OPEN MINDS

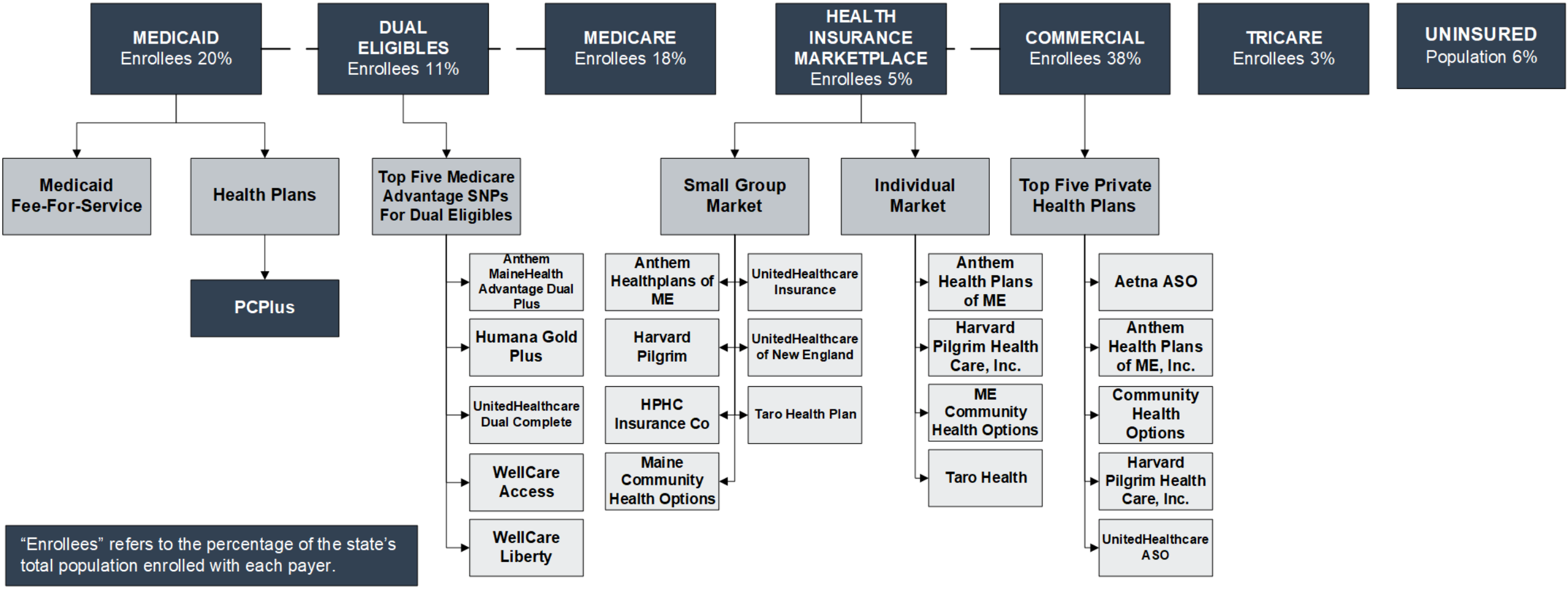
Maine Health & Human Services System Market Profile: 2025

Health & Human Services Market Profile Overview

A. Executive Summary

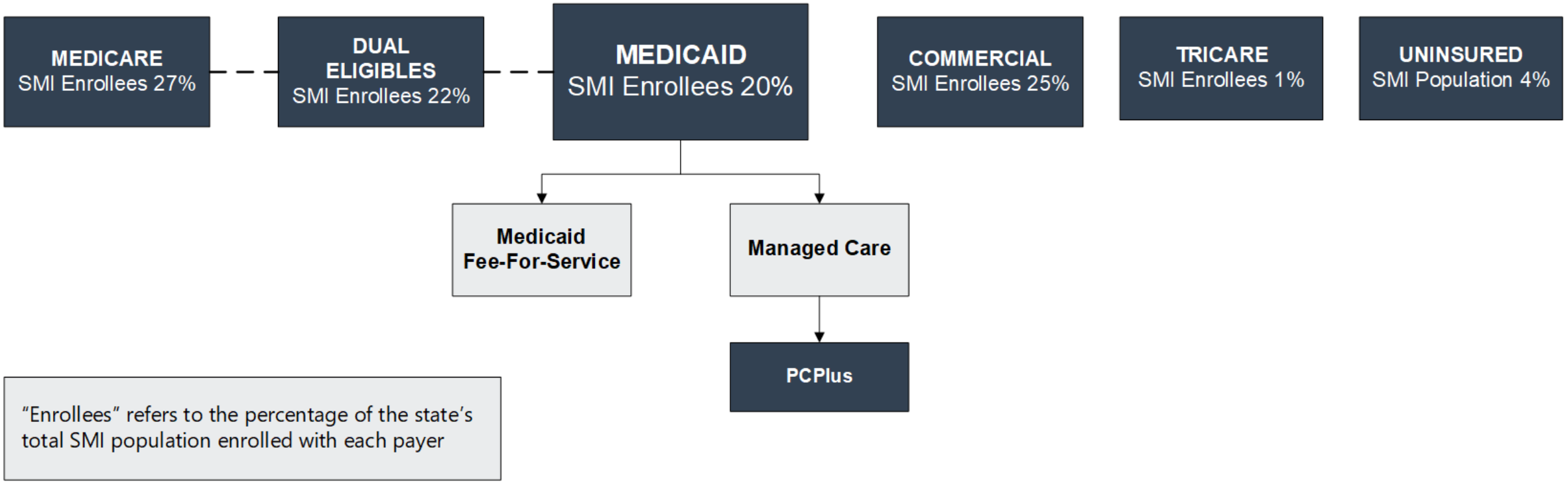
A.1. Maine Physical Health Care Coverage by Payer

Total Maine Population- 1,395,722
Estimated SMI Population- 83,743



Totals may not equal 100% due to rounding.

A.1. Maine Behavioral Health Care Coverage by Payer



Totals may not equal 100% due to rounding.

A.2. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan		None
Primary Care Case Management (PCCM)	✓	Maine considers its PCPlus program to be managed care.
Accountable Care Organization (ACO) Program	✓	The state calls its ACOs Accountable Communities.
Affordable Care Act (ACA) Model Health Home	✓	Maine operates three health home programs: one for persons with chronic conditions, one for adults with SMI or children with SED, and one for individuals with opioid use disorder.
Patient-Centered Medical Home (PCMH)	✓	All health home provider organizations must be certified as PCMHs.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state has been awarded seven CCBHC grants.
Other Care Coordination Initiatives		None

A.3. Health Care Safety-Net Delivery System

State Agencies Responsible For Uninsured Citizens & Delivery System Model

Physical Health Services

- The Office of Rural Health and Primary Care within the state Department of Health and Human Services (DHHS) provides physical services to the uninsured population.

Mental Health Services

- The Office of Substance Abuse and Mental Health Services within DHHS provides mental health services to the uninsured population through a network of provider organizations.

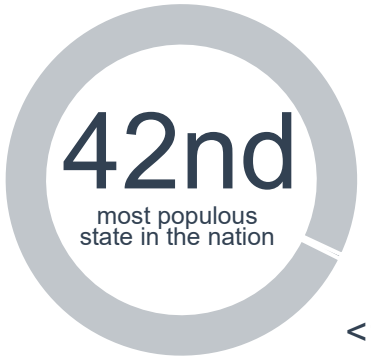
Addiction Treatment Services

- The Office of Substance Abuse and Mental Health Services within DHHS provides addiction treatment services to the uninsured population through a network of provider organizations.

B. Maine Health Financing System Overview

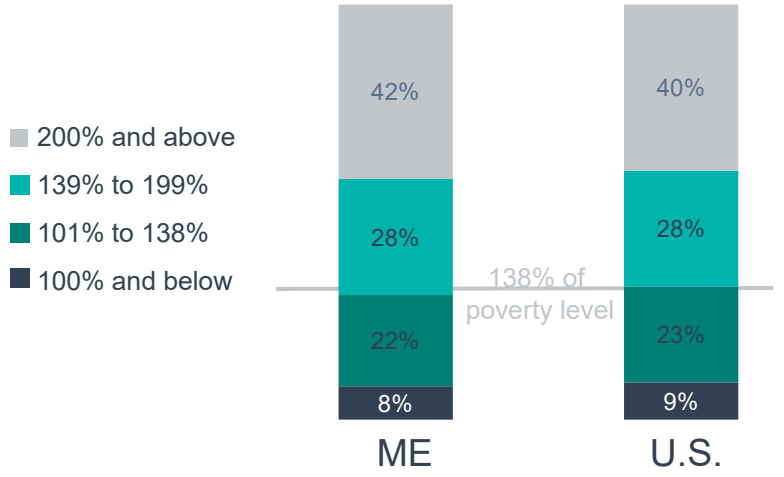
B.1. Population Demographics

Total Maine Population- 1,395,722
Estimated SMI Population- 83,743



<1% of the
U.S. population

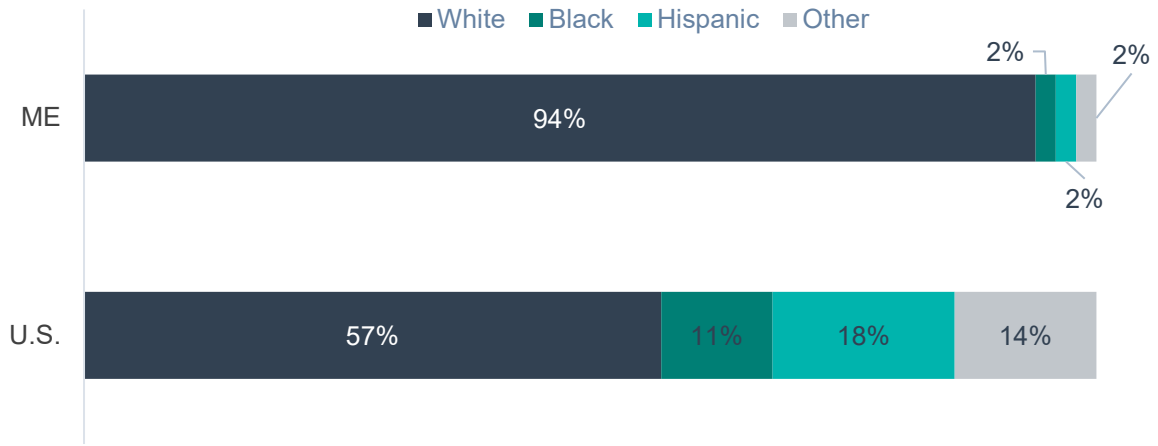
Population Distribution By Income To Poverty Threshold Ratio



