilot is focused on assessing outcomes with the goal of replacing current supervised visitation contracts. Leveraging available funding through the 1115 Demonstration, Maine's plan is to expand this pilot program beyond this limited area through RFP to further test the hypothesis that this model results in increased reunification rates and improved timelines to permanency for children and thus fewer adverse

[21] Marty Beyer, Ph.D. "Strengths/Needs-Based Support for Children, Youth & Families." Retrieved from https://martybeyer.com/content/visit-coaching

childhood experiences (ACEs). With fewer ACEs, families affected by SUDs can concentrate on treatment, recovery, and improving their overall quality of life and health outcomes.

Pilot services administered by structured recovery housing programs (performance-based contracting)

This waiver initiative seeks to provide bundled and cost-based Per Member Per Month (PMPM) payments to certified recovery residences[22] that support parents with SUD who are at-risk of or currently involved with CPS, in order for these residences to address eligible enrollees' specific health determinants to improve health outcomes and lower healthcare costs. Eligible residences will pilot evidence-based interventions addressing housing, transportation, food, and interpersonal safety and toxic stress. Residences delivering health and social services will coordinate non-medical care to address health determinants potentially adversely affecting health and community engagement. Under the pilot program, Maine will develop a pathway to value-based payments for the pilot providers by incentivizing the delivery of high-quality services that reduce health care costs and improve quality of care. Importantly, these services are being offered in the context of highly-structured recovery residences which do not currently directly bill MaineCare for fee-for-service SUD services, but contribute to the overall quality and cost of care for residents and are well-positioned to manage additional community connections and services. Results from this pilot will inform whether other SUD treatment providers or programs could be expected to deliver similar results and/or if the models supported by this pilot are scalable statewide.

This pilot is modeled after North Carolina's recently approved "Healthy Opportunities" Pilot program.[23] Similar to the North Carolina pilot, Maine's pilot services would include but are not limited to: **tenancy support and sustaining services** (e.g. assist the individual in budgeting for housing/living expenses, including financial literacy education on budget basics and locating community-based credit counseling bureaus, developing a crisis plan for if housing is jeopardized, providing funding related to utility set-up and moving costs provided that such funding is not available through any other program), **housing quality and safety improvement services** (e.g. repairs or remediation for issues such as mold if this provides a cost-effective method of addressing occupant's health condition and will lead to independent living), **food support services and meal delivery services, non-emergency health-related transportation** (e.g. transportation to social services that promote community engagement), **interpersonal violence (IPV)-related transportation** (e.g. linkages and transportation to IPV service providers), **legal assistance** (e.g. directing enrollees to available legal services for IPV related issues), **child-parent support** (e.g. evidence-based parent support programs).

Year 1 of the pilot will be used to establish the bundled PMPM rates for the majority of "case-management type" pilot services. Cost-based reimbursement will only be used to cover services such as home modifications or expenses related to utility set-up and security deposit. Combined, the pilot funding will not exceed an agreed upon fiscal cap, as negotiated by OMS and CMS during review of this 1115 waiver application.

Year 2 would begin the service and reimbursement delivery, accompanied with monitoring-only metrics on performance.

[22] The Maine Association of Recovery Residences defines recovery residences as "Non-medical settings designed to support recovery from substance use disorders, providing a substance-free living environment commonly used to help individuals transition from highly structured residential treatment programs back into their day-to-day lives (e.g., obtaining employment and establishing more permanent residence)."

[23] North Carolina Department of Health and Human Services. "Healthy Opportunities Pilots." Retrieved from https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots

In Years 3-5, a percent of the PMPM will be withheld pending performance on agreed upon performance measures related to health care utilization, health care costs, independent living success, reunification success, community engagement, employment, and other measures, as approved by CMS.
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 residence 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 the provision of all pilot services to eligible enrollees within State and CMS guidelines.

All of the above services must be part of a comprehensive plan of care and are voluntary.

This demonstration project, with the prescribed goals and milestones (see Section III below), provides an ideal framework to address the SUD delivery system across all ages and services. Specific activities will be addressed in the Implementation Plan, due to CMS no later than 90 days post demonstration approval.

