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MEMORANDUM

To: Joint Standing Committee on Health and Human Services
Joint Standing Committee on Appropriations and Financial Affairs
From: Maine Department of Health and Human Services
Date: February 25, 2026
Subject: Responses to Questions on DHHS Supplemental Budget Initiatives

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Throughout this document "H.R. 1" and "PL 119-21" are used to reference the July 2025 Federal Budget Reconciliation bill, also known as the One Big Beautiful Bill Act.

Impacts of New Federal Requirements and Restrictions

1. What are the new requirements and obligations under H.R. 1 that require positions and funding? (Lemelin, Graham)

There are several sections of P.L. 119-21 that have significant financial and process impacts to the State of Maine, including:

Section 71119: Community Engagement or work requirements. This requirement is effective January 2027, with related outreach requirements starting in June 2026. This requirement changes renewal periods from annual to bi-annual (six months), impacting 100,000 members and effectively doubling the required recertification work for staff. The section also makes changes to retroactive eligibility and adds new verification requirements that require manual processing due to community engagement requirements. The Department is requesting 46 positions to support this additional work. Timely renewals will be key for members to maintain coverage as significant disenrollments and lack of coverage would put undue financial stress on the healthcare system.

Section 71202: Temporary Payment Increase Under the Medicare Physician Fee Schedule. This section requires a temporary increase to the physician fee schedule for calendar year 2026 of 2.5%.

Section 10105: SNAP Benefits Cost Sharing. The State will need to achieve a Payment Error Rate (PER rate) of under 6% to avoid cost sharing for SNAP benefits. Historically, while the state funds have supported SNAP administration, the benefits have been fully federally funded. The FFY24 PER rate was 10.26%, under the national average of 10.93%. Cost sharing will begin 10/1/2027 (FFY28) and be based on the period from 10/1/2025 to 9/30/2026. There are 44 positions requested related to this section as the potential cost sharing penalties are significant. In order to reduce Maine's PER to below 6% in the long-term, Maine will need to process SNAP transactions more timely, conduct additional verifications that require more staff to process, and

set up dedicated positions to provide secondary review of SNAP benefit calculations. More information about the PER cost sharing risk is available in the Department's response to q. 4.

Section 10106: SNAP Administrative Cost Sharing Increase. Under this section the State will be responsible for 75% of the administrative costs instead of the 50% established in 1974, P.L. 93-347. $4.6 million General Fund is requested for this increase in cost sharing.

Section 71106: Medicaid Payment Error Rate. Starting in October 2029, error rates will be expanded to a broader scope of activities and states may no longer avoid penalties for eligibility-related errors. This impact could be seen earlier as the Centers for Medicare & Medicaid Services (CMS) already has the authority under current law to impose penalties for rates exceeding 3%. As an illustration of the scope of potential penalties, if the MaineCare error rate for medical payments was at the national average of 5%, the Department would be subject to a $65 million penalty. This does not count any impact from an excessive eligibility error rate. Presently, DHHS has a medical error rate under 3% and has proposed 3 positions to work with providers to review provider documentation and deliver education and training to comply with claiming and documentation requirements to avoid error rates. MIHMS changes will also be needed to comply with this section.

Sections 71109 and 71110: Non-citizen Coverage Changes. Certain non-citizen categories will no longer be eligible for 90/10 match under Medicaid Expansion. Funding is needed for the decreased federal match and minor MIHMS changes.

Further, and broadly, H.R. 1 introduces new volatility into Medicaid financing, an already fluid program, due to stricter eligibility rules and new exclusions, elimination of some enhanced federal match, increased scope and decreased flexibility regarding payment error rate penalties, and the moratorium on provider tax changes. To accommodate these new requirements on Medicaid, DHHS requires additional actuarial services and strategic financial staffing to improve projections, tracking of experience compared to projections, and 1115 waiver compliance.

2. What is the overall financial impact of H.R. 1 to the state? (Matlack, Graham)

The Governor's Supplemental Budget requests General Fund of $14,748,801 for compliance with the requirements contained in P.L. 119-21. The Budget also requests $4,911,388 in one-time transfers from the Budget Stabilization Fund to be allocated in Other Special Revenue accounts.

Further, the Governor's Supplemental Budget requests $2,249,459 in General Fund to offset provider impact of Section 71113, which prohibits federal match for payments to prohibited entities for a 1-year period beginning July 4, 2025. These are mostly primary care related claims.

There are significant other costs that are difficult to capture and quantify, including impacts to the work force and individual health due to lost coverage. Individual providers may be able to better estimate the impact to their revenues and services.

3. Prior to H.R. 1, what has Maine paid for SNAP? (Blier)

In State Fiscal Year 2025, SNAP program expenditures included:

Program	State Funds	Federal Funds	Total
SNAP Administration*	$14,629,720	$14,105,644	$28,735,364
Federal SNAP Benefits**	--	$358,671,648	$358,671,648
State SNAP benefits	$11,118,577	--	$11,118,577
Total	**$26,362,788**	**$372,777,292**	**$399,140,080**

*SNAP Administration includes General Funds appropriated to Regional Office and Central Office accounts and allocated for SNAP Admin expenses, such as eligibility staff. These expenses are eligible for a 50% federal match through September 30, 2026 and then will be eligible for a 25% federal match effective October 1, 2026 due to the changes made by H.R. 1.

** Federal SNAP benefits are authorized by states, paid by USDA directly, and have been 100% federally funded since SNAP began as a program. Effective October 1, 2027, states will pay for 0-10% of these benefits based on their Payment Error Rate (PER).

4. Explain more about the SNAP Payment Error Rate (PER) and Medicaid/MaineCare Payment Error Rate Measurement (PERM). Why do we have the rate we do and why do we need budget initiatives to address it? What are recent trends in both rates? Ducharme: PERM/PER – can you talk to us about this? See this as a systemic problem, why are you building into budget? (Ducharme, Daigle, Gattine, McCabe)

Medicaid Payment Error Rate Measurement (PERM) *Section 71106: Medicaid Payment Error Rate* – Fall 2029, potential for earlier impacts

The PERM program measures improper payments in Medicaid and CHIP and produces improper payment rates for each program. The improper payment rates are generated by reviews of the Fee-For-Service (FFS), managed care, and eligibility components of Medicaid and CHIP in the year under review. It is important to note that the improper payment rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory, or administrative requirements. 2008 was the first year in which CMS reported improper payment rates for each component of the PERM program.

