# MAINE

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Types of Facilities

*Mental Health (MH)*: Maine regulates two types of adult residential MH services, crisis residential services and private non-medical institutions providing residential services.

- *Crisis residential service*: a residential service designed to provide temporary shelter and respite for individuals experiencing crisis."

- *Private non-medical institution (PNMI)*: a MaineCare provider that is required to meet special requirements to provide either Community Supports or Residential Services. This may include supported housing, residential programs, or intensive in-home services. A PNMI means a provider licensed by the Department of Health and Human Services to provide PNMI services to medically eligible individuals, in single or multiple facilities receiving MaineCare or under a written agreement with the State of Maine. A PNMI shall not be a health insurance organization, hospital, nursing home or community health care center. They may include facilities treating those with dual diagnosis. NOTE: Although these apply to those serving MaineCare residents, others may be served in the facilities and, therefore, the reach is broader than Maine Medicaid.

*Substance Use Disorder (SUD)*: Regulated adult SUD residential treatment programs include four facility types (categories I-III and freestanding residential detoxification programs). Residential treatment programs are generally defined as corresponding to ASAM level III and as providing “services in a full (24 hours) residential setting. The program shall provide a scheduled treatment regimen which consists of diagnostic, educational, and counseling services; and shall refer clients to support services as needed. Clients are routinely discharged to various levels of follow-up services.”

- *Category I*: provides a basic focus on early recovery skills, including the negative impact of chemical dependency, tools for developing support, and relapse prevention skills. Examples include extended shelters and residential rehabilitation programs. The term of residency may not exceed 45 days without documented assessment of client’s need for the extension and a treatment plan indicating goals congruent with the definition and purpose of this component.

- *Category II*: provides a structured residential milieu, to help clients transition from a substance abusing lifestyle to a solid recovery environment. Clients may initially receive a treatment focus similar to that of Category I programs but will transition to a treatment focus that addresses the cultural, social, educational, and vocational needs of the client. Examples include halfway houses. Length of treatment is up to 180 days.

- *Category III*: provides a long-term supportive and structured environment for chemically dependent clients with extensive substance abuse debilitation. These programs provide a supervised living experience within the program. Qualified staff members teach attitudes, skills and habits conducive to facilitating the client's transition back to the community. The treatment mode may vary with the client's needs and may be in the form of individual, group or family counseling. Outcome goals may range from custodial care to further treatment services and recovery. Examples include extended care programs. Length of treatment is over 180 days.

- *Freestanding Residential Detoxification Programs*: equivalent to ASAM Level III 7-D/medically monitored inpatient detoxification and provides care to persons whose withdrawal signs and symptoms indicate the need for 24-hour residential care. Services include a biopsychosocial evaluation, medical observation, monitoring, and treatment, counseling, and follow-up referral. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Services must be conducted in a freestanding or other appropriately licensed/certified healthcare or addiction treatment facility.

- Additional requirements apply to a private non-medical institution (PNMI), which is a MaineCare provider.

*Unregulated Facilities*: Researchers did not locate reference to regulated MH facilities or to regulated SUD facilities other than those described under 1a.

## Approach

*Mental Health (MH)*: The general licensing rules govern all mental health agencies, facilities, or programs including but not limited to those funded by the Maine Department of Health and Human Services (DHHS) for the provision of mental health services.

*Substance Use Disorder (SUD)*: Licensure by DHHS is required for the four types of adult substance use residential facilities described in 1.a, other than residential programs operated by hospitals that are accredited by the Joint Commission.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- A certificate of need is required for alcohol abuse, drug abuse, and mental health services.

*Mental Health (MH)*:

- Licensure by DHHS is required for both types of adult mental health residential facilities described in 1.a. The same general licensing requirements apply to all types of adult mental health agencies, and include that the applicant be in substantial compliance with core standards, be incorporated, deliver mental health services in Maine, be able to secure sufficient funds for the first year of operation, and have a site from which it administers and/or delivers mental health services that is approved for occupancy. A survey is required for licensure and renewal. Neither statute nor regulation indicates duration of other licenses.