Eligibility Expansion

Lastly, through this waiver, OMS seeks to continue providing MaineCare eligibility to previously eligible MaineCare parent(s) of a child who has been removed from the home of the parent pursuant to Title 22, section 4036-B until either the Department determines that the parent is no longer participating in the rehabilitation and reunification plan as required by the plan, or until parental rights have been terminated pursuant to Title 22, Section 4056, whichever event happens first. This population has high SUD-related treatment needs and faces barriers to continuity of care due to lapses of MaineCare eligibility when family size calculations change during the rehabilitation and reunification process.

III. Goals

The goals of this waiver are predetermined by CMS and outlined in State Medicaid Director Letter 17-003.[24] The overarching goal is to improve the service delivery systems for people with SUD. During the demonstration period, the state seeks to achieve the following:

1115 to improve access to and quality of treatment for MaineCare members with SUD

[24] Centers for Medicare and Medicaid Services. SMD 17-003 (. https://www.medicaid.gov/federal-policy-Guidance/index.html.

1. Increased rates of identification, initiation, and engagement in treatment.
2. Increased adherence to and retention in treatment, especially in community settings.
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.
6. Improved access to care for physical health conditions among beneficiaries.

Alongside the above goals, the State anticipates improvement in health outcomes for parents and children affected by SUD through the four pilot programs' services designed to support SUD treatment and recovery while addressing social determinants of health. Through this holistic, family-based approach to SUD treatment and recovery, the State anticipates a reduction in the number of ACEs for children, improved health outcomes for parents with SUD, and increase in cost-efficient utilization of health care resources.

The State will achieve these goals by working with stakeholders to focus on the care continuum with emphasis on early interventions, screening and successful referral to address comorbid mental, behavioral, and physical health needs; community-based step-up/step-down clinical services; inpatient residential treatment when appropriate; and development of community-based supports to maintain recovery, health and wellness. This process will involve robust engagement with Maine's five federally recognized Tribes through ongoing direct tribal consultation as well as efforts to bring Tribal leaders into relevant larger discussions.

The federal government has established milestones for each of these populations to guide states in the achievement of the aforementioned goals (see Appendix A). Per CMS guidance, states must submit an Implementation Plan that outlines the initiatives the state will undertake to meet the program milestones. DHHS is committed to meeting the milestones set by CMS and commits to submitting the implementation plan describing the various timelines and activities the state will undertake to achieve the established milestones as part of a post-approval protocol.

IV. Delivery System

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

V. Demonstration Eligibility

DHHS proposes to implement the following initiatives across all eligibility groups. Cost sharing under this demonstration is consistent with the provisions of the approved State Plan with no new cost-sharing provisions for added services.

VI. Type of Waiver Requested

Expenditure Authority

DHHS is requesting expenditure authority under Section 1115 to claim as medical assistance the costs of services provided to eligible individuals ages 21-64 residing in facilities meeting the regulatory definition of an IMD. Additional expenditure authorities needed to operate the four pilot programs will be discussed during the federal review process.

Waiver Authorities

Statewideness §1902(a)(1)

To the extent necessary to permit any limited service benefit described in the Demonstration application.

Comparability §1902(a)(10)(B)

To the extent necessary to limit certain benefits as set forth in the Demonstration Application.

Freedom of Choice §1902(a)(23)(A)

To the extent necessary to limit certain benefits as set forth in the Demonstration Application.

VII. Demonstration Area and Timeframe

DHHS seeks a five-year waiver approval period for this demonstration. The IMD Exclusion portion of this waiver and the eligibility expansion would operate statewide while the three other service pilots may be operated on a less than statewide basis based on assessment of service delivery capacity and other approaches that limit service availability (e.g. phased-in approaches, RFP geographic limitations).

VIII. Implementation Schedule

All initiatives will be implemented within six months of demonstration approval (estimated July 1, 2020).

IX. Hypothesis and Evaluation

Through this demonstration, DHHS intends to evaluate several hypotheses (see Table 3). 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.

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.

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 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.

Table 3. 1115 Waiver Hypotheses and Potential Measures

1	Reimbursement of IMD services for adults will: • Increase the availability of residential beds in facilities that meet the definition of an IMD.