Median Household Income	
Maine	$73,733
U.S.	$77,719

Population Distribution By Age

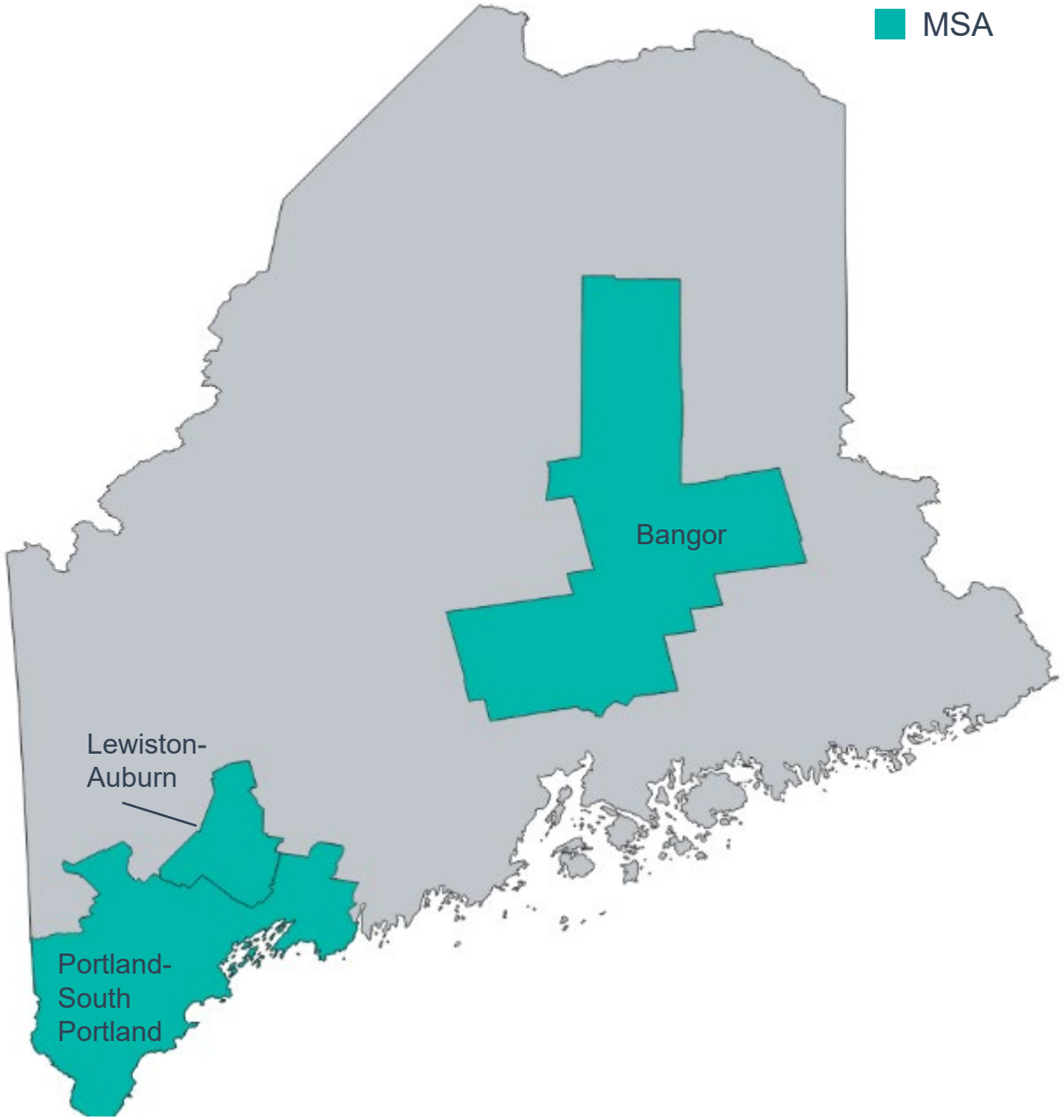
Maine & U.S. Racial Composition



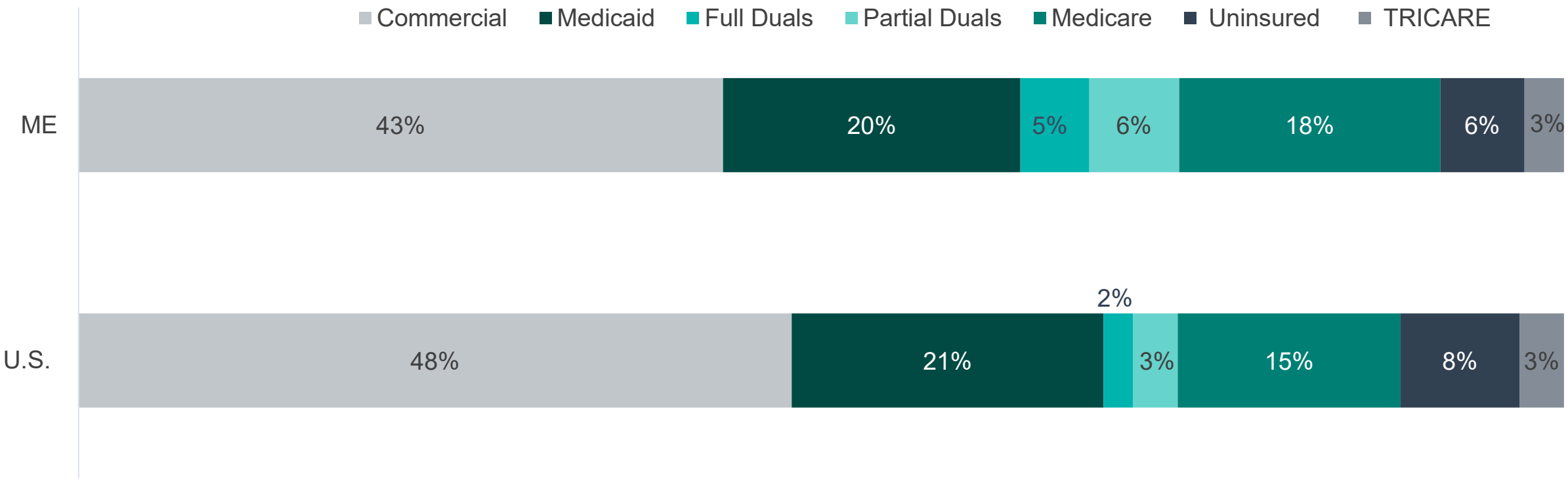
Totals may not equal 100% due to rounding.

B.2. Population Centers

Metropolitan Statistical Areas (MSAs)		
MSA	**Maine MSA Residents**	**Percent Of Population**
Total MSA Population	**843,646**	**60%**
Portland-South Portland, ME	571,534	41%
Bangor, ME	156,840	11%
Lewiston-Auburn, ME	115,272	8%

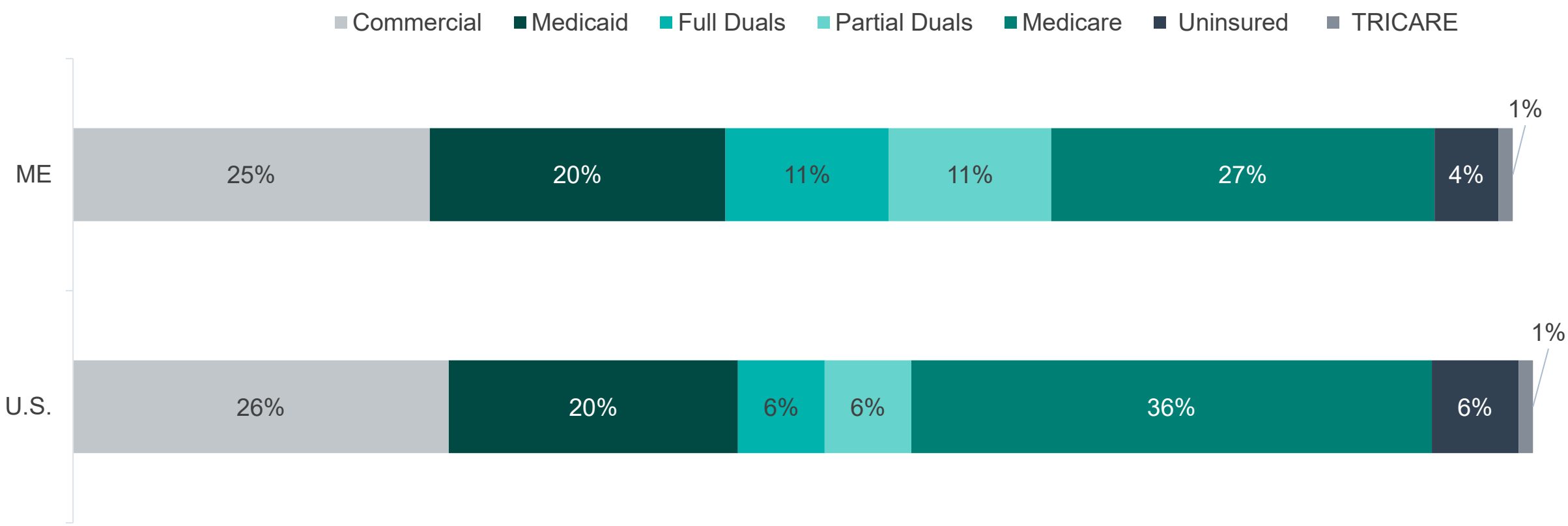


B.3. Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.3. SMI Population Distribution By Payer: National vs. State



Totals may not equal 100% due to rounding.

B.4. Largest Maine Health Plans By Enrollment

Plan Name	Plan Type	Enrollment*
Maine Medicaid Fee-For-Service (FFS)	Medicaid	366,751
Anthem Health Plans of Maine	Commercial	276,264
Maine Medicare FFS	Medicare	160,681
PCPlus	Medicaid managed care	77,983
Harvard Pilgrim Health Care	Commercial	69,357
Martin's Point Generations Advantage	Medicare Advantage	62,898
Aetna ASO	Commercial administrative services only(ASO)	61,098
UnitedHealthcare ASO	Commercial ASO	41,290
TRICARE	Other public	39,909
Harvard Pilgrim Health Care ASO	Commercial ASO	34,012

*Medicaid enrollment as of July 2025; TRICARE as of December 2023; Commercial as of October 2023; Medicare enrollment as of May 2024

B.4. Largest Maine Health Plans By Estimated SMI Enrollment

Plan Name	Plan Type	Enrollment*	Estimated SMI Enrollment
Maine Medicaid FFS	Medicaid	366,751	32,274
Maine Medicare FFS	Medicare	160,681	20,889
Anthem Health Plans of Maine	Commercial	276,264	13,537
Martin's Point Generations Advantage	Medicare Advantage	62,898	8,177
PCPlus	Medicaid managed care	77,983	6,863
Harvard Pilgrim Health Care	Commercial	69,357	3,398
Sierra Health and Life Insurance Company	Medicare Advantage	25,600	3,328
Aetna ASO	Commercial ASO	61,098	2,994
Aetna Medicare	Medicare Advantage	20,502	2,665
Anthem MediBlue	Medicare Advantage	17,006	2,211

*Medicaid enrollment as of July 2025; TRICARE as of December 2023; Commercial as of October 2023; Medicare enrollment as of May 2024

B.5. Health Insurance Marketplace

Health Insurance Marketplace	
Marketplace Plan Percentage	5%
Type of Marketplace	State-run
Individual Enrollment Contact	https://coverME.gov
	1-866-636-0355
Small Business Enrollment Contact	https://coverME.gov
	1-866-636-0355

2025 Individual Market Health Plans
1. Anthem Health Plans of Maine
2. Community Health Options
3. Harvard Pilgrim Health Care, Inc.
4. Taro Health Plan

2025 Small Group Market Health Plans
1. Anthem Health Plains of Maine
2. Community Health Options
3. Harvard Pilgrim
4. HPHC Insurance Company, Inc
5. Taro Health
6. UnitedHealthcare Insurance Company
7. UnitedHealthcare of New England