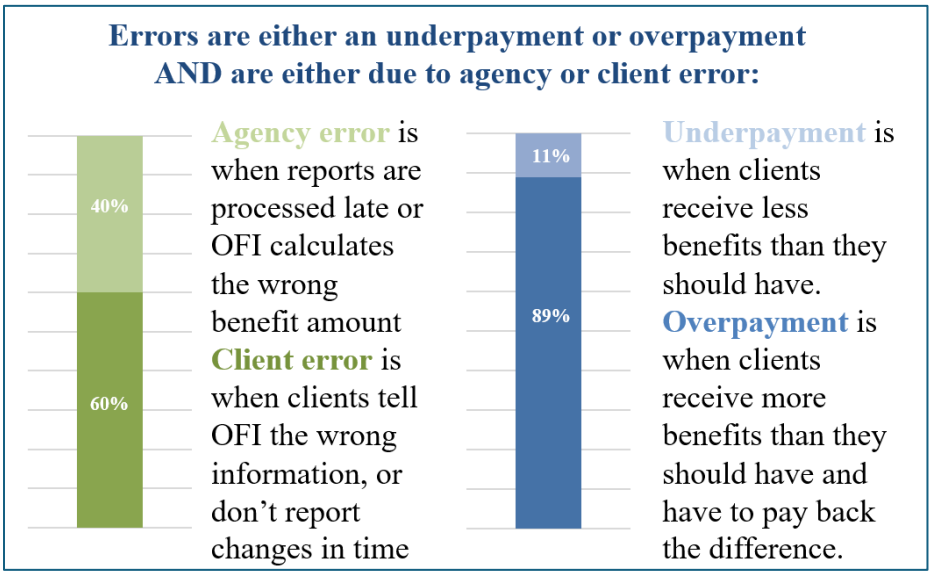
Payment error rates for Medicaid eligibility and medical payments must remain below 3 percent in order to avoid penalties. Starting in October 2029, error rates will be expanded to a broader scope of activities, and a state's ability to receive a good faith waiver of a penalty if it is above the 3 percent threshold will be restricted to only certain errors. In reality, states may face increased risk immediately, as the Centers for Medicare & Medicaid Services (CMS) already has the authority under current law to impose penalties for error rates exceeding the 3 percent -- historically CMS has broadly issued good faith waivers rather than charge states steep penalties. This practice may well change.

Although MaineCare metrics recently met the 3 percent threshold, historic error rates have been as high as 20 percent. To indicate the scope of the risk, even if MaineCare error rates were at the national average of 5 percent, for medical payment error rates alone this would currently subject the Department to a $65M penalty absent a waiver.

In order to reduce the risk of future error rates in excess of 3 percent, the Department requires: 1) accurate and timely systems upgrades to reflect requirements, 2) Provider education and training to ensure they meet documentation requirements, and 3) Staff education and training to ensure proper claims adjustments and eligibility processes.

SNAP Payment Error Rate (PER) *Section 10105: SNAP Benefits Cost Sharing* - Fall 2027

The SNAP Payment Error Rate (PER) measures the percentage of total benefits issued incorrectly by state agencies, including both overpayments (too much) and underpayments (too little) to eligible households, as well as payments to ineligible households. Additionally, each error is identified as a client error or an agency error. The breakdown of these is shown in a graphic below, from a presentation to the Committees in October 2025. PER is a quality control metric, not a measure of fraud, representing unintentional mistakes in eligibility or benefit.



Maine's FFY24 PER was 10.26 percent compared to a national average of 10.93 percent. The current FFY25 PER (YTD, as of February case reviews) is 9.58 percent. In the last decade, it has been as high as 19.1 percent (FFY19) and the Department has worked hard to bring it lower with improved policy and practice.

To avoid financial penalties to the State, OFI will need to reduce its PER to below 6 percent as soon as possible. The last opportunity to avoid cost sharing will be FFY26 (October 1, 2025-September 30, 2026).

Cost sharing for benefits begins October 1, 2027 (FFY28). Cost sharing is determined by the PER from SFY25 or SFY26 (at a state's discretion, assumedly the lower of the two). Based on current annual benefit issuance, the range of cost sharing risk for Maine is:

SNAP Payment Error Rate	Estimated Maine Obligation
Below 6%	$0
6-7.99%	$17.8 million
8-9.99%	$35.6 million
10% and above	$53.4 million

Rapidly reducing the SNAP PER to below 6 percent will require substantial technology investments as well as hiring and training more Eligibility Specialists to be able to provide more timely agency actions and make it easier for clients to be able to report changes.

5. Summarize the technology needs related to H.R. 1 (Ducharme, Blier)

P.L. 119-21 (H.R. 1) establishes new eligibility, compliance and verification requirements. Technology changes include some of the components of eligibility and enrollment modernization including a new Automated Client Eligibility System (ACES) front-end/user interface designed to improve accuracy long-term (and reduce PER), integration of our task management system (Siebel) into ACES to ensure we more accurately process tasks (especially income related changes which drive PER), and Intelligent Optical Character Recognition technology for automated paystub income record creation. Other system changes include noncitizen coverage changes, SSA death master file review, Thrifty Food Plan system changes, Able Bodied Adults without Dependents changes, and standard utility allowance changes.

6. Does Maine receive federal match for the administrative costs of H.R. 1 the way we usually do for Medicaid and SNAP administrative costs? (Gattine) What about for technology? (Moore)

Yes, and/but the match rate varies by program and expenses. That match is included as federal participation in budget initiatives.