	• Reduce Emergency Department (ED) utilization from individuals receiving residential and community-based SUD services. • Reduce ED lengths of stay among members with SUD. • Increase State resources available for community-based services.
2	The overall impact of this waiver will improve health outcomes for members with SUD and affected families. Such as: • Increase the proportion of individuals who receive follow-up services within 7 days following an inpatient stay. (NQF#0576). • Increase the capacity of providers to screen, intervene, and refer individuals to appropriate services related to co-occurring physical and behavioral health needs. • Reduce the number of child protective determinations related to SUD. • Reduce the long-term cost of medical care and improve health outcomes for child welfare involved children through decreasing ACEs and increasing the number of families that successfully reunify or rehabilitate. • Increase member housing stability for individuals transitioning from recovery residences to community-living. • Reduce the number of readmissions to same or higher levels of care for residential treatment.
3	Increased access to appropriate SUD care and recovery support will reduce MaineCare's overall long-term costs for members with SUD.
4	The stakeholder engagement related to this waiver will increase stakeholder (internal and external) understanding of the service delivery system(s) available to MaineCare members. • Increase the proportion of individuals newly diagnosed with SUD that are connected to treatment (IET: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment). • Improve opioid prescription stewardship and promote alternative treatments to pain.

X. Demonstration Financing

From CMS consultation and a review of similar waiver requests, Maine believes potential expenditures incurred pursuant to the waiver of expenditure authority contained within this proposal, are likely considered "hypothetical expenditures."[25] For these hypothetical expenditures, CMS adjusts the budget neutrality test to effectively treat these expenditures as if they were approved Medicaid State Plan services and 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 requirement of §42 CFR 431.412 the tables below provide historical data and projects for total expenditures and annual enrollment for the past two State Fiscal Years (SFY) and the five proposed Demonstration Years (DY) (beginning with DY 1 which is equivalent to SFY 21). Importantly, the estimates below include assumptions around Medicaid expansion, which is currently being implemented.

Table 4. Historic Annual Aggregate Expenditures and Enrollment

	SFY 18 (Actual)	SFY 19 (Actual)
Enrollment	255,517	270,006
Total Expenditures	2,759,576	2,925,174

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

Table 5. Projected Annual Aggregate Expenditures and Enrollment

	DY 1 (SFY 21) (Estimate)	DY 2 (SFY 22) (Estimate)	DY 3 (SFY 23) (Estimate)	DY 4 (SFY 24) (Estimate)	DY 5 (SFY 25) (Estimate)
Enrollment	313,395	316,529	319,694	322,891	326,120
Total Expenditures	$3,216,420	$3,3345,077	$3,478,880	$3,618,035	$3,762,756

Anticipated increase in enrollment and expenditures

- The proposed expansion of eligibility to provide continuous coverage to parents during the rehabilitation and reunification process would result in an increase of expenditures of approximately $2,161,000 in total dollars and $1,377,000 federal dollars annually and would provide coverage to an additional 413 parents
- The State estimates residential IMD SUD treatment capacity to increase by 30 beds through this demonstration which, assuming current utilization and reimbursement, would result in $973,123 in additional spend (State and federal). A portion of these costs will represent shifting of treatment to a more clinically appropriate setting and are not necessarily new expenditures.
- All other pilot program spending will be negotiated through the Standard Terms and Conditions and application review process with CMS as the State anticipates spending caps for each pilot initiative.

Anticipated savings

There are anticipated savings from the waiver as a whole that are described below. These areas of improvement are aligned with the goals and milestones of this waiver opportunity.

Improved assessment of need, quality of care, and care transitions is expected to result in a reduction in readmissions to same or higher levels of residential treatment facilities	During State Fiscal Year 2019, 65 members had a readmission with 30 days to the same or higher level of SUD residential treatment. A reduction of 20% in this utilization would result in a savings of nearly $30,000 annually.
Improved integration of co-morbid behavioral conditions, as well as ensuring properly managed community-based services, is expected to result in (1) a reduction in hospitalizations related to high-cost and high-prevalence areas of infection/parasitic disease, injuries/poisoning, circulatory and SUD and, (2) non-emergent ED visits (the highest cost category relating to infection, respiratory conditions, and SUD).	Individuals with SUD have nearly double the rate of hospitalizations as MaineCare members without SUD (13.7% as compared to 6.9%). A 10% reduction in hospitalizations for this population would result in over $4 million dollars in savings. A 10% reduction in non-emergent ED visits would result in a savings of nearly $2 million annually for this population.
Additional services to support family permanency may result in changes to expenditures, though the impact and drivers of these changes need to be further evaluated through this pilot.	Initial analysis shows an increase in costs for both parent ($74 PMPM increase) and child ($389-$469 PMPM increase depending on family risk profile) following removal of the child from the home; however, some of these costs may represent parents and children accessing medically necessary services that previously were not being accessed for various reasons.