- Accreditation is not required. Waivers of requirements and deemed status may be obtained but the regulations do not indicate how.

*Substance Use Disorder (SUD)*:

- Licensure by DHHS is required for the four types of adult substance use residential facilities described in 1.a, other than residential programs operated by hospitals that are accredited by the Joint Commission.

- While accreditation is not required, facilities that have accreditation as specified in the prior sentence are deemed to have met all the licensure requirements of the regulations, although DHHS reserves to right to conduct surveys. Substance use treatment facilities require licensure, including an application, a fee, and an inspection, as well as a renewal application. Duration of licensure is two years.

## Cause-Based Monitoring

*Mental Health (MH)*: In addition to shortened licensure for new or noncompliant facilities, agencies must report any legal proceedings to the Department. The governing body of the agency is required to undertake periodic reviews of financial status and must have annual audits by a CPA or seek approval of another auditing approach.

*Substance Use Disorder (SUD)*: DHHS may inspect the facility at any time and access any information required under the rules. Upon finding noncompliance with the rules, the state may initiate legal action against non-licensed facilities, or act against a licensed facility's license,

including refusal to renew, issuance of a conditional license, voiding a conditional license, modifying a license, or suspending or revoking a license. Financial audits also are required annually.

## Access Requirements

*Mental Health (MH)*: For all residential treatment, the agency is required to have policies and procedures governing the establishment of a waiting list for mental health residential treatment, that minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring clients to other providers. Applicable general access requirements for mental health agencies also include requirements related to providing services in the chosen language of the client, not denying services due to having a SUD in addition to mental illness, and not denying services based on refusal of other services.

*Substance Use Disorder (SUD)*: DHHS has wait time requirements for substance use residential facilities. All treatment programs must maintain a log or register listing individuals actively seeking treatment whenever a program's service capacity has been reached. If such a listing is needed, it must be monitored. Individuals are appropriately placed on a waiting list when they meet screening and eligibility criteria for services of the program. Other access requirements are also identified, namely that clients will receive services within the least restrictive and most accommodating environment possible.

## Staffing

*Mental Health (MH)*: General requirements for mental health agencies require written personnel policies, including regarding qualifications and responsibilities, receipt of policies and procedures, recruitment, termination, personnel records, discipline, supervision, and other matters. Orientation and on-going training are required on topics including, among other things, training on patient rights; physical intervention techniques; the agency's mission, philosophy, clinical and other mental health services; and safety procedures.

For crisis residential services, staff must receive additional training, including but not limited to nationally recognized training in managing people who act out aggressively (e.g. MANDT, Nappi); training in crisis stabilization; and training in residential/milieu management. Researchers did not find any requirements on education or training on trauma-informed care. According to DHHS staff, residential programs must meet the minimum staffing ratios in accordance to Maine’s Assisted Living Standards/ For both residential services generally and crisis residential services, if medical services are not provided on site, other arrangements must be made by the facility for accessing medical services.

The requirements specific to PNMIs do have general information on the types of services that may be provided and who is qualified to provide them. Services at PNMIs generally may only be provided by certain licensed or registered staff members, identified in the regulations. All providers must hold appropriate licensure in the state or province in which services are provided and must practice within the scope of these licensing guidelines. Clinical consultant services must be provided by licensed or certified professionals within all State and Federal regulations specific to the services provided.

*Substance Use Disorder (SUD)*: Substance use programs generally must have personnel policies in place and assure that staff are properly credentialed and meet core competencies. Among the requirements are ones related to employee discipline, communicable disease, evaluations, job descriptions, and background checks. Although specific facility types may have more detailed requirements, these general requirements also identify minimum clinical staff, credentials for clinical staff, credentials for medical directors, credentials for clinical supervisors, require evidence that those providing treatment to clients with co-occurring disorders are qualified to do so, and requirements for contract staff, volunteers, and students. Orientation and ongoing training are required. Ongoing training for clinical staff must assure they meet licensing requirements and must include at least 20 hours of annual in-service or external training, including at least 4 hours related to SUD issues. Information about education or training on trauma-informed care was not found. Programs must have a program manager who may be shared between programs.

