1115 Waiver Application
Department of Health and Human Services
State of Maine

February 22, 2019

Contents

I. Introduction

The Office of MaineCare Services 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 $2.6 billion annually in its Medicaid program, and covers approximately 260,000 individuals. While Maine has recently adopted Medicaid expansion, enrolling members under this program is just beginning. Currently, 19% of Maine's population is covered by Medicaid/CHIP. Maine's relative geographic size to population has fostered challenges to the state's mental health and Substance Use Disorder (SUD) service delivery systems.

While geographic struggles are not unique to Maine, it stands out for its disproportionately high share of residents who are seniors and shortage of certain qualified health professionals, including those who provide behavioral health services. As such, the state is seeking new opportunities to innovate in the delivery system.

Over the past several years, DHHS has introduced new MaineCare covered services to improve quality of care and work toward a full continuum of services in state. Notably:

- In 2014, Maine introduced Behavioral Health Homes to better integrate physical and behavioral healthcare by reimbursing a multi-disciplinary team of professionals to coordinate care for individuals with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Since 2014, the Behavioral Health Home program has grown each year in both service providers and members enrolled; the program currently serves over 12,000 members, including over 5,000 children.

- Medication Assisted Treatment coverage is robust under MaineCare, with Methadone and office-based buprenorphine available in a variety of settings. This is complemented with some adult coverage of Targeted Case Management for adults with SUD. Building upon the Behavioral Health Home program and the integrated team-based approach to care, Maine introduced Opioid Health Homes in 2017 to improve the quality and availability of Integrated Medication Assisted Treatment (IMAT) services statewide. This program currently serves nearly 500 MaineCare members with Opioid Use Disorder (OUD) monthly.

- In 2018, MaineCare adopted regulations to reimburse for Psychiatric Residential Treatment Facilities (PRTFs) to better meet the needs of individuals under the age of 21 who require inpatient services and are appropriate for this type of non-hospital setting. DHHS is hopeful that this service addition can meet the needs of some of Maine's most high-needs children and avoid out-of-state placements.

Maine continues to seek ways to both innovate and refine service delivery and service administration to increase access and quality of care. Maine is now seeking an 1115 Demonstration Waiver benefit from

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

the United Stated Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to support comprehensive behavioral health services.

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 and SMI[2] by Institutions of Mental Disease (IMDs), with the goal of testing whether this improves access to and the affordability of care for people with complex behavioral health 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 individual 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]

Maine has several enrolled IMDs (primarily in-state and out-of-state psychiatric facilities) that would immediately participate in this proposed demonstration; it is possible that, with this funding stream available, additional facilities would begin providing these services or expand their current services to the point of reaching the definition of an IMD (e.g. residential treatment facilities may expand capacity to above sixteen beds),[5] when allowable under state law. Reimbursement for these services would supplement 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.

As a relevant precursor to this work, from 2012-2015, Maine participated in the Medicaid Emergency Psychiatric Demonstration (MEPD) established under Section 2707 of the Affordable Care Act to evaluate the effects of providing Medicaid reimbursements to private psychiatric hospitals that treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions. Experience with this pilot provides a valuable foundation for the proposed demonstration that expands this to a broader range of individuals and providers to assess the effects of this coverage on health outcomes, quality of care, overall Medicaid costs, and more comprehensive societal impacts.[6]

The federal government has presented two separate opportunities for seeking 1115 waivers of the IMD exclusion: one for SUD treatment services and one for the service delivery system addressing SMI for adults and Serious Emotional Disturbances (SED) for children.[7] DHHS is pursing both options simultaneously through this application. An overview of Maine Medicaid, specifics related to each

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[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.

[6] More information about the MEPD, including the Final Report can be found at https://innovation.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/.