XI. Documentation of the State's Compliance with Tribal Consultation and Public Noticing

DHHS conducted public hearings, public notice, and tribal consultation in accordance with the requirements in 42 CFR 431.408. The following describes the actions taken by DHHS to ensure the public was informed and had the opportunity to provide input on the proposed waiver amendment.

On February 22, 2019, DHHS published a press release and posted a full public notice seeking input on the draft waiver application in major newspapers around the State. The 30-day public comment period thus began on February 22, 2019 and ended on March 25, 2019.

DHHS created a public webpage that includes the public notice, the public input process, scheduled public hearings, the draft amendment application, and a link to the Medicaid webpage on Section 1115 demonstrations. The webpage, which will be updated as the amendment process moves forward, can be found at http://www.maine.gov/dhhs/oms/rules/demonstration-waivers.shtml .

The webpage and public notice stated clearly that a copy of the waiver amendment documents, including the final waiver amendment application once complete, could be obtained from DHHS at no charge by downloading the documents from the website or by visiting any DHHS office. The webpage and public notice further explained that public comments were welcome and were accepted for 30 days (from February 22, 2019 to March 25, 2019). Written comments on the changes could be sent by email, or regular mail.

DHHS conducted two public hearings in geographically distinct areas of the state and included teleconference capabilities for both hearings.

Hearing 1:	**Portland Public Hearing**
Date:	March 6, 2019
Time:	10:00AM
Location:	Burton M. Cross Building 111 Sewall St. Augusta, Maine 04330

Hearing 2:	**Augusta Public Hearing**
Date:	March 7, 2019
Time:	10:00 AM
Location:	Department of Health and Human Services 151 Jetport Blvd. Portland, ME 04101

DHHS also held a MaineCare Advisory Meeting to discuss the waiver on March 6, 2019, which had in-person and telephone capabilities, and consulted with representatives of the federally recognized tribes located in Maine, in accordance with the Maine State Plan tribal consultation process. Tribal consultation included a presentation of the proposed waiver during the March 5, 209 tribal consultation conference call

and individual letters sent to designated Tribal Nation contacts on March 6, 2019 describing the proposed waiver with a link to the State's waiver webpage for more information. There were no major issues raised during tribal consultation. The Department has and will continue to consult both the MaineCare Advisory Committee and the Tribal Nations throughout the waiver review process. Please see Appendix B for the full report on comments received and how the Department considered comments in waiver development. Most notably, based on public comment, the Department decided shift focus from a combined SMI/SUD waiver request to focus solely on SUD. The SUD proposal had broad support from constituents to expand access to treatment and recovery services given the level of need Maine has for SUD services. Following public comment, the Department chose to delay requesting approval for the IMD expenditure authority for adults with SMI, pending further comprehensive service delivery system assessment.

XII. Demonstration Administration

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Appendix A: Milestones

CMS has established the following milestones for the two waiver opportunities:

Milestones: 1115 to improve access to and quality of treatment for MaineCare members with SUD

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

Appendix B: Summary and Response to Comments

General Comments:

1. Commenter chose to make no comment on the Department seeking the 1115 Demonstration waiver for the IMD exclusion for SUD facilities, and state that they strongly opposed the waiver for SMI/SED. The commenter paraphrased Department staff at the public hearing stating the Department wanted to increase community-based care and did not want to create additional psychiatric beds. The Department discussed undertaking a comprehensive assessment of the system of care, which the commenter supports, but stated that it was absent from the draft waiver application. The commenter believes that an assessment of the system will show no need for more psychiatric beds for adults with SMI. The commenter stated that Maine's waiver application does not promote Medicaid's objective to provide services to help individuals with mental illness retain the capability for independence or self-care, and asserted that the Department's waiver application would lead to inappropriate institutionalization prohibited by the ADA and the decision Olmstead v. L.C. The commenter stated that the 1115 Waiver application is for states seeking new opportunities to innovate the service delivery system and charged "there is nothing innovate or experimental in the waiver application as it applies to SMI or SED that assists in promoting the purposes of Medicaid." The commenter stated it wasn't clear why children with SED or Psychiatric Residential Treatment Facilities (PRTFs) were referenced in the application as the IMD exclusion only applies to individuals aged 21-65. The commenter feels that PRTFs do not work as well as home and community-based services, which produced better outcomes, using results from the CMS study on PRTF Demonstration Project. The commenter stated that PRTF is not a missing level of care in Maine, but "reliable and adequate home and community-based services" are missing for many children. The commenter stated that the Department has not proposed to increase funding for home and community-based services and the children discharged from PRTFs will have the same struggle of being put on waitlists for services. The commenter discussed a recent assessment completed of Maine's children's behavioral health system, which called for developing a strategic plan for children's behavioral health services, which the commenter feels should be the next step, "not increasing institutionalization of children without a plan on how to deliver services."