B.6. Accountable Care Organizations

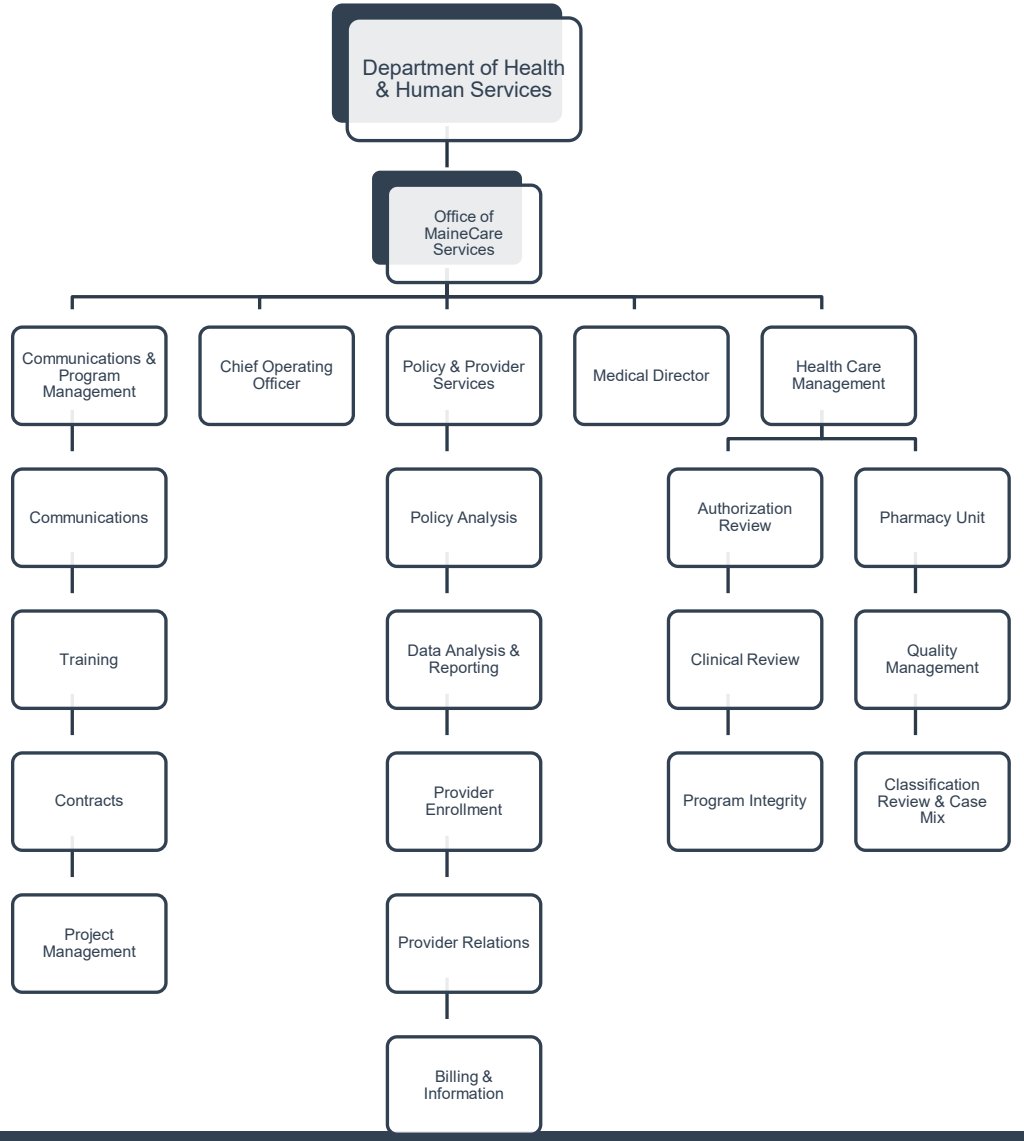
Medicare Shared Savings ACOs
1. NH-Cares ACO LLC
2. Beacon Rural Health, LLC
3. Community Care Partnership of Maine, LLC
4. MaineHealth Accountable Care Organization

Medicaid Accountable Communities
1. Beacon Health, LLC
2. Community Care Partnership of Maine (CCPM)
3. Kennebec Region Health Alliance
4. MaineHealth Accountable Care Organization, LLC

Commercial ACOs	
ACO	**Commercial Insurer**
Intermed	Aetna, Cigna
Kennebec Regional Health Alliance	Cigna
MaineGeneral Health ACO	Aetna
MaineHealth Accountable Care Organization, LLC	Aetna
Martin's Point Health Care	Aetna, Beacon Health, Cigna, Martin's Point
Mercy Health Collaborative Accountable Care	Cigna
Penobscot Community Health Care Collaborative Accountable Care	Cigna

C. Medicaid Administration, Governance & Operations

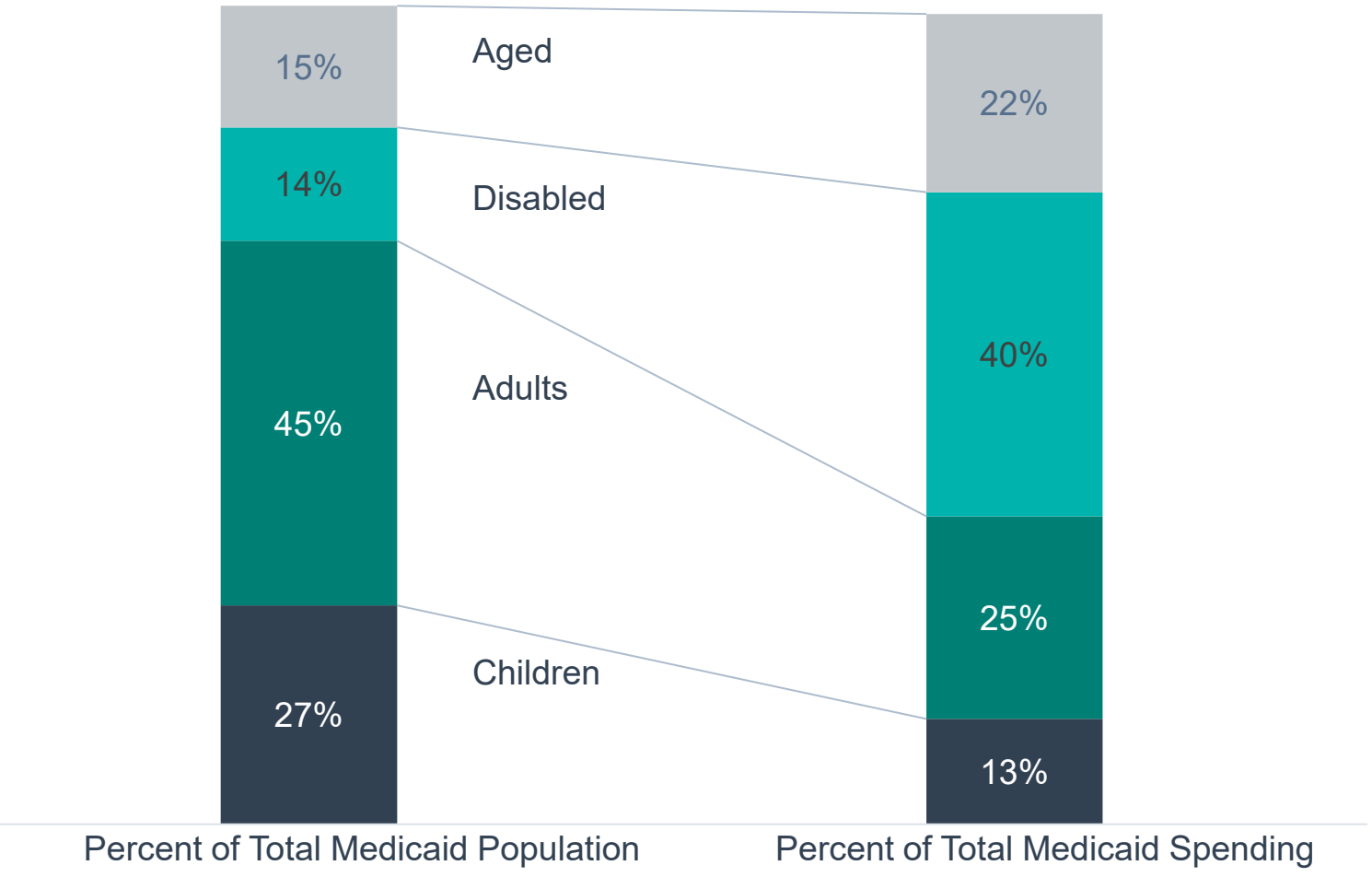
C.1. Medicaid Governance: Organization Chart



C.1. Medicaid Governance: Key Leadership

Name	Position	Department	Email
Sara Gagne-Holmes	Acting Commissioner	Department of Health and Human Services	sara.gagne-holmes@maine.gov
Hilary Schneider	Director	Office of the Health Insurance Marketplace	hilary.schneider@maine.gov
Michelle Probert	Director of MaineCare Services	Office of MaineCare Services	michelle.probert@maine.gov
Jonathan Savinelli	Chief Operating Officer	Office of MaineCare Services	jonathan.savinelli@maine.gov
Courtney Pladsen	MaineCare Medical Director	Office of MaineCare Services	courtney.pladsen@maine.gov
Kayla Sargent	Associate Director, Communications and Planning	Office of MaineCare Services	kayla.sargent@maine.gov
Jessica Miller	Acting Associate Director, Policy	Office of MaineCare Services	jessica.miller@maine.gov

C.2. Medicaid Program Spending By Eligibility Group



Medicaid Spending Per Enrollee, FY 2022		
	U.S.	ME
All populations	$8,813	$9,147
Children	$3,786	$4,575
Adults	$5,443	$3,419
Expansion adults	$7,569	$6,583
Blind and disabled	$25,483	$25,629
Aged	$19,191	$13,540

Based on FY 2022 data

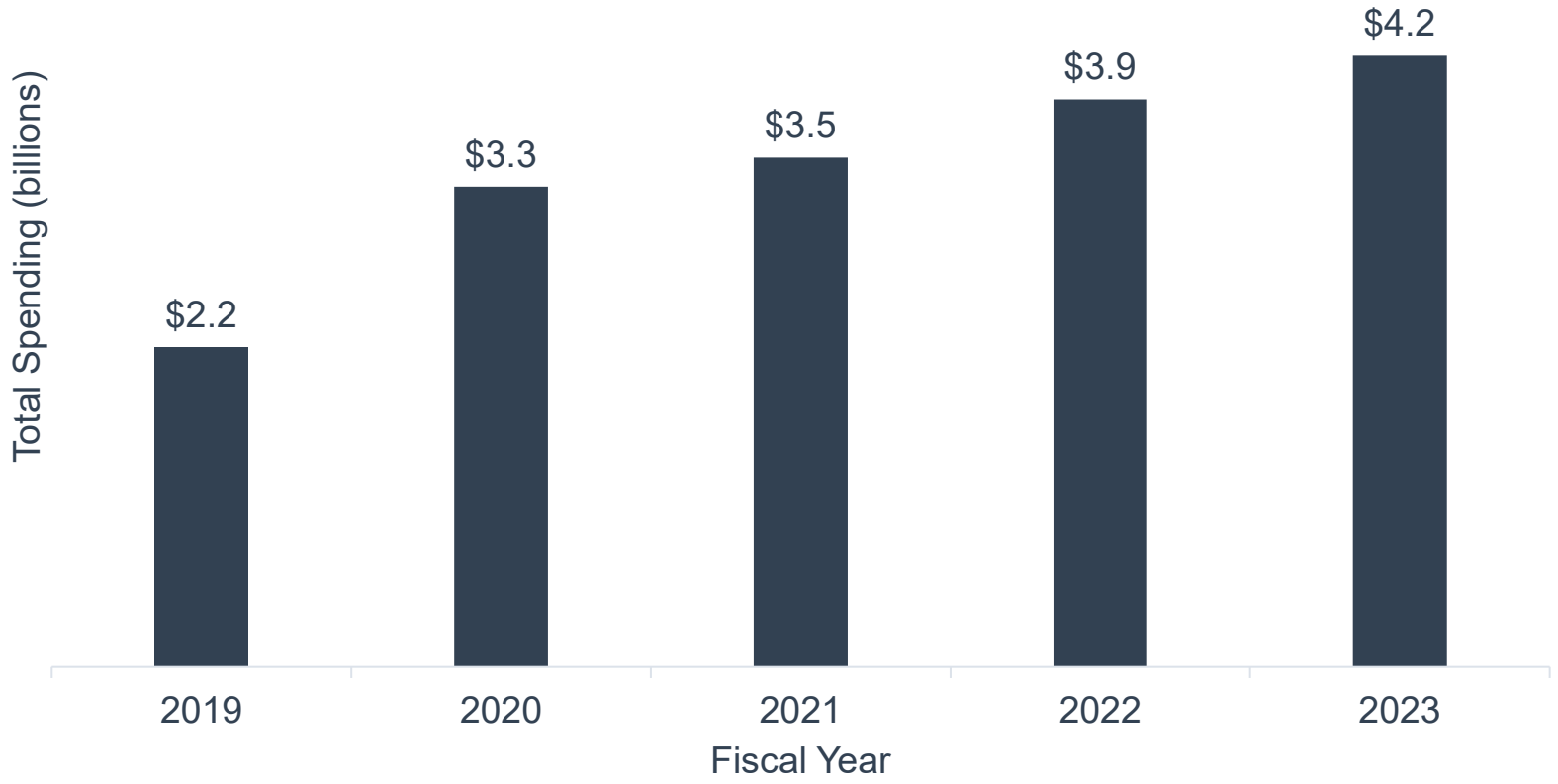
Total may not equal 100% due to rounding.