[7] Services for children with SED are included as part of this comprehensive approach to improve the service delivery system; however, it should be noted that the expenditure authority requested for FFP for IMD services mainly impacts adults aged 21 and over due to the separate Medicaid benefit category covering psychiatric hospital services for individuals under the age of 21.

population, and requirements that are shared across the two populations are presented here for public review:

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Maine, like many other states across the nation, has challenges with substance use disorders. 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.[8] OUD has continued to grow, having a dramatic effect on Maine people. In 2017, 360 opioid-related deaths were reported in Maine, at a level of 29.9 persons per 100,000, which is nearly double the national average of 14.9.[9] Of additional concern is the rise in cases of neonatal abstinence syndrome in Maine from 3 cases per 1,000 to 30.4 cases per 1,000 in the period from 2002-2013. The average across 28 states in 2013 was 6 cases per 1,000.[10]

Maine has aimed to address SUD and the opioid epidemic through various mechanisms. Maine 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 Medication Assisted Treatment (MAT) and recovery supports (see Table 2). The State has worked aggressively to control overprescribing of opioids through a robust Prescription Monitoring Program (PMP), revised prescribing guidelines, promoted alternative treatments to pain management, and offered provider education. Additionally, DHHS has deployed resources to improve syndromic surveillance, create seven peer recovery centers statewide, pilot rapid access programs in hospital emergency departments, improve care transitions for individuals leaving county jails, promote clinical screening and referral for pregnant women with SUD through the SnuggleME guidelines, integrate MAT into child protective case work, and several other interventions. In 2019, a recent executive order created a Prevention and Recovery Cabinet, and the Governor has appointed a Director of Opioid Response.

DHHS is well-positioned to continue aggressively addressing SUD as whole, and the opioid epidemic more specifically. Currently, MaineCare provides reimbursement for the following SUD services:[11]

Table 1. MaineCare State Plan SUD Services

Service	Brief Description
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

[8] 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.

[9] Scholl L, Seth P, Kariisa M, Wilson N, Baldwin G. Drug and Opioid-Involved Overdose Deaths — United States, 2013–2017. MMWR Morb Mortal Wkly Rep 2019;67:1419–1427. DOI: http://dx.doi.org/10.15585/mmwr.mm675152e1.

[10] Maine Opioid Summery from the National Institute on Drug Abuse, retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-summaries-by-state/maine-opioid-summary

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

	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 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. Office-Based Opioid Treatment (OBOT)) or a certified Opioid Treatment Program (OTP).
Opioid Health Homes	Integrated MAT services, including office visits with an 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 Population – Specific High Intensity Residential Programs	Services delivered according to ASAM level 3.3, Category II, include scheduled therapeutic and rehabilitative treatment designed to enable the member to sustain a substance free lifestyle in an unsupervised community situation. 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 substance abuse. Available to adults and children.
Inpatient	
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.

Through the demonstration period, the State will be revisiting the strengths and opportunities for improvement within these programs with a strong focus on evidence-based treatment, assessments, and successful transitions of care. DHHS is also 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).

1115 to improve the service delivery system for adults with an SMI or children with SED

Maine has consistently outpaced national averages in several key areas including prevalence of SMI in adults aged 18 or older and Major Depressive Episodes (MDE) among adolescents ages 12-17. Data from SAMHSA's Behavioral Health Barometer Volume 4 – Maine describe these data in Figures 1 and 2 below.[12]

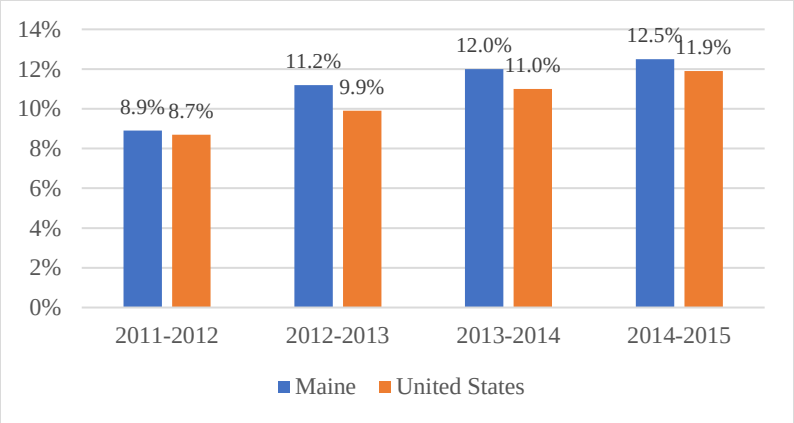

Figure 1. Prevalence of SMI as a Percent of Population

According to Maine's recent State Health Improvement Plan, 11% of Maine adults have 14 or more days in a month in which their mental health is poor, 24% of adults have been diagnosed with depression in their lifetime, 20% have been diagnosed with anxiety, and on average 27 people die by suicide every year. [13]

Within the same time period (2011-2015), Maine has provided treatment for over half (53.9%) of individuals with any mental illness, which surpasses the national average of 42.9%[14], but leaves room for improvement. While Maine's offerings are robust, service providers are harder to come by in less populated rural areas. The challenges lie in having qualified individuals available to deliver a service in less populated areas that may not be able to produce a sustainable business model. The impact of this issue has been a decrease in service accessibility and an increase in individuals accessing emergency services for mental and behavioral health care.