Category I programs must have staff coverage 24 hours a day, including weekends. The program must maintain a medical staffing pattern that enables it to meet specified physical care requirements. Physician back-up and on-call staff shall be provided to deal with medical emergencies. The program may not subcontract any of its obligations and rights pertaining to medical service, although physician consultant services are not considered subcontracting.

Category II programs do not have specific staffing requirements separate from the general ones above.

Category III programs must have a written agreement with an ambulance service to assure twenty-four (24) hour access to transportation to emergency medical care facilities for clients requiring such transport. Physician back-up and on-call staff must be provided to deal with medical emergencies. A program may not subcontract any of its obligations and rights pertaining to medical services described in these regulations with the exception of physician consultant services.

Freestanding residential detoxification programs must be staffed by physicians or physician extenders who are available 24 hours a day by telephone. A nurse must be on site at all times and an RN or other licensed and credentialed nurse must be available to conduct a nursing assessment on admission. Appropriately licensed and credentialed staff must be available to administer medications in accordance with physician orders. Credentialed alcohol and drug

counselors and an interdisciplinary team of appropriately trained clinicians are required. The level of nursing care and other care must be appropriate to the severity of client need.

## Placement

*Mental Health (MH)*: As part of the general requirements for mental health agencies, preliminary screening of eligibility for services is required.

For crisis residential programs, an assessment of the client must be completed within 24 hours of admission and must include, among other things, history; physical health status; emotional, psychiatric and psychological strengths and needs; substance use; history of abuse; need for crisis services; social supports; and certain other needs.

For residential treatment, a comprehensive assessment must be conducted by an individual chosen or agreed to by the client or legally responsible party, with the client's participation, within 20 working days of the client's admission. The information to be included in the assessment is similar but not identical to that for crisis residential services.

For PNMI residential services, a comprehensive assessment must be conducted within 20 days of admission that is similar to that under the residential licensing regulations.

There is no mention of the LOCUS assessment tool in these regulations, although DHHS staff indicate it is required by the state Medicaid program. In non-crisis residential settings, there are additional requirements for other assessments not linked to placement.

*Substance Use Disorder (SUD)*: Every substance use treatment program must have written admission policies and procedures that include criteria for determining the eligibility of individuals for admission. Assessment for admission is based on determining the individual needs and capabilities of the client, and the capacity for those needs to be addressed within the framework of the program, as well as appropriateness of treatment to the level and restrictions of care provided by the program component. An initial assessment must be completed prior to development of the treatment plan. A mental health screening is also required to identify whether there is a need for a complete assessment of the mental health condition. There must be policies to incorporate any information about a mental health condition found in this or prior assessments, into the substance abuse record, and integrate it into the service plan.

In addition, freestanding residential detoxification programs require an immediate medical evaluation upon admission.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH)*: No treatment/service planning requirements were identified in the mental health licensing core regulations, although discharge planning is required.

Specific to residential treatment, a service plan must be developed within 72 hours after admission with the client's participation. A comprehensive service plan is required within 20 working days of admission, including criteria for discharge or release to a less restrictive setting, and must be reviewed at least every 90 days. Planning for discharge is required, contingent on the client's consent to establishing discharge as a goal. Aftercare/follow-up requirements are required, whereby programs shall develop written follow-up plans for all clients who are discharged from the treatment program that describe the program's responsibility for facilitating the transfer of the client to follow-up treatment services, other identified professional services, or a client support system.

For crisis residential treatment, a service plan must be developed with the client's consent, within 24 hours of admission and must include criteria for discharge.

For all residential treatment, a protocol must be in place to protect against summary discharge. For PNMIs providing residential services, similar service and discharge planning requirements are in place as are required by the general residential licensing regulations. According to DHHS staff, all consumers must have a crisis plan, which is reviewed quarterly.