7. In DHHS testimony, page 9 initiative (F-A-7216 on p. T-3, or Green Doc lines 171-172) is $569k in FY26 and $13.4M in FY27. Why is there a big jump? (Fredericks)

This work is projected to start in Q4 of the current state fiscal year (FY26) and carry through all of state fiscal year 2027. The bulk of the work and expenses related to deliverables for these modernizations/ upgrades will take place in state fiscal year 2027 and the budget request is aligned accordingly. $4.3 million of the requested amount is state funds.

8. Provide a geographical distribution of SNAP recipients. (Shagoury)

As of February 2026, SNAP recipients by county are:

County	Individuals	Households	Population	% Population
Androscoggin	19,090	10,447	111,139	9.40%
Aroostook	12,842	7,595	67,105	19.14%
Cumberland	22,973	14,377	303,069	7.58%
Franklin	4,179	2,475	29,456	14.19%
Hancock	4,877	2,901	55,478	8.79%
Kennebec	16,268	9,471	123,642	13.16%
Knox	3,823	2,302	40,607	9.41%
Lincoln	3,193	1,818	35,237	9.06%
Oxford	9,864	5,540	57,777	17.07%
Penobscot	21,627	12,971	152,199	14.21%

Piscataquis	2,917	1,618	16,800	17.36%
Sagadahoc	2,790	1,654	36,699	7.60%
Somerset	10,012	5,824	50,477	19.83%
Waldo	5,393	3,070	39,607	13.62%
Washington	6,170	3,515	31,095	19.84%
York	16,710	9,958	211,972	7.88%

Notes: One household may include multiple individuals. Population numbers used are from the 2020 US Census counts: https://www.maine.gov/dafs/economist/census-information

Health Care Cost Growth & FMAP

9. Provide additional detail related to growth in cost and enrollment cited in testimony. How is that measured, can you break down cost drivers and increases? (Moore, Ducharme)

Healthcare cost growth always ties back to a combination of three factors: enrollment, price, and utilization. Healthcare costs almost always increase year-over-year, regardless of payer (commercial, Medicare or Medicaid). Following is a summary of how these factors contributed to MaineCare cost growth over the past year.

- **Enrollment:** while enrollment saw slight decreases largely due to the end of COVID-related continuous coverage requirements, we are not seeing any corresponding decrease in costs. This is because individuals who lost coverage due to the end of the continuous coverage requirements (the "Unwinding") were lower cost and utilized fewer healthcare services than those who remained enrolled. This happened across the country. Average healthcare utilization has therefore been higher, compared to FY24 and FY25, for members who remained enrolled.

  MaineCare has also seen enrollment growth in its Aged population, a group which is more costly and often eligible for MaineCare coverage of Medicare premiums, copays and deductibles, which also rise.
- **Price:** MaineCare has seen considerable cost growth in services reimbursed through cost settlement, especially hospital services, where the program does not have any levers under current policy to control growth. Additionally, the use of high-cost drugs is expanding, and Medicare drives price increases for MaineCare where we benchmark reimbursement to Medicare and pay member cost sharing on behalf of dually enrolled members (premiums have increased by about 10%). Lastly, as planned, the program has invested in hospital and nursing facility reimbursement reforms.
- **Utilization:** As indicated above, average per member utilization has increased as people using fewer healthcare services dropped from the program. As an example, compared with last year, the total number of inpatient hospital admissions has increased over 4%. In addition, as our population ages, the number of members receiving Section 19 Home and Community Based Services has increased by 19%.

  Lastly, likely as a result of increased rate investments over the past several years, the number of pay-to providers in the MaineCare program has increased by 2.2%, increasing access for members and also increasing total claims expenditures.

In summary, given these price and utilization factors, per member per month (PMPM) spending has followed an upward trend compared with last year that has led to overall increased spending despite relatively flat enrollment trends.

10. Explain the Federal Medical Assistance Percentage (FMAP) and how it changes. (Ducharme)

FMAP is the rate at which the federal government matches state spending on approved Medicaid services. It is different for each state and jurisdiction, and is set by the U.S. Department of Health and Human Services using a formula that compares the average per capita income for each state to the national average. Generally, if a state's average per capita income improves relative to the national average, the FMAP declines. Maine has experienced several years of consistent FMAP decreases due to increases in relative per capita income.

FMAP may not be less than 50 percent by law. According to KFF, a nonpartisan health policy organization, in FFY 2026, the highest FMAP across the 50 states is Mississippi at 76.9% and there are 10 states at the minimum 50.0% (CA, CO, CT, MD, MA, NH, NJ, NY, WA, and WY).

Hospitals & Rebasing (Green Doc lines 119-122, 145-146, language part L)
11. How is the rebasing initiative similar and different to how we've done it in the past? (Moore)

The Hospital Tax has been rebased several times historically. This rebasing ensures hospitals are being taxed on the most recent year of revenues earned. In several instances in the past, when the hospital tax was rebased the supplemental pool payments paid to hospitals also increased, offsetting the tax increase. However, recent federal scrutiny on provider taxes has made clear that states should not be holding providers harmless for tax obligations, including making an offsetting supplemental payment. As a result, the Department has instead proposed using the increased revenue to cover cost growth associated with hospitals, including Medicare-Related increases to account for changes in the market basket index, interim cost settlement increases, and increases in Hospital Prospective Interim Payment obligations.

12. Did the Federal Government prohibit provider taxes? How can we do rebasing? (Arata)

PL 119-21 included two provisions regarding provider taxes. One section, (section 71117), closes a loophole CMS claims states use to construct taxes in a way that avoids uniformity provider tax requirements. CMS has issued a final rule essentially formalizing this section into rule. This rule does not impact Maine or its ability to rebase taxes.

Another section, (Section 71115), effectively bans new provider taxes by setting the indirect hold harmless threshold equal to the percent of net patient revenue for health care-related taxes enacted and imposed as of July 4, 2025. While there is significant uncertainty with how CMS will implement this provision, the department believes that even with rebasing its hospital tax it will still be within the set percent of net patient revenue for the hospital provider class.

It is important to note that these changes are effective October 1, 2026. Due to uncertainty over how CMS will implement the provider tax moratorium under PL 119-21, the May 2026 tax payment may be the last opportunity to increase revenue from the hospital tax to reinvest in state services with federal match.