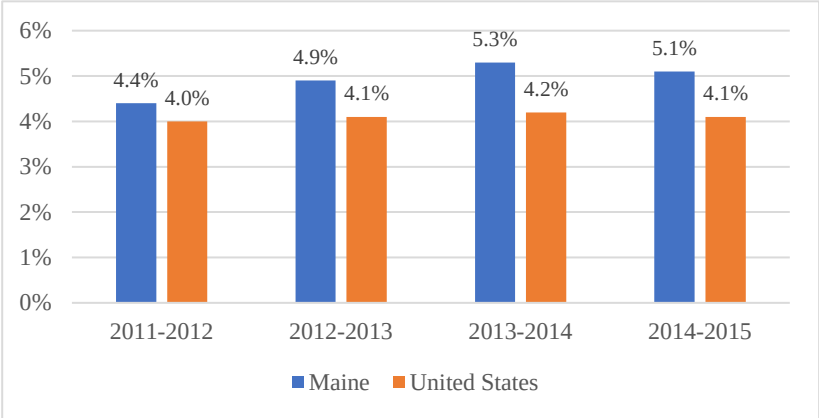

Figure 2 – Prevalence of Major Depressive Episodes as a Percent of Population for Youth Aged 12-17

Upon entering the system of care, providers in Maine utilize a number of psychosocial and standardized assessments to guide treatment decisions and assess an individual's level of care. Types of assessments include biopsychosocial assessment, Child and Adolescent Needs and Strengths Assessment (CANS), LOCUS, and ANSA. These assessments are designed to measure a baseline of the member's needs and to identify the medically appropriate service to begin treatment in the service delivery system. Improvements in use and integration of the tools will be integral to the success of DHHS's work under this waiver.

[12] Data from SAMHSA Behavioral Health Barometer Volume 4 -Maine retrieved from https://www.samhsa.gov/data/sites/default/files/Maine_BHBarometer_Volume_4.pdf

[13] State Health Improvement Plan 2018-2020, Maine Center for Disease Control and Prevention, retrieved from https://www.maine.gov/dhhs/mecdc/ship/

[14] Data from SAMHSA Behavioral Health Barometer Volume 4 -Maine retrieved from https://www.samhsa.gov/data/sites/default/files/Maine_BHBarometer_Volume_4.pdf

The following services are part of MaineCare's service delivery system to SMI/SED services:[15]

Table 2. MaineCare State Plan SMI and SED Services

Service	Brief Description
Targeted Case Management	Services consist of assessment, planning, referral and related activities, and monitoring and follow-up activities for children with behavioral health disorders.
Behavioral Health Homes	Comprehensive care management and health promotion 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 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.
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 focused on solving problems that interfere with treatment and rehabilitation. Available to children.
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	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

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

	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-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.

In addition to coverage of these services, DHHS acknowledges challenges remain regarding access to services in certain geographic areas, access to services for high-intensity or high-need individuals, including access gaps in crisis intervention services. DHHS recently commissioned an independent assessment of its behavioral health services offering for children and adolescents under age 21. While the state is still absorbing the findings and recommendations within the report, five main areas emerged as themes: access, proximity, appropriateness, quality, and coordination. The report described that services may not be available immediately or at all, either due to an increased level of need or lack of available providers in certain geographic areas. This, in turn, has resulted in youth receiving any service when it becomes available, versus receiving the appropriate service from the start. Quality assurance and oversight remains a challenge to successfully and sustainably operationalize. Workforce shortages and turnover make it difficult to ensure highly trained and experienced staff are delivering services. Considering turnover, training, workforce shortages and a lack of available providers, coordination, specifically for individuals transitioning to adulthood, continues to need improvement.[16] In closing, although the assessment was specific to behavioral health services for children and adolescents, some findings may be applicable to Maine's behavioral health system as a whole.