*Substance Use Disorder (SUD)*: All SUD programs must have an individual treatment plan for each client. The initial plan must be developed within 72 hours of admission to a residential program and reviewed and updated every week for programs of duration 30 days or less, monthly for programs of duration 31-180 days, and every 3 months otherwise. Programs must incorporate any information about a mental health condition found in intake or prior assessments into the service plan in the SUD program. All SUD programs must have discharge policies and procedures including that no client be automatically discharged for using substances or for displaying symptoms of a co-occurring disorder. Among other things, programs must have procedures to determine if clients need shelter and to ensure they are linked with appropriate follow-up services. All SUD programs must have written follow-up plans for discharging clients.

For freestanding detoxification, there must be an individualized treatment plan, including problem identification, treatment goals, measurable treatment objectives, and activities designed to meet those objectives, and a record of discharge/transfer planning, beginning at admission.

## Treatment Services

*Mental Health (MH)*: Residential services should include support and training in housekeeping and home maintenance skills; mobility and community transportation skills; interpersonal relationships; health maintenance; safety practices; financial management; basic academic skills; management of personal and legal affairs; contingency planning, problem-solving, decision-making; self-advocacy and assertiveness training; utilization of community services and resources; recreational and leisure time activities; work attitude and skills exploration; menu planning and meal preparation; use of the telephone; human sexuality; and client affairs and rights.

*Substance Use Disorder (SUD)*: All residential SUD treatment programs must provide, either on site or through referral: evaluation of the client's medical and psycho-social needs; a medical examination by the program's physician within 5 days of admission unless the physician has approved a prior examination conducted within the last 30 days; opportunities for learning basic living skills; educational services, vocational placement and training, and recreational opportunities as appropriate to the client group to be served; and encouragement for participation in self-help groups. The program shall make agreements with community resources to provide client services through referrals when the program is unable to provide them.

Category I programs must include individual and group counseling at a minimum of 14 hours per week or 2 hours per day for each client. The qualified staff shall teach attitudes, skills and habits conducive to good health and the maintenance of a substance free lifestyle. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling at a minimum of fourteen (14) hours per week. Treatment will include daily didactic/educational presentations.

Category II programs must provide group/individual/family treatment sessions appropriate to the phase of treatment; living skills training according to the phase of treatment; vocational assessment and preparation; and supervised housekeeping responsibilities.

Category III programs provide group/individual/family treatment sessions appropriate to the phase of treatment; living skills training according to the phase of treatment; vocational assessment and preparation; supervised housekeeping responsibilities; transportation available 24 hours a day; and extended care services based on a scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment.

Freestanding residential detoxification programs must provide a biopsychosocial evaluation, medical observation, monitoring, and treatment, counseling, and follow-up referral. Services must include group therapies and withdrawal support; availability of hourly or more frequent nurse monitoring; a range of cognitive, behavioral, medical, mental health, and other therapies; health education services; services to families and significant others; availability of specialized

clinical consultation and supervision for biomedical, emotional, and behavioral and cognitive problems. Providers shall make and maintain arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the program; direct affiliation with other levels of care; ability to conduct or arrange for appropriate laboratory and toxicology tests; and nutritional services, including special diets, as needed.

## Patient Rights and Safety Standards

*Mental Health (MH)*: Individuals have the right to service in the least restrictive appropriate setting, a representative to assist in protecting their rights, a right to state grievances/complaints and have due process related to that, confidentiality, compensation for work, and protection during experimentation or research. Formal grievances/complaints have a process that can involve reporting to the state. Critical incidents must be reported to the state and will be investigated. According to DHHS staff, restraint is prohibited.

*Substance Use Disorder (SUD)*: Among other rights, clients have the right to be informed of their rights, including of the complaint or grievance process. Researchers did not find required reporting of complaints/grievances to the state. Critical incidents must be reported to the state which can result in a state inspection/audit. Researchers did not find a requirement that restraint and seclusion be reported to the state. Policies and procedures must address emergency procedures regarding suicide intervention.