13. Explain hospital cost settlement process, step-by-step. (Ducharme)

After the end of the hospital's fiscal year, they have 5 months to "close their books" and submit cost reports to the Department. Then, per rule, the Division of Audit has 12 months from the date of receipt of each hospital's cost report to determine whether their cost reports reflect an overpayment or underpayment relative to payments made to hospitals throughout the fiscal year in question and issue the interim settlement amount. During the interim settlement process, the hospital expenses are compiled, and the hospital revenue is reconciled to both the financial statements and the as-filed Medicare cost report. MaineCare claims data is then used to determine the MaineCare portion of allowable costs. Subsequently, a final MaineCare review is conducted to determine the final overpayment or underpayment to the hospital, once the final Medicare-audited cost report is received.

If discrepancies or questions develop during the review, additional information may be requested from the hospital, which can extend the timeline of payments.

Behavioral Health & Psychiatric Residential Treatment Facility (Green Doc Line 44)
14. How many children and adults are being served out of state? (Lemelin)

As of January 2025, 64 children were receiving residential treatment services out of state. This information is available on the Department's Children's Behavioral Health Services dashboard: https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/childrens-behavioral-health

DHHS does not have a complete picture of all adults receiving residential services outside the state; our insight is limited to services funded by DHHS programs, individuals who are under public guardianship, and/or providers licensed by the Department. While this would cover most cases, it is possible there are additional individuals in residential care outside of Maine that are unknown to the Department. As of February 25, 2026, MaineCare's Complex Case Unit (CCU) is aware of 79 adults receiving services outside of Maine for significant medical and behavioral health needs, including mental health and rehabilitative services, brain injury, intellectual and developmental disabilities (IDD) and/or other disabilities.

15. Does Maine have an established policy for PRTF (including standards of care) and are we ready to pay for it? If so, provide. (Gattine)

MaineCare Benefits Manual Ch. 3, Section 107 provides Principles of Reimbursement for Psychiatric Residential Treatment Facility Services. This policy is in process to be updated to reflect revised standards of care and revised reimbursement rates resulting from a rate determination completed in 2025. The policy is expected to be updated by early 2027, which aligns with when the Department expects a PRTF to be operational in Maine, pending approval of the budget initiative. All MaineCare policies are available on the Department's website: https://www.maine.gov/sos/rulemaking/agency-rules/mainecare-benefits-manual

16. Does MaineCare pay for out-of-state services? What is the comparison of out of state costs to anticipated PRTF costs in state? (Gattine)

MaineCare does pay for out-of-state residential services if services are not available in state (or services available in the state are not appropriate for a specific individual's need), they meet medical necessity, the service is approved through a prior authorization process, and the provider is enrolled with MaineCare.

While there are established rates for these services that would be the same for in-state and out of state providers, MaineCare is often required to negotiate unique provider rates for these services based on the state and by level of service/acuity of the members.

While a direct comparison at present would take additional analysis, a 2023 analysis by DHHS for the HHS Committee identified the average out-of-state PRTF cost (both medical services and room/board) was $615.50 per day, while the estimated in-state PRTF cost at that time was $585.75. While the average rate has likely changed since then, and the updated MaineCare rate has not yet been finalized, this analysis from 3 years ago provides a directional comparison.

17. In the state-funded services, who are the uninsured clients who receive these services? (Green Doc lines 7-9, 43, 66) (Lemelin)

The Office of Aging and Disability Services' Long-Term Services and Supports Unit manages two state-funded home and community-based programs that provides home-based services in members' homes. These programs are Section 63 Home-Based Services and Supports (HBSS) and Section 69 Independent Services and Supports (ISS), also known as Homemaker Services.

- Section 63 helps with activities of daily living (ADLs), including bathing, dressing, toileting, eating, locomotion, and transfers. It also covers instrumental activities of daily living (IADLs), such as light housekeeping, meal preparation, and grocery shopping, as well as nursing services.
- Section 69 is limited to assistance with instrumental activities of daily living, as defined above, and may also include transportation to medical appointments.

Eligibility for these programs is based on both functional and financial eligibility criteria. Functional eligibility is determined through a standardized assessment conducted by the Department's contracted assessing services agency. Individuals found eligible for either program must not be eligible for similar MaineCare covered services.

Financial eligibility is based on asset limits. Individuals must have liquid assets of no more than $50,000. For couples, the combined asset limit is $75,000.

Once eligibility is established, members, unless they qualify for a waiver, are required to contribute 20% of the value of services toward the cost of their care.

Similarly, for behavioral health services, clients who are denied MaineCare coverage may be eligible for state funded services for services including medication management if they are uninsured, or for Section 17 services (Assertive Community Treatment, Community Integration)

if they meet medical necessity criteria and are underinsured (have coverage that does not cover these services). Higher acuity and intensive services are often not covered by private insurance plans.

Riverview Psychiatric Center Security (Green Doc lines 1-2)

18. Provide additional information on this initiative (Initiative F-A-1407). How many Capitol Police officers support this work? Is this cost neutral, and is the level of service changing? If so, why? (Gattine, Blier)

This initiative moves General Fund from the Riverview accounts, where it was appropriated, to the Department of Public Safety so that the positions can be funded in the most direct and appropriate way. The transfer of General Fund in FA 1407 continues to support a total of 5 positions, 4 Capitol Police Officers and one Capitol Police Sergeant. The companion initiative in the Department of Public Safety requests a total of $784,902, which is a net request of General Fund of $281,347.

For over a decade, DHHS has had a memorandum of understanding (MOU) with the Department of Public Safety regarding services at Riverview Psychiatric Center. When the original arrangement with Capitol Police was established, officers were required to have a 24/7 presence at Riverview and respond to code calls. Since the original agreement with the Capitol Police, significant work has been completed to improve the milieu and regain CMS certification, which had been lost over a decade ago. Importantly, Riverview has adjusted processes for responding to acute patients and dangerous behaviors.