Response: The Department thanks the commenter for the comment. The Department agrees that further assessment and development would be beneficial to move forward with an 1115 Waiver Demonstration for lifting the IMD exclusion for SMI/SED; therefore, the Department has elected to not move forward with a waiver for the SMI/SED population at this time. The Department has decided to move forward with a 1115 Waiver Demonstration for the IMD exclusion only for the SUD population.

2. Commenter discussed the Augusta Mental Health Institute (AMHI) Consent Decree, a 30-year-old case that states in paragraph 23, it is required to provide all services within the comprehensive mental health system that shall be oriented towards supporting class members to continue to live in the community and to avoid hospitalization. The commenter feels that pursuing a waiver solely as a means of paying for beds is problematic to the Consent Decree as it does not look at the problems in the mental health system that "cause a bottleneck in beds." The commenter discussed a lack of contract enforcement as a means of holding providers accountable for refusing to accept members, leading members to be stuck in hospitals. The commenter appreciated the Department explaining its interest in a comprehensive mental health assessment but feels stating that seeking this waiver due a lack of capacity to meet the current need is premature, as the true need cannot be known without proper contract enforcement to assure members get placed.

Response: The Department thanks the commenter for the comment. Please see the Department's response to comment 1.

3. Four commenters discussed the importance of the 1115 Waiver and supporting the Department's waiver proposal which will help increase capacity and bring in additional federal matching dollars. The commenters felt the additional flexibility the Department receives under a Section 1115 waiver to expand services or access Federal Financial Participation (FFP) would be helpful to Maine. One commenter felt the 16-bed limit is arbitrary and "limits many of the advantages and economies of scale that would come from operating slightly larger SUD treatment facilities."

Response: The Department thanks the comment for the comment and appreciates the support in applying for an 1115 Demonstration Waiver.

4. Commenter stated that 1115 waivers are being used across the country for very innovative models of care, including expansion of services impacting population health and the social determinants of health, and encouraged the Department to explore these as well.

Response: The Department thanks the commenter for this comment. Based on public comment, the Department has decided to narrow its focus of the 1115 Waiver application solely to members with SUD concerns and have updated the application to include a number of service additions to the care delivery system in an attempt to improve treatment and health outcomes for this population.

5. Commenter was supportive of the waiver, but urged that money received from FFP for IMDs are invested in community-based care. Another commenter reiterated the point and requested the Department seek to expand access to other treatment to ensure a full continuum of care for people with SUD and SMI/SED, including investment in home and community-based treatment.

Response: The Department thanks the commenter for this comment. The Department agrees that bolstering community-based care is an important aspect to this Demonstration Waiver, and as such is proposing a number of initiatives to improve the care delivery system and health outcomes for members.

6. Commenter stated that there are several bills in the legislature to study the mental health system and to study the children's mental health system. The commenter stated "we should undertake that study before deciding to create institutions unnecessarily. We shouldn't go backwards. Maine should think about where it wants to go and develop a plan to get there."

Response: The Department thanks the commenter for the comment. Please see the Department's response to comment 1.

7. Commenter felt the 1115 waiver could be an opportunity to help the Department further its goal of establishing a care continuum that emphasizes early intervention, screening and prevention, which can also aim to reduce unnecessary use of hospital emergency departments.

Response: The Department thanks the commenter for the comment and agrees the 1115 Demonstration waiver can add flexibility to improve the state's care delivery system.