C.2. Medicaid Program Spending: Budget

Budget Item	SFY 23 Spending	Percent Of Budget
Hospital	$985,000,000	24%
Home-and community-based LTSS	$926,000,000	22%
Other acute	$780,000,000	19%
Institutional LTSS	$589,000,000	14%
Medicare premiums and coinsurance	$282,000,000	7%
Drugs	$174,000,000	4%
Clinic and health center	$140,000,000	3%
Physician	$138,000,000	3%
Other practitioner	$105,000,000	3%
Dental	$33,000,000	1%
Managed care and premium assistance	$31,000,000	1%
Total Spending: $4,183,000,000		

Federal & County Financial Participation	
FY 2025 Federal Medical Assistance Percentage (FMAP)	62.1%
CY 2025 Newly Eligible FMAP (expansion population)	88%
Counties contribute to state Medicaid share	No

C.2. Medicaid Program Spending: Change Over Time



C.3. Medicaid Expansion Status

Medicaid Expansion	
Participating In Expansion	Yes, originally, the Office of MaineCare Services fought Medicaid expansion, but with the election of Governor Janet Mills, a judge ordered the Medicaid expansion.
Date Of Expansion	January 10, 2019
Medicaid Eligibility Income Limit For Able-Bodied Adults	138% of the Federal Poverty Level (FPL) for parent and caretaker adults.
Legislation Used To Expand Medicaid	Executive Order One from Governor Janet Mills
Number Of Individuals Enrolled In The Expansion Group (June 2024)	395,870
Number Of Enrollees Newly Eligible Due To Expansion	112,072
Benefits Plan For Expansion Population	The alternative benefit plan provides parents, caretaker relatives, and childless adults with the same benefits as the state plan including mental health and addiction treatment services.

C.4. Medicaid Program Benefits

Federally Mandated Benefits

1. Inpatient hospital services other than services in an institution for mental disease (IMD)
2. Outpatient hospital services
3. Rural Health Clinic services
4. Federally Qualified Health Center (FQHC) services
5. Laboratory and x-ray services
6. Nursing facilities for individuals aged 21 and over
7. Early and Periodic Screening and Diagnosis and Treatment (EPSDT)
8. Family planning services and supplies
9. Free standing birth centers
10. Pregnancy-related and postpartum services
11. Nurse midwife services
12. Tobacco cessation programs for pregnant women
13. Physician services
14. Medical and surgical services of a dentist
15. Home health services
16. Nurse practitioner services
17. Non-emergency transportation to medical care

Maine's Optional Benefits

1. Prescription drugs
2. Chiropractor services
3. Podiatrist services
4. Diagnostic, screening, and preventative services
5. Rehabilitative services
6. Clinic services
7. Dental services (limited for adults)
8. Physical and occupational therapy
9. Speech, language, and hearing services
10. Inpatient psychiatric care for people under 21 and over 65
11. Intermediate care facility/IDD services
12. Case management services
13. Private duty nursing
14. Personal care services
15. Hospice care
16. Eye care

D. Medicaid Financing & Service Delivery System

D.1. Medicaid Financing & Service Delivery System

Medicaid System Characteristics		
Characteristics	**Medicaid Fee-For-Service (FFS)**	**Medicaid Managed Care (PCPlus)**
Enrollment (May 2025)	366,751	77,983
SMI Enrollment	• Maine does not specifically preclude individuals with SMI from enrolling in managed care. • Estimated 18% of SMI population is enrolled in managed care, 82% in FFS	
Management	Office of MaineCare Services	Office of MaineCare Services
Payment Model	FFS	FFS and per member per month (PMPM) fee
Geographic Service Area	Statewide	Statewide

Total Medicaid: 444,734 | Total Medicaid With SMI: 39,136

D.1. Medicaid System Overview

Medicaid Financial Delivery System Enrollment	
Total Medicaid population distribution	• As of May 2025: 82% in fee-for-service (FFS), 18% in managed care (Maine considers its PCPlus to be managed care)
SMI population inclusion in managed care	• Maine does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care. • Estimated 82% of population in FFS, 18% in managed care
Dual eligible population inclusion in managed care	• Dual eligibles are excluded from managed care. • Estimated 100% of population in FFS

Medicaid Financing & Risk Arrangements: Behavioral Health		
Service Type	**FFS Population**	**Managed Care Population**
Traditional behavioral health	Covered FFS by the state	Covered FFS by the state (state operates as PCPlus)
Specialty behavioral health	Covered FFS by the state	Covered FFS by the state
Pharmaceuticals	Covered FFS by the state	Covered FFS by the state
LTSS	Covered FFS by the state	Covered FFS by the state

D.1. Medicaid Care Coordination Initiatives

Medicaid Care Coordination Entities For Chronic Care Populations (Including SMI)		
Care Coordination Entity	**Active Program**	**Description**
Managed Care Health Plan		None
Primary Care Case Management (PCCM)	✓	Maine considers its PCPlus program to be managed care.
Accountable Care Organization (ACO) Program	✓	The state calls its ACOs Accountable Communities.
Affordable Care Act (ACA) Model Health Home	✓	Maine operates three health home programs: one for persons with chronic conditions, one for adults with SMI or children with SED, and one for individuals with opioid use disorder.
Patient-Centered Medical Home (PCMH)	✓	All health home provider organizations must be certified as PCMHs.
Dual Eligible Demonstration		None
Managed Long-Term Services and Supports (MLTSS)		None
Certified Community Behavioral Health Clinics (CCBHC) Grant	✓	The state has been awarded seven CCBHC grants.
Other Care Coordination Initiatives		None

D.1. Medicaid Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or PCPlus	Mandatory PCPlus Enrollment
Parents and caretakers	✓		
Children	✓		
Blind and disabled individuals			✓
Aged individuals			✓
Dual eligible*	✓		
Medicaid expansion			✓
Individuals residing in nursing homes	✓		
Individuals in adoptive/foster care		✓	
Other populations	• Individuals with other health insurance • Individuals expected to be enrolled for less than three months • Alaskan Natives or Native Americans • Members receiving home and community benefits	• Established relationship with non-PCPlus provider organization for chronic disease, disability, or terminal illness • Language or cultural need • Greater than 30-minute travel time to PCPlus provider organization • Status as a migrant farm worker or dependent • Homelessness • Hospice care at time of enrollment	• Pregnant individuals • Women with breast or cervical cancer

*Dual Eligibles also have the option to join an MA SNP plan.

D.2. Medicaid FFS Program: Overview

- *OPEN MINDS* estimates that FFS enrollment as of May 2025 was 366,751.
- Maine calls its Medicaid program MaineCare.

D.2. Medicaid FFS Program: Behavioral Health Benefits

Maine contracts with Acentra Health to provide utilization management services for MaineCare mental health and addiction treatment benefits.

FFS Mental Health Benefits
1. Inpatient psychiatric care for people under 21 and over 65
2. Partial hospitalization
3. Crisis residential services
4. Community support services
5. Outpatient services
6. Family psychoeducation treatment
7. Medication management
8. Neurobehavioral exam, neuropsychological testing, psychological testing
9. Children's assertive community treatment
10. Children's home- and community-based treatment
11. Children's behavioral health day treatment
12. Mental health psychosocial clubhouse

FFS Addiction Treatment Benefits
1. Inpatient detoxification
2. Non-hospital detoxification
3. Residential treatment
4. Outpatient services
5. Intensive outpatient services
6. Medication management
7. Medication assisted treatment (MAT)
8. Tobacco cessation treatment

D.2. Medicaid FFS Program: SMI Population

- Maine does not specifically preclude individuals with SMI from enrolling in managed care; therefore, most of the SMI population is enrolled in managed care.
- As of May 2025, *OPEN MINDS* estimates that 82% of the SMI population is enrolled in FFS.
- Individuals with SMI may qualify for additional non-Medicaid services under the Augusta Mental Health Institute (AMHI) Consent Decree.

D.2. Medicaid FFS Program: Pharmacy Benefit

Maine FFS Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the preferred drug list is called MaineCare PDL.
State Uses A PDL For Mental Health Drugs	Yes, anxiolytics, antidepressants, and antipsychotics are included in the general PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, alcohol deterrent, smoking cessation, and narcotic antagonist drugs are included in the general PDL.
Coverage Of Antipsychotic Injectable Medications	Yes, antipsychotic injectable medications are covered as a pharmacy benefit if preferred drugs were tried and failed due to lack of efficacy or intolerable side effects before injectable medications will be approved.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects, or there must be a condition that prevents the usage of a non-preferred drug before non-preferred drugs will be approved. • Restrictions vary by drug and may include quantity limits, dosing limits, age limits, and prior authorization.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	An individual may be locked in or restricted to one prescriber and one pharmacy if suspected of medication abuse. Additionally, some individuals may be enrolled in the lock-in program if awaiting prior authorization for certain medications.

D.3. Medicaid Managed Care Program: Overview

- *OPEN MINDS* estimates that managed care enrollment as of May 2025 was 77,983.
- Primary Care Plus (PCPlus) is MaineCare's new value-based approach to support primary care. PCPlus replaced Primary Care Case Management, Primary Care Incentive Payment, and primary care Health Homes with a single, integrated initiative and offers primary care practices greater flexibility and incentives to meet MaineCare members' health care needs.
  - Primary care physicians act as "gatekeepers" to specialty services.
  - Primary care provider organizations are paid a fee of $3.50 PMPM for care coordination.
  - Medical services are reimbursed on an FFS basis.
- PCPlus transitions away from a volume-based (fee-for-service) payment system toward an approach that provides population-based payments tied to cost- and quality-related outcomes.
- For the first year or PCPlus, the Practice Level PMPM is not adjusted for performance – instead, each practice received the same automatic upwards adjustment
  - Beginning with payment in July 2023, the Practice Level PMPM portion of the PCPlus rate will be adjusted every quarter for performance ranging from -10% to +25%.
- The state also contracts with accountable care organizations (ACOs) to serve the state's PCPlus population called Accountable Communities.

D.3. Medicaid Managed Care Program: Behavioral Health Benefits

- All PCPlus behavioral health benefits are provided FFS by the state.
- Maine contracts with Acentra Health to provide utilization management services for MaineCare mental health and addiction treatment benefits.