At this point, a fee-for-service relationship with Capitol Police is much more appropriate to meet the hospital's needs. This will be established through an MOU, for transportation of legal hold patients for emergent medical issues/appointments and occasional transport back to a county jail when the county is struggling to do a discharge transport. The Capitol Police would still respond to emergency calls, like they would for any other State building in the capitol area.

Housing First (Green Doc lines 5-6)

19. How does the Housing First Program (referenced in initiative F-A-1930 comport with federal changes to Housing First policy as described by the Executive Order (EO) issued by the White House on July 24, 2025? (Arata)

The July 2025 EO is not expected impact Maine's Housing First (also known as Home for Good) program because the program is funded with state, not federal, dollars collected through the Real Estate Transfer Tax.

Lifespan Waiver (Green Doc lines 52-53)

20. What is the Department's plan for implementing the recently completed rate determination for the Lifespan waiver? Is there additional funding needed to meet those new rates? (Stover)

The Department is aiming for Centers for Medicare & Medicaid (CMS) approval of its Lifespan waiver application by October 2026, though the actual approval date is dependent on CMS, and implementation is contingent on numerous systems and process changes that the Department is

working to have in place. The Department has requested and received other appropriations related to implementation of the Lifespan waiver in the past and has not sought additional funding at this time.

21. Provide information on the additional services for Lifespan that are not currently part of Secs. 21 and 29. (Gattine)

The Lifespan Waiver effectively combines two legacy waiver programs, Sections 21 and 29, into a single, flexible waiver serving individuals beginning at age 14 and continuing throughout the lifespan. It is designed to offer a broader, more individualized range of service options to support people to live in their own home or apartment, pursue employment, and participate in their communities. Lifespan proposes new services not currently available under Sections 21 and 29, such as Community Supported Living, Community Transportation, Co-Worker Supports, and Peer Support, and expands opportunities for self-direction, including allowing additional service types (e.g., select employment services) to be self-directed. Additionally, once enrolled in Lifespan, individuals would not need to transition to a different waiver as they age or if their needs increase. The Office of Aging and Disability Services has published a 2026 information sheet with additional detail; it is available on the Lifespan project homepage, along with other helpful, easy to read resources: https://www.maine.gov/dhhs/oads/about-us/initiatives/hcbs-lifespan-project.

Importantly, individuals currently enrolled in Sections 21 and 29 may remain in their current waiver if they choose, or transition to Lifespan when eligible.

Maine Veterans' Homes (Green Doc lines 147-152, language part WW)

22. What is the Department's perspective on the proposal the Maine Veterans' Homes presented? (Arata)

The Department appreciates MVH's support for its proposal to transition the MVH NF supplemental payment into a separate per diem rate for MVH Nursing Facilities, which is defensible based on differences in cost data analyzed under NF rate reform. The Department does not support an ongoing supplemental payment for MVH Residential Care Facilities, as their proposal institutionalizes additional state-only reimbursement to these facilities above and beyond what other comparable non-MVH Residential Care Facilities receive, prior to the Department conducting rate reform for these facilities to determine whether differential reimbursement is appropriate. If on-going differential reimbursement is appropriate, the Department would propose to take a similar approach to NF reimbursement, and recognize meaningful cost difference in the base reimbursement rates once reform is implemented, rather than rely on supplemental payments paired with cost settlement, which provides no incentive for facility cost control.

Further, Maine Veterans Homes' proposal to reallocate funding proposed for a supplemental payment to Residential Care Facilities to the Nursing Facilities account would likely not be feasible. In order to get federal match for these payments, the Department must seek SPA approval from CMS. Under the SPA, the payments are based on the difference between facility costs and MaineCare reimbursement for each facility as shown on a recent cost report. Simply

moving the funding to the nursing facilities account does not ensure federal funding, and the Department would be unable to make any payment above the demonstrated difference. There is a portion of the supplemental payment to Residential Care Facilities that is able to receive federal match, and the Department has proposed to make this payment up to a level that covers the anticipated difference between reimbursement and costs. It has additionally proposed funding to cover a portion of the difference between costs and state-only Room and Board reimbursement with General Fund dollars.

SNAP Heating Assistance Proposal (Green Doc line 170, language part XX)

23. Explain the Standard Utility Allowance (SUA). How much is a full SUA? (Ducharme)

Since actual utility costs are often hard to determine, states can use Standard Utility Allowances (SUAs), which are standard amounts that represent low-income household utility costs in the state or local area. SUAs may be used in lieu of the household's actual costs when determining eligibility and benefit amounts. Maine's Federal Fiscal Year (FFY) 2025 SUAs were:

- Heating and Cooling Utility Allowance (HCSUA): $1,047
- Basic/Limited Utility Allowance (BUA/LUA): $353
- Phone: $60

SNAP benefits are calculated individually for each household. Because SNAP households are expected to spend about 30% of their own resources on food, benefits are based on the maximum monthly allotment for household size, less 30% of the household's net income for the month. SNAP rules allow for several deductions from income including a standard deduction from earned income, dependent care expenses, medical expenses for some households, and "excess shelter costs." Excess shelter costs are those that exceed more than half of the household's income after other deductions. Allowable costs include: fuel to heat and cook with, electricity, water, the basic fee for one telephone, rent or mortgage payments and interest, and taxes on the home.

24. If heating is included in someone's rent payment, would they still be eligible? (Arata)

Yes, all SNAP households will receive the energy assistance payment.

Maine CDC Initiatives (Green Doc lines 175-177, 180)

25. Are positions for STI and HIV investigation work being reduced (F-A-1127, 1128 and 1129) at Maine CDC? (Rana)

Maine CDC's Infectious Disease Prevention Program ensures statewide surveillance, prevention, investigations, and outbreak response for HIV. STI and Viral Hepatitis. The two proposed positions for STI and HIV investigation will maintain critical resources for statewide infectious disease control, including investigation of new diagnoses, clusters, and outbreaks of HIV, syphilis, gonorrhea, and chlamydia, linking individuals to testing and treatment, and promoting prevention interventions (e.g. PrEP, syringe services, safer sex) to reduce the spread of infectious diseases.