## Quality Assurance or Improvement

*Mental Health (MH)*: All agencies providing mental health services must have a written plan that addresses how the organization currently monitors, evaluates and improves quality. The agency must be able to demonstrate that it identifies, monitors, and attempts to improve areas deemed to be critical to quality client care. There must be documented evidence that quality management activities are conducted on an ongoing and regular basis. The effectiveness of quality management must be assessed and documented at least annually and involves input from a variety of stakeholders. Each agency must have a process for monitoring and evaluating the appropriateness of admission to or initiation of service and the provision of continued service to the client.

*Substance Use Disorder (SUD)*: All SUD programs must have a quality management program. This must include documentation of a performance improvement program. Also included under quality management are requirements for policies regarding managing critical incidents; reports of abuse, neglect, or exploitation; grievances; and licensing violations.

## Governance

*Mental Health (MH)*: Governance requirements include ones related to bylaws, policies and procedures, mission statement, governing body, oversight of management and program changes, agency executive director requirements, a mechanism for client input, and compliance with the ADA and other laws.

*Substance Use Disorder (SUD)*: Governance requirements were located including ones related to the governing authority, conflicts of interest, operation and management, and fiscal management.

## Special Populations

*Mental Health (MH)*: The state identifies as a special population type, for those receiving services from a mental health agency, those with long-term mental illness and specifies: the right to a service system that employs culturally normative and valued methods and settings; the right to coordination of the disparate components of the community service system; the right to individualized developmental programming that recognizes that each recipient with long-term mental illness is capable of growth or slowing of deterioration; the right to a comprehensive array of services to meet the recipient's needs; and the right to the maintenance of natural support systems, such as family and friends of recipients with long-term mental illnesses, individual, formal and informal networks of mutual and self-help.

*Substance Use Disorder (SUD)*: Other than requirements related to provision of services for clients with co-occurring disorders, no specific requirements related to special populations in residential treatment were found.

## Location of Regulatory and Licensing Requirements

Department of Health and Human Services. Standards and Licensure[1]. Regulatory data collected May 8, 2019.

## Other Information Sources

K. Temple (DHHS); National Conference of State Legislatures CON Program Overview, http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx

[1] See https://www.maine.gov/sos/cec/rules/10/chaps10.htm#193.

# MAINE MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Maine Department of Health and Human Services (DHHS) oversees the state Medicaid program. Maine historically does not rely on the in lieu of provision but has relied on Disproportionate Share Hospital (DSH) payments for reimbursement of some services in Institutions for Mental Diseases (IMDs). The state does not have a current relevant section 1115 waiver.

*Mental Health (MH)*: IMDs for the treatment of mental health conditions are not covered by Maine Medicaid. To the extent, however, that short-term non-Crisis Residential Services (CRS) mental health residential treatment services for adults are covered, Medicaid-enrolled providers of mental health services as entities are defined by the regulations as Mental Health Agencies (MHAs). To the extent that any residential mental health treatment facilities may enroll in Medicaid, they likely would do so as MHAs.

*Substance Use Disorder (SUD)*: Maine does not currently have a section 1115 waiver permitting Medicaid coverage of residential treatment for substance use in an IMD, although an application is pending. IMDs for the treatment of SUD conditions are not covered by Maine Medicaid. To the extent, however, that short-term non-PNMI SUD residential treatment services for adults are covered, Medicaid-enrolled providers of SUD services as entities are defined by the regulations as Substance Abuse Agencies (SAAs). To the extent that any residential facilities may enroll in Medicaid, they would do so as an SAA.

## Types of Facilities

*Mental Health (MH)*: In addition to MHAs, described above, Maine covers:

- *Crisis Residential Services (CRS)*: individualized therapeutic interventions provided to a member during a psychiatric emergency, and/or crises originating from problems associated with an intellectual disability, autism, or other related condition to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post-crisis period, in order to stabilize the member's condition. These services may be provided in a temporary out-of-home setting.