DHHS also expects that there are best practices to be learned from projects with various funding streams that can be more effectively applied to MaineCare populations. For example, Maine has a continuum of services to address needs of homeless youth including outreach, drop-in and shelter services. Within these services, there is a focus to meet the housing and behavioral health needs of youth and address long-term needs through direct intervention and referral to services. Moreover, the state wants to explore a "hub and spoke" model of SUD treatment similar to what Vermont implemented. Unlocking some of the resources

[16] Children's Behavioral Health Services Assessment Final Report. Retrieved from https://www.maine.gov/dhhs/ocfs/cbhs/documents/ME-OCFS-CBHS-Assessment-Final-Report.pdf

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 SMI, SED, and SUD. This demonstration project, with the prescribed goals and milestone (see Section III below), provides an ideal framework to address the behavioral health service 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.

III. Goals

The goals of this waiver are predetermined by CMS and outlined in two separate State Medicaid Director Letters.[17] The overarching goal is to improve the service delivery systems for people with SUD and SMI/SED. 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

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.

1115 to improve the service delivery system for adults with an SMI or children with SED

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

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 developing 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

[17] SMD 17-003 (published November 1, 2017) and 18-011 (published November 13, 2018). https://www.medicaid.gov/federal-policy-Guidance/index.html.

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.

VI. Type of Waiver Requested

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.

VII. Demonstration Area and Timeframe

DHHS seeks a five-year waiver approval period for this demonstration. This demonstration will operate statewide.

VIII. Implementation Schedule

All initiatives will be implemented within six months of demonstration approval (estimated June 1, 2019).

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. 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 number of adult out-of-state placements related to SMI/SUD. • Reduce ED utilization from individuals receiving residential and community-based SMI/SED/SUD services. • Reduce ED lengths of stay among members with SMI/SED/SUD. • Increase state resources available for community-based services, including implementation of a hub-and-spoke model of treatment for SUD.
2	The overall impact of this waiver will improve health outcomes for members with SMI/SED/SUD. Such as: • Increase the proportion of individuals who receive follow-up services within 7 days following an inpatient stay. (NQF#0576). • Increase the proportion of members who have had a primary care visit, including adolescent well-care visits, for individuals with SED. • 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.
3	Increased access to appropriate behavioral and SUD care will reduce overall MaineCare costs for members with SMI/SED/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.

X. Demonstration Financing

DHHS understands that the potential expenditures incurred pursuant to the waiver of expenditure authority contained within this proposal, are considered "hypothetical expenditures."[18] 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. For this reason, DHHS has not included a budget neutrality assessment, but commits to reporting all SUD/SMI/SED-related IMD stays consistent with the special terms and conditions for the demonstration.

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 20). Importantly, the estimates below include assumptions around Medicaid expansion, which is currently being implemented.

DHHS utilized data (per discharge rates and bed days) from the MEPD to provide estimates below related to increased costs for IMD stays. As noted above, the MEPD was established under Section 2707 of the Affordable Care Act to evaluate the effects of providing Medicaid reimbursements to private psychiatric hospitals that treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions; Maine was one of eleven states to participate in the pilot, which spanned from 2012 to 2015. Though the scope of the MEPD was more limited than this request as far as eligible populations, it provides robust information to inform the work of this demonstration as well as cost projections.

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

Table 4. Historic Annual Aggregate Expenditures and Enrollment.

	SFY 17 (Actual)	SFY 18 (Actual)
Enrollment	270,511	260,177
Total Expenditures	$2,602,187,148	$2,759,743,593

Table 4. Projected Annual Aggregate Expenditures and Enrollment.

	DY 1 (Estimate)	DY 2 (Estimate)	DY 3 (Estimate)	DY 4 (Estimate)	DY 5 (Estimate)
Enrollment	331,676	331,676	331,676	331,676	331,676
Total Expenditures	$3,428,225,473	$3,563,977,965	$3,741,929,730	$3,928,779,083	$4,124,970,904

XI. Public Notice

[To be completed and described prior to submission and in accordance with the requirements in 42 C.F.R. 431.408.]

XII. Demonstration Administration

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XIII. 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.

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

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 Continuum of Care Including Crisis Stabilization Services.
4. Earlier Identification and Engagement in Treatment Including Through Increased Integration.