FFS Mental Health Benefits
1. Inpatient psychiatric care for people under 21 and over 65
2. Partial hospitalization
3. Crisis residential services
4. Community support services
5. Outpatient services
6. Family psychoeducation treatment
7. Medication management
8. Neurobehavioral exam, neuropsychological testing, psychological testing
9. Children's assertive community treatment
10. Children's home- and community-based treatment
11. Children's behavioral health day treatment
12. Mental health psychosocial clubhouse

FFS Addiction Treatment Benefits
1. Inpatient detoxification
2. Non-hospital detoxification
3. Residential treatment
4. Outpatient services
5. Intensive outpatient services
6. Medication management
7. Medication assisted treatment (MAT)
8. Tobacco cessation treatment

D.3. Medicaid Managed Care Program: SMI Population

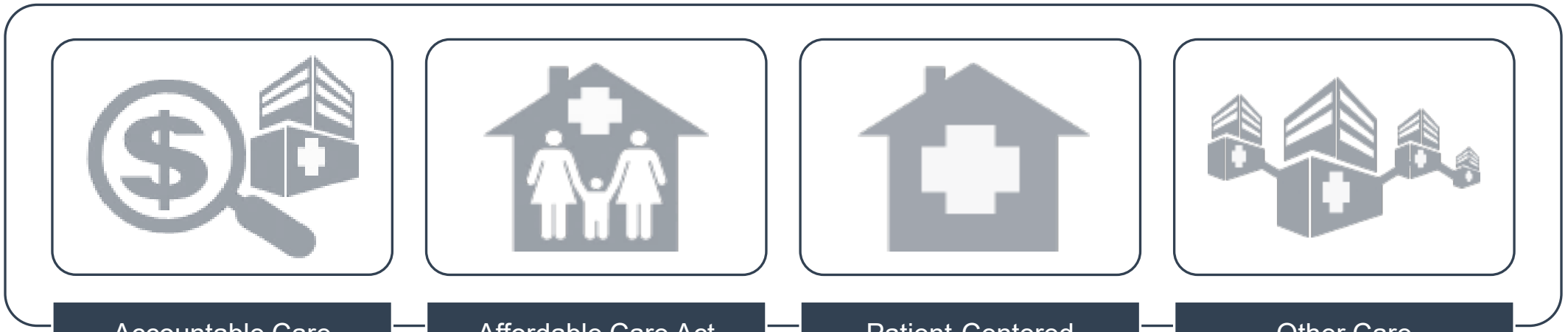
- Maine does not specifically preclude individuals with SMI from enrolling in managed care.
- As of May 2025, *OPEN MINDS* estimates that 18% of the SMI population is in managed care.
- Individuals with SMI may qualify for additional non-Medicaid services under the Augusta Mental Health Institute (AMHI) Consent Decree.

D.3. Medicaid Managed Care Program: Pharmacy Benefit

All PCPlus pharmacy benefits, including mental health and addiction treatment drugs, are covered FFS.

Maine Managed Care Program Pharmacy Benefit & Utilization Restrictions	
State Uses Pharmacy Benefit Manager	No
Responsible For Financing General Pharmacy Benefit	Medicaid FFS
Responsible For Financing Mental Health Pharmacy Benefit	Medicaid FFS
State Uses A Preferred Drug List (PDL) For General Pharmacy	Yes, the preferred drug list is called MaineCare PDL.
State Uses A PDL For Mental Health Drugs	Yes, anxiolytics, antidepressants, and antipsychotics are included in the general PDL.
State Uses A PDL For Addiction Treatment Drugs	Yes, smoking cessation, alcohol deterrent, and narcotic antagonist drugs are included in the general PDL.
Coverage Of Antipsychotic Injectable Medications	Yes, antipsychotic injectable medications are covered as a pharmacy benefit if preferred drugs were tried and failed due to lack of efficacy or intolerable side effects before injectable medications will be approved.
Utilization Restrictions For Mental Health Or Addiction Treatment Drugs	• The preferred drug must be tried and failed due to lack of efficacy or intolerable side effects, or there must be a condition that prevents the usage of a non-preferred drug before non-preferred drugs will be approved. • Restrictions vary by drug and may include quantity limits, dosing limits, age limits, and prior authorization.
State Has A Pharmacy Lock-In Program Or Other Restriction Program	An individual may be locked in or restricted to one prescriber and one pharmacy if suspected of medication abuse. Additionally, some individuals may be enrolled in the lock-in program if awaiting prior authorization for certain medications.

D.4. Medicaid Program: Care Coordination Initiatives



Accountable Care Organization (ACO) Program	Affordable Care Act Health Home	Patient-Centered Medical Home (PCMH)	Other Care Coordination Initiatives
The Medicaid ACO initiative is called Accountable Communities.	The state has three health home programs: One for individuals with SMI, one for individuals with opioid use disorder, and one for pregnant and postpartum people with opioid use disorder and their infants.	All health home provider organizations must be certified as PCMHs.	None

D.4. State Medicaid Health Home Characteristics: Behavioral Health Homes

ME Behavioral Health Homes	
Target Population	• Adults with SMI • Children with serious emotional disturbance (SED)
Enrollment Model	• Passive enrollment with opt-out; based on claims data demonstrating eligibility and a relationship with a provider organization who has been approved as a health home. • Individuals may not simultaneously receive both targeted case management (children) or community integration services (adults) and behavioral health home services; individuals must choose between the two.
Geographic Service Area	Statewide
Care Delivery Model	• State will designate certain licensed mental health practices as Behavioral Health Home Organizations (BHHOs) • Enrollees must identify a partnering enhanced primary care practice (EPCP) as their primary care provider organization • EPCPs must achieve NCQA PCMH recognition • Provision of the six core health homes functions and additional state-specific functions • Team-based model through an integrated care plan
Payment Model	• PMPM rate of $ 572.491 for adults; and $641.06 for children. • To receive payment, the BHHO must develop or update the plan of care every 90 days, submit required reports, and deliver at least one hour of health home services per month. • BHHOs have 1% of PMPM payments withheld to ensure they achieve the minimum quality on pay-for-performance measures.
Practice Performance & Improvement	• Hospital, ER, and SNF admission rate • 30-day all-cause hospital readmissions • Follow-up after hospitalization for mental illness • Performance ratings are viewed every six months.

D.4. State Medicaid Health Home Characteristics: MaineMOM

	MaineMOM
Target Population	• Pregnant and postpartum people with opioid use disorder and their infants.
Enrollment Model	• The provider shall identify members for services based on the service eligibility criteria. • The member can choose to receive services once confirmed eligible. • The Department, or its Authorized Entity, must approve members through a certification process with the certification effective the earliest date without risk of duplicative services. • The member can choose not to participate in MaineMOM services at any time by notifying the MaineMOM provider, the Department, or its Authorized Entity, for certifications of services.
Geographic Service Area	Statewide
Care Delivery Model	• There are three types of MaineMOM provider service models of care, offering different types and intensities of services: The Integrated Model Service is for members who are receiving their prenatal and postpartum medical services at the same service location as OUD services, the Partnership Model Service is for members who are receiving OUD services onsite from the provider and prenatal and postpartum medical services from a different provider and service location, and the Perinatal Navigation Model Service is for members who receive only prenatal and postpartum medical services from the provider and/or are receiving their OUD treatment from a different non-provider and service location.
Payment Model	• There are three PMPM rates: 1) Integrated service model bundled rate is $1,344.69; 2) Partnership service model bundled rate $1,227,18; 3) Perinatal Navigation service model rate is $694.39
Practice Performance & Improvement	• Access to postpartum care • Hepatitis C Virus Screening for Pregnant Members

D.4. State Medicaid Health Home Characteristics: Opioid Health Homes

Opioid Health Homes (OHH)	
Target Population	• Medicaid members and uninsured individuals diagnosed with opioid use disorder and a secondary chronic condition. • The goal is to provide services for approximately 400 individuals.
Enrollment Model	• OHH provider organizations identify and submit certification application for potentially eligible individuals • Individuals opt-in to the program
Geographic Service Area	Statewide
Care Delivery Model	• Team-based model of care through employed or contracted personnel • Minimum services include Monthly office visit with MAT prescriber; at least one monthly counseling session related to opioid dependency; one health home covered service per month; provision of MAT prescription (to be filled onsite or at an outside pharmacy) • Individual treatment plan and coordination of behavioral and physical health care
Payment Model	• The minimum performance threshold is a composite score of 27%. When an OHH provider meets this minimum, they will receive the balance of their full reimbursement. • The excellence performance threshold is a composite score of 34%. When an OHH provider meets this threshold, they are eligible to receive a bonus payment when funding allows. • Treatment for Medicaid members is financed through the Medicaid system and treatment for uninsured individuals is funded by a state grant.
Practice Performance & Improvement	• Reporting on OHH core standards: Leadership, team-based approach, population stratification and risk-management, enhanced access, care management, behavioral and physical health integration, inclusion of consumers and families, connection to community and social support services, reduction of wasteful spending, and integration of health information technology • OHH quality measures including claims, clinical data, DHHS Enterprise Information System, certification submissions, and surveys

D.4. State Medicaid Program Care Coordination Initiatives: Accountable Communities

- Accountable Communities are Maine's version of ACOs for the Medicaid population.
- The state contracts with lead entities, who in turn contract with other provider organizations. Lead entities can be provider organizations or organizations that contract with provider organizations.
  - Each Accountable Community must directly provide primary care services, meet PCPlus requirements, and include at least one chronic condition, one developmental disability, and one behavioral health provider organization.
- Savings and losses are calculated by retrospectively comparing actual total cost of care to the benchmark total cost of care. The benchmark cost of care includes physical and behavioral health services. Accountable Communities have the option to include institutional care and home- and community-based waiver services in their benchmark costs. There are two models that Accountable Communities may utilize:
  - Model I: Minimum of 1,000 members; savings must meet or exceed 2.5% based on performance of defined quality benchmarks for the performance year
  - Model II: Minimum of 2,000 members; savings must meet or exceed 2.0% based on performance of defined quality benchmarks for the performance year
- Members may be attributed to an Accountable Community based on six months of continuous eligibility or nine months of non-continuous eligibility, health home participation, number of primary care visits, or emergency department visits at an affiliated hospital.
- The Department plans to establish a one-year transitional period for the AC program, during which the Department will not assess performance for the purposes of issuing any shared savings payments. This transition year covers the performance period from July 1, 2024 – June 30, 2025. The Department will continue to engage with AC lead entities on contractual agreements. This year enables the Department and the AC led entities to take additional time for contracting, data analyses, vendor procurement, and analyses before advancing into a reformed program in SFY 26.

D.4. State Medicaid Program Care Coordination Initiatives: Accountable Communities Quality Measures

Measure	Core/Elective Monitoring	Measure Definition	Comparison Group
Use of spirometry testing, COPD	Core	Percentage of members over 40 with a new diagnosis of COPD who received appropriate spirometry testing to confirm	Maine Non-AC
Controlling high blood pressure	Core	Percentage of members between 18 and 85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled	Evidence-based benchmark
Diabetic Glucose A: Glucose poor control B: HbA1c testing	Core	A: Percentage of members between ages 18 and 75 with diabetes whose most recent HbA1c level was greater than 9% or was missing a result B: Percentage of members between ages 18 and 75 with diabetes who received an HbA1c test	A: Evidence based benchmark B: Maine Non-AC
Screening for depression	Core	Percentage of members over the age of 12 screened for clinical depression on the date of encounter	Evidence Based Benchmark

D.4. State Medicaid Program Care Coordination Initiatives: Accountable Communities Quality Measures (cont.)