Infectious Disease Prevention staff resources are primarily supported through Federal funding agreements with US CDC and HRSA: approximately 23.5 program FTE of 24 FTE total are federally funded. Federal funding continues to be dynamic. US CDC issued a one-year extension to the COVID STI funding through Feb. 28, 2027, and we anticipate reduction in disease investigation resources once these funds end.

26. Is the expansion of the Maine Immunization Program new? (Fredericks) Is the increase for MIP expected to be one-time or ongoing? (Arata)

The Maine Immunization Program (MIP) works with the Maine Vaccine Board (MVB), an independent entity with appointed members, to make vaccines available at no cost to providers across the state through the Universal Vaccine Program. The Program was established in 2010 to ensure that children in Maine had equitable access to vaccines that were available through the U.S. Vaccines for Children (VFC) program. It is funded by a fee on insurance carriers calculated by covered lives in lieu of billing and reimbursement by encounter. The MVB votes annually to determine which vaccines are covered under this program and the annual assessment fee to be paid quarterly by Maine health insurers. Until now, this program only covered children but Maine recently passed legislation to expand the scope of the Universal Vaccine Program to include insured adults 19-64 years of age (Public Law 2025 Ch. 440). This expansion is effective July 1, 2026.

Due to the changes in amount of fees collected (dependent on the decision of the MVB), changes in allotment for the program to ensure they are able to spend the funds collected are not uncommon. The volume of this allotment increase ($10M) is larger than prior requests due to the expansion of the program in PL 2025, Ch. 440. As a reminder, there is no General Fund ask associated with this initiative.

OCFS Special-Needs Trusts (Green Doc lines 47-51)

27. What are the special-needs trusts for children? (Moore)

Currently, when a child is in custody of the State and receives federal benefits, such as SSI/SSA survivor benefits, those benefits are used by the State to offset the cost of care for the child. This proposal, in alignment with proposals before the HHS Committee in LD 52 during the 132nd Legislature and LD 2078 in the 131st Legislature (both unanimously approved), would instead provide General Funds to cover those costs and establish special-needs trusts to conserve the child's benefits for their use.

The Department is bringing forward this proposal for two reasons. First, advocacy around the importance of preserving these benefits for the child's use has been growing and compelling in the last several years. These benefits, if placed in a special-needs trust, provide vulnerable youth in the child welfare system with financial resources when they transition into adulthood and provide them with a safety net that may not otherwise be there. Second, the U.S. Administration for Children and Families (ACF) has changed policy and required additional tracking requirements for these benefits that will require a separate account for each child. Transitioning to this system will require investment which the Department determined is better invested in preserving these benefits for children's use.

28. How much of the funding requested for the special trusts is going to fund the management analysts as compared to what will go into the accounts? (Blier)

The cost of the two management analyst II positions is $210,656 across accounts in SFY27. The funding to offset benefits is $2,808,128 all funds, with $1.48 million of that state general funds, in SFY27. The amount that will be placed into each child's account will depend on individual benefits, but the $2.8 million is the total estimated need to account for redirecting these funds for direct use by the children in care.

There are additional costs associated with this initiative, including a contract with a fiscal agent for management of the accounts (standard practice in states that use this model), of just over $890,000, and additional legal, technology, and training costs.

Psychotropic Medication Settlement (referenced on Green Doc lines 16-24)
29. Provide information about the psychotropic medication lawsuit referenced. (Ducharme)

In November 2024, the Court approved a settlement agreement regarding a 2021 lawsuit against the Department. The Settlement Agreement requires the Department to put in place updated policies and procedures about the oversight and administration of Psychotropic Medications to children in foster care in Maine. These policies and procedures will, for example:

1. Improve medical and mental health record-keeping and sharing;
2. Ensure that children ages 14 and over provide informed consent for a physician's prescription for Psychotropic Medications; and
3. Create a review process where a Clinical Review Team reviews certain Psychotropic Medications before and after they are prescribed.

The Department's progress in implementing these processes will be monitored and reported on to the Court by a third-party Implementation Reviewer. The Agreement will remain in effect for 5 years from the date the Implementation Reviewer's contract begins – we made an award for this position but it was appealed, so we have reissued the RFP. Accordingly, the 5 years has not started yet, but the Department has created the required policies and forms.

The positions requested are to help ensure the Department can meet the terms and performance criteria of the Settlement Agreement.

The agreement is posted on the Department's website and available here:
https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Bryan%20C%20v%20Lambrew%20Settlement-Agreement.pdf

MaineCare Rate Cost of Living Adjustments (COLAs)
30. What would it cost to implement full COLAs? (Fredette)

As an initial estimate, a 3.07% COLA for services that would otherwise have been scheduled to receive COLAs on 7/1/26 and 1/1/27 would likely cost between $30M and $40M general fund annually. FY27 costs will be somewhat lower because the 1/1/27 COLAs would only reflect 6 months of impact. This estimate is dependent on also receiving MaineCare baseline and hospital cost growth initiatives. The OMS analytics team will continue to refine this estimate.

31. How are COLAs determined? How was the 1% COLA determined since CPI is higher? (Arata)

The COLA applied during this fiscal year was 1.0% due to the language and appropriation in PL 2025, Ch. 388, Part GGG.

MaineCare uses different indices for COLAs based on what the costs of the service include. We do not itemize all costs to their own relevant index, but indices do vary.

In September of each year, Maine Department of Labor (Maine DOL) calculates the minimum wage for the upcoming year using the federal Bureau of Labor Statistics August update to the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Maine DOL compares the previous August to the most recent August data to determine the % increase in the CPI-W index (rounded to nearest 5 cents).

Maine DOL publishes the new minimum wage as late as December each year, which is midway through the state fiscal year, when MaineCare is operating under a budget passed the previous legislative session. This time lag leads to confusion and potential conflict that the Department is seeking to address in its proposed LD 2177.

Positions and Headcount
32. Provide a summary chart of the requested positions. (Zager)

Positions begin in SFY 2027 unless marked with an asterisk (*); those positions begin in SFY 2026. Please see q. 1 and 4 for additional information about the work to be completed by the positions related to H.R. 1. FTE stands for full-time equivalent, or a full-time position. One position, marked below with a double asterisk (**) is a limited period position.