8. Commenter strongly supported the Department's commitment to seeking input from a cross section of stakeholders on this proposal and supports Maine's commitment to investing in expanded access to the full continuum of mental health and substance use disorder services.

Response: The Department thanks the commenter for the comment and the support.

9. Commenter stated they were proud of the state's recent decision to reject the "harmful and unnecessary" proposal to require proof of work as a condition of Medicaid coverage and appreciated Maine's implementation of Medicaid expansion available under the Affordable Care Act.

Response: The Department thanks the commenter for the comment and support on recent decisions.

10. The commenter stated they are often at the front line of seeing the effect of opioid use on women and encouraged the Department to ensure that women are at the forefront of discussions on how to advance effective programs and policies to address the opioid epidemic particularly.

Response: The Department thanks the commenter for this comment. The Department agrees with the commenter and has included expanding home-visiting services for parents in an effort to increase permanency and health outcomes. In addition to this 1115 Demonstration Waiver application, the Department submitted an application to the Centers for Medicare and Medicaid Innovation (CMMI) to implement the Maternal Opioid Misuse (MOM) model of care. If awarded/approved, by implementing both the waiver and MOM model of care, the Department hopes to improve quality of care and reduce costs for mothers, families, and their children affected by SUD.

11. A commenter stated that they understood the 1115 waiver would provide the state flexibility in funding to develop a full continuum of care but expressed concern that receiving FFP for IMD services has a potential to expand institutions and Maine's institutional services. The commenter stated their preference is to fully fund community-based services, as a means of preventing individuals from needing higher level of care. The commenter felt the draft application was unclear on how and when community services would be funded, and stated their preference is to focus efforts on community-based care prior to moving forward with anything else. "Any further delay in funding these community support services while simultaneously developing institutional services would create and overreliance on institutions when the need could be met in the community."

Response: The Department thanks the commenter for this comment. The Department agrees that bolstering community-based care is an important aspect to this Demonstration Waiver, and as such is proposing a number of initiatives to improve the care delivery system and health outcomes for members. During public comment it was noted increasing capacity of the State's SUD programs would be welcomed, allowing providers to instantly serve a greater number of people.

12. Commenter agreed with previous commenters surrounding urging Maine to complete a behavioral assessment prior to seeking an 1115 waiver to lift the IMD exclusion for individuals with Serious Mental Illness. The commenter additionally stated that her organization wants peer respite beds back in Maine. The commenter stated that Maine used to be a leader in peer services, and that peer respite is an alternative to crisis services. The commenter stated that since the program closed a couple of years ago, there has not been another respite program like it.

Response: The Department thanks the commenter for the comment. The Department will take peer respite service under consideration.

13. Commenter discussed the history of his organization in delivering SUD services to members in Maine communities. The commenter discussed that the IMD exclusion forced the provider to

immediately reduce capacity of his facility by 50% which has created significant operational challenges for his program. He stated that upon approval of the waiver he could instantaneously add 20% more beds, from 16 to 20, which would reduce his waitlist and bring more people into care. The commenter supports the waiver application and modest expansion of beds to increase access "to those who desperately need it."

Response: The Department thanks the commenter for this comment and appreciates the support in the waiver application and agrees that CMS approval of the application can have a positive effect on a member's access to medically necessary care.

14. One commenter criticized Maine's Medicaid system "MaineCare" stating "The worst patients I see in terms of outcome are those on MaineCare." The commenter stated they resent that MaineCare does not limit visits or emphasize outcomes while taxpayers with other insurances have these limits. The commenter stated that "throwing money into recovery programs many of which are based on addictive drugs is not the answer to the drug problem." The commenter hopes the current Governor does not create a situation where hospitals are not paid enough or in a timely manner to stay open. The commenter challenged the Governor to show outcomes and gave an example outcome of "how many of these folks receiving services become productive wage-earning individuals who give back more than they have taken."

Response: The Department thanks the commenter for this comment. The Department strives for improved health outcomes for Medicaid members and effective use of taxpayer dollars. The Department acknowledges the commenter's concerns on Maine's Medicaid system. The purpose of this waiver demonstration is to add flexibility to the system of care for members seeking medically necessary services addressing SUD. SUD is complex and an ongoing epidemic garnering attention across the country. This waiver is one step in attempting to address the needs of Maine's members living with SUD.