Measure	Core/Elective Monitoring	Measure Definition	Comparison Group
Tobacco Use: Screening and Cessation intervention	Core	Percentage of members ages 18 and over who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention	Evidence-based benchmark
Evaluation or interview for risk of opioid misuse.	Core	Percentage of members ages 18 and over who were prescribed opiates for longer than 28 days evaluated for risk of opioid misuse	Evidence-based benchmark
Follow-up after hospitalization for mental illness	Elective	Percentage of discharges for individuals over the age of six who were hospitalized for treatment of mental health disorders and had an outpatient visit, intensive outpatient encounter, or partial hospitalization within 7 days of discharge	Maine Non-AC practices.
Body Mass Index Screening and Follow-Up plan.	Core	Percentage of members over age 18 with a documented BMI during the encounter or during the previous year and with a BMI outside of normal parameters, and a follow-up plan is documented within the last year	Evidence Based Benchmark

D.4. State Medicaid Program Care Coordination Initiatives: Accountable Communities Quality Measures (cont.)

Measure	Core/Elective Monitoring	Measure Definition	Comparison Group
Developmental screening- First three years of life.	Core	Percentage of children under the age of three who had a developmental screening	Maine Non-AC practices.
Follow-up care for children prescribed ADHD medication	Core	Percentage of children who were newly prescribed ADHD medications who had at least three follow up care visits within a 10-month period, one of which was within 30 days after first prescribed medication.	Maine Non-AC practices.
Childhood immunization status	Core	Percentage of children over the age of three who had four DTaP, three IPD, one MMR, three HiB, three HepB, one VZV, four PCV, one HepA, two or three RV, and two flu vaccines	Maine Non-AC practices.
Adolescent immunization status	Core	Percentage of members over age 16 who had one dose of meningococcal vaccine, one Tdap vaccine, and the complete HPV series	Maine Non-AC practices.
Pediatric Well-Care Visits	Core	A: Percentage of 0–15-month-olds with six or more well care visits B: Percentage of 3–6-year-olds with at least one well care visit per year C: Percentage of 7–11-year-olds with at least one well care visit per year D: Percent of 12–21-year-olds with at least one comprehensive well-care visit with a PCP or OB/GYN per year	Maine Non-AC practices.

D.4. State Medicaid Program Care Coordination Initiatives: Accountable Communities Quality Measures (cont.)

Measure	Core/Elective Monitoring	Measure Definition	Comparison Group
Primary Care Prevention Intervention as Offered by Primary Care Providers	Elective	Percentage of 1-20-year-olds who received a fluoride varnish application during the measurement period	Maine Non-AC practices.
Ambulatory care-sensitive condition admissions	Core	Prevention quality indicator composite of chronic conditions per population	Maine Non-AC practices.
Non-emergent ED use.	Core	Member's non-emergent ED visited per 1,000 member months	Maine Non-AC practices.
Plan All-cause readmissions	Core	For members over the age of 18, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days	Maine Non-AC practices.
Patient Experience Survey	Core	Consumer assessment of healthcare providers and systems or other validated patient experience measure negotiated between the department and the AC lead entity	Evidence-based benchmark
Concurrent use of opioids and benzodiazepines	Monitoring	Percentage of members over the age of 17 with concurrent use of prescription opioids and benzodiazepines	N/A

D.5. Medicaid Program: Demonstration & Care Management Waivers

Waiver Title	Waiver Description	Waiver Type	Enrollment Cap	Effective Date	Expiration Date
Maine Section 1115 Demonstration for Individuals with HIV/AIDS	Authorizes the state to provide full benefits—including anti-retroviral therapies—to individuals at or below 133% of the FPL, and limited benefits to enrollees with income up to 250% of the FPL.	1115	None; however, the state may implement a cap if needed.	07/01/2002	12/31/2028
Maine Substance Use Disorder Care Initiative	Authorizes the state to waive the “institutions of mental disease” exclusion to allow MaineCare to reimburse for evidence-based SUD treatment. Also allows the state to implement four pilot programs focused on MaineCare enrolled parents with SUD who are involved or at risk of involvement with child protective services.	1115	None	01/02/2021	12/31/2025
Maine Non-Emergency Transportation Waiver (ME-01)	Authorizes the state to contract with a single vendor to provide non-emergency transportation services.	1915 (b)	None	06/05/2012	03/31/2027

D.5. Medicaid Program: Section 1915 (c) HCBS Waivers

Waiver Title	Target Population	2025 Enrollment Cap	Operating Unit	Concurrent Management Authority
ME Home and Community Services for Adults w/ID or Autism Spectrum Disorder (0159.R07.00)	Individuals with autism and developmental disabilities over the age of 18	3,473	Office of Aging and Disability Services	Yes, with the state's 1915 (b) waiver
ME Support Services for Adults with Intellectual Disabilities or Autism Spectrum Disorder (0467.R03.00)	Individuals with autism and developmental disabilities over the age of 18	3,050	Office of Aging and Disability Services	Yes, with the state's 1915 (b) waiver
ME Elderly and Adults with Disabilities (0276.R06.00)	Individuals who are over the age of 65 or aged 21 to 64 who are physically disabled	3,930	Office of Aging and Disability Services	Yes, with the state's 1915 (b) waiver
ME HCBS for Member with Brain Injury (1082.R02.00)	Individuals with brain injury over the age of 18	250	Office of Aging and Disability Services	Yes, with the state's 1915 (b) waiver
ME HCBS for Adults w/Other Related Conditions (0995.R02.00)	Individuals who are over the age of 65 or aged 21 to 64 who are physically disabled	67	Office of Aging and Disability Services	Yes, with the state's 1915 (b) waiver

D.6. Medicaid Program: New Initiatives

- There are no new or pending initiatives currently.

E. Medicare Financing & Service Delivery System

E.1. Medicare Financing & Service Delivery System

Medicare System Characteristics		
Characteristics	**Traditional Medicare (FFS)**	**Medicare Advantage**
Enrollment (May 2024)	160,681	216,294
SMI Enrollment	• *OPEN MINDS* estimates 57% of the population in Medicare Advantage, 43% in Traditional Medicare.	
Management	• Part A: Inpatient hospital, skilled nursing facility care, nursing home care, hospice and home health care • Part B: Clinical research, ambulance services, durable medical equipment, mental health and limited outpatient prescription drugs	• Medicare Advantage Plans provide Part A and Part B benefits, plus additional benefits based on plan chosen
Payment Model	• Part A & B cover up to 80%, remaining costs can be paid out of pocket	• Fixed amounts paid based on health plan chosen
Geographic Service Area	Statewide	Statewide

Total Medicare: 376,975 | Total Medicare With SMI: 49,006

E.1. Medicare Financing & Service Delivery System

Medicare Financial Delivery System Enrollment	
Total Medicare population distribution	As of May 2024: 57% Medicare Advantage,43% in traditional Medicare.
SMI population inclusion in managed care	Estimated 57% of population in Medicare Advantage, 43% in traditional Medicare.
Medicare population inclusion in Chronic special needs plan or (C-SNP).	Estimated that less than 1% of population is enrolled in C-SNP plans.
Medicare population inclusion in Institutional Special Needs Plan (I-SNP).	There are no I-SNP plans in Maine.

E.2. Medicare System: Overview

- Medicare enrollment as of May 2024 was 376,975.
- It is estimated around 18% of the state's total population is enrolled in Medicare, compared with about 19.5% of the U.S. population enrolled in Medicare.
  - *OPEN MINDS* estimates approximately 27% of the state's SMI population is enrolled in a Medicare plan.
- There are 55 Medicare Advantage plans available for purchase in 2025, with an average monthly premium of $12.84.
- There are 17 insurers in Maine that offer Medigap plans, as well as several association groups that offer Medigap coverage in the state.
- As of August 2024, there were 309,616 Medicare beneficiaries in Maine enrolled in Part D coverage.
  - More than 205,000 beneficiaries had Part D coverage integrated with Medicare Advantage plans. There were also more than 103,000 who had stand-alone Part D plans.
- For 2025 coverage, there are 16 stand-alone Medicare Part D plans available in Maine, with premiums starting at $0 per month.
- Many Medicare beneficiaries receive financial assistance through Medicaid with the cost of Medicare premiums, prescription drug expenses, and services not covered by Medicare – such as long-term care.

E.3. Medicare ACOs

Medicare Shared Savings ACOs
1. NH-Cares ACO LLC
2. Beacon Rural Health, LLC
3. Community Care Partnership of Maine, LLC
4. MaineHealth Accountable Care Organization

E.4. Medicare System: New Initiatives

- There are no new or pending initiatives currently.

F. Dual Eligible Financing & Service Delivery System

F.1. Dual Eligible Medicaid Financing & Service Delivery System

Dual Eligible* Medicaid System Characteristics	
Characteristics	**Medicaid Fee-For-Service (FFS)**
Enrollment (March 2024)	56,540
Estimated SMI Enrollment	11,873
Management	Office of MaineCare Services
Payment Model	FFS
Geographic Service Area	Statewide

Total Dual Eligible Enrollment: 56,540 | Total Dual Eligible Enrollment With SMI: 11,873

*Unless otherwise noted, the term *dual eligibles* in this section refers to Medicare enrollees with full Medicaid benefits.

F.2. Largest Dual Eligible Health Plans By Estimated SMI Enrollment

Health Plans	Parent Company	Plan Type	March 2023 Enrollment	Estimated SMI Enrollment
UnitedHealthcare Dual Complete	UnitedHealthcare	Medicare Advantage D-SNP	10,032	2,107
Anthem MaineHealth Advantage Dual Plus	Anthem, Inc.	Medicare Advantage D-SNP	8,681	1,823
Humana Gold Plus	Humana, Inc.	Medicare Advantage D-SNP	4,528	951
WellCare Access	Centene	Medicare Advantage D-SNP	3,386	711
WellCare Liberty	Centene	Medicare Advantage D-SNP	2,185	459
Aetna Medicare Assure Plan	Aetna/ CVS	Medicare Advantage D-SNP	2,103	442
HumanaChoice	Humana, Inc.	Medicare Advantage D-SNP	1,103	232
WellCare Dual Liberty Open	Centene	Medicare Advantage D-SNP	760	160

F.3. Dual Eligible Medicaid Financing & Delivery System: Overview

- Dual eligible enrollment as of March 2024 was 56,540.
- Medicare covers most acute services (which may include psychiatric care), while Medicaid, the payer of last resort, covers LTSS and non-physician behavioral health services.
- Dual eligibles are required to enroll in the FFS system to receive Medicaid services.
- D-SNP enrollment as of March 2023 was 32,778, SMI enrollment for D-SNPs was 6,883.

F.4. Dual Eligible Medicaid Financing & Delivery System: New Initiatives

- Maine has no new initiatives related to Dual Eligibles at this time.

G. Long-Term Services & Supports Financing & Service Delivery System

G.1. LTSS Financing & Service Delivery System

- Maine does not operate a MLTSS program

LTSS Medicaid System Characteristics	
Characteristics	**Medicaid Managed Care**
Enrollment (December 2024)	N/A
Estimated SMI Enrollment	N/A
Management	N/A
Payment Model	N/A
Geographic Service Area	N/A

Total LTSS Enrollment: N/A | Total LTSS Enrollment With SMI: N/A

G.1. Medicaid LTSS Service Delivery System Enrollment By Eligibility Group

Population	Mandatory FFS Enrollment	Option To Enroll In FFS Or PCPlus	Mandatory PCPlus Enrollment
Disabled adults			✓
Disabled children			✓
Blind individuals			✓
Aged individuals			✓
Dual eligibles	✓		
Individuals with I/DD	✓		
Individuals residing in nursing homes	✓		
Individuals residing in ICF/IDD	✓		
Other HCBS Recipients	✓		
Other populations	• Individuals with other health insurance • Individuals expected to be enrolled for less than three months • Alaskan Natives or Native Americans • Members receiving home and community benefits	• Established relationship with non-PCPlus provider organization for chronic disease, disability, or terminal illness • Language or cultural need • Greater than 30-minute travel time to PCPlus provider organization • Status as a migrant farm worker or dependent • Homelessness • Hospice care at time of enrollment	• Pregnant individuals • Women with breast or cervical cancer

G.2. LTSS Medicaid Financing & Delivery System: Overview

- Maine does not offer MLTSS services and instead all individuals receive care through the FFS system.