FTE	Position	Office	Purpose	Federal Match
1	Health Program Manager	CDC	STI and HIV investigations	Yes - 50%
1	Public Health Educator III	CDC	STI and HIV investigations	No
2	Child Protective Services Nurse Consultant	OCFS	Psychotropic medication settlement (see q. 29)	Yes – 21% federal grants
1	Management Analyst II	OCFS	Psychotropic medication settlement (see q. 29)	Yes – 28% federal grants

1	Child Protective Services Case Aide	OCFS	Psychotropic medication settlement (see q. 29)	Yes – 21% federal grants
2	Management Analyst II	OCFS	Child-centered benefits management program	Yes – 28% federal grants
40	Eligibility Specialist II	OFI	SNAP Payment Error Rate requirements in H.R.1	Yes – 55.2%
4	Family Independence Unit Supervisors	OFI	SNAP Payment Error Rate requirements in H.R.1	Yes – 55.2%
35	Eligibility Specialist I	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
4	Family Independence Unit Supervisors	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
1*	Program Administrator - Family Independence	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
1*	Management Analyst II	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
1	Senior Planner	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
3	Eligibility Specialist II	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
1*	Business Systems Administrator	OFI	MaineCare/Medicaid requirements in H.R.1	Yes – 75%
1*	Comprehensive Health Planner II	OMS	Payment Error Rate Measurement (PERM) requirements in H.R.1	Yes - 50%
1**	Comprehensive Health Planner II	OMS	MaineCare/Medicaid requirements in H.R.1	Yes - 50%
1*	Provider Relationship Specialist	OMS	Payment Error Rate Measurement (PERM) requirements in H.R.1	Yes - 50%
2*	Eligibility Specialist II	OMS	MaineCare/Medicaid requirements in H.R.1	Yes - 50%
1	Public Service Coordinator I	OMS	MaineCare/Medicaid requirements in H.R.1	Yes - 50%
1*	Public Service Coordinator I	OMS	MaineCare/Medicaid requirements in H.R.1	Yes - 50%
1*	Management Analyst II	OMS	MaineCare/Medicaid requirements in H.R.1	Yes - 50%

33. How many positions did the Department request last year? (Fredericks)

The Department requested, and the Legislature approved, 85 new permanent positions in the SFY26-27 biennial budget. Of those 85 positions, 45 were making permanent long-standing limited period positions that staff the OFI Wilton Call Center.

34. Provide current vacancies at DHHS, where they are, and how long have they been vacant. (Fredericks & Lemelin)

Vacancies provided are as of January 31, 2026:

Office	# Vacant	Total	Rate
CDC	37	417	8.87%
Central Ops.	12	172	6.98%
DDPC	13	259	5.02%
DLC	13	91	14.29%
OADS	19	334	5.69%
OBH	25	146	17.12%
OCFS	79	865	9.13%
OFI	112*	913	12.27%
OHIM	1	11	9.09%
OMS	13	164	7.98%
RPC	84	362	23.20%
Total	**408**	**3734**	**8.62%**

Notes

*OFI has higher than normal vacancies within Disability Determination Services (DDS) currently due to a federal hiring freeze. These positions are funded through the Social Security Administration as a state-federal partnership. There are additional, higher than normal vacancies in the Division of Support Enforcement and Recovery (DSER – child support) due to ongoing reorganization of the office.

The vast majority of these positions became vacant within the last calendar year and, notwithstanding the federal hiring freeze, are in the HR process for hiring.

35. Why would the functional job analysis (FJA) take 8 years? (Zager)

The extended delay in the FJA referenced in the budget was due to active litigation over the reclassification, which led to prolonged settlement discussions. While litigation was ongoing, legal counsel advised maintaining the status quo until a final agreement or adjudication was reached.

36. Green Doc lines 45-46: In DHHS testimony there is an initiative for an HR settlement agreement that is pending – if it's pending, how do we know how much to budget? (Moore)

When budget initiatives were initially submitted for consideration, the amount was still pending. The reclassification of the 9 positions was approved 12/29/25 and the amount is now confirmed.

37. Does the dollar amount in budget initiatives for new positions include everything (benefits)? (Blier)

Yes, the initiative amounts include all funds needed for that position, including benefits.

38. What is the reason for the cost adjustments (moving 2% of costs from one account to another, for example)? (Ducharme)

Many positions perform tasks that can or should be billed to federal grants. The Department routinely reviews cost allocations to ensure that staff time is appropriately allocated between different funding streams. When a change is identified, the Department will adjust the funding of

the position through the budget process to align the funding with tasks that are performed and amounts allowable under federal grants.

39. The State has added 4,000 positions in 8 years. Were employees overworked prior to adding these new positions? (Blier)

New positions that have been requested during this Administration have been tied to specific needs or system pressures, outlined at the time of request and approval.

40. What is the difference between the former and new job description for the employee-initiated reclassification in F-A-1735 (Green Doc line 11)? (Lemelin)

Below we have provided the description of each job specification as listed by the Bureau of Human Resources. Additional information about these classifications is posted under the job title on BHR's website: https://apps.web.maine.gov/cgi-bin/bhrsalary/jobs.pl?pagenum=2&pagereq=actSpec/joblist3a.asp?Alf_Let=S

Original position - Social Services Manager I: This is professional services work of a managerial nature in planning, directing, and coordinating social services within specific program areas of a regional office. Responsibilities include developing and promoting community relations; developing and coordinating resources and services; developing, coordinating, and delivering statewide and regional training programs; and participating in statewide policy development and decision making. Work is performed under administrative direction.

Reclassified position - Social Services Program Manager: This is professional services work of a managerial nature in planning, coordinating, and directing various operational aspects of a major social service or mental health/ developmental disabilities program. Responsibilities include developing and implementing statewide policies and procedures; and conducting program planning, evaluation, budgeting, and staffing functions. Work is performed under administrative direction.

OIG Audit of Rehabilitative and Community Support Services Provided to Children Diagnosed with Autism

41. Are the additional positions requested to support program integrity appeals (Green Doc lines 83-84) related to the $45.6M in improper payments in OIG audit? (Arata)

No, these positions are related to implementing new requirements in H.R. 1.

42. Provide additional background on the OIG audit findings and the process used to determine how much money to recoup from Medicaid providers and pay back to the federal government. How will that be paid for and what is the timeline? (Gattine, Arata)

The referenced audit developed an extrapolation based on a small portion of claims data. The Department's Program Integrity Unit (PIU) is currently reviewing the specific findings and associated medical records to validate the accuracy of the OIG's findings and overpayments. To

conduct a thorough and accurate review of the OIG's assertions in their audit, the Department must review hundreds of claims for:

1. Whether violations of the applicable federal or state regulations exist, and
2. The appropriate sanction(s) to apply under state rules for any identified violations.

This requires reviewing all documentation supplied by the OIG, and requesting additional documentation from providers when needed. The PIU estimates that it will finalize its reviews of the sample findings by the end of April 2026 and will issue Notices of Violation (NOV) to any providers with identified improper payments by the end of June 2026. The Department intends to refund the federal share of any improper payments it can validate within 1 year of the date of the NOV in accordance with federal regulations.

Other Questions Not Related to Specific Initiatives

43. How many people are enrolled in the Low Cost Drugs for the Elderly program? (Moore)

As of December 2025, there were 49,052 people enrolled in the Low Cost Drugs for the Elderly program. Note that the vast majority of these members also receive additional, separate benefits, such as support for Medicare premiums and cost sharing.

44. What accounts at DHHS are carrying? (Arata)

Here is a table of carrying accounts at DHHS:

Account #	**Account Name**	**Carrying Authority**
010-10A-0129-01	Office of MaineCare Services	5 MRSA, §1591, part 2-C
010-10A-0129-02	Office Of MaineCare Services - Carrying	5 MRSA, §1591, part 2-C
010-10A-0130-01	General Assistance	22 MRSA, §4326
010-10A-0131-01	Supplemental Payments for SSI	22 MRSA, §3273, part 10
010-10A-0131-02	Supplemental Payments for SSI - Carry Account	22 MRSA, §3273, part 10
010-10A-0137-01	IV-E Foster Care/Adoption Assistance	22 MRSA, §4062, part 2
010-10A-0138-01	TANF	22 MRSA, §3769, part 3
010-10A-0139-01	State Funded Foster Care/Adoption Assist	22 MRSA, §4062, part 2
010-10A-0140-02	Office of Aging and Disability Services Central Office - Carrying	5 MRSA, §1591, part 2-A
010-10A-0143-03	Maine Center for Disease Control and Prevention - Carrying	PL 1999, c. 731
010-10A-0146-01	ASPIRE	22 MRSA, §3769, part 3
010-10A-0147-01	Medical Care Services	22 MRSA, §3177
010-10A-0147-03	Accountable Communities - Shared Savings	22 MRSA, §3177
010-10A-0148-01	Nursing Facilities	22 MRSA, §3177
010-10A-0202-01	Drugs for Maine's Elderly	22 MRSA, §254-D, part 2
010-10A-0211-01	Independent Housing with Services	5 MRSA, §1591, part 2-A
010-10A-0307-02	Office of Child and Family Services Central-Carrying	PL 2023, c.447, 22 MRSA §4004
010-10A-0420-01	Long Term Care - Office of Aging and Disability Services	5 MRSA, §1591, part 2-A

010-10A-0453-02	Office for Family Independence-Dist Carrying	PL 2019, Ch 616 PT MM
010-10A-0563-01	Child Care Services	PL 2023, c.643, part RR
010-10A-0728-01	Public Water Drinking Fund	PL 2023, c.412, part MMMM, 5 MRSA, §1591
010-10A-Z008-01	Maternal & Child Health Block Grant Match	PL 2005, c. 386, Part A
010-10A-Z009-01	PNMI Room & Board	PL 2005, c. 386, Part A
010-10A-Z019-02	Food Supplemental Admin-Carrying	PL 2021, c 1, part P
010-10A-Z198-03	Bureau of Mental Health - Carrying Account	5 MRSA, §1591, part 2-D
010-10A-Z199-01	Office of Behavioral Health	5 MRSA §1591, sub-§2, part J. PL 23, c.412 part MMMM-2
010-10A-Z199-02	Office of Behavioral Health - Carry	PL 2015, c.378
010-10A-Z201-40	MH Svcs Community Medicaid	34-B MRSA, §3009
010-10A-Z202-41	OSA-Medicaid Seed	PL 1997 c. 24, Section VV-9
010-10A-Z204-01	Consent Decree	5 MRSA, §1591, part 2-E
010-10A-Z205-01	Bridging Rental Assistance Payment (BRAP)	5 MRSA §1591, sub-§2, part H
010-10A-Z207-80	MH Svcs Child Medicaid	34-B MRSA, §6242
010-10A-Z210-50	Medicaid Match - Developmental Services	34-B MRSA, §5003-A, part 4
010-10A-Z211-59	Developmental Services Waiver-MaineCare	34-B MRSA, §5003-A, part 4
010-10A-Z212-54	Developmental Services Supports Waiver	22 MRSA, §3177
010-10A-Z214-51	Traumatic Brain Injury Seed	5 MRSA, §1591, part 2-B
010-10A-Z215-01	Consumer Directed Services	5 MRSA §1591, sub-§2, part I, PL23, c.412 MMMM-1
010-10A-Z217-56	Medicaid Waiver For Other Related Conditions	5 MRSA, §1591, part 2-G
010-10A-Z218-58	Medicaid Waiver For Brain Injury Residential/ Community Services	5 MRSA, §1591, part 2-F
010-10A-Z220-10	Disproportionate Share – Riverview	34-B MRSA, §1409, part 15*
010-10A-Z225-15	Disproportionate Share – Dorothea Dix	34-B MRSA, §1409, part 15*
010-10A-Z362-01	Progressive Treatment Program Fund	34-B MRSA §3873-B