*Substance Use Disorder (SUD)*: In addition to SSAs, described above, Maine covers:

- A private non-medical institution (PNMI) is a MaineCare provider that is required to meet special requirements to provide, among other things, Residential Services for MH/SUD. They may include facilities treating those with dual diagnosis. To be a Medicaid provider in a residential setting, a PNMI must be a facility with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of a Substance Abuse Treatment Facility (SATF). SATFs may include, among others, non-hospital based detoxification, halfway house services, and residential rehabilitation services types I and II.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- All Medicaid providers must complete an initial enrollment application followed by subsequent enrollment applications to take place every five years, or as requested by the Department. A provider agreement must be in place and all required licensures or certifications. Enrollment may be denied or terminated, and other sanctions applied.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Medicaid regulations include specific requirements for credentials and training for providers of any behavioral health services that are clinicians or other qualified staff, direct support professionals, and providers of behavioral health services for members who are deaf or are hard of hearing.

The Medicaid regulations also contain PNMI staffing requirements in addition to those in the licensure standards.

SATFs must follow all State of Maine licensing regulations and guidelines for staffing levels and must maintain professional staffing sufficient to serve the individual needs of each recipient as reflected in his individual service plan. Professional services may be provided only within the scope of the professional's license.

*Mental Health (MH)*: Staff providing Crisis Services for adults with mental health as a primary condition must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be a clinician practicing within the scope of their licensure.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD)*: DHHS staff indicate that use of the LOCUS is required by the state Medicaid program. Requirements were not explicitly described in the state Medicaid regulations.

*Mental Health (MH)*: Crisis Residential Services require prior authorization, which is limited to 7 days with the possibility of extension upon application.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Medicaid regulations include specific requirements for assessment and treatment plans. Individualized plans include the Individual Treatment Plan, the Crisis/Safety Plan (where indicated by the Covered Service), and the Discharge Plan. Unless otherwise specified for a facility type, the plan must be developed within 30 days of beginning services.

*Mental Health (MH)*: An individual treatment plan must be completed for Crisis Residential Services within 24 hours of admission and reviewed on the seventh day of service and every two days thereafter if continued stay is approved by DHHS or an Authorized Entity. A crisis stabilization plan is required.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Medicaid Manual provides general guidance on co-occurring services, which are integrated services provided to a member who has both a mental health and a substance abuse diagnosis. When mental health and substance abuse diagnoses occur together, each is considered primary and is assessed, described and treated concurrently. Co-occurring Services consist of a range of integrated, appropriately matched interventions that may include Comprehensive Assessment, treatment and relapse prevention strategies that may be combined, when possible within the context of a single treatment relationship. Co-occurring services also include addressing family therapy or counseling issues involving mental health, substance abuse or other disorders where MaineCare services cover family therapy or counseling.

*Mental Health (MH)*: Components of Crisis Residential Services include assessment; monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and implementing crisis and post-crisis stabilization activities; and supervising the member to assure personal safety. Services include all components of screening, assessment,

evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health care.

## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD)*: The Medicaid regulations include specific requirements for quality assurance including conducting periodic review of cases to assure quality and appropriateness of care in accordance with the quality assurance (QA) protocols established by DHHS.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

A PNMI must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. They must, among other things, submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations, other than that co-occurring MH/SUD must be addressed.

## Location of Medicaid Requirements

Department of Health and Human Services Chapter 101: MaineCare Benefits Manual[2]. Regulatory data collected January 7, 2020.

[2] See https://www.maine.gov/sos/cec/rules/10/ch101.htm.

## Other Information Sources

Maine Substance Use Disorder Care Initiative -- Pending
https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=53628

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services

This state summary is part of the report **"State Residential Treatment for Behavioral Health Conditions: Regulation and Policy"**. The full report and other state summaries are available at https://aspe.hhs.gov/state-bh-residential-treatment.