G.3. Medicaid LTSS Program: Health Benefits

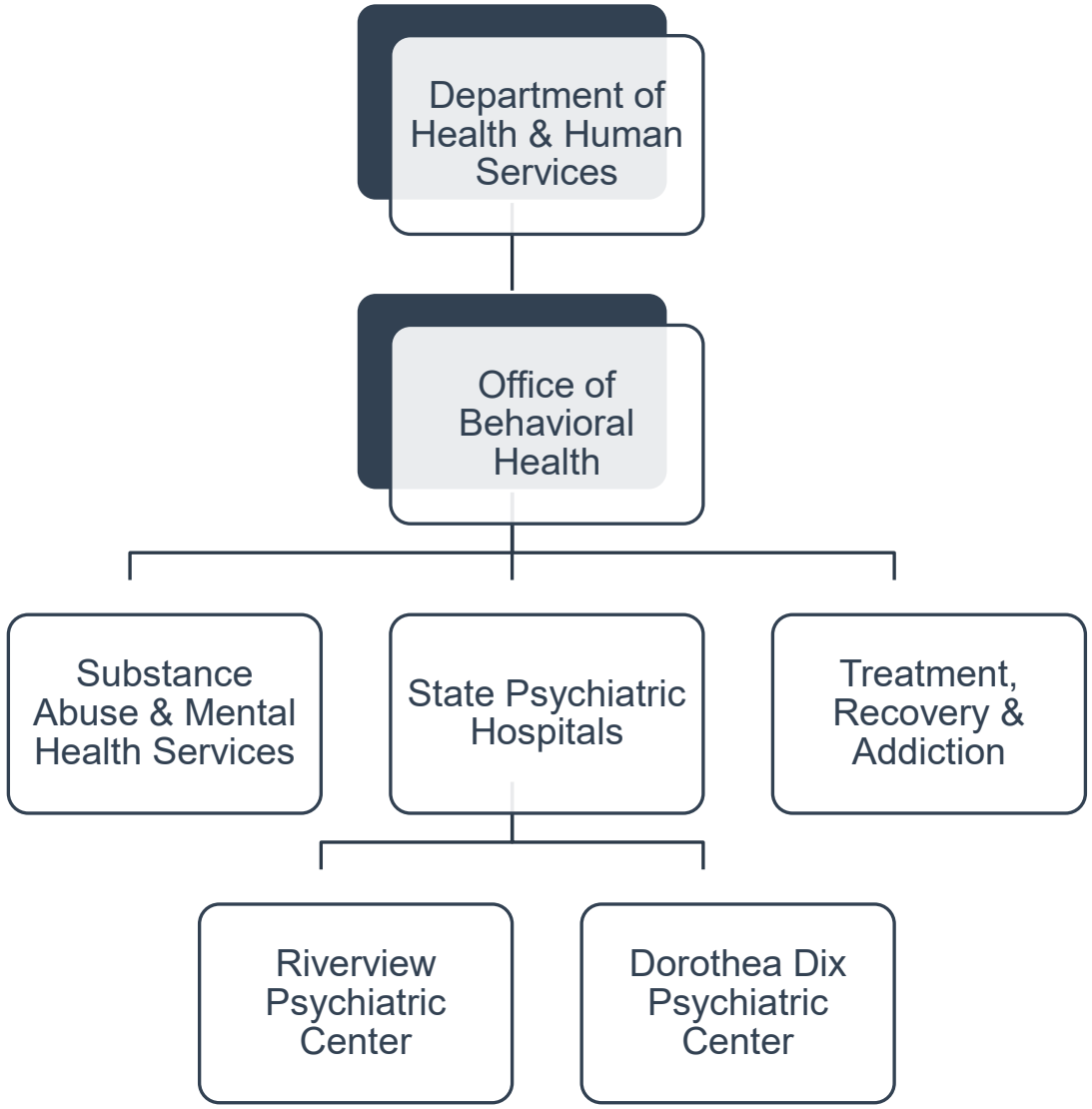
- Maine does not offer MLTSS services and instead all services are the same as the FFS program.

G.4. LTSS Medicaid Financing & Delivery System: New Initiatives

- Maine has no pending initiatives that will influence the finance or delivery systems of the LTSS population.

H. State Behavioral Health Administration & Finance System

H.1. Office of Behavioral Health: Organization Chart



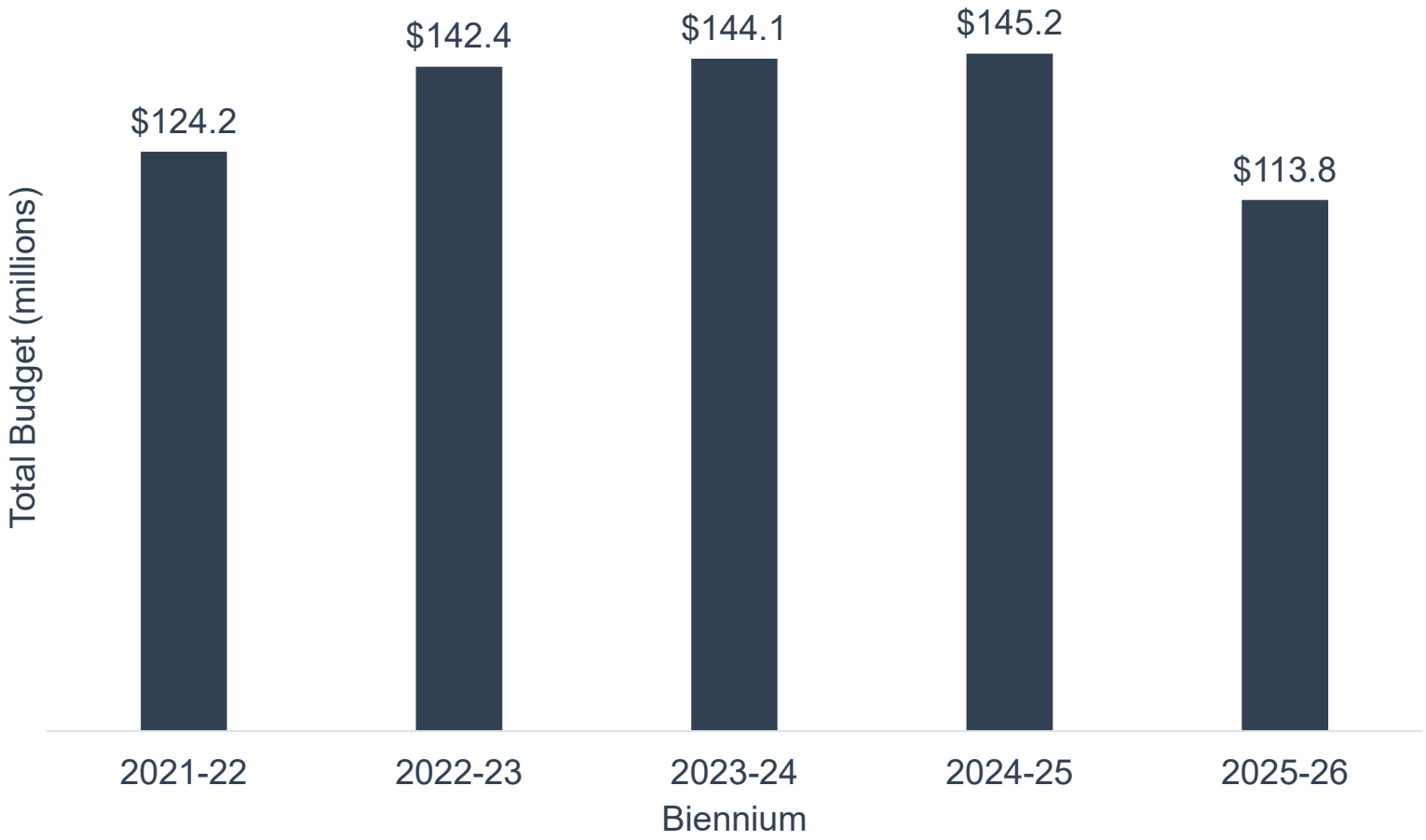
H.1. Office Of Behavioral Health: Key Leadership

Name	Position	Department	Email
Sara Gagne-Holmes	Acting Commissioner	Department of Health and Human Services	sara.gagne-holmes@maine.gov
Sarah Squirrell	Director	Office of Behavioral Health	sarah.squirrell@maine.gov
Katherine Coutu	SUD Team Manager/ State Opioid Treatment Authority	OBH	katherine.coutu@maine.gov
Debra Poulin	Clinical Services Director	OBH	Not available
Brianne Masselli	Mental Health Tretment Manager	OBH	brianne.masselli@maine.gov
Stephanie George-Roy	Superintendent, Riverview Psychiatric Center	DHHS	stephanie.george-roy@maine.gov
Carolyn Dimek	Superintendent, Dorothea Dix Psychiatric Center	DHHS	carolyn.dimek@maine.gov

H.2. Office Of Behavioral Health: Budget

Budget Item	SFY 2025-26 Budget Request	Percent Of Budget
Mental Health Services - community	$36,472,467	32%
Office of Behavioral Health	$27,289,686	24%
Riverview Psychiatric Center	$27,170,585	24%
Dorothea Dix Psychiatric Center	$22,915,619	20%
Budget Total: $ 113,848,357		

H.2. Office Of Behavioral Health: Budget Over Time



H.3. State Psychiatric Institutions

State Psychiatric Institutions		
Institution	**Location**	**Beds**
Dorothea Dix Psychiatric Center	Bangor	51
Riverview Psychiatric Center	Augusta	92
Total		**143**

H.4. Behavioral Health Safety-Net Delivery System

- The Office of Substance Abuse and Mental Health Services (SAMHS) within DHHS provides mental health and addiction treatment services to the uninsured population through a network of provider organizations.
- Uninsured individuals receive referral to treatment services by contacting the DHHS office in their area.
- SAMHS treatment services include:
  - Crisis intervention services
  - Residential treatment services
  - Shelter services
  - Case management
  - Behavioral health homes
  - Supported employment services
  - Medication management and medication assisted treatment (MAT) services
  - Ambulatory detoxification services
  - Outpatient and intensive outpatient services
  - State forensic evaluations
  - Recovery support services
  - Peer supports

H.4. Behavioral Health Safety-Net Delivery System

- In the summer of 1989, poor conditions at the Augusta Mental Health Institute (AMHI) contributed to the deaths of ten individuals. AMHI closed in 2004 and was replaced by Riverview Psychiatric Center. A subsequent class action lawsuit resulted in the AMHI Consent Decree Settlement Agreement Plan of 2007.
- The plan requires the state to provide the following services to individuals with SMI in order to prevent psychiatric hospitalization, or to facilitate transition to community living:
  - Individualized support plan (ISP)
  - Community integration and community support services
  - Housing and residential support services
  - Crisis intervention services
  - Treatment services
  - Family support services
  - Vocational employment services
  - Transportation
  - Access to recreational, social, avocational, and spiritual opportunities
  - Access to medication assisted treatment
- Individuals gain access to consent decree services by applying through the Department of Health and Human Services or one of its contracted agencies. The state is required to assign a caseworker to everyone within seven days of application.

