

December 14, 2020

The Honorable Janet Mills
Governor of the State of Maine

The Honorable Troy Jackson
President of the Maine Senate

The Honorable Ryan Fecteau
Speaker of the Maine House of Representatives

Governor Mills, Senate President Jackson, and Speaker Fecteau,

In January 2020, you invited the Substance Use Prevention and Treatment Initiative of the Pew Charitable Trusts (Pew), along with its partner the Johns Hopkins Bloomberg School of Public Health (Johns Hopkins) to provide technical assistance to support Maine's efforts to address the opioid crisis.

Our efforts focused on increasing access to medications for opioid use disorder (MOUD). Specifically, you solicited policy recommendations on expanding MOUD access in the areas of residential care, recovery housing, coverage of substance use disorder (SUD) treatment services by private payers, and workforce licensing and certification. We continue to collaborate with the Urban Institute on a treatment capacity study and to support Johns Hopkins as they analyze Maine's data availability and integration to better inform and evaluate the state's response to the opioid crisis. These latter components of the project are ongoing, and the Urban Institute and Johns Hopkins will provide related deliverables.

Pew staff met with more than 40 key stakeholders, conducted data and policy analysis, researched promising practices in other states, and consulted with national experts. Pew provides for your consideration the following 11 recommendations to address the opioid crisis in Maine.

Align licensure regulations for residential treatment and inpatient medically supervised withdrawal facilities with best practices and require meaningful access to MOUD.

Recommendation 1: To improve the quality of residential treatment and inpatient medically supervised withdrawal in Maine, the Governor should consider the following actions:

- a) Direct the Maine Department of Health and Human Services (DHHS) to amend current residential treatment and inpatient medically supervised withdrawal licensure regulations to align with clinical guidelines;
- b) Direct DHHS to use its Section 1115 waiver implementation process to require these facilities to ensure meaningful access to all FDA-approved MOUD (including methadone) onsite or by direct coordination with outpatient providers;
- c) Direct DHHS to use its Section 1115 waiver implementation process to require these facilities to use a common patient placement tool based on clinical guidelines.

State examples:

- **Virginia:** Virginia's Addiction and Recovery Treatment Services (ARTS) Medicaid benefit, established as part of the state's Section 1115 demonstration, requires that residential treatment

providers [ensure meaningful access to MOUD](#) and conduct [an assessment and patient placement decision](#) based on the [American Society of Addiction Medicine \(ASAM\) levels of care guidelines](#).

- **Vermont:** As outlined in the state's [Section 1115 demonstration](#), Vermont [requires use of the ASAM patient placement criteria](#) by all licensed providers. Vermont also aligns its residential treatment services with ASAM levels of care guidelines.
- **Louisiana:** Louisiana Act 425 [requires all residential facilities](#), as a condition of licensure, to offer onsite access to at least one partial opioid agonist medication and one opioid antagonist medication by January 1, 2021.
- **Massachusetts:** Massachusetts took targeted action to streamline the integration of methadone into residential facilities by [permitting exceptions](#) to its methadone take-home dosing policy.

Currently, Maine's licensure regulations for residential treatment and inpatient medically supervised withdrawal facilities are not aligned with clinical guidelines, such as the ASAM levels of care. As a result, patients may receive inappropriate services which in turn [may lead](#) to lower retention, higher relapse rates, and additional system costs. Maine also does not require the use of a single patient placement tool. Widespread use of evidence-based placement criteria is [one of six milestones](#) measured during Section 1115 demonstrations, and consistent placement criteria across the OUD treatment system furthers system integration and ensures that patients transition smoothly between different providers and treatment settings.

In addition, MOUD access in both residential treatment and inpatient medically supervised withdrawal facilities is limited and inconsistent. According to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s [Treatment Services Locator](#), 39 percent of residential treatment facilities in the state do not initiate patients on any form of MOUD.¹ Stakeholders confirmed that MOUD is not an integrated component of many residential treatment programs, and indicated that some facilities that will accommodate MOUD continuation will not facilitate initiation.

According to interviews with facility leadership and information provided to the National Survey of Substance Abuse Treatment Services, neither of the two freestanding inpatient medically supervised withdrawal facilities in Maine offer initiation on MOUD, although they do use medications to manage withdrawal symptoms. Prompt MOUD initiation in conjunction with medically supervised withdrawal can decrease [likelihood of relapse](#) and [behavioral health admissions](#). Notably, [full withdrawal](#) is [not required](#) for initiation on buprenorphine or methadone; therefore, clinically unnecessary withdrawal prior to initiation is a barrier to care.

Our findings suggest that access to methadone in residential facilities is even more limited than access to other forms of MOUD. Stakeholders reported that some individuals taking methadone are required by these facilities to switch to buprenorphine as a condition of admission. Decisions regarding MOUD type should be made jointly by provider and patient and based on clinical necessity rather than facility preference, and individuals should ideally have access to [all three types of MOUD](#) in all OUD treatment settings.

Maine's pending [Section 1115 demonstration waiver application](#) takes steps toward improving access to high quality residential OUD treatment in the state, including requesting authority to provide MaineCare

¹ Accessed July 20, 2020.

reimbursement for adults in facilities that meet the definition of an Institution for Mental Disease. Maine could leverage the waiver implementation process to address some of the challenges identified above.

Evaluate Medicaid rates for MOUD and related services to ensure the availability of treatment.

Recommendation 2: The Legislature should consider supporting, through any necessary funding, the Office of MaineCare Services' recommended rate changes for SUD treatment services.

State examples:

- **Virginia:** Virginia's [ARTS](#) delivery system reform established enhanced SUD treatment rates that were on par with commercial payers. Combined with other Medicaid reforms, the higher rates helped [increase the number of providers](#) offering and individuals receiving MOUD.
- **New Jersey:** In 2016, New Jersey [invested \\$127.5 million](#) to increase Medicaid rates for behavioral health services following an updated assessment of the costs of providing high-quality services. The higher rates resulted in an [increased number of providers](#) participating in the Medicaid program.

Medicaid rates are [one tool](#) to help ensure treatment is available to patients and to support an adequate treatment workforce. More than 80 percent of states (including Maine) increased rates for at least one service associated with SUD treatment between 2014 and 2019, according to [an analysis](#) from the U.S. Government Accountability Office (GAO), and larger rate increases were associated with greater growth in SUD treatment service availability.

Although Pew heard that some rates – such as those for OTP services – have improved in recent years, providers working in other parts of the treatment system cited MaineCare rates as one of the most significant barriers to hiring and retaining high quality staff. State officials have recognized this issue and are already working to address it, both as part of the [comprehensive MaineCare rate evaluation](#) process that began in January 2020 and the narrower assessment of SUD-specific rates as part of the [SUPPORT for ME](#) planning grant from the [Centers for Medicare and Medicaid Services](#) (CMS).

Use mobile prescribing units to increase access to MOUD.

Recommendation 3: The Governor should consider working with DHHS in partnership with community providers to launch a minimum of three mobile MOUD prescribing unit pilot projects. The state may consider the following while selecting pilot sites:

- Geographical diversity in service areas
- Variation in medication type; for example, ensuring that at least one unit is operated by an Opioid Treatment Program (OTP) committed to providing mobile methadone services when permitted to do so under federal law
- The potential of these pilots to expand access to MOUD in existing SUD treatment or medical facilities not currently able to offer MOUD initiation and/or maintenance on site, such as residential facilities and recovery residences

State examples:

- **Maryland:** [Project Connections at Re-Entry \(PCARE\)](#) is a mobile treatment van that parks directly outside the Baltimore Jail [four mornings per week](#). The van is staffed with a

buprenorphine-waivered primary care provider, a nurse, a driver/site manager, and a peer recovery specialist.

- **Colorado:** The [Colorado Department of Human Services](#) and the Office of Behavioral Health used money from their State Opioid Response grant to provide startup funding to [six mobile health units](#) specializing in MOUD with the goal of improving access in rural and underserved areas. Over time, funding for these projects has transitioned to Medicaid reimbursement for provided services.

Mobile prescribing units are one tool – along with those discussed in Recommendations 1, 9 and 10 – that could expand MOUD access in both underserved areas and at fixed-site facilities unable or unwilling to offer MOUD onsite, such as nursing homes, correctional facilities, recovery housing and residential treatment centers. In addition, multiple stakeholders mentioned the need to expand MOUD access in Maine’s rural areas and in suburban areas poorly served by public transit. States have leveraged federal grant funding to assist with the start-up costs of mobile pilots while ensuring that they are ultimately able to bill Medicaid for provided services.

Pew heard from stakeholders that methadone is less well integrated into Maine’s treatment system than other forms of MOUD. Consequently, mobile methadone may be particularly valuable. While there are no federal restrictions on prescribing buprenorphine or naltrexone from a mobile unit, in recent years, the Drug Enforcement Administration (DEA) has not approved new mobile methadone units. In February 2020, however, the DEA [proposed a rule](#) that would allow new units to be registered. To prepare, policymakers in all states should ensure there are no barriers to licensing or reimbursement that would prevent the dispensing of methadone from a mobile unit.

Ensure providers across the healthcare workforce can screen for OUD and prescribe or refer patients for MOUD.

Recommendation 4: The Legislature should consider proposing, and the Governor should consider supporting, legislation that requires all Maine medical schools, advanced practice nursing programs, and physician assistant training programs to integrate the treatment of OUD into their curricula such that graduates satisfy the DEA and SAMHSA requirements for a buprenorphine waiver.

State examples:

- **Massachusetts:** In 2015, the Governor and Secretary of Health and Human Services convened a working group that included the deans of Massachusetts’ four medical schools to [develop a set of core competencies](#) for the prevention and management of SUD. These competencies were integrated into medical school curricula and assessments statewide.
- **Arizona:** As part of the [2018 Arizona Opioid Epidemic Act](#), the Arizona Legislature required opioid-related clinical education for students enrolled in any medical program in the state.
- **Rhode Island:** In 2017, in partnership with the Rhode Island Department of Health, Brown University’s medical school [launched a new curriculum](#) that allows Brown graduates to be eligible to receive a buprenorphine waiver by their second year of residency.

Federal rules established by the DATA 2000 Act require providers to complete additional training and obtain a waiver to prescribe buprenorphine. These regulations [limit](#) the [number](#) of [physicians](#) who prescribe buprenorphine and restrict the size of the MOUD workforce. Integrating this training into medical school, advanced practice nursing, and physician assistant training program curricula would

increase the workforce and their comfort level with treating this patient population. The [National Center on Addiction and Substance Use](#) at Columbia University has argued that all medical schools and residency training programs, as well as training programs for other health professionals, should educate and train students to address SUD, including with MOUD.

According to the [DEA](#), in 2019 there were 886 providers waived to prescribe buprenorphine in Maine. This included 622 physicians, representing only 14 percent of [active physicians](#) in the state. Many waived prescribers are concentrated in densely populated areas leaving significant regions underserved (see Appendix A). Stakeholder interviews indicate that while buprenorphine availability has improved in Maine over the past several years, more provider education is needed to ensure providers are able to screen for OUD, make referrals to MOUD providers, or prescribe themselves. While some medical schools and other training programs in Maine are already providing some SUD-related content, the state could benefit from a more coordinated, consistent approach.

Allow OTPs to utilize their workforce as effectively and efficiently as possible while developing treatment plans that meet clients' individual needs.

Recommendation 5: The Governor should consider directing the Department of Professional and Financial Regulation to amend the regulations that require OTPs to register with the Board of Pharmacy as a “retail pharmacy” and maintain a “pharmacist in charge.”

State examples:

- **Massachusetts:** [Regulations](#) require that a registered nurse, nurse practitioner, physician assistant, or licensed practical nurse is onsite during hours when medication is dispensed.
- **Ohio:** [Regulations](#) require that the medical director of an OTP be onsite at least 40 percent of the time, and that a physician assistant, registered nurse, licensed practical nurse, or pharmacist is onsite during all hours when medication is being administered.

Recommendation 6: To allow OTPs to make the most effective use of their counseling workforce and encourage the development of treatment plans based on individual need, the Governor should consider directing the Division of Licensing and Certification of DHHS to amend Section 19.8.5 of Maine’s [Regulations for Licensing and Certifying of Substance Abuse Treatment Programs](#) and any corresponding MaineCare reimbursement policies to remove the requirement that OTP patients receive a set number of counseling hours in each of five phases of treatment.

State examples:

- **Massachusetts:** [Massachusetts](#) requires that OTPs provide counseling “which conform[s] to accepted standards of care” but does not require a certain amount of counseling received by individual patients.
- **Ohio:** [Regulations](#) require that each OTP makes SUD counseling available “to every patient as is clinically necessary” and that counselor caseloads allow for counseling to be offered at least weekly during the first 90 days of treatment.

State-level regulations around OTPs, the only facilities permitted to provide methadone, vary widely across the country. Many are [not evidence-based](#) and impose restrictions beyond the federal regulations, which may make it more difficult for individuals with OUD to access methadone treatment. Pew

identified two restrictions in Maine’s OTP regulations that are out of step with national best practices and pose workforce challenges for OTP operators.

First, Maine was one of [only nine](#) states (as of 2018) that require OTPs to employ a “pharmacist in charge.” Maine additionally [requires](#) that the pharmacist in charge (or another licensed pharmacist designated by the pharmacist in charge) be physically present at the facility to prepare drugs for delivery. This limits the ability of OTPs to offer flexible operating hours while stretching staffing budgets. State officials in Maine worked to address some of these challenges in response to [the COVID-19 public health emergency](#), but should also consider changes that would apply outside of a civil emergency proclamation. Federal regulations recognize that there are many highly qualified professionals who can oversee safe and effective MOUD dispensing and require only that opioid agonist treatment medications are administered or dispensed by a practitioner whose scope of practice permits such administering or dispensing.

Second, Section 19.8.5 of Maine’s [Regulations for Licensing and Certifying of Substance Abuse Treatment Programs](#) requires that clients at OTPs receive a set number of hours of counseling in each of five “phases” of treatment. While [federal regulations](#) require that OTPs provide adequate counseling “to each patient as clinically necessary,” Maine’s regulations are much more prescriptive. Stakeholders told Pew that these requirements impede the ability of OTPs to: develop individualized treatment plans; maximize the effectiveness of their counseling workforce; integrate methadone patients into other treatment settings (such as residential programs); and ensure continued MOUD access during counselor shortages.

While counseling does benefit many people with OUD, the medication, even without regular counseling, is effective as treatment. Access to medication should not be contingent on adherence to a schedule of counseling appointments. [Evidence suggests that](#) individuals on methadone who do not receive regularly scheduled counseling show no significant differences in treatment retention and illicit drug use compared to those who do.

Improve private payers’ coverage for SUD treatment services and compliance with federal parity laws.

Recommendation 7: The Governor should work with the Legislature to consider legislation to increase compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), based on the [model bill](#) prepared for Maine [by the American Psychiatric Association](#) and supported by [ASAM](#). This bill would require the Superintendent of Insurance to proactively ensure compliance with federal parity laws.

State example:

- **Illinois:** [Senate Bill 1701, signed into law in August 2018](#), includes the requirement that the Department of Healthcare and Family Services proactively ensure parity compliance by mandating extensive reporting by insurers, evaluating complaints, and performing parity compliance audits whose results are made public in an annual plain-language report and presented to the General Assembly.

Parity refers to the principle that group health plans and health insurance issuers that provide mental health or SUD benefits should not impose less favorable limitations on those benefits than on medical and surgical benefits, a principle enshrined in federal law by the [MHPAEA](#). Theoretically, parity laws should improve coverage of SUD treatment services by private payers. However, the impact of the MHPAEA on

access to treatment has so far been [limited](#). While almost all states have passed a parity law of some kind, [most states](#) have yet to implement sufficiently robust frameworks for transparency and accountability from private health insurance providers.

The Maine Revised Statutes [include](#) a [number](#) of [sections related to parity](#); however, evaluation of these statutes combined with stakeholder interviews suggest that existing laws do not require insurance companies to report enough information for the state to robustly monitor compliance. The Superintendent of Insurance's [January 2020 parity compliance report](#) relies on a survey tool that asks insurance companies to self-report compliance without providing specific plan data, a methodology that does not allow for independent verification. [SAMHSA](#) recommends proactive compliance measures such as detailed annual reviews of all benefits; regular analysis of data from consumers and providers through complaints, denial rates and appeal rates; and routine market conduct exams.

Expand access to recovery residences, particularly for people taking MOUD.

Recommendation 8: DHHS should consider convening a working group of stakeholders to amend Maine's General Assistance (GA) Manual to include a comprehensive policy on the eligibility of people living in recovery residences for GA support, along with clear instructions on how to dispute eligibility decisions. Any changes should be disseminated widely, and DHHS should monitor implementation and ensure compliance.

State example:

- **Ohio:** In [FY 2018-2019](#) the state of Ohio provided \$3.5 million in state general revenue funding and \$20 million in capital funds to support recovery residences, including support to residents. [Several counties](#) also provide stipends to new recovery housing residents.

Recommendation 9: The Governor should consider directing DHHS to take the following actions to facilitate access to recovery residences for people taking MOUD:

- a) Codify an understanding of recovery housing that explicitly permits the use of MOUD.
- b) Establish, maintain, and disseminate a voluntary registry of recovery residences that includes whether they allow MOUD, updated at least bimonthly.
- c) Provide training and support to recovery house operators on how to accommodate people receiving MOUD.

State examples:

- **Ohio:** [Ohio](#) sets standards for recovery housing (beyond those set by the state National Alliance for Recovery Residences [NARR] affiliate) that specify residents may be permitted to receive MOUD. The state also developed a [searchable database](#) of residences that can filter for MOUD acceptance and used SAMHSA grant funds to provide [training and support](#) to operators on how to accommodate MOUD.
- **Wisconsin:** Wisconsin passed [legislation](#) to create a recovery housing registry that does not include residences that reject residents solely on the basis of MOUD.

Recommendation 10: The Governor's Office, with funding support from the Legislature, should consider options to ensure the long-term sustainability of programs that support recovery residences allowing MOUD, such as the Recovery Residence Pilot Program.

State example:

- **Missouri:** The Missouri Department of Mental Health, Division of Alcohol and Drug Abuse offers [financial support](#) for NARR-certified recovery residences using federal grant funding. Eligibility for this funding is determined using a survey to assess support for residents on MOUD, and those deemed unsupportive are ineligible.

Housing is a crucial component of recovery: people with OUD who [have stable housing](#) are [less likely to overdose and relapse](#). [Recovery residences](#) are a vital part of the recovery housing spectrum. Cost and a lack of residences that accept people on MOUD were identified by stakeholders as the two primary barriers people with OUD face while trying to access recovery housing in Maine.

Maine’s GA program helps individuals and families to meet their basic needs, including housing costs. While not an OUD-specific program, stakeholders told Pew that many people with OUD rely on GA to cover costs associated with living in recovery residences. In some localities, however, recovery residence residents face challenges accessing GA support due to staff uncertainty about how to determine eligibility for people living in these settings. Lack of clarity also means that rejected applicants may be unsure about the feasibility of an appeal. DHHS’s January 31, 2020 memorandum [General Assistance for Recovery Residences](#) provides guidance on one aspect of such eligibility determinations — whether a recovery residence is a “shared dwelling unit” for the purpose of GA — but a more comprehensive policy would provide additional clarity.

While the cost of recovery residences can be a barrier for some, others struggle to find residences that will accept people on MOUD. Currently, both Maine’s definition of recovery residences (as outlined in [LD 1523/SP472](#)) and voluntary certification standards through the Maine Association of Recovery Residences (MARR) are silent on the role of MOUD in recovery. While data are not publicly available, MARR reported to Pew that 70 percent of certified recovery residences (32 out of 46) and an estimated one-third of non-certified residences allow MOUD. Other stakeholders reported that there may be areas of the state in which no local recovery residences will accept people who are taking it. MARR currently lists certified recovery residences on their [website](#); however, this list does not provide any indication of whether residences permit MOUD.

Pew applauds Maine’s effort to restrict state funding to recovery residences that allow MOUD through the [Recovery Residences Pilot Program](#) and the recovery residence services pilot outlined in Maine’s Section 1115 demonstration waiver application, discussed further in Recommendation 11. The Recovery Residences Pilot Program, according to stakeholders, has motivated recovery residence operators to accept people taking MOUD and helped ensure the financial sustainability of MOUD-friendly residences.

Reduce the risk of homelessness for people in early or unstable recovery.

Recommendation 11: Upon conclusion of the initial five-year Section 1115 demonstration, the Office of MaineCare Services should consider submitting a renewal of the housing services pilots (home-based skill development services and pilot services administered by structured recovery housing programs) and expand the eligible populations to all adults with SUD enrolled in MaineCare.

State examples:

- **Massachusetts:** In Massachusetts, the Medicaid program reduced emergency health care utilization and [saved over \\$3 million](#) in one year by providing supportive services for people with SUD or other health conditions experiencing chronic homelessness.
- **Washington:** [Washington state's Section 1115 demonstration](#) includes coverage of home and community-based services for people with SUD.
- **North Carolina:** The North Carolina Section 1115 demonstration initiative [Healthy Opportunities](#), which served as a model for some of the services included in Maine's Section 1115 demonstration waiver application, is not limited to parents with SUD.

While recovery residences are a vital part of the recovery housing spectrum, many of these residences are not equipped to accommodate those in early or unstable phases of their recovery due to strict policies around abstinence, limited onsite services and lack of case management capacity. Stakeholders identified a dearth of housing for this population in Maine, although also noted that initiatives like the [Homeless Opioid Users Service Engagement Pilot Project](#) were encouraging. In addition, Maine's recent Section 1115 demonstration application includes two pilot programs aimed at better meeting the housing needs of MaineCare-enrolled parents with SUD who are at risk of involvement with Child Protective Services, including home-based skill development services and supportive services delivered through recovery residences, both of which include housing supports.

While these initiatives are steps in the right direction, they share a narrow focus on small sub-populations of people with SUD. Maine could further its efforts in this area by reimbursing for supportive housing services — including housing tenancy and case management — in MaineCare, for all adults with SUD.

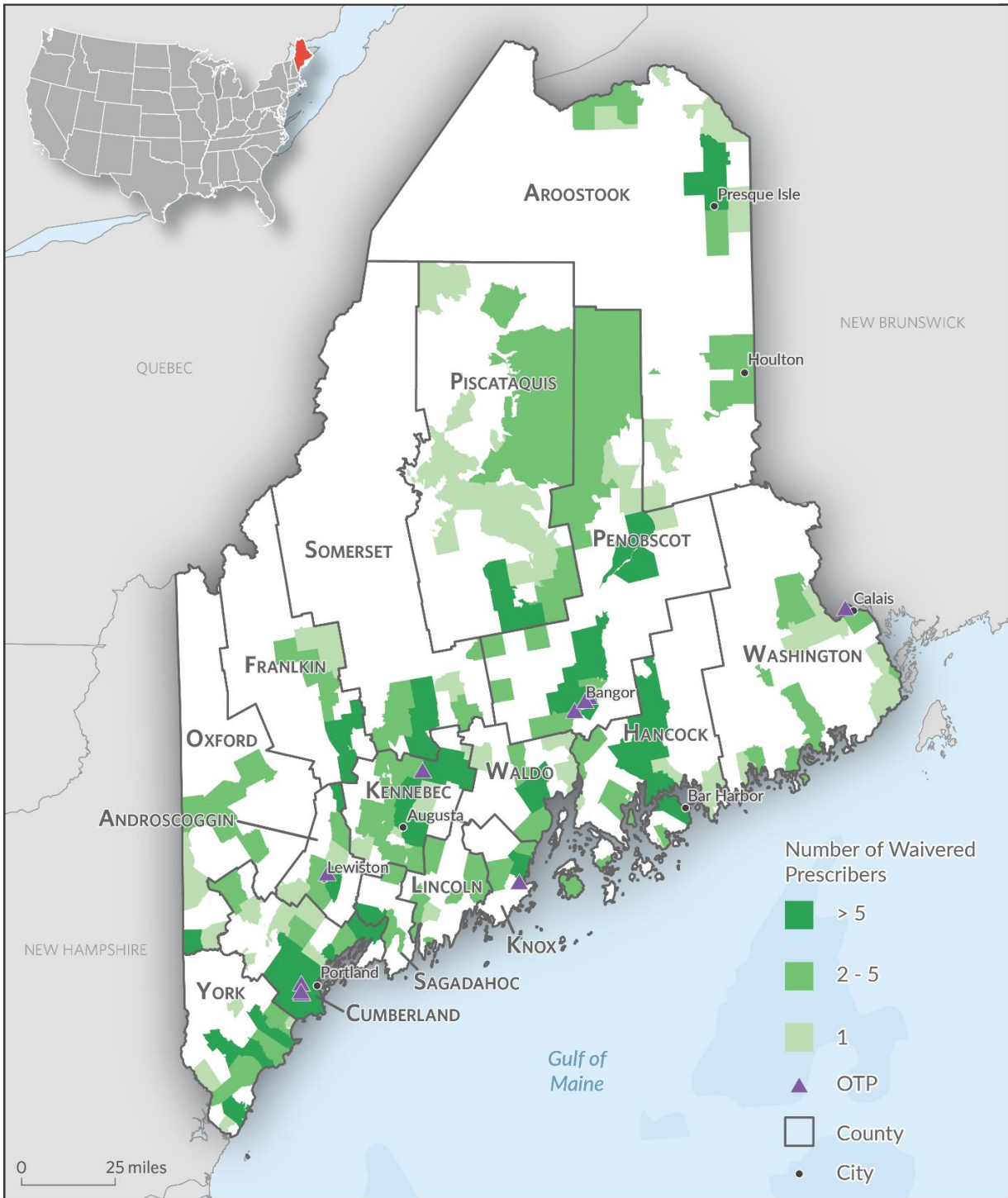
This recommendation is contingent upon CMS approval of Maine's pending Section 1115 demonstration application. Should CMS not approve the proposed housing services pilots, Maine should seek to provide as many of the proposed services as possible through the authority of a 1915i State Plan Amendment.

Thank you for the opportunity to provide technical assistance to the state of Maine. Should you have any questions or need additional information, please contact Alyssa Stryker, Senior Associate, at astryker@pewtrusts.org. We look forward to working with you on the implementation of these recommendations.

Sincerely,

Beth Connolly
Project Director, Substance Use Prevention and Treatment Initiative
The Pew Charitable Trusts

Appendix A: ZIP codes with waived buprenorphine prