State of Maine
Department of Health and Human Services
Government Evaluation Act Report

Produced and submitted pursuant to Title 3 M.R.S.A., Ch. 35
by the Maine Department of Health and Human Services
to the Joint Standing Committee on Health and Human Services

January 2026

Contents

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Governor

Sara Gagné-Holmes
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January 2026

Senator Henry Ingwersen, Senate Chair
Representative Michele Meyer, House Chair
Joint Standing Committee on Health and Human Services
Cross Office Building, Room 215
Augusta, Maine 04333

Dear Senator Ingwersen, Representative Meyer, and Honorable Members of the Joint Standing Committee on Health and Human Services,

As required under the Government Evaluation Act, 3 M.R.S. §956 et seq., (the "Act"), the Department of Health and Human Services (DHHS) is providing the following Program Evaluation report to the Joint Standing Committee on Health and Human Services.

The work of DHHS is broad and comprehensive. Given its mission, the Department strives to ensure that: Maine children grow up in safe, healthy, and supportive environments, allowing them to thrive throughout their lives; all adults have the opportunity to work, live with independence, and have good health; and older Mainers live with dignity in the place that balances their needs and preferences.

This report provides a broad overview of the purpose and programs of the Department of Health and Human Services. We are confident that the Department has met its legislative purpose and mission for the report period and trust that you will find the report and accompanying information informative. We are ready to provide you with additional information you may require and look forward to our continued work together on behalf of the people of Maine.

Sincerely,

Sara Gagné-Holmes
Commissioner

The Government Evaluation Act (GEA)

The Government Evaluation Act of 1995 establishes a system for periodic review of the executive branch agencies and independent agencies of state government to evaluate their efficacy and performance. This report was produced in compliance with 3 M.R.S. §951 by the Maine Department of Health and Human Services ("the Department" or "DHHS"). The statute specifies several areas of information to be included in this evaluation report, as follows:

A. Enabling or authorizing law or other relevant mandate, including any federal mandates;

B. A description of each program administered by the agency or independent agency, including the following for each program:

(1) Established priorities, including the goals and objectives in meeting each priority;

(2) Performance measures or other benchmarks used by the agency to measure its progress in achieving the goals and objectives; and

(3) An assessment by the agency indicating the extent to which it has met the goals and objectives, using the performance measures. When an agency has not met its goals and objectives, the agency shall identify the reasons for not meeting them and the corrective measures the agency has taken to meet the goals and objectives;

C. Organizational structure, including a position count, a job classification and an organizational flow chart indicating lines of responsibility;

D. *Repealed*

E. Financial summary, including sources of funding by program and the amounts allocated or appropriated and expended over the past 10 years;

F. *Repealed*

G. Identification of those areas where an agency has coordinated its efforts with other state and federal agencies in achieving program objectives and other areas in which an agency could establish cooperative arrangements, including, but not limited to, cooperative arrangements to coordinate services and eliminate redundant requirements;

H. Identification of the constituencies served by the agency or program, noting any changes or projected changes;

I. A summary of efforts by an agency or program regarding the use of alternative delivery systems, including privatization, in meeting its goals and objectives;

J. Identification of emerging issues for the agency or program in the coming years;

K. Requests from committee of jurisdiction

Note: Members of the Health and Human Services Committee of the 132nd Legislature made specific requests for information outside of this report following discussions held during the first regular session. Information responsive to these requests can be found in the "Legislative Requests pursuant to 3 M.R.S. §956(2)(K)" section of this report.

L. A comparison of any related federal laws and regulations to the state laws governing the agency or program and the rules implemented by the agency or program;

M. Agency policies for collecting, managing and using personal information over the Internet and nonelectronically, information on the agency's implementation of information technologies and an evaluation of the agency's adherence to the fair information practice principles of notice, choice, access, integrity and enforcement;

N. A list of reports, applications and other similar paperwork required to be filed with the agency by the public. The list must include:

(1) The statutory authority for each filing requirement;

(2) The date each filing requirement was adopted or last amended by the agency;

(3) The frequency that filing is required;

(4) The number of filings received annually for the last 2 years and the number anticipated to be received annually for the next 2 years; and

(5) A description of the actions taken or contemplated by the agency to reduce filing requirements and paperwork duplication;

O. A list of reports required by the Legislature to be prepared or submitted by the agency or independent agency;

P. A copy of the single-page list of organizational units and programs within each organizational unit required pursuant to section 955, subsection 1, placed at the front of the report; and

Q. Identification of provisions contained in the agency's or independent agency's enabling or authorizing statutes that may require legislative review to determine the necessity of amendment to align the statutes with federal law, other state law or decisions of the United States Supreme Court or the Maine Supreme Judicial Court.

This report is broken down by individual office, division, or hospital, and provides responses to each of the required sections above. It will provide an overview of the Department, and its current and ongoing work as a whole.

Overview: Maine Department of Health and Human Services

The Department of Health and Human Services oversees a wide range of programs impacting Mainers across the state from MaineCare (Medicaid) health insurance, public assistance, child support payments, water testing, disease control, and background checks. DHHS provides services to approximately a third of the State's population including children, families, older Mainers, individuals with disabilities, mental health issues, and substance use disorders.

Enabling Legislation
The Maine Department of Health and Human Services is established by 22-A M.R.S. Chapter 1, which broadly outlines the department's responsibilities. Programs operated by DHHS derive their statutory authority and obligations through many titles of Maine Revised Statutes. Further citations are provided throughout the report.

Program Descriptions
The Maine Department of Health and Human Services promotes health, safety, resilience, and opportunities for people in Maine through a wide range of programs and services. Its duties include administering programs to support health coverage, financial assistance, behavioral health services, and additional support services for unique populations. The Department also oversees public health initiatives, operates two state psychiatric hospitals, licenses and certifies health care providers, and regulates certain programs to ensure compliance with state and federal rules.

DHHS employs over 3,400 people across the state. An up-to-date organizational chart of Department leadership can be found on the Department's website, here: https://www.maine.gov/dhhs/about/staff.

As part of its mission, the Department strives to ensure that:

- Maine children grow up in safe, healthy, and supportive environments, allowing them to thrive throughout their lives.
- All adults have the opportunity to work, live with independence, and have good health.
- Older Mainers live with dignity in the place that balances their needs and preferences.

The Department is comprised of the Commissioner's Office and 10 program and service-delivery offices, divisions, and hospitals, including:

- Division of Licensing and Certification
- Maine Center for Disease Control and Prevention
- Office for Family Independence
- Office of Aging and Disability Services
- Office of Behavioral Health
- Office of Child and Family Services
- Office of Health Insurance Marketplace
- Office of MaineCare Services
- Dorothea Dix Psychiatric Center

- Riverview Psychiatric Center

The Department has developed a wide variety of relationships with other federal, state and local government agencies. These partnerships enhance the department's ability to provide essential health, safety, support and social services to the people of Maine. Specific information for each office or program area can be found in the sections below.

The Department serves a wide variety of constituencies including the general public, individuals who meet eligibility criteria for programs and services, and the regulated entities and individuals pursuant to statutory authority.

Percent Change in Population			
	2020-2025	2025-2030	2020-2030
Age 0-19 years	-7.4%	-2.3%	-9.5%
Age 20-39 years	1.5%	-3.5%	-2.0%
Age 40-64 years	-4.7%	-3.0%	-7.6%
Age 65+ years	17.6%	15.8%	36.2%

Emerging Issues

Despite an increase to Maine's minimum wage and higher entry level salaries, many Maine families continue to experience economic insecurity. As of December 2024, over 72,000 families in Maine lived below 200 percent of the Federal Poverty Level.

Maine also faces demographic challenges as Maine's prime working-age population (age 20-64) is projected to decrease by 5.3 percent from 2020 to 2030, as the Baby Boom generation continues to age out of the workforce. The number of people aged 65 and older is expected to grow by 36.2 percent from 2020 to 2030 as the youngest Baby Boomers age into retirement. Because Demographic data[1] projects a shrinking workforce and an increasing older Maine population, DHHS has and is working on ways to support continued services for our population.

On December 29, 2025 the State of Maine received official notification from the U.S. Centers for Medicare & Medicaid Services (CMS) of a $190 million award for Year 1 of the federal Rural Health Transformation Program (RHTP). The award period spans from December 29, 2025, through October 30, 2026, and will support Maine's efforts to expand access to care, improve population health, strengthen the rural health workforce, advance technology and data integration, and promote the long-term sustainability of rural health

1 in 3 Mainers is served by DHHS

- Nearly 400,000 people are enrolled in some level of coverage through MaineCare (Medicaid)
- Over 170,000 people receive food assistance through the Supplemental Nutrition Assistance Program (SNAP)
- Over 4,000 children receiving care through the child care affordability program
- Supported over 6,700 individuals in accessing substance use disorder treatment in 2024

Data is a snapshot from September 2025 unless otherwise noted

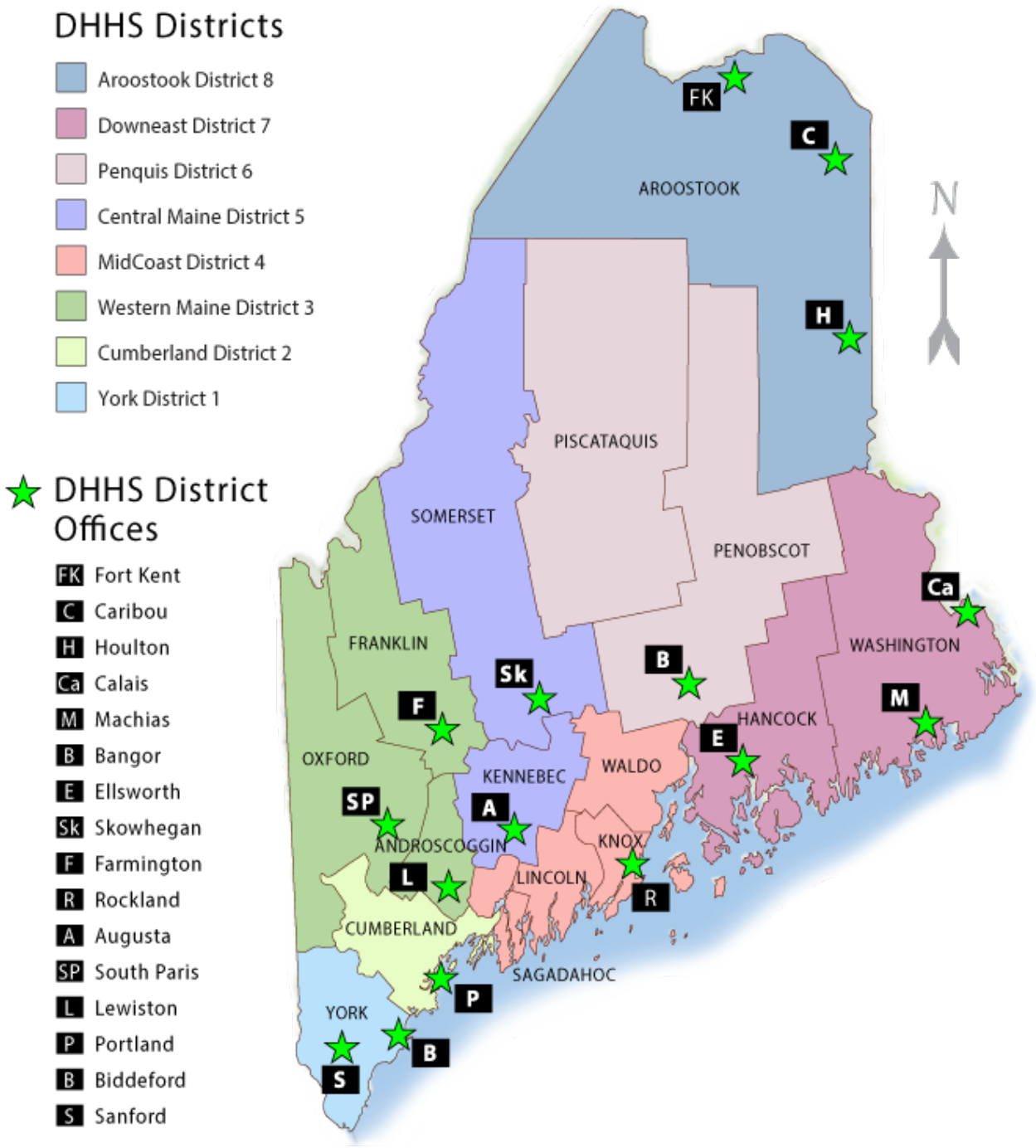
[1] Maine Population Outlook 2020-2030 Office of State Economist: https://www.maine.gov/dafs/economist/sites/maine.gov.dafs.economist/files/inline-files/Maine%20Population%20Outlook%20to%202030_0.pdf

systems statewide. The RHTP was created within the Federal budget reconciliation bill, H.R. 1, signed into law on July 4, 2025. The law makes significant and permanent cuts to health care funding, which are expected to increase the number of uninsured individuals and costs to provide health care over the next several years, particularly in rural areas. Funding provided by the RHTP is likely to be only a fraction of the $5 billion that Maine is estimated to lose under the law.

The Mills Administration has created or reinstituted Cabinet-level groups that break down silos in state government and help find better solutions for Maine people. In partnership with the Office of Policy Innovation and the Future, DHHS participates in and chairs the Children's Cabinet, which meets with the goal of helping all young Maine children enter kindergarten prepared to succeed and all of Maine's youth to enter adulthood healthy and connect to workforce opportunities and/or education. DHHS also participates in and co-chairs the Cabinet on Aging, which strives to help all older Maine residents get and maintain the supports they need as they age.

DHHS has partnered with other state agencies to recruit, train and support more people to work in health care through marketing campaigns like Careers with Purpose and the creation of training portals like Healthcare Training for ME. A snapshot of major DHHS workforce initiates can be found here. The Department remains committed to the continued work with all our statewide partners to address the complex challenges faced by the State of Maine.

To learn more about who the Department serves and other metrics of engagement, utilization, and impact, you can visit the DHHS By The Numbers Dashboard at www.maine.gov/dhhs/by-the-numbers.


DHHS Districts
Aroostook District 8
Downeast District 7
Penquis District 6
Central Maine District 5
MidCoast District 4
Western Maine District 3
Cumberland District 2
York District 1
DHHS District Offices
FK Fort Kent
C Caribou
H Houlton
Ca Calais
M Machias
B Bangor
E Ellsworth
Sk Skowhegan
F Farmington
R Rockland
A Augusta
SP South Paris
L Lewiston
P Portland
B Biddeford
S Sanford
AROOSTOOK
PISCATAQUIS
SOMERSET
PENOBSCOT
FRANKLIN
WASHINGTON
HANCOCK
OXFORD
KENNEBEC
WALDO
ANDROSCOGGIN
KNOX
LINCOLN
CUMBERLAND
SAGADAHOC
YORK
N

Commissioner's Office

The DHHS Commissioner's Office oversees all work across DHHS Offices and provides guidance and support across all programs, contracts, and DHHS staff.

Enabling Legislation
In accordance with 22-A M.R.S. § 204, the Department is under the control and supervision of the Commissioner of Health and Human Services. The scope of the Commissioner's powers and duties are outlined with 22-A M.R.S. § 205 – 208, including the power to "distribute the functions and duties given to the commissioner . . . among the various offices of the department so as to integrate the work properly and to promote the most economical and efficient administration of the department." Accordingly, the Commissioner's Office is established to support the work carried out across the Department.

Program Descriptions
The Commissioner's Office is committed to providing the highest quality services to the people of Maine and ensuring support and safety to every DHHS employee. In addition to providing guidance and coordination between all DHHS offices, the work of the Commissioner Office is structured around four areas:

<u>Staff Support</u>
- Set common expectations and training across all Offices to create common culture and work toward goals
- Implemented permanent telework policy
    - Implementing strategies for an inclusive work culture and engagement

<u>Operational Support</u>
- Dedicated staff to support Offices in hiring, contracting, budgeting, management

<u>Communication and Engagement</u>
- Issue frequent press releases, created a blog, and overhauled website
- Created Department wide and Office-specific data dashboards
- Improved constituent services, stakeholder engagement, and FOAA process

<u>Initiatives and Special Projects</u>
- Deployment of leadership time and specialized staff to coordinate and support high priority, urgent, or complicated work

The Commissioner's Office employs 169 individuals and includes the Commissioner, Deputy Commissioners, Policy and Communications Advisors, special program staff including research and evaluation, cross-office coordination, workforce development, operational excellence, as well as several additional units including: administrative hearings, contract management, budget, audit, and human resources (in partnership with DAFS). These individuals and teams support and augment work across the Department to ensure efforts are cohesive and coordinated to the greatest extent possible.

Recognizing the shared responsibility that all people and programs have to keep children safe by keeping families strong, the Commissioner's office is home to the special projects manager for child and family well-being. This position has provided collaborative leadership with state and community partners toward the development and implementation of the Child Safety and Family Well-Being Plan.[2] This work is a key public-private partnership between Maine DHHS and the Maine Child Welfare Action Network.

Coordination with State and Federal Agencies
The Commissioner's Office is responsible for coordinating policy and program efforts between the entities within state government and DHHS related matters with the Federal government.

Within state government, the Commissioner's Office frequently coordinates with the Governor's Office, the Office of the Attorney General, the Maine Department of Administrative and Financial Services, the Maine Department of Professional and Financial Regulation, the Maine Department of Labor, the Maine Department of Corrections, the Maine Department of Public Safety, and the Maine Department of Education.

The Commissioner's Office also monitors Federal law and policy to create and execute state plans and ensure compliance with federal changes.

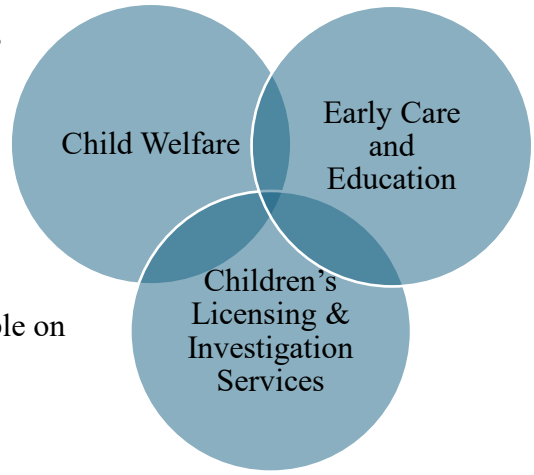
[2] https://www.maine.gov/dhhs/programs-services/human-services/child-safety-and-wellbeing-plan

Office of Child and Family Services

The Office of Child and Family Services supports Maine's children and their families by: regulating child care facilities and providers; assisting Maine families in accessing and paying for child care; and administering Maine's child welfare system, including overseeing fostering and adoption services.

Enabling Legislation
The enabling legislation that applies to the programs and services provided by the Office of Children and Family Services is 22-A M.R.S. § 203(1)-(2).

Program Descriptions
The Office of Child and Family Services is committed to supporting the safety, stability, happiness and health of all Maine Children and Families. The Office operates around the guiding principles that child safety is our first priority, that parents have the right and the responsibility to raise their children, that children deserve to live in a safe and nurturing family, that all children deserve a permanent family and that how OCFS does our work is as important as the work we do.



OCFS currently employs over 850 people, including staff within Central Office and 14 regional offices within the 8 districts statewide. OCFS organizational charts are available on the Office's website, here: https://www.maine.gov/dhhs/ocfs/about-us.

The Office is made up of several different service areas:

Child Welfare – Staff in this division work to support safety, well-being, and permanent homes for children. They work with professionalism and respect the dignity of all families. Child abuse reports are investigated on behalf of Maine communities, working to keep children safe and to guide families in creating safe homes for children.

Under Child Welfare, the Department is statutorily required (22 M.R.S. §4004(2)) to *"act to protect abused and neglected children and children in circumstances that present a substantial risk of abuse and neglect, to prevent further abuse and neglect, to enhance the welfare of these children and their families and to preserve family life wherever possible."* In furtherance of this requirement, OCFS:

- Receives reports of alleged abuse and/or neglect, screening each report to determine which are appropriate for investigation based on OCFS' governing statues, rules, and policies.
- For reports deemed appropriate for investigation, conducting a comprehensive investigation of the allegations in the report and any additional allegations uncovered through the investigation. At the conclusion of the investigation, a determination is made that abuse and/or neglect is unsubstantiated, indicated, or substantiated.

- OCFS may file court action to obtain custody of a child when necessary to ensure the safety of the child while safety concerns are ameliorated. OCFS may also file court action to compel the family to engage in services without removal of the child. In both types of cases the Department works to help children obtain safety, stable, and permanent homes.
- When a child is ordered into the Department's custody by the Maine District Court, OCFS provides services including a Rehabilitation and Reunification Plan, monthly contacts with case participants, Family Team Meetings, service provision and monitoring, visitation, etc. The goal is most often to reunify the child with their family of origin, but other permanency options include adoption and permanency guardianship. OCFS seeks to place children removed from their homes with kin whenever possible and seeks to minimize the use of congregate care settings. Maine has historically had one of the lowest, if not the lowest, rate of use of congregate care for children in state custody in the nation.
- OCFS provides specialized support for older youth in care and youth who have turned 18 while in state custody. Specialized Youth Transition Staff provide support, access to services and resources, etc. Maine was one of the first states in the nation to voluntarily expand eligibility for voluntary extended care beyond the federally required age of 21. Youth in Maine who turn 18 in custody are now eligible to engage in the voluntary extended care program up to age 23.

Early Care and Education (ECE) – The Early Care and Education team manages the Child Care Affordability Program (CCAP) that helps eligible families pay for child care so they can work, go to school, or participate in a job training program. This team also manages other services and supports related to early childhood, including the ECE Consultation for ME Program, First4ME, and the Preschool Development Grant (PDG). (see ECE Annual Report for additional details[3]):

- The Child Care Affordability Program (CCAP) – Enhances the accessibility and quality of early childhood education and care to Maine families.
- Child Care Infrastructure Grants – $15 million of federal funding designated by Governor Mills in the Maine Jobs and Recovery Plan[4] to provide grants to current child care programs to expand capacity and for new providers to establish a child care program.
- Head Start – OCFS contracts with 11 Head Start grantees using state funds to support increased access to Early Head Start for infants and toddlers.
- ECE Consultation for ME Program – Formerly known as ECCP, this program is an infant and early childhood mental health consultation program that helps child care providers, educators, and caregivers of young children build an understanding of the social-emotional needs of young children and develop the skills to meet those needs.
- Help Me Grow – A free informational service linking families and professionals to information about child development, pregnancy, and community resources for children and families. The intent is to strengthen knowledge of the services available for children and families statewide and build connections between families and service providers.

[3] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/ECE%20Annual%20Report%20FFY23-24%20Final.pdf
[4] https://www.maine.gov/jobsplan/

- Parent Ambassador Program – A 12-month intensive parent empowerment and advocacy training provided through Kennebec Valley Community Action Program (KVCAP) and Educare Central Maine.
- Early Childhood Educator Workforce Salary Supplements – A tier system of salary supplements for individuals working in licensed child care programs that incentivizes (through increased payments) the advancement of the workforce's education and experience.
- Child Care Employment Award – Working in tandem with CCAP, the employment awards provide a workplace benefit for staff working licensed child care programs by covering the cost of child care for their children.
- Maine Roads to Quality (MRTQ) – The State's professional development network for early childhood and out-of-school time professionals as they seek to expand their expertise and ability to provide high-quality care.
- Rising Stars for ME – Maine's Quality Rating and Improvement System (QRIS) which is designed to increase awareness of the basic standards of early care and education, recognize and support early care and education programs in providing care above and beyond the basic standards, educate the community about the benefits of higher quality care, and provide the community with identifiable standards of quality among programs.
- Childcarechoices.me – A comprehensive online resource for families providing information and resources on licensed child care providers, the Rising Stars for ME rating of programs, the importance of high-quality care and education, etc.
- Preschool Development Grant – Maine is the recipient of this federal grant intended to improve the early child care and education mixed delivery system to support the Governor's Children's Cabinet goal that all Maine children enter kindergarten prepared to succeed.
- Baxter Child Care Management System – Brings together Child Care Licensing and CCAP into one unified system to decreasing processing times and increase approval turnaround for child care programs and families. Through Baxter providers can electronically submit licensing applications and information, receive CCAP payments, etc. Parents can use the system for apply for and administer CCAP benefits.

Children's Licensing and Investigation Services (CLIS) – This specialized team licenses, monitors, and investigates child care programs, children's residential facilities, child placing agencies, emergency children's shelters, and homeless shelters for youth. This program conducts out-of-home child abuse and neglect investigations in a wide array of settings that are licensed and funded by the Department. The program also conducts investigations in collaboration with or on behalf of other State Departments.

- Child Care Licensing – Ensures compliance with state and federal laws and regulations regarding child care programs, including federally required fingerprint-based background checks for staff of child care programs.
- Children's Residential Licensing – Licenses and oversee children's residential programs statewide, ensuring compliance with state and federal requirements including the congregate care provisions of the Family First Prevention Services Act.

Violence Intervention and Response Program (VIRP) – This team is responsible for administering federal grants and overseeing statewide contracts for violence prevention services

(including domestic violence and sexual assault services) as well as managing the Sexual Assault Forensic Examiner (SAFE) program. The VIRP plans, monitors, and evaluates the delivery of violence prevention services statewide including programs, policies, and resource allocations. Within this program there are two main entities:

- Maine's Federal Victims of Crime Act (VOCA) funding administrator – Supports service delivery for victim assistance efforts through contracts with Maine's statewide domestic violence and sexual assault coalitions. Services include support groups, hotlines, statewide needs assessments, free civil legal assistance to victims, specialized forensic interviews for child victims of sexual abuse, and victim advocacy. In the last fiscal year VOCA funds supported services for 35,000 victims and survivors.
- Sexual Assault Forensic Examiner (SAFE) Program – Provides education, training, and technical assistance for health care providers that care for patients who have been subjected to sexual assault, domestic violence, child sexual abuse, and dependent adult abuse/neglect.

OCFS uses multiple performance measures to measure its progress in achieving the goals and objectives. We maintain a data dashboards for ECE[5] and Child Welfare[6] which provide real-time tracking of important metrics.

Within the ECE program the metrics involve the number of children served, the number of licensed providers by county and Rising Stars for ME rating, the number of children served by CCAP and number of those children being served in high quality programs. The child welfare dashboard measures key metrics like the number of children in care, safety of children in care, the rate of children achieving permanency within 12 months, the rate of success in permanency, etc.

The Child Welfare Division is also subject to extensive oversight in achieving key federal metrics and statewide goals and objectives. The details of all such oversight were compiled in a January 2022[7] report from the Office of Program Evaluation and Government Accountability. Individuals specified in 22 M.R.S. §4011-A are required to file mandated reports with OCFS when they know or have reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. In 2024 OCFS received 29,656 reports to its Child Protection Intake. Of these reports, 29 percent (8,729) were deemed appropriate for investigation. OCFS is unable to predict the number of reports that will be received in the coming years, although the average has been between 25,000 and 30,000 per year typically.

OCFS has streamlined the reporting process for categories of professionals who report most frequently (law enforcement, medical providers, and educators/schools) by implementing a Mandated Reporter Portal (MRP) which can be used to submit reports electronically. Furthermore, OCFS has worked to strengthen and streamline the phone system for those who are not eligible to use the MRP or may prefer to make a report by phone.

[5] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/early-childhood-education
[6] https://www.maine.gov/dhhs/ocfs/data-reports-initiatives/child-welfare
[7] https://legislature.maine.gov/doc/7924

Any individual seeking to be licensed via OCFS is required to submit an application to the appropriate OCFS division. Resource parents are licensed via the Child Welfare Division while child care providers, children's residential providers, homeless shelters that serve youth, child placing agencies, etc. are licensed via CLIS. Each type of license is governed by applicable rules promulgated per the APA and is subject to renewal by the provider at regular intervals. There are presently 1,361 licensed child care providers statewide.

Coordination with State and Federal Agencies

OCFS works with our federal partners on various types of oversight. This includes regular audits of the Child Care Affordability Program, specialized ad-hoc audits within child welfare, the Child and Family Services Review (CFSR), the accompanying Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR). Reports from these audits and reviews provide consistent ongoing monitoring of OCFS' performance and important aspirational reference points for key measures. Furthermore, OCFS' Child Welfare division is also subject to oversight from the Maine Child Welfare Ombudsman Program[8] and three federally-required Citizen Review Panels – the Maine Child Welfare Advisory Panel (MCWAP), the Child Death and Serious Injury Review Panel (CDSIRP), and the Justice for Children Taskforce.

Each of these entities reports quarterly to the Health and Human Services Committee of the Maine Legislature and produces annual or bi-annual reports with findings and recommendations. OCFS also reports quarterly to the Health and Human Services Committee.

The Office of Child and Family Services regularly coordinates with a significant number of state and federal government partners, as well as community-based organizations. This includes, but is not limited to the:

- Child Death and Serious Injury Review Panel
- Child Welfare Ombudsman
- Maine Department of Corrections
- Federal Administration for Children & Families and Head Start
- Maine Child Welfare Action Network
- Maine Child Welfare Advisory Panel
- Maine Children's Cabinet
- Maine State Police/Child Protective Services
- Preschool Development Grant
- Public Health Nursing Program
- Maine Department of Education
- U.S. Department of Justice's Office for Victims of Crime related to funding, federal laws and regulations, etc.

Furthermore, OCFS' Child Welfare division has a relationship with the Wabanaki Nations of Maine, working together to uphold the requirements of the Federal and Maine Indian Child Welfare Acts.

[8] https://cwombudsman.org/

OCFS works cooperatively with multiple providers to ensure comprehensive and cohesive service delivery across each of its divisions. Within ECE this includes working together with child care providers to support them through licensing, financial support, and professional development services. OCFS contracts for both its Professional Development Network and its Quality Rating and Improvement System. The Cutler Institute at the University of Southern Maine holds the contracts for both of these services. Within Child Welfare OCFS has a specific statutory mandate to carry out much of the direct work related to the intervention of child welfare services in the lives of families (including receiving reports, investigating appropriate reports, seeking court orders to remove children or compel services, engaging in reunification efforts, etc.)

OCFS contracts with providers for related services such as supervised visitation between children in care and their parents; transportation; resource parent recruitment, training, and support; and staff training. These contracts are held by various community agencies. All of the work within CLIS is performed internally. VIRP staff facilitate contracts with Maine's sexual assault and domestic violence coalitions and funding for various services primarily flows through these contracts to individual community providers who deliver services as required per the contracts.

Emerging Issues

At present, OCFS leadership is focused on specific initiatives to improve child welfare services across the state. Recognizing the importance of input and collaboration, OCFS has engaged extensively with community partners, legislators, OCFS staff, the DHHS Commissioner's Office, and external stakeholders like the Public Consulting Group (PCG), to identify and address the most pressing issues related to ensuring that all of Maine's children and families have the conditions to be safe, stable, happy, and healthy.

As part of this effort, OCFS produced a 2025-2027 Strategic Plan that can be found here.[9] The Strategic Plan provides an overview of the four program units of OCFS: Child Welfare, Early Care and Education, Children's Licensing, and the Violence Intervention and Response Program. Within each section, OCFS sets forth its primary objectives, strategies, and outcomes for the two-year period. In Appendix B. OCFS provides detailed responses to hundreds of recommendations that were received with respect to child welfare improvements. Some, but not all, of the issues OCFS has a plan to address include:

- Recruit and Retain Case Aides: As with many sectors across the human services continuum, recruiting and retaining a workforce continues to be a challenge. To address burnout, turnover, vacancies, and workload, OCFS has undertaken several initiatives to both directly and indirectly address this specific issue. This includes increasing the pay for casework and supervisory positions, establishing Supervisor Training positions to support the onboard and training needs of new and more tenured staff, strengthening the internal management structure and support for frontline staff both through a reorganization of the child welfare division and a comprehensive review of decision-making processes at all levels of OCFS, and establishing ongoing discussion between

[9] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/OCFS%20Strategic%20Plan%20%282025-2027%29%20Final%2008042025_.pdf

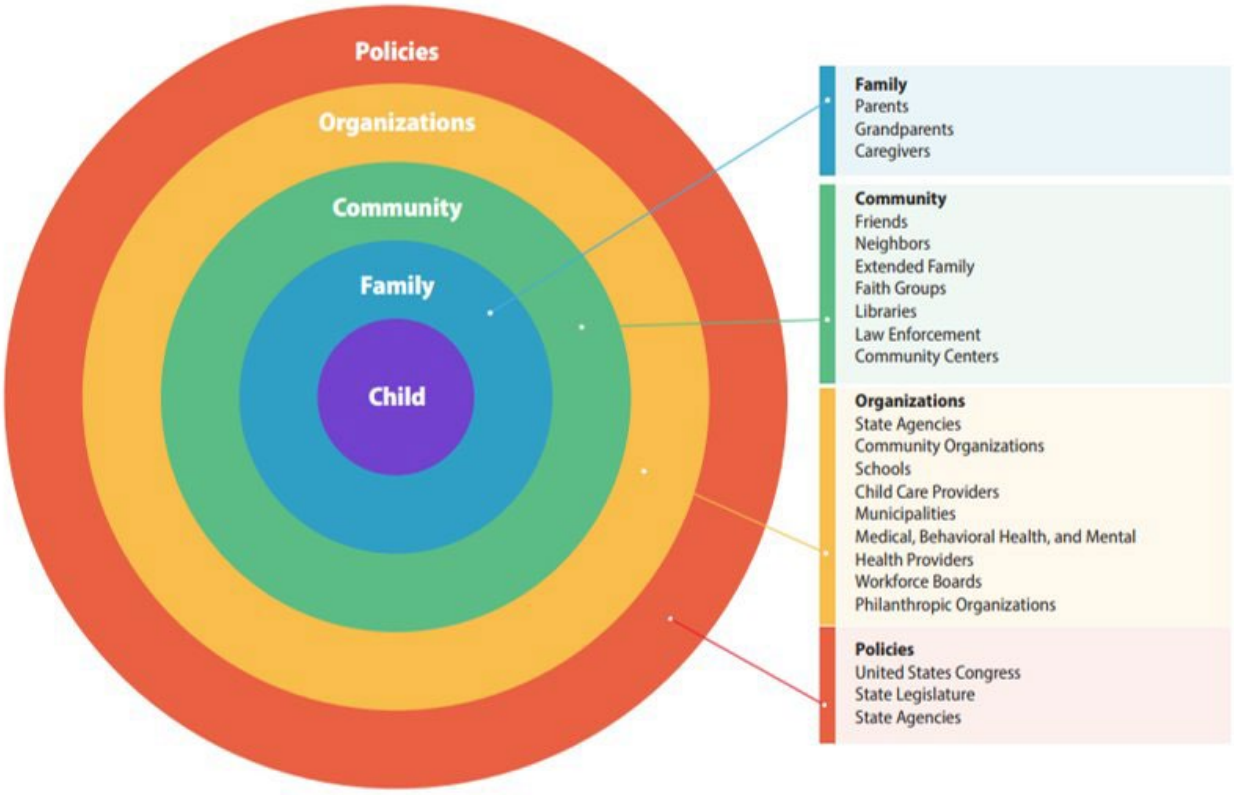
child welfare leadership and frontline staff. These efforts have already decreased the vacancy rate by roughly 50 percent and will remain ongoing.

- Service Improvements: One of the most consistent pieces of feedback that has been received from a slate of stakeholders is related to the use of hotels and hospital emergency departments (ED) as temporary placement. To ensure placement options exist outside of these two locations, OCFS hired a dedicated hotel and ED coordinator and is engaged in the national dialogue regarding this topic which is being experienced in jurisdictions throughout the country. The Department continues to explore solutions through partnerships with other offices, including the Maine Center for Disease Control, the Office of MaineCare Services, and the Office of Behavioral Health so strengthen the continuum of community-based and residential supports in Maine for children and youth. OCFS has built a team of community sitters to provide coverage in hotels and EDs, stood up an intensive short term foster home model, and is working with partners to create resources to meet the needs of youth in care in need of behavioral and mental health supports.

  OCFS understands and shares in the urgency to address this ongoing concern, and will continue its robust engagement with local, state, and national partners to be responsive to this recommendation.

- Prevention: In partnership with the Maine Child Welfare Action Network, the Department has developed the Maine Child Safety and Family Well-being Plan.[10] Rooted in the guiding principle that "we can keep children safe by keeping families strong," the plan serves as both a theory of change and a call to action. Everyone – from state agencies and community organizations to neighbors, friends, professionals, can support families in some fashion. By supporting families earlier, we can create the conditions for strong families and limit the need for involvement by OCFS.

[10] https://www.maine.gov/dhhs/programs-services/human-services/child-safety-and-wellbeing-plan



Led by the Special Project Manager for Child and Family Well-being out of the Commissioner's Office, the Plan continues to evolve with ongoing cross-office and cross-departmental collaboration. These efforts are also coordinated with the work of the Children's Cabinet in the Governor's Office.

Consequently, in July 2024, the Maine Child Welfare Action Network and DHHS launched the Be There for ME website and campaign. Designed to support parents and caregivers in Maine, Be There for ME aims to reduce the stigma of asking for help and provides a judgement-free place to find support. The campaign was developed in partnership with a diverse group of parents and caregivers, as well as many community organizations. As a result, the campaign reflects the type of support parents and caregivers of children of all ages said they need and how they spoke about their experience. Both the Child Safety and Family Well-being Plan and the Be There for ME campaign and website will continue to evolve and be responsive to emerging issues.

- **National Best Practices:** In 2021, Collaborative Safety recommended that OCFS should examine national best practices for assessment timeframes to ensure that whatever timeframe is selected, it is compatible with expected workload. In response, OCFS convened a stakeholder group made up of staff from throughout OCFS to advise on the timeframe to complete investigations as well as other components of investigation practice. The investigation policy was updated in 2023, and it extended the investigation timeframe to 45 days to better align with workload expectations.

  In July 2024, the Biden administration released guidance that states should update their definitions of abuse and neglect to differentiate between financial inability to provide

adequate housing or other material needs, OCFS was pleased to support[11] LD 1406, An Act to Amend Certain Definitions in the Child and Family Services and Child Protection Act, in the first regular session of the 132nd Legislature. This bill, signed in law by Governor Mills,[12] decoupled poverty with Maine's definition of abuse and neglect clarifying that a child's needs are willfully withheld.

Another recommendation that has been received is to look at national best practices for how training should occur on basic foundational topics throughout the staffs' tenure, and that training for staff should be aligned with national best practices. OCFS continues to work closely with the Catherine Cutler Institute at the University of Southern Maine (USM) to develop staff training. USM's contract requires them to evaluate national best practices as part of this process.

OCFS remains committed to being responsive to each recommendation it has received related to all program areas. The Office strives to continue its engagement with all stakeholders, including those at the national level, to inform and guide current and future best practices.

[11] https://legislature.maine.gov/backend/app/services/getDocument.aspx?doctype=test&documentId=188717
[12] https://legislature.maine.gov/backend/App/services/getDocument.aspx?documentId=119621

Office for Family Independence

The Office for Family Independence (OFI) connects Maine families to services and programs. OFI determines initial and ongoing eligibility for the MaineCare (Medicaid), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) public assistance programs and issues benefits for SNAP and TANF. Through the ASPIRE, SNAP Employment & Training (E&T), and HOPE programs OFI helps eligible individuals meet their long-term employment and education goals. The Office also provides transitional and short-term assistance and oversees and provides funding for municipal General Assistance (GA) programs. The Division of Support Enforcement and Recovery (DSER), Maine's child support agency, helps families establish paternity, locate parents, and determine, enforce, and collect on child support obligations. Additionally, in partnership with the federal Social Security Administration, Disability Determination Services (DDS) makes decisions on medical eligibility for federal Social Security and Supplemental Security Income disability benefits.

Enabling Legislation
The enabling legislation that applies to the programs and services provided by the Office for Family Independence is 22-A M.R.S. § 203(1).

In addition, OFI's programs and services are authorized by and guided by the following federal and state laws and regulations.

Division of Support Enforcement and Recovery (DSER)

Title IV, Part D, of the Social Security Act (P.L. 93-647)
The Child Support Enforcement Amendments of 1984 (P.L. 98-378)
The Family Support Act of 1988 (P.L. 100-485)
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193)
The Child Support Performance and Incentive Act of 1998 (CSPIA) (P.L. 105-200)
Child support provisions in the Deficit Reduction Act of 2005 (P.L. 109-171)
Title 19-A, Maine Revised Statutes
Code of Maine Rules, 10-144 C.M.R., Chapter 351, Maine Child Support Enforcement Manual

Disability Determination Services (DDS)

Section 221(a) and 1633 of the *Social Security Act*

General Assistance (GA)

22 M.R.S. § 4323
Code of Maine Rules, 10-144 C.M.R., Chapter 323, General Assistance Manual
20 CFR 404-1603

MaineCare (Medicaid) Eligibility

Title XIX of the Social Security Act, section 1902
42 CFR § 431.10
Code of Maine Rules, 10-144 C.M.R., Chapters 332 – 336, MaineCare Eligibility Manual

Supplemental Nutrition Assistance Program (SNAP)

7 U.S.C. § 2013 (a)(1)
22 M.R.S. § 3104(1)
Code of Maine Rules, 10-144 C.M.R., Chapter 301, Supplemental Nutrition Assistance Program Rules and Chapter 609, SNAP E&T Program Rules

Temporary Assistance for Needy Families (TANF)

Title IV, Part-A of the *Social Security Act*
Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193 enacted August 22, 1996

Program Description

The Office for Family Independence connects Maine residents to services and programs that foster health, safety, resilience, and opportunity to help people meet a wide variety of needs. OFI is comprised of three divisions: Eligibility, Child Support, and Disability Determinations. The Office is led by a Director, with a Chief Operating Officer, multiple Associate Directors, Program Managers, and Program Administrators who are located statewide. There are 913 positions at OFI of which 800 were filled as of August 31, 2025. The central office unit provides support to the Department's 16 regional offices as well as managing policy and program functions and monitoring benefit distribution through quality assurance, investigations, and recovery operations. OFI provides integrated eligibility for MaineCare, SNAP, and TANF, Employment and training programs, and oversight and support for the Municipal General Assistance Program:

Disability Determination Services (DDS)

Disability Determination Services processes disability claims on behalf of the Federal Social Security Administration. Performance requirements are established by federal requirements and failure to meet those may result in corrective action.

Division of Support Enforcement and Recovery (DSER)

The Division of Support Enforcement and Recovery helps establish, enforce, and collect child support payments, locate parents, and establish paternity. Performance requirements are established by federal requirements and failure to meet those may result in corrective action up to funding cuts.

General Assistance (GA)

General Assistance is a municipally administered and statutorily required program that helps individuals and families to meet their basic needs. This may include help paying for housing, household and personal items, food, fuel and utilities, medical and burial costs. Performance requirements and corrective action procedures are established by statute.

MaineCare Eligibility

MaineCare (Medicaid) provides free and low-cost health insurance to Mainers who meet certain requirements, based on household composition and income. There are also additional options for people with disabilities and certain health conditions and those who need long-term care. OFI

manages eligibility and enrollment for MaineCare and the Office for MaineCare Services (OMS) manages MaineCare benefits. MaineCare is funded through state contributions with a federal matching percentage. MaineCare performance requirements are established by federal requirements and failure to meet those may result in corrective action up to financial penalties on the state.

Temporary Assistance for Needy Families (TANF)
TANF provides cash assistance to families while they work towards becoming self-sufficient. TANF is funded through a federal block grant with state maintenance of effort contributions. Additional Support for People in Retraining and Employment (ASPIRE) helps TANF participants move towards financial independence through case management, job training, education, support, and employment services. Parents as Scholars (PaS) is a monthly benefit through TANF that helps parents working through a two- or four-year degree-granting education program. Alternative Aid Assistance helps TANF eligible parents who need short term help to find or maintain employment and Emergency Assistance (EA) provides benefits during emergency situations. TANF block grant funding also supports statewide contracted Whole Family Services and the Higher Opportunity for Pathways to Employment (HOPE) Program which supports parent-students in accomplishing their education goals leading to employment.

TANF performance requirements are established by federal requirements and failure to meet those may result in corrective action steps up to financial penalties on the state.

Supplemental Nutrition Assistance Program (SNAP)
SNAP helps low-income households buy nutritious food through an electronic benefits transfer (EBT) card. Maine SNAP-Education provides nutrition education services with helpful information on how to eat healthy on a budget. SNAP Employment and Training (E&T) helps connect SNAP participants with job training and education. The majority of these benefits are 100 percent federally funded and the State pays a portion of the administrative costs. SNAP

performance requirements are established by federal requirements and failure to meet those may result in corrective action up to financial penalties on the state.

SUN Bucks
The Summer EBT program provides families with a one-time benefit each year to buy healthy food for eligible children during school vacation

OFI's services and program benefits are available to those who apply and meet the eligibility criteria for various benefit programs. Eligibility for the varying benefits and services are program dependent and are based on federal and statutory requirements and those established in program rules.

OFI utilizes alternative delivery systems by contracting with vendors for certain activities. Current vendors include:

- University of Massachusetts for medical review decisions utilized for MaineCare eligibility
- Community Action Agencies to provide TANF-funded Whole Family Services
- Fedcap to provide services for the TANF Employment and Training Program and Additional Support for People in Retraining and Employment (ASPIRE)
- Jobs for Maine Graduates to provide student navigator services for Higher Opportunity for Pathways to Employment (HOPE) and Parents as Scholars (PaS) participants
- Multiple community agencies to provide SNAP Employment and Training Services and Outreach.

In order for individuals to receive OFI program benefits or services an application is required. There is a general OFI application for all programs and alternative versions that limit the program being applied for. These are available in print paper format or can be submitted using OFI's online portal, My Maine Connection.[13] GA applications are available and processed by individual municipalities within the state.

Coordination with State and Federal Agencies
OFI regularly collaborates with local, state and federal partners, including but not limited to:

- Offices across Maine DHHS
- Community Colleges
- Maine Department of Education
- Maine Department of Labor
- Maine Municipal Association
- Maine Welfare Director's Association
- MaineCare Advisory Council
- Municipal General Assistance Programs
- State Nutrition Action Council
- Statewide Communication Action Agencies
- TANF Advisory Council
- University of Maine System

[13] https://www.mymaineconnection.gov/benefits/s/?language=en_US

Emerging Issues
Given the constant pace of policy changes at the state and federal levels, OFI continues to have significant staffing and technology needs. We anticipate those needs will continue in the future. In order to ensure the Office balances compliance, access, and customer service functions, OFI consistently evaluates staffing needs and new technology offerings that comply with state and federal laws to best provide services for over a third of the state's population.

Individuals seeking supports through OFI routinely report that providing their information multiple times to multiple entities creates a burden. To address this, OFI has developed the SupportLink Program that will allow information exchange with approved agencies in Maine in order to assist individuals and families in finding other services or benefits they may be eligible for and to help in verifying eligibility for them.

Division of Licensing and Certification

The Division of Licensing and Certification (DLC) oversees the safety and quality of medical and long-term care facilities, manages the Certified Nursing Assistant (CNA) registry, conducts background checks for health care staff, and investigates reports of unsafe practices in facilities like hospitals, nursing homes, assisted living, and group homes.

Enabling Legislation
The Division of Licensing and Certification operates under a dual regulatory framework that includes both federal and state laws, depending on the type of facility or program being licensed or certified. In many cases, DLC is responsible for enforcing both sets of standards concurrently, particularly in federally certified health care facilities.

The authority of the Division of Licensing and Certification is established in and guided by several state statutes, including:

- Adult Day Service Programs- 22 M.R.S. § 7801
- Ambulatory Surgical Facilities- 22 M.R.S. §§ 1812-E, 1815
- Assisted Living and Assisted Housing -22 M.R.S. Chapters 1661, 1663,1664, 1666, 1666-B; and 22 M.R.S. § 3173; 22-A M.R.S. § 205 (2)
- Behavioral Health Organizations - 5 M.R.S. §§ 20001-20007(A), 20024; 22 M.R.S. §§ 42 (1), (1-A), 1501-1507, 7801-7807, 8001-8005; 22-A M.R.S. § 205 (2); 34-B M.R.S. §§ 1203-A, 3603
- Certificate of Need - 22 M.R.S. §§1, 3, 42(1), 312, 342; 5 M.R.S. § 8054
- Certified Nursing Assistant and Direct Care Worker Registry - 22 M.R.S. §§ 42, 1812-G; 42 CFR §§ 483, 488
- Employee Assistance Programs - 26 M.R.S. § 683
- End Stage Renal Disease Units/Facilities - 22 M.R.S. §§ 2041-2042
- Home and Community Support Service Agencies - 22 M.R.S. § 42, 34-B M.R.S. §§ 1203-B, 5605
- Home Health Care Agencies and Services - 22 M.R.S. §§ 42, 2141-2148, 7931 et seq.
- Hospitals - 22 M.R.S. Chapter 405; 22 M.R.S. § 42; 22-A M.R.S. § 205
- Hospice Programs - 22 M.R.S. §§ 8621-8631
- Intermediate Care Facilities - 22 M.R.S. §§ 42, 1812-K (2)
- Maine Background Check Center - 22 M.R.S. Chapter 1691
- Maine Medical Laboratories (“CLIA”) - 22 M.R.S. Chapter 411 and § 42; 22-A M.R.S. § 205
- Personal Care Agencies - 22 M.R.S. §§ 1717, 1723
- Portable X-ray Services - 22 M.R.S. § 674
- Skilled Nursing Facilities and Nursing Facilities (Long Term Care) - 1 M.R.S. §§ 401, 402, 407, 408; 22 M.R.S. §§ 3, 6, 42, 47, 1811-1818, 1820, 1822, 1824-1830, 3477-3479, 7921-7925, 7931-7938, 7941-7949, 8551-8552; 32 M.R.S. §§ 61, 7905; 5 M.R.S. § 1; 22 M.R.S. § 802; 22 M.R.S. § 7944
- Sentinel Events - 22 M.R.S. Chapter 1684; 22 M.R.S. § 42; 22-A M.R.S. § 205
- Temporary Nurse Agencies - 22 M.R.S. Chapters 417 and 417-A.

The primary source of federal authority is the Centers for Medicare & Medicaid Services (CMS), under the U.S. Department of Health & Human Services. DLC acts as the designated State Survey Agency for Maine, implementing the federal regulatory requirements found in:

- 42 CFR Part 482 – Conditions of Participation for Hospitals
- 42 CFR Part 483 – Requirements for Long-Term Care Facilities (e.g., Skilled Nursing Facilities and Nursing Homes)
- 42 CFR Part 491 – Certification of Rural Health Clinics
- 42 CFR Part 493 – Clinical Laboratory Improvement Amendments (CLIA)
- Social Security Act (Title XVIII and XIX) – Governing Medicare and Medicaid participation

These regulations establish uniform national standards related to patient safety, quality of care, staff qualifications, emergency preparedness, and more.

- State Laws and Regulations - DLC is also responsible for enforcing state-specific licensing rules as authorized by Maine law, including:
- Title 22 of the Maine Revised Statutes – Health and Welfare statutes that govern licensing of health care and residential care facilities, home health agencies, assisted housing programs, and other care settings.
- State Rules (10-144 CMR Chapters) – Implementing regulations promulgated by DLC, including: Chapter 113 – Regulations for the Licensing of Assisted Housing Programs, Chapter 110 – Regulations for Facilities Administering Medications (CRMA), Chapter 112 – Regulations Governing the CNA Registry and Training, Chapter 118 – Licensing of Home and Community-Based Services (newly adopted), and others.

Differences and Alignment:

- Scope of Oversight - Federal regulations apply only to facilities that receive Medicare or Medicaid funding, while state regulations apply to all licensed facilities, including those that do not participate in federal programs.
- Survey Processes - DLC conducts CMS-mandated surveys using federal protocols and timelines, while state surveys may be more flexible and responsive to local concerns.
- Enforcement Tools - Federal oversight includes specific remedies (e.g., denial of payment, termination from Medicare), whereas state enforcement may include licensing actions, corrective plans, or civil penalties under Maine law.
- Workforce Regulation - While federal rules set some standards for staffing and training, Maine has state-specific requirements for certification and registry of CNAs, PSSs, and CRMAs that exceed federal minimums in some areas.

DLC requires a range of filings from health care providers, direct care workers, and the general public to support its regulatory functions. These include applications for facility licensure and renewal, submissions to the Background Check Center, CNA Registry applications, complaint reports, incident reporting by facilities, and Certificate of Need (CON) applications.

Facility licensure is authorized under 22 M.R.S. §§ 1811–1820 and is typically required every one to two years. DLC receives approximately 1,200 - 1,250 applications annually, with increases expected due to expansion in community-based services.

Background checks, governed by 22 M.R.S. § 9054, are required upon hire and every five years for direct care staff. With the upcoming implementation of fingerprinting, filings are expected to grow from about 16,500 in 2024 to over 18,000 annually. CNA Registry applications, under 10-144 CMR Chapter 112, are submitted upon training completion and updated based on employment. Approximately 4,000 - 4,500 filings are received annually.

The Division also receives between 2,500 - 2,800 public complaints each year, as well as reportable incident submissions from facilities, as required by state and federal rules. CON applications are less frequent, with less than 10 anticipated annually.

To reduce paperwork and duplication, DLC has expanded the use of secure online systems for licensure, registry management, background checks, and complaint reporting. The Division also collaborates with training providers and other state offices to reduce redundant submissions, improve access, and streamline processing.

DLC serves a broad range of constituencies across Maine's health care and long-term care systems. These include (1) Health care consumers and the General Public, particularly older adults, individuals with disabilities, and other vulnerable populations who rely on safe, high-quality care in regulated facilities and programs. (2) Medical and Long-Term Care Providers, including hospitals, nursing homes, assisted living facilities, behavioral health providers, home health agencies, temporary nurse agencies, and group homes. (3) Direct Care Workforce, such as Certified Nursing Assistants (CNAs), Personal Support Specialists (PSSs), and Certified Residential Medication Aides (CRMAs), who are supported through training, registry maintenance, and background check systems. (4) Community-Based Service Agencies, especially those funded by Medicaid, provide care in less institutional and more home-like settings. (5) Federal and State Partner Agencies, such as CMS, OMS, OADS, and the State and Federal Bureaus of Investigation, who rely on DLC's regulatory role for alignment with safety, funding, and compliance goals.

Program Description

DLC is overseen by a Director, an Associate Director for Medical Facilities, an Associate Director for Community Health Care Programs, and with support from an executive and program management team. The division is organized around key program areas including medical facilities, community health programs, and operations. DLC employs over 100 people including state workers and contract staff.

The Division of Licensing and Certification primarily delivers its regulatory functions through a state-operated model to ensure accountability, consistency, and alignment with both state and federal mandates. However, DLC strategically incorporates alternative delivery systems where appropriate to improve efficiency, expand access, and meet emerging needs.

One key area where DLC utilizes an alternative delivery model is through the Background Check Center (BCC). While oversight remains within the Division, the BCC operates in coordination with both state and federal agencies, including the State Bureau of Identification (SBI) and the Federal Bureau of Investigation (FBI). The Division is currently implementing fingerprinting services for direct care workers, a process that may involve contracted vendors or external

service providers to conduct fingerprint collection across various regions in Maine, improving accessibility and reducing administrative burden on the state. In the area of training and workforce development, DLC works closely with approved private training providers and educational institutions to deliver CNA, CRMA, and PSS certification programs.

This public-private partnership model allows the Division to maintain regulatory oversight and quality assurance, while leveraging external expertise and infrastructure to train the direct care workforce efficiently and at scale. Although DLC has not broadly pursued privatization of its core regulatory responsibilities, such as facility inspections, complaint investigations, or licensing determinations, any consideration of such models would be evaluated carefully for potential impacts on quality, transparency, and public trust. The Division continues to assess opportunities to enhance service delivery through partnerships, contracting, and technological innovation while retaining the core public protections that are central to its mission.

At present, the priorities for DLC include:

- Workforce Development: CNA registry, Certified Residential Medication Aid (CRMA) and Personal Support Specialist (PSS) training, and oversight
- Licensing and Certification: Oversight of personal care agencies, assisted housing, home/community services, behavioral health, medical facilities, (nursing homes and hospitals) and temporary nurse agencies
- Safety and Reporting: We accept and investigate complaints, build a direct care workforce through education and policy, improve patient safety through Sentinel Event program, and run Maine Background Check Center.
- Health\ Care Oversight: Certificate of Need (CON) and general health care oversight functions

DLC has made consistent progress toward achieving its objectives across all program areas and utilizes a range of performance measures and benchmarks to evaluate progress toward its goals and objectives across core priority areas. Some important highlights include:

<u>Workforce Development</u>
DLC has met targets for maintaining an up-to-date CNA registry and supporting training pathways for CRMA and PSS roles. However, challenges in workforce recruitment and retention, particularly in rural areas, have impacted certification volume. DLC is collaborating with other state agencies and education partners and exploring flexible training delivery models to expand access. Metrics for assessing success include:

- Number of individuals certified or trained annually (CNA, CRMA, PSS)
- Time to process applications and certifications
- Compliance with training and registry standards

<u>Licensing and Certification</u>
Most licensing and certification timelines are being met, and oversight activities remain stable. Occasional delays in survey completion have occurred due to staffing shortages and underfunding by the federal government. DLC is actively recruiting surveyors and has

implemented cross-training to improve coverage and reduce backlogs. Metrics for assessing success include:

- Number and timeliness of facility licensure or renewal decisions
- Frequency and outcomes of inspections/surveys
- Rate of deficiency-free surveys and corrective action plans implemented

Safety and Reporting

Our agency continues to respond to complaints and incident reports in a timely manner, with a majority resolved within targeted timeframes. However, surges in complaint volume can slightly extend investigation timelines. DLC has made ongoing efforts to streamline intake processes and enhancing case triage to prioritize high-risk reports. Metrics for assessing success include:

- Volume and timeliness of complaint investigations
- Resolution time for substantiated complaints
- Background check processing time and error rates

Health Care Oversight

Certificate of Need reviews are completed on schedule. Stakeholder feedback has periodically indicated a need for increased transparency in the process, which the DLC is addressing through updated website posting, guidance materials, and improved communication tools. Metrics for assessing success include:

- Timeliness of Certificate of Need (CON) reviews and decisions

Retention

DLC has seen progress in hiring and retention strategies to fill critical vacancies, especially in surveyor roles, is much quicker with the State's new PRISM system; Many process improvements for background checks and complaint triage; Partnership work on the expansion of workforce training access via online and hybrid models; and ongoing stakeholder engagement to refine, speed up, and make transparent, licensing and oversight procedures

Coordination with State and Federal Agencies

The Division maintains collaborative relationships with both federal and state agencies to achieve its program objectives and promote efficient oversight of health care and long-term care providers. At the federal level, DLC operates under the guidance and authority of the Centers for Medicare & Medicaid Services (CMS) for the regulation of hospitals, laboratories, skilled nursing facilities, and nursing homes. This partnership enables DLC to perform certification surveys and inspections that ensure compliance with federal requirements and support provider eligibility for federal funding.

In addition, DLC works closely with the:

- Federal Bureau of Investigation
- Maine State Bureau of Identification

These agencies support the criminal background screening of direct care staff to protect the safety and well-being of vulnerable populations.

At the state level, DLC regularly collaborates with the:

- Maine State Board of Nursing
- Maine's Long Term Care Ombudsman (LTCOP)
- Office of Aging and Disability Services
- Office of Behavioral Health
- Office of MaineCare Services

These partnerships and others are critical to the coordination of services, reduction of administrative burden, and enforcement of consistent standards across programs. Looking ahead, there are additional opportunities to strengthen interagency coordination. These include enhancing data-sharing systems to identify and address compliance issues more efficiently, developing joint training and outreach initiatives to reduce redundancy, and exploring the creation of a unified complaint and incident reporting system across relevant DHHS offices. Such efforts would further streamline regulatory processes, improve service delivery, and enhance consumer protection statewide.

Emerging Issues

DLC's constituencies have expanded recently due to new responsibilities. Licensing of Home and Community-Based Service (HCBS or HCB) Agencies that serve individuals with intellectual and developmental disabilities have been added, extending DLC's oversight to a growing and critical area of Maine's service delivery system. Also, implementation of fingerprinting in the Background Check Center is underway. This change will expand services to include fingerprint-based background checks for direct care workers across Maine, enhancing safety and compliance with national standards.

The DLC anticipates several emerging issues that will shape its regulatory work and operational priorities in the years ahead. These issues reflect evolving health care delivery models, workforce challenges, and increasing complexity in oversight responsibilities. First, we expect workforce shortages and capacity pressures to build. Maine, like many states, continues to face significant shortages in the direct care workforce, including CNAs, PSSs, and CRMAs. This impacts not only the availability of care but also the compliance and operational capacity of licensed facilities. As demand for long-term services grows, particularly among an aging population, DLC will need to support efforts that expand training access, streamline certification processes, and ensure provider readiness to meet care standards.

We also expect further expansion of home and community-based services (HCBS). The continued shift from institutional care to community-based care models presents new oversight challenges. DLC's recent expansion into licensing HCBS agencies that serve individuals with intellectual and developmental disabilities reflects this trend. Ensuring consistent quality and safety across diverse, often decentralized, care settings will require updated regulatory frameworks and robust provider engagement.

We expect significant activity around the implementation of fingerprinting in Background Check Center. DLC is preparing for the statewide implementation of fingerprint-based background checks for direct care workers. This initiative enhances public safety and aligns Maine with national best practices. However, it will require new infrastructure, coordination with vendors

and law enforcement, and education for providers and job seekers navigating the new requirements.

Finally, we expect continued Federal and State policy changes. Changes in federal regulations, Medicaid waivers, and CMS guidance may require DLC to adjust its programs and enforcement strategies. In addition, any state-level policy shifts related to aging, behavioral health, or health care reform could expand the Division's scope or redirect priorities.

Maine Center for Disease Control and Prevention

The Maine Center for Disease Control and Prevention (Maine CDC) works to protect and improve the health and well-being of the people of Maine. Through comprehensive education, prevention efforts, direct services, emergency preparedness planning, and community partnerships, Maine CDC focuses on a wide range of public health areas including vaccinations, maternal and child health, drinking water safety, environmental health, and disease prevention.

Enabling Legislation

The Maine CDC is the office within the Department, pursuant to 22-A MRS § 203(1), mandated to protect public health and has specific legal authorities to enforce its rules related to public health matters. The Maine CDC administers rules under the authorities within M.R.S. Titles 17-Crimes, 19-A- Domestic Relations, 22-Health and Welfare, 20-A- Education, 29-A Motor Vehicles and Traffic, 32-Professions and Occupations, and 36-Taxation.

Program Description

The Maine CDC's mission is to protect and improve the health and well-being of the people of Maine. Its work addresses public health for all citizens across the state by focusing on issues that affect the entire population, from birth to death. The Maine CDC is accredited by the Public Health Accreditation Board (PHAB).

The Maine CDC is led by its Director, and supported by a Deputy Director and Chief Operating Officer, the State Epidemiologist, a Communications and Marketing Associate Director and administrative staff. The Maine CDC's infrastructure consists of multiple divisions: Operations, Disease Surveillance, Disease Prevention, Medical Epidemiology, Public Health Nursing, Environmental and Community Health, Health and Environmental Testing Laboratory, Population Health Equity, the Office of Readiness and Response and the Office of Violence Prevention.

The Maine CDC has over 400 positions across the state and contracts for over 100 additional staff depending on funding and program needs. More than half (63 percent) of the Maine CDC's capacity for delivering public health services are funded through receipt of federal grants, including block grants and competitive grant awards, as well as via the Tobacco Master Settlement Agreement. Philanthropic awards to external partners are also leveraged to conduct public health work across the state.

In addition to state lines, the agency oversees positions employed via contracted services to ensure that the delivery of services meets the needs of the consumers and the Department. The agency is committed to a procurement management system that ensures the best value, utilizing best business practices, which supports the DHHS public mission, and is in compliance with State and Federal statutes, rules, and regulations.

The Maine Center for Disease Control and Prevention is organized into units:

Office of Readiness and Response

The Office of Readiness and Response (ORR) promotes and integrates programs, data, communications, and policies to strengthen the public health system to prepare and respond to public health system threats and emergencies. The Maine CDC All Hazards Emergency Operations Base Plan provides a comprehensive framework for all jurisdictions of government and non-governmental health care partners within the State of Maine for Public Health Emergency Management.

ORR includes the following core programs:

- *Public Health and Emergency Preparedness (PHEP)* is the capability of the State public health and health care systems, communities, and individuals, to prepare for, respond to, and recover from health emergencies like pandemics or natural disasters.
- *Hospital Preparedness Program (HPP)* provides leadership and funding through cooperative agreements to states, territories, and eligible major metropolitan areas to increase the ability of funding recipients to plan for and respond to large-scale emergencies and disasters.
- *Rural Health and Primary Care (RHPC)* promotes access to quality health care for residents living in all of Maine's rural and underserved areas by increasing resources and reducing costs for health care statewide with a focus on rural areas; facilitating communication among stakeholders on rural health issues, increasing access to primary, mental and dental health care services for underserved populations; and reducing geographic, financial, transportation and other barriers that prevent access to health care.
- *Data, Research and Vital Statistics (DRVS)* administers Maine's vital statistics system and provides quantitative information for surveillance, planning, policy development, program management, and evaluation. These functions are accomplished through the development and implementation of data collection, data processing, and analytical activities. DRVS consists of four units: Electronic Data, Statistical Services, Vital Records and Cancer Registry.
- *Electronic Data* maintains the electronic registration system for vital events and provides training and ongoing technical support for users.
- *Statistical Services* conducts population-based surveillance systems; analyzes and reports vital statistics and data, including detailed population estimates; compiles data on health status and health resources; and will serve as the statewide Amyotrophic Lateral Sclerosis (ALS) registry, a mandate established by recent legislation. DRVS provides technical assistance and consultation on survey procedures and statistical analysis to other agencies in the Department.

- *Cancer Registry* is a statewide population-based cancer surveillance system that serves to collect, monitor and evaluate cancer incidence data and patterns in Maine residents to improve cancer prevention, treatment, and control.
- *Vital Records (VR)* provides vital registration services and technical services for the general public, health care professionals, funeral directors, hospitals, State agencies, court officials, and municipal clerks in the registration of vital records (i.e. records of births, deaths, fetal deaths, marriages, and divorces). VR maintains vital record data, including adoption data, and provides additional vital registration services such as acknowledgements of paternity, corrections, supplemental cause of death, divorces, delayed registration of records, court determinations, and preparation of and changes to birth records.
- *District Public Health (DPH), including District Liaisons and Tribal Liaisons* serve as the connection between the Maine CDC and local public health partners at the District and Tribal level. These District and Tribal Liaisons participate in planning, response, and recovery at the district level, coordinating with regional Health Care Coalitions (HCCs), county Emergency Management Agencies (EMAs) and other local agencies to facilitate efficient communication between the state and local agencies. DPH is also responsible for coordinating technical assistance and trainings to Local Health Officers in their districts. Each municipality is required under State law to appoint and employ a Local Health Officer (LHO) for up to a three-year term; these LHOs serve locally and play a key role in coordinating state and local public health and enforcing public health laws.

The Division of Population Health Equity (DPHE)

DPHE works to advance health equity by identifying social, economic, and other systemic barriers that create obstacles to accessing care and result in poor health outcomes. DPHE collaborates with internal programs across the Maine CDC and Maine DHHS as well as external community partners to ensure that Maine's public health initiatives are informed by, and reflect the needs of, the diverse people we serve.

DPHE was re-established in 2021 in place of the long-defunct Office of Minority Health to steward a $32.1M grant from the U.S. CDC to address the root causes of COVID-19 disparities. In addition, DPHE operates the following programs:

- CommunityCare Referral[14] to help connect Maine people with health programs, social services, and other resources.
- Health Equity Advisory Council[15] to ensure DPHE programming and strategies are responsive to community needs, with an explicit focus on Black, Indigenous, and People of Color (BIPOC") communities.

The Division of Disease Surveillance (DDS)

DDS is responsible for coordinating efforts to contain the spread of infectious diseases. This work includes conducting case investigations and contact tracing, outbreak control measures including mandatory reporting and interventions such as isolation and quarantine, coordination

[14] https://www.maine.gov/dhhs/mecdc/healthy-living/health-equity/community-care-program
[15] https://www.maine.gov/dhhs/mecdc/healthy-living/health-equity

of immunization efforts, and expert consultation to members of the public, state partners and health care practitioners. Public health programs within DDS include:

- *Infectious Disease Prevention* provides critical information and resources aimed to reduce occurrence of and limit exposure to infections such as influenza, measles, tuberculosis, sexually transmitted infections, insect- and animal-borne illnesses like Lyme disease and rabies, and access to HIV/STD prevention and harm reduction services.
- *Infectious Disease Epidemiology* conducts surveillance on health care-associated infections, outreach related to disease management and provides health care professionals with information on emerging science-based prevention, treatment, and adherence practices.
- *Maine Immunization Program (MIP)* partners with public and private health practitioners and community members, to provide vaccines, comprehensive education and technical assistance, vaccine-preventable disease tracking and outbreak control, accessible population-based management tools, and compassionate support services that link individuals into comprehensive health care systems. Maine is a universal vaccine state, which means that MIP provides vaccines to providers at no cost to be available for children and adults. Vaccine purchases are funded through the federal Vaccines for Children program, fees assessed on health insurers that cover people in Maine, and additional federal funding.

<u>The Division of Environmental and Community Health (DECH)</u>

DECH works to preserve, protect and promote the health and wellbeing of the population through the organization and delivery of services designed to reduce disease risk by controlling environmental hazards, providing education, and ensuring access to technical and health expertise. Among other responsibilities, DECH provides oversight, inspections, and licensing for businesses, hospitals, radioactive material, radon, public water systems, laboratories, and serves in a technical advisory role to other agencies on work related to per- and polyfluoroalkyl substances (PFAS), including soils, private wells, agricultural products and human blood serum concentrations. The division has established performance measures for its environmental and health programs that include the following focus areas:

- *Maine Drinking Water Program* is responsible for overseeing public water systems throughout Maine, administering the Federal Safe Drinking Water Act and the Maine Rules Relating to Drinking Water. Five teams within the program work together to meet the primacy requirements for the Safe Drinking Water Act, including regular inspections, technical assistance, and enforcement; monitoring and rules compliance determinations; engineering reviews; water resource protection and resilience; and environmental laboratory accreditation (and certification of cannabis testing laboratories). Additionally, the Drinking Water Program oversees the State Revolving Fund and grants for Drinking Water Improvements and Subsurface Wastewater responsible for monitoring septic systems, cemeteries and crematoria.
- *Radiation Control Program (RCP)* works to reduce unnecessary radiation exposure through the licensing and inspection of human-made and natural radiation sources. Licensees include hospitals, construction companies, lead-in-paint testers, paper mills, energy production facilities and colleges and universities. The RCP Team works to minimize the public health impact associated with radon in air and water, provides oversight of low-level radioactive waste generators, and conducts environmental

surveillance of nuclear facilities. RCP is also charged with responsibility for preparedness and response to radioactive emergencies.

- *Health Inspection Program (HIP)* works to protect and promote public health through licensing and inspection services for a range of approximately 8,500 businesses including restaurants, lodging places, campgrounds, youth camps, sporting camps, public pools and spas, and a variety of body artists. In addition to businesses in the hospitality industry, HIP also regulates school cafeterias and mass gatherings.
- *Toxicology and Environmental Epidemiology Program* provides objective, scientific evaluation of health risks for chemical and radiological exposure to develop and provide health risk analyses to inform public and regulatory decision making. The Program includes the office of the State Toxicologist and is the primary environmental toxicology and environmental epidemiology for the State, providing consultative services for the Department and other State agencies. Current topics of work include but are not limited to PFAS contamination of Maine's environment, private well water safety and testing, carbon monoxide poisoning, fish consumption advisories, and heat-related illness. The Program operates a toxicology consultation phone service for Maine residents with concerns about arsenic and other contaminants in their well water. The Program also operates and maintains the Maine Tracking Network - an online, interactive public health data portal that can be found here.[16]
- *Childhood Lead Poisoning Prevention Program* monitors thousands of blood lead level tests each year, identifies children with elevated blood lead levels and works with families, their physicians, visiting nurses, and lead inspectors to reduce exposure and improve health and safety. Epidemiological surveillance informs the landscape of lead poisoning in Maine, and the Maine CDC provides education on PFAS testing and exposure through public messages.[17]

Office of Injury and Violence Prevention (OIVP)

OIVP was recently established by statute in 2024 and leads statewide efforts to reduce injury and violence in Maine through education, awareness, evidence-based strategies, and improved collaboration. It supports secure storage efforts and manages a data and resource hub. OIVP includes two teams working collaboratively, with one focused primarily on community violence prevention and the other focused on suicide and injury prevention. The office also oversees the Maine Integrated Youth Health Survey (MIYHS) and school-based health center services.

Division of Disease Prevention (DDP)

DDP works to improve the health of Mainers across their lifespan by focusing on preventing and controlling chronic disease to reduce risks to health and safety and the impact of emergencies through preventative measures such as decreasing tobacco use and other substances harmful to health, increasing appropriate health screenings and service connections; promoting environments that support healthy eating and physical activity, and by providing education and resources for people to take control of their own health and prevent injuries. Programs within DDP include:

[16] https://data.mainepublichealth.gov/tracking/
[17] https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/ME%20CDC_PFAS_wells_0.pdf

- *Oral Health Program* works with partners across Maine to promote oral health in children through community collaboration. It provides school-based oral health services that include oral health education, oral health assessment and screening, fluoride treatments, dental sealants, and assistance with care coordination to a dental home
- *Women, Infants and Children (WIC) Nutrition Program*, funded by the United States Department of Agriculture (USDA), is a supplemental nutrition program for pregnant, breastfeeding or postpartum women and infants and children from birth to five years. WIC counselors provide growth assessment, health screening, breastfeeding promotion and support and referrals, along with individualized nutritious food benefits to eligible families whose income is less than or equal to USDA income. WIC food benefits follow federal regulations. The WIC Program goals include positive pregnancy outcomes and optimal growth for infants and children.
- *Tobacco and Substance Use Prevention and Control Program* works to decrease the initiation of tobacco and substance use among Maine's youth and young adult population as well as promote adolescent health and injury prevention. By focusing on support and development of healthy, safe environments, this program seeks to prevent the onset of use of tobacco and other substances. It provides funding to local communities for these efforts through the Maine Prevention Network initiative for the implementation of programming, outreach, and education rooted in evidence-based models of service. This program strives to reduce risk factors while increasing known protective factors for youth across Maine.
- *Chronic Disease Prevention and Control Program* works to prevent, detect, and control some of the most serious chronic health conditions (asthma, cancer, obesity, diabetes, Alzheimer's disease, and cardiovascular diseases). This program applies collaborative strategies to improve the health of Maine people by: mobilizing partners to support evidence-based prevention efforts; gathering and disseminating data to drive healthy decision making; empowering patients to self-manage chronic disease; promoting evidence-based guidelines to strengthen health care systems; linking health care systems with community resources; and increasing access to and awareness of screening for early detectable chronic diseases.
- *Maternal and Child Health (MCH) Program* works to improve the health of the MCH population (women 15 to 44 years, children birth through 21 years, and children with special health needs). The MCH Program provides direct funding for community-based and public health nursing services. Data collection, analysis and dissemination are conducted to ensure programming is based on need and emerging health trends. The MCH Program collaborates with many different entities to ensure seamless services across the service population spectrum. It provides education on key topics such as safe sleep. The MCH Program also oversees the Maternal, Fetal, and Infant Mortality Review Panel (MFIMR) and publishes an annual report based on its findings.

<u>Division of Public Health Nursing (PHN)</u>
PHN provides vital services and support to vulnerable populations in homes, virtually, and in communities. Public Health Nurses routinely provide maternal and child health support and education, referral services, adult health services, and communicable disease control and prevention. Public Health Nursing offers expertise in community and stakeholder groups, facilitates immunization clinics, and helps protect communities in emergency preparedness.

Health and Environmental Testing Laboratory (HETL)

HETL is the State of Maine's public health laboratory. The laboratory works to isolate, identify, analyze, and monitor biological, chemical, and/or radiological hazards which can cause harm to human health and the environment. HETL serves as the testing facility for public health programs at the Maine CDC such as the Drinking Water Program, Childhood Lead Poisoning Prevention, Infectious Disease Prevention Program, and Public Health and Emergency Preparedness, and works with other agencies in the prevention, treatment, and control of such hazards which threaten the community or environment.

Coordination with State and Federal Agencies

State and federal partnerships are essential for effective emergency response, addressing health disparities, managing resources, and navigating complex policy environments. The Maine CDC regularly collaborates with State and Federal partners on multiple public health functions (i.e. food safety regulations; vaccine access; outbreak investigations and disease responsiveness, including public health advisories and other non-pharmaceutical control measures; harm reduction services; emergency preparedness; workplace health and safety; opioid crisis response; drinking water safety and environmental health management, including monitoring and responding to contaminant exposure; forensic testing services for criminal proceedings; maternal and child health needs; mortality reviews of adults and children that include firearm fatality, suicides and premature deaths). Partnerships, include but are not limited to:

Federal Partners:

- Administration for Children and Families
- Administration for Strategic Preparedness and Response
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Department of Homeland Security
- Department of Justice
- Drug Enforcement Administration
- Federal Emergency Management Agency
- Food and Drug Administration
- Health Resources and Services Administration
- Substance Abuse and Mental Health Services Administration
- U.S. Department of Agriculture
- U.S. Environmental Protection Agency

State Partners:

- Department of Administrative & Financial Services (DAFS), including the Maine Bureau of Alcoholic Beverages and Lottery and the Office of Cannabis Policy partners with the Maine CDC for collaboration and coordination with the Health Inspection Program and Certification of Cannabis testing labs
- Maine Department of Agriculture, Conservation and Forestry
- Maine Department of Corrections
- Maine Department of Education
- Maine Department of Environmental Protection

- Maine Department of Inland Fisheries and Wildlife
- Maine Department of Labor
- Maine Department of Professional and Financial Regulation
- Maine Department of Public Safety
- Maine Department of Transportation
- All offices within DHHS
- Maine Emergency Management Agency
- Maine Office of Information Technology
- Office of Chief Medical Examiner
- Office of the Attorney General
- Office of the State Fire Marshal

Emerging Issues

State public health departments, including the Maine CDC, are experiencing a period of significant challenges. A combination of workforce strain, shifting funding landscapes, growing public uncertainty, and the accelerating health impacts of climate change will shape the agency's priorities and operations in the years ahead. These pressures are further compounded by the rise of chronic diseases, infectious disease threats, and widening health inequities.

Workforce and Funding Challenges

Workforce Attrition and Burnout: Nationally, the public health workforce has faced significant attrition after the COVID-19 pandemic. Maine is not immune to this trend in addition to impacts as national and state priorities change. Remaining staff face high levels of burnout and low morale, threatening the stability and effectiveness of public health programs.

Unstable Funding: Temporary funding increases during the COVID-19 pandemic have largely receded and, along with changes in federal priorities, is leaving public health departments under-resourced for the services the public has come to expect. In addition to this, 80 percent of the U.S. CDC's budget directly supports states, meaning that budget cuts to the U.S. CDC could severely impact Maine's ability to sustain prevention efforts and core services.

Trust and Misinformation

Navigating Public Uncertainty: When people are unsure what information to trust, it can become harder for them to interpret and navigate public health recommendations. This uncertainty makes it more challenging for public health officials to provide effective communication and engage with communities in a meaningful way.

Misinformation and Disinformation: Information that is not grounded in reputable scientific or evidence-based sources can be quickly amplified across social networks, and can result in confusion, vaccine hesitancy, and reduced uptake of evidence-based interventions.

Climate Change and Environmental Health

Health Impacts of a Changing Climate: Maine is already experiencing the effects of climate change, including more frequent extreme heat events and the spread of vector-borne diseases. These trends are expected to intensify.

Chemical Exposures: PFAS and lead continue to pose serious environmental health risks. Monitoring, mitigation, and public education around these exposures will remain a top priority.

Data and Technology Modernization

Outdated Systems: Decades of underinvestment have left many public health data systems outdated and fragmented. Modernizing these systems is essential for timely surveillance and response.

Privacy and Governance: As Maine explores digital health tools and AI integration, ethical concerns around data privacy, consent, and governance must be addressed to maintain public trust.

Health Equity

Persistent Health Inequities: Systemic inequities and social drivers of health continue to drive disparities in health outcomes. It is critical that the Maine CDC prioritize equity in all programs and policies in order to promote health for all of Maine.

Addressing Social Drivers: Issues such as housing, poverty, and employment are deeply intertwined with health. Cross-sector collaboration will be essential to address these root causes.

Shifting Disease Landscape

Chronic Disease Burden: Non-communicable diseases including heart disease, diabetes, cancer, and injuries remain leading causes of morbidity and death and require sustained prevention and management strategies. Maine, especially in rural areas, continues to experience gaps in access to behavioral health services needed to support mental health challenges faced by Maine people.

To address these emerging issues, the Maine CDC is committed to:

- Strategic Planning and Resource Allocation: Ensuring Federal and State resources are aligned with workforce needs and public health priorities.
- Robust Communication Strategies: Utilizing the Maine Health Alert Network (HAN), media partnerships, and social media platforms to share timely, accurate information with health professionals and the public.
- Collaborative Partnerships: Working with local, tribal, and statewide partners to ensure public health messages and services reach all Maine people.
- Equity-Centered Approaches: Embedding health equity into public health planning, programming, and evaluation.

The Maine CDC publishes updates to our State Health Improvement Plan (SHIP) online. The most updated plan Maine 2024-2029 State Health Improvement Plan (PDF)[18] advances science and health equity and affirms the agency's commitment to one unified vision—a strong, safe, and healthy Maine. The plan leverages 4 key priorities:

- Maine has an inclusive and equitable culture of mental health, resiliency, and well-being for all;
- Maine has housing that equitably meets the diverse needs of all;

[18] https://www.maine.gov/dhhs/mecdc/sites/maine.gov.dhhs.mecdc/files/Maine_SHIP_r3_122324.pdf

- Maine is a place where all people have equitable access to care that promotes health and well-being; and
- All people living in Maine thrive in a healing, supportive environment that equitably addresses substance use, from prevention to recovery, and its impacts on individuals, families, and communities.

The Maine 2024–2029 SHIP was developed by members of the Maine SHIP Planning Team, comprised of health experts, stakeholders, and residents from throughout the state, and led by the Maine Center for Disease Control and Prevention. More information about that group can also be found on our website.[19] The SHIP is a collaborative framework for ensuring all people in Maine have a fair and just opportunity to attain their highest level of health.

[19] https://www.maine.gov/dhhs/mecdc/about-us/commissions-review-panels/statewide-coordinating-council-for-public-health

Office of Behavioral Health

The Office of Behavioral Health (OBH), formerly the Office of Substance Abuse and Mental Health Services (SAMHS), works to support a full continuum of behavioral health and substance use disorder services in the state and assists people who are uninsured or have inadequate health insurance coverage to meet their service needs.

Enabling Legislation
The OBH carries out programs and services pursuant to 22-A M.R.S. § 203(1)(B), (F) supporting mental health and behavioral health services and substance use disorder prevention, treatment, and recovery services. In addition, OBH is the office within the Department responsible for the promotion and guidance of mental health programs within Maine communities in accordance with 34-B M.R.S. § 3001. The State Forensic Service, housed within OBH, is established by 34-B M.R.S. § 1212.

The following federal law requirements are overseen and carried out by OBH:

- Public Law 118-42: The Consolidated Appropriations Act, 2024: Permanent Supported Housing Program
- Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C 11301 et seq.: Permanent Supported Housing Program
- Public Law 101-645: Projects for Assistance in Transition from Homelessness

Program Description
The Office of Behavioral Health is committed to supporting a complete and coordinated behavioral health continuum of care. Our vision is to ensure all Maine residents with mental health challenges, substance use disorders, and co-occurring disorders are not simply managing symptoms, but are living independent lives of dignity, hope, and meaning.

OBH assists people who are uninsured or have inadequate health insurance coverage to meet their need for mental health and substance use disorder services. OBH is committed to supporting a complete and coordinated behavioral health continuum of care that serves the whole person and the whole community. OBH provides leadership for and supports an evidence-based behavioral health system that recognizes the importance of meeting people where they are, and is trauma informed, inclusive, consumer driven, and proactive. The following are individuals that OBH most frequently works to support:

- Individuals with mental illness, including serious mental illness;
- Individuals with behavioral health disorders, substance, opioid, and alcohol use disorders; co-occurring disorders;
- Individuals in recovery;
- Unhoused individuals and those in transitional or non-traditional housing;
- Justice-involved individuals (including intensive case management, forensic evaluations);
- Individuals in need of employment support and services;
- Children and families of children with mental and/or behavioral health disorders;

The Office of Behavioral Health has 141 positions. An organizational chart can be found in the appendices. The Office of Behavioral Health is organized at a high-level into five distinct programmatic areas supportive of (Housing, State Forensic Services, Substance Use, Mental Health, and Children's Behavioral Health Services) as well as cross-cutting programs (Policy, Communications and Compliance, Finance and Contracts, Grants, and Data and Quality) that support core office operations. The organizational chart included in the subsequent section is representative of the positions and areas that compromise the OBH Senior Team, which supports Office operations, provides fiscal and programmatic oversight, and strategically upholds the mission and vision[20] of OBH. Comprehensive detailed information for each of the areas can be found in the DHHS Legislative Orientation Materials[21] (Slides 252-300 are specific to OBH) as well as in various subsections on the OBH website.[22]

Program areas are supported with a mixture of Federal and State authority and funding and receive both state and federal funding. Federal funding, including the Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant, typically require an annual application and performance report that identify performance measures as well as narrative on past performance. Federal grant opportunities often include overarching priority areas that OBH is then able to tailor to support state-specific needs. Critical grant material[23] is posted online to support public review of information, and comment forms are also available to ensure for public input.

The following are two examples from two of the core federal Block Grants that provide funding to OBH. The Mental Health Block Grant requires: that 10 percent of the award be spent on evidence-based programs for those with Early Serious Mental Illness (ESMI); 5 percent of the award be spent on crisis services; that the State submits a plan for providing comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; that funding for children's mental health services be supported by the state at the same level that it was in 1994; that the award supplements rather than supplants state funding for mental health services; and that states expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant. OBH uses funding to support this by committing funding to: Expand First Episode Psychosis treatment and training; supplement crisis services; support peer recovery centers, as well as youth peer support services and family peer support services.

The Substance Use Prevention Treatment and Recovery Services Block Grant requires: that 20 percent of the award be spent on Primary Prevention; that funding for services for pregnant women and women with dependent children be supported by the state at the same level that it was in 1994; that the award supplements rather than supplants state funding for substance use services; and that the state conducts outreach regarding intravenous substance use. OBH uses funding to support this by committing funding to: residential treatment services (including specific programs for women); treatment and recovery court case management, naloxone

[20] https://www.maine.gov/dhhs/obh/about
[21] https://legislature.maine.gov/doc/11376
[22] https://www.maine.gov/dhhs/obh
[23] https://legislature.maine.gov/doc/11376

distribution and overdose education; opioid treatment programs, outpatient and intensive outpatient services; recovery coaching in emergency departments; and supporting the Maine Prevention Network – a series of local community health coalitions tasked with prevention efforts across Maine - to implement primary prevention services.

Additionally, state funding is used to support programming identified by both legislative and OBH specific priorities or requirements. An example of the latter is the now-resolved Consent Decree, the result of a class action lawsuit that guided the provision of community mental health services for over 30 years. The Consent Decree was resolved in 2024 based on long-term investments in the system of care tied to compliance standards such as timely access to care as well as monitoring and oversight of system compliance. Further detail, including performance standards still reviewed, can be found on slides 259-261 of the Legislative Orientation Materials.[24]

Finally, OBH is guided by activities and goals outlined in the Comprehensive Behavioral Health Plan for Maine,[25] a result of a resolution passed by the 130th Maine Legislature: "Resolve, Directing the Department of Health and Human Services to Develop a Comprehensive Statewide Strategic Plan to Serve Maine People with Behavioral Health Needs throughout Their Lifespans" (2021 ME Legis. Sess.), which directed OBH to develop a comprehensive strategy that covers children and adults. OBH is in the midst of reviewing and updating the plan since its original publishing in early 2023. The Plan includes four parts.

- Consumer choice - providing person-centered planning and access to preferred services for behavioral health.
- Activities tailored or targeted to support different population groups, and describes actions around children and adolescents, justice-involved individuals, and lifespan supports that allow for service adjustments over time.
- What has been done to address gaps and expand access by major areas, including Crisis Services, Community-based Services, Care Coordination and Case Management, Substance Use Disorder and finally Peer and Family Supports.
- Infrastructure and related services that are pre-requisites to a high-functioning system that produces optimal behavioral health outcomes, including housing, transportation, employment and a behavioral health workforce.

The following is a brief synopsis of each program area within OBH:

Substance Use Disorder[26] (SUD)
SUD Programs are designed to assist individuals diagnosed with a substance use disorder or struggling with substance misuse. SUD Programs follow Evidence Based Practice standards and align with the American Society of Addiction Medicine's (ASAM) level of care placement criteria. Services included, Outpatient, Intensive Outpatient, Residential, Medically Supervised Withdrawal and Medication Assisted Treatment programs, which utilize Food and Drug Administration (FDA) approved medication for the treatment of SUD. Under the Mills Administration, the SUD Program has expanded its footprint focused on Opioid Response

[24] https://legislature.maine.gov/doc/11376
[25] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20LD1262%20FINAL%20Report.pdf
[26] https://www.maine.gov/dhhs/obh/support-services/substance-use-disorder-services

efforts, increasing access to withdrawal management and residential beds, Medication Assisted Treatment (Methadone, Suboxone, Naltrexone). These efforts are overseen in close coordination with the Governor's Office and under the Opioid Strategic Plan.[27]

Included in the Substance Use Disorder Program area is the Driver Education and Evaluation Program, which is a legislatively mandated operating-under-the-influence (OUI) countermeasure program. The goal of the programs is to reduce the incidences of injury, disability and fatality that result from alcohol and other drug related motor vehicle crashes, and to reduce the risk of re-offense for OUI.

Mental Health Programs[28]
Mental Health Programs are designed for individuals with a mental health diagnosis and aim to enhance their emotional, psychological, and social well-being, ultimately improving their daily functioning through evidence-based interventions. Services included: Outpatient, Intensive Outpatient, Residential, Community Integration, Assertive Community Treatment, Daily Living Skills, and Skills Development.

Included in the Mental Health Program area is Behavioral Health Crisis Services, safety net services for individuals experiencing a crisis. These services are modeled after the Substance Abuse and Mental Health Services Administration's (SAMHSA) national best practices to ensure access to a person to call, a person to respond, and a safe place to be. As a result, Maine has a centralized crisis hotline (988). This mobile response team meets individuals in their homes or community settings, as well as in crisis residential programs, for those who need short-term, 24/7 stabilization support, and provides walk-in, 24/7 crisis receiving services. All services support crisis screening, de-escalation, stabilization, and follow-up support services, allowing individuals to receive support in the least restrictive setting and remain in the community.

Children's Behavioral Health Services[29] (CBHS)
CBHS focuses on treatment and services for children from birth to their 21st birthday. Services include providing information and assistance with referrals for children and youth with developmental disabilities or delays, intellectual disability, Autism Spectrum Disorders, and mental health disorders. The three foundational principles of the CBHS system of care include: establishing a single point of access to services; eliminating wait time for youth seeking services; and improving quality and consistency of services.

The State Forensic Service[30] (SFS)
SFS conducts evaluations of an individual's mental condition on behalf of any Maine court. The Service is responsive to individual court orders and tracks the progress toward completion of each order. In addition to evaluation, SFS staff provide consultation to judges, attorneys and hospital staff, as well as training and professional development pertaining to forensic assessments and for professionals in the mental health and legal systems.

[27] https://www.maine.gov/future/sites/maine.gov.future/files/inline-files/GOPIF_OpioidReport_2023.pdf
[28] https://www.maine.gov/dhhs/obh/support-services/mental-health-services
[29] https://www.maine.gov/dhhs/obh/about/about-cbhs
[30] https://www.maine.gov/dhhs/obh/support-services/justice-system-related-services

Under the leadership of OBH's Clinical Director are two distinct areas, including the Justice and Health Intensive Case Management teams as well as Peer and Recovery efforts. Intensive Case Managers supportive reentry services to individuals who are transitioning out of correction facilities and back to the community. Under the Mills Administration, multiple recovery focused efforts have been a focus, including support for Recovery Residences,[31] which offer a healthy, safe, substance-free living environment to support individuals in treatment and recovery for substance use disorder, as well as Recovery Community Centers and Recovery Coaches,[32] which build on community connections and individuals with lived experience to provide support and reduce stigma for those in recovery for substance use disorder.

Housing Programs[33]
OBH oversees the administration of several supportive housing programs, including the Bridging Rental Assistance Program, Permanent Supportive Housing Program, Projects for Assistance in Transition from Homelessness (PATH), and works with partners to support other programs such as Home for Good (also known as Housing First) and Recovery Residences for individuals with substance use disorder. Each of these are designed to assist individuals in finding and maintaining stable, independent housing. This is often supported via housing vouchers, which provide rental assistance for individuals who meet certain criteria, such as experiencing homelessness or having a serious mental illness. A key component of Housing programs includes supportive services, which can help to assess whether individuals are able to remain housed and if they exit to a permanent housing option.

In addition to the specific Program areas, OBH also has teams that support Policy, Communications and Compliance, Grants, Contracts and Finance, as well as Data and Quality. Some of these areas, including Grants, Contracts and Finance, are the business side of OBH, ensuring for the influx and egress of available funding which supports core programmatic operations of the areas listed above. Other areas, including the Data and Quality team, support both cross-Office data analysis and reporting while also maintaining discrete areas of oversight, including the Prescription Monitoring Program.

Coordination with State and Federal Agencies
The Office of Behavioral Health partners extensively with organizations and individuals at the state, and local level, including but not limited to the following entities:

- Administrative Office of the Courts
- Behavioral Health Providers who support a wide range of services including: Targeted Case Management, Behavioral Health Home, 988 / Maine Crisis Line / Crisis Providers, Certified Community Behavioral Health Clinics, Private Nonmedical Institutions, Opioid Treatment Providers, Medication Management Providers, Assertive Community Treatment Teams
- Board of Pharmacy
- Consumer Council System of Maine
- Maine Department of Corrections
- Maine Department of Education

[31] https://www.maine.gov/dhhs/obh/support-services/housing-services
[32] https://www.maine.gov/dhhs/obh/support-services/substance-use-disorder-services/recovery-supports
[33] https://www.maine.gov/dhhs/obh/support-services/housing-services

- Disability Rights Maine
- Employment Services Providers
- Hospitals and Federally Qualified Health Centers
- Maine Bureau of Motor Vehicles
- Maine Career Centers and Job Bank
- Maine Continuum of Care
- Maine State Housing Authority
- National Alliance on Mental Illness
- Maine Office of the Attorney General
- Office of the Chief Medical Examiner
- All offices within DHHS
- Recovery Residences
- State Board of Veterinary Medicine
- Statewide Homeless Council
- Statewide Quality Improvement Council
- Substance Use Disorder Services Commission
- The Municipal Jails and Statewide Carceral System
- U.S. Veterans Affairs and Maine Bureau of Veterans Affairs
- University of Maine and other academic institutions

Emerging Issues

The Senior Leadership team at OBH routinely reviews emerging issues and impact to potential programming. OBH annually plans for what might be emerging priorities or responses to emerging challenges. Broadly, OBH has observed an increased need for services for uninsured individuals, or for a level of care that private insurance does not cover. This is seen across OBH program areas comprehensively, including Mental Health, Substance Use and Children's Behavioral Health Services. This trend is not likely to change for at least the near future and will necessitate OBH in coordination with other DHHS Offices like OMS and CDC to routinely review how resources are utilized, considering OBH supports mental health and the under/uninsured populations as part of its core mission and vision.

Other programmatic areas have started to experience more specific issues. For example, housing programs have been confronted by the lack of affordable and accessible housing that has been an emerging issue for the past handful of years and has led to pressure-points on the allocation of housing vouchers as well highlighted the importance of housing supports, such as outreach workers. Further, for the State Forensic Service, a "competency crisis" (individuals found incompetent to stand trial) has led to a stark increase in referrals for court ordered evaluations of defendants by the State Forensic Service, straining limited resources among a specialized field.

Office of MaineCare Services

The Office of MaineCare Services (OMS) administers Maine's Medicaid program (called MaineCare), the Children's Health Insurance Program (CHIP), and some state-funded health coverage programs. It is funded by the federal and state government. MaineCare provides free or low-cost health insurance and other health benefits to Mainers who meet certain requirements, usually based on income, disability, or age.

Enabling Legislation
The enabling legislation related to Maine's Medicaid and Children's Health Insurance programs is 22 M.R.S. § 3173 and 3174-T. The Medicaid program is established federally by the United States Social Security Act, Title XIX and the Children's Health Insurance Program is established by the Social Security Act, Title XXI.

OMS also administers a small number of state-funded health insurance coverage benefits to defined populations, as determined by the Legislature. The enabling legislation for which is outlined in various provisions of 22 M.R.S. Chapter 855.

Program Description
MaineCare administers the state's Medicaid program and provides health insurance coverage for Maine children and adults who have lower incomes and/or are older or have disabilities. Lower incomes are considered 138 percent of the Federal Poverty Level (FPL) for all non-pregnant adults, and, as of October 2023, 300 percent FPL for children through age 20. Maine's Medicaid program and Children's Health Insurance Program are jointly funded by the federal government and the state.

As of September 2025, OMS has 152 state line staff and 42 contract staff for a total of 194 employees. The OMS senior leadership team includes the Director, Deputy Director of Policy and Programs, Chief Operating Officer, Medical Director and four Associate Directors.

MaineCare serves over 400,000 residents and those eligible for the program typically face higher health burdens, more individual health vulnerabilities and greater structural and social inequality.

OMS is required to follow federal Medicaid requirements of basic coverage. Those include:

- Providing mandatory services to mandatory populations.
- Making all services (outside a waiver) available statewide for any willing and qualified provider to deliver.
- Allowing members to choose their providers.
- Providing services that much be "sufficient in amount, duration, and scope to reasonably achieve their purpose," "medically necessary," and "limited based on policies to promote quality of care and prevent over-or inappropriate utilization."

OMS also manages all the states Medicaid Waivers. Medicaid waivers are outside of the state plan. The state submits special applications to CMS to waive certain federal requirements, in exchange for meeting cost neutrality or cost efficacy requirements. Applications are often

burdensome and subject to additional scrutiny, reporting, monitoring, and evaluation requires Maine's waiver programs include:

- *1915 (c) Home and Community Based Waiver (HCBS)* - Prevents the need for care in an institutional setting by waiving comparability of services and eligibility requirements. Includes:
  - Section 18, HCBS for Adults with Brain Injury
  - Section 19, Home and Community Benefits for the Elderly and Adults with Disabilities
  - Section 20, HCBS for Adults with Other Related Conditions
  - Section 21, Home and Community Benefit for Members with Intellectual Disabilities or Autism Spectrum Disorder
  - Section 29, Support Services for Adults with Intellectual Disabilities or Autistic Spectrum Disorder

- *1915(b) Managed Care Waiver* - Enables states to provide services through managed care delivery systems and waives the members choice of provider. Includes:
  - *Non-Emergency Transportation (NET):* Transportation to MaineCare-covered services for full benefit MaineCare members, including children and members utilizing services under HCBS waivers. NET is operated under a federal 1915(b) waiver. The state is federally required to competitively procure broker contracts and currently contracts with three brokers for eight MaineDOT transportation regions. The brokers contract with dozens of transportation providers and are accountable for managing cost and administration of the program. The program provides roughly 2 million trips annually. Current brokers are:
    - ModivCare: Androscoggin County, Aroostook County, Cumberland County (all towns but Brunswick and Harpswell), Franklin County, Hancock County, Town of Isle au Haut, Oxford County, Town of Patten, Washington County, and York County
    - Penquis Community Action Program: Kennebec County, Penobscot County (all towns but Patten), Piscataquis County, and Somerset County
    - Waldo Community Action Partners/MidCoast Connector: Towns of Brunswick and Harpswell, Knox County (all towns but Isle au Haut), Lincoln County, Sagadahoc County, and Waldo County
- *1115 Research and Demonstration Project* - Provides states flexibility to test new service models to promote Medicaid's objectives. The initiative must be budget neutral and it allows states to waive certain provisions of Medicaid law.

OMS has established the following four priorities:

- Incent and improve access to high value, equitable care that meets members' health needs and health-related social needs.
- Strengthen our technology, systems, and skills to maximize our efficiency and effectiveness and our ability to make well-informed and data driven decisions that reflect real world experience.
- Maintain a culture of compliance and promote responsible fiscal stewardship.
- Foster employee engagement through a positive, supportive, inclusive workplace environment.

OMS uses performance measures included in the annual Child and Adult Core Sets to measure progress in achieving goals and objectives and data on key indicators is reported through the Medicaid and CHIP (MAC) Scorecard. The MAC Scorecard provides data about the administration and outcomes of Medicaid and CHIP programs at both the state and federal levels and provides information about several program characteristics like care delivery and quality, and the use of data to support program improvement, eligibility and enrollment, and expenditures. The scorecard includes measures reported by the state as well as measures calculated from federal administrative processes.

The Department regularly monitors service quality, cost, and access, and uses the MAC Scorecard as a tool to assess performance. The Department works, often collaboratively across offices, to develop programs and policies that address areas for improvement when identified. Links to the MAC Scorecard and Core Measures included Medicaid and CHIP Scorecard - Explore Data[34] and Child and Adult Health Care Quality Measures | Medicaid[35]

Title 22 M.R.S. §3174-X[36] establishes contracted ombudsman services to Medicaid members regarding MaineCare services. The Medicaid Ombudsman program is currently contracted with Consumers for Affordable Health Care and must report to the Department on services provided. While no frequency is specified in statute, OMS requires a report quarterly (four times per year), specified in the services contract with the Ombudsman. The Ombudsman has filed 8 reports over the last 2 years, and the Department anticipates they will file an additional 8 reports over the next 2 years.

OMS previously set a goal of having at least 40 percent of MaineCare payments paid through alternative payment models (APM) by 2022. As of 2025, over 57 percent of payments are paid through APM's. OMS competitively procures vendors to support several functions such as: actuarial services, audit, call centers, claims processing, rate studies, and third-party liability recoveries.

Accountable Communities (AC)

AC is a multi-pronged initiative aimed at reducing costs while improving quality and outcomes for MaineCare members. MaineCare's AC program contracts with groups of providers who volunteer to participate in the shared risk model. DHHS provides ACs with monthly and quarterly patient cost and quality data. The payment model creates incentives for ACs to make investments that improve cost and quality outcomes. If an AC succeeds in reducing costs while meeting quality benchmarks, the AC shares in the savings it achieves for the MaineCare program in the form of a shared savings payment, which is tied to the amount of the AC's savings and its quality performance. If the AC exceeds benchmarked costs, a shared loss payment is due back to the Department.

[34] https://www.medicaid.gov/state-overviews/scorecard/main
[35] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures
[36] https://legislature.maine.gov/statutes/22/title22sec3174-X.html

There are four ACs in the program:

- Community Care Partnership of Maine, LLC
- Kennebec Regional Health Alliance
- MaineHealth Accountable Care Organization
- Beacon Health, LLC

Coordination with State and Federal Agencies

Cross-agency coordination is crucial to the administration of MaineCare programs. Some of the entities OMS is regularly in contact with include but are not limited to the:

- Maine Bureau of Insurance
- Maine Department of Administrative and Financial Services
- Maine Department of Corrections
- Maine Department of Transportation
- Maine Health Data Organization
- Maine State Housing Authority
- Office for Affordable Health Care
- Office of the Attorney General
- Office of the Inspector General
- State Forensic Service

OMS is responsible for the provision of coverage and reimbursement for MaineCare-covered services that are often coordinated/overseen in collaboration with the DHHS Offices including the Office of Behavioral Health, the Office of Aging and Disability Services, Maine Center for Disease Control and Prevention, and Office of Children and Family Services.

The Office for Family Independence (OFI) is responsible for MaineCare eligibility and enrollment, including obtaining authority for changes to eligibility requirements. OFI enrolls individuals in the appropriate MaineCare categories and oversees the annual recertification process for maintaining MaineCare eligibility.

OMS collaborates with OFI and the Office of the Health Insurance Marketplace (OHIM) regarding outreach activities, strategy, and enrollment analysis and projections, and with the Division of Licensing and certification on provider enrollment and compliance with licensing requirements.

Additionally, OMS closely coordinates with the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA)

Emerging Issues

The number of Maine children and adults who have lower incomes is rising. Lower incomes are defined as 138 percent of the Federal Poverty Level (FPL) for all non-pregnant adults, and, as of October 2023, 300 percent FPL for children through age 20, and/or are older or have disabilities. Currently 30 percent of all Mainers are covered by MaineCare, 50 percent of children in Maine

are covered by MaineCare and 39 percent of births in 2023 were paid for by MaineCare.[37] While constituent need is expected to rise, federal eligibility rules have changed.

OMS anticipates significant disenrollment in the future due to changes in the Federal Budget Reconciliation signed into law, or H.R. 1, and outlined below.

The recently passed federal legislation, H.R. 1 or the July 2025 Budget Reconciliation Act, included several policy changes that will have significant impact on MaineCare.

- H.R. 1 eliminated federal coverage eligibility for certain immigrant groups such as refugees, asylees, trafficking survivors, and certain parolees. (Sec.71109) This population will still be eligible for Emergency Services coverage with a reduced federal match rate. This excludes children and adults under 21 years old, and pregnant and postpartum people, due to Maine's state-only coverage of this population.
- A Medicaid provider tax moratorium was also included in H.R. 1 (Sec. 71115), which means OMS cannot create any new provider taxes. Provider tax revenues play a critical role in helping to ensure the financial sustainability of Medicaid programs nationally – Maine is one of 49 states with provider taxes. Provider tax revenue comprises roughly 12 percent of state dollars used to fund MaineCare. Limitations on states' ability to levy provider taxes inhibits Maine's ability to generate additional revenue needed for the program and to update revenue bases to reflect growth in the program due to changes in enrollment, utilization, and prices.
- Additionally, H.R. 1 expands the sorts of errors that can subject states to financial penalties and restricts waivers of these penalties. Accuracy of our systems as well as human error all impact our payment error rate measurement (PERM) rates and thus our exposure to risk/penalties.
- H.R. 1 established a one-year moratorium on Federal reimbursements for services provided by providers meeting certain criteria– in Maine, Planned Parenthood and Maine Family Planning. (Sec. 71113) Maine still covers abortion services with these providers per state only coverage required by Maine law.
- By December 31, 2026, the state must implement new work/community engagement requirements (Sec. 71119) for certain MaineCare members – primarily the expansion population. Impacted adults must complete 80 hours of work or community service each month to maintain their MaineCare eligibility. Additionally, H.R. 1 requires eligibility redeterminations every six months for the expansion members (Sec. 77107), which is a change from the current 12-month requirement.

[37] https://www.maine.gov/dhhs/oms/mainecare-data-reporting

Office of Aging and Disability Services

The Office of Aging and Disability Services (OADS) supports Maine's older and disabled adults by providing and coordinating Adult Protective, Brain Injury, Other Related Conditions, Intellectual and Developmental Disability, Long Term Care, and Aging and Community services to the people of Maine.

Enabling Legislation
Pursuant to 22-A M.R.S. § 203(1), (3), OADS provides the programs and services of the Department related to developmental disability services, physical health services, adult protective services, and long-term care services for older adults and adults with disabilities. OADS was created through the combination of the Office of Elder Services (OES) and the Office of Adults with Cognitive and Physical Disability Services (OACPDS) in 2012. OADS provides services for adults across Maine, under the following authorizations:

OADS Programs Related to Aging and Older Adults:

- Older Americans Act, 42 U.S.C. 3001 *et seq.*
- State Health Insurance Assistance Program, Section 4360 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (PL 101-508)
- Senior Medicare Patrol Program, Omnibus Consolidated Appropriation Act of 1997 (PL 104-208)
- Medicare Improvements for Patients and Providers Act of 2008, PL 110-275

OADS Programs Related to Long Term Services and Supports (LTSS):

- 22 M.R.S. §§ 7301-06, 7321-23: In-home and community support services for adults with long-term care needs
- 22 M.R.S. Chapter 1664: Assisted Housing facilities
- 22 M.R.S. § 3174-I. Medicaid eligibility determinations for applicants to nursing homes

OADS Programs Related to Adult Protective Services (APS) and Public Guardianship:

- 22 M.R.S. Chapter 958-A: Adult Protective Services Acts
- 10-149 Chapter 2 DHHS Office of Aging and Disability Services Policy Manual
- 18-C M.R.S. § 5-701
-
- 10-149 Chapter 5, Section 15 Adult Protective Services: Guardianship/Conservatorship

OADS Programs Related to Developmental Disabilities and Brain Injury Services:

- Social Security Act, Title XIX, 1915(C) Home and Community Based Services
- Home and Community Based Settings Rule, 42 CFR § 441.301(c) et seq.
- Americans with Disability Act, Title II
- 22 M.R.S. Governs Department of Health and Human Services; MaineCare Administration and LTSS to include Brain Injury
    - 22 M.R.S. §§ 3088, 3088-A
- 34-B MRSA Governs Developmental Services and related programs.
    - 34-B M.R.S. § 5003-A
    - 34-B M.R.S. § 6003

Program Description

The Office of Aging and Disability Services mission is to promote the highest level of independence, health, and safety for older adults and adults with disabilities throughout Maine. The Office is managed by a director, associate director and multiple program staff. OADS organizational charts can be found in the appendix and are available on the Office's website here.[38]

OADS is responsible for services that support older adults, adults with physical disabilities, adults with intellectual/developmental disabilities (IDD) and autism, and adults with brain injuries and other related conditions. OADS has three major program areas:

Adult Protective Services (APS)

Adult Protective Services serves incapacitated adults and dependent adults. Incapacitated audits are anyone over the age of 18 years old or older who are unable to receive and evaluate information and/or are unable to make or communicate decisions, even with supportive services, technological assistance or supported decision making. A dependent adult is an adult who has a physical or mental condition that substantially impairs their ability to adequately provide for their daily needs. This includes residents of a nursing home or an assisted living facility, a person who receives services because of a disability, including a developmental disability or a brain injury, and/or a person who is wholly or partially dependent upon another person for care or support due to significant limitations in mobility, vision, hearing, or emotional or mental functioning. APS programs include adult protective services; estate management services; and public guardianship program.

Aging and Long-Term Services & Supports (LTSS)

OADS is designated as Maine's State Unit on Aging under the federal Older Americans Act (OAA) and is responsible for planning, developing, managing and providing services to promote independence for older adults, in accordance with a federally approved State Plan on Aging. Maine's current plan was recently approved through 2028. OADS contracts with five Area Agencies on Aging (AAAs) which serve as local "one-stop-shops" to provide referrals to and answer questions about a wide range of services and resources.

Maine uses a "No Wrong Door" approach for people seeking long term services and supports. Entry points may include:

- Area Agencies on Aging, which operate Aging and Disability Resource Centers
- Independent Living Center (Alpha One)
- Maine's Long Term Care Ombudsman (LTCOP)
- Application to Office for Family Independence for MaineCare LTSS eligibility
- Referrals to Assessing Services Agency (Maximus), which commonly come from physicians, hospitals, providers, individuals and family members

[38] https://www.maine.gov/dhhs/oads/about-us/staff.

LTSS programs include the MaineCare benefit section 19, aging and disabled waiver services, MaineCare State Plan services, State-funded programs, quality management, and Older Americans Act funded aging in community services.

Developmental Disabilities & Brain Injury Services (IDD and Brain Injury)
Individuals with intellectual and Developmental Disabilities and/or autism strive to live as independently as possible. A range of services and supports are available to help them achieve this goal in their homes, in the community, and in the workplace. IDD and Brain injury programs include Brain Injury services including MaineCare benefit, section 18 brain injury waiver services, MaineCare benefit, section 20, other related conditions waiver services, developmental services including MaineCare benefits section 21 and section 29 waiver services, employment services, and crisis services. Access to services can be found on our website.[39]

OADS receives federal and state funds to support programs and services for older and dependent adults. OADS/SUA works to ensure aging and disabled adults can remain active and independent within their communities. The SUA is responsible for the oversight and funding support to Maine's five local area agencies on aging (AAAs) to deliver services to adults ages 60 and older. Services are provided to older adults with the greatest social and economic need and are focused on serving older adults with low socioeconomic status, minorities, and those with limited English language proficiency.

Services provided include meals, information and assistance, legal services, caregiver services, and health promotion and disease prevention programs. The SUA collaboratively provides long-term services and supports (LTSS), including adult day services, homemaker, personal care, home and community-based services (HCBS), through various partnerships and funding allocations. OADS works closely with providers, other government agencies, elected officials, advocacy groups, older adults, and adults with disabilities.

Performance monitoring relies on reliable, regular indicator measurement that confirms participants have received the services they need and that these services are effective. Data collection includes information found in program participant surveys, such as the Core-Q or Home and Community Based Services (HCBS), Consumer Assessment of Healthcare Providers and Systems (CAHPS®), quality assessments, service provider reports, and other related service records (e.g., health care usage), to track whether services are being used and if those services meet participant needs.

OADS regularly monitors information collected from these data sources to evaluate program outcomes related to timely, safe, and person-centered service delivery, which promotes choice-making and independence for people receiving OADS services. Measures are also used to evaluate the success of new initiatives and to identify priorities for future system changes. Some metrics are required by Federal or State rules and follow remediation and/or corrective action procedures at least annually.

OADS has partnered with the Maine Office of MaineCare Services (OMS) and Division of Licensing and Certification (DLC) to implement rate reform in Nursing Facilities (NFs), moving away from the administratively burdensome cost-settlement process toward a prospective payment model which incentivizes low use of temporary agency staff and includes a value-based purchasing (VBP) initiative to drive quality, value, and fiscal sustainability. OADS receives an average of 120 applications from

[39] https://www.maine.gov/dhhs/oads/get-support/adults-intellectual-disability-and-autism

agencies or individual providers seeking approval to become a provider of Section 18, 20, 21 and 29 MaineCare waiver services each year.

OADS works directly with OMS on the following MaineCare Benefits Manual Sections of Policy:

- Section 12, Consumer Directed Attendant Services
- Section 13, Targeted Case Management for Adults with Intellectual Disability or Autism Spectrum Disorder
- Section 18, HCBS for Adults with Brain Injury
- Section 19 HCBS For Older and Disabled Adults
- Section 20, HCBS for Adults with Other Related Conditions
- Section 21, HCBS Support Waiver for Adults with IDD/Autism
- Section 29, HCBS Comprehensive Waiver for Adults with IDD/Autism
- Section 50: Intermediate Care Facilities for Individuals with Intellectual Disability
- Section 67, Nursing Facility Services for Acquired Brain Injury
- Section 96, Private Duty Nursing and Personal Care Services
- Section 97, Private Non-Medical Institutions for Adults with Brain Injury or Adults with Intellectual Disability
- Section 102, Rehabilitation Services for Adults with Brain Injury

OADS administers policy, eligibility standards, and oversight of case management services delivered by a network of private agencies under MaineCare contracts, delivering conflict-free community case management, assessing services vendors for independent assessments for level of care.

OADS is currently working to launch the Lifespan Waiver. OADS developed the Lifespan Waiver to address long-standing fragmentation in Maine's HCBS system, including multiple age- and diagnosis-specific waivers, overlapping waiting lists, delayed access to services until adulthood, and limited flexibility to adjust supports as people's needs change over time. Under the current structure, individuals and families must often navigate several waivers, experience service gaps during key life transitions, and remain on waiting lists even while receiving services through another program, creating confusion and inequity. The Lifespan Waiver responds by establishing a single, statewide "waiver for life" that eligible individuals can access beginning at age 14 and remain in as they age, supporting earlier intervention, smoother transitions, and continuity of services. The waiver emphasizes coordinated planning across all formal and informal supports; services that promote independence, inclusion, employment, and community participation; and modern service and payment approaches, such as tiered supports, expanded self-direction, use of a standardized assessment of need, technology-enabled services, and quality-focused payment models to better align services with individual goals, family needs, and workforce realities.

Coordination with State and Federal Agencies

OADS is designated as Maine's State Unit on Aging under the federal Older Americans Act (OAA) and is responsible for planning, developing, managing and providing services to promote independence for older adults, in accordance with a federally-approved State Plan on Aging.[40]

[40] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2025-2028_Maine_State_Plan_on_Aging_Final.pdf

Maine's current plan was recently approved through 2028. In addition to OADS, Maine's Aging Network is comprised of five Area Agencies on Aging, Legal Services for Maine Elders, and the Maine Long Term Care Ombudsman Program, as well as community service Providers.

Area Agencies on Aging (AAAs)

AAAs Maine offer a variety of services to Maine's older adults, including, but not limited to: information and assistance; in-home services; congregate and home delivered meals; educational programming, including chronic disease self-management programs; family caregiving support and training; and health insurance and benefits counseling, including Medicare education regarding insurance and prescription drug benefits, identification and reporting of health insurance fraud, waste, and abuse. Maine has five AAAs, all of which are private, non-profit agencies. They are the Aroostook Agency on Aging, Eastern Area Agency on Aging, SeniorsPlus, Spectrum Generations, and Southern Maine Agency on Aging. The agencies serve all regions of the state. These agencies maintain a statewide association dedicated to statewide aging advocacy and leadership called the Maine Association of Area Agencies on Aging (M4A). Maine's five AAAs are also designated Aging & Disability Resource Centers (ADRCs) as part of Maine's No Wrong Door System to answer questions from both older adults and adults with disabilities, about a wide range of in-home, community-based, and institutional services. Attachment D includes a map of the state designated and federally approved Planning and Service Areas (PSAs) and contact information for each AAA.

Legal Services for Maine Elders, Inc

Legal Services for Maine Elders, Inc. is a private non-profit agency designated by the State and funded under the Older Americans Act to provide free legal services statewide to individuals ages 60 and older. The agency also receives state funding as well as funding from other private and public organizations and private donors to support its activities.

Maine Long Term Care Ombudsman Program (LTCOP)

LTCOP is a private, non-profit organization designated by the state to provide advocacy for older adults and disabled recipients of long- term care services and support throughout the state. LTCOP serves residents in nursing homes, assisted housing programs (residential care and assisted living), adult day programs, and recipients of home care services. An Ombudsman is an advocate, specially trained to investigate and resolve complaints made by, or on behalf of, long-term care consumers. The Ombudsman's role is to educate consumers and long-term care providers about residents' rights and good care practices. Maine law, 22 MRSA § 5106(11-C), originally enacted in 1991, requires the Department to support and maintain a long-term care ombudsman program per the Older Americans Act, by agreement with a nonprofit organization. The Maine Long- Term Care Ombudsman Program, a nonprofit corporation registered in the State of Maine, has fulfilled the OAA requirements as the Ombudsman and has held a contract with the Department for several years.

OADS also collaborates with the partner organizations listed below:

- Administration for Community Living
- Age-Friendly State Committee
- Adoptive and Foster Families of Maine
- Aging and Disability Mortality Review Panel

- American Association of Retired Persons
- Area Agencies on Aging
- Catherine Cutler Institute at the University of Southern Maine
- Catholic Charities of Maine
- Center for Independent Living
- Center for Medicare and Medicaid Services
- Disability Rights Maine
- Elder Abuse Institute of Maine
- Home Care and Hospice Alliance of Maine
- Houlton Band of Maliseet Indians
- Immigrant Resource Center of Maine
- Legal Services for Maine Elders
- Maine Alzheimer's Association
- Maine Association of Community Support Providers
- Maine Association of Personal Care Agencies
- Maine Center for Disease Control
- Maine Council on Aging
- Maine Department of Labor
- Maine Department of Professional and Financial Regulation
- Maine Department of Public Safety
- Maine Developmental Disabilities Council
- Maine Developmental Services Oversight and Advisory Board
- Division of Licensing and Certification
- Maine Elder Death Analysis Review Team
- Maine Health Care Association
- Maine Long Term Care Ombudsman Program
- MaineCITE
- Mi'kmaq Nation
- Office for Family Independence
- Office of Behavioral Health
- Office of Child and Family Services
- Office of MaineCare Services
- Opportunity Alliance
- Passamaquoddy Tribe
- Penobscot Nation
- Penquis
- Social Security Administration
- Speaking Up for Us
- State of Maine Governor's Cabinet on Aging
- State of Maine Housing Authority
- State of Maine Office of the Attorney General
- University of Maine
- University of Southern Maine Muskie School

Emerging Issues

The demographics of Maine's population present a workforce challenge for the state because the number of older adults in need of services is rising and the number of available workers across Maine is declining. According to the U.S. Census Bureau, Maine has the highest median age of any state or territory at 44.8 in 2021, and will rise to 49 in 2050, with the older adult population likely to grow at a much faster rate during that time. Maine's older adult population is already rapidly changing. From 2017 to 2022, Maine residents aged 65 to 74 years old grew to over 25,000 people. By 2050, it is anticipated that older adults, those aged 65+, will make up 29 percent of Maine's population. The ratio of people ages 20-64 persons per person ages 65 and older is projected to decline from 2.6 people in 2020 to 1.8 in 2050, largely due to higher death rates than birth rates over time. The declining ratio of younger to older persons has significant implications for the available workforce to serve Maine's older aging population.

Older adults in Maine also experience increased poverty rates as they age. While under one-quarter of 55–64-year-old Mainers have incomes below 200 percent of the federal poverty level (FPL) ($34,000 in 2022) nearly one-third of people 75+ have incomes below that level. Over 100,000 Mainers 60 and older have annual income below 200 percent of the FPL.

Housing, Food and Nutrition, and Transportation are among the top issues reported in Maine's State Plan on Aging 2025-2028.[41]

Additionally, the demand for Home and Community-Based Services (HCBS) continues to grow among older adults and individuals with disabilities who wish to remain safely in their homes and communities. At the same time, Care Coordination providers across the state are facing significant capacity challenges. The complexity of service planning and ongoing care management has increased beyond what many agencies are currently able to support. Contributing factors include persistent workforce shortages, administrative burden, rising case complexity, and challenges to recruit and retain qualified staff.

Without additional resources or meaningful system efficiencies, individuals may experience delays in accessing needed services, reductions in the quality and consistency of Care Coordination, and increased stress for families and caregivers. These capacity constraints serve as a growing barrier to ensuring that Maine people can age in place safely and with the supports they need.

[41] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2025-2028_Maine_State_Plan_on_Aging_Final.pdf

Riverview Psychiatric Center

Built in 2004 concurrently with the closure of the Augusta Mental Health Institute (AMHI), Riverview Psychiatric Center (RPC) is a 92-bed, state-operated inpatient psychiatric hospital treating patients with severe and persistent mental illness. Riverview is a leader in the science of inpatient care.

Enabling Legislation
Riverview Psychiatric Center's enabling legislation is 22-A M.R.S. § 208, whereby the Commissioner of the Department shall maintain two state mental health institutes ("one at Bangor called the Dorothea Dix Psychiatric Center and the other at Augusta called the Riverview Psychiatric Center.")

Program Description
Riverview Psychiatric Center provides care and treatment to individuals with serious and persistent mental illness through inpatient and outpatient services on a voluntary or involuntary basis. RPC provides care and treatment to individuals who are found Incompetent to Stand Trial and those who are Committed for Observation through the criminal justice system.

The hospital, located in Augusta, is a 92-bed psychiatric hospital organized into major clinical, administrative, and support services departments. There are four inpatient treatment units which provide acute level of care, treatment, and recovery. In addition to the inpatient units, RPC offers a state-of-the-art dental clinic that services patients within the hospital, as well as community members with mental health and developmental disabilities. In the last couple of years, a neurology clinic was opened for both RPC and DDPC patients, and there is an outpatient clinic in Augusta that currently serves 63 Not Criminally Responsible (NCR) clients who reside in the community under modified release and release status court orders.

In 2024, the hospital became a member of Harbor Performance Initiative (HPI) – a consortium of state psychiatric hospitals and specialty units (including university-affiliated ones throughout the country to create and establish best practices on inpatient psychiatric hospital operations, with a major focus on patient and safety.

Also in 2024, RPC implemented a new nursing apprenticeship program, initiated a program to accept University of New England students for internships with the hospital's pharmacy, and piloted a mentorship program for mental health workers. The hospital also obtained accreditation from the American Psychology Association (APA) for the predoctoral psychology internship program, which has led to a significant increase in applicants.

Riverview is tasked with reviewing and submitting the Authorization to Release Information for the purpose of Applying for a Concealed Firearm Permit in accordance with 25 M.R.S. § 2003(1)(E)(1). Riverview also reviews and signs (when in agreement) extensions for Progressive Treatment Program's (PTP) from outside agencies.

Pursuant to 15 M.R.S. § 104-A(1), the hospital also has a duty to issue periodic reports related to each individual in the custody of the Commissioner who has been found Not Criminally

Responsible. Each report contains the opinion of a staff psychiatrist addressing whether the person may be released or discharged without the likelihood of injury to that person and is filed in Superior Court.

Additionally, RPC complies with all Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) federal laws, state statutes, and internal confidentiality and privacy policies. Below is a list of those policies.

HIPPA Confidentiality and Privacy Policies as it pertains to patients and medical records	
Policy Number	**Subject**
2.1	Confidentiality/Privacy
2.2	Identifying a Valid Authorization and Criteria for Determination of PHI
2.2.1 & 2.2.1a	Use and Disclosure of Mental Health, SA, HIV information
2.2.4	Using, Disclosing, and Requesting the Minimum Necessary Amount of PHI
2.2.6	Use and Disclosure via Fax
2.6, 2.9, 2.10, 2.13, 2.21, 2.23, 2.26	Disclosures of PHI required by law, to family, other organizations, law enforcement
3.7	Destruction of Confidential Information
Policies and Procedures to comply with the standards, implementation specifications, and other requirements of HIPPA and HITECH	
IS-001	Overview: Information Security Policies, Procedures, and Documentation
IS-002	Security Management Process
IS-003	Security Sanctions
IS-004	Assigned Security Responsibility
IS-005	Information Access Management
IS-006	Security Awareness and Training

Coordination with State and Federal Agencies

Riverview Psychiatric Center partners with organizations and individuals at the federal, state, and local level, including but not limited to the following entities:

- Center for Medicare and Medicaid Services
- Department of Public Safety
- Division of Licensing and Certification
- Maine Center for Disease Control
- Maine Department of Corrections
- Maine Department of Education
- Maine Department of Labor

- Maine Department of Public Safety
- Maine Health Care Coalition
- Maine Judicial Branch
- Maine National Guard
- Office for Family Independence
- Office of Aging and Disability Services
- Office of Behavioral Health
- Office of MaineCare Services
- Office of the Attorney General
- State Board of Pharmacy
- State Forensic Services
- University of Maine System

RPC partners closely with the Office of Behavioral Health to deliver community-based placements for appropriate individuals who are committed to the care and custody of the Commissioner due to being found Not Criminally Responsible for a crime. Placements in the community allow for additional bed capacity and the least restrictive environment of care.

Emerging Issues
As the federal and state landscape continues to change, both RPC and DDPC anticipate navigating a number of emerging issues in the coming years. This includes, but is not limited to, increased legal holds impacting admissions and discharges due to length of stay in state statute, and issues related to discharge planning as a result of ongoing impacts and delays due to evolving community resources.

Additionally, given the constant pace of policy changes at the state and federal levels, both RPC and DDPC continue to closely monitor changes to state, federal, and joint commission rules and regulations to ensure compliance with all requirements.

Dorothea Dix Psychiatric Center

Dorothea Dix Psychiatric Center (DDPC), formerly known as Bangor Mental Health Institute, located in Bangor, Maine, is a 67-bed, state-operated psychiatric hospital that provides services for people with severe mental illness.

Enabling Legislation
Dorothea Dix Psychiatric Center's enabling legislation is 22-A M.R.S. § 208, whereby the Commissioner of the Department shall maintain two state mental health institutes ("one at Bangor called the Dorothea Dix Psychiatric Center and the other at Augusta called the Riverview Psychiatric Center").

Program Description
DDPC is a 67-bed psychiatric hospital, located in Bangor, and provides state of the art, individualized care and inpatient services for people with severe mental illness that are either admitted voluntarily or court committed. The hospital focuses on enhancing symptom management, promoting skill development, increasing knowledge, and challenging people to use their strengths to lead more hopeful and autonomous lives.

The hospital's mission is to collaborate with individuals with severe and persistent mental illness, their community, and personal supports to provide recovery oriented, respectful, compassionate, and effective psychiatric care and treatment in the least restrictive, safest, and most therapeutic environment that can be created.

Dorothea Dix is tasked with reviewing and submitting the Authorization to Release Information for the purpose of Applying for a Concealed Firearm Permit in accordance with 25 M.R.S. § 2003(1)(E)(1). Riverview also reviews and signs (when in agreement) extensions for Progressive Treatment Program's (PTP) from outside agencies.

Pursuant to 15 M.R.S. § 104-A(1), the hospital also has a duty to issue periodic reports related to each individual in the custody of the Commissioner who has been found Not Criminally Responsible. Each report contains the opinion of a staff psychiatrist addressing whether the person may be released or discharged without the likelihood of injury to that person and is filed in Superior Court.

DDPC's Strategic Plan and Quality Assurance Performance Improvement (QAPI) reporting are forefront in establishing priorities and include goals and objectives as well as Key Performance Indicators (KPIs). The Strategic Plan's approach to Goals and Objectives follows both quantitative and qualitative methodology whereas the QAPI measures are driven by quantitative measurement with qualitative description for understanding of measure and accompanying improvement efforts. DDPC's KPIs are exclusively measured quantitatively and reflect core hospital interests.

DDPC's QAPI reports also include regulatory reporting that reflect key components of compliance and performance for a psychiatric hospital. DDPC's hospital-inclusive QAPI

measures are determined related to trends, failures or decreases in performance or observed deficiencies most notably driven through our robust and stringent Incident Reporting system.

This assessment takes place quarterly, with individual reporting department monitoring monthly for Strategic Plan, KPIs and QAPI report. All are submitted and reviewed by the Executive Leadership, the Advisory Board with inclusion of the DHHS Commissioner's Office, as well as committees responsible for individual reports/reporting and QAPI reports are disseminated to all staff. For goals and objectives not meeting expected targeted measurement, further plans of correction are implemented and disseminated.

Additionally, DDPC complies with all Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH) federal laws, state statutes, and internal confidentiality and privacy policies. Below is a list of those policies.

HIPPA Confidentiality and Privacy Policies as it pertains to patients and medical records	
Policy Number	**Subject**
2.1	Confidentiality/Privacy
2.2	Identifying a Valid Authorization and Criteria for Determination of PHI
2.2.1 & 2.2.1a	Use and Disclosure of Mental Health, SA, HIV information
2.2.4	Using, Disclosing, and Requesting the Minimum Necessary Amount of PHI
2.2.6	Use and Disclosure via Fax
2.6, 2.9, 2.10, 2.13, 2.21, 2.23, 2.26	Disclosures of PHI required by law, to family, other organizations, law enforcement
3.7	Destruction of Confidential Information
Policies and Procedures to comply with the standards, implementation specifications, and other requirements of HIPPA and HITECH	
IS-001	Overview: Information Security Policies, Procedures, and Documentation
IS-002	Security Management Process
IS-003	Security Sanctions
IS-004	Assigned Security Responsibility
IS-005	Information Access Management
IS-006	Security Awareness and Training

Coordination with State and Federal Agencies
Dorothea Dix regularly collaborates with local, state, and federal partners, including but not limited to:

- Center for Medicare and Medicaid Services
- Department of Public Safety
- Division of Licensing and Certification
- Maine Center for Disease Control and Prevention
- Maine Department of Corrections
- Maine Department of Education
- Maine Department of Labor
- Maine Department of Public Safety
- Maine Health Care Coalition
- Maine Judicial Branch
- Maine National Guard
- Office for Family Independence
- Office of Aging and Disability Services
- Office of Behavioral Health
- Office of MaineCare Services
- Office of the Attorney General
- State Board of Pharmacy
- State Forensic Services
- University of Maine System

Emerging Issues
As the federal and state landscape continues to change, both DDPC and RPC anticipate navigating a number of emerging issues in the coming years. This includes, but is not limited to, increased legal holds impacting admissions and discharges due to length of stay in state statute, and issues related to discharge planning because of ongoing impacts to community resources.

Additionally, given the constant pace of policy changes at the state and federal levels, both DDPC and RPC continue to closely monitor changes to state, federal, and joint commission rules and regulations to ensure compliance with all requirements.

Office of Health Insurance Marketplace

The DHHS Office of the Health Insurance Marketplace (OHIM) operates CoverME.gov, Maine's state-based health insurance marketplace.

Enabling Legislation
The Maine Health Insurance Marketplace is established pursuant to 22 M.R.S. § 5403 to conduct the functions defined in 42 USC § 18031(d)(4).

Program Description
The Office of the Health Insurance Marketplace is responsible for operating Maine's State-Based Exchange as established by the Affordable Care Act (ACA). Operationally, this is done through CoverME.gov, the public-facing website that includes the enrollment platform for health and dental plans sold through the state-based exchange. All plans sold through CoverME.gov are compliant with the standards set by the Affordable Care Act. The main priorities for this office are to increase the number of insured Mainers, and to offer affordable coverage options to consumers, as CoverME.gov is the only place Mainers can access financial assistance for health coverage. OHIM is responsible for determining consumer eligibility for financial assistance, which includes premium tax credits and cost-sharing reductions. Eligibility standards for financial assistance are set by the Internal Revenue Code and the Internal Revenue Service (IRS).

OHIM serves Mainers who meet the eligibility requirements set by 45 CFR §155.305. Recent federal changes (e.g. CMS Final Marketplace Integrity & Affordability Rule, H.R. 1) have tightened eligibility requirements for coverage through the Marketplace. Deferred Action for Childhood Arrivals (DACA) recipients are no longer eligible for health plans sold through CoverME.gov as of August 25, 2025. In the coming years and because of these federal changes, several groups will lose access to financial savings (e.g. tax credits, cost-sharing reductions), which is likely to reduce the affordability and related accessibility of plans sold through CoverME.gov.

Enrollment opportunities through CoverME.gov include the annual open enrollment period (Nov 1 – Jan 15), during which individuals can enroll in a plan or switch plans, as well as special enrollment periods which are available for special circumstances and are outlined in 45 CFR § 155.420. OHIM is responsible for determining eligibility for special enrollment periods when consumers apply outside of the open enrollment period. During open enrollment, OHIM is required to share weekly reports with the Center for Medicaid and Medicare Services (CMS). These reports include data on received applications for qualified health plans and stand-alone dental plans.

Coordination with State and Federal Agencies
OHIM collaborates broadly with local, state, and federal partners. This includes, but is not limited to,

- Department of Labor (U.S. and state)
- Internal Revenue Service and Maine Revenue Service
- Maine Bureau of Insurance

- Maine Community College system.
- Maine Department of Agriculture
- Office for Family Independence
- Office of MaineCare Services
- U.S. CDC
- U.S. Department of Health and Human Services
- University of Maine

Additionally, OHIM works with several private organizations to deliver services to constituents. Private insurance carriers work with OHIM to offer qualified health and dental plans on the marketplace, where constituents can access publicly funded tax credits and other savings to afford these privately administered plans. The Office holds contracts with networks of private brokers, assisters, and navigators to help consumers understand plan options and enroll in coverage. These private organizations are contractually obligated to maintain OHIM's privacy and security standards.

Emerging Issues

The most pressing issue for OHIM and marketplace enrollees continues to be the affordability of health insurance plans offered on the marketplace. Several recent federal changes, including the July 2025 budget reconciliation bill and CMS's amended Marketplace Integrity and Affordability Rule, challenge accessibility of affordable health care plans for Maine people seeking coverage on the marketplace.

New federal legislation has made changes to the Premium Tax Credits (PTCs) that supplement individual and family purchases of health insurance on the marketplace. PTCs will no longer be available to several vulnerable groups, including certain immigrants and low-income Simplified Employee Pension (SEP) enrollees. The income-based cap on Advanced Premium Tax Credit (APTC) repayment has been removed, creating an unexpected tax liability for many plan holders. This will disproportionately impact those with highly variable incomes like those who are self-employed, low-wage, hourly wage and/or seasonal employees. These consumers will need to regularly update projected income with CoverME.gov to avoid tax liabilities. The reduced affordability is likely to decrease enrollment in health coverage.

Of the 61,000 Maine people who enroll through CoverME.gov, 85 percent rely on premium tax credits to reduce their monthly costs. Federal changes repealing those premium tax credits will make buying insurance less affordable for Maine families. Families are expected to see an average premium increase of $258 per month if/when the enhanced credits expire. The average increase for households will approach $286 per month when combined with insurer-submitted 2026 rate increases. Nearly 9,500 consumers or 18 percent of those receiving assistance will lose all premium support if the enhanced credits expire, leading to average increases of more than $900 per month.

At the time of this report's submission, there is still discussion in Congress about extending the EPTCs and OHIM continues to monitor those legislative efforts.

Legislative Requests pursuant to 3 MRSA §956(2)(K)

Pursuant to 3 M.R.S. §956(2)(K) of the Government Evaluation Act, the Joint Standing Committee on Health and Human Services requested that the Department of Health and Human Services provide additional information on the following requests:

1) **A review of the Department's use of the progressive treatment program (PTP), as authorized by Title 34-B Maine Revised Statutes, Section 3873-A. The committee is particularly interested in any recommendations the department has to improve upon the PTP to better support individuals subject to a PTP order and their families.**

The Progressive Treatment Program (PTP) is a form of court-ordered outpatient services for patients with severe and persistent mental illness who would benefit from an individualized treatment plan in the community. The criteria for PTP admission (34-B M.R.S. § 3873-A(1)) are: the patient suffers from severe and persistence mental illness; patient poses a likelihood of serious harm; the patient would benefit from a suitable individualized treatment plan; there is an available licensed and qualified community provider to support the treatment plan; the patient would be unlikely to follow the plan voluntarily; court-ordered compliance will help protect the patient from interruptions in treatment, relapses or deterioration of mental health; and compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm.

Background

Maine's PTP is established in Title 34-B M.R.S. §3873-A. The Legislative website has posted an overview of the program here: https://legislature.maine.gov/doc/8880 and the results of a recent, legislatively-directed work group facilitated by the Department can be found here: https://legislature.maine.gov/doc/8084.

The current PTP statute largely resembles the same laws that have been in place for nearly a decade. The statute allows designated parties to make an application and then petition the District Court to order the admission of a patient to the PTP. These designated parties specifically include: the superintendent or chief administrative officer of a psychiatric hospital (both state and nonstate), the DHHS Commissioner, the director of an ACT team, a medical practitioner, a law enforcement officer, or the legal guardian of the patient who is subject to the application. The application must be accompanied by a certificate from a medical practitioner providing the facts and opinions necessary to support the application. The application must also include a proposed individualized treatment plan and identify one or more licensed and qualified community providers willing to support the plan. The applicant must also provide a written statement certifying that a copy of the application and the accompanying documents were given personally to the patient and that the patient and the patient's guardian or next of kin, if any, have been notified of the patient's rights regarding appointment of counsel and selection of an independent examiner.

Upon filing of the application, the District Court issues a notice of hearing to be held within 14 days of when the application is filed, unless good cause is shown to continue the hearing for up to 21 additional days. Barring certain exceptions, the hearing is confidential, and a report of the proceedings may not be released to the public or press.

Filing of the application also triggers the District Court to cause the patient to be examined by a medical practitioner. The independent examiner must report to the court on whether the patient is a mentally ill person, is suffering from a severe and persistent mental illness, and is posing a likelihood of serious harm, all terms defined elsewhere in Title 34-B.

Patients who are subject to a PTP application must be afforded an opportunity to be represented by counsel. The District Court is required to appoint counsel if none is provided by the patient or others. Although the statute does not specify when the court must make such appointment, the court's practice is to appoint counsel when issuing the notice of hearing.

Admission to the PTP is contingent upon the following conditions: the patient suffers from a severe and persistent mental illness; the patient poses a likelihood of serious harm; the patient has the benefit of a suitable individualized treatment plan; licensed and qualified providers are available to support the plan; the patient is unlikely to follow the plan voluntarily; court-ordered compliance will help protect the patient from interruptions in treatment, relapses or deterioration of mental health; and compliance will enable the patient to survive more safely in a community setting without posing a likelihood of serious harm. In terms of evidence presented at hearing, the patient, the applicant, and noticed parties are afforded the opportunity to appear, to testify, and to present and cross-examine witnesses. Additionally, the applicant is required to submit to the court expert testimony to support the application and to describe the proposed individual treatment plan.

After notice, examination, and hearing, the court may issue an order effective for a period of up to 12 months directing the patient to follow an individualized treatment plan and identifying incentives for compliance and potential consequences for noncompliance. Compliance measures can include endorsement of an application for the patient's admission to a psychiatric hospital under the emergency involuntary hospitalization procedures set forth in 34-B M.R.S. § 3863 conditioned upon a certificate from a medical practitioner that the patient has failed to comply with an essential element of the treatment plan. This certificate and endorsement are colloquially referred to as the "green paper." Other consequences include the ability of the applicant to file a motion for enforcement with the court supported by a certificate of a medical practitioner identifying the patient's noncompliance with the plan. Additionally, if the court directs a patient to follow an individualized treatment plan, the court may prohibit the patient from possessing a dangerous weapon for the duration of the treatment plan. Finally, for good cause shown, any party to the application may move to dissolve or modify an order or to extend the term of the treatment plan for an additional term of up to one year.

In terms of costs, the PTP statute provides that the applicant bears the expense of providing witnesses to testify in support of the application and to describe the proposed individual treatment plan. All other expenses are the responsibility of the District Court, including fees of

appointed counsel for the patient, witness, and notice fees, and expenses of transportation for the patient.

Current Status and Recommendations

As of December 2025, DHHS is the petitioner for approximately 70 PTP cases across the state. This is not comprehensive of all cases, as this data would reside with the Courts. Maine DHHS is always looking for ways to improve the PTP program and, per legislative Resolve 2021, Chapter 60, completed a stakeholder group process and report in 2022.[42] The group examined the PTP program to look at barriers to filing applications to the District court by authorized persons and assess the consistency and efficiencies of processes by which a person may be involuntarily admitted to a psychiatric hospital or receive court-order community treatment.

Many of the strategies considered in that report are to improve PTP center around providing additional resources for PTP associated activities. One step that the Office of Behavioral Health will take in the second session of the 132nd Legislature is to put forward a bill to allow mental health care providers to request reimbursement from the Department of Health and Human Services for both the initiation and renewal of progressive treatment programs and removes the cap of $800. Current law allows for reimbursement to private entities to initiate such programs and expanding this allowance will strengthen the PTP program using available resources. This bill has been printed as LD 1989 and will be considered by the Health and Human Services Committee in 2026.

[42] https://legislature.maine.gov/doc/8084

2) A review of the MaineCare non-emergency medical transportation (NET), including a review of the contracting process for NET and of system capacity. The committee understands that there may be limitations to this review given ongoing litigation, but requests that the department asses the program to the extent possible.

Maine's Non-Emergency Transportation (NET) brokerage system was implemented in August of 2013 and works across the state to broker contracts with transportation providers who provide rides to Maine people for medical purposes. Maine has the 5th highest utilization of NET in the nation by population according to the Centers for Medicare and Medicaid Services Report to Congress, NEMT 2018-2020[43]. Maine NET programs provide 1.86 million rides on average per year and provide over 2 million rides a year prior to the pandemic. Given the volume of transportation needs met, the NET program is the largest public transit system in the state of Maine.

Background

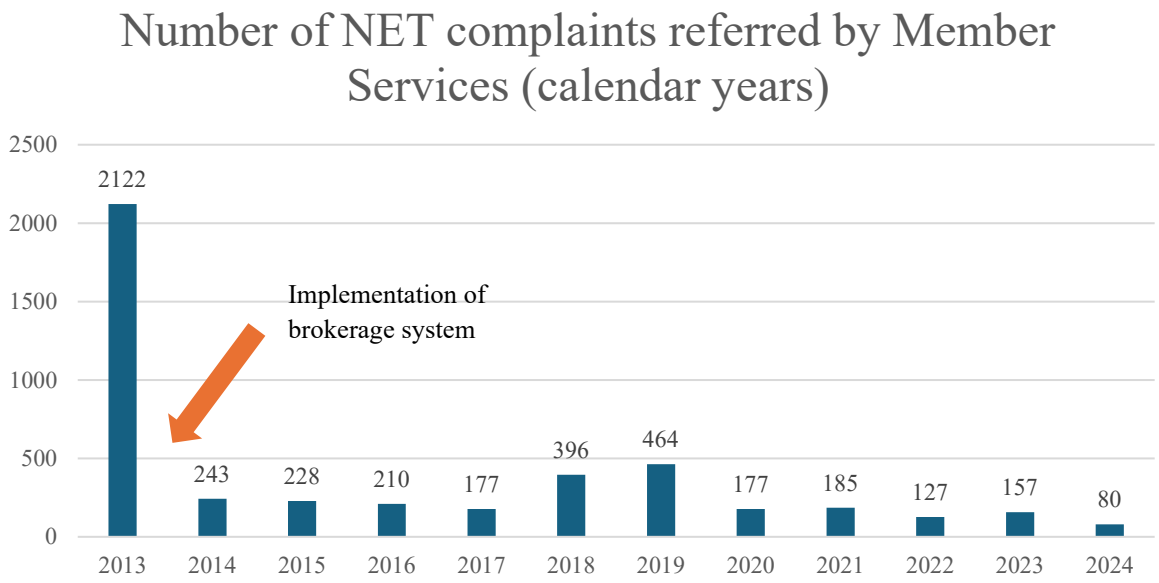
NET services offer transportation to and from MaineCare covered services for full benefit MaineCare members, including children and members utilizing services under HCBS waivers. To access a ride, a member calls a broker to schedule a ride, the broker verifies the members' eligibility, MaineCare service, and appointment. Then, the broker dispatches the trip to a transporter under contract with a broker. The transporter picks up the member at their residence and drops the member off at their appointment. After the appointment the transporter brings the member back home.

The program operates under a federal 1915(b) waiver as a Pre-paid Ambulatory Health Plan (PAHP) and there are three brokers for eight MaineDOT transportation regions accountable for managing cost and administration of the program: ModivCare, Penquis Community Action Corp., and Waldo Community Action Partners (also known as MidCoast Connector). Providers must meet requirements for safety, quality, and timeliness. Brokers contract with dozens of transportation providers, employing hundreds of drivers who provide rides to MaineCare members.

The Office of MaineCare Services is committed to ensuring that members and the public have a process for dealing with issues and complaints and for tracking the status of rides and complains within the program. To help ensure accountability and oversight of the program, members can find resources on the OMS webpage www.maine.gov/dhhs/oms/member-resources and the Department publishes monthly NET Quarterly Reports on our website.[44] Since the 2013 implementation of the Broker system complaints about NET have reduced significantly from a high of 2,122 complaints in 2013 to a low of 80 NET complaints referred by Member services in 2024.

[43] nemt-rtc.pdf

[44] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Third%20Quarter%20Non-Emergency%20Transportation%20Broker%20Performance%20and%20Complaint%20Report.pdf



Although we recognize that due to the volume of rides provided there will always be complaints and challenges, NET performance has seen steady improvement over the years. On time percentage has improved from averaging 86 percent to now averaging 92 percent (contract requirement is 85 percent on time). Missed trip percentage has decreased from nearly 1 percent to .04 percent (contract requirement is no more than 1 missed trip per 100 trips or 1 percent). Commensurate with improving trip data, complaint rates have also come down over time and now average between .02 percent and .07 percent (contract requirement is 1 percent or less). Utilization and the number of annual trips is climbing back up toward pre-Covid levels. During Covid-19, annual trip count was below 1.5 million. It is now at 1.86 million and continuing to rise towards 2 million trips annually where the number of trips was prior to the Covid-19 pandemic.

Contracting

The contracting process for all DHHS contracts, including NET Request for Proposals (RFPs) and subsequent contracts, are handled by the Division of Contract Management. The Division of Contract Management (DCM) exists to ensure DHHS effectively procures and manages its contracts for services. With just over 25 staff, over 2200 procurement documents are reviewed, approved, and processed per year. The DCM also oversees competitive bidding of services for DHHS and provides management tools for recording contract and performance information while providing technical assistance regarding contract development and management.

Division of Contract Management staff endeavor to coordinate RFPs and manage contracts with the greatest degree of consistency, accountability and cost effectiveness. The goal is to ensure that the delivery of services meets the needs of the consumers and the Department. DCM is committed to a procurement management system which ensures the best value, utilizing best business practices, which supports the DHHS public mission, and is in compliance with State and Federal statutes, rules, and regulations.

As outlined in "5 M.R.S. §1825-B. Bids, awards, contracts and grants", the Department of Health and Human Services (DHHS) is required to award contracts through a competitive bidding process. These competitive bids are posted with Maine Department of Administrative and Financial Services Division of Procurement Services (DAFS). System capacity is part of the RFP process.

The State of Maine is federally required to competitively procure broker contracts. In October of 2023, all eight region contracts were awarded to Modivcare. That decision was appealed and an administrative hearing panel validated the Department's decision on April 24, 2024. The case was appealed to the Business and Consumer Court, and in January of 2025, the court upheld the Department's decision. That case is currently under appeal before the Maine Supreme Judicial Court with a decision pending. As a result, the current contracts, with the current three vendors, were extended until June 30, 2026.

Despite significant improvements in the NET program, we continue to find that maintaining and improving Maine's NET program is challenging primarily because of Maine's size and limited workforce availability. Drivers travel long distances to reach members in rural areas and bring them to and from medical appointments. Rural public and private transit is limited in Maine and is especially challenging in rural parts of the state. OMS tracks roughly 2,000 rides per month where the member fails to show up for their scheduled ride, which takes drivers away from other rides they could have offered. Lastly, workforce shortages experienced after the COVID-19 pandemic continue to be an issue for the program. During and after the pandemic, many drivers retired or moved to other jobs and wages in the sector have remained low. Additionally, many volunteer drivers did not return to the service.

Despite these challenges, Maine's NET program continues to improve. The number of complaints to member services continues to fall and the number of rides provided for members continues to grow. OMS continues to work with members, providers, and transporters to identify ways to improve the program.

3) **A review of the timeliness of payments to grantees and MaineCare providers. The committee continues to hear concerns from state grantees and MaineCare providers regarding delayed payments. We therefore request that the Department conduct a high-level examination of barriers to timely payments, with a specific focus on identifying any systemic, cross-program impediments.**

DHHS continues to take steps to resolve payment delay challenges and improve timely payments to providers. In general, invoices are paid timely and within the statutory requirement of 25 working days, which equates to 33 calendar days. Over the past twelve months, the average processing time was just under 23 calendar days from the time a proper invoice was received until the time the payment was released. During the past 12 months, DHHS processed over 13,000 invoices. DHHS believes that as the influx of pandemic and post-pandemic funding winds down, many of the issues resulting from increased volumes of Department invoices will subside, and DHHS will be able to increase turnaround time for making payments.

For reference, payments to state contractors are guided by the following statutes:

- 5 M.R.S. §1553 requires that payments be made 25 business days (translating into 33 calendar days) after receipt of an error-free (proper) invoice. It also provides that in the event an invoice is deemed improper and returned for corrections, the date of receipt shall be the date of the updated invoice.
    - However, DHHS (and DAFS) standard contract language states that payments will be made within thirty (30) calendar days after receipt of an error-free (proper) invoice; a higher standard than what is required by 5 M.R.S. §1553.
- 5 M.R.S. §1554 allows for an additional fifteen (15) days "following another date agreed to by the state agency and the business concern" before a late fee may be applied. In the case of service contracts, the thirty (30) days defined in the contract are the "another date agreed to". The two periods added together total forty-five (45) calendar days.

Given this, DHHS is tracking both milestones: invoices paid within 30 days, and again within 45 days of receipt of a proper invoice. The following numbers are based on this premise. Over the twelve-month period ending September 2025, DHHS is paying 87 percent of invoices within 30 days, the number increases to 93 percent within 45 days. This is an increase from the previous report for which the numbers were 82 percent in 30 days and 91 percent in 45 days. For invoices related to behavioral health and housing assistance program payments, DHHS is paying in similar timeframes—88 percent within 30 days and 94 percent within 45 days. While still not where DHHS wants to be, these numbers demonstrate improvements from the last time this data was reported to the Committee.

Specific to MaineCare providers, these payments are made in multiple ways through claims, prospective interim payments and cost settlements. The Department has improved turnaround times specifically for high-dollar hospital claims that are now only subject to a 30-day pend, where previously they may have been pended for several months.

The Department is aware of legislative efforts like LD 331, which would have changed the timeline for hospital payments, and is not opposed to initiatives and ideas to expedite payments to providers, so long as sufficient resources are supplied.

The increase in contract volume in recent years continues to be the primary reason for contract payment delays. Generally, DHHS pays the majority of invoices within the statutorily required timeframes. Given the volume, and the increase in volume, in recent years in particular, this is a success. However, as a result of the pandemic and influx of federal funding, the number of contract documents processed annually by DHHS increased significantly, going from an average of 1,550 in the fiscal years leading up to the pandemic to 2,100 during fiscal years 2021-2024, an increase of 35 percent. The volume of contract documents processed remains high, as just over 2,200 were processed during fiscal year 2025. This increase in contract volume naturally caused an increase in invoices. Prior to the pandemic, DHHS was averaging roughly 850 invoices processed per month, or just over 10,000 annually. DHHS processed over 13,000 invoices in fiscal year 2025.

Maintaining consistent staffing levels and retaining people was still a challenge over past fiscal year. The Division of Contract Management had some experienced people leave over the past year due to retirements or promotions. The turnover rate for DCM has improved at the entry level position of "contract administrator." DHHS program offices have also experienced similar staffing challenges. These have led to delays in getting contract documents to DCM for processing. This started the ripple effect, leading to delays in getting contracts encumbered. DHHS has felt the workforce shortage that has been experienced in Maine and nationwide. DCM and program offices have struggled to keep positions filled with skilled employees. Because the DCM workforce was more stable than previous years, it was able to improve processing time for invoices and was able to improve its ability to encumber contracts more quickly.

The State Procurement Review Committee (SPRC) reviews and approves all state contracts and amendments with a value of $1 million or more. While the SPRC review and approval process has improved, the SPRC has been impacted similarly by the same factors affecting DHHS, including significantly increased volume, changes in staff, and the need to ensure proper contract terms and documents before issuing final approval.

Many of DHHS' contracts with the non-profit behavioral health organizations flow through SPRC review, including Shalom House, Wellspring, Kennebec Behavioral Health, The Opportunity Alliance, Community Health and Counseling Services, Preble Street, Penobscot Community Health Center, Sweetser, and Spurwink.

With the increase in contract and invoice volume, there still is an increase in exception processing and triaging problems that require resolution at a higher level, such as DCM and program office leadership. Issues range from questions related to how to resolve payment issues with contracts, such as funding lines without allotment, interpretation of policies and procedures, and contracting and RFP options. This means there is less time for leadership to devote to monitoring timeliness, management, and training.

Because of the aforementioned issues, DHHS is continually reviewing internal processes and procedures with the goal of ensuring that contracts are encumbered and invoices are paid timely. Examples of additional improvements included:

- Reviewing, documenting, and streamlining standard operating procedures to clarify Departmental roles and responsibilities and to confirm that contract processes were streamlined, predictable, repeatable, and well-documented.
- Improving reports that provide insight into turnaround times and improve communication across, and between, Departmental contract teams.
- Enhancing the internal workflow system to reduce double data entry between DHHS' contract tracking system and the State's financial system. Portions of the job required significant data-entry.
- Providing improved and expanded training for DCM and program offices. The training highlights statutory requirements, outlined staff responsibilities based upon their role, reviewed Department process flows, walked through how to use the computer systems to move invoices through for approvals and payments, and gave guidance on how to handle common exceptions.
- Providing improved information for providers, including standard (abbreviated) guidance for providers on how to submit invoices and technical assistance to providers when they have questions or are experiencing challenges with submitting invoices or getting them paid.

With these changes, DHHS continues to reduce the time it takes for contracts to be encumbered, and to reduce the average time to make payments, even while processing significantly more contracts and invoices.

4) **An examination of information technology and the costs associated with contracting out development and maintenance of technological systems. The committee understands that the department utilizes a variety of complex and specialized programs and databases and that much of the work involved in creating, updating and maintaining these systems is contracted out to third party vendors. The committee requests that the department review these contracts and make recommendations to the committee as to whether any of this work could be moved in-house, and whether such a move would result in cost savings to the state.**

To ensure the Department is getting the best value for services, both technology products and services are secured in accordance with State procurement practices through a competitive Request For Proposal (RFP) process. A crucial factor of the RFP scoring process is the consideration of cost. Currently, State rules require minimum 25 percent of the scoring be cost-based. As members of the RFP evaluation team, both DHHS program representatives and MaineIT representatives must keep this in mind with all scoring. The resulting technology contracts for awardees are IT contracts that were developed and approved by both DHHS and MaineIT.

A key driver to the cost trends seen across the technology industry and is the continuing increase in state technology costs are trends that reflect rising annual costs between 6-9 percent in each of the past 5 years. Additionally, most technology initiatives do not purely require new technology to be implemented but also include business transformation as a key deliverable. For example, a business process redesign that ensures we automate good business processes versus automating existing historical processes.

The Department's annual average technology contract spending equates to approximately $115M. This figure is inclusive of new implementation costs as well as licensing, SaaS (software as a service) fees, infrastructure, supporting information security tools and technical resources for both standard "keep the lights on" support as well as enhancements for existing solutions driven by Federal mandates, State legislation, and operational efficiency enhancements. For many of our system applications, the total cost is funded through a combination of Federal funds (often ranging between 50-75 percent of the annual operations and maintenance costs and up to 90 percent for Medicaid-related system implementations) and State General Funds.

Because of the intertwined relationship with state departments, the decision for DHHS to build its own system development operation does not lie within the Department of Health and Human Services. To date, such operations have been prohibited.

Additionally, for several years, MaineIT has shifted their strategic direction resulting in a reduction in the number of system applications they build and maintain. There has been an increased focus on consultation, oversight, and guidance on all aspects of technology for executive branch departments. As such, consideration of such a model would require DAFS/MaineIT leadership input, review, and approval.

If such a shift occurred, it is important to note that there is significant complexity to changing technology platforms from a vendor to an in-house operation. This is due to the vast transfer of

knowledge that would be required. This would include, but is not limited to, the system software and code, the supporting database, the underlying requirements of the infrastructure supporting the system, and the critical security layers. Additionally, it is common for the solution to have integration components with other systems, including systems within the vendor's sub-contractors.

As many sectors are facing workforce challenges, the technology sector is no different. It would be difficult to hire the proper skilled resources at the capacity level required to adequately meet the need and there would also be challenges with retention considering the pay differential for technology resources in the public versus private sector. Finally, there could be legal obstacles to navigate, such a change in that some of the vendors' products may be proprietary. This would also be costly to the state.

5) **A plan for how the Department will implement or otherwise address recommendations related to child welfare. The committee is aware that the department has engaged in significant work to improve the child welfare system in recent years and has developed a list of many recommendations for reform. The committee requests that the department describe its plan for implementing these recommendations over the coming years. The committee is amendable to the department including this information in its annual report to the committee, rather than this program evaluation report, should the department wish.**

Following years of input and recommendations, as well as shifting landscape in communities and child welfare specifically, OCFS developed the 2025-2027 Strategic Plan to detail the objectives, strategies, and outcomes OCFS will pursue over the next two years. While the Strategic Plan covers the whole office, it also includes specific strategies to improve child welfare practice, prioritize the safety of children, ensure permanency and well-being, and support the child welfare workforce. Some highlights include:

- Increasing secondary/tertiary prevention services for families to prevent unnecessary removal of children;
- Ensuring that the number of children that experience repeat maltreatment is at or below the national average;
- Streamlining kinship licensing processes.
- Decreasing the length of time from removal to permanency.
- Increasing the rate of completion and quality of Rehabilitation and Reunification Plans and ensure that children and parents are engaged in the development of the plan;
- Ensuring all children in care have recommended and required health visits and immunizations within required time periods;
- Improving well-being outcomes for children in care through a focus on medical, dental, mental/behavioral health, education, cultural connections, peer relationships, and transitions to adulthood;
- Updating child welfare policies in collaboration with child welfare staff, children, parents, and other key stakeholders; and
- Resolving the most acute challenges that impact the ability of OCFS caseworkers to effectively complete their duties, such as Hotel/Emergency Department coverage.

The full Strategic Plan can be found here.[45] Additionally, the plan was presented to the Health and Human Services Committee in September 2025 as part of the quarterly child welfare update. That presentation is also available online here: https://legislature.maine.gov/doc/11960.

Further, OCFS sees every recommendation as an opportunity to examine our practice, lean into other perspectives and improve our services and support as part of the system in which we

[45] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/OCFS%20Strategic%20Plan%20%282025-2027%29%20Final%2008042025_.pdf

collectively strive to improve the safety and lives of children and their families. A list of key recent accomplishments that provides detailed responses to hundreds of recommendations OCFS has received with respect to child welfare improvements can be found here.[46] As a reminder to the Committee, improvement work has been ongoing. Following Director Johnson's appointment in January 2024, OCFS contracted with Public Consulting Group (PCG) to conduct a targeted assessment of OCFS' child welfare services. In the report, PCG made a series of recommendations for improvement in four key areas: management structure; professional development; communication; and retention, engagement, and culture.

Following the receipt of this report, OCFS began reviewing and redesigning the organizational and management structure in light of the report's recommendations. Additionally, PCG provided OCFS with further technical assistance and guidance to incorporate in the organizational redesign during implementation. Some of the many benefits of the redesign include:

- Enables focused District Office oversight to advance consistency and cultural improvements in and across districts;
- Consolidates and more closely aligns strategy, training, and policy implementation to improve workflow and to balance workload across new manager positions;
- Creates a child welfare senior management team that can collaborate effectively, with clearly defined roles and responsibilities, and have a strong leadership pipeline from the districts up to the Director;
- Appropriately sections programmatic oversight from business operations and creates conditions for clear governance and decision-making for distinctly different functions; and
- Allows for supervision practices to align with best practices at every level of Central Office and creates conditions for the level of coaching and management required to strengthen consistency and culture.

The Department also announced[47] in January 2024 that children's behavioral health services would move to the Office of Behavioral Health. This happened quickly and integrated children's services into the OBH workflow, better coordinating services across the lifespan and aligning efforts to expand workforce and capacity.

These changes are part of an ongoing commitment to address challenges in child welfare, support the workforce, and improve outcomes for Maine children and families. The Mills

[46] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Status%20of%20Recommendations%20to%20OCFS%20%282025%29%20Final.pdf
[47] https://www.maine.gov/dhhs/blog/maine-dhhs-reorganizes-behavioral-health-better-serve-children-and-families-2024-01-18

Administration and Legislature have taken significant actions[48] toward these goals during the last several years. The annual Child Welfare Report (PDF)[49] also provides details on these efforts.

[48] https://www.maine.gov/dhhs/blog/maine-takes-further-action-improve-child-welfare-system-2024-05-09
[49] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Status%20of%20Recommendations%20to%20OCFS%20%282025%29%20Final.pdf

6) A review of the Department's response to the COVID-19 pandemic, including how the department coordinated its activities with other state agencies, and recommendations for improving the department's readiness to respond to future emergencies.

The Department of Health and Human Services is extremely proud of Maine's response to the COVID-19 Pandemic that begin in Maine in March of 2020. The Department assembled two department-wide internal reports that reviewed our response and provided recommendations for how Maine could continue to improve its response to major public health emergencies in our state.

The first report is entitled "Covid Response Review 2022," and provided an "In Progress" review of the COVID-19 response in Maine. The review focused on six core areas: Statewide policies, COVID-19 prevention checklists, Testing, Social Supports, Health Care Workforce Support, and Vaccination efforts. In addition to a review of Executive Orders and Policies, the report includes insights from meetings and participant experiences which provide information about the Departments response.

The second report is entitled "Maine CDC COVID-19 After Action Report (AAR)" and was developed with a focus on the Maine CDC's COVID-19 response activity from the beginning of the pandemic through July of 2022. The AAR provides an exhaustive look at Maine's COVID-19 efforts and coordination across the state and with the Federal Government.

Both reports were created for the purposes of internal use to inform and improve the Department's efforts going forward. Both reports provide details about the long hours, challenging circumstances, and commitment shown by the people of Maine, including public servants, to meet the challenges of the pandemic.

Lastly, the Committee requested that, "pursuant to Title 3 Maine Revised Statutes, Section 956, subsection 2, paragraph J and L, the department describe, to the extent possible, its plan to address possible reductions in federal funding, including reductions to disease prevention and health promotion services, to MaineCare funding, and to block grants"

The Department continuously monitors changes in federal budget and policy and works year-round to help support the preparation of the DHHS portion of the Governor's budget and supplemental budget each year. When large changes do happen at the Federal level, DHHS strives to communicate those changes and plans to the Legislature. Since May 2025, when HHS made this request, the Department has done just that.

On July 4, 2025, the Federal Budget Reconciliation bill, also called H.R. 1, was signed into law and will have sweeping effects on DHHS programs. DHHS reviewed the bill and found several policy changes that shift costs and administrative burdens to states. New eligibility, reporting, and verification mandates have been created that will add costs to Maine programs. Also, the bill contains new restrictions on the state's ability to be flexible in certain programs. While the Department had been modeling and communicating potential impact while the bill was considered, just days after it was signed the Department published a complete estimate of the impact on programs and people online[50].

Compliance with H.R. 1 and new rules will necessitate the state invest in staff, eligibility systems, and data infrastructure to meet the new federal mandates. Overall, the bill will create greater administrative burdens, tighter eligibility requirements for individuals seeking services, and result in gaps in existing funding and our programs. DHHS reported the full analysis of the new legislation to the AFA and HHS committees on October 17, 2025. The full presentation can be found online.[51]

The Department is working with the Department of Administrative and Financial Services and the Governor's Office on a plan to address the changes in federal policy and funding. funding The State's ability to backfill the federal government is limited, and multiple competing priorities will be considered and negotiated. The Department will continue to provide information to the Legislature, answer questions, and work together to find solutions for the people of Maine.

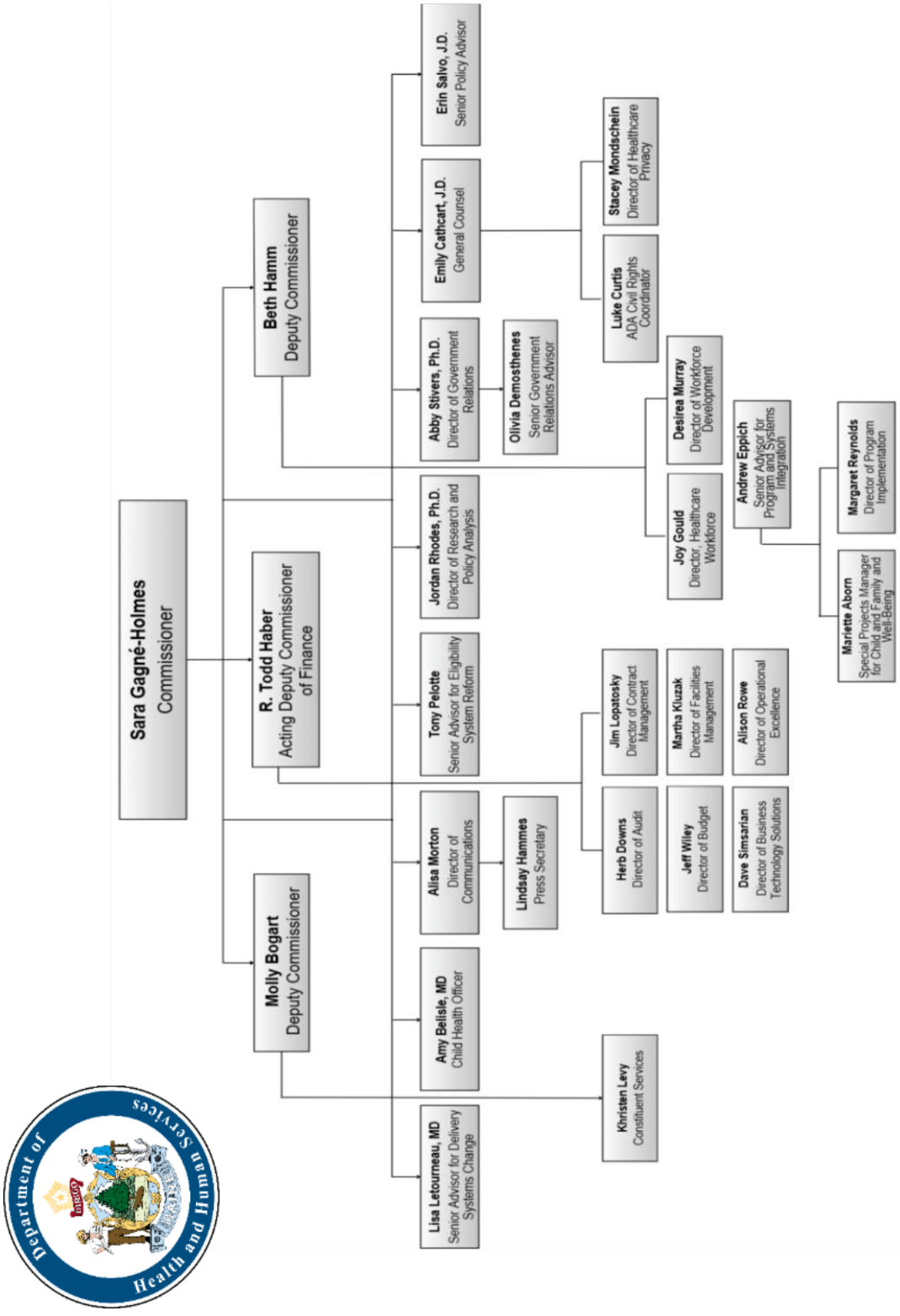
[50] https://www.maine.gov/dhhs/blog/federal-budget-reconciliation-law-now-effect-impacts-mainecare-snap-covermegov-2025-07-11
[51] https://legislature.maine.gov/doc/12036

Appendix A: Office Orientations and Organizational Charts

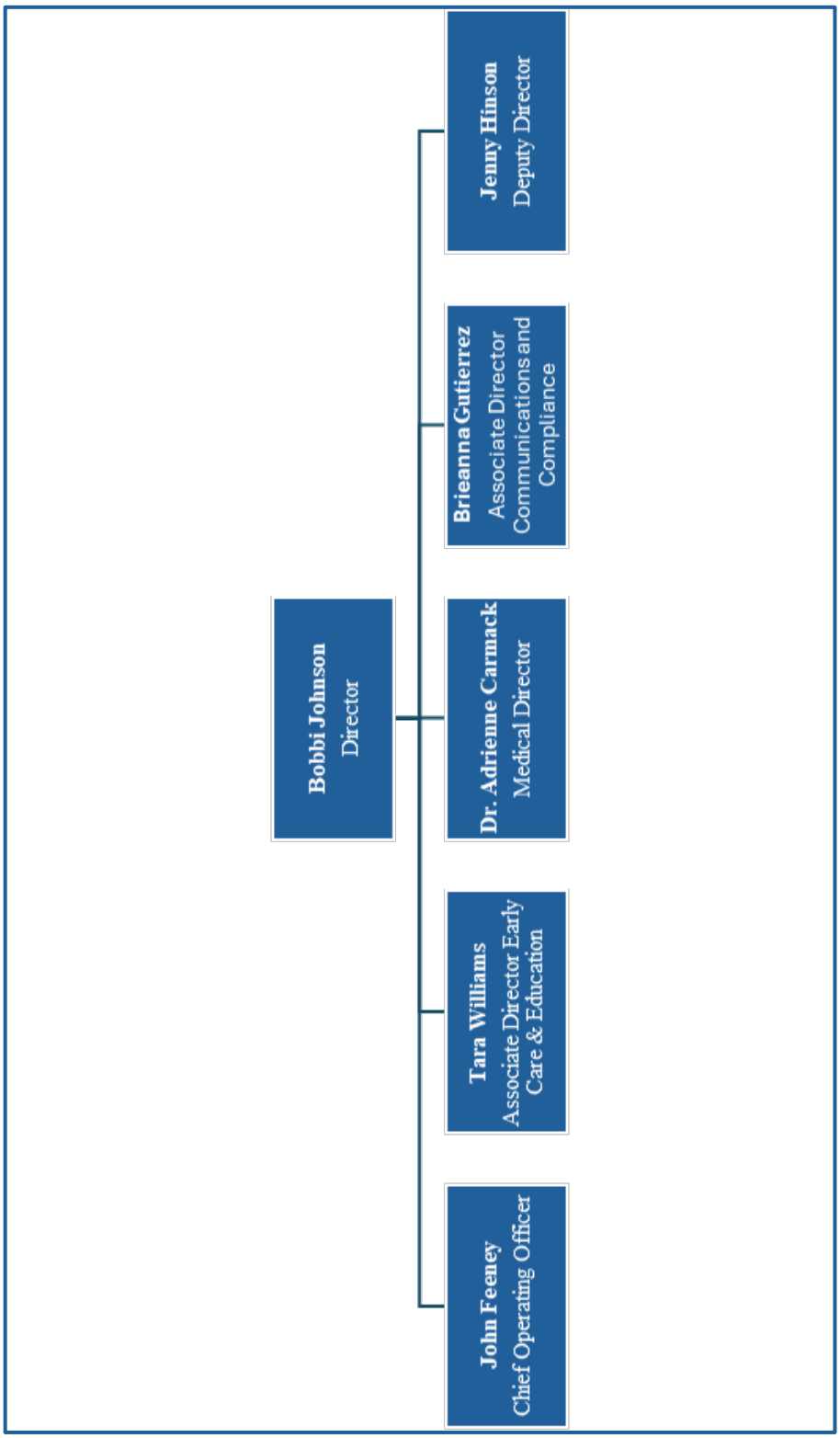
At the beginning of the First Regular Session of each Maine Legislature, the Department of Health and Human Services provides thorough orientations to the Joint Standing Committee on Health and Human Services of the Offices, Division, and Hospitals that comprise DHHS. The full complement of slides for the January 2025 orientations can be found online here: https://legislature.maine.gov/doc/11376.

Below you will find an organizational chart for each office within DHHS.

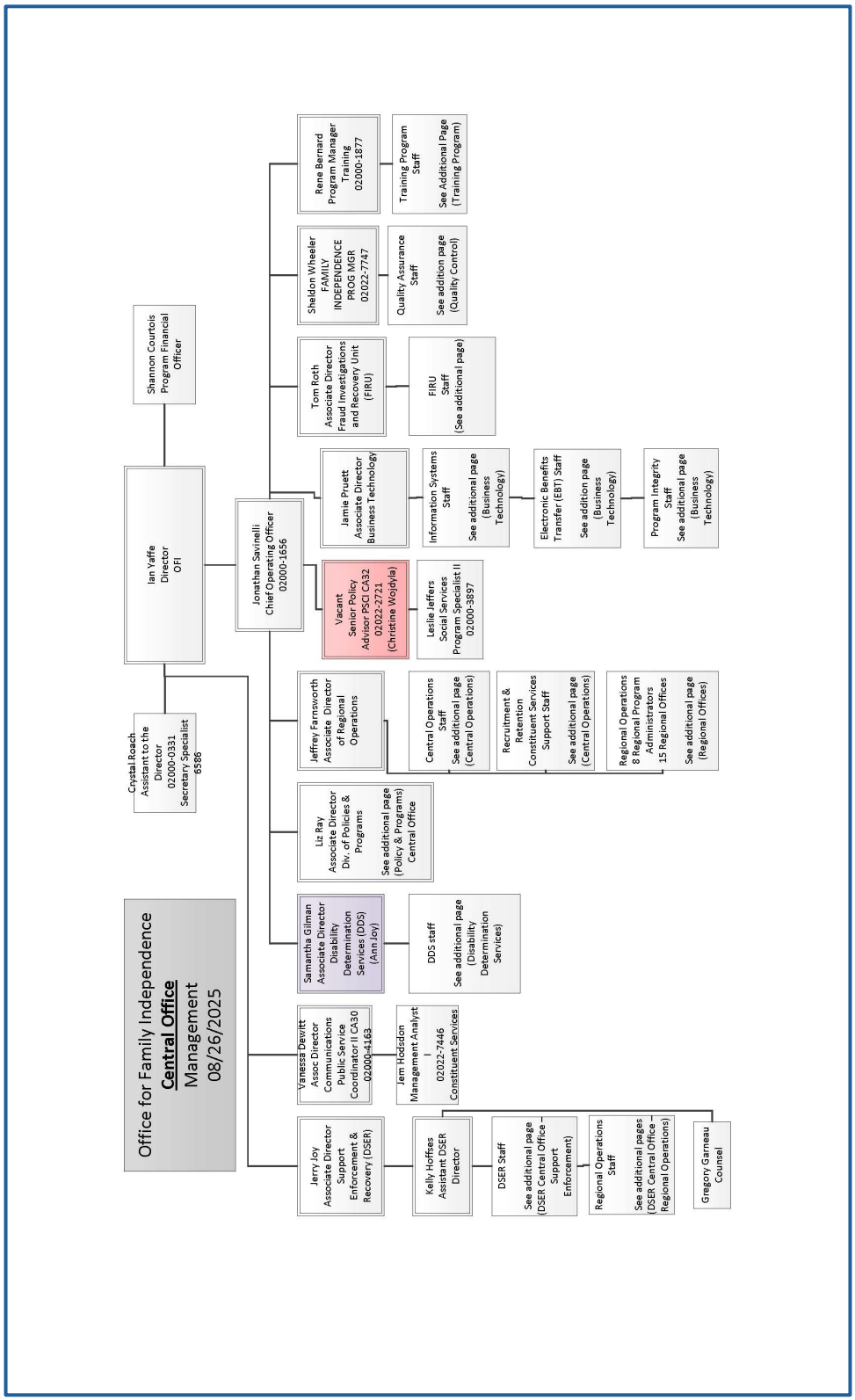
Commissioner's Office



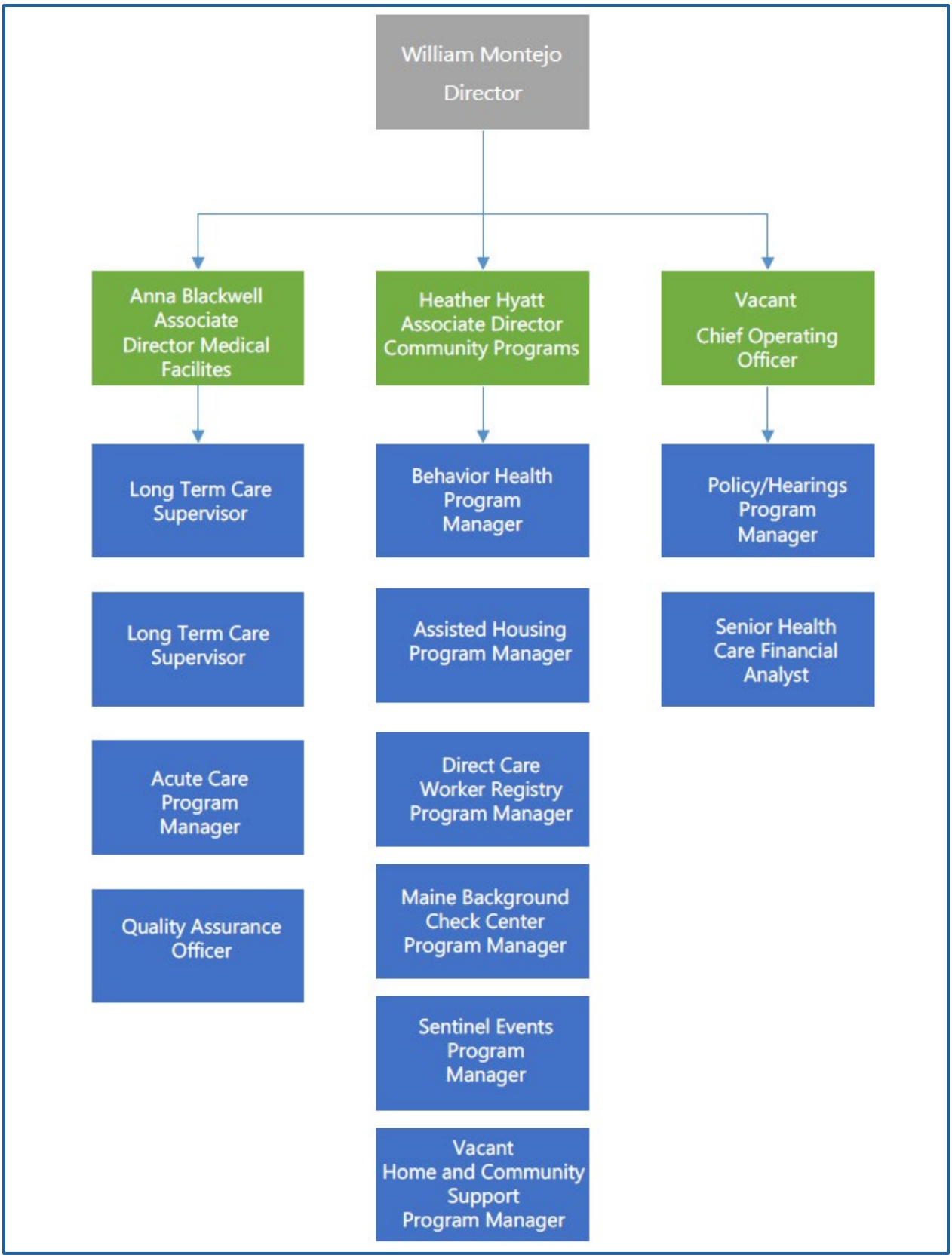
Office of Child and Family Services



Office For Family Independence –

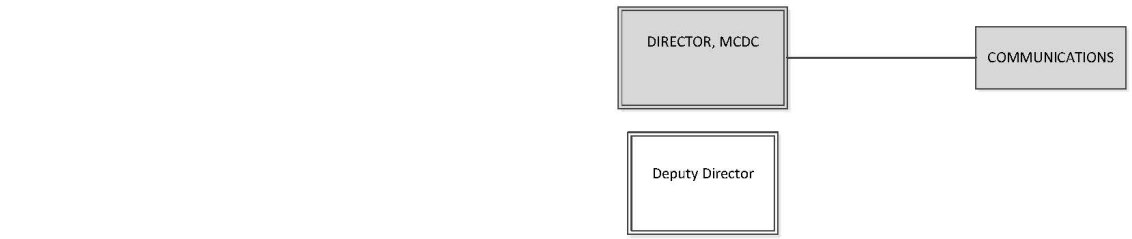


Division of Licensing and Certification



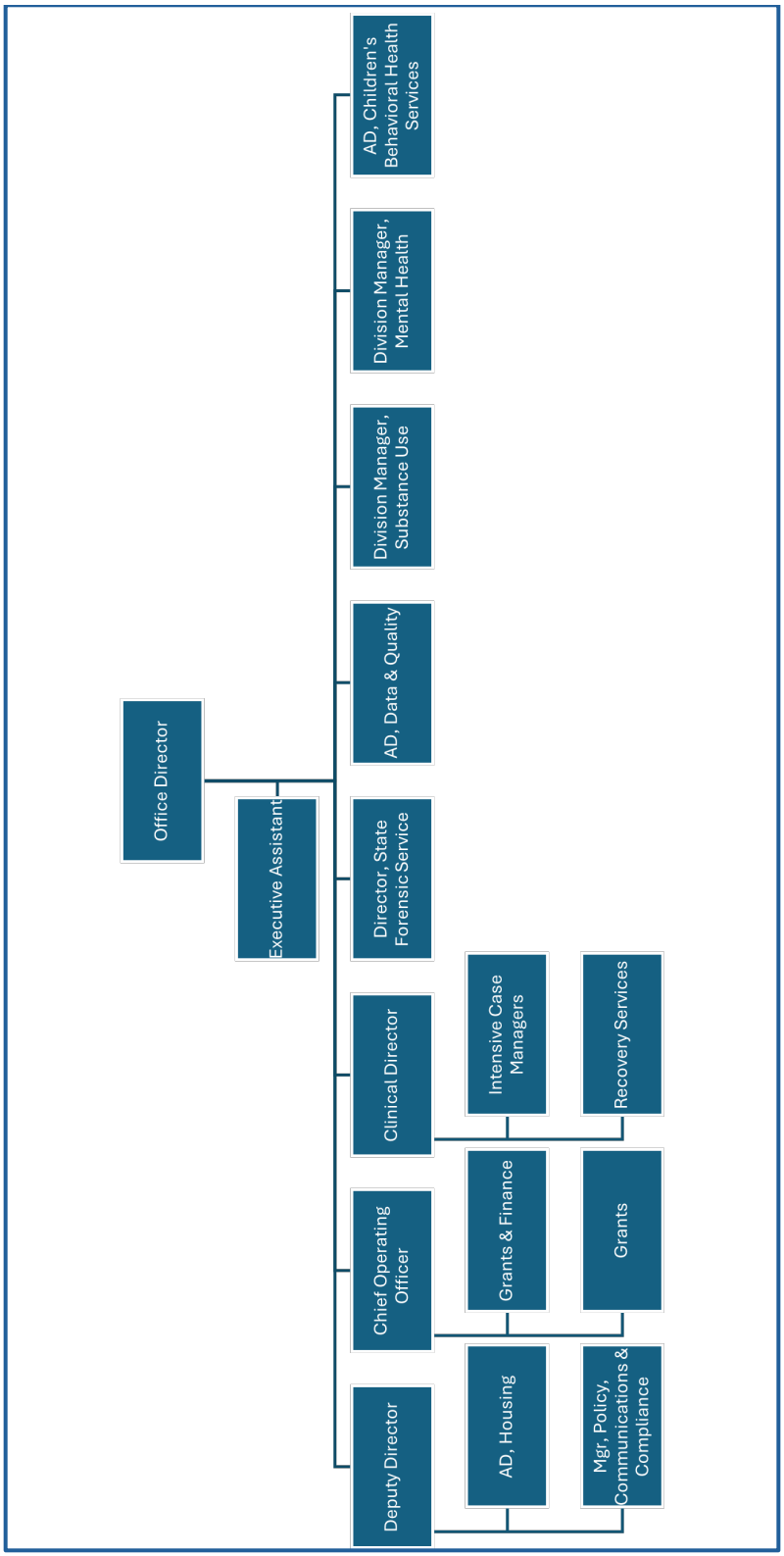
Maine Center for Disease Control & Prevention
Organizational Chart

7/1/25

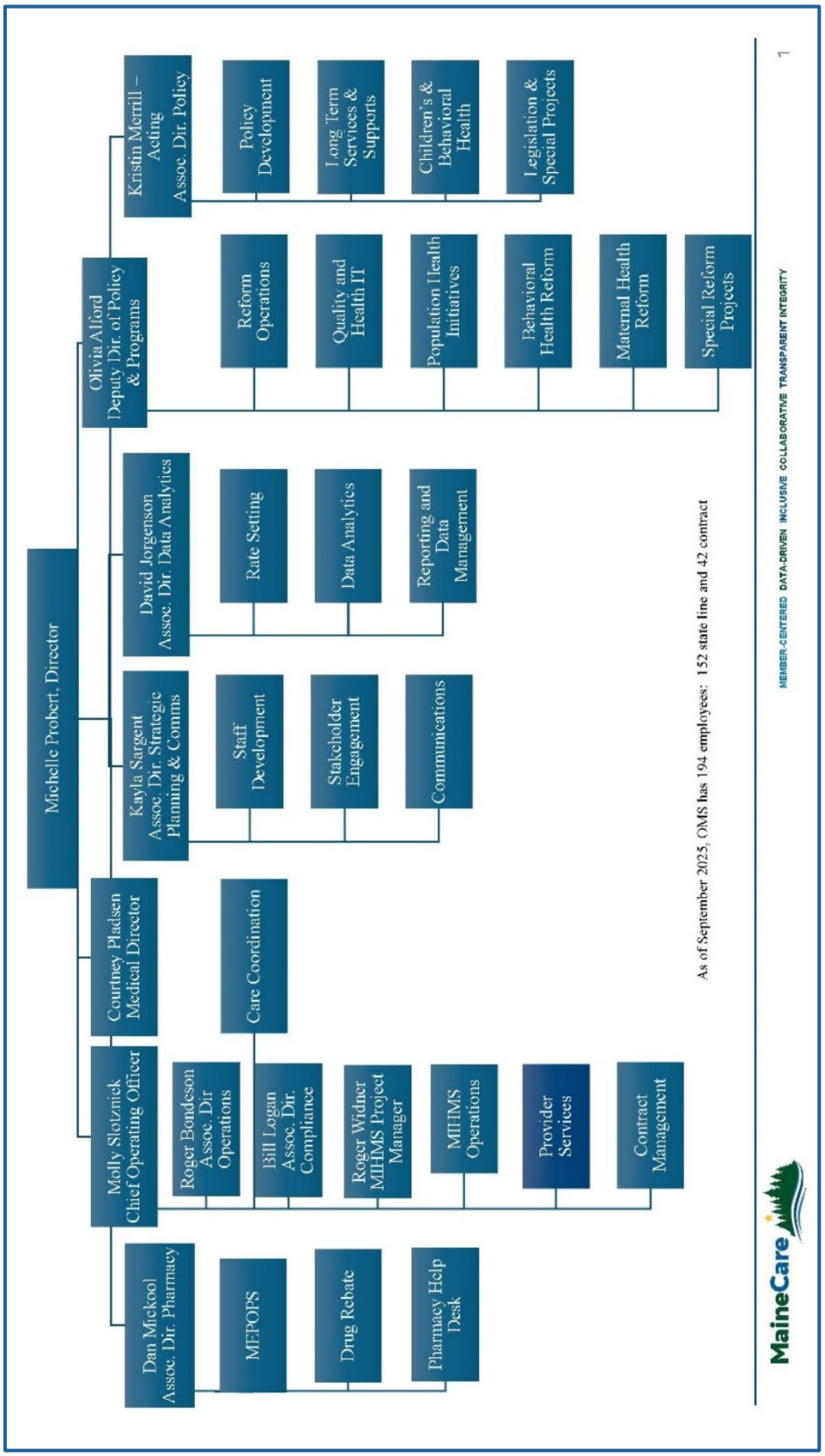


Operations	State Epidemiology	Environmental & Community Health	Disease Prevention	Public Health Nursing	Office of Readiness & Response	Disease Surveillance	Health & Environmental Testing Laboratory	Office of Population Health Equity	Office of Violence Prevention
Personnel Coordination Grants & Contract Management Policy & Compliance Regulation & Enforcement Financial Administration Business Operations & Systems Management Accreditation & Performance Improvement	State Epidemiologist / Chief Medical Officer Healthcare Associated Infections	Drinking Water Program Water Resources & Resiliance Laboratory Certification Health Inspection Radiation Control Radon Environmental Public Health Tracking Childhood Lead Poisoning Prevention Toxicology & Environmental Epidemiology	Maternal & Child Health Adolescent Health & Injury Prevention Women, Infants, & Children (WIC) Tobacco & Substance Use Prevention Chronic Disease Prevention Oral Health	Central & District Public Health Nursing	District Public Health Readiness & Response Data, Research, and Vital Records Statistical Services Vital Records Cancer Registry Rural Health & Primary Care	Maine Immunization Infectious Disease Prevention HIV/STD Prevention HIV Care Epidemiology Informatics Central & Field Epidemiology Hepatitis & Harm Reduction Disease Intervention	PFAS LRN-C TB / Rabies Molecular Diagnostics, Bacti & Blood Lead Virology, Serology Wastewater / Sequencing Lab Safety Quality Assurance Inorganics Organics Lead Program Forensics	Health Equity Program	Office of Violence Prevention

Office of Behavioral Health

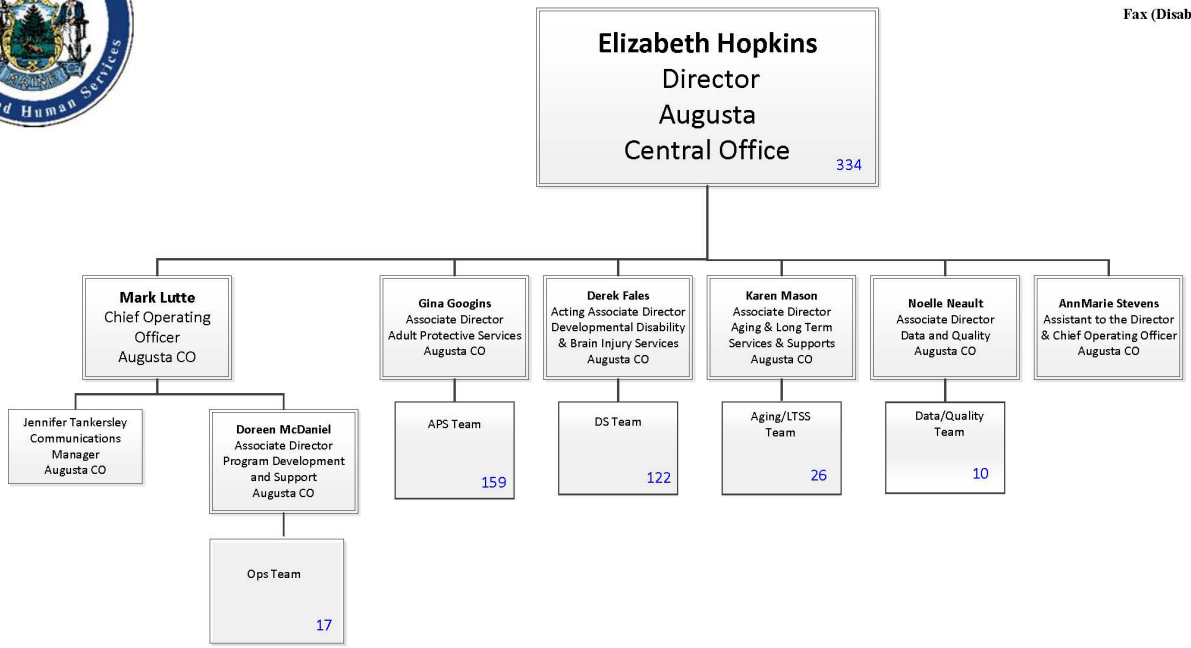


Office of MaineCare Services



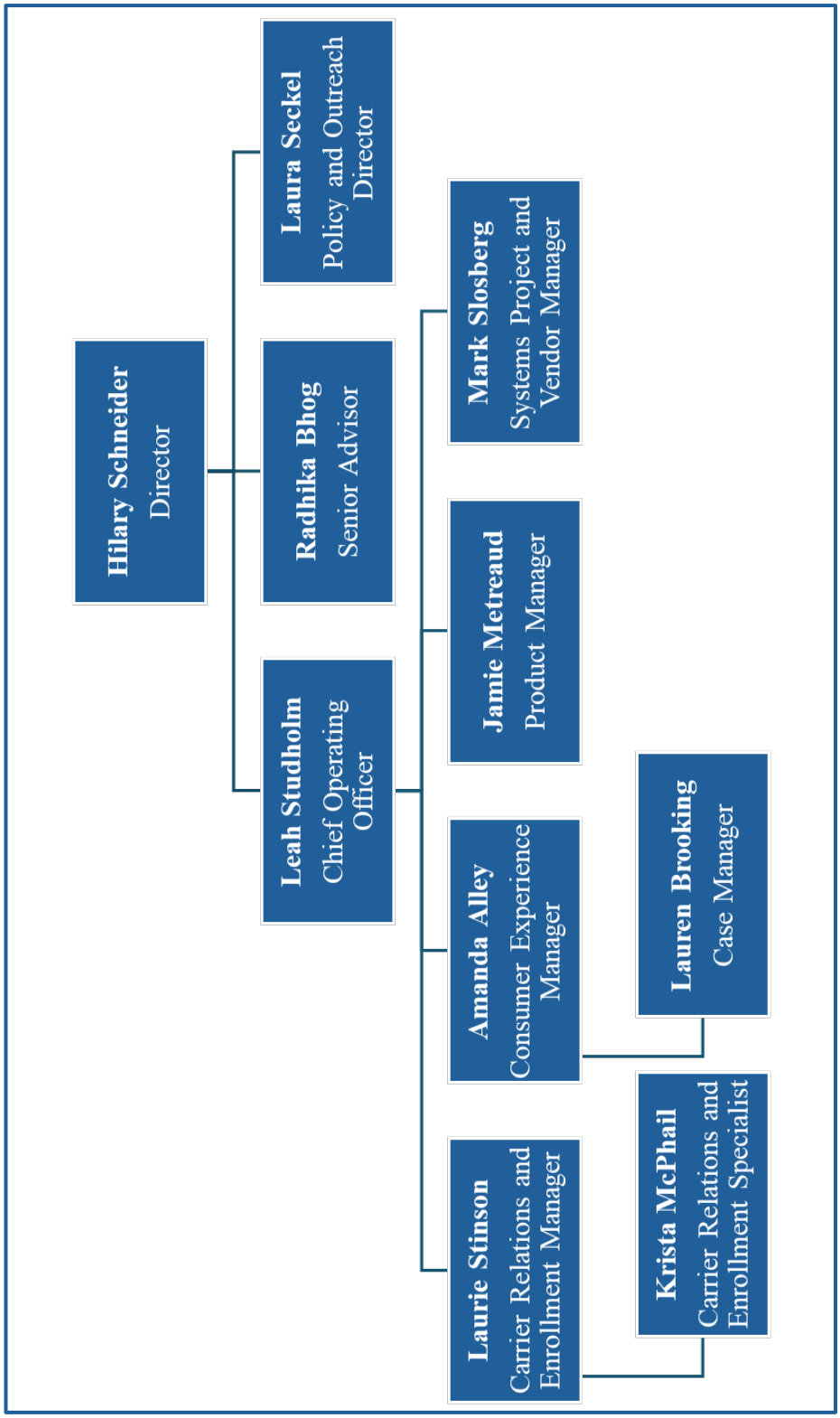
Office of Aging and Disability Services

Maine Department of Health and Human Services
Aging and Disability Services
11 State House Station
41 Anthony Avenue
Augusta, Maine 04333-0011
Tel; (207) 287-9200; Toll Free: (800) 262-2232
Fax (Disability) (207) 287-9915; Fax (Aging) (207)287-9229
TTY: Dial 711 (Maine Relay)

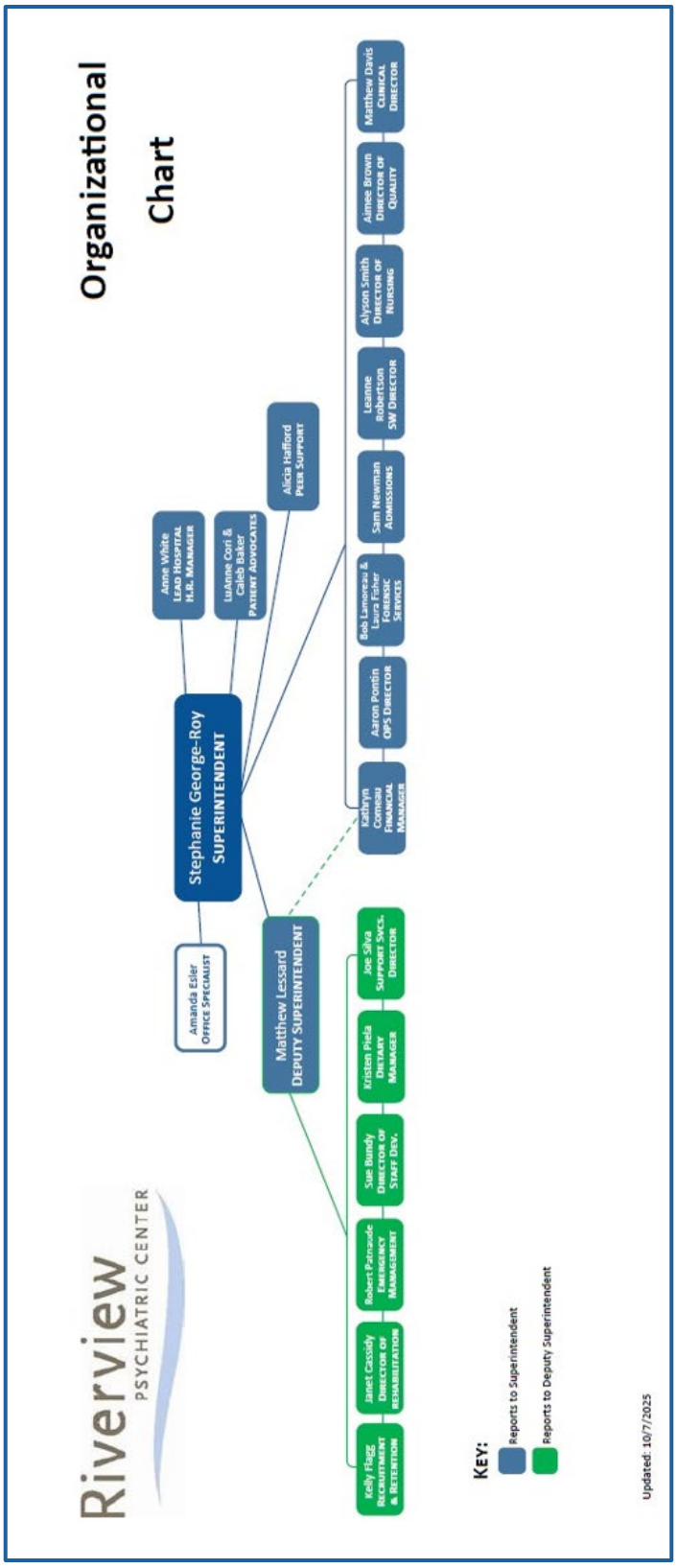


September 2025

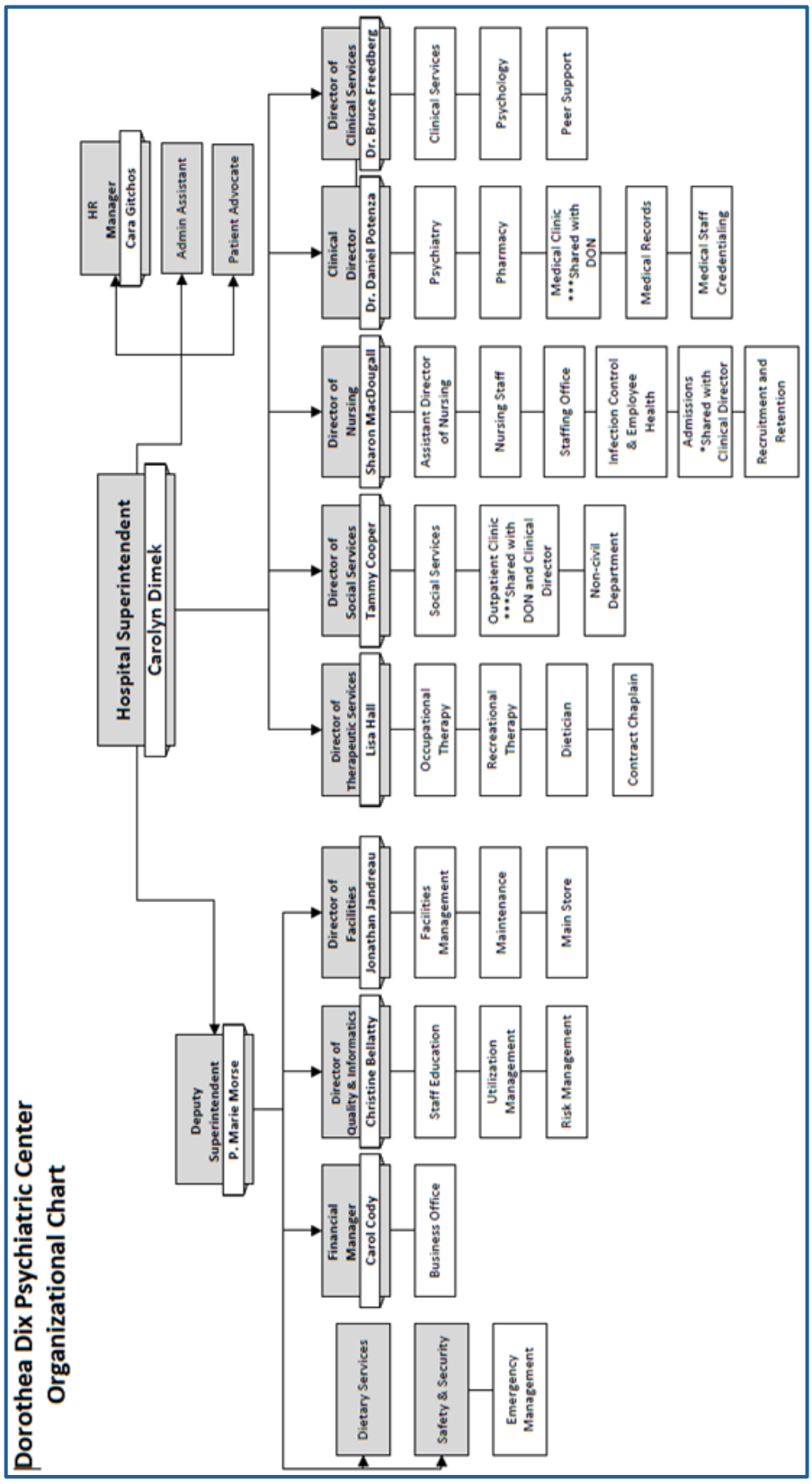
Office of Health Insurance Marketplace



Riverview Psychiatric Center



Dorothea Dix Psychiatric Center



Appendix B: Acronyms

Acronyms list here

Abbreviations and Acronyms	
ACA	Affordable Care Act
AC	Accountable Communities
ACF	Administration for Children and Families
ALS	Amyotrophic Lateral Sclerosis
APM	Alternative Payment Models
APS	Adult Protective Services
APSR	Annual Progress and Services Report
APTC	Advanced Premium Tax Credit
ASAM	American Society of Addiction Medicine
ASPIRE	Additional Support for People in Retraining and Employment
ASPR	Administration for Strategic Preparedness and Response
ATGP	Alumni Transition Grant Program
BABLO	Maine Bureau of Alcoholic Beverages and Lottery
BIPOC	Black, Indigenous and People of Color
BTAM	Behavioral Threat Assessment and Management
CAA	Community Action Agencies
CAC	Child Advocacy Center
CCAP	Child Care Affordability Program
CCS	Columbia Regional Care Center
CDSIRP	Child Death and Serious Injury Review Panel
CFSP	Child and Family Services Plan
CFSR	Child and Family Services Review
CHIP	Children's Health Insurance Program
CLIS	Children's Licensing and Investigation Services
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nursing Assistant
CPS	Child Protective Services
CRMA	Certified Residential Medication Aide
DACA	Deferred Action for Childhood Arrivals
DACF	Department of Agriculture, Conservation and Forestry
DAFS	Department of Administrative & Financial Services
DDS	Disability Determination Services
DDPC	Dorothea Dix Psychiatric Center
DDP	Division of Disease Prevention
DECH	Division of Environmental and Community Health
DEEP	Driver's Education and Evaluation Program
DHS	Department of Homeland Security
DHHS	Department of Health and Human Services
DLC	Division of Licensing and Certification
DOC	Department of Corrections

DOJ	Department of Justice
DOT	Department of Transportation
DPFR	Department of Professional and Financial Regulation
DPH	District Public Health
DPHE	Division of Population Health Equity
DRVS	Data, Research and Vital Statistics
DSER	Division of Support Enforcement and Recovery
EA	Emergency Assistance
E&T	SNAP Employment and Training
EBT	Electronic Benefits Transfer
ECCP	Early Childhood Consultation Partnership
ECE	Early Care and Education
EMA	Emergency Management Agencies
EPA	Environmental Protection Agency
EPTC	Enhanced Premium Tax Credit
ESMI	Early Serious Mental Illness
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
FPL	Federal Poverty Level
FOAA	Maine's Freedom of Access Act
FTR	Failure to Reconcile
GA	General Assistance
HAN	Maine Health Alert Network
HCBS	Home and Community-Based Services
HCB	Home and Community-Based Services (alternate acronym)
HCC	Health Care Coalitions
HCSS	Home and Community Support Service
HETL	Health and Environmental Testing Laboratory
HIV	Human Immunodeficient Virus
HIP	Health Inspection Program
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
HOPE	Higher Opportunity for Pathways to Employment
HRSA	Health Resources and Services Administration
HPP	Hospital Preparedness Program
IDD	Intellectual and Developmental Disabilities
IFW	Department of Inland Fisheries and Wildlife
IRS	Internal Revenue Service
KVCAP	Kennebec Valley Community Action Program
LHO	Local Health Office
LTCOP	Maine Long Term Care Ombudsman Program
LTSS	Long Term Services and Supports
MAC	MaineCare Advisory Council
MACSP	Maine Association of Community Support Providers
MBCC	Maine Background Check Center

MBM	MaineCare Benefits Manual
MCH	Maternal and Child Health
MCWAP	Child Welfare Advisory Panel
MCWAN	Maine Child Welfare Action Network
MECDC	Maine Center for Disease Control
MeDART	Maine Elder Death Analysis Review Team
MEMA	Maine Emergency Management Agency
MFIMR	Maternal, Fetal, and Infant Mortality Review Panel
MHCA	Maine Health Care Association
MIYHS	Maine Integrated Youth Health Survey
MIP	Maine Immunization Program
MMA	Maine Municipal Association
MRS	Maine Revenue Service
MRTQ	Maine Roads to Quality
MSBON	Maine State Board of Nursing
MWDA	Maine Welfare Director's Association
NCR	Not Criminally Responsible
NET	Non-Emergency Transportation
NFs	Nursing Facilities
NRC	Nuclear Regulatory Commission
OACPDS	Office of Adults with Cognitive and Physical Disability Services
OADS	Office of Aging and Disability Services
OAG	Office of the Attorney General
OBH	Office of Behavioral Health
OBRA	Omnibus Budget Reconciliation Act
OCME	Office of Chief Medical Examiner
OCP	Office of Cannabis Policy
OE	Open Enrollment
OES	Office of Elder Services
OIG	Office of the Inspector General
OIT	Maine Office of Information Technology
OFI	Office for Family Independence
OIVP	Office of Injury and Violence Prevention
OMS	Office of MaineCare Services
ORR	Office of Readiness and Response
OSHA	Occupational Safety and Health Administration
OVC	U.S. Department of Justice's Office for Victims of Crime
PaS	Parents as Scholars
PDG	Preschool Development Grant
PERM	Payment Error Rate Measurement
PFAS	Per- and Polyfluoroalkyl Substances
PHAB	Public Health Accreditation Board
PHEP	Public Health and Emergency Preparedness
PHN	Public Health Nursing
PMP	Prescription Monitoring Program

PNMI	Private Non-Medical Institution
PSS	Personal Support Specialist
PTC	Premium Tax Credit
PTP	Prescription Treatment Program
QAPI	Quality Assurance Performance Improvement
QRIS	Quality Rating and Improvement System
RCP	Radiation Control Program
RHPC	Rural Health and Primary Care
RPC	Riverview Psychiatric Center
SAFE	Sexual Assault Forensic Examiner
SAMHSA	US Substance Abuse and Mental Health Services Administration
SFS	State Forensic Service
SNAC	State Nutrition Action Council
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAC	TANF Advisory Council
TANF	Temporary Assistance for Needy Families
USDA	United States Department of Agriculture
VOCA	Victims of Crime Act
VBP	Value-Based Purchasing
VIRP	Violence Intervention and Response Program
WIC	Woman, Infants, and Children

Appendix C: DHHS Financial Documents

Standard financial documents are displayed in a larger format and are provided as an attachment to this report.

Department of Health and Human Services
Legislatively Approved Expenditure Budget for SFY 2008 - 2027 and Actual Expenditures for SFY 2008 - 2025 (By Office & Fund)
(Includes Personal Services, All Other, & Capital)
Source: BFMS Budget Guideline Report - Expenditures & Expenditure Cube

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

Commissioner's Office

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
CO	010	$ 29,984,171	$ 30,563,930	$ 31,383,719	$ 28,751,731	$ 30,316,778	$ 25,241,852	$ 28,352,659	$ 23,689,600	$ 24,637,392	$ 23,527,804
	013	11,730,964	4,381,349	2,080,141	840,918	2,641,864	753,854	2,710,608	703,851	386,512	481,700
	014	13,061,811	10,060,391	23,093,949	14,917,443	21,965,082	16,928,992	21,913,058	15,158,511	20,784,513	14,292,835
	015	442,687	272,866	452,020	224,915	-	(5,130)	-	-	-	-
	020	-	-	-	-	-	-	-	72,342	-	1,336,315
	022	-	-	-	-	-	-	-	-	-	-
	023	-	-	-	-	-	-	-	-	-	-
		$ 55,219,633	**$ 45,278,536**	**$ 57,009,829**	**$ 44,735,007**	**$ 54,923,724**	**$ 42,919,568**	**$ 52,976,325**	**$ 39,624,304**	**$ 45,808,417**	**$ 39,638,654**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 17,817,537	$ 23,165,687	$ 25,299,707	$ 25,770,321	$ 21,030,024	$ 24,615,495	$ 22,572,519	$ 22,389,110	$ 22,904,761	$ 20,839,408
389,565	247,066	373,191	181,790	373,191	152,564	525,291	45,864	525,291	127,428
20,276,962	15,620,997	21,475,074	17,163,355	21,907,722	16,944,546	20,221,751	15,716,315	20,441,319	16,391,158
-	-	-	-	-	-	-	-	-	-
123,203	407,496	77,416	697,066	4,361	-	4,361	-	4,361	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 38,607,267	**$ 39,441,246**	**$ 47,225,388**	**$ 43,812,532**	**$ 43,315,298**	**$ 41,712,605**	**$ 43,323,922**	**$ 38,151,289**	**$ 43,875,732**	**$ 37,357,994**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 22,856,783	$ 23,026,031	$ 22,844,196	$ 24,989,246	$ 25,259,189	$ 24,764,851	$ 23,205,184	$ 24,612,035	$ 24,937,713	$ 25,359,849
152,100	19,260	152,100	-	152,100	-	152,100	-	152,100	-
20,283,426	15,581,841	20,310,483	14,551,454	20,161,319	15,008,706	20,697,543	15,039,767	21,409,967	15,374,962
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	48,858	-	419,717	-	8,821
-	-	-	-	-	-	-	-	2,449,157	756,094
$ 43,292,309	**$ 38,627,132**	**$ 43,306,779**	**$ 39,540,700**	**$ 45,572,608**	**$ 39,822,415**	**$ 44,054,827**	**$ 40,071,519**	**$ 48,948,937**	**$ 41,499,726**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 25,457,510	$ 25,816,552	$ 7,929,813	$ 26,981,382	$ 8,060,123	$ 27,726,447	$ 30,297,340	$ -	$ 30,824,627	$ -
152,100	-	152,100	-	152,100	-	152,100	-	152,100	-
21,363,887	16,292,701	21,836,532	19,529,768	22,043,236	21,864,929	23,448,214	-	23,809,070	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
3,562,330	638,164	1,932,636	1,312,689	851,000	542,741	851,000	-	851,000	-
$ 50,535,827	**$ 42,747,417**	**$ 31,851,081**	**$ 47,823,839**	**$ 31,106,459**	**$ 50,134,117**	**$ 54,748,654**	**$ -**	**$ 55,636,797**	**$ -**

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund	
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP		

Office of Child and Family Services

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OCFS	010	$ 119,400,295	$ 104,694,678	$ 106,350,825	$ 103,874,697	$ 105,065,614	$ 99,122,014	$ 99,348,864	$ 101,349,039	$ 101,246,650	$ 93,013,570
	013	67,940,771	39,340,118	67,966,535	39,383,226	68,468,484	39,776,876	67,651,524	40,192,646	67,540,490	40,991,452
	014	22,239,835	18,352,052	23,400,448	16,396,946	22,882,137	16,919,224	22,321,771	16,086,256	19,721,781	17,379,319
	015	29,354,017	35,350,896	30,503,012	27,089,200	33,881,731	27,535,818	33,961,344	22,199,320	34,061,722	23,313,163
	020	-	-	-	-	2,866,740	2,573,311	1,678,000	2,237,096	-	364,919
	021	-	-	-	-	-	4,239,727	-	6,734,720	-	329,383
	022	-	-	-	-	-	-	-	-	-	-
	023	-	-	-	-	-	-	-	-	-	-
	024	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
	026	-	-	-	-	-	-	-	-	-	-
		$ 238,934,918	**$ 197,737,744**	**$ 228,220,820**	**$ 186,744,069**	**$ 233,164,706**	**$ 190,166,970**	**$ 224,961,503**	**$ 188,799,077**	**$ 222,570,643**	**$ 175,391,806**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 96,330,051	$ 93,217,210	$ 105,002,897	$ 104,740,366	$ 108,072,333	$ 106,147,366	$ 116,662,386	$ 114,419,046	$ 117,474,086	$ 109,915,229
48,958,638	35,121,285	45,618,739	37,018,345	45,603,878	35,954,946	45,511,622	39,058,779	45,517,887	45,553,209
16,690,409	14,953,430	13,671,416	8,328,689	14,136,903	9,141,638	12,254,555	9,423,455	12,522,836	11,371,748
33,983,819	20,064,656	30,512,530	21,251,862	30,653,468	24,320,093	30,585,595	28,242,590	30,613,690	28,984,319
-	181,021	-	19,100	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	3,325,698	3,283,296	3,325,698	3,312,234	3,900,698	3,653,952	3,900,698	4,138,127
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 195,962,917	**$ 163,537,602**	**$ 198,131,280**	**$ 174,641,658**	**$ 201,792,280**	**$ 178,876,277**	**$ 208,914,856**	**$ 194,797,822**	**$ 210,029,197**	**$ 199,962,632**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 116,520,459	$ 101,847,245	$ 137,021,844	$ 132,413,241	$ 134,692,485	$ 136,979,800	$ 139,271,672	$ 147,649,127	$ 154,153,696	$ 153,061,424
34,148,501	35,583,580	34,731,835	36,880,055	36,021,041	39,009,555	38,681,077	43,041,537	52,480,525	50,277,825
11,913,864	13,815,293	13,381,695	14,982,662	17,267,443	21,181,054	18,678,556	26,228,737	19,714,077	21,023,835
33,020,480	38,469,313	34,578,808	38,313,973	48,771,608	49,126,100	48,840,461	56,286,244	58,065,259	61,545,094
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	16,699	-	2,705,515	-	35,532
-	-	-	-	-	-	-	-	6,114,916	11,538
3,325,698	3,276,505	3,325,698	3,204,071	5,825,698	4,728,263	5,825,698	6,324,619	3,325,698	3,681,893
-	-	-	-	-	-	-	-	-	115,395
-	-	-	-	-	-	-	-	-	58,303,156
$ 198,929,002	**$ 192,991,936**	**$ 223,039,880**	**$ 225,794,002**	**$ 242,578,275**	**$ 251,041,471**	**$ 251,297,464**	**$ 282,235,779**	**$ 293,854,171**	**$ 348,055,691**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 188,622,359	$ 168,841,330	$ 220,914,954	$ 203,937,578	$ 206,434,617	$ 231,351,724	$ 231,311,099	$ -	$ 230,557,544	$ -
54,337,789	50,897,766	68,459,935	53,932,440	65,508,870	57,690,260	79,255,762	-	79,859,719	-
20,889,221	20,426,465	21,964,518	21,272,331	42,547,366	40,935,712	26,139,551	-	26,681,021	-
71,426,499	43,193,894	75,076,334	60,298,940	68,465,887	53,329,931	69,222,371	-	69,362,281	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
9,121,559	2,197,838	107,941	5,905,906	107,942	3,957,608	107,942	-	107,942	-
3,325,698	3,200,748	3,325,698	3,120,013	3,325,698	3,391,450	3,325,698	-	3,325,698	-
-	852,010	2,437,496	972,595	2,437,496	824,510	-	-	-	-
43,693,097	55,088,192	43,408,780	6,535,286	40,920,284	-	500	-	500	-
$ 391,416,222	**$ 344,698,243**	**$ 435,695,656**	**$ 355,975,089**	**$ 429,748,160**	**$ 391,481,195**	**$ 409,362,923**	**$ -**	**$ 409,894,705**	**$ -**

Office for Family Independence

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OFI	010	$ 66,290,835	$ 65,907,951	$ 68,133,904	$ 71,126,687	$ 70,022,472	$ 75,508,860	$ 67,755,680	$ 66,726,460	$ 70,508,194	$ 71,015,942
	013	29,563,681	21,880,510	30,649,101	21,814,576	28,137,807	17,348,741	28,688,219	20,902,793	27,776,742	24,060,542
	014	148,702,346	108,782,976	149,271,947	115,277,186	163,391,122	115,361,112	162,502,663	119,823,021	159,300,724	110,377,102
	015	75,576,021	72,790,813	75,649,553	79,301,839	76,068,275	67,842,205	76,173,074	71,027,937	75,858,542	74,156,890
	020	-	-	-	90,530	-	6,779,838	-	3,014,992	-	1,084,494
	021	-	-	-	-	-	12,105,486	-	11,461,815	-	-
	022	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
	026	-	-	-	-	-	-	-	-	-	-
	027	-	-	-	-	-	-	-	-	-	-
		$ 320,132,883	**$ 269,362,250**	**$ 323,704,505**	**$ 287,610,818**	**$ 337,619,676**	**$ 294,946,242**	**$ 335,119,636**	**$ 292,957,018**	**$ 333,444,202**	**$ 280,694,970**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 69,577,924	$ 67,620,346	$ 73,578,421	$ 73,729,159	$ 74,099,306	$ 68,824,560	$ 76,016,849	$ 71,828,718	$ 71,818,999	$ 67,927,587
33,050,945	24,210,983	33,478,516	23,299,675	33,539,255	26,034,585	33,547,518	28,027,200	33,979,967	27,638,957
162,008,007	113,731,207	142,916,921	116,009,317	143,672,337	120,409,112	146,042,005	120,901,601	147,437,118	121,972,438
75,899,942	49,566,680	76,009,543	37,454,808	76,144,913	31,723,566	80,241,565	33,645,138	80,417,731	45,536,526
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 340,536,818	**$ 255,129,216**	**$ 325,983,401**	**$ 250,492,959**	**$ 327,455,811**	**$ 246,991,823**	**$ 335,847,937**	**$ 254,402,657**	**$ 333,653,815**	**$ 263,075,508**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 77,561,312	$ 67,344,833	$ 77,635,681	$ 59,030,278	$ 78,761,868	$ 71,829,870	$ 78,814,431	$ 78,368,991	$ 80,261,778	$ 82,408,334
33,423,147	27,470,096	33,816,940	26,430,370	33,939,080	26,831,191	34,810,329	26,968,056	35,768,095	27,762,738
140,541,663	124,265,740	141,452,663	128,111,884	147,561,194	143,585,999	152,333,567	145,743,526	159,129,849	135,170,732
93,416,562	60,974,083	104,103,932	67,510,506	111,991,471	56,125,990	114,970,403	75,944,890	115,703,369	65,305,019
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	888,623	-	10,470
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	3,850,659
-	-	-	-	-	-	-	-	-	-
$ 344,942,684	**$ 280,054,752**	**$ 357,009,216**	**$ 281,083,038**	**$ 372,253,613**	**$ 298,373,050**	**$ 380,928,730**	**$ 327,914,086**	**$ 390,863,091**	**$ 314,507,953**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 86,548,747	$ 77,489,240	$ 97,106,569	$ 107,366,619	$ 90,513,859	$ 90,310,670	$ 104,493,152	$ -	$ 97,216,053	$ -
36,442,585	28,833,145	37,538,708	31,430,126	50,306,991	45,350,329	51,886,745	-	52,603,749	-
170,813,507	141,764,671	169,242,977	139,666,711	176,080,338	143,228,063	171,729,971	-	172,861,774	-
118,563,716	88,791,623	120,882,218	87,880,862	121,052,922	100,214,030	119,490,238	-	119,560,887	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	500,000	344,319	-	-	-	-	-	-
-	-	-	240,086	-	-	-	-	-	-
-	-	-	-	1,450,000	-	1,450,000	-	1,450,000	-
$ 412,368,555	**$ 336,878,679**	**$ 425,270,472**	**$ 366,928,722**	**$ 439,404,110**	**$ 379,103,092**	**$ 449,050,106**	**$ -**	**$ 443,692,463**	**$ -**

Division of Licensing and Certification

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
DLC	010	$ 3,483,556	$ 3,333,515	$ 3,267,325	$ 3,175,044	$ 2,897,702	$ 2,767,028	$ 2,568,244	$ 2,833,536	$ 3,212,374	$ 2,674,635
	013	3,431,556	2,707,514	3,257,099	3,054,642	3,480,886	3,066,667	211,558	225,290	155,574	482,523
	014	971,187	988,754	1,044,434	1,057,296	1,639,608	1,268,608	6,763,496	5,300,650	6,062,530	4,442,964
	015	777,788	747,408	772,846	703,629	905,883	840,499	-	-	12,313	-
	020	-	-	-	-	-	13,464	-	21,877	-	33,185
	022	-	-	-	-	-	-	-	-	-	-
		$ 8,664,087	**$ 7,777,191**	**$ 8,341,704**	**$ 7,990,611**	**$ 8,924,079**	**$ 7,956,266**	**$ 9,543,298**	**$ 8,381,353**	**$ 9,442,791**	**$ 7,633,307**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 3,382,032	$ 2,977,767	$ 3,761,939	$ 3,181,069	$ 3,924,498	$ 3,570,006	$ 4,240,552	$ 3,975,949	$ 4,303,083	$ 3,651,551
1,628,642	425,874	781,158	689,198	1,406,743	1,065,275	1,406,743	1,009,586	1,406,743	943,745
6,414,601	5,007,565	6,714,020	5,768,797	6,939,027	6,946,202	9,549,820	7,315,280	9,938,834	8,072,121
12,313	-	13,517	-	13,517	-	-	-	-	-
-	232	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 11,437,588	**$ 8,411,438**	**$ 11,270,634**	**$ 9,639,064**	**$ 12,283,785**	**$ 11,581,483**	**$ 15,197,115**	**$ 12,300,815**	**$ 15,648,660**	**$ 12,667,417**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 3,991,336	$ 3,995,730	$ 4,007,510	$ 3,723,332	$ 4,148,697	$ 3,406,495	$ 3,503,164	$ 3,351,885	$ 3,942,848	$ 2,974,939
1,406,743	1,061,173	1,406,743	413,052	1,406,743	177,942	1,406,743	232,770	1,406,743	301,105
9,826,284	7,511,763	8,943,586	7,299,363	9,382,025	7,687,071	9,715,665	8,221,839	10,205,644	8,760,157
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	5,728	-	76,976	-	14,700
$ 15,224,363	**$ 12,568,666**	**$ 14,357,839**	**$ 11,435,747**	**$ 14,937,465**	**$ 11,277,236**	**$ 14,625,572**	**$ 11,883,470**	**$ 15,555,235**	**$ 12,050,901**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 4,042,556	$ 2,301,611	$ 3,885,999	$ 2,765,307	$ 4,020,388	$ 3,209,147	$ 3,982,799	$ -	$ 4,111,928	$ -
1,406,743	119,804	1,406,743	130,681	1,406,743	121,135	522,566	-	522,566	-
10,728,433	10,085,848	8,172,944	7,215,240	9,137,175	8,344,280	10,389,542	-	10,661,209	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 16,177,732	**$ 12,507,263**	**$ 13,465,686**	**$ 10,111,228**	**$ 14,564,306**	**$ 11,674,562**	**$ 14,894,907**	**$ -**	**$ 15,295,703**	**$ -**

Maine Center for Disease Control and Prevention

010 = General Fund 014 = Other Special Revenue Funds 018 = General Bond Fund 021 = ARRA Block Grant 023 = Fed - ARP State Fiscal Relief 025 = Federal Expenditures Fund-ARF 027 = Maine Recovery Fund
013 = Federal Expenditures Fund 015 = Federal Block Grant Fund 020 = ARRA Federal Funds 022 = Federal Expenditure Fund-CRF 024 = Fund for a Healthy Maine 026 = Federal Block Grant - ARP

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
CDC	010	$ 12,854,916	$ 12,421,654	$ 12,347,367	$ 12,259,151	$ 16,024,799	$ 15,429,479	$ 14,281,403	$ 13,514,212	$ 15,140,864	$ 14,324,135
	013	64,633,169	53,513,593	67,484,100	57,057,853	71,339,446	58,152,142	70,293,725	54,905,645	68,135,099	55,288,650
	014	32,444,569	26,871,734	34,995,564	30,747,471	39,451,802	29,138,483	39,620,169	28,104,583	37,340,579	34,168,830
	015	5,122,531	3,896,626	5,292,153	3,845,445	5,612,736	3,841,733	5,598,557	3,398,842	4,840,176	2,600,547
	018	-	2,700,000	-	2,400,000	-	-	-	3,400,000	-	265,162
	020	-	-	2,175,000	458,970	500,000	1,760,675	-	4,085,762	-	3,396,072
	022	-	-	-	-	-	-	-	-	-	-
	023	-	-	-	-	-	-	-	-	-	-
	024	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
	027	-	-	-	-	-	-	-	-	-	-
		$ 115,055,185	**$ 99,403,607**	**$ 122,294,184**	**$ 106,768,890**	**$ 132,928,783**	**$ 108,322,512**	**$ 129,793,854**	**$ 107,409,044**	**$ 125,456,718**	**$ 110,043,396**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 14,594,027	$ 13,505,539	$ 15,282,449	$ 14,491,000	$ 15,304,506	$ 13,766,077	$ 15,904,178	$ 13,041,942	$ 16,049,886	$ 11,766,638
72,418,238	60,820,667	71,401,296	57,418,147	71,916,195	56,256,918	70,351,406	51,509,046	70,668,278	50,930,390
33,960,296	32,241,330	32,650,523	24,216,456	34,267,204	23,637,700	33,832,264	26,441,148	34,003,815	25,097,548
4,317,440	2,816,541	4,695,461	3,130,282	4,825,419	3,915,526	5,403,604	3,152,002	5,458,606	3,034,945
-	-	-	7,685,047	-	1,731,605	-	-	-	-
-	1,094,712	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	14,170,441	12,632,515	14,207,344	12,757,061	14,163,724	10,990,383	14,311,591	10,039,196
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 125,290,001	**$ 110,478,789**	**$ 138,200,170**	**$ 119,573,447**	**$ 140,520,668**	**$ 112,064,887**	**$ 139,655,176**	**$ 105,134,521**	**$ 140,492,176**	**$ 100,868,717**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 15,644,585	$ 12,697,151	$ 16,010,179	$ 12,762,884	$ 18,487,573	$ 15,884,608	$ 20,225,434	$ 24,415,754	$ 26,966,170	$ 24,941,599
60,101,475	48,172,532	60,328,397	49,576,102	60,398,879	54,095,206	60,922,328	79,756,951	60,750,597	111,101,106
32,576,612	28,648,420	32,813,135	27,309,776	32,815,178	29,937,744	32,989,884	22,184,373	32,632,097	32,191,166
4,770,993	2,974,100	4,819,280	3,745,324	4,862,631	3,814,019	5,209,970	3,677,620	5,054,097	4,248,930
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	84,374	-	23,631,543	-	13,403,687
-	-	-	-	-	-	-	-	10,051,484	-
9,531,221	9,479,893	10,020,265	8,404,873	16,480,978	13,166,301	16,786,267	13,705,594	11,051,909	11,575,583
-	-	-	-	-	-	-	82,495	-	9,131,890
-	-	-	-	-	-	-	-	-	-
$ 122,624,886	**$ 101,972,096**	**$ 123,991,256**	**$ 101,798,959**	**$ 133,045,239**	**$ 116,982,252**	**$ 136,133,883**	**$ 167,454,330**	**$ 146,506,354**	**$ 206,593,962**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 31,666,005	$ 22,122,224	$ 33,557,165	$ 30,067,461	$ 43,043,649	$ 34,018,550	$ 40,201,934	$ -	$ 37,667,279	$ -
119,824,959	108,654,452	121,194,835	91,778,503	127,352,528	90,428,859	145,658,501	-	146,305,228	-
32,774,786	31,311,061	37,605,896	36,996,476	37,768,003	39,964,762	48,091,160	-	49,551,628	-
5,795,732	3,812,047	5,727,872	4,392,597	6,032,149	4,467,655	6,212,707	-	6,293,362	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	134,377	-	-	-	-	-	-	-	-
15,051,484	3,607,502	8,000,000	5,024,773	8,000,000	7,150,423	8,000,000	-	8,000,000	-
18,581,786	11,484,414	18,749,933	15,910,968	18,789,874	18,489,737	18,916,943	-	17,724,562	-
14,013,455	8,821,556	17,046,355	8,848,003	16,776,591	8,485,811	15,820,790	-	15,888,726	-
-	-	-	-	1,350,000	-	1,350,000	-	1,350,000	-
$ 237,708,207	**$ 189,947,633**	**$ 241,882,056**	**$ 193,018,780**	**$ 259,112,794**	**$ 203,005,796**	**$ 284,252,035**	**$ -**	**$ 282,780,785**	**$ -**

Office of Behavioral Health

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OBH	010	$ 42,963,707	$ 41,307,625	$ 38,035,242	$ 37,915,363	$ 40,703,091	$ 39,945,968	$ 39,474,359	$ 37,515,439	$ 47,452,132	$ 41,184,866
	013	15,323,855	11,468,870	20,694,195	11,958,471	22,104,452	11,685,169	22,110,320	8,273,715	17,857,527	8,086,561
	014	4,890,313	1,674,999	3,186,689	3,361,389	532,892	28,976	532,892	91,551	2,451,208	2,190,753
	015	8,258,210	7,773,172	8,205,321	7,212,612	8,045,645	6,059,965	8,040,770	7,262,855	8,044,860	6,986,459
	022	-	-	-	-	-	-	-	-	-	-
	024	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
	026	-	-	-	-	-	-	-	-	-	-
	027	-	-	-	-	-	-	-	-	-	-
		$ 71,436,085	**$ 62,224,666**	**$ 70,121,447**	**$ 60,447,835**	**$ 71,386,080**	**$ 57,720,078**	**$ 70,158,341**	**$ 53,143,560**	**$ 75,805,727**	**$ 58,448,639**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 43,082,584	$ 39,984,005	$ 42,201,602	$ 40,807,038	$ 45,950,684	$ 44,869,455	$ 52,731,630	$ 48,189,928	$ 56,438,045	$ 46,507,585
13,356,365	7,932,233	12,770,938	10,008,131	12,780,496	11,225,449	13,875,219	9,169,133	13,875,219	7,969,211
2,461,880	1,903,473	3,313,574	2,310,331	613,574	303,806	661,719	72,176	661,701	109,783
8,061,189	6,891,189	8,055,222	8,766,035	8,091,709	7,363,692	8,091,473	6,513,389	8,111,839	7,261,322
-	-	-	-	-	-	-	-	-	-
-	-	1,848,306	1,739,583	1,848,306	1,785,130	1,848,306	1,662,956	1,848,306	1,590,576
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 66,962,018	**$ 56,710,900**	**$ 68,189,642**	**$ 63,631,118**	**$ 69,284,769**	**$ 65,547,532**	**$ 77,208,347**	**$ 65,607,582**	**$ 80,935,110**	**$ 63,438,477**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 52,832,708	$ 45,036,053	$ 59,645,700	$ 49,413,741	$ 59,859,687	$ 46,912,990	$ 58,665,719	$ 47,570,242	$ 73,338,279	$ 64,250,952
14,028,685	8,236,117	14,035,561	12,412,478	16,089,267	19,542,852	16,097,940	18,985,007	22,659,414	24,585,040
975,127	110,849	100,127	441,225	100,627	392,902	100,627	771,563	100,627	1,319,255
8,033,602	9,190,690	8,260,603	10,489,950	8,229,379	7,820,269	8,258,188	10,676,758	10,355,662	12,904,368
-	-	-	-	-	8,148	-	577,754	-	-
1,070,802	835,048	1,070,802	1,153,187	3,698,223	2,086,091	5,575,644	3,574,428	2,070,802	2,580,639
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	98,784
-	-	-	-	-	-	-	-	-	-
$ 76,940,924	**$ 63,408,757**	**$ 83,112,793**	**$ 73,910,581**	**$ 87,977,183**	**$ 76,763,252**	**$ 88,698,118**	**$ 82,155,752**	**$ 108,524,784**	**$ 105,739,038**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 62,902,021	$ 58,844,212	$ 69,558,884	$ 66,354,252	$ 105,826,118	$ 85,690,719	$ 100,460,522	$ -	$ 102,929,472	$ -
26,699,567	25,765,139	30,004,381	22,590,180	32,418,724	28,539,599	31,219,297	-	31,225,860	-
2,592,302	2,603,867	3,929,800	7,410,040	13,756,586	15,497,437	16,704,245	-	17,818,028	-
35,018,791	9,456,316	35,069,455	10,777,649	41,899,124	12,138,429	33,683,435	-	33,708,075	-
-	-	-	-	-	-	-	-	-	-
2,070,802	1,529,172	1,070,802	1,638,828	1,070,802	894,682	1,070,802	-	1,070,802	-
-	166,967	430,648	544,529	-	-	-	-	-	-
8,778,860	1,155,781	8,778,860	4,517,664	11,167,277	3,122,081	7,526,892	-	-	-
-	-	-	-	3,350,000	-	3,350,000	-	3,350,000	-
$ 138,062,343	**$ 99,521,454**	**$ 148,842,830**	**$ 113,833,143**	**$ 209,488,631**	**$ 145,882,948**	**$ 194,015,193**	**$ -**	**$ 190,102,237**	**$ -**

Office of Multicultural Affairs

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund			
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP				

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OMA	010	$ 1,363,673	$ 323,964	$ 295,641	$ 295,641	$ 156,110	$ 156,110	$ 87,291	$ 24,956	$ 93,879	$ 55,512
	013	880,194	910,122	1,080,753	1,080,753	1,272,697	1,272,697	1,580,613	1,067,608	1,540,327	1,259,918
	015	163,189	163,189	14,588	14,588	-	-	-	-	-	-
		$ 2,407,056	**$ 1,397,275**	**$ 1,390,982**	**$ 1,390,982**	**$ 1,428,807**	**$ 1,428,807**	**$ 1,667,904**	**$ 1,092,564**	**$ 1,634,206**	**$ 1,315,430**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 90,315	$ 60,329	$ 96,863	$ 85,465	$ 101,324	$ 100,154	$ 113,425	$ 99,248	$ 114,918	$ 95,830
1,542,926	1,145,020	1,546,029	1,202,913	1,550,713	1,340,960	1,627,538	2,012,897	1,634,946	1,750,827
-	-	-	-	-	-	-	-	-	-
$ 1,633,241	**$ 1,205,349**	**$ 1,642,892**	**$ 1,288,378**	**$ 1,652,037**	**$ 1,441,114**	**$ 1,740,963**	**$ 2,112,145**	**$ 1,749,864**	**$ 1,846,657**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 120,128	$ 193	$ 120,276	$ -	$ 125,430	$ 57,245	$ 124,429	$ 60,737	$ 130,993	$ 117,530
1,560,022	1,226	1,469,748	40	1,469,748	-	1,469,748	-	1,469,748	-
-	-	-	-	-	-	-	-	-	-
$ 1,680,150	**$ 1,419**	**$ 1,590,024**	**$ 40**	**$ 1,595,178**	**$ 57,245**	**$ 1,594,177**	**$ 60,737**	**$ 1,600,741**	**$ 117,530**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 130,969	$ 126,947	$ 140,321	$ 115,813	$ 148,220	$ 157,464	$ 11,451	$ -	$ 11,451	$ -
1,469,748	-	1,469,748	-	1,469,748	-	500	-	500	-
-	-	-	-	-	-	-	-	-	-
$ 1,600,717	**$ 126,947**	**$ 1,610,069**	**$ 115,813**	**$ 1,617,968**	**$ 157,464**	**$ 11,951**	**$ -**	**$ 11,951**	**$ -**

Office of MaineCare Services Administration

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OMSA	010	$ 29,890,916	$ 26,933,406	$ 24,225,367	$ 22,937,837	$ 33,558,704	$ 28,910,739	$ 30,202,505	$ 30,288,104	$ 30,679,818	$ 28,073,087
	013	55,684,471	43,294,381	72,596,616	58,607,585	79,413,744	58,784,052	70,482,329	52,541,132	85,161,464	73,269,233
	014	3,425,765	824,700	3,432,352	601,339	1,469,917	363,498	1,469,917	378,763	1,487,906	303,356
	015	857,121	62,783	930,277	7,353,303	941,270	260,983	52,797	390,623	3,357,004	2,617,455
	020	-	-	-	-	700,000	1,012,408	-	970,547	1,974,438	46,805,144
	022	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
		$ 89,858,273	**$ 71,115,270**	**$ 101,184,612**	**$ 89,500,064**	**$ 116,083,635**	**$ 89,331,680**	**$ 102,207,548**	**$ 84,569,169**	**$ 122,660,630**	**$ 151,068,275**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 13,983,896	$ 20,857,984	$ 27,841,118	$ 23,525,011	$ 28,629,008	$ 23,193,997	$ 28,210,641	$ 24,470,704	$ 28,320,209	$ 28,231,489
108,103,053	51,155,536	104,645,558	79,112,158	93,389,854	71,970,628	88,548,919	76,615,356	88,541,051	85,027,341
1,487,906	284,633	1,487,956	264,436	1,487,956	257,663	1,487,956	142,741	1,487,956	124,565
3,566,592	2,954,820	5,366,530	3,018,869	5,366,530	2,036,656	5,366,530	1,002,173	5,366,530	222,695
1,479,438	29,497,036	1,479,438	21,788,555	1,479,438	20,250,976	1,505,768	16,119,823	1,505,768	15,779,137
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 128,620,885	**$ 104,750,009**	**$ 140,820,600**	**$ 127,709,029**	**$ 130,352,786**	**$ 117,709,920**	**$ 125,119,814**	**$ 118,350,797**	**$ 125,221,514**	**$ 129,385,227**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 27,871,747	$ 25,094,275	$ 28,172,993	$ 29,139,335	$ 29,172,792	$ 25,489,339	$ 28,337,297	$ 28,767,207	$ 30,628,098	$ 25,699,645
88,103,715	71,476,436	88,271,878	78,501,941	88,857,958	59,730,827	88,951,924	72,975,939	94,005,124	64,637,261
1,587,956	138,545	1,587,956	267,997	1,587,956	318,248	1,587,956	470,221	1,588,456	123,101
5,491,299	197,846	5,491,299	210,752	5,370,561	128,001	5,370,561	297,788	5,370,561	177,492
1,505,768	10,323,809	1,505,768	4,852,297	1,505,768	2,063,189	1,505,768	2,193,908	1,505,768	5,033,974
-	-	-	-	-	-	-	246,409	-	5,076
-	-	-	-	-	-	-	-	-	91,074
$ 124,560,485	**$ 107,230,911**	**$ 125,029,894**	**$ 112,972,322**	**$ 126,495,035**	**$ 87,729,604**	**$ 125,753,506**	**$ 104,951,472**	**$ 133,098,007**	**$ 95,767,622**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 31,017,511	$ 30,698,892	$ 31,439,400	$ 31,316,185	$ 33,513,872	$ 34,789,370	$ 32,558,200	$ -	$ 32,935,650	$ -
94,778,083	81,945,978	97,657,210	88,102,271	103,868,452	106,490,363	102,892,680	-	103,917,506	-
1,588,456	12,359,079	1,588,456	15,221,516	1,642,515	28,938,476	1,514,795	-	1,514,795	-
5,495,471	394,221	5,495,471	310,477	5,995,471	354,301	1,424,285	-	1,424,285	-
1,505,768	388,828	1,505,768	19,967	1,505,768	-	500	-	500	-
-	-	-	-	-	-	-	-	-	-
-	367,076	300,000	196,756	-	-	-	-	-	-
$ 134,385,289	**$ 126,154,074**	**$ 137,986,305**	**$ 135,167,172**	**$ 146,526,078**	**$ 170,572,510**	**$ 138,390,460**	**$ -**	**$ 139,792,736**	**$ -**

Office of MaineCare Services MAP

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OMSM	010	$ 652,157,384	$ 643,297,847	$ 586,359,188	$ 593,289,208	$ 440,128,107	$ 469,737,003	$ 512,150,142	$ 526,277,028	$ 761,377,355	$ 776,213,687
	013	1,436,433,942	1,296,501,055	1,664,039,408	1,545,048,196	1,627,946,894	1,504,276,812	1,699,170,852	1,470,827,615	1,655,463,543	1,425,065,109
	014	202,389,925	195,582,578	213,252,663	200,391,681	208,544,788	193,976,702	216,236,744	221,545,493	225,119,973	242,840,171
	015	25,178,645	23,961,829	25,178,645	27,780,417	25,397,323	28,813,827	28,549,111	27,371,654	27,817,962	26,240,709
	020	-	-	184,101,236	162,473,130	229,296,976	272,103,850	184,499,228	198,997,107	-	(4,420,542)
	023	-	-	-	-	-	-	-	-	-	-
	024	-	-	-	-	-	-	-	-	-	-
		$ 2,316,159,896	**$ 2,159,343,309**	**$ 2,672,931,140**	**$ 2,528,982,632**	**$ 2,531,314,088**	**$ 2,468,908,194**	**$ 2,640,606,077**	**$ 2,445,018,897**	**$ 2,669,778,833**	**$ 2,465,939,133**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 751,238,453	$ 751,344,584	$ 756,039,437	$ 750,176,375	$ 754,320,691	$ 755,996,995	$ 770,651,682	$ 782,103,596	$ 769,693,108	$ 756,843,971
1,705,588,775	1,478,968,657	2,013,337,978	1,732,344,654	1,711,668,640	1,474,030,665	1,759,624,878	1,564,521,384	1,781,080,974	1,598,748,303
235,201,424	258,846,429	407,429,813	419,599,702	223,895,617	239,803,667	237,916,013	241,449,303	238,523,357	233,805,329
27,806,574	27,977,760	27,806,574	21,233,628	27,808,379	21,634,382	32,833,398	29,063,628	34,295,576	33,080,966
-	(1,726,387)	-	(420,461)	-	(85,063)	-	(61,895)	-	(38,265)
-	-	-	-	-	-	-	-	-	-
-	-	34,510,488	34,097,942	35,872,828	35,625,367	33,425,101	33,267,962	33,425,084	33,129,964
$ 2,719,835,226	**$ 2,515,411,043**	**$ 3,239,124,290**	**$ 2,957,031,840**	**$ 2,753,566,155**	**$ 2,527,006,013**	**$ 2,834,451,072**	**$ 2,650,343,978**	**$ 2,857,018,099**	**$ 2,655,570,268**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 775,213,645	$ 770,325,481	$ 812,685,276	$ 813,538,726	$ 880,924,419	$ 838,634,222	$ 814,112,858	$ 735,828,967	$ 762,751,860	$ 786,794,612
1,830,488,468	1,704,523,791	1,914,355,307	1,815,811,598	2,237,242,685	2,060,335,247	2,589,677,215	2,398,588,869	2,825,133,196	2,772,461,782
249,761,544	281,766,278	256,352,856	269,290,360	291,821,117	286,553,549	294,175,695	288,800,116	312,238,720	304,063,844
36,153,294	33,682,250	36,772,281	33,843,277	34,630,103	32,903,339	30,175,788	33,267,185	29,853,629	34,188,928
-	(2,895)	-	(1,533)	-	(5,473)	-	(4,902)	-	(224)
-	-	-	-	-	-	-	-	3,699,552	-
38,425,084	37,667,606	38,425,084	38,001,738	38,425,084	37,033,650	34,342,005	32,725,928	32,778,464	32,087,158
$ 2,930,042,035	**$ 2,827,962,511**	**$ 3,058,590,804**	**$ 2,970,484,166**	**$ 3,483,043,408**	**$ 3,255,454,534**	**$ 3,762,483,561**	**$ 3,489,206,163**	**$ 3,966,455,421**	**$ 3,929,596,101**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 902,726,900	$ 906,903,770	$ 1,153,132,441	$ 1,149,425,159	$ 1,445,643,015	$ 1,396,581,718	$ 1,488,282,929	$ -	$ 1,477,851,782	$ -
3,015,668,673	2,924,479,579	2,878,471,932	2,920,859,513	3,099,422,944	3,233,391,822	3,435,383,486	-	3,435,263,202	-
340,317,982	349,812,618	320,362,752	401,991,293	351,879,997	431,755,631	342,277,680	-	343,862,466	-
44,348,889	36,390,012	36,987,036	52,785,399	39,627,280	71,171,064	48,952,336	-	49,337,449	-
-	(128)	-	-	-	(3)	-	-	-	-
-	-	-	-	-	-	-	-	-	-
33,448,552	32,988,445	38,416,149	38,198,214	39,845,674	39,622,940	40,497,895	-	40,667,651	-
$ 4,336,510,996	**$ 4,250,574,296**	**$ 4,427,370,310**	**$ 4,563,259,578**	**$ 4,976,418,910**	**$ 5,172,523,172**	**$ 5,355,394,326**	**$ -**	**$ 5,346,982,550**	**$ -**

Office of Aging and Disability Services

010 = General Fund | 013 = Federal Expenditures Fund | 014 = Other Special Revenue Funds | 015 = Federal Block Grant Fund | 018 = General Bond Fund | 020 = ARRA Federal Funds | 021 = ARRA Block Grant | 022 = Federal Expenditure Fund-CRF | 023 = Fed - ARP State Fiscal Relief | 024 = Fund for a Healthy Maine | 025 = Federal Expenditures Fund-ARF | 026 = Federal Block Grant - ARP | 027 = Maine Recovery Fund

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OADS	010	$ 55,400,516	$ 54,819,845	$ 54,318,522	$ 57,275,116	$ 52,974,738	$ 54,279,227	$ 51,550,506	$ 51,155,614	$ 51,016,106	$ 49,034,129
	013	9,694,318	9,018,603	9,853,786	8,363,296	9,989,610	9,106,686	10,391,245	9,886,657	9,936,908	10,178,059
	014	620,360	691,564	620,360	252,655	731,275	289,116	731,275	258,135	1,160,115	647,051
	015	150,000	278,192	112,500	-	415,000	311,252	415,000	386,148	415,000	441,101
	020	-	-	-	-	-	532,117	-	175,949	-	81,227
	022	-	-	-	-	-	-	-	-	-	-
	023	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
		$ 65,865,194	**$ 64,808,204**	**$ 64,905,168**	**$ 65,891,067**	**$ 64,110,623**	**$ 64,518,398**	**$ 63,088,026**	**$ 61,862,503**	**$ 62,528,129**	**$ 60,381,567**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 47,204,199	$ 44,330,152	$ 48,663,763	$ 46,239,653	$ 50,602,893	$ 47,384,321	$ 53,726,107	$ 44,377,208	$ 55,752,449	$ 52,599,211
11,269,017	9,927,083	11,541,146	9,590,683	11,552,278	10,093,948	11,529,230	9,419,111	11,552,412	7,915,378
2,199,646	1,841,541	2,333,965	1,879,584	2,388,276	1,955,870	2,434,439	2,036,711	2,477,795	2,095,050
415,000	380,416	415,000	412,542	415,000	378,471	415,000	408,645	415,000	380,040
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ 61,087,862	**$ 56,479,192**	**$ 62,953,874**	**$ 58,122,462**	**$ 64,958,447**	**$ 59,812,610**	**$ 68,104,776**	**$ 56,241,675**	**$ 70,197,656**	**$ 62,989,679**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 55,725,232	$ 48,693,866	$ 57,432,714	$ 53,095,671	$ 59,621,316	$ 54,313,026	$ 63,848,833	$ 59,035,860	$ 70,437,766	$ 57,243,149
11,299,949	9,469,479	11,311,563	9,193,017	10,974,358	11,418,285	10,993,924	9,760,925	11,260,858	8,251,053
2,378,445	2,088,667	2,418,821	2,151,205	2,772,253	2,495,849	3,117,983	2,562,768	3,774,192	3,668,197
415,000	455,358	415,000	422,839	415,000	400,177	415,000	370,399	415,000	401,493
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	39,597	-	1,183,158	-	456,341
-	-	-	-	-	-	-	-	5,100,000	15,000
-	-	-	-	-	-	-	-	-	1,631,329
$ 69,818,626	**$ 60,707,370**	**$ 71,578,098**	**$ 64,862,732**	**$ 73,782,927**	**$ 68,666,934**	**$ 78,375,740**	**$ 72,913,110**	**$ 90,987,816**	**$ 71,666,560**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 81,027,296	$ 70,404,365	$ 88,796,213	$ 78,542,216	$ 96,662,280	$ 84,765,905	$ 97,625,880	$ -	$ 95,310,547	$ -
13,300,805	13,221,340	13,338,940	11,223,461	15,858,778	10,886,348	15,819,459	-	15,839,303	-
3,392,605	3,100,486	3,435,083	4,275,953	4,859,617	5,519,741	5,818,639	-	5,923,605	-
415,000	432,196	415,000	367,865	415,000	417,234	415,000	-	415,000	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	1,756,794	2,472,897	1,676,838	670,860	1,511,255	670,860	-	670,860	-
2,782,751	2,922,450	2,817,751	3,358,233	2,817,751	1,369,509	1,400,000	-	-	-
$ 100,918,457	**$ 91,837,631**	**$ 111,275,884**	**$ 99,444,565**	**$ 121,284,286**	**$ 104,469,994**	**$ 121,749,838**	**$ -**	**$ 118,159,315**	**$ -**

Riverview Psychiatric Center

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund	
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP		

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
RPC	010	$ 1,087,650	$ 1,059,234	$ 1,031,506	$ 1,030,961	$ 666,719	$ 616,823	$ 2,527,248	$ 3,933,833	$ 2,094,055	$ 2,648,703
	013	17,493,300	17,493,300	18,522,377	18,522,377	19,178,208	19,178,208	18,214,907	18,214,907	16,590,051	16,590,051
	014	2,462,736	2,734,463	1,719,477	3,264,117	4,533,397	2,883,796	5,286,347	1,229,940	3,808,981	1,553,529
	022	-	-	-	-	-	-	-	-	-	-
		$ 21,043,686	**$ 21,286,997**	**$ 21,273,360**	**$ 22,817,455**	**$ 24,378,324**	**$ 22,678,827**	**$ 26,028,502**	**$ 23,378,680**	**$ 22,493,087**	**$ 20,792,283**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 16,387,899	$ 15,578,660	$ 16,968,316	$ 17,598,339	$ 18,734,030	$ 17,020,766	$ 21,109,628	$ 20,378,003	$ 21,269,184	$ 23,629,765
14,672,557	14,672,557	15,176,137	15,176,137	15,992,026	15,992,026	14,000,000	14,000,000	14,000,000	13,466,102
4,871,178	837,470	1,195,693	353,659	3,481,707	2,882,636	4,177,629	419,212	4,615,799	559,305
-	-	-	-	-	-	-	-	-	-
$ 35,931,634	**$ 31,088,687**	**$ 33,340,146**	**$ 33,128,135**	**$ 38,207,763**	**$ 35,895,428**	**$ 39,287,257**	**$ 34,797,215**	**$ 39,884,983**	**$ 37,655,172**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 21,998,536	$ 24,585,400	$ 22,281,319	$ 43,231,085	$ 23,162,868	$ 26,868,612	$ 23,230,492	$ 20,642,522	$ 23,902,045	$ 21,177,078
14,000,000	14,000,000	14,000,000	18,025,707	20,160,754	19,352,523	21,190,040	22,070,487	22,470,734	19,344,546
6,165,618	(70,376)	6,615,490	136,619	921,856	912,409	921,856	1,309,934	1,747,456	196
-	-	-	-	-	612,889	-	1,694,593	-	1,133,989
$ 42,164,154	**$ 38,515,024**	**$ 42,896,809**	**$ 61,393,411**	**$ 44,245,478**	**$ 47,746,433**	**$ 45,342,388**	**$ 45,717,536**	**$ 48,120,235**	**$ 41,655,809**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 25,627,929	$ 21,093,859	$ 28,475,466	$ 25,739,080	$ 27,106,722	$ 32,945,208	$ 29,167,595	$ -	$ 29,388,776	$ -
23,031,892	20,737,401	23,589,387	18,975,313	23,900,024	18,794,194	25,057,599	-	25,586,897	-
1,747,456	833,936	1,747,456	886,387	1,747,456	1,281,521	1,747,456	-	1,747,456	-
-	-	-	-	-	-	-	-	-	-
$ 50,407,277	**$ 42,665,196**	**$ 53,812,309**	**$ 45,600,781**	**$ 52,754,202**	**$ 53,020,923**	**$ 55,972,650**	**$ -**	**$ 56,723,129**	**$ -**

Dorothea Dix Psychiatric Hospital

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund			
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP				

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
DDPC	010	$ 3,700,654	$ 3,188,818	$ 3,561,372	$ 3,679,563	$ 2,820,857	$ 3,105,677	$ 2,317,351	$ 2,593,755	$ 3,857,863	$ 3,314,182
	013	14,024,975	14,023,000	14,820,000	14,820,000	14,895,370	14,895,370	14,017,735	14,017,735	10,969,947	10,969,947
	014	1,720,641	1,501,506	1,211,801	2,432,210	5,542,476	2,583,534	5,422,699	1,522,374	4,687,536	1,730,059
	022	-	-	-	-	-	-	-	-	-	-
		$ 19,446,270	**$ 18,713,324**	**$ 19,593,173**	**$ 20,931,773**	**$ 23,258,703**	**$ 20,584,581**	**$ 21,757,785**	**$ 18,133,864**	**$ 19,515,346**	**$ 16,014,188**

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 8,133,367	$ 7,150,468	$ 8,525,714	$ 7,855,317	$ 8,608,615	$ 9,854,459	$ 9,131,301	$ 8,938,196	$ 9,161,793	$ 9,353,579
8,535,130	8,535,130	8,802,920	8,802,920	11,599,574	11,599,574	11,500,000	11,784,399	11,500,000	12,530,221
3,082,415	1,600,374	2,978,257	1,379,973	545,154	200,023	1,615,188	1,286,195	1,762,601	173,763
-	-	-	-	-	-	-	-	-	-
$ 19,750,912	**$ 17,285,972**	**$ 20,306,891**	**$ 18,038,210**	**$ 20,753,343**	**$ 21,654,056**	**$ 22,246,489**	**$ 22,008,790**	**$ 22,424,394**	**$ 22,057,563**

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 9,552,858	$ 9,420,167	$ 9,679,990	$ 10,211,603	$ 11,907,506	$ 10,411,852	$ 12,486,146	$ 11,728,256	$ 13,886,477	$ 13,040,670
12,100,000	11,612,986	12,100,000	13,007,483	15,877,509	16,389,609	17,373,898	17,996,118	17,578,176	18,843,218
2,023,521	1,414,200	2,241,389	1,475,035	1,962,028	(532,785)	1,962,028	3,155,796	2,462,548	1,835,661
-	-	-	-	-	384,831	-	1,175,759	-	962,273
$ 23,676,379	**$ 22,447,353**	**$ 24,021,379**	**$ 24,694,121**	**$ 29,747,043**	**$ 26,653,507**	**$ 31,822,072**	**$ 34,055,929**	**$ 33,927,201**	**$ 34,681,822**

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ 16,329,472	$ 13,515,629	$ 15,813,647	$ 19,002,963	$ 16,406,949	$ 19,875,946	$ 17,462,814	$ -	$ 17,715,691	$ -
17,860,904	18,290,622	18,956,532	18,509,916	19,141,836	19,227,449	20,149,745	-	20,471,152	-
2,462,548	1,576,996	2,462,548	1,638,339	2,462,548	2,027,464	2,462,548	-	2,462,548	-
-	-	-	-	-	-	-	-	-	-
$ 36,652,924	**$ 33,383,247**	**$ 37,232,727**	**$ 39,151,218**	**$ 38,011,333**	**$ 41,130,859**	**$ 40,075,107**	**$ -**	**$ 40,649,391**	**$ -**

Office of the Health Insurance Marketplace

010 = General Fund	014 = Other Special Revenue Funds	018 = General Bond Fund	021 = ARRA Block Grant	023 = Fed - ARP State Fiscal Relief	025 = Federal Expenditures Fund-ARF	027 = Maine Recovery Fund
013 = Federal Expenditures Fund	015 = Federal Block Grant Fund	020 = ARRA Federal Funds	022 = Federal Expenditure Fund-CRF	024 = Fund for a Healthy Maine	026 = Federal Block Grant - ARP	

		SFY 2008		SFY 2009		SFY 2010		SFY 2011		SFY 2012	
Office	Fund	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
OHIM	010	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	013	-	-	-	-	-	-	-	-	-	-
	014	-	-	-	-	-	-	-	-	-	-
	025	-	-	-	-	-	-	-	-	-	-
		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

	SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
010	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
013	-	-	-	-	-	-	-	-	-	-
014	-	-	-	-	-	-	908,122	-	7,636,920	2,838,846
025	-	-	-	-	-	-	-	-	-	-
	$ -	$ -	$ -	$ -	$ -	$ -	$ 908,122	$ -	$ 7,636,920	$ 2,838,846

SFY 2013		SFY 2014		SFY 2015		SFY 2016		SFY 2017	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	-	-	-	-
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	-	500	-	500	-	500	-	500	-
13,249,596	11,452,830	13,647,551	11,925,305	13,708,363	13,983,160	18,221,894	-	18,233,318	-
-	523,081	-	-	-	-	-	-	-	-
$ 13,249,596	$ 11,975,911	$ 13,648,051	$ 11,925,305	$ 13,708,863	$ 13,983,160	$ 18,222,394	$ -	$ 18,233,818	$ -

SFY 2018		SFY 2019		SFY 2020		SFY 2021		SFY 2022	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	-	-	-	-	-	-	-	-	-
-	-	-	-	-	-	908,122	-	7,636,920	2,838,846
-	-	-	-	-	-	-	-	-	-
$ -	$ -	$ -	$ -	$ -	$ -	$ 908,122	$ -	$ 7,636,920	$ 2,838,846

SFY 2023		SFY 2024		SFY 2025		SFY 2026		SFY 2027	
Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
-	-	500	-	500	-	500	-	500	-
13,249,596	11,452,830	13,647,551	11,925,305	13,708,363	13,983,160	18,221,894	-	18,233,318	-
-	523,081	-	-	-	-	-	-	-	-
$ 13,249,596	$ 11,975,911	$ 13,648,051	$ 11,925,305	$ 13,708,863	$ 13,983,160	$ 18,222,394	$ -	$ 18,233,818	$ -

Appendix D: Policies

The following policies are included in accordance with Title 3 §956 sub-§2(M).

Information Technology

- **State of Maine Information Privacy Policy:** https://www.maine.gov/oit/sites/maine.gov.oit/files/inline-files/InformationPrivacyPolicy.pdf
- **State of Maine Information Security Policy:** https://www.maine.gov/oit/sites/maine.gov.oit/files/inline-files/SecurityPolicy.pdf
- **State of Maine System and Information Integrity Policy and Procedures**: https://www.maine.gov/oit/sites/maine.gov.oit/files/inline-files/SystemInformationIntegrityPolicy.pdf
- **Office of the Commissioner Privacy and Security Sanctions Policy** (Below)

Notices of Privacy Practices

- **Office of Aging and Disability Services**: https://www.maine.gov/dhhs/oads/about-us/privacy
- **Office of MaineCare Services:** https://www.maine.gov/dhhs/oms/member-resources/privacy
- **Riverview Psychiatric Center:** https://www.maine.gov/dhhs/riverview/patient-information/privacy
- **Dorothea Dix Psychiatric Center:** https://www.maine.gov/dhhs/ddpc/patient-information/notice-of-privacy-practices

Accessibility of Information and Services

- **State of Maine Digital Accessibility Policy:** https://www.maine.gov/oit/sites/maine.gov.oit/files/inline-files/DigitalAccessibilityPolicy.pdf
- **State of Maine Reasonable Accommodation Policy:** https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/3.10.pdf
- **State of Maine Non-Discrimination in Employment Policy:** https://www.maine.gov/bhr/sites/maine.gov.bhr/files/inline-files/SOM%20Non-Discrimination%20Policy.pdf

Office of the Commissioner

Privacy and Security Sanctions Policy

Policy #: DHHS-04-14

Issue Date: 04/02/14
Revised Date: 12/14/18
Revised Date: 01/20/22
Revised Date: 02/10/25

I. SUBJECT

Privacy and Security Sanctions Policy

II. POLICY STATEMENT

The Maine Department of Health and Human Services (the Department) and its workforce will act in good faith to comply with applicable Federal and State laws regarding the use, disclosure, maintenance or transmission of Protected Health Information (PHI) as defined below; electronic PHI; any other personally identifiable consumer information; or confidential business information of the Department (collectively, "Protected Information" or "PI"), in any format.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), its updates, and other applicable federal or state laws and legal mandates, any member of the Department's workforce who intentionally, willfully, knowingly or repeatedly violates any policy involving the privacy or security of Protected Information, will be subject to the application of this policy.

This policy applies to the Department's entire workforce, including those working for both HIPAA-covered and non-HIPAA covered entities.

III. RATIONALE

As required by law, the Department will ensure that intentional or repeated actions taken in violation of the Department's information privacy and security policies will be addressed by this policy, regardless of the professional status or pay grade of the workforce member.

IV. PROCEDURE STATEMENT

A. Workforce Obligations

Consumer information that is provided to or maintained by the Department is confidential. Members of the Department's workforce are expected to maintain such confidentiality and only use the minimum necessary PI to perform his or her role within the organization, consistent with the Department's Minimum Necessary Policy. Workforce members, including, but not limited to all employees, permanent or temporary staff, students, medical or other clinical residents, volunteers, and contractors will comply with all privacy and security policies, and also agree to maintain the confidentiality of the Department's business information to which they have access.

B. Prohibition on Unauthorized Access, Use or Disclosure

No member of the Department's workforce may access, use, disclose or transmit PI unless it is necessary to fulfill that workforce member's role within the Department. Workforce members further agree that they will keep PI confidential and secure, and that they will not, among other things:

- Share user names, passwords or other identification that might permit unauthorized access to the Department's PI;
- Forward PI to a non-work related email address;
- Reveal or independently suggest that an individual receives services from the Department;
- Post PI relating to an individual receiving services from the Department on social media or other websites unless specifically part of that workforce member's job and the consumer has provided written authorization for such posting;
- Leave computers or other electronic devices unsecured or unattended while logged into an electronic medical record, billing record, or other electronic system or document containing PI;
- Leave PI in any format unattended and/or in view of any non-workforce members, whether in a vehicle, at home, or in any other unsecure location;
- Respond to any unsolicited email or other communication (phishing) seeking details of DHHS technology resources or consumer information;
- Fail to assist the Department in complying with a privacy or security requirement or obligation.

C. Duty to Report

Members of the Department's workforce, as well as the Department's Business Associates, are required to report known or suspected violations of privacy, security, and/or any actual or potential breach of PI in any format to their Privacy/Security Liaison,and/or the Director of Healthcare Privacy, within 24 hours or, if the incident is discovered after business hours, one business day. Workforce members who fail to report known or suspected breaches or violations of privacy or security policies may be subject to disciplinary action consistent with this policy.

D. No Retaliation for Good Faith Reports

The Department will not retaliate against a workforce member who makes a good faith report of a violation involving PI in any format, whether or not a violation is found to have occurred.

E. Investigation and Enforcement of this Policy

The Department will enforce this Privacy and Security Sanctions Policy consistently, regardless of the role or status of the Department workforce member.

Alleged violations will be investigated by the Director of Healthcare Privacy together with the General Counsel and the Privacy/Security Liaison of the impacted Department office, and other workforce members or hired professionals (e.g., forensic experts) as necessary. A report of the investigation will be submitted to the Commissioner's Office for review and final determination. The investigation may include:

1. Documentation regarding the alleged violation;
2. Communication with the person who allegedly committed the violation;
3. Interviews with appropriate workforce members and other individuals as necessary to gather the most complete information regarding the incident;
4. Consultation with appropriate Department specialists (e.g., Human Resources, Audit) or consultants (legal, technology, forensic, etc.) as needed;
5. Review of all circumstances surrounding the violation, including, but not limited to:
    - Whether the workforce member at issue has a history of privacy/security violations;
    - The degree of seriousness and impact of the violation;
    - Any loss of or unlawful access to PI in any format;
    - Any potential fines or other penalties;
    - Any state and/or federal reporting requirements;

- Any potential regulatory investigations and resulting business injury; and
- Intentional or willful nature of the violation.

F. Disciplinary Action - Sanctions

In collaboration with the Bureau of Human Resources, the Commissioner or her designee, with guidance from the Director of Healthcare Privacy, the General Counsel, and/or other appropriate advisors, will determine any disciplinary sanction on a case-by-case basis, taking into account the circumstances of each alleged violation. Sanctions may include disciplinary actions up to, and including, termination of employment. The intention of, and degree of harm caused by, the workforce member to individual patients, members, clients or consumers of the Department may be considered when imposing disciplinary sanctions.

Factors that may be considered include, but are not limited to: a) Prior privacy/confidentiality/security violation(s) by the individual at issue; b) Obligations of state and federal regulations requiring notification of individuals of the breach of their unsecured PI; c) mandatory notification to regulators, the media and consumer reporting agencies, depending on the type of PI exposed and the number of consumers affected; d) follow up audits of Department records; e) financial penalties imposed on the Department; and f) other potential sanctions against the Department by governmental entities.

G. Confidentiality and Security Statement

Each member of the Department's workforce shall sign a Workforce Confidentiality Statement (Attachment A) certifying that the workforce member has read, understands and agrees to comply with this policy, and to policies and laws relating to the protection of the Department's patient, member, client or consumer information. The signed statement will be maintained in the workforce member's employment file.

V. DEFINITIONS

Definition of Protected Health Information:

Protected Health Information means information, including demographic and billing information that may identify the patient, member, client or consumer, and which relates to:

- The past, present or future physical or mental health or condition of an individual,
- The provision of health care to an individual, or
- The past, present or future payment for the individual's health care services that identifies or could reasonably be used to identify the individual.

VI. DISTRIBUTION

All workforce via posting on the DHHS Intranet.

VII. ATTACHMENT

Workforce Confidentiality Statement and Acknowledgement of Sanctions for Violations

2-10-2025
Date

Sara Gagné-Holmes
Commissioner

Maine Department of Health and Human Services

Workforce Confidentiality Statement and Acknowledgement of Sanctions
For Privacy or Security Violations

I, _____, have read and understand the Privacy and Security Sanction Policy of the Maine Department of Health and Human Services (the Department) referring to the protection of Protected Health Information and other identifiable or confidential consumer information (together, "Protected Information"). I understand that I must comply with this policy, as well as with applicable federal and state laws, regulations and rules, and the Department's other policies and procedures that protect such identifiable or confidential information, as a condition of my employment.

I agree to maintain the privacy, security, and integrity of Protected Information.

I agree only to use, access, create, maintain, transmit or disclose the minimum necessary Protected Information for the purpose of performing my work for the Department, and only access that Protected Information that I need to know to accomplish my required work-related tasks.

I will comply with these policy requirements for the protection of Protected Information in any format whether working on site or off-site.

I will never a) reveal or independently suggest that a particular individual receives Department services; b) forward Protected Information to a non-work-related email address such as a personal email address; c) post Protected Information related to a patient, member, client, consumer or other individual receiving services or in Department custody to a social media or other website without written authorization of the individual and the specific permission of my Director; d) leave or use Protected Information in any format in view in a locked or unlocked vehicle, home or other unsecure location.

I will use reasonable and appropriate safeguards to avoid impacting the integrity of Protected Information in any format, whether held in an electronic record system, on paper records, film, or other medium, including on portable devices. I will immediately report the loss of, or technical concern regarding portable media or mobile devices, or suspicion of unauthorized access, use or disclosure of Protected Information to my Privacy/Security Liaison, my supervisor and the Director of Healthcare Privacy.

I understand and agree that failing to comply with any of the policies or requirements mentioned in this statement, or violating a policy that relates to the protection of an individual's Protected Information or the confidential business information of the Department could lead to disciplinary sanctions, up to and including termination of employment.

Date: _____

Printed Name: _____

Signature: _____

Witness: _____

Appendix E. Legislative Reports

Commissioner's Office (CO)	
Report Title	**Statutory Citation**
Rulemaking Activity	PL 2003, c. 689 §205; LD 1913

Office of Child and Family Services (OCFS)	
Report Title	**Statutory Citation**
Services & Progress Plan *(Federal Requirement)*	45 CFR §1357.16
Help Maine Grow	22 §3923; PL 2021, c. 457; LD 1712
Children in DHHS Custody	22 §4003 (5); PL 2021, c. 620, §1; LD 1721
Child Death and Serious Injury Review	22 §4004; PL 2023, c. 261, §1 (AMD); PL 2023, c. 447, §1
Child Death & Serious Injury Review Panel (CDSIRP)	22 §4004; PL 2023, c. 261; LD 1325
Transition Grant Program	22 §4010-C; PL 2025, c. 272, §2; LD 46
Office of Child and Family Services Report	22 §4010-E; PL 2023, c. 261, §3; LD 1325
Child Advocacy Centers (CAC)	22 §4019 (10); PL 2013, c. 364, §1; LD 1334
Child Welfare Report	22 §4066; PL 1997, c. 322, §1; LD 1002
Early Care and Education Consultation Program	34-B §15011; PL 2021, c. 679, §1; LD 533
Child Welfare Caseload and Workload Analysis (Final Report 2030)	Resolve 2019, c. 34; LD 821
Report & Response to Child Welfare (CW) Ombudsman Annual Report	22§ 4087-A; PL 2001, c. 439; LD 855
Maine Child Care Affordability Program (CCAP)	22 §3740-A; PL 2023, c. 412
Child Care Subsidies Evaluation and Recommendations (Maine Child Care Affordability Program)	22 §3740-A; PL 2023, c. 412; LD 258
Child Death & Serious Injury Panel (CDSIRP)	22 §4004; PL 2023, c. 261

Office for Family Independence (OFI)	
Report Title	**Statutory Citation**
State Supplemental Income for Blind, Disabled and Elderly (Errors Bill)	22 §3203; PL 2023, c. 405; LD 2010
Measures of Child and Family Economic Security for Families Participating in Maine's Public Assistance Programs (LIFT Survey Data)	22 §3109 (3) (B); PL 2021, c. 648; LD 1748
Potential Extension of the General Assistance Program Eligibility Period	22 §4327; PL 2023, 575; LD 1732

Division of Licensing and Certification (DLC)	
Report Title	**Statutory Citation**
Certificate of Need (CON)	22 §343; PL 2009, c. 383; LD 1395
Sentinel Events	22 §8754 (4); PL 2025, c. 305; LD 1961
Temporary Nurse Agencies Report (TNA)	22 §2131; PL 2023, c. 434; LD 451
Residential Facilities Data	Resolve 2025, c. 92; LD 979

Maine Center for Disease Control and Prevention (MECDC)	
Report Title	**Statutory Citation**
Tribal-State Collaboration Act	5 §11055 (2); PL 2021, c. 681; LD 585
Gambling Addiction and Treatment Fund	5 §20006-B (2); PL 2011, c. 657; LD 1746
Public Schools Radon Progress	20-A §4013 (1); PL 2019, c. 172; LD 1079
Office of Violence Prevention Activities (OVP)	22 §1427 (7); PL 2023, c 643 Sec. FFFF-1; LD 2214
Maternal, Fetal and Infant Mortality Review (MFIMR)	22 §261, (5) (B); PL 2017, c. 203; LD 1112
Aging and Disability Mortality Review Panel (ADMRP)	22 §264 (6)(B); PL 2021, c. 398, Pt. MMMM, §2; LD 221
Health Care Provider Child Lead-Screening Summary	22 §1317 (C); PL 2007, c. 628; LD 2218
Hypodermic Apparatus Exchange Program (SSP)	22 §1341 (3); PL 2007, c. 346; LD 1786
Firearm Fatalities and Hospitalizations	22 §1425; PL 2021, c. 369; LD 1392
Lyme and Tick-Borne Illnesses	22 §1645; PL 2009, c. 494; LD 1709
Public Health Nursing Vacancy Notices	22 §1964; PL 2017, c. 312
Patient-Directed Care at End-of-Life Statistics (Death with Dignity)	22 §2140 (17) (D); PL 2019, c. 271; LD 1313
Lead Testing in School Drinking Water	22 §2604-B (5); PL 2019, c. 158; LD 153
Dental Services for Children under Medicaid (Oral Health Program)	22 §3174-S (4); PL 2021, c. 635; LD 1995
Newborn Hearing Program	22 §8823; PL 1999, c. 647; LD 1814
Birth Defects Findings & Activities	22 §8945; PL 1999, c. 344; LD 1905
Primary Care Access Credit Program	36 §5219-LL; PL 2013, c. 599; LD 440
US Safe Drinking Water Act Capacity *(Federal Requirement)*	42 USC §300g-9 (c)(3)
Report Card on Health	22 §413 (3); PL 2009, c. 355; PL 2023, c. 643; LD 2214
Universal Immunization Program	PL 2025, c. 440; 22 §1066

Office of Behavioral Health (OBH)

Report Title	Statutory Citation
Driver Education and Evaluation Programs (DEEP)	5 §20077; PL 1991, c. 601, §28; PL 2011, c. 657, Pt. AA §52; LD 1746
Substance Use Disorder (SUD) Treatment Center Community Outreach	5 §20005 (23); PL 2023, c. 412, Pt. QQQ, §1; LD 258
Prescription Monitoring Program (PMP)	22 §7250 (8); PL 2025, c. 37; LD 765
Children's Behavioral Health Services Program (CBHS)	34-B §15003 (9); PL 2021, c. 191, §1; LD 118
Rights of Recipients of Mental Health Services (ROR)	Resolve 2021, c. 132; LD 1080
Controlled Substances Prescription Monitoring Program	22 §7250; PL 2025, c. 37
DHHS/Maine State Housing Authority (MSHA) Housing First Fund Program Evaluation	22 §20-A (7); PL 2023, c. 412, Pt. AAAA, §1; LD 258

Office of MaineCare Services (OMS)	
Report Title	**Statutory Citation**
Maine Rx Plus Program Summary	22 §2681 (10); PL 1999, c. 786, Pt. A, §3
Prescription Drug Academic Detailing Program	22 §2685 (6); PL 2007, c. 327, §1
MaineCare Rate-setting Benchmarking	22 §3173-J; PL 2021, c. 639; LD 1867
Index of MaineCare Rates by Service Code	22 §3173-J (7); PL 2021, c. 639, §2; LD 1867
MaineCare Managed Care	PL 2009 c. 571 (QQQQ) (1); LD 1671

Office of Aging and Disability Services (OADS)	
Report Title	**Statutory Citation**
Long-Term Care (LTC) Services and Supports	22 §50; PL 2019, c. 612; LD 2054
Developmental Services Advisory Board Response	34-B §1223 (9)(E); PL 2007, c. 356, §7; PL 2007, c. 695, Pt. D, §3
System of Support for Adults with Developmental Disabilities (IDD) or Autism Spectrum Disorder (ASD) & Quality Assurance Activities and Strategies	34-B §5003-A (6); PL 2021, c. 321, §5; LD 1490
Biennial Report for Adults with Developmental Disabilities (IDD) or Autism Spectrum Disorder (ASD)	34-B §6004; PL 2011, c. 348, §11; LD 1345
Commission To Study Long-term Care Workforce Issues Progress	PL 2021, c. 398 Section AAAA-7; LD 2109
Biennial Plan for Adults with Developmental Disabilities (IDD) or Autism Spectrum Disorder (ASD)	34-B § 5003-A (3); PL 2011, c. 542, Pt. A, §83; LD 1845

Office of the Health Insurance Marketplace (OHIM)	
Report Title	**Statutory Citation**
Open Enrollment Overview	22 §5411; PL 2019, c. 653, Pt. A, §1; LD 2007

Maine CDC COVID-19 After Action Report

May 2023

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INTRODUCTION

On March 12, 2020, the first case of Coronavirus Disease 2019 (COVID-19) was confirmed in the State of Maine. As of the date of this after-action report (AAR), over 315,000 cases of COVID-19 have been recorded in the State of Maine, with nearly 3,000 deaths attributed to COVID-19 across the state. Throughout the past three years, the Maine Center for Disease Control and Prevention (Maine CDC) has worked tirelessly with our partners – federal, state, county, and local governments, the private sector, non-profit organizations, and Mainers across the state – to promote awareness of COVID-19 and the welfare of the entire population through encouraging mitigation efforts, vaccination, and educational campaigns, among other activities.

This AAR has been developed with a focus on Maine CDC's COVID-19 response activity from the beginning of the pandemic through July of 2022. Despite seemingly endless days of work in new and challenging circumstances, regularly changing information, and extended time away from their families, every person was committed to their work, regardless of the task. Overall, the AAR identifies and highlights many lessons learned and best practices from Maine CDC's response efforts. Recognizing and correcting these areas is essential to improving our preparedness for future emergency events. Similarly, we must embrace our successes, ensuring they contribute to updated standards and methodologies to support future actions to protect Mainers.

To complete this AAR, we gathered information by reviewing plans and operational documents, deployed surveys, and conducting numerous interviews and focus groups with staff who worked intensively on the pandemic response. This AAR intends to be comprehensive in scope regarding the Maine CDC's involvement and during the timeframe specified while serving as a high-level review, highlighting and contextualizing the most significant observations, findings, and recommendations of the COVID-19 pandemic response. There are myriad lessons learned and best practices from across Maine's public health response to the COVID-19 pandemic which are not directly captured in this document due to the practicality of time, effort, and expense. Every functional area of the response should examine the specific details of their activities to discover and document lessons learned and best practices as part of a deliberate continuous improvement initiative.

This report, and the improvements which will result from the findings herein, is dedicated to the commitment of all staff involved in the response and recovery from COVID-19 across the State.

EXECUTIVE SUMMARY

OVERARCHING OBJECTIVES

The COVID-19 pandemic caused unforeseen health effects, health disparities, and economic loss throughout the State and around the world. While many operational objectives were met throughout the course of the pandemic, the following priorities remained consistent throughout the response:

1. Providing accurate, science based, timely information to all Maine residents.
2. Identifying and encouraging actions that aimed to prevent, detect, and reduce the impact of COVID-19 infection and illness on the population of the state.
3. Coordinating across federal, state, Tribal, and local entities to ensure situational awareness.
4. Assuring an equitable distribution of resources and supplies.

NARRATIVE SUMMARY OF TIMELINE

Maine CDC's COVID-19 timeline of progression indicators, response, and recovery activities closely follow the U.S. CDC's Pandemic Intervals Framework (PIF).[1] The six intervals include Investigation, Recognition, Initiation, Acceleration, Deceleration, and Preparedness. Each indicator is triggered by designated pandemic metrics such as the increase or decrease in COVID-19 infection rates.

The Investigation Interval began on December 31, 2019, when the Wuhan Municipal Health Commission reported a cluster of potential pneumonia cases. On January 21, 2020, U.S. CDC confirmed the first case of novel coronavirus within the U.S., and Maine CDC activated its public health incident command structure. On January 31, 2020, the U.S. declared COVID-19 a public health emergency. This declaration signaled the start of the PIF's Recognition Interval. The virus was officially named SARS-CoV-2 and the disease was labeled Coronavirus Disease 2019 on February 11, 2020. On February 14, 2020, Maine CDC added COVID-19 information to their website. United Ways of Maine began taking COVID-19 consults on March 1, 2020, and on March 3, 2020, Maine CDC held their first COVID-19 media briefing.

The Initiation Interval commenced on March 6, 2020, when MaineHealth and Environmental Testing Laboratory (HETL) ran their first SARS-CoV-2 polymerase chain reaction (PCR) test. The first lab-confirmed COVID-19 case in the State was identified on March 12, 2020. Governor Mills declared a Civil State of Emergency on March 15, 2020. Maine CDC managed early pandemic operations from their headquarters until March 23, 2020, when they transitioned to a Unified Command with the Maine Emergency Management Agency (MEMA). It was March 26,

[1] Pandemic Intervals Framework (PIF) | Pandemic Influenza (Flu) | CDC

2020, when the first COVID-19 related death was reported in the State of Maine. To end the Initiation Interval, Governor Mills issued an executive order mandating quarantine of all travelers entering the state on April 3, 2020.

On April 4, 2020, Maine CDC investigated its first COVID-19 outbreak; this was the start of the first Acceleration Interval. During this interval COVID-19 cases increased rapidly throughout the state, and by April 26, 2020, Maine CDC reported 1,000 confirmed COVID-19 cases. On April 28, 2020, the U.S. reported one million COVID-19 cases. On May 7, 2020, HETL partnered with IDEXX Laboratories to support COVID-19 testing needs. Staff from various divisions within Maine CDC were redeployed to assist the Infectious Disease Epidemiology COVID-19 response team on May 25, 2020. Then, on May 26, 2020, U.S. CDC deployed support staff to Maine CDC to assist in the response. Dismally, on June 9, 2020, Maine CDC reported 100 COVID-19 related deaths. By September 18, 2020, Maine CDC reported 5,000 COVID-19 cases. Restrictions for indoor gatherings were reimposed on November 1, 2020, to attempt to minimize the spread of disease. Beginning on November 9, 2020, Air and Army National Guard staff were deployed to assist Maine CDC in their COVID-19 response.

To end the first Acceleration Interval, the Food and Drug Administration (FDA) issued an Emergency Use Authorization (EUA) for the Pfizer COVID-19 vaccine on December 11, 2020. On December 13, 2020, the first Pfizer COVID-19 vaccines arrived in the state of Maine. Vaccines were then administered on December 14, 2020. It was December 18, 2020, when the FDA authorized the Moderna vaccine for emergency use. Despite the beginnings of vaccinations, on December 29, 2020, the first case of the B.1.1.7 (alpha) variant was reported in the U.S. On January 13, 2021, Governor Mills announced all health care workers, other response staff, and individuals ages 70 and older would be prioritized for vaccination.

The Deceleration Interval that began on February 10, 2021, came with lowering case counts and death rates. On February 26, 2021, Governor Mills announced an updated age-based vaccine eligibility approach. Beginning on March 3, 2021, Maine expanded eligibility for those 60 years and older. The new age-based allocation method was effective in balancing the supply and demand for vaccine until federal allocations were substantial. By April 7, 2021, all Maine residents ages 16 and over were eligible for vaccination. On May 7, 2021, Maine had reached over half of Maine residents having received full vaccination status.

Given the effectiveness of the COVID-19 vaccines and willingness of residents to follow Maine CDC recommendations for vaccination, Governor Mills announced the State of Civil Emergency would end on June 30, 2021. Unfortunately, this did not occur due to the emerging variants that were circulating at that time. Booster shots became available for all Mainers ages 16 and older on December 10, 2021, and on December 17, 2021, the Omicron variant was reported within Maine's borders. This variant perpetuated the second Acceleration Interval until January 10, 2022, when the second Deceleration Interval began as booster shots were then available for all Mainers ages 12 and older. On January 28, 2022, 23 different sites across the state enrolled in wastewater testing. This additional surveillance method allowed for Maine CDC to proactively identify hot spots. On September 2, 2022, bivalent booster shots became available for those ages 12 and older. On December 8, 2022, bivalent booster shots were available for all Mainers ages six months and older. These booster shots greatly halted the aggressive spread of the Omicron variant and concluded the second Deceleration Interval.

FEDERAL, STATE, AND LOCAL COORDINATION

The COVID-19 pandemic emphasized the importance of a unified response across all sectors. Constant information and resource sharing was pivotal to the coordinated response effort between Maine CDC and their critical partners. A list of these partners is in Appendix E: Partners and Stakeholders List. What started out as two briefings daily within the State Emergency Operations Center (EOC) greatly increased due to the ever-changing response

needs, scope, and information. To bolster the federal, state, and local coordination, the State transitioned to a Unified Command structure two months later. Situation reports were sent daily to 147 recipients such as the Office of the Governor, Office of the Commissioner, National Emergency Management Association (NEMA) partners, Maine CDC district liaisons, Department of Transportation (DOT) partners, U.S. CDC, hospital systems, etc. Coordination of agencies at all levels of government was effective in supporting population needs and the overall response. This AAR highlights both strengths and areas of improvement pertaining to federal, state, and local coordination in the face of a disaster.

INCORPORATING AT-RISK POPULATIONS

Populations considered to be at-risk during the COVID-19 pandemic included the elderly, infants and very young children, the immunocompromised, migrant workers, rural residents, healthcare workers, people experiencing homelessness and the unvaccinated. It was especially difficult to reach all residents as Maine is the least densely populated state within the New England region. Therefore, the response from Maine CDC had to reach all corners of the state. In addition, roughly 31% of Maine's population is over the age of 60, the oldest population by median age in the United States.

To mitigate effects on these at-risk populations, Maine CDC created a Vaccine Equity Work Group and county-based strike teams to ensure all health initiatives and allocation of resources met the needs of all people. This dynamic approach to population health resulted in an age-based vaccine eligibility system that proved to be equitable and efficient. These two groups traveled across the state, including islands, to conduct vaccination clinics and home health visits. The Office of Population Health Equity within Maine CDC advocated for these vulnerable populations. The current vaccination rates of those fully vaccinated at 83% and those having received one dose at 97% serve as a testament to the comprehensive, equitable response from Maine CDC. To enumerate this point, the national rate of those fully vaccinated stands at 66.4% and those having received one dose at 81.3%.

EFFECTIVE PRACTICES

Through the development of an AAR, it is just as important to recognize and celebrate successes as it is to identify areas for improvement. Numerous successes were discovered through interactions with Maine CDC staff and response partners in the discovery phase of AAR development. Thematically, chief among these successes was the ability of staff to improvise and adapt in response to the often-changing circumstances of the pandemic response. With many aspects of the response having been previously unanticipated, staff filled gaps in existing plans through recognition of need, analysis of capabilities, and swift action to support change. Little was known about the virus early in the response, and as new information became available, staff demonstrated time and again their adeptness at adjusting approaches for success. Working from established and new partnerships alike, Maine CDC leveraged relationships with public sector, private sector, and non-government organizations to solve problems that emerged. Specific successes are listed below and throughout the document.

Maine CDC, with support from the Maine National Guard and others, redeveloped a medical supply receiving and distribution system that was effective and efficient, ensuring that personal protective equipment, vaccines, and other goods were received, organized, and cataloged accurately; and when orders were placed by local governments and other stakeholders, these supplies were delivered promptly, even to the most rural areas of the state.

Throughout the pandemic, Maine consistently had among the lowest COVID-19 case counts and fatalities from COVID-19. This was greatly attributed to "consistent (public health) messaging and leadership" and "widespread testing, combined with effective contact tracing"[2]. Maine was also a national leader in COVID-19 vaccination[3].

Maine CDC, like many government agencies, suffered from staffing gaps prior to the pandemic. As significant staffing needs were identified throughout the pandemic, Maine CDC grew exponentially through a variety of temporary staffing strategies to accomplish their mission. They reassigned staff from within their agency, utilized redeployed staff from other state agencies, had Maine National Guard personnel assigned, engaged several staffing contracts, and utilized a cadre of volunteers. Onboarding, equipping, and managing these hundreds of personnel, however, is a significant challenge which was also met with success by Maine CDC.

State lab personnel maintained situational awareness of the emerging COVID-19 virus before it was declared a pandemic. Anticipating the potential need for a variety of laboratory supplies, they submitted and received orders before the global surge and supply chain failures. These supplies helped the lab be more responsive early in the pandemic and helped them overcome many of the supply chain issues that plagued others.

Maine CDC District Liaisons proved to be an invaluable link between the agency and local governments. They ensured that concerns of local governments were brought to the attention of the right people, communicated information to the jurisdictions within their districts, and helped implement numerous Maine CDC programs in cooperation with those jurisdictions. They were leaned on as a valuable component of the response by both Maine CDC and the jurisdictions which they supported.

[2] https://pirg.org/articles/the-maine-way-to-stop-covid-19-in-its-tracks/

[3] https://www.maine.gov/covid19/vaccines/dashboard

METHODOLOGY AND DEVELOPMENT PROCESS

The discovery process and organization of the AAR revolves around 8 domains, identified by the U.S. CDC Pandemic Intervals Framework (PIF). Corresponding with each interval are designated evaluation objectives, developed by the AAR Steering Committee from Maine CDC to assist in focusing the scope of the AAR effort. These evaluation objectives, organized by domain include:

Incident Management

1. Assess the effectiveness of principal incident management practices in the Maine CDC departmental operations center.
2. Assess the human resource management practices as they apply to incident management.
3. Assess the processes of collection, evaluation, and sharing of situational information.

Risk Communication

1. Assess Maine CDC PIO activity and coordination with other state agencies.
2. Assess the accessibility and inclusivity of messaging.
3. Assess processes and procedures for communications monitoring and improvement, including the identification and management of rumors, misinformation, and disinformation.

Surveillance and Epidemiology

1. Assess the process of data collection and coordination in support of case investigation operations.
2. Assess the process of data collection and coordination in support of contact tracing operations.
3. Assess the analysis, visualization, and distribution of surveillance data.
4. Assess the adaptability of data systems and data capacities for infectious disease.
5. Assess the ability to increase and decrease staffing across epidemiological operations.

Testing and Laboratory

1. Assess the process utilized to increase Maine Health and Environmental Laboratory testing capacity, to include mobile testing operations.
2. Assess the ability to increase and decrease Maine Health and Environmental Testing Laboratory staffing levels.
3. Assess the adaptability of data systems and data capacities for laboratory data.

Community Mitigation

1. Assess the effectiveness of risk and hazard communication efforts to the public in regard to COVID-19 mitigation.
2. Assess the effectiveness of community resource distribution (i.e., masks, disinfectant, and tests) for COVID-19 mitigation.
3. Assess the enforcement of COVID-19 prevention requirements.

Medical Care and Countermeasures

1. Assess the effectiveness of resource tracking, acquisition, and distribution for medical countermeasures, to include ventilators and monoclonal antibody treatments.
2. Assess the ability to support medical surge through use of alternate care strategies.

Vaccine

1. Assess partnership engagement in the distribution of the COVID-19 vaccine.
2. Assess public education efforts for COVID-19 vaccine.
3. Assess the decision process for determining COVID-19 vaccine eligibility.
4. Assess COVID-19 vaccine site planning efforts.
5. Assess the effectiveness of COVID-19 vaccine and related supply inventory management systems.
6. Assess the processes associated with ensuring COVID-19 vaccine equity and inclusion.

State and Local Coordination

1. Assess the effectiveness of systems, processes, and organizations that supported coordination between Maine CDC and healthcare systems throughout the state.
2. Assess the effectiveness of systems, processes, and organizations that supported multiagency coordination between Maine CDC and local governments.

The discovery process for the AAR was conducted by the state's contractor for this project, Emergency Preparedness Solutions, using a mixed methods research approach encompassing document reviews, surveys, and stakeholder interviews. Maine CDC staff provided access to extensive incident documentation, plans, reports, incident action plans, and more, which gave insight into multiple facets of the response and recovery.

Quantitative data regarding case counts, logistical objectives for clinics and hospitals, vaccine rollout numbers, and more were analyzed to better understand the response metrics and trends throughout the state's response to the COVID-19 pandemic. Qualitative data were derived from response plans, situation reports, and transmission index reports. These document reviews allowed our team to better understand the ongoing activity of various stakeholder groups.

Coupled with document reviews, a survey was deployed to all interviewed participants from Maine CDC, asking them to list all partner agencies and organizations they worked with during the response and recovery. Responses to the survey were able to paint a picture of who Maine CDC collaborated with and in what fashion this took place.

Lastly, a variety of teams comprised of Maine CDC staff and various other stakeholder groups were interviewed to assess key areas for improvement and best practices regarding key response activities surrounding each of the 8 domains. Nearly two dozen interviews were conducted that provided a summative assessment of Maine CDC's COVID-19 pandemic response from the Investigation Interval through July of 2022.

RESPONSE ANALYSIS

This response analysis is organized by U.S. CDC PIF Domains as a method to organize information for a pandemic response. Descriptions of each domain are provided followed by key observations, analysis, and recommendations. Added to the response analysis are the topics of policy, recovery, and continuity of operations.

INCIDENT MANAGEMENT

Incident Management: the broad spectrum of activities and organization providing effective and efficient operations, coordination, and support applied to plan for, respond to, and recover from an incident.

Planning is the foundation of preparedness and response. The Maine CDC's Pandemic Influenza Operations Plan (April 2013), like most other similar plans around the world, had assumptions that did not align with the COVID-19 pandemic. A review of the document finds the concept of operations to be largely inadequate to support an effective response. Along with being well out of date, including the tasking of many staff no longer with the agency, the plan only vaguely alludes to response priorities, and provides little strategic information describing how priorities will be accomplished.

Recommendations:

1. Redevelop the Maine CDC's Pandemic Influenza Operations Plan, incorporating lessons learned and best practices from the COVID-19 pandemic, to include detailed strategic direction and annexes to address activities within each of the U.S. CDC Pandemic Domains.
2. Develop and implement a regular training and exercise program for Maine CDC staff to support familiarity with the plan and to validate aspects of the plan.

One aspect of the Pandemic Influenza Operations Plan which would have supported organization and management of Maine CDC's response to the COVID-19 pandemic was that of incident management. While this aspect of the plan did not provide abundant detail, per the previous observation, it could have served as a starting point to support Maine CDC's management of the incident.

Many groups interviewed stressed that full activation of the Public Health Emergency Operations Center (PHEOC) and full utilization of concepts of the Incident Command System (ICS), as called for in the Pandemic Influenza Operations Plan and various standards, such as the National Incident Management System (NIMS)[4], would have likely resulted in a more organized and efficient response.

Public Health Emergency Preparedness (PHEP) staff and some others advocated the use of ICS principles, but this was not overtly encouraged by leadership. Further, many Maine CDC staff were not trained, familiar with, or practiced in the use and implementation of ICS.

While functional areas of Maine CDC received and managed their tasks on a regular basis, there is little documented evidence of agency-wide action planning and assignments. As such, it was challenging to identify

[4] https://www.fema.gov/emergency-managers/nims

what the agency priorities and objectives were at any point in the response and how the agency was organized to address those priorities.

Recommendations:

3. Ensure agency emergency plans include a depth of specific and expected actions of incident management responsibilities and processes.
4. Develop and implement a regular training and exercise program for Maine CDC staff to support familiarity with ICS and related incident management processes.

While many staff interviewed complimented the leadership of Maine CDC's Director Dr. Shah and attributed many successes of Maine CDC's mission to his leadership, many Maine CDC staff, especially those with key responsibilities, felt they were not "in the loop" with Maine CDC leadership and the Maine Department of Health and Human Services (DHHS) Commissioner's office. Staff assigned the role of Command for CDC stated there were several occasions where Command was either overridden or circumvented by a policy group.

Recommendations:

5. Ensure that Maine CDC plans and procedures account for the roles and responsibilities of a policy group and agency leadership in incident management.
6. Ensure Maine CDC and DHHS leadership are trained in the Maine CDC's response plans and incident management systems and are included in exercises to support their understanding of the roles they play.

There was a great deal of frustration by Maine CDC staff assigned to the State EOC. While the State EOC was stated to have been organized utilizing a Unified Command, composed of a representative from the MEMA and from Maine CDC, Maine CDC staff interviewed rarely felt they were part of the Unified Command. Maine CDC staff felt the lack of familiarity in public health response by other State EOC staff hindered the integration of Maine CDC into State EOC organization and operations. Physically, in the State EOC, Maine CDC staff were assigned to a room separate from the primary EOC. Staff from other agencies, including those with no public health background, were tasked with public health responsibilities, such as the distribution of personal protective equipment (PPE), causing confusion and frustration regarding why emergency management was seemingly in charge of a public health response.

Recommendations:

7. Convene a multi-agency planning and coordination group to present the updated Pandemic Influenza Operations Plan with other agencies and to ensure an alignment of roles, responsibilities, and expectations in a state-wide response.

Receiving, Staging, and Storage (RSS) operations plans were proven to be mostly adequate for meeting the needs of the COVID-19 pandemic. The RSS plans accounted for most organization, management, and operations of the existing RSS site, though some gaps were discovered. The existing RSS plans addressed management of the facility which Maine CDC had an existing lease for prior to the pandemic, however it did not account for the setup of a new site, which was deemed necessary based upon operational demand. The plan also did not account for long-term cold storage and lacked a sustainable transportation plan.

The Maine National Guard has been strongly credited with many of the successes associated with setting up the new RSS site and developing a transportation plan for goods. National Guard members with specific skillsets and backgrounds in warehouse operations and parcel delivery were able to provide direct support to these areas.

Recommendations:

8. Update RSS plans based upon lessons learned and best practices from RSS operations. Include reference materials and job action sheets.
9. Develop just-in-time training packages for staff who may be assigned to manage and staff RSS operations in the future.

RSS Operation Highlights:

- Over 1 million miles driven accident free
- Developed a partnership with UPS to support delivery.
- Civil Air Patrol helped provide timely delivery at a distance.
- Strong support by the Maine National Guard as well as public-private partnerships contributed to successful operations.

Volunteers were used extensively to augment certain Maine CDC activities. The COVID-19 pandemic saw the largest use of volunteers ever by Maine CDC. The scaling of established systems was found to be problematic, especially regarding on-site supervision of medical volunteers. Previous standards called for all volunteers to be supervised by state employees or qualified contractors, though this was not found to be sustainable at such a scale. Volunteer management staff established a system of oversight for on-site volunteers with off-site support which worked well. Several volunteer procedures and plans were developed during the response.

Recommendations:

10. Update volunteer management plans to incorporate lessons learned, best practices, and procedures developed during the response. Include job action sheets.
11. Develop just-in-time training packages for key volunteer leadership areas.

Many impacts of the COVID-19 pandemic were personal and unseen, greatly affecting the mental health of staff. Long hours, little time off, and a prolonged stressful incident contributed to adverse psychological impacts. Efforts, supported by Maine CDC leadership, were made within Maine CDC to identify and address mental health impacts. A survey was deployed to assess needs and support programs were put into place, including remotely accessible sessions with therapists. Many staff interviewed for the development of this report cited personal and professional challenges and stressors they encountered throughout the incident. Some directly stated appreciation for and utilization of the resources which were provided by the agency to support mental health. Despite these efforts, people reported excessive stress, burnout, and fatigue – often because of pressures associated with limited staff in certain positions.

Recommendations:

12. Develop a mental health plan for staff (to include volunteers) which can be leveraged for any response.

Maine CDC generated regular situation reports (SitReps) throughout the response, providing various metrics on COVID-19 cases, vaccination efforts, supplies, and more. The SitReps are labeled as intended for distribution to state and local partners only. An overview of state-wide case numbers is among the most important information to

be found in the SitRep as it supports the overall scope of the incident, and as such this was always provided in a table at the beginning of the document. However, much of the remainder of the SitRep format was difficult to read, with no logical flow. Some information was clearly copied and pasted from other sources, resulting in a lack of consistent font and a great deal of space was wasted with narrow tables that would sometimes span multiple pages. There was frequent use of different font colors and highlights, but with no legend denoting their significance. This resulted in reports that looked chaotic and unprofessional, despite the effort that went into their development. Much of the information provided was either cumulative or covered only the reporting period, with no trend analysis or other analytics provided, severely diminishing the importance of much of the information provided in the greater context of the incident.

Narrative information was limited within the SitReps, providing little context or explanation of efforts, priorities, challenges, or upcoming activity. While there was some evolution of the SitRep format and information reported through the incident, there was modest improvement over time. Increased use of tables and less copy/paste helped to streamline the reports, though extensive and random color variations continued, with overall little narrative information provided to explain efforts and priorities.

Recommendations:

13. Identify essential elements of information which Maine CDC must capture, analyze, and report upon for public health emergencies. Consider the information needs of various audiences which would receive reports. Include analytics of relevant data points to better contextualize the evolution of an incident.
14. Develop a SitRep format that supports the organized reporting of essential elements of information, to include narrative explaining public health priorities and major lines of effort in response and recovery operations.

Maine CDC's ability to augment staffing was highly successful throughout the COVID-19 response. While some specific effective practices are highlighted in other areas of this report, there was an overall effort throughout Maine CDC during the pandemic response to address the elevated and urgent staffing needs which emerged.

Staff Augmentation:

- Hundreds of additional staff were obtained from various sources to support key Maine CDC functions throughout the pandemic.
- Staff were onboarded and provided role-specific training.

As needs were identified, Maine CDC utilized several temporary staffing strategies to meet those needs. In addition to reassigning Maine CDC personnel in accordance with agency continuity of operations plans, they also requested and assigned redeployed staff from other state agencies as well as active-duty personnel from the Maine National Guard. Several staffing contracts and volunteers were also utilized to support staffing needs across numerous tasks.

With the addition of hundreds of additional personnel to support functions such as contact tracing, case investigation, the state lab, RSS, and others, there was an added challenge of onboarding, equipping, and managing these staff in a volume and environment never before performed. Beyond typical state onboarding practices, incoming personnel needed to be provided with just-in-time training in accordance with their job duties. To further the challenge, nearly all of this was performed remotely for most staff.

Recommendations:

15. Develop written procedures for requesting, onboarding, and assigning surge personnel, accounting for various staffing sources, as well as remote and in-person assignments.

16. Develop just-in-time training packages for key staff surge functions.

The broad need for remote work was a challenge faced by all employers. The prior capacity within the Maine Virtual Private Network (VPN), managed by the Maine Office of Information Technology, was not prepared to support the entire state network with the large addition of remote workers. Correspondingly, temporary, full-time, and contract workers all required personal profiles within this system. Volunteers and temporary workers often required access to file share infrastructure, which posed potential cybersecurity concerns.

The transition to remote work also came with difficulty in procuring and deploying hardware. The Deployment of Hardware Plan did not meet the scale of need. While current needs are largely met, processes, systems, and state infrastructure must be improved to support remote access and a distributed workforce.

Recommendations:

17. Stratify the workforce into various categories providing corresponding access and information relevant to that job.
18. Increase capacity within the VPN.
19. Update the Deployment of Hardware Plan to meet greater capacity needs.

RISK COMMUNICATION

Risk Communication: the exchange of real-time information, advice, and opinions between experts and people facing threats to their health, economic, or social well-being.

Throughout the pandemic, the communications team excelled at reaching all groups of people within the state with accurate and timely information. Public information and communications staff within Maine CDC consistently delivered information to diverse audiences on many platforms. As the pandemic was ever-changing, the team adjusted their strategies and tactics based on internal analysis, determining how to best optimize information, time, and staff. This high level of adaptability was a best practice that should be incorporated into all plans, training, and exercises. A focus on optimization of resources and skills is vital to ensuring ample, accurate information can be translated and disseminated to all Maine inhabitants.

Adaptability of the CDC Communications Team:

- Followed three main pillars in their strategy:
    1. Language Access
    2. Interpretation
    3. Readability
- Followed continuous improvement practices throughout the pandemic to ensure they met all needs and challenges.

Communication staff maintained awareness of their operational effectiveness throughout the response, continuously analyzing their own strengths and areas for improvement, adjusting as needed. Language access, interpretation, readability, and accuracy of information effectively combat circulating misinformation.

Members of the public information team collaborated efficiently with all departments' pandemic response functions, crossing roles to fill gaps as needed. Members of the team were given true autonomy and permission to achieve their ultimate goal of providing accurate, easily accessible information to the public.

Despite these successes, there exists a noted absence of an emergency public information plan for Maine CDC. While Maine CDC communications staff were successful because of their experience, the lack of a plan diminishes the sustainability of future efforts with the inevitability of changes. This, however, does not negate the need to recruit and retain staff with future experience.

Recommendations:

20. Develop an agency emergency public information plan integrating lessons learned and best practices from COVID-19 efforts.

Management of misinformation, disinformation, and rumors was extremely proactive. To combat any misinformation and disinformation, the communications team monitored various platforms. Their interaction and engagement with the public via several media platforms was pivotal to the management of both misinformation and disinformation. Platforms included social media, hotlines, web chats, livestreams, and websites. This gave the team unprecedented access to the front lines of rumors and false information.

Regardless of this strength, social media, hotline, and web staff lacked the utilization of a defined incident management structure, which contributed to limiting access to information and the ability to provide public

information perspective to discussions and decisions. The result of this was a communications staff that often had to be reactive to decisions and actions of which they were unaware.

Recommendations:

21. Maine CDC emergency plans should utilize an incident management system which provides public information officers increased access to command and integrates a public information perspective into decisions and actions.

The Maine CDC communications team interfaced regularly with the public information officers of other agencies and entities. A form of a joint information system (JIS) was established through regular calls, established by the Governor's Office, with other state agencies, to form and maintain a unified communications plan. Separate from this effort, Maine CDC communications staff met with other stakeholders, including local public health, EMS, and emergency management agencies, to identify their communications needs such that those needs could be addressed through their evolving communications strategy. These actions occurred despite a comprehensive joint information system plan being in place.

Recommendations:

22. Develop a comprehensive public information plan that incorporates multi-agency joint information coordination, embracing lessons learned and best practices from the pandemic response. Ensure integration with MEMA public information/JIS plans.

SURVEILLANCE AND EPIDEMIOLOGY

Surveillance and Epidemiology: the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes.

Early in the pandemic, Maine CDC made a functional differentiation between case investigation and contact tracing. The role of case investigators was to collect information on cases as part of disease surveillance. The data collected was used to inform policy and dictate response actions. Corresponding to this, the role of contact tracers was to assess and manage people exposed to COVID-19. This split supported the preservation of personally identifiable information (PII) as the contact tracers would not be aware of the identity of the original infected person, limiting the release of information through their duties that might inadvertently disclose PII.

Recommendations:

23. Continue the separation of case investigation and contact tracing for other infectious disease reporting.

Case investigation supported identification and control of outbreaks. Many of the outbreaks came from hospitals, long-term care facilities, businesses, and events. Unfortunately, many facilities did not adhere to or implement guidance to prevent outbreaks, often due to limited staff and resources. Facilities were concerned with losing their certification and licensing because of outbreaks, which often resulted in lack of reporting. In steady state, this activity is supported by Maine CDC's Healthcare Associated Infection (HAI) program, but they were quickly overwhelmed by the number of facilities requiring support. Other offices within Maine CDC had limited resources to support HAI in these facilities.

Recommendations:

24. Advocate for increased funding and staff to support compliance and assistance to HAI work in long-term care and other facilities.

Case Investigation Best Practices:

- Case Investigation onboarded hundreds of new case investigators to support the COVID-19 response, inclusive of hiring, training, equipping, ensuring technology access, developing procedures, and providing appropriate supervision, resulting in highly effective operations.

As identified in Incident Management, staffing surge was needed across all of Maine CDC during the pandemic. The successes of this surge in Case Investigation is a specific example that is being identified as a best practice. While other functional areas of the response typically surged staff numbering less than a few dozen, Case Investigation ultimately onboarded nearly 300 staff to fulfill their mission, the majority of which joined the Case Investigation team within six months. The seven field epidemiologists staffed at Maine CDC prior to the pandemic were immediately overwhelmed with contact tracing, case investigation, and triage work. A strategy was developed for identifying and hiring staff, developing and implementing training, deploying equipment, and creating a management system to support this larger

organization. All staff worked remotely, allowing for increased capacity while limiting personal exposure, proving sustainable and nimble enough to address increases in activity that resulted from surges caused by variants.

Recommendations:

25. Document recruitment, onboarding, and management protocols for remote case investigation.

COVID-19 surveillance data was always in high demand by both the public and those in leadership positions. On a daily basis, information regarding COVID-19 case counts, hospitalizations, case fatality rates, age, ethnicity, and racial distribution of cases were updated to the online, public COVID-19 dashboard. In addition to these data metrics, the dashboard also provided public facing frequently asked questions (FAQs) and healthcare information pertaining to specific groups and areas.

Data Informatics Best Practices:

- Refined visualizations published to the online dashboard based upon questions from the public.
- Developed several automated technology tools that supported data transfer, integration, and quality control that supported labs, surveillance, and access to immunization information.

The data informatics team did an extraordinary job of providing information that supported health literacy and education. Icons and maps were utilized to increase visual understanding of information provided to the public. The Tableau visualization proved to be a best practice as it provided a greater reach of public accessibility and comprehension.

Informatics also did extensive work behind the scenes, supporting data transfer, integration, and quality control through activities such as:

- Interfacing directly with IIS to query immunizations without having to manually enter data into the surveillance system. This resulted in significant time savings of managing patient-specific immunization data.
- Utilizing a non-traditional means for labs around the state to report test results by using RedCap instead of faxing test results. This saved a great deal of manual entry and supported quality control.
- Through the use of automated bots coded in Python, COVID cases were automatically entered into the surveillance system and updates were automatically quality controlled.
- Development of a web portal that supported bulk upload of test results from labs across the state. This upload was then quality controlled by HETL staff and integrated into state-wide data.

Recommendations:

26. Develop written protocols for surveillance data communication and informatics based upon best practices and lessons learned from the COVID-19 pandemic.

One potential hurdle regarding the distribution of surveillance data was the number of identified individuals in low populated rural areas. It was perceived by some that community members may have had an ability to ascertain who was infected in their community based on data published on the public dashboard. While Maine CDC did not disclose personal identifying information (PII) of cases, the perception was that some persons were inadvertently exposed to recognition simply due to low population densities in their zip code.

Recommendations:

27. Reinforce data security policies and practices through training.

To reduce the spread of disease, the contact tracing team referred contacts to social services agencies. This support was crucial considering exposed and infected individuals were instructed to be home bound. Services such as providing a place to stay, groceries, utility assistance, trash pickup, etc., were all offered to every Mainer who was reached by the contact tracing team. Contact tracing staff felt residents had relatively high compliance in answering these phone calls, reporting accurate information, and utilizing the resources offered.

Recommendations:

28. Identify and document common support and wrap-around services and sources which would be provided to or coordinated for the homebound/those in isolation or quarantine.

A recurring issue faced by the contact tracing team was the lack of interpretation integration. A separate interpretation line was available for people to call if they did not speak the languages spoken by the contact tracing team, but this line was scrutinized by residents as they reported harsh, inflexible assistance. Eventually, Maine CDC and social services agencies identified interpreters from community groups across the state to meet a higher level of cultural competency.

Recommendations

29. OPHE to identify improved sources for language interpretation to be used in steady-state and emergency operations.

Wastewater surveillance strongly supported early identification of emerging COVID-19 community presence. Maine CDC established a partnership with the U.S. CDC to support COVID-19 wastewater testing at 16 sites across the state. The data received from wastewater testing have proven to be useful in observing general trends in the prevalence of COVID-19 activity throughout the state.

Recommendations:

30. Include wastewater surveillance in plans for other infectious disease outbreak response/data collection, as appropriate.

At the onset of COVID 19, the Infectious Disease Epidemiology program was originally comprised of seven field epidemiologists. This small number was only able to sustain the workload for three weeks as the need for more people quickly became apparent. Following this, the team followed their continuity of operations (COOP) plan, which identified the minimum number of staff needed to maintain business and what tasks were deemed mission essential functions versus those which could be delayed. This plan worked well at the start but proved to not be sustainable based on the needs of the pandemic.

The next phase of action involved the redeployment of staff from other areas within Maine CDC. The Infectious Disease Epidemiology program drew upon staff from the Environmental and Occupational Health program, Infectious Disease Prevention program, Maine Immunization program, Environmental Health program, HIV/AIDS prevention program, and Health and Environmental Testing Laboratory (HETL) which were all in the Division of Disease Surveillance. As this staff realignment was taking place, changes to master service agreements with various temporary service agencies were worked on. With various hourly wage and hours worked thresholds that could not be exceeded, acquiring temporary staff for contact tracing and case investigation purposes was hindered. The procurement processes utilized by the Division of Contract Management also provided challenges to securing the necessary workforce. All agencies within the Department of Health and Human Services had to wait until processes were changed in order to obtain more staff.

Even with emergency procurement policies enacted, it took 3-4 weeks for amendments to be made to master service agreements. Although these procurement practices would normally take up to nine months to resolve, the one month waiting time was far too long given the emergency circumstances of the pandemic, severely delaying the robust response Maine CDC needed to employ.

As the response progressed, Infectious Disease Epidemiology personnel and contracted staff were further augmented by Maine National Guard, DHHS, and other staff redeployed from across Maine CDC to meet increased and continued demand.

Recommendations:

31. Revise the current COOP plan to be able to withstand the caliber of response needed for a pandemic or other large disaster.
32. Amend emergency procurement policies to support more effective response to emergency situations, in reference to the Administrative Preparedness Annex.

The coordination of digital information was a significant undertaking throughout the pandemic response. The Maine Office of Information Technology (OIT) supports all state agencies and staff with information technology infrastructure, hardware, software, and assistance. The work of OIT, especially in the early stages of the pandemic, was undertaken on a scale never seen as they supported a state-wide distributed workforce as well as very specific needs of certain state agencies.

Maine CDC was one of the agencies requiring extensive support given their priority missions during the pandemic, many of which stemmed from surveillance and epidemiology functions. In steady-state operations, OIT tasks one individual with supporting the needs of several different agencies. This individual becomes familiar with the specific needs and nuances of those agencies and the systems they utilize.

Maine CDC staff, which were composed of Maine CDC staff, redeployed staff from other state agencies, temporary and contract staff, and volunteers, needed access to a variety of systems and programs including those native to/owned by the state, commercial software solutions, and federal systems.

Maine CDC staff needed access to a U.S. CDC provided system called the National Electronic Disease Surveillance System (NEDSS) Base System (NBS) as an integrated information tool to support local, state, and territorial health

departments in the management of reportable disease data[5]. Along with ensuring access, privacy of health information was a key concern addressed with every decision.

Obtaining hardware, creating profiles, granting access, and providing training to staff was extremely time consuming for OIT and Maine CDC management staff.

Recommendations:

33. Coordinate with OIT to ensure backup IT personnel to support Maine CDC's systems.
34. Coordinate with OIT to develop an agency-specific surge plan to address IT needs in the event of an emergency, modeled from the lessons learned and best practices of the pandemic. Consider that IT needs in future incidents may be significantly different from current needs.

[5] https://www.cdc.gov/nbs/overview/index.html

TESTING AND LABORATORY

Testing and Laboratory: the ability to implement and perform methods—including collection of specimens for clinical diagnosis—to detect, characterize, and confirm public health threats; as well as to report timely data, provide investigative support, and use partnerships to address surge capacity.

Before the COVID-19 pandemic, the state public health lab's clinical testing capacity was approximately 35,000 tests per year. The surge of pandemic operations increased state lab capacity to roughly 250,000 tests per year. Further complicating the matter was the novel nature of COVID-19, requiring alternations in laboratory methodologies compared to influenza or other common viruses. As a method to support testing capacity, the Department contracted with a third-party veterinary testing provider, IDEXX. This contract aided in the procurement of a mobile BSL-2 facility that was physically attached to the state public health lab. This increase in staff, equipment, and space allowed for a decrease in turnaround time for COVID-19 tests to within 36-48 hours. The state lab would not have been able to meet testing capacity needs without the additional testing contract. The addition of the mobile lab was crucial, though this lab is not a permanent complement to the state public health lab. In the event of future lab surge, the state lab does not have the staff, equipment, or space to meet the need.

Recommendations:

35. Allocate on a yearly basis funding for the state lab to acquire the necessary equipment and supplies needed for another testing surge.
36. Establish standby contracts with service providers to support laboratory surge.
37. Identify surge space for laboratory support functions such as data entry.

Although the mobile testing lab was pivotal to the testing needs of the state of Maine, there were issues with the IDEXX testing services. One of these issues included the contract origination, where state lab personnel were not involved in the arrangement determinations for IDEXX. No preparations were in place to accommodate the physical space of the mobile lab, state lab personnel had no knowledge of the capabilities or capacity of the vendor's equipment or personnel, and vendor personnel required training to ensure use of practices consistent with the state lab's regulatory requirements. While the vendor's personnel were qualified, veterinary testing standards differ from those required for humans. State lab personnel were diverted from laboratory duties to develop protocols and train vendor personnel.

Recommendations:

38. Ensure that personnel from any functional area have input to the procurement of contracts, personnel, or other resources or services intended to support their work.
39. The state lab should develop written protocols and procedures, as well as just-in-time training to accommodate adjunct support facilities and surge staffing.
40. Vendor experience with clinical regulations should be considered in future procurements.

Testing capacity was greatly supported by the ability for Maine CDC to secure support and technical staffing for state lab operations. Over 1,000 personnel were utilized over time through various staffing agencies and activation of the Maine National Guard.

As a matter of practice for state lab personnel prior to the pandemic, lab employees were cross trained to perform various tasks. In steady state operations, this practice supported continuity and allowed state lab staff to adjust to varying demands. This was found to be beneficial in the onboarding of temporary surge staff for the pandemic, as state lab staff were able to rotate into supporting training needs and shift to other functions as needed. The involvement of state lab personnel in the training supported good connections between mobile lab staff, support staff, and state lab staff. Staff from all groups were able to come together to share ideas on how to make the workflow more seamless. This best practice of cross-training and collaboration between staff groups was essential to meeting COVID-19 testing needs.

HETL Cross Training:

- Cross training of lab personnel to support continuity and flexibility to meet needs.

Recommendations:

41. Continue the use of cross-training with all lab personnel to support COOP practices.

In steady state operations, a main role of the state lab is to conduct specialized tests for other labs which may not have the capability. Adapting to alternate testing needs, such as quickly ramping up testing capacity was not within their usual scope of practice. In December 2019, with global discussion of an emerging novel virus with the potential for pandemic, members of the state lab placed larger orders for testing swabs and other supplies for which they anticipated need in the event of a pandemic. This proactive action gave the lab an advantage at the beginning of the pandemic.

HETL Situational Awareness:

- HETL staff maintained situational awareness of the COVID-19 virus pre-pandemic, ordering and receiving lab supplies in anticipated need ahead of global shortages and supply chain issues.

Recommendations:

42. Identify key supplies and enter into master agreements with vendors which can be used to obtain key supplies in the event of a surge need.
43. Maine CDC should develop plans for scripted proactive actions that can be taken throughout the agency in response to emerging threats which may have potential to impact the State of Maine.

Prior to the pandemic, most labs were utilizing a paper-based system of data reporting. This was not a sustainable method with a volume of data reporting needs. Labs clearly needed to expand the way they were able to accept and receive data. Developing the infrastructure for digital systems created a massive IT burden as Maine CDC had to make use of physical servers to send and store data.

The eventual utilization of Northern Data Systems (NDS), a system used in over a dozen states, supported some automations, though unfortunately, this software did not offer the flexibility to scale operations to the extent needed. Burdensome coding utilized abundant space and resulted in frequent system crashes.

Recommendations:

44. Secure funding to address the IT needs of lab data processing, storage, and transmittal.

COMMUNITY MITIGATION

Community Mitigation: the set of actions that people and communities can take to slow the spread of infectious diseases, with the goal of slowing spread and protecting all individuals, especially those at increased risk for severe illness, while minimizing the negative impacts of these strategies.

As a means of supporting COVID-19 mitigation activities, Maine CDC devised the 2020 Municipal COVID-19 Awareness Campaign. This program was made available to all municipalities in the state, with the objective to best position all municipalities and Tribal governments to provide accurate, quality education and prevention information to their residents. A total of $13.1 million was awarded and allocated from the federal Coronavirus Aid, Relief, and Economic Security (CARES Act). In total, this campaign and its corresponding funding was able to assist 134 towns and tribes that represented 76% of the state's population. Funded activities included digital signage for public messaging and safety alerts, protective barriers to facilitate queueing and support social distancing, PPE and sanitation supplies, community education and outreach, hiring staff to monitor enforcement and safety, and technology upgrades.

Community Mitigation Highlight:

- 2020 Municipal COVID-19 Awareness Campaign reached 76% of the State's population.
- The campaign increased messaging, community awareness, and public health literacy.

State facilitators of this campaign were satisfied with the way they allocated funding across all municipalities. DHHS health inspectors spearheaded this allocation effort as they all worked with their corresponding municipalities. This effort required extensive coordination among various stakeholders.

The 2020 Municipal COVID-19 Awareness Campaign proved to be extremely beneficial for a large number of municipalities and tribal governments, but there were challenges associated with the implementation of these prevention activities. Some of the reported challenges included the limited number of communities willing to participate, lack of manpower to support activities, limited time frame for completion, and supply shortages. Once the campaign ended, participants made several recommendations to improve this type of campaign if it were to be utilized for future emergencies. Most of the recommendations underlined the need for a streamlined state application and guidance on acceptable practices for a campaign. Ultimately, this campaign was deemed a success.

Recommendations:

45. Develop a best practices whitepaper to model and identify lessons learned from this program for future potential application.
46. Develop a draft application which could be utilized for future campaigns. Prior to the start of the campaign, create guidance for implementation.

DHHS health inspectors managed the surge in non-compliance complaints submitted by community members to legal mitigation measures enacted through executive order. Over 4,000 complaints relating to violations of protective measures for restaurant and lodging facilities were filed. The time required to perform COVID-19 prevention-related enforcement activities distracted from the health inspectors' normal work and in many cases damaged relationships between inspectors and owners/operators of facilities. It was estimated that health inspectors lost over half a year of their inspection schedule due to COVID-19 enforcement activities.

The use of health inspectors for COVID-19 enforcement was questioned, particularly regarding regulatory authority. Prior to the pandemic, health inspectors were involved primarily with enforcement of regulations under the Maine food code and other requirements for licensed eating and lodging establishments. Health inspectors would only address infectious disease prevention measures in the event of a foodborne illness that involved an infected worker. No policy or regulation existed for the enforcement of public health emergency orders at this scale or magnitude. A legal team was assembled to address this matter, but no definitive opinion was provided.

While discussions took place regarding the development of a Governor's office for pandemic enforcement, this action never occurred. As such, there was no alternative to health inspectors being used to enforce COVID-19 executive orders.

Recommendations:

47. Codify enforcement of emergency public health provisions and related executive orders, designating a primary responsible agency and supporting agencies, and providing them with the resources to fulfill this responsibility.
48. Provide legal authority for municipalities to enforce public health executive orders.

MEDICAL CARE AND COUNTERMEASURES

Medical Care and Countermeasures: medical care and the health care delivery system's ability to respond to events that exceed day-to-day capacity and capability of health and emergency response systems. The assessment of countermeasures examines the ability to provide medical countermeasures to targeted populations to prevent, mitigate, or treat the adverse effects of a public health incident.

In April of 2020, Governor Mills requested plans for two alternate care sites. Most hospitals were already overwhelmed with COVID-19 cases, and there was ample concern regarding the number of hospital beds not meeting surge capacity. Due to this, the alternate care sites were primarily going to be used to house COVID-19 patients that were not in need of acute care.

A variety of stakeholders assembled for this planning process. Representatives from MEMA, Maine National Guard, and Maine CDC PHEP came together to assemble a tangible plan for these sites. Unfortunately, hospitals were unable to join in this initial planning process as they were overburdened with high case counts. Once all Assistant Secretary for Preparedness and Response (ASPR) (now Administration for Strategic Preparedness & Response) standards for the alternate care sites were met, non-binding lease agreements were put into place. These agreements were established for the Cross Insurance Arena in Portland and the Cross Insurance Center in Bangor.

Once finalized agreements were in place, hospital partners were brought in to identify their staffing and equipment needs. The resources needed were vast and expensive; hospitals were also unable to provide staff for these facilities. Other states were unable to support via mutual aid, leading Maine CDC to suggest that Maine hospitals only provide essential operations, meaning all elective surgeries would be postponed so COVID-19 services could be maximized. Furthering difficulties, FEMA was not prepared to support the costs of these sites.

Maine National Guard was able to anticipate and mobilize resources for these sites, with most equipment coming directly from Maine CDC. The work of Maine National Guard was imperative to preparing these alternate care sites, though they were never opened to treat patients.

The obstacle of obtaining medical staff was determined to be nearly impossible to overcome. After the extensive planning process for these sites, written plans were shelved and the contracts for each site were withdrawn. As COVID-19 in-patient numbers did not result in a drastic surge, other established medical facilities were utilized to take on any overflow of COVID-19 cases.

Regardless of the integrated partnerships that were initiated during the alternate care site planning process, the lines of communication were not open at all levels. It was quickly determined that higher-level leaders and stakeholders of various organizations were not coordinating with those leading the response and planning efforts. Decisions were being made for these sites, but those in functional leadership positions and other operational staff were not informed, resulting in integrated partnerships not unified across agencies. This notion fueled the lack of understanding of prior surge plans, alternate care plans, and available staff and other necessary resources.

Recommendations

49. Continue to foster partnerships between PHEP, MEMA, and the Maine National Guard for public health preparedness matters.
50. Clearly define the roles and responsibilities of all stakeholders for unified coordination purposes.
51. Adjust and maintain surge and alternate care site plans for future response needs and training purposes.
52. Validate all plans through training and exercises.
53. Implement information sharing regarding alternate care sites and surge plans between hospital systems.

Therapeutics were first distributed to Maine on May 4, 2020. Ten cases of remdesivir, a COVID-19 antiviral, were allocated to the State in this initial round. Once more therapeutics were authorized for use, the HHS Administration for Strategic Preparedness and Response (ASPR) divided up shipment quantities based on therapeutic thresholds, orders, and jurisdictional replenishment requests. Shipments of these therapeutics were funneled through Maine CDC to then go to hospital systems across the state. In addition to distributing these therapeutics, Maine CDC was also tasked with educating all health providers. As these monoclonal antibody treatments were relatively new, it was pivotal to provide accurate educational information to all providers. This was a difficult undertaking as the Omicron variant was spreading across the state, consuming needed resources.

Regardless of the acceleration of COVID-19 cases throughout the state of Maine, it took providers some time to accept the use of the novel monoclonal antibody treatments. These drugs were only given an emergency authorization use, not a full FDA approval, which made providers and patients reluctant. To combat this sense of fear and mistrust of therapeutics, Maine CDC conducted webinars on all available therapeutics. These webinars were scheduled based on interest, and information was distributed via the health alert network (HAN). In addition to these webinars, weekly coordination calls were held with any providers or hospital systems who wanted more information on these therapeutics. This central communication was able to establish norms in the face of therapeutic ambiguity.

As more providers were joining in on the weekly calls, Maine CDC adapted their educational methods from provider input. It was the providers who saw first-hand the needs of special populations, so Maine CDC was able to anticipate and adapt to changing needs. Communication channels were set up to educate clinicians who served homeless populations, long-term care facilities, group homes, jails, and prisons. The prior relationships between Maine CDC and hospital systems and providers allowed for the introduction of therapeutics to run smoothly. The responsiveness and transparency on both sides created a strong alliance that quicky became apparent to the public.

Provider Engagement

- Maine CDC conducted weekly calls with providers to educate about therapeutics.
- These calls provided other benefits, including anticipation of resource needs and helping to address special populations.

COVID-19 antivirals received FDA Emergency Use Authorization in December 2021 and the first of the two antiviral medications, Paxlovid, began shipping that same month. State health departments received allocations of antivirals and monoclonal antibodies and designated pharmacy partners and other health system partners to receive these medications on a weekly basis. The federal government was also shipping product directly to healthcare facilities. Maine CDC initially partnered with a wide variety of care sites for monoclonal antibody distribution and administration, and initially selected certain pharmacy partners to receive antivirals. Maine CDC staff worked to use recent COVID-19 case investigation data and social vulnerability index data to identify the most appropriate pharmacy locations to optimize access for the largest proportion of Maine's population. There was no existing equity strategy for medication distribution, and no clear national vision for how the extensive thinking related to vaccine access equity should apply to therapeutic countermeasures.

Due to resource limitations, the RSS was unable to directly support distribution of these medical countermeasures, though eventually an acquisition and tracking system was set up in conjunction with RSS operations. Further discussion within Maine CDC led to the recognition that distributing antiviral medications and monoclonal antibody medications to different care sites could contribute to a fragmented care delivery system. Following this

recognition, Maine CDC developed a strategy to partner with healthcare facilities to offer "one-stop" services where persons with COVID-19 could get tested for COVID-19, and, if warranted, seen by a healthcare provider, and then treated with either monoclonal antibody or antiviral medication. Additional supplies of monoclonal antibodies continued to flow to some sites offering only monoclonal antibody infusion, and additional supplies of antivirals continued to flow to some pharmacies offering only medication dispensing. Maine CDC maintained ongoing communication with clinicians and therapeutics partners through weekly calls with healthcare providers and health system and pharmacy partners who distributed medications.

Maine CDC used case investigation data to identify age groups and other characteristics of COVID-19 patients at highest risk for severe disease and used these to build treatment guidelines prior to the release of U.S. CDC treatment guidelines. Maine CDC also developed online resources to assist patients in understanding who should get treated for COVID-19 and how to access treatment, and to assist clinicians in understanding which patients to treat for COVID-19 and how to select and manage the right treatment protocol. Maine CDC partnered with clinicians and pharmacists to develop video modules containing training on COVID-19 treatments.

Recommendations:

54. Develop an equity strategy encompassing multiple aspects of medical countermeasures such as vaccines, therapeutics, and continued access to certain core health services that cannot be deferred until the end of a declared emergency.
55. Building on the successes of COVID-19 treatments, establish a steady-state system for training, education, and sharing of best practices and concerns for all matters that intersect public health and healthcare.
56. Advocate for pharmacist prescribing privileges for antiviral medications during declared public health emergencies and develop a guidance framework for same.

With acute medical surge concerns, physicians were ethically pressured in their allocation of ventilators and other medical resources. The Crisis Standards of Care were not consistent in practice across the state, and although the state's guidance was reviewed early in the pandemic, physicians were not willing to endanger their licenses. The choice of who lives and dies was extremely daunting to physicians, and there were accompanying, inherent liabilities. Fortunately, they were not pushed into making these legal and ethical decisions. To support potential future needs, legislation is expected to be revisited which will address Crisis Standards of Care and physician liability.

Recommendations

57. Revisit the current Crisis Standards of Care and recommend legislation to address concerns and anticipated medical surge needs.

VACCINE

Vaccine: refers to key resources and information for states, tribes, and localities including operational guidance, funding, reporting, training, and all items related to vaccine ordering, distribution, and administration.

Maine's COVID-19 vaccination efforts are among the top in the nation6, with much of this success attributed to early and continuous planning by Maine CDC and key partners. A COVID-19 vaccine strategic plan was developed before vaccines were available, leading to development of the *COVID-19 Interim Draft Vaccination Plan*, which was a federal requirement. With changes in science and information about COVID-19 and the vaccinations soon to become available, the Interim Draft Vaccination Plan was fully revised to follow the federal plan for phase 1a.: vaccination for critical healthcare workers and other public-facing healthcare personnel, residents and staff of long-term care facilities, public safety personnel, and critical COVID-19 response personnel.

The first vaccine allocation arrived in Maine on December 13th, 2020. With each allotment a specific allocation strategy was developed to address geographic and equity concerns. The strategy was subject to approval by the Commissioner's Office, a process which was often lengthy. There was no process or guidance developed to support decision making at any level for this process.

Toward the end of this initial phase, Maine CDC deviated from the national plan to implement a plan primarily based on age. While this difference from the federal approach was controversial, it allowed for a highly efficient vaccination program as there were no specific screenings that had to occur.

Recommendations:

58. Develop a standard equity-based vaccination plan, to include best practices and lessons learned, for the purpose of it being used as a guiding document for future public health vaccine efforts.
59. Define and document the roles of public health and the Commissioner's Office including responsibilities, timelines, deliverables, etc. in resource allocation activities/operations.

A vaccine equity working group was convened to ensure equitable COVID-19 vaccination efforts. This group worked to assess needs, implement community engagement strategies to promote vaccine, and increase vaccine confidence through education and outreach, and included representation from underserved populations such as BIPOC community, LGBTQAI+, unhoused persons, New Mainers, rural, and tribal representation. U.S. CDC requirements also stipulated engaging with key populations, including persons of color, homebound, rural areas, and people with disabilities. At least 10% of grant funds had to focus on equity efforts within these groups.

The District Liaisons and Commissioners Office assisted in defining these populations. Finding the most accessible locations, so vaccine distribution could be maximized, varied from county to county. Geographical accessibility and population density were two of the biggest variables in determining these locations.

The Aging and Disability Resource Center (ADRC) and Office of Adult Disability Services (OADS) also helped to identify people and their needs for vaccine and supported these needs through local providers and transportation resources or through providing homebound vaccine services through public health nursing staff. Through the response it was identified that there was a need for increased engagement with the public to increase public

[6] https://usafacts.org/visualizations/covid-vaccine-tracker-states

health literacy and promote health services and other issues to combat misinformation and mistrust throughout the pandemic. The Commissioner's Office developed a social support team to provide support for isolation, quarantine, homebound populations, etc.

Maine responded to the unique needs of residents and the states' geographical location to support vaccine efforts. This included working with:

- Maine Migrant Health to establish evening and weekend vaccine clinics to increase vaccine access
- Sea Farish Friends to board ships and vaccinate crew members from other countries
- Muslim populations to provide education and vaccine services in mosques
- Maine Sea Coast Mission to serve island populations with vaccines
- Northern Light Health clinics that were able to work with insurance providers to advocate for patients

Although many of these relationships were in place prior to COVID-19, it was identified that working through the logistics of the pandemic has strengthened the ability of Maine CDC to communicate, coordinate, and operate with external partners.

Even with the proactive response in working to ensure vaccine equity and inclusion there were several issues identified. Many efforts were made to target different populations throughout the state, however, addressing the needs of transient populations and persons experiencing homelessness had delays. This was partially due to supply delays with the J&J vaccine, a single-dose vaccination series.

The mobile clinic approach seemed to come late in the vaccine program. Although community and pop-up clinics were supported by community leaders and emergency response agencies, there was initially no process in place to request and obtain logistical support for these operations, even in high need areas. A pop-up clinic request form was eventually developed.

Recommendations:

60. Document partner agency capabilities to support response efforts/operations in plans.
61. Vaccination pre-plans should include vaccine equity and inclusion for future public health responses.

Maine utilized several partners to support administration of vaccines as a means to ensure efficient and equitable distribution. Some of these partners included the Maine National Guard, Maine Response (Medical Reserve Corps), pharmacies, long term care facilities, Maine CDC's Office of Population Health Equity and district liaisons, county emergency management, local/county public health and EMS providers. The primary responsibilities that stemmed from these partnerships included:

- Ensure equitable distribution of the vaccine as quickly as possible
- Prioritizing highest need individuals
- Education on limited vaccine supplies
- Education on the vaccine (administration, handling, supplies, etc.)

Maine CDC organized county-based strike teams to share information, support education, enhance local capabilities, and help address gaps. In many areas the strike teams include Emergency Medical Service (EMS) providers. Supporting infectious disease vaccination was new to EMS providers. The State EMS Director developed and provided training to support the use of EMS.

To enhance coordination and education on the vaccine process the Maine Immunization Program began hosting weekly calls with vaccine providers to to share relevant, timely information and answer questions from providers and included other states, legislators, and vaccine manufacturers. This quickly became a best practice and was beneficial in maintaining situational awareness and a common operating picture.

Recommendations:

62. Include the use of EMS providers and strike teams in future planning efforts as public health force multipliers.

To monitor vaccine inventory and distribution, the Maine Immunization Information System (IIS) became a central repository for data throughout the pandemic, allowing for a central location to collect data and provide a "whole picture" in real time.

The IIS is used to order and track vaccines and to collect data at the provider level through the federal level. The ability to collect and access data in one central system was beneficial at many levels:

- The ability to share real-time data allowed for better decision-making
- It allowed for a more equitable allocation of vaccine by working with the federal pharmacy program to monitor data for rural areas to increase access
- It assisted in the movement of vaccine from one provider to another instead of ordering additional vaccine
- The data quality supported insurance needs

This system proved to be very valuable in the COVID-19 response. However, there were challenges in onboarding new providers to support the use of IIS. Data sharing agreements or Memoranda of Understanding (MOUs) were developed during the pandemic that outlined the process of how non-typical providers would capture and share data. Although these agreements worked, it was identified that having these agreements in place prior to or, at minimum, having a MOU template to be utilized in an infectious disease response could streamline the process of registration for providers.

The COVID-19 pandemic highlighted the need to have the capability to collect and track data. This process was difficult early in the COVID-19 response as the equipment (servers) could not support the processes in a timely fashion. Eventually, additional servers were added to enhance the capability of data collection and tracking.

Recommendations:

63. Continue to utilize IIS and document the benefits and capabilities of data sharing through this system. Develop procedures and policies to support continued implementation.
64. Identify/develop agreements or MOUs for non-typical providers for data entry/sharing through IIS. Consider an agreement that is not disease or vaccine specific with a caveat of having addenda for specific responses as necessary.
65. Allocate funding to support data tracking equipment (servers, etc.).

Maine CDC district liaisons were essential throughout the pandemic response. Their coordination and communication efforts were heavily utilized in the COVID-19 vaccine site planning efforts.

Maine CDC worked with state and local emergency management offices in establishing vaccine sites with a target throughput of 1,000 persons a day for each. Meetings occurred early into the vaccine planning process to share information with partners and gauge the capacity for vaccine distribution. The Commissioner's Office and Maine CDC developed a Request for Vaccination Partners. This document listed what was expected of vaccine partners and what Maine CDC would provide. Ultimately this turned into MOUs to support vaccination sites.

An innovative staffing model was developed to support vaccine clinics using students, emergency responders, drone operators, and volunteers. Although many districts utilized MaineResponds to support clinics with volunteer staffing, some opted to utilize local volunteers only.

A COVID-19 vaccine toolkit was developed for vaccine clinic partners that included resources to support set up, workflow, staffing, supplies, etc. Additionally, a pop-up clinic application was developed during the pandemic that allowed community-based organizations an opportunity to request a vaccine clinic.

Recommendations:

66. Update plans to include vaccine site locations successfully utilized during the pandemic.
67. Include lessons learned from volunteer usage in volunteer management plans.
68. Include guidance and updated MOU template(s) in plans for future reference and use in vaccine plans.

Vaccine educational efforts were of high priority throughout the pandemic as they rebuked misinformation and disinformation and increased vaccine uptake. Multiple methods and activities occurred to provide education to the public on COVID-19 vaccines.

Providing information to students, which would likely be passed along to parents and guardians, was identified as a gap. The Maine Department of Education (DOE) had limited involvement in the support or development of any public education regarding COVID-19 vaccine efforts. Their involvement could have supported greater access to schools, students, and parents.

U.S. CDC and FDA information was adapted to the specific needs of Maine and used to educate populations on the vaccine. Additional focus was given to how to talk about and educate specific population groups regarding the vaccine. Community groups were identified and utilized as a resource to target community education needs and to provide information. A political strategist was also engaged to support communications and outreach.

The state was proactive in engaging the community and providing information in multiple formats. Some of these best practices include the development of a You Tube channel called "Vaccine Answers for Me." It focused on addressing public questions and providing education in short clips available online. Vaccine manufactures were invited to attend meetings and educate attendees on their vaccines and providers were encouraged to share best practices on weekly calls.

The Maine Department of Transportation (DOT) became a critical partner in supporting outreach. DOT has a video recording studio utilized to develop short videos. These videos were typically under 3 minutes and were posted and shared online and via social media sites.

Recommendations:

69. Work with the Department of Education to define roles, responsibilities, and capabilities of supporting a public health emergency.
70. Identify DOT media production capabilities for communication plans.

Vaccine Answers for Me

- This YouTube channel was an effective means to answer many common questions Mainers had about COVID-19 vaccines.

STATE AND LOCAL COORDINATION

State and Local Coordination: ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness and coordination or resources among state and local levels of government.

Maine CDC quickly partnered with healthcare systems throughout the state to effectively navigate the pandemic response. Northern Light Health, Maine General Health, MaineHealth, and Central Maine Medical Center were three systems that united, in cooperation with Maine CDC, to meet the needs of all Maine inhabitants. Early in the pandemic, the Maine CDC Director orchestrated weekly calls with all hospital physicians. These calls supported a unity of effort among physicians, regardless of their hospital affiliation.

The Director also initiated weekly calls with health system CEOs, supporting communication of best practices and policy throughout hospital systems. Similar coordination calls were also conducted through other Maine CDC program areas. Overall, these calls supported discussion on resource allocation and sharing. Maine CDC acted as the inventory informational hub. Each week, resource tracking metrics were shared with Maine CDC for situational awareness and quality assurance purposes. These reports were also of great benefit for predicting PPE need, as well as testing and vaccination shortages across the state. As a result of these resource inventory calls, there was never considerable competition for resources. Nearby hospitals would work together and share resources when necessary.

Recommendations:

71. Continue to cultivate the public/private relationship amongst hospital systems and Maine CDC.
72. Memorialize the preemptive resource tracking and sharing system to continue providing resource metrics beyond the pandemic and into steady state operations.

Regardless of the successful internal communication between hospital systems and Maine CDC during the pandemic, misunderstandings, and lack of regular communication prior to the pandemic led to several challenges during the pandemic.

Limited funding and lack of prioritization of public health emergency preparedness and hospital emergency preparedness led to outdated plans and disconnections. Emergency plans had not been effectively updated to meet the scale of response required by the pandemic. It was discovered during the pandemic response that mass fatality planning, medical surge planning, and other preparedness activities did not involve all necessary public health, hospital, and associated stakeholders; resulting in gaps in awareness and capability which had to be developed amid the pandemic response.

Recommendations:

73. Ensure preparedness activities of public health, hospitals, emergency management, and other parties have a unity of effort.

District liaisons served as the primary link between local health departments and Maine CDC. Their main role was to effectively communicate the local situation and needs back to incident command at Maine CDC, and to serve as a conduit of information and support from Maine CDC to local health departments. The district liaisons met

multiple times each week to coordinate the local response and monitor new information. Whether it was coordinating with local EMS providers and EM agencies to acquire sufficient PPE and vaccines or work with homeless shelters and long-term care facilities to navigate an outbreak, the district liaisons were a backbone in response. Their coordination, support, and clarification throughout the response proved to be a best practice.

District Liaisons – A Critical Interface:

- District liaisons served as 'the fixers of everything that was broken'.
- Served as a key interface between Maine CDC and the local pandemic response.

The high level of trust between district liaisons and the communities they served also required understanding and boundaries. For example, schools and businesses looked to the district liaisons to make decisions about closure, decisions which are not within their jurisdiction or authority.

Although the district liaisons were an essential piece in the pandemic response, their capacity, typically a single person for each district, was stretched and found to not be sustainable given the duration of the pandemic and number of communities within their districts requiring support. Further, position classification provided that district liaisons are not eligible for overtime, which caused decreased morale.

Recommendations:

74. Hire additional district staff to support a sustainable response, as well as steady-state preparedness efforts.
75. Review policies and procedures associated with overtime approvals for certain positions.

RECOMMENDATIONS

The analysis performed in the development of this report found several common themes from across the domains. The most common theme across many of the observations made is the need for improved documentation. For many undertakings of Maine CDC throughout the pandemic, plans, protocols, procedures, and policies were either nonexistent or outdated. During the response, there was a severe lack of documentation to track operational priorities, activities, assignments, and decisions. As we reflect upon the pandemic, it is important for Maine CDC to commit to:

- Develop and properly maintain emergency plans to address all facets of a public health response.
- Ensure that emergency plans address protocols for documenting operational information as a best practice of incident management and post-incident reference.
- Properly and regularly train staff on emergency plans and exercise those plans to ensure validity.

Complementing the need for planning, training, and exercises is the need to establish and implement a NIMS-consistent incident management system to support execution of plans, coordination of efforts, integration of interagency response, situational awareness, and management of resources, to support strong multi-agency coordination efforts in preparedness, response, and recovery activities.

Despite the many successes accomplished by Maine CDC staff during the pandemic, the lack of plans and poor use of incident management systems was an apparent frustration regularly expressed by staff and noted through the lack of comprehensive incident documentation.

Several recommendations for technology improvements and implementations were made across the domains. Reliable technology, scalable to meet the needs of a large emergency, which complements public health activity is necessary for documenting, tracking, and reporting essential information. Adding resiliency and capacity to the proper IT capabilities is critical.

CONCLUSION

Maine CDC was the central component of the State of Maine's successful response to the COVID-19 pandemic. CDC staff worked tirelessly to perform their duties, rising to meet all challenges posed to them. It is said that disaster management is a team sport, and as such many of the successes accomplished throughout the pandemic response were due to collaborative efforts, not only among CDC's staff, volunteers, contractors, and temporary hires; but through working in concert with other state agencies, federal agencies, county and local governments, the private sector, and non-government organizations to successfully meet the needs of all Mainers. This is the hallmark of an effective response.

No incident, large or small, is managed perfectly. The size, duration, scope, and impacts of the COVID-19 pandemic, many of which were unanticipated, gave us all cause to approach many problems differently, finding unique solutions. While some plans worked as designed, there were some problems for which we had no plans, and other problems were best addressed by deviating from existing plans. We must celebrate our successes and ensure that processes are refined to incorporate what we did well. We must also scrutinize what was done and why to identify best practices and lessons learned. The focus of this report was on the approaches we used and the systems we implemented to solve the challenges we faced, not to scrutinize the individuals involved in those approaches and systems. This report is not written to find fault in people or decisions, but to identify what can be done better with the intent of embracing progressive improvement. It is only through this analysis that we can embrace a philosophy of continuous improvement, ensuring that our response to future disasters, be they pandemics or otherwise, will be done with the best knowledge, skills, and abilities our agency and staff can provide.

APPENDICES AND RESOURCES

APPENDIX A: IMPROVEMENT PLAN MATRIX

This matrix provides a summary of observations and corrective actions. For full context, please reference the appropriate section in the after-action report. It is the responsibility of stakeholders to task responsible parties and identify timeframes for completion.

*Capability elements include planning, organizing, equipping, training, and exercises (POETE).

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
Incident Management	The Maine CDC's Pandemic Influenza Operations Plan is outdated	1. Redevelop the Pandemic Influenza Disease Operations Plan	Planning	PHEP	In process	4Q23
		2. Develop and implement a training and exercise program for Maine CDC staff to support implementation of the Pandemic Influenza Operations Plan	Training and Exercises	PHEP	In process	4Q23
	Incident management practices must be incorporated into	3. Ensure agency response plans include a depth of incident management procedures, processes, and responsibilities	Planning	PHEP	In process	4Q23

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Maine CDC plans and procedures	4. Develop and implement a training and exercise program to support use of incident management practices	Training and Exercises	PHEP	In Process	4Q23
	The role and responsibilities of Maine CDC and HHS leadership in emergencies is not defined	5. Ensure Maine CDC plans and procedures account for roles and responsibilities of a policy group and agency leadership in incident management	Planning	PHEP	In process	4Q23
		6. Train Maine CDC and DHHS leadership in their roles and responsibilities during emergencies. Include leadership in exercises.	Training and Exercises	PHEP	In process	4Q23
	Maine CDC integration into the State EOC did not meet Maine CDC expectations	7. Convene a multi-agency planning and coordination group to socialize the updated pandemic influenza plan and ensure alignment with state response expectations	Planning	PHEP	In process	4Q23

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	RSS operations were highly successful, developing several best practices	8. Update RSS plans based on lessons learned and best practices from the pandemic	Planning	PHEP	In process	4Q23
		9. Develop just-in-time training packages for key RSS positions and functions	Training	PHEP	In process	4Q23
	Volunteer management had many successes	10. Update volunteer management plans based on lessons learned and best practices from the pandemic	Planning	PHEP	In process	1Q24
		11. Develop just-in-time training packages for key volunteer leadership positions and functions	Training	PHEP	In process	1Q24
	Staff had numerous mental health impacts from the pandemic response.	12. Develop a mental health plan for staff support which can be leveraged in any response	Planning	PHEP	In process	1Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	COVID-19 response situation reports from Maine CDC lacked in format and content	13. Identify essential elements of information (EEI), needs of various audiences, and analytic tools to determine key content areas for utilization in SitReps	Planning	PHEP	In process	4Q23
		14. Develop a SitRep format that supports the previously identified elements and incorporates narrative explaining public health priorities	Planning	PHEP	In process	4Q23
	The onboarding process for surge staff was cumbersome and did not meet capacity needs	15. Develop written procedures for requesting, onboarding, and assigning surge personnel	Planning	Maine CDC Operations Unit	In process	1Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
		16. Develop just-in-time training packages for key staff surge functions	Training	Maine CDC Operations Unit	In process	1Q24
	The VPN was not prepared to support the transition to remote work	17. Stratify the workforce into various categories	Equipping	OIT	In process	TBD
		18. Increase capacity within the VPN	Equipping	OIT	In process	TBD
		19. Update the Deployment of Hardware Plan	Planning	OIT	In process	TBD
Risk Communication	The Maine CDC Communications team was highly successful, but little to no plans exist for the function	20. Develop an agency emergency public information plan integrating lessons learned and best practices from the pandemic response	Planning	Maine CDC Communications	In process	4Q23

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Maine CDC Communications staff were often 'out of the loop' in key discussions and decisions, causing them to be reactive and reducing effectiveness	21. Ensure all Maine CDC emergency plans utilize a common incident management system which provides public information officers increased access to command and integrates public information into key decisions and actions	Planning	PHEP	In process	4Q23
	Joint information coordination existed, but appeared to not follow any formal plans	22. Develop or update public information plans that incorporate multi-agency coordination	Planning	Maine CDC Communications	In process	4Q23
Surveillance and Epidemiology	A separation of case investigation and contact tracing staff helped streamline processes and protected PII	23. Continue the separation of case investigation and contact tracing for other infectious disease reporting	Organizing	Division of Disease Surveillance	Completed	

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	The State of Maine had limited resources to support infection mitigation activity in facilities	24. Advocate for increased funding and staff to support compliance and assistance to HAI for long-term care and other facilities	Organizing	Maine CDC Executive Management	FY25	FY25
	Case Investigation successfully onboard nearly 300 personnel who were trained, organized, equipped, managed, and assigned to work remotely.	25. Document recruitment, onboarding, and management protocols for remote case investigation.	Planning	Division of Disease Surveillance	In Progress	1Q24
	Data informatics supported health literacy and education	26. Develop written protocols for surveillance data communication and informatics	Planning	Division of Disease Surveillance	In progress	1Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	There were perceived challenges in protecting public discovery of confirmed cases in low population areas	27. Reinforce data security policies and practices	Training	Division of Disease Surveillance	4Q23	4Q23
	The contact tracing team referred contacts to social services	28. Identify and document support and wrap-around services and sources to be provided to those homebound or in quarantine/isolation	Planning	Division of Disease Surveillance	Completed	
	Lack of language interpretation was a constant issue	29. Identify sources for language interpretation to be used in steady-state and emergency operations	Organizing	OPHE	In progress	2Q24
	Wastewater surveillance was highly effective at early identification of cases	30. Include wastewater surveillance in plans for infectious disease outbreak response and data collection	Planning	Division of Disease Surveillance	In progress	2Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Epidemiology staff was quickly overwhelmed by the pandemic, requiring additional staffing in a timely fashion. Emergency procurement policies were too slow to support rapid staffing solutions.	31. Revise COOP plan to be able to withstand this large of a disaster	Planning	Division of Disease Surveillance	In progress	2Q24
		32 Amend emergency procurement policies to support swifter emergency procurements	Planning	Maine CDC Operations Unit	In progress	2Q24
	OIT staff did incredible work supporting Maine CDC's surge in staffing, but the model is not sustainable	33. Coordinate with OIT to ensure backup IT support, trained to meet Maine CDC's needs	Organizing	Division of Disease Surveillance/OIT	In progress	TBD
		34. Coordinate with OIT to develop an agency-specific surge plan for IT needs	Planning	OIT	In progress	TBD

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
Testing and Laboratory	The State Lab requires planned abilities to expand to meet surge demands	35. Allocate funding for the state lab to acquire equipment and supplies which can support surge capacity	Equipping	Maine CDC Executive Management	FY25	FY25
		36. Establish stand-by contracts with laboratory service providers to support laboratory surge	Organizing	Maine CDC Operations Unit	4Q23	1Q24
		37. Identify surge space for laboratory support functions	Equipping	Maine CDC Operations Unit/DHHS Facilities Mgt	4Q23	1Q24
	The State Lab was not involved in the IDEXX procurement process, decreasing their preparedness for integration	38. Ensure that staff from any functional area have input to the procurement of contracts, staff, or other resources or services intended to support their work	Planning	Maine CDC Operations Unit	Completed	
		39. Develop written protocols and procedures as well as just-in-time training to support integration of surge support	Planning and Training	HETL	1Q24	3Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
		40. Vendor experience with clinical regulations should be considered in future procurements	Planning	Maine CDC Operations Unit	Completed	
	Cross training of state lab staff as a standard of practice supported testing surge and integration of additional staffing	41. Continue the practice of cross training of lab staff	Training	HETL	In progress	Continuous
	State lab staff anticipated the potential need for mass testing and laboratory services prior to a pandemic being declared.	42. Identify key suppliers and procure master contracts to support surge needs	Equipping	HETL	In progress	3Q23
		43. Maine CDC should develop plans for scripted proactive actions in response to emerging threats	Planning	PHEP	In progress	Continuous

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	State lab record keeping and reporting requires sustainable, modern IT capabilities	44. Secure funding to address the IT needs of lab data processing, storage, and transmittal	Equipping	Maine CDC Executive Management	FY25	FY25
Community Mitigation	The 2020 Municipal COVID-19 Awareness Campaign was a significant success	45. Develop a best practices whitepaper to model and identify lessons learned from this program for future potential application	Planning	Division of Environmental and Community Health	2Q24	4Q24
		46. Develop a draft application and implementation guidance which could be used for future programs	Planning	Division of Environmental and Community Health	2Q24	4Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	The use of health inspectors to enforce public health emergency provisions did not have clear legal authority, impacted the relationships between health inspectors and facilities, and deferred their caseload	47. Codify enforcement of emergency public health provisions and related executive orders, designating a primary responsible agency and providing that agency with the resources to fulfill this responsibility	Planning	Maine CDC Executive Management	FY25	FY25
		48. Provide legal authority for municipalities to enforce public health directives	Planning	Maine CDC Executive Management	FY25	FY25
Medical Care and Countermeasures	Many best practices and lessons learned came from activity to plan alternate care sites	49. Continue to foster relationships between PHEP, MEMA, and the Maine National Guard for public health preparedness matters	Organizing	PHEP	In process	Continuous

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
		50. Clearly define roles and responsibilities of all stakeholders for unified coordination purposes	Planning	PHEP	In process	3Q23
		51. Adjust and maintain surge and alternate care site plans	Planning	PHEP	In progress	3Q23
		52. Support and validate all plans through training and exercises	Training and Exercises	PHEP	4Q23	4Q24
		53. Implement information sharing regarding alternate care sites and surge plans between hospital systems	Planning	PHEP	4Q23	4Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	There were numerous successes and lessons learned in the equitable distribution of medical countermeasures	54. Develop an equity strategy encompassing multiple aspects of medical countermeasures	Planning	Medical Epidemiology Division	4Q23	1Q24
	Maine CDC conducted webinars and conference calls with providers to ensure they had the best information on therapeutics	55. Establish a steady state system for training, education, and sharing of best practices and concerns for issues that intersect public health and healthcare	Planning	Medical Epidemiology Division	In process	Continuous
	Capabilities of the full spectrum of healthcare providers should be embraced during a public health emergency	56. Advocate for pharmacist prescribing privileges for antiviral medications during declared public health emergencies and develop guidance for same	Planning	Maine CDC Executive Management	FY25	FY25

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Crisis standards of care lack detailed explanation and legal protections for providers	57. Revisit the current Crisis Standards of Care and recommend legislation to address concerns and anticipated medical surge needs	Planning	PHEP	In process	4Q23
Vaccine	Plans for COVID-19 vaccination were adapted as lessons were learned in Maine and across the nation	58. Develop a standard vaccination plan, to incorporate best practices and lessons learned from the COVID-19 effort, as guidance for future use	Planning	Division of Disease Surveillance	In process	1Q24
		59. Define and document the roles of public health and the HHS Commissioner's Office including responsibilities, timelines, deliverables, etc. in resource allocation activities and operations	Planning	Maine CDC Executive Management	3Q23	4Q23

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Great strides were made in vaccine equity and access, despite changes in plans and little existing prior to the pandemic	60. Document partner agency capabilities to support response efforts/operations in vaccination plans	Planning	Division of Disease Surveillance	In process	1Q24
		61. Ensure vaccination plans include vaccine equity and inclusion for future responses	Planning	Division of Disease Surveillance	In process	1Q24
	The vaccine effort required extensive coordination and partnering efforts, including the use of EMS providers, and decisions on allocation	62. Include EMS providers and county strike teams in future vaccine planning efforts	Planning	Division of Disease Surveillance	In process	1Q24
	Use of IIS to support vaccine operations was	63. Develop policies and procedures to support continued use of IIS	Planning	Division of Disease Surveillance	In process	1Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	critical, though access of staff and IT issues posed challenges	64. Develop policy, procedure, and agreements for non-typical providers to access IIS	Planning	Division of Disease Surveillance	In process	1Q24
		65. Allocate funding to support data tracking technology	Equipping	Maine CDC Executive Management	FY25	FY25
	Local partnerships and coordination were essential to the vaccine effort. A COVID-19 vaccine toolkit was developed to support vaccination activity	66. Update plans to include vaccine site locations successfully used during the pandemic	Planning	Division of Disease Surveillance	In process	1Q24
		67. Incorporate lessons learned from volunteer usage for vaccine into volunteer management plans	Planning	Division of Disease Surveillance	In process	1Q24
		68. Include guidance and updated MOU templates in plans for future reference and use in vaccine plans	Planning	Division of Disease Surveillance	In process	1Q24

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Public outreach regarding vaccination was effective, but needed improvement	69. Coordinate with the Maine Department of Education to define roles, responsibilities, and capabilities of supporting a public health emergency	Planning	Division of Disease Surveillance	In process	Continuous
		70. Identify DOT media production capabilities in communication plans	Planning	Maine CDC Communications	In process	4Q23
State and Local Coordination	Maine CDC partnerships with healthcare systems were effective throughout the pandemic	71. Continue to cultivate the public/private relationship between hospital systems and Maine CDC	Organizing	PHEP	In process	Continuous
		72. Memorialize the preemptive resource tracking and sharing system between hospital systems and Maine CDC	Equipping	PHEP	In process	Continuous

Domain	Observation	Corrective Action	Capability Element*	Primary Person / Team Responsible	Start Date	Completion Date
	Gaps in multi-agency preparedness efforts prior to the pandemic resulted in inefficiencies during the response	73. Ensure preparedness activities of public health, hospitals, emergency management, and other parties have a unity of effort	Organizing	PHEP	In progress	Continuous
	Maine CDC district liaisons were a critical link between Maine CDC and local response efforts. Staffing limited their capacity to work across their districts and is not sustainable for large responses	74. Hire additional district staff to support a sustainable response as well as steady-state support of preparedness efforts.	Organizing		Completed	
		75. Review policies and procedures associated with overtime approvals for certain positions	Organizing	Maine CDC Executive Leadership	4Q23	1Q24

APPENDIX B: PLANS, POLICIES, PROTOCOLS, AND AGREEMENT LIST

This listing includes plans, policies, protocols, agreements, and other documents that were cited in interviews and surveys as either being referenced or developed by staff during response and recovery efforts.

Document Name	Date of Publication	Source
Amended Memorandum of Understanding for Use of Maine Responds Volunteers	03/07/22	Maine DHHS & Central Maine Healthcare
COVID-19 Interim Draft Vaccination Plan	10/16/20	Maine CDC
COVID-19 Testing Site- Augusta Armory After-Action Review and Improvement Plan	03/23/22	Maine CDC
Emergency Services Agreement	07/31/20	Cumberland County & Global Spectrum
Maine Immunization Program (MIP) Routine and Emergency Vaccine Storage and Handling Plan	-	Maine DHHS
Maine Immunization Program COVID-19 Policy and Procedure Manual	-	Maine DHHS
Pandemic Influenza Operations Plan	04/30/13	Maine CDC
Public Health Emergencies Involving Infectious Diseases Human Resource (HR) Policy	09/10/14	Maine DHHS
System Wide Surge Response Plan	12/06/21	Central Maine Healthcare
Vaccination Clinic-Augusta Armory After-Action Review and Improvement Plan	03/18/22	Maine CDC

APPENDIX C: RESPONSE TIMELINE

Date	Event
Investigation Interval	
December 31, 2019	Wuhan Municipal Health commission, China, reports a cluster of cases of pneumonia.
January 9, 2020	The World Health Organization (WHO) issues a statement confirming the disease is caused by a novel coronavirus.
January 21, 2020	The US CDC confirms the first case of novel coronavirus in the US
January 21, 2020:	Emergency operations center (EOC) and Incident Command System (ICS) are activated
January 24, 2020	Maine CDC begins daily meetings to prepare for COVID-19
January 31, 2020	US declares COVID-19 a public health emergency
Recognition Interval	
February 11, 2020	The virus is named SARS-CoV-2, and the disease is called Coronavirus Disease 2019
February 14, 2020	Maine CDC adds COVID-19 to their website
March 1 2020	211 Maine begins taking COVID-19 consults
March 3, 2020	Maine CDC holds their first COVID-19 media briefing
March 4, 2020	Maine CDC publishes a COVID-19 FAQ document
Initiation Interval	
March 6, 2020	Maine HETL runs their first SARS-CoV-2 PCR test
March 11, 2020	WHO Declares COVID-19 a pandemic
March 12, 2020	Maine CDC investigates first lab confirmed case in the state
March 14, 2020	Maine CDC Epidemiology program moves to a seven-day work week
March 15, 2020	Governor Mills declares a civil state of emergency and submits emergency unemployment bill
March 18, 2020	Gathering restrictions of more than ten people are prohibited in indoor areas
March 23, 2020	Maine CDC transitions to Unified Command
March 24, 2020	Governor Mills orders all non-essential businesses to close
March 25, 2020	Maine CDC reports 100 cases of COVID-19
March 26, 2020	Maine records the first COVID-19 related death in the state
April 1, 2020	Maine Health Inspection Program (HIP) responds to their first complaint of COVID-19 related violation by a licensed facility
April 3, 2020	Governor Mills issues an executive order mandating quarantine of travelers entering the state
Acceleration Interval (first)	
April 4, 2020	Maine CDC investigates the first COVID-19 outbreak in the state
April 10, 2020	Maine CDC forms a phone-line intake team to answer infectious disease consultation hotline
April 20, 2020	Maine CDC sets up a consult team to handle incoming COVID-19 related consults
April 22, 2020	Temporary updates are made to the Maine notifiable disease and conditions list to include COVID-19 related deaths
April 26, 2020	Maine CDC reports 1,000 confirmed COVID-19 cases
April 28, 2020	U.S. surpasses one million COVID-19 cases
April 30, 2020	The first antigen tests are offered in Portland
May 7, 2020	HETL partners with IDEXX lab for testing purposes
May 19, 2020	The first inmate in the state test positive for COVID-19
May 25, 2020	Staff from other Maine CDC programs are redeployed to the ID Epi COVID-19 response team
May 26, 2020	U.S. CDC deploys staff to Maine CDC to help support COVID-19 response efforts
May 27, 2020	U.S. surpasses 100,000 COVID-19 deaths

June 1, 2020	State parks and beaches reopen to 50% capacity
June 9, 2020	Maine CDC reports 100 deaths from COVID-19
June 10, 2020	Maine CDC starts enrolling contracts in Sara Alert system
June 17, 2020	Maine CDC launches a new COVID-19 website
July 8, 2020	Governor Mills announces executive order to enforce mask-wearing
July 12, 2020	Maine CDC begins hiring case investigators to keep up with the increase in COVID-19 cases
April 17, 2020	COVID-19 becomes the third-leading cause of death in the U.S.
April 28, 2020	The first whole genome sequence confirmed case of COVID-19 reinfection is reported in the U.S.
September 9, 2020	HETL announces that it will begin working with providers to submit electronic test ordering and reporting through the Lab Web Portal
September 18, 2020	Maine CDC reports 5,000 COVID-19 cases
October 22, 2020	US Food and Drug Administration (FDA) approves antiviral drug, remdesivir, to treat COVID-19
November 1, 2020	Restrictions for indoor gatherings are reimposed
November 4, 2020	U.S. reports 100,000 cases in one day for the first time
November 9, 2020	Air and Army National Guard are deployed to assist Maine CDC in response
November 9. 2020	Total U.S. COVID-19 cases surpass ten million
November 21, 2020	Maine CDC reports 10,000 cases of COVID-19
December 11, 2020	FDA issues Emergency Use Authorization (EUA) for Pfizer COVID-19 vaccine
December 13, 2020	First COVID-19 vaccines arrive in the state
December 14, 2020	First doses of vaccine are administered in Maine
December 18, 2020	FDA issues an EUA for Moderna COVID-19 vaccine
December 22, 2020	Governor Mills extends state of civil emergency through January 20, 2021
December 29, 2020	The first case of the B.1.1.7 (alpha) variant is reported in the U.S.
January 4, 2021	Assisted living facilities begin vaccinating residents
Deceleration Interval (first)	
February 10, 2021	UK variant is confirmed in Maine
February 16, 2021	Maine expands school-based COVID-19 testing to support in-person learning
February 26, 2021	Governor Mills announces age-based approach to vaccine eligibility
April 7, 2021	All Maine residents ages 16 and up are eligible for vaccination
May 7, 2021	Maine reaches milestone of over half of Mainers receiving full vaccination status
May 10, 2021	All Maine residents ages 12 and up are eligible for vaccination
May 13, 2021	Moving Maine Forward Plan is enacted to limit capacity and distancing requirements
Acceleration Interval (second)	
June 11, 2021	Governor Mills announces state of civil emergency will end June 30, 2021
August 9, 2021	80% of adults in Maine have received at least one dose of the COVID-19 vaccine
August 12, 2021	Governor Mills requires all health care works must be vaccinated
September 22, 2021	Booster shots become available in Maine for immunocompromised individuals 16 and older
October 29, 2021	All Maine residents ages 5 and up are eligible for vaccination
November 19, 2021	First pediatric vaccine doses arrive in the state
November 21, 2021	Booster shots become available for all Maine residents ages 18 and older
December 10, 2021	Booster shots become available for all Maine residents ages 16 and older
December 22, 2021	US FDA issues EAU for Pfizer's Paxlovid for the treatment of mild to moderate COVID-19
December 23, 2021	US FDA issues EAU for Merck's molnupiravir for the treatment of mild to moderate COVID-19
Deceleration Interval (second)	
January 10, 2022	Booster shots become available for all Maine residents ages 12 and older

January 14, 2022	Maine CDC issued a Standing Order that authorizes medical staff to collect and submit specimens for SARS-CoV-2 PCR tests
January 28, 2022	23 sites have enrolled in wastewater testing
May 23, 2022	Booster shots become available for all Maine residents ages 5 and older
June 18, 2022	All Maine residents ages six months and up are eligible for vaccination
June 19, 2022	First doses for those ages six months to five years old arrived in the state
September 2, 2022	Bivalent booster shots become available for all Maine residents ages 12 and older
October 13, 2022	Bivalent booster shots become available for all Maine residents ages 5 and older
December 8, 2022	Bivalent booster shots become available for all Maine residents ages six months and older

APPENDIX D: PANDEMIC INTERVALS DOMAIN/PREPAREDNESS CAPABILITIES CROSSWALK

Domain	Capabilities	Description
Incident Management	PHEP – 3 HPP – 2	Incident Management is the broad spectrum of activities and organizations providing effective and efficient operations, coordination, and support applied at all levels of government, utilizing both governmental and nongovernmental resources to plan for, respond to, and recover from an incident, regardless of cause, size, or complexity.
Surveillance & Epidemiology	PHEP – 13	Public health surveillance and epidemiological investigation is the ability to create, maintain, support, and strengthen routine surveillance and detection systems and epidemiological investigation processes.
Laboratory & Testing	PHEP – 12	Laboratory testing is the ability to implement and perform methods to detect, characterize, and confirm public health threats. It also includes the ability to report timely data, provide investigative support, and use partnerships to address surge capacity. Testing is the ability to collect specimens for clinical diagnosis by laboratories.
Community Mitigation	PHEP – 2, 11	Community mitigation is a set of actions that people and communities can take to slow the spread of infectious diseases. The goal of community mitigation in areas with local COVID-19 transmission is to slow its spread and to protect all individuals, especially those at increased risk for severe illness, while minimizing the negative impacts of these strategies.
Medical Care & Countermeasures	PHEP – 5, 8, 9, 10, 14 HPP – 2, 3, 4	Medical care is the health care delivery system's ability to respond to events that exceed the day-to-day capacity and capability of existing health and emergency response systems and countermeasures are the ability to provide medical countermeasures to targeted population(s) to prevent, mitigate, or treat the adverse health effects of a public health incident.
Vaccine	PHEP – 8, 14, 15 HPP – 3, 4	Refers to key resources for states, tribes, localities, and territories with COVID-19 vaccination information including operational guidance, funding, reporting, training, and all items related to vaccine ordering, distribution, and administration.
Risk Communications	PHEP – 4	Risk communication refers to the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being.
State/Tribal/Local Coordination	PHEP – 1, 2, 6, 15 HPP – 2	Ability to conduct multijurisdictional and multidisciplinary exchange of health-related information and situational awareness and coordination of resources among federal, state, local, tribal, and territorial levels of government.

References:

CDC Pandemic Interval Framework Updated Preparedness and Response Framework for Influenza Pandemics
Public Health Emergency Preparedness (PHEP) and Response Capabilities
Hospital Preparedness Program (HPP) Healthcare Preparedness and Response Capabilities

APPENDIX E: PARTNERS AND STAKEHOLDERS LIST

Federal	State
Assistant Secretary for Preparedness and Response (ASPR) (now Administration for Strategic Preparedness and Response)	Maine National Guard
U.S. Centers for Disease Control and Prevention (U.S. CDC)	Maine Emergency Management Association
Congressional Budget Office	Maine Department of Environmental Protection
Department of Defense	Maine State Laboratories
Department of Homeland Security (DHS)	Department of Transportation
Federal Emergency Management Agency (FEMA)	Maine Department of Human Resource Management
U.S. Department of Health and Human Services (HHS)	National Emergency Management Association (NEMA)
U.S. Marshalls	Maine Department of Economic and Community Development
	Redeployed State of Maine staff
	Maine Center for Disease Control and Prevention (Maine CDC)
	Maine Office of Information Technology (OIT)
	Maine Responds Volunteers
	Maine Department of Education
	211 Maine
	Maine Department of Agriculture
County/Local Stakeholders	
County emergency managers	
Local health departments	
Local emergency medical services (EMS)	
Municipal governments	
Veterinary facilities	
Correctional facilities	
Local law enforcement and first responders	
County Administration	
Private and NGO Stakeholders	
Atlantic Staffing	Federally Qualified Health Centers (FQHC)
Home healthcare agencies	University of New England
IDEXX	New Mainers Project
Johnson & Johnson	Northern New England Poison Center
Long-term care facilities	Catholic Charities
Maxim Staffing	Funeral Directors Association
Medical Care Development Inc.	SaviLinx
Moderna	Concentra
Pfizer	Maine General Health
Treatment facilities	Spectra Venue Management
United Parcel Service (UPS)	Northern Light Health
University of Southern Maine	Red Cross
	Central Maine Healthcare

APPENDIX F: RESPONSE DATA SOURCE LIST

Numerous documents were reviewed as part of the discovery process for this after-action report. The plans, policies, protocols, agreements, and reports listed below constitute those most relevant to the research team. Some documents identified standards by which pandemic and other related emergency operations would take place, though implementation during the COVID-19 pandemic revealed planning assumptions inconsistent with the environment created by this novel virus. Other documents supported actions which were taken, through policy guidance, strategic planning, and tactical implementation.

Document Name	Date of Publication	Source
Annex 11. Community & Workforce Support: Psychosocial Considerations and Information	-	Disaster Behavioral Health Response Team
Annex 6. Vaccines: Use and Distribution	-	Maine CDC
Community Vaccination Clinics Toolkit	-	Maine DHHS
COVID Response Review: Addressing COVID-19 Disparities	06/22	Maine DHHS
COVID Response Review: COVID-19 Prevention Checklists	06/22	Maine DHHS
COVID Response Review: COVID-19 Statewide Policies	06/22	Maine DHHS
COVID Response Review: COVID-19 Testing	06/22	Maine DHHS
COVID Response Review: Healthcare Workforce	06/22	Maine DHHS
COVID Response Review: Vaccination	06/22	Maine DHHS
COVID-19 Provider Enrollment Checklist	-	Maine DHHS
COVID-19 Vaccine Training: General Overview of Immunization Best Practices for Healthcare Providers	-	Maine CDC
Maine COVID-10 Vaccine Ordering Process	05/21/21	Maine DHHS
Maine COVID-19 Response Alternate Care Sites	11/02/20	Maine EMA, Maine DHHS
Summary of the Keep Maine Healthy 2020 Municipal COVID-19 Awareness Campaign	-	Maine CDC Division of Environmental & community Health

APPENDIX G: ACRONYM LIST

Acronym	Definition
AAR	After Action Report
ADRC	Ageing and Disability Resource Center
ASPR	Administration for Strategic Preparedness and Response (formerly Assistant Secretary for Preparedness and Response)
BSL	Bio-security Level
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CDC	Centers for Disease Control and Prevention
COOP	Continuity of Operations
COVID-19	Coronavirus Disease 2019
DHHS	Department of Health and Human Services
DHS	Department of Homeland Security
DOA	Department of Agriculture
DOE	Department of Education
DOT	Department of Transportation
EEI	Essential Elements of Information
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EUA	Emergency Use Authorization
FAQ	Frequently asked questions
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
FQHC	Federally Qualified Health Center
HAI	Healthcare Associated Infection
HAN	Health Alert Network
HETL	Health and Environmental Testing Laboratory
HIP	Health Inspection Program
HPP	Hospital Preparedness Program
HR	Human Resource
ICS	Incident Command System
IIS	Immunization Information System
IT	Information Technology
JIC	Joint Information Center
JIS	Joint Information System
MEMA	Maine Emergency Management Agency
MIP	Maine Immunization Program
MOU	Memorandum of Understanding
NBS	Need Base System

NDS	Northern Data Systems
NEDSS	National Electronic Disease Surveillance System
NEMA	National Emergency Management Association
NIMS	National Incident Management System
OADS	Office of Aging and Disability Services
OIT	Office of Information Technology
PCR	Polymerase Chain Reaction
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health Emergency Preparedness
PIF	Pandemic Interval Framework
PII	Personally Identifiable Information
PIO	Public Information Officer
POD	Point of Distribution
POETE	Planning, Organizing, Equipping, Training, Exercising
PPE	Personal Protective Equipment
RSS	Receiving, Storage, and Staging site
SitReps	Situation Reports
UPS	United Parcel Service
VPN	Virtual Private Network

COVID Response Review: June 2022
Healthcare Workforce

Background / Description of Effort

At various points in the pandemic, Maine Center for Disease Control and Prevent (CDC) and Department of Health and Human Services (DHHS) COVID-19 response included healthcare workforce support that augmented existing staffing efforts in hospitals, other healthcare entities such as Long-Term Care facilities, and at vaccination and testing sites. Throughout various deployments and similar efforts, Maine CDC / DHHS staff worked with Maine National Guard (MENG), Maine Emergency Management Agency (MEMA) and Federal Emergency Management Agency (FEMA) contacts in addition to the Governor's office and healthcare leadership regarding all aspects of prioritization, request, deployment, and on-going need assessment. These efforts were critical in vaccinating a significant majority of the population on an accelerated timeline, as well as providing vital support to hospitals during the confluence of the Delta and Omicron surges.

Healthcare workforce support was provided primarily in five ways:

1. Maine Responds volunteers, who primarily supported vaccine and some testing efforts;
2. Maxim staffing support (through Coronavirus Relief Funds and U.S. CDC grant funds) at Long-Term Care facilities (in Long-Term Care facilities with outbreaks or severe staffing crisis, and in hospital for decompression), community-based vaccine efforts, and in quarantine shelters;
3. Guidance and Staffing Waivers issued by the Division of Licensing and Certification (DLC) that allowed nursing facilities to increase infection prevention planning as well as formally request a waiver of mandated staffing ratios, permitting a facility to open additional beds lower staff ratios;
4. Maine National Guard (MENG) support at community-based vaccine and testing sites, on both a short- and long-term basis, as well as at hospitals during the peak of the Delta and Omicron surge (winter, 2021-2022); and
5. Federal Emergency Management Agency (FEMA) resource requests, which supported the mobile vaccine effort (spring, 2021), hospital / healthcare needs during Delta and Omicron surge (winter, 2022), and testing (January 2022, described in the Testing review).

The most common method for securing and overseeing the healthcare worker resource deployments were Memoranda of Understanding (MOUs). MOUs are required to be in place prior to the deployment of any assets from Maine Responds or Maine National Guard and assist in ensuring that there is appropriate oversight as well as that all other available resources have been explored prior to deployment. MOUs were also used at some of the mass vaccination sites as tools to assist with the FEMA reimbursement process. MOUs specific to this response were, at

minimum, between the State of Maine (DHHS, MEMA) and the entity requesting support. At the start of calendar year 2021, MOU templates were first created, but needed to be modified multiple times based on LD1, as the bill made its way through the Legislature in the spring of 2021. Each revision to the bill had a ripple effect to the MOU, which resulted in additional legal review not just internally to DHHS but MEMA, and then provider partner sites.

Securing staff support through the FEMA resource request process required clear documentation of need as well as exhaustion of local resources, supported with data, job descriptions, and a clear plan for how resources would be utilized and their proposed impact on overall capacity / throughput; this included federal assets as well as the MENG. These formal resource requests were submitted to MEMA and, upon their approval, would be forwarded to FEMA for consideration. While MENG support staff were deployed through the MENG command center, FEMA approval was needed to determine whether the resource request was eligible for reimbursement under Title 37B, which would cover the expense of the deployed service men and women through federal funding versus state funding.

Resource requests involved significant effort as part of the official submission process, often requiring multiple iterations prior to formal consideration by FEMA. Maine DHHS and MEMA staff would frequently meet with FEMA staff to officially consult on requests, while dialogue regarding the appropriate type and size of request would occur in the "background." Prior to deployment, FEMA would meet with, at minimum, State staff but likely also healthcare providers who would receive support in order to "level set" on deployment conditions.

Once FEMA awarded assets to Maine and it was determined that an extension would be needed, the team would work with the requesting facility and submit a new resource request for that extension. In the case of American Medical Response (AMR ambulances) and AMN Healthcare (mAb and vaccination staff) resources, multiple extensions were requested, submitted, and approved during the deployment period. The team built a strong relationship with Maine's regional FEMA point of contact that allowed for an open line of communication, reduced unnecessary work, and facilitated a quicker review and approval. FEMA Region 1, which includes Maine, had the highest number of resource requests and approvals than any other region in the U.S. The FEMA Region 1 liaison shared that this was a direct result of the teamwork during this highly intense period.

Vaccine Staffing:

Maine has consistently ranked in the top-five leading State in terms of vaccination status, in part because of its workforce support. Vaccination efforts during the first half of calendar year 2021 were herculean in scope and depth. A robust and diversified staffing approach was critical in supporting multiple sites –large, small, mobile, and pop-up – with staff coming from multiple channels.

During the winter and spring of 2021 when COVID-19 vaccines increasingly became widely available, Maine responded with the creation of multiple large "community vaccination sites." These vaccination sites were predominately a public-private partnership, with each one taking a slightly different shape and form based on local conditions and stakeholder participation. Most sites included a mix of healthcare staff (whether redeployed or retained for this intent), volunteers (both through Maine Responds and other channels), MENG, local EMA, and other stakeholders. No one partner could have ever achieved the results, and the effort was a true collaboration between the State of Maine, hospitals and healthcare partners, MEMA and local EMA, and many other stakeholders. Three which were critical to mass-vaccination efforts are highlighted here.

Maine National Guard

The MENG had already established themselves as partners in Maine's COVID-19 response, through testing support as well as staffing augmentation within Maine CDC. Early in the planning stages for mass-vaccination sites, Maine CDC / DHHS and MEMA identified the MENG as a potential partner. Aside from their inward facing efforts to vaccinate DOD employees, MENG provided critical non-clinical support at three mass vaccination clinics: Auburn Mall; Augusta Civic Center; and Scarborough Downs. Depending on day of operation and time during vaccine response, there were up to 14 Guard Members at each site. All three clinics reported that this support was critical, and that the respective clinic operations could never have reached the levels that they did without MENG on site.

Maine CDC and MEMA staff participated in routine planning calls with the MENG, which supported advanced preparation for local needs. These calls also supported dialogue regarding how MENG could step into providing clinical support, whether directly as part of a "mobile" or "strike team" approach (in collaboration with Maine CDC Public Health Nursing) or at one of the existing sites that they supported. There was extensive legal review necessary to allow for the MENG to act in a clinical capacity (vaccinator, pharmacist or vaccine prepper), and the ability for MENG to act in this capacity was not determined in a timely enough manner for support at most of the large clinic locations. However, over time, this was achieved, and MENG provided clinical support at ad hoc clinics with Public Health Nursing as well as at the Maine CDC-led vaccine at the Augusta Armory in Winter 2021.

Maine Responds

Maine Responds is a statutorily enabled resource through the Maine CDC Public Health Emergency Preparedness program that connects volunteers with entities in need. Historically, this has been more specific to exclusively state-operated efforts (i.e., Nurse Consult line, refugee resettlement at Portland Expo). However, health systems leaders highlighted the burden associated with reviewing and processing the volunteer paperwork through existing hospital channels. This led to Maine Responds being utilized to support operations at multiple clinics,

most notably the Auburn Mall and FEMA Mobile Unit as it relates to mass vaccination efforts. Overall, volunteers dedicated 6,705 hours to support these sites as well as some others. For the Auburn Mall site, volunteers were used in critical roles of pharmacy technicians ("vax preppers") and vaccinators.

Mobile Vaccine Unit

Maine received one of the Federally supported mobile vaccine units (MVUs) to support vaccine administration in underserved areas. Maine was the second State in New England, and the sixth nationally, to receive an MVU. It came with the mobile unit itself, which expanded to have two vaccine areas as part of pop-outside / exterior tents as well as an interior pharmacy area, basic equipment, and staffing support of both clinical and non-clinical nature – both of which came in multiple waves. It needed auxiliary state support for traffic control, clinical management, and logistics – including promotion and scheduling. It was in operation from April 12 to June 18, 2021 and visited 12 communities across Maine: Windham, Biddeford, Fryeburg, Turner, Waterville, Old Town, Milbridge, Calais, Madawaska, Portland, and Old Orchard Beach. It administered over 10,000 doses of COVID-19 vaccine.

Long-Term Care Facilities:

Prior to the authorization of the vaccine, long-term care facilities were especially vulnerable to COVID-19. Their residents tend to have risk factors associated with serious illness, and some facilities' design (e.g., double rooms) and staffing patterns made it challenging to contain spread of this highly contagious disease. This disproportionate impact, coupled with visitors' restrictions and perennial workforce challenges, led to sporadic, dire staffing shortages starting in 2020.

DLC provided waivers and guidance that allowed for staffing flexibilities for facilities, while other existing requirements were still in place to ensure minimum health and safety standards were met, such as more general requirements about meeting care needs of residents and administrator responsibilities. DLC approved individual waivers for facilities, based on specific circumstances, such as allowing non-certified staff to administer medications if they had education, training or experience related to medication administration in a different setting and allowing facilities to operate over capacity to consolidate staffing resources and other similar circumstances. In addition to the waivers, DLC recognized the need to provide global guidance to ensure facilities understood the flexibility of the regulatory rules and began participating in calls organized by CDC, Office of Aging and Disabilities (OADs), and Office of Behavioral Health (OBH) as a way to further support facilities to identify potential solutions to their staffing challenges.

In recognition of the need for additional support for long-term care facilities, OADS, using Coronavirus Relief Funding, secured a contract in 2020 with Maxim for nurses and other clinicians to conduct infection prevention and control training and, over time, on-site staff

support when a facility was in an outbreak status. This group of contracted clinicians became known as the Rapid Response Team. The mission changed along with the ebbs and flows of the pandemic, and the team expanded to support COVID-19 vaccine administration and testing activities, provide medical care at the Emergency Shelter in Lewiston and Quarantine Shelter in Scarborough, and, with the Delta and Omicron surges, staff swing beds in hospitals.

Delta and Omicron Surge Staffing:
Without additional assistance and stopgaps to compensate for the critical health worker shortfalls, Maine was at risk for being unable to withstand the Delta and Omicron surges – particularly within rural communities and large tertiary medical centers. At the peak of Omicron, there were hundreds of assets deployed across dozens of organizations from Maine Responds, Maxim Staffing, Maine National Guard, and FEMA.

Hospitals:
The rising caseload between October 2021 and February 2022 as a result of the Delta and Omicron variants strained hospitals across the state. Large regional and tertiary hospitals could not accept patients who needed care; patients overcrowded Emergency Departments, often awaiting beds; and workforce shortages in lower levels of care, such as skilled nursing, prevented hospitals from discharging patients whose acuity had dropped. Regional hospitals reported boarding as many as 30 to 40 admitted patients in their emergency departments, with some patients intubated and needing critical care.

This increase in acuity and demand for care was exacerbated by staffing levels, which directly limited the ability to admit patients or accept transfers. For instance, Eastern Maine Medical Center saw an increase in the number of patients awaiting transfer to their facility and a larger number of patients expiring due to lack of appropriate care. In the year 2021, 47 patients died while on their regional transfer list, while by the end of January 2022 (one month), 49 patients had died while waiting. It was projected that as many as 147 patients would die in 2022 as a result of not receiving tertiary care when needed. Smaller rural and independent hospitals were caring for patients with an acuity that exceeded their staffing capacity, and even their medical expertise. In January, it was not uncommon to hear of Critical Access Hospitals (CAHs) taking care of several intubated COVID-19 patients that were awaiting transfer, but without the ability to do so. Further exacerbating this demanding time, hospitals were faced with a growing number of outbreaks within their medical units and direct care workers infected with COVID-19 who were unable to work.

On December 8, 2021, when it became apparent that the Delta variant would continue to increase serious illness from COVID-19, the Governor activated the National Guard to help alleviate capacity constraints at hospitals and maintain access to inpatient health care services for Maine people amid a sustained surge of COVID-19. On January 11, 2022, the day after the number of

hospitalized COVID-19 patients exceeded 400 for the first time during the pandemic, the Governor deployed additional members of the Guard to support hospitals.

A total of 230 members of the Maine National Guard were deployed to Maine hospitals to help maintain critical care. They served at 16 hospitals, nearly half of all hospitals in Maine. They performed several jobs, such as helping to administer monoclonal antibody treatments, caring for people convalescing from COVID-19 in special units, and providing nutrition and other supports for hospital staff who have been exhausted by the strain of the long-running pandemic. Hospitals and their staff uniformly reported that the support came at a crucial time, when high transmission was causing both increased demand for hospital care and more staff out with COVID-19 or caring for family members with the disease.

Maine also secured Federal clinical staff to complement the non-clinical work of the Maine National Guard in hospitals. This included:

- 15 clinicians from the National Disaster Medical Team deployed to Maine Medical Center from December 11 to December 24;
- 20 clinicians from the Department of Defense deployed to Central Maine Medical Center from February 1 to February 25;
- 40 clinicians from the Department of Defense deployed to Eastern Maine Medical Center from to February 18 to mid-March.
- 18 paramedics with 9 ambulances deployed to hospitals across Maine mostly from December 28, 2021 to March 27.

The Maine Responds Emergency Health Volunteer System that organizes health care, public health, and volunteers to respond to emergency situations also engaged 50 clinicians in Maine to serve in hospitals during the surge and help administer therapeutic treatment for COVID-19 in December 2021.

Long-Term Care Facilities:
With substantially higher COVID transmission during the Delta and Omicron surges, staffing shortages stressed long-term care facilities, particularly within under-resourced facilities relying upon per diem staffers to plug shortfalls. Many facilities fell into an outbreak, which limited their ability to accept new admissions from hospitals. Further, as long-term care residents contracted COVID-19 and became critically ill, they were transferred to a hospital to receive more advanced treatment, further straining hospitals.

While MENG and Federal personnel were concentrated on hospitals, DLC was active in working with nursing facilities on waivers. The staff ratio waiver for NFs that were initiative in November 2021 resulted in 15 facilities accepting 322 patients from hospitals.

Prioritization of Resources:

During the pandemic, the demand for healthcare workforce support significantly increased beyond what the State could support. The DHHS team supporting healthcare workforce supports, by necessity, developed a system to manage requests. Several factors impacted the prioritization and deployment of resources to facilities seeking staffing support. The following were considered when determining resource allocation:

- Hospital surge capacity and ability to care for the most ill: staff were placed if it:
    - Opened or maintained staffed medical beds allowing patients to be moved out of the emergency department.
    - Allowed a hospital to accept patient transfers from CAHs, independent hospitals, or long-term care facilities.
    - Allowed patients to be moved to a lower level of care, such as a swing bed.
- Long-Term Care capacity and ability to admit new patients from hospitals or withstand an outbreak: staff were placed if it:
    - Opened new beds allowing the facility to admit patients from the hospital setting.
    - Prevented facilities in an outbreak from transferring patients to another facility or closing.
- Other sites: staff were placed if it had:
    - Capacity to administer high throughput vaccinations and testing to the public.
    - Capacity to administer therapeutic medications to the most vulnerable and at-risk populations.
    - Capacity to care for those placed in public quarantine and isolation shelters, including for the homeless.

Total Number of Staffing Assets Deployed:

Below is the list of healthcare workforce deployments and waivers during the COVID-19 pandemic across all types of settings and functions:

- Maine Responds deployed volunteers between March 2020 to February 2022 for a total of **41,475 hours** across 60 sites supporting vaccination, testing, outbreaks, hospitals, long-term care, and schools.
- Maxim Staffing Support deployed:
    - 19 individuals comprising of RNs, LPNs and CNAs at over 20 sites.
- Waivers issued by Division of Licensing and Certification (DLC):
    - April 21, 2020 issued waiver (retroactive to March 1, 2020) for recertification training for CRMA staff in residential care facilities.
    - April 24, 2020 issued waiver (retroactive to March 1, 2020) for completion of PSS training within 120 days in residential care facilities.
    - November 2021 issued conditional waiver of state minimum staffing ratios in nursing facilities.
- Maine National Guard deployed:
    - Vaccination: 53
    - Testing: 14

- mAb Administration: 20
- Hospitals/Swing Bed: 211
  - First MENG Deployment Announced December 8, 2021
  - Second MENG Deployment Announced January 14, 2022
- **Total at peak surge: 298**

- FEMA Assets deployed during the Delta and Omicron surge:

Facility Name	Resource Description	Number Personnel	Number Ambulances	Arrival Date	Demob Date	Days on Site
Auburn Mall/Central Maine Med	IV mAb/Vaccination Team	4		1/10/2022	3/22/2022	71
Cary Medical Center	Ambulance & Personnel	2	1	1/27/2022	3/27/2022	59
Central Maine Medical Center	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
Central Maine Medical Center	Small DOD Team	20		1/31/2022	3/1/2022	29
Eastern Maine Medical Center	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
Eastern Maine Medical Center	2 Small DOD Teams	40		2/19/2022	3/20/2022	29
Franklin Memorial Hospital	Ambulance & Personnel	2	1	12/28/2021	2/25/2022	66
Maine General Medical Center	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
Maine Health	Vaccination Team	3		1/10/2022	1/28/2022	17
Maine Medical Center	Heath and Medical Task Force (HMTF)	15		12/10/2021	12/23/2021	13
Maine Medical Center	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
Mid Coast Hospital	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
Southern Maine Health Care	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89
St. Joseph Hospital	Ambulance & Personnel	2	1	12/28/2021	3/27/2022	89

Flashlight Moments:

AMR Resources: "We can confidently state that this service has reduced our wait time by 50% throughout our hospital system. In addition, we have opened capacity by removing this barrier to transfers and discharges by at least two beds weekly throughout the system. Also, this service has assisted with acute transfers for additional community hospitals."

MENG: "The National Guard helped CMMC increase capacity during this deployment and opened up a 16-bed swing waiver unit while supporting our exhausted health care professionals. These efforts allowed us to combat the increase of COVID cases, take care of more people within our community, and do this with quality of care at our core."

AMN/Maine Responds/MENG at Auburn Mall: "The vaccine clinic will have administered 5060 vaccines in 2022 (as of February). The ability to administer vaccines relies on current AMN, volunteer, and National Guard Resources. Without these resources, the vaccine clinic will not maintain vaccination at the current rate."

Successes & Challenges

Successes:

1. Despite hospitals being pushed to the brink by COVID-19, no alternate care sites were ever utilized. Maine hospitals maintained operations and continued to accept and care for

patients (COVID and non-COVID) while a significant portion of healthcare workers were unable to work due to COVID-19 infection. Quality of care in healthcare settings by definition is higher than alternative care sites, resulting in better patient outcomes. This would not have been possible without the resources deployed from FEMA, MENG, Maine Responds, and Maxim Staffing combined with facility waivers and the flexibility guidance provided by DLC.

2. Hospitals demonstrated the "Maine Way" by working with each other and Long-Term Care facilities in their regions and demonstrating flexibility and creativity. Hospitals filed waivers to open temporary swing bed units, flexed to create new units for skilled nursing patients, moved staff within their organization to better support areas of need, accepted and rapidly trained non-healthcare resources, and leveraged every resource to ensure capacity and ability to care for all Mainers. On the vaccine front, many of Maine's larger hospitals stepped into supporting the state's largest mass vaccination sites, with necessary support from MENG, Maine Responds and other auxiliary staffing supports. At times, and especially in the early days of vaccination, it likely felt cumbersome to staff clinics with individuals from across multiple primary channels – yet all clinics leaned in and were able to make large clinics the basis for Maine's vaccination success.
3. During the Delta and Omicron surges, hospitals, facilities, and associations were reaching out daily to multiple points of contact seeking staffing supports while at the same time multiple requests for facilities across the state were in different stages of process. The sheer volume of requests and level of need was unprecedented. To ensure streamlined coordination and prioritization of requests, designated point people within Maine CDC, DHHS, MENG and MEMA – as well as FEMA – maintained open lines of communication and had multiple daily check-ins; this worked well for coordination and communication and facilitated the rapid identification, acquisition, and deployment of resources.
4. "Level-setting" calls between internal and external stakeholders were identified as a critical component of successfully meeting a staffing need at a facility. Level-setting calls included a meeting between the provider seeking assets and DHHS to discuss deployment parameters, solicit questions, identify key point-people, and other factors which facilitated "all parties being on the same page" and confirming point people or decision makers in the process. During these calls, standard information needed to facilitate the deployment, such as Memorandums of Understanding (MOU), job role, number of staff needed, or time of deployment, were discussed and expectations were shared.

Challenges:

1. The human response to support vaccination, testing, hospitals and long-term care was truly remarkable; however, tracking individual staff deployed across facilities and specific roles was challenging across the multiple partners involved. Stakeholders used a

myriad of systems for tracking staffing deployments (Sign Up Genius, Microsoft Office Forms, Excel spreadsheets). In January 2022, the DHHS Op Ex team created a dashboard that highlighted locations of deployment and level of staffing that was updated manually each week.

2. MOUs between Maine DHHS and provider sites were time consuming to pursue and finalize, even after the challenges with LD1 were resolved. While the intent of them – to ensure appropriate oversight and coverage – is critical, the time for development and legal review was overly burdensome, especially during times of crisis or intense pandemic response.
3. The deployment of resources was not always aligned with periods of greatest need. Examples include:
    - Mobile vaccination effort: Initial demand was high because the unit arrived during a time when age-based restrictions were recently eliminated; because of the designated time at each site plus travel time, demand leveled-off after the first set of sites. By the final stops, need had significantly petered out, but the resource was unable to pivot in time with demand.
    - Second round of MENG deployment during Omicron surge: Deployment occurred "about a week" later than it was most needed, and by the end of the deployment, some MENG reported being of little utility to their host-facility because demand had decreased precipitously.
    - Nursing facilities in a staffing crisis: Facilities identified as at risk of having to transfer patients to an alternate facility due to a several staffing shortages were prioritized and supplemental staff through Maine Responds and Maxim Staffing Contract were requested; however, the MOUs and contracting was protracted and by the time agreements were in place, the critical time had passed.
    - Varied need across various partners at different times: The ebb and flow of need from both a supply and demand perspective could change quickly, making advanced planning challenging and resulting in a reticence to let go of a resource because of the unpredictability of the situation. Many front-line providers (i.e., hospital, Long-Term Care facility) requested longer or renewed deployments of resources that were in precious supply. Maine CDC / DHHS staff needed to draw firm lines regarding whether an addition deployment was appropriate to consider the request.
4. The Pandemic response cross-cut multiple different professions and departments – health, emergency management, public health, military, licensing, emergency medical services – that have different ways of communicating and responding. For much of the vaccine and healthcare support efforts, planning and implementation support followed non-traditional channels: two contractors (one at Maine CDC, one within DHHS Commissioner's Office) led the majority of efforts within DHHS; and County EMAs were not routinely involved in some of the larger vaccine and hospital support efforts. In the absence of some of the traditional partners, there wasn't always clear pathways for decision-making and

communicating efforts specific to vaccine and staffing. Further, decision-making was a multi-agency approach which often occurred at high levels – appropriately so – and sometimes communicated via informal pathways (i.e., after hours communication, separate conversations that didn't include all impacted parties). For nursing facility and long-term care support efforts, internal and external stakeholders didn't always have a clear understanding of what a facility type meant, such as Private Non-Medical Institution (PNMI) or Assisted Living Facility (ALF), and had unreasonable expectations for what the available staff at those facilities could manage. For instance, there may not be nursing staff on site, which would limit the ability to place certain types of staffing resources that required nursing oversight.

Scrap Book:

MENG Support at the Augusta Civic Center Vaccine Clinic

MENG Arriving at Maine Medical Center

MENG at Stephen's Memorial Hospital

MENG at Franklin Memorial Hospital

MENG Support at Spring Harbor Hospital

CMMC's Farewell to Department of Defense Medical Team:
https://www.dropbox.com/s/lpme2kzteh2t6au/CMHC%20Send%20off%20cermony%202-28-22.mp4?dl=0

Department of Health and Human Services Government Evaluation Act Report

January 2026

The Government Evaluation Act (GEA)

The Government Evaluation Act of 1995 establishes a system for periodic review of the executive branch agencies and independent agencies of state government to evaluate their efficacy and performance. This report was produced in compliance with 3 MRSA §951 by the Maine Department of Health and Human Services.

The statute specifies that several areas of information to be incorporated in the evaluation including:

- Enabling Legislation
- Organizational Structure
- Financial Summary
- Coordination with Other State and Federal Agencies
- Constituencies Served
- Alternative Delivery Systems
- Emerging Issues
- Policies for Collecting and Managing Personal Information
- Department Reports List

The GEA Report

Contents

The DHHS GEA Report is broken down by individual office, division, and hospitals.

It provides an overview of the Department, and its current and ongoing work as a whole.

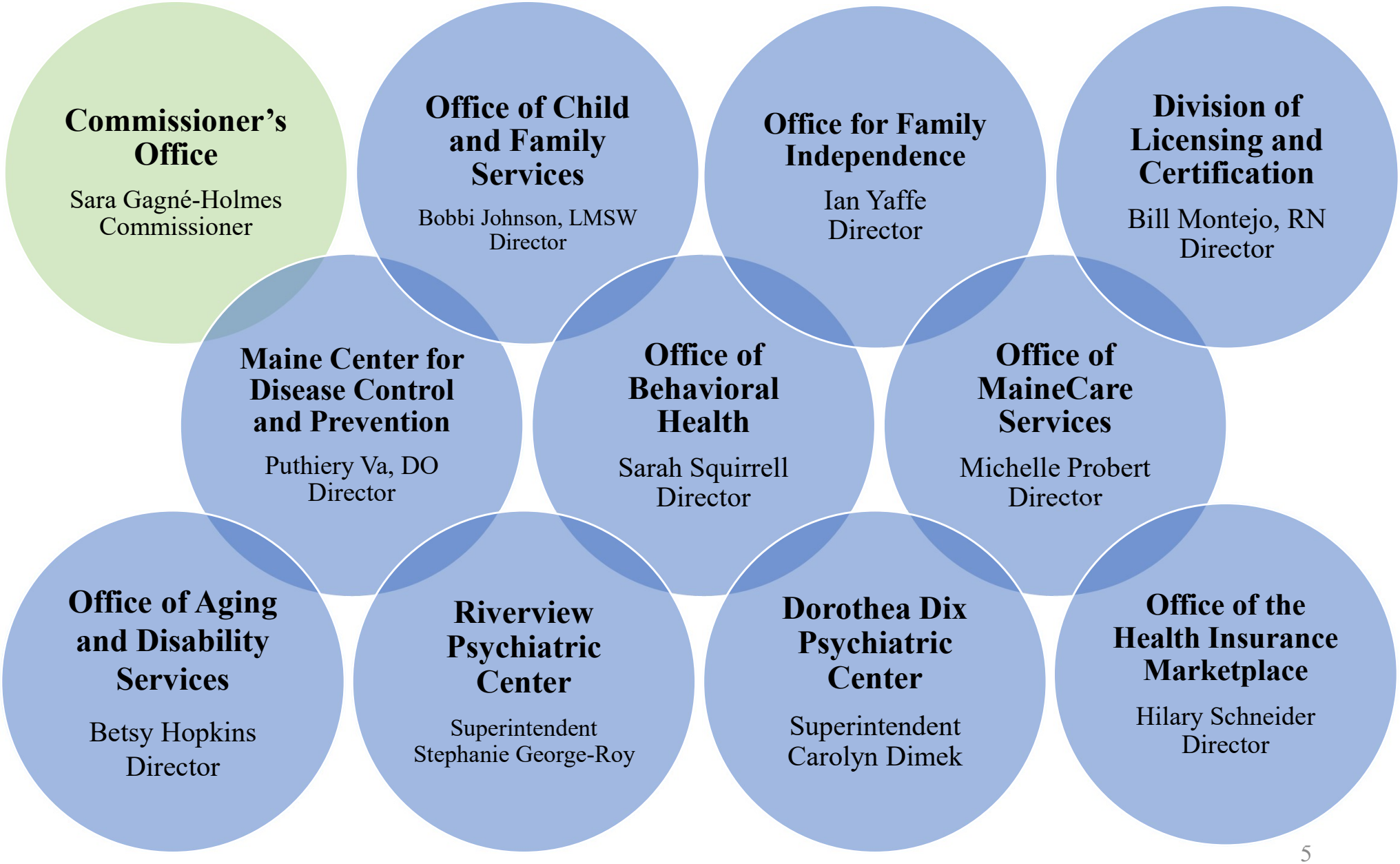
Department of Health and Human Services

The Department of Health and Human Services oversees a wide range of programs impacting Mainers across the state including MaineCare health insurance, child support payments, water testing, disease control, and background checks. DHHS provides services to approximately one-third of the State's population that include children, families, older Mainers, individuals with disabilities, mental health issues, and substance use disorders.

Enabling Legislation

The Maine Department of Health and Human Services is established by 22-A M.R.S. ch. 1, which broadly outlines the department's responsibilities. Programs operated by DHHS derive their statutory authority and obligations through many titles of Maine Revised Statutes. Further citations are provided throughout the report.

DHHS Offices: Organized by Service Population



Who We Are

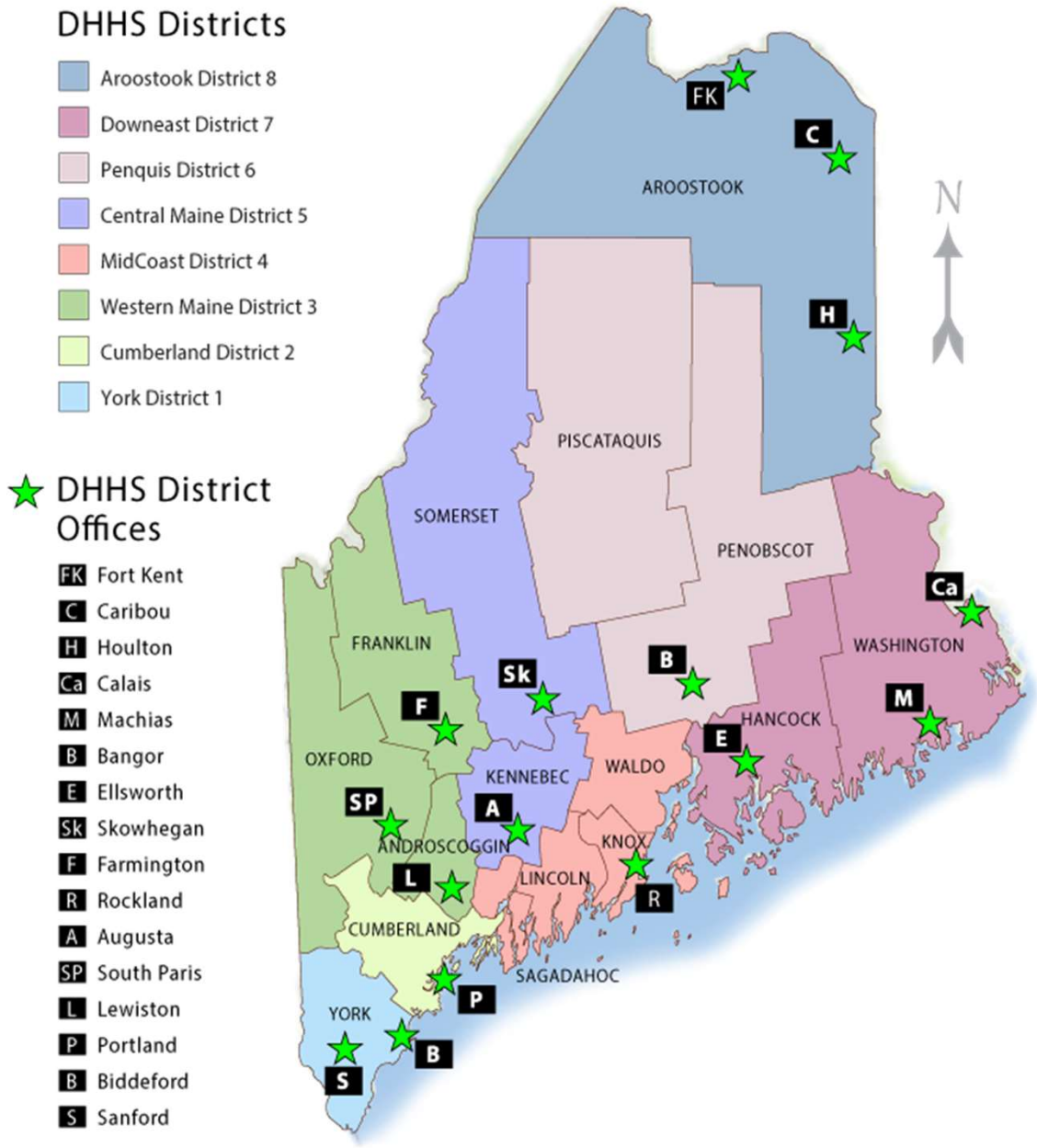
The Maine Department of Health and Human Services (DHHS) is dedicated to promoting health, safety, resilience, and opportunity for Maine people.

The Department promotes public health through an array of services. We operate two state psychiatric hospitals, provide oversight to health care providers, oversee public benefits and support child care and child welfare services, behavioral health services, long-term supports and services and access to private insurance through CoverME.gov.

The Department strives to ensure that:

- Maine children grow up in safe, healthy, and supportive environments, allowing them to thrive throughout their lives
- All adults have the opportunity to work, live with independence, and have good health
- Older Mainers live with dignity in the place that balances their needs and preferences

Who We Are



Nearly 400,000 people are enrolled in some level of coverage through MaineCare (Medicaid)

Over 170,000 people receive food assistance through the Supplemental Nutrition Assistance Program (SNAP)

Over 4,000 children receive care through the child care affordability program

Supported over 6,700 individuals in accessing substance use disorder treatment in 2024

Commissioner's Office

The DHHS Commissioner's Office oversees all work across DHHS Offices and provides guidance and support across all programs, contracts, and DHHS staff.

Enabling Legislation

In accordance with 22-A M.R.S. § 204, the Department is under the control and supervision of the Commissioner of Health and Human Services. The scope of the Commissioner's powers and duties are outlined in 22-A M.R.S. § 205 – 208, including the power to "distribute the functions and duties given to the commissioner . . . among the various offices of the department so as to integrate the work properly and to promote the most economical and efficient administration of the department." Accordingly, the Commissioner's Office is established to support the work carried out across the Department.

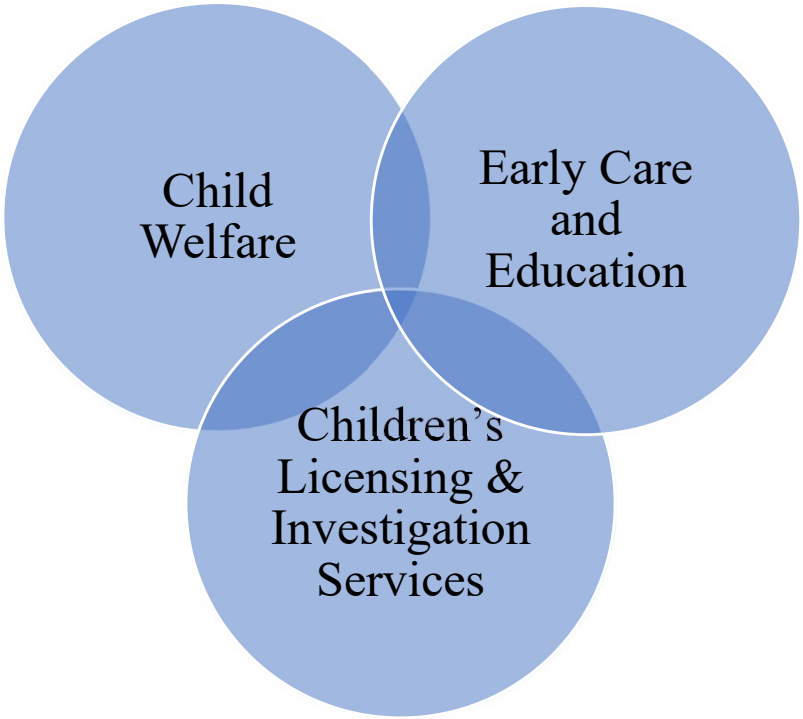
Commissioner's Office

The Commissioner's Office is committed to providing the highest quality services to the people of Maine and ensuring support and safety to every DHHS employee. In addition to providing guidance and coordination between all DHHS offices, the Commissioner's Office provides:

Staff Support	Operational Support	Communication and Engagement	Initiatives and Special Projects
• Set common expectations and training across all Offices to create common culture and work toward goals	• Dedicated staff to support Offices in hiring, contracting, budgeting, management	• Issue frequent press releases, created a blog, and overhauled website • Created Department wide and Office-specific data dashboards • Improved constituent services, stakeholder engagement, and FOAA process	• Deployment of leadership time and specialized staff to coordinate and support high priority, urgent, or complicated work

Office of Child and Family Services

The Office of Child and Family Services supports Maine's children and their families by: Regulating child care facilities and providers; Assisting Maine families in accessing and paying for child care; Administering Maine's child welfare system; Overseeing fostering and adoption services; and facilitating access to child behavioral health services.



Enabling Legislation

The enabling legislation that applies to the programs and services provided by the Office of Child and Family Services is 22-A MRS § 203(1)-(2).

Office of Child and Family Services

The Office of Child and Family Services (OCFS) works in partnership with the community to ensure all Maine children and families are safe, stable, happy, and healthy. The Office is made up of several different service areas:

Child Welfare **–** Staff in this division seek safety, well-being and permanent homes for children, working with professionalism and respecting the dignity of all families. Child abuse reports are investigated on behalf of Maine communities, working to keep children safe and to guide families in creating safe homes for children.

Early Care and Education - The Early Care and Education team manages the Child Care Affordability Program (CCAP) that helps eligible families pay for child care so they can work, go to school, or participate in a job training program, as well as managing other services and supports related to early childhood including Early Childhood Consultation Partnership (ECCP), Help Me Grow (HMG), First4ME, and the Preschool Development Grant (PDG).

Children's Licensing and Investigation Services - This specialized team licenses, monitors and investigates child care programs, children's residential facilities, child placing agencies, emergency shelters, and homeless shelters for youth. This program conducts child abuse and neglect investigations in a wide array of out-of-home settings that are licensed, subject to licensure, and funded by the Department. The program also conducts investigations in collaboration with or on behalf of other State Departments.

Violence Intervention and Response Program (VIRP)- This team is responsible for administering federal grants and overseeing statewide contracts for violence prevention services (including domestic violence and sexual assault services) as well as managing the Sexual Assault Forensic Examiner (SAFE) program. The VIRP plans, monitors and evaluates the delivery of violence prevention services statewide including programs, policies, and resource allocations.

Child Welfare Across DHHS

OMS established a MaineCare rate for comprehensive medical evaluations of children who enter the Department's care

OBH, OADS, and OCFS to coordinate to transition youth with mental and behavioral health needs from children's services to adult services

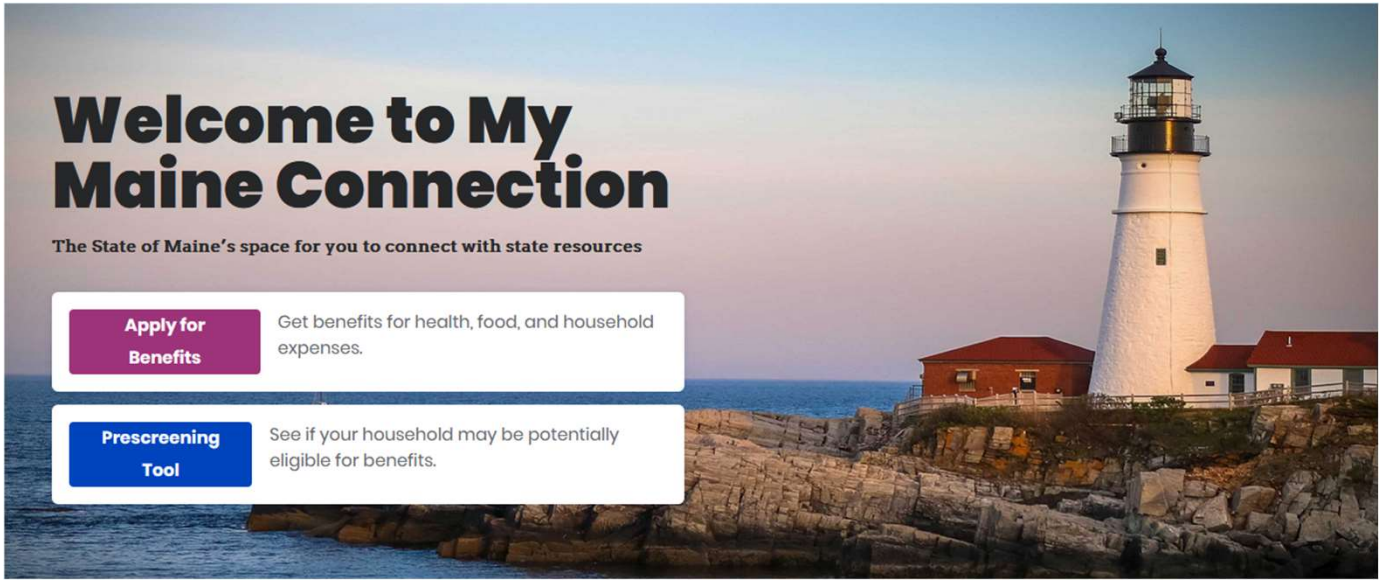
OCFS and OBH work closely to address substance use and that partnership has led to additional training opportunities for OCFS staff, establishment of clinical staff with expertise in substance use as consultants and MaineCare's establishment of the MaineMOM program

OFI collaborates with OCFS to provide economic assistance to families and this collaboration allows Maine to maximize available economic supports and reduce the need for child welfare involvement

Maine CDC supports maternal and child health through public health nursing and home visiting services to support parents of newborns. Maine CDC also operates the WIC program.

The Office for Family Independence

The Office for Family Independence (OFI) connects Maine families to services and programs.



Enabling Legislation

The enabling legislation that applies to the programs and services provided by the Office for Family Independence is 22-A MRS § 203(1).

The Office for Family Independence

The Office for Family Independence (OFI) connects Maine families to services and programs and provides healthcare, food, and basic needs for one-third of Maine's population.

- Determine initial and ongoing eligibility for the MaineCare (Medicaid), Supplemental Nutrition Assistance Program (SNAP), and Temporary Assistance for Needy Families (TANF) public assistance programs, and issue benefits for SNAP and TANF

- Through our ASPIRE, SNAP E&T, and HOPE programs, OFI helps eligible individuals meet their long-term employment and education goals, and provides transitional and short-term assistance and oversee and reimburse for municipalities' General Assistance (GA) programs

- OFI's Division of Support Enforcement and Recovery (DSER), Maine's child support agency, helps families establish paternity, locate parents, and determine, enforce, and collect on child support obligations

- Office of Disability Determination Services (DDS) makes decisions on medical eligibility for federal Social Security and Supplemental Security Income disability benefits

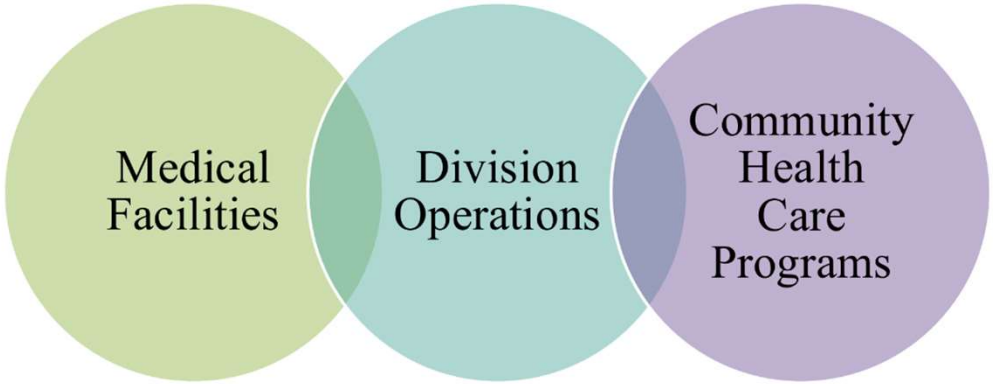
- The Fraud Investigation and Recovery Unit (FIRU) examines allegations of fraud and pursues administrative or criminal sanctions in cases of intentional program misuse.

Division of Licensing and Certification

The Division of Licensing & Certification (DLC) within DHHS oversees the safety and quality of medical and long-term care facilities. It manages the Certified Nursing Assistant (CNA) registry, conducts background checks for health care staff, and investigates reports of unsafe practices in facilities like hospitals, nursing homes, assisted living, and group homes.

The Division of Licensing and Certification operates under a dual regulatory framework that includes both Federal and State laws, depending on the type of facility or program being licensed or certified. For a complete list of Enabling Legislation please see the GEA report.

Division of Licensing and Certification



Medical Facilities, Division Operations, and Community Health Care Programs are the three operational divisions within DLC. Current priorities across the Office include:

- Workforce Development: CNA registry, Certified Residential Medication Aid (CRMA) and Personal Support Specialist (PSS) training, and oversight
- Licensing & Certification: Oversight of personal care agencies, assisted housing, home/community services, behavioral health, medical facilities, (nursing homes and hospitals) and temporary nurse agencies
- Safety & Reporting: We accept and investigate complaints, build a direct care workforce through education and policy, improve patient safety through Sentinel Event program, and run Maine Background Check Center.
- Healthcare Oversight: Certificate of Need (CON) and general healthcare oversight functions

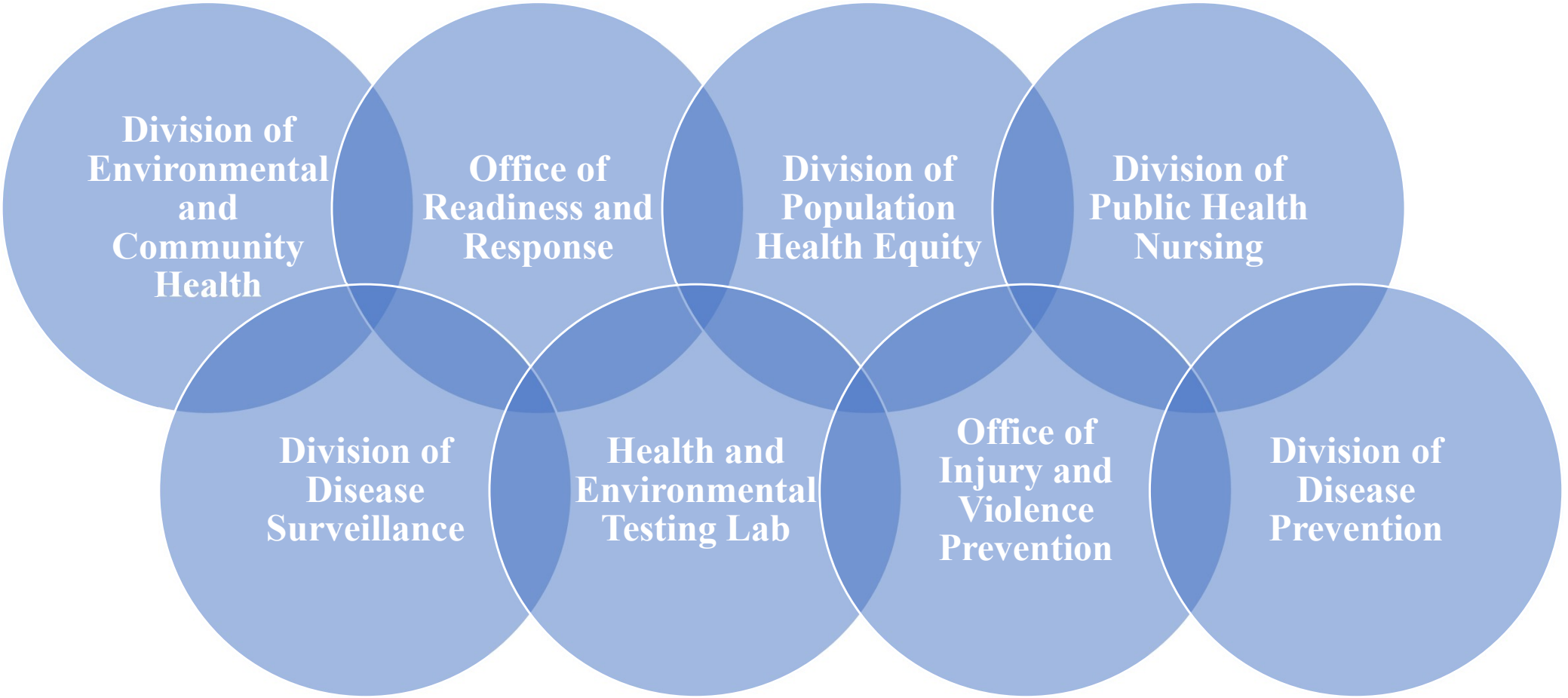
Maine Center for Disease Control and Prevention

The Maine Center for Disease Control and Prevention (Maine CDC) works to protect and improve the health and well-being of the people of Maine. Through comprehensive education, prevention efforts, direct services, emergency preparedness planning, and community partnerships, the Maine CDC focuses on a wide range of public health areas -- including vaccinations, maternal and child health, drinking water safety, environmental health, and disease prevention.

Enabling Legislation

The Maine Center for Disease Control and Prevention (Maine CDC) is the office within the Department, pursuant to 22-A MRS § 203(1), mandated to protect public health and has specific legal authorities to enforce its rules related to public health matters. Maine CDC administers rules under the authorities within MRS Titles 17-Crimes, 19-A- Domestic Relations, 22-Health and Welfare, 20-A- Education, 29-A Motor Vehicles and Traffic, 32-Professions and Occupations, and 36-Taxation.

Maine Center for Disease Control and Prevention



Office of Behavioral Health

The Office of Behavioral Health (OBH), formerly the Office of Substance Abuse and Mental Health Services (SAMHS), assists in meeting the need for mental health and substance use disorder services.

Enabling Legislation

The Office of Behavioral Health (OBH) carries out programs and services pursuant to 22-A MRS § 203(1)(B),(F) supporting mental health and behavioral health services and substance use disorder prevention, treatment, and recovery services. In addition, OBH is the office within the Department responsible for the promotion and guidance of mental health programs within Maine communities in accordance with 34-B MRS § 3001. The State Forensic Service, housed within OBH, is established by 34-B MRS § 1212.

The following federal law requirements are overseen and carried out by OBH:

- Public Law 118-42: The Consolidated Appropriations Act, 2024: Permanent Supported Housing Program
- Title IV of the McKinney-Vento Homeless Assistance Act 42 U.S.C 11301 et seq.: Permanent Supported Housing Program
- Public Law 101-645: Projects for Assistance in Transition from Homelessness

Office of Behavioral Health

Program areas in OBH include:

- Substance Use Disorder (SUD): SUD Programs are designed to assist individuals diagnosed with a substance use disorder or struggling with substance misuse. SUD Programs follow Evidence Based Practice standards and align with the American Society of Addiction Medicine's (ASAM) level of care placement criteria. Services included, Outpatient, Intensive Outpatient, Residential, Medically Supervised Withdrawal and Medication Assisted Treatment programs, which utilize Food and Drug Administration (FDA) approved medication for the treatment of SUD.

- Mental Health Programs: Mental Health Programs are designed for individuals with a mental health diagnosis and aim to enhance their emotional, psychological, and social well-being, ultimately improving their daily functioning through evidence-based interventions.

- Children's Behavioral Health Services (CBHS): CBHS focuses on treatment and services for children from birth to their 21st birthday. Services include providing information and assistance with referrals for children and youth with developmental disabilities or delays, intellectual disability, Autism Spectrum Disorders, and mental health disorders.

Continued on the next slide

Office of Behavioral Health

Program areas in OBH include:

- The State Forensic Service (SFS): SFS conducts evaluations of an individual's mental condition on behalf of any Maine court. The Service is responsive to individual court orders and tracks the progress toward completion of each order.

- Housing Programs: OBH oversees the administration of several supportive housing programs, including the Bridging Rental Assistance Program, Permanent Supportive Housing Program, Projects for Assistance in Transition from Homelessness (PATH), and works with partners to support other programs such as Home for Good (also known as Housing First) and Recovery Residences for individuals with substance use disorder. Each of these are designed to assist individuals in finding and maintaining stable, independent housing.

- Prescription Monitoring Program (PMP): The Prescription Monitoring Program (PMP) is a secure database that is used across the State of Maine to improve public health by providing controlled substance drug use information prior to prescribing or dispensing those drugs. The PMP is a key part of the State of Maine's Opioid Response Strategy by decreasing the amount and frequency of opioid and controlled substances prescribing.

Office of MaineCare Services

MaineCare is Maine's Medicaid program. It is funded by the federal and state government. MaineCare provides free or low-cost health insurance and other health benefits to Mainers who meet certain requirements, usually based on income, disability, or age.

Enabling Legislation

The enabling legislation related to Maine's Medicaid and Children's Health Insurance programs is 22 MRS § 3173 and 3174-T.
The Medicaid program is established federally by the United States Social Security Act, Title XIX and the Children's Health Insurance Program (CHIP) is established by the Social Security Act, Title XXI.

OMS also administers a small number of state-funded health insurance coverage benefits to defined populations, as determined by the Legislature. The enabling legislation for which is outlined in various provisions of 22 MRS ch. 855.

Office of MaineCare Services

MaineCare is the state's Medicaid program and provides health insurance coverage for Maine children and adults who have lower incomes and/or are older or have disabilities. Lower incomes are considered 138 percent of the Federal Poverty Level (FPL) for all non-pregnant adults, and, as of October 2023, 300 percent FPL for children through age 20. Maine's Medicaid program and Children's Health Insurance Program (CHIP) are jointly funded by the federal government and the state.

MaineCare manages all the State's Medicaid waivers and works across Offices like OADS who oversee HCBS waiver services and OBH on the SUD waiver

Office of Aging and Disability Services

The Office of Aging and Disability Services (OADS) supports Maine's older and disabled adults by providing Adult Protective, Brain Injury, Other Related Conditions, Intellectual and Developmental Disability, Long Term Care, and Aging and Community services to the people of Maine.

Enabling Legislation

Pursuant to 22-A MRS § 203(1),(3), the Office of Aging and Disability Services (OADS) provides the programs and services of the Department related to developmental disability services, physical health services, adult protective services, and long-term care services for older adults and adults with disabilities. OADS was created through the combination of the Office of Elder Services (OES) and the Office of Adults with Cognitive and Physical Disability Services (OACPDS) in 2012.

OADS provides services for adults across Maine under multiple authorizations which can be found in the full GEA report.

Office of Aging and Disability Services

Program areas in OADS include:

- Adult Protective Services (APS): Adult Protective Services serves incapacitated adults and dependent adults. Incapacitated adults are anyone over the age of 18 years old or older who are unable to receive and evaluate information and/or are unable to make or communicate decisions, even with supportive services, technological assistance or supported decision-making.

- Aging and Long- Term Services & Supports (LTSS): OADS is designated as Maine's State Unit on Aging under the federal Older Americans Act (OAA) and is responsible for planning, developing, managing and providing services to promote independence for older adults, in accordance with a federally-approved State Plan on Aging. Maine's current plan was recently approved through 2028

- Developmental Disabilities & Brain Injury Services (IDD and Brain Injury): Individuals with intellectual and Developmental Disabilities and/or autism strive to live as independently as possible. A range of services and supports are available to help them achieve this goal in their homes, in the community, and in the workplace

Riverview Psychiatric Center and Dorothea Dix Psychiatric Center

Built in 2004, Riverview Psychiatric Center (RPC) is a 92-bed, inpatient psychiatric hospital located in Augusta treating patients with severe and persistent mental illness. Riverview is a leader in the science of inpatient care. Our hospital is state-run and constructed on the campus of one of the nation's oldest state psychiatric hospitals.

Dorothea Dix Psychiatric Center (DDPC), formerly known as Bangor Mental Health Institute, located in Bangor, Maine, is a state psychiatric hospital. DDPC is a 67-bed psychiatric hospital that provides services for people with severe mental illness and operates a geropsychiatric unit.

Enabling Legislation

Riverview Psychiatric Center's enabling legislation is 22-A MRS § 208, whereby the Commissioner of the Department shall maintain two state mental health institutes ("one at Bangor called the Dorothea Dix Psychiatric Center and the other at Augusta called the Riverview Psychiatric Center.").

Office of Health Insurance Marketplace

The DHHS Office of the Health Insurance Marketplace (OHIM) operates CoverME.gov, Maine's state-based health insurance marketplace for affordable health coverage

Enabling Legislation

The Maine Health Insurance Marketplace is established pursuant to 22 MRS § 5403 to conduct the functions defined in 42 USC § 18031(d)(4).

coverME.gov
AFFORDABLE HEALTH COVERAGE FOR MAINE

Emerging Issues

Demographic data project a shrinking workforce and increasing older Maine population, which present challenges to DHHS service implementation

Percent Change in Population			
	2020-2025	2025-2030	2020-2030
Age 0-19 years	-7.4%	-2.3%	-9.5%
Age 20-39 years	1.5%	-3.5%	-2.0%
Age 40-64 years	-4.7%	-3.0%	-7.6%
Age 65+ years	17.6%	15.8%	36.2%

Workforce issues affect the healthcare workforce of Maine as well as the DHHS workforce

In addition to workforce needs, other Emerging Issues include:

- Changing Federal Policies
- Technology Needs
- Evolving Best Practice Standards

Specific information on Emerging Issues by Office can be found in the full GEA report

Questions?

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