H.5. Behavioral Health System: New Initiatives

- There are no new or pending initiatives currently.

I. Appendices

I.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Commercial	4.9% of the commercially insured population over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicaid	8.8% of persons enrolled in traditional Medicaid	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a
Medicare	13% of persons in the Medicare population, not dually eligible for Medicaid	Figueroa, J. F., Phelan, J., Orav, E. J., Patel, V., & Jha, A. K. (2020). Association of mental health disorders with health care spending in the Medicare population. Retrieved July 2023 from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2762948#:~:text=Results%20Of%204%20358%20975,had%20no%20known%20mental%20illness

I.1. *OPEN MINDS* Estimates For Share Of SMI Consumers Per Payer/Plan

Enrollment Category	Serious Mental Illness (SMI) Prevalence Estimate	Source
Medicare-Medicaid Dual Eligibility	21% of persons in the Medicare population dually eligible for full Medicaid benefits	ATI Advisory. (2022). A Profile of Medicare-Medicaid Dual Beneficiaries. Retrieved March 2023 from https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf
Other Public	4.5% of persons served by the Veterans Administration health care system or the TRICARE military health system	U.S. Census Bureau (2022). Table HHI-01. Health Insurance Coverage Status and Type of Coverage--All Persons by Sex, Race and Hispanic Origin: 2017 to 2021. Retrieved March 2023 from https://www2.census.gov/programssurveys/demo/tables/health-insurance/time-series/hic/hhi01.xlsx
No Health Care Insurance	6.7% of uninsured persons over age 18	Substance Abuse and Mental Health Services Administration. (2022). Results from the 2021 National Survey on Drug Use and Health: Mental Health detailed Tables. Retrieved March 2023 from https://www.samhsa.gov/data/sites/default/files/reports/rpt39441/NSDUHDetailedTabs2021/NSDUHDetailedTabs2021/NSDUHDetTabsSect6pe2021.htm#tab6.8a

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Alternative Benefit Plan	ABP	State designed benefit package for the Medicaid expansion population (childless adults with income below 138% of the FPL). The benefit package must include the ten essential benefits as laid out in the PPACA. The Medicaid expansion population deemed medically frail (including those with SMI) are exempt from receiving benefits through the ABP.
Accountable Care Organizations	ACO	ACOs are groups of provider organizations—such as physicians and hospital systems—that form an agreement to coordinate care for a set group of individuals. If the ACO delivers high quality care—measured through performance metrics—and lowers the cost of providing care against a baseline, then the organization receives a portion of the savings generated. ACOs can exist alongside all payment structures (fee-for-service and managed care delivery systems) and payers (Medicare, Medicaid, commercial).
Administrative Services Organization	ASO	An arrangement in which an organization hires a third party to deliver administrative services to the organization, such as claims processing and billing. The ASO is not at-risk.
Capitation		A set amount of money paid per enrollee per month to a health care entity to cover the cost of health care services. Capitation can cover the cost of all health care services or subset of services, such as care coordination or home- and community-based services.
Carve-out		A carve-out is a Medicaid managed care financing model where some portion of Medicaid benefits—dental services, pharmacy services, behavioral health services, etc.—are separately managed and/or financed. Carve-out services can be financed on an at-risk basis by another organization or retained by the state Medicaid agency on a fee-for-service basis.
Certified Community Behavioral Health Clinic	CCBHC	Behavioral health clinics specially certified in a demonstration established by section 223 of the Protecting Access to Medicare Act of 2014. The clinics are designed to provide community-based mental health and addiction treatment services, to advance the integration of behavioral health with physical health care, and to provide care coordination across the full spectrum of health services.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Community Mental Health Center	CMHC	An organization that can demonstrate that it is actively providing all services in section 1913(c)(I) of the Public Health Services Act, including a.) Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of the CMHC's mental health service area who have been discharged from inpatient treatment at a mental health facility; b.) 24 hour-a-day emergency care services; c.) Day treatment, or other partial hospitalization services, or psychosocial rehabilitation services; and d.) Screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission. Additionally, the organization must meet the specifications for the state where it provides services.
Dual Eligible		An individual who is eligible for Medicare (Part A and B) and Medicaid. Medicare serves as the individual's primary insurance, and Medicaid acts as a supplement. Dual eligibles are sometimes referred to as Medicare-Medicaid enrollees (MMEs).
Federal Poverty Level	FPL	The U.S. Department of Health and Human Services sets a standard level of income that is used to determine eligibility for services and benefits, including Medicaid. In 2025, the FPL is $15,060 for an individual and $31,200 for a family of four.
Fee-For-Service	FFS	A system where the payer, in this case Medicaid, contracts directly with provider organizations and pays for providing care on a unit by unit basis. Health plans may also reimburse provider organizations on a FFS basis meaning they pay for each unit of care or test.
Health Home		A "whole person" care coordination model that specifically targets populations with chronic conditions including those with SMI. Health homes provide six essential functions: 1.) Comprehensive care management; 2.) Care coordination and health promotion; 3.) Comprehensive transitional care from inpatient to other settings, including appropriate follow-up; 4.) Individual and family support; 5.) Referral to community and social support services; 6.) Use of health information technology to link services. Health homes were originally developed as a Medicaid program, but have been adopted by other payers. For a state to have an official health home program they must have an approved state plan amendment.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Health Insurance Marketplace	HIM	Created by the PPACA, the health insurance marketplace is an online platform where individuals and small businesses can purchase health insurance. The federal government subsidizes coverage purchased on the marketplace through premium tax credits for individuals with income up to 400% of the FPL.
Home- & Community-Based Services	HCBS	Long-term services and supports provided in the home or community in order to avoid institutionalization. Traditionally provided through 1915(c) waivers, HCBS services are usually limited to specific populations and a specific number of people. HCBS services include skilled nursing care, personnel care services, assistance with activities of daily living, and custodial care.
Institutions For Mental Disease	IMD	A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including addiction. Federal financial participation is available for Medicaid IMD services for individuals under the age of 21 and age 65 and over. In recent years, CMS has relaxed the rules prohibiting payments in IMDs for individuals ages 21-64. Medicaid health plans may provide up to 15 days of IMD services per month in lieu of state plan services if medically appropriate, cost effective, and consented to by the individual. Additionally, states may be granted a 1115 waiver authority to allow individuals to receive addiction and mental health treatment in IMDs.
Long-Term Services & Supports	LTSS	Services provided in the home, community, or institutional setting to those who experience difficulty living independently and completing activities of daily living as a result of cognitive disabilities, physical impairments, disabling chronic conditions, and/or age.
Managed Care		A health care delivery and financing system designed to manage cost, utilization, and quality. In Medicaid, states generally implement managed care through contracts with health plans, which provide a limited set of benefits to enrollees through a capitated or per person per month (PMPM) rate. The health plans generally assumes full-risk for the cost of treatment, and therefore contracts with a network of provider organizations to provide care at the most efficient rate possible while still maintaining member health.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicaid		Medicaid is a joint federal-state program that provides health coverage to economically disadvantaged populations, such as low-income adults, children, and aged, blind, and disabled (ABD) individuals. States establish their own eligibility standards, benefit packages, provider payment policies, and administrative structures under broad federal guidelines. Financing is a shared responsibility of the federal government and the states.
Medicaid Waiver		Granted by CMS, waivers allow states to make temporary changes to their Medicaid program in order to test out new ways to deliver health coverage.
Medicaid Waiver Section 1115	1115 waiver	Known as research and demonstration waivers, states can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
Medicaid Waiver Section 1915(b)	1915(b) waiver	States can apply for waivers to provide services through managed care delivery systems, or otherwise limit an individual's choice of health plan or provider organization.
Medicaid Waiver Section 1915(c)	1915(c) waiver	States can apply for waivers to provide long-term care services in home- and community-based settings, rather than institutional settings.
Medical Home		A medical home is not a physical place, but a model for care coordination. Medical homes provide primary care services, care coordination, enhanced access to care, and care that is culturally and linguistically appropriate. Medical homes exist across multiple payers.
Medicare		Federal health insurance for individuals over the age of 65, individuals with certain disabilities, and individuals with end stage renal disease. Medicare covers most acute care services (which may include psychiatric care), but does not cover LTSS or non-physician behavioral health services.
Medicare Advantage	MA	Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Medicare Advantage Special Needs Plan	SNP	A special type of Medicare Advantage plan that is designed to provide targeted coordinated care to individuals who are a) institutionalized; b) dual eligible; and/or c) meet the severe chronic disabled conditions set forth by CMS. Plans emphasize improved care primarily through continuity of care and care coordination.
Medicare Part A		Hospital Insurance: Covers hospital, skilled nursing care, hospice, and home health care for most eligible individuals at no cost. Financed through payroll tax and deductibles, copayments are only charged if a stay becomes long-term.
Medicare Part B		Supplementary Medical Insurance: Covers most outpatient services, and consumers pay a premium based on income level.
Medicare Part C		Medicare Part C - also known as Medicare Advantage - is a program which allows individuals who are eligible for Medicare Parts A and B to elect a private health plan to provide their Medicare coverage. The federal government pays the plan's premiums up to a set level, and individuals are responsible for the difference.
Medicare Part D		Outpatient Prescription Drug Benefit: Private plans contract with Medicare to provide coverage for prescription drugs. Most consumers pay premiums based on their income.
Metropolitan Statistical Area	MSA	An urbanized area with a population of at least 50,000 plus adjacent territory that has a high degree of social and economic integration as measured by commuting ties.
Patient-Centered Medical Home	PCMH	See Medical Home.
Patient Protection & Affordable Care Act	PPACA or ACA	U.S. health care reform signed into law in 2010. The legislation regulates certain aspects of private and public health insurance programs and authorizes an individual mandate to secure essential health coverage, premium tax credits for the purchase of private health insurance, and increased insurance coverage of preexisting conditions. In 2012 the Supreme Court ruled that state participation is optional for provisions of the law expanding Medicaid coverage to adults ages 18 to 64 with incomes under 138% of the FPL. In 2017, Congress repealed the tax penalties associated with the individual mandate essentially ending the mandate.

I.2. Glossary Of Terms

Word	Abbreviation	Definition
Primary Care Case Management	PCCM	A health care delivery system model with limited utilization and cost control. Under the PCCM model, Medicaid enrollees choose a primary care physician who acts as a gatekeeper for more intensive services. The primary care physician generally receives a per person per month (PMPM) fee for care coordination, and is reimbursed fee-for-service for all medical services provided.
Program Of All Inclusive Care For The Elderly	PACE	PACE serves populations over the age of 55 who are eligible for skilled nursing home care by utilizing a comprehensive delivery system of social, medical, and long-term care services to keep enrollees in the community for as long as possible. PACE is an optional state Medicaid program, and may only be available in certain states, or regions within states.
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder that lasts for a sufficient duration of time and causes impairment of major life activities. Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder.
Supported Employment		Provides services and supports to help individuals with disabilities become employed in an integrated or competitive work environment, and retain that employment.
Supported Housing		Housing provided for as long as needed at little or no cost to individuals with mental illness, or other vulnerable populations who are homeless or at-risk for homelessness. Mental health and social services are offered to participants, but are not a condition for participation in the program. The goal is to allow individuals to live as self-sufficient, independent lives as possible.
Value-Based Reimbursement	VBR	Reimbursement model in which payers financially reward or penalize health care provider organizations for performance on quality and cost of care. VBR payment mechanisms include P4P; capitation; shared savings models; shared risk models; and payments based on clinically-defined episodes, called episodes of care or bundled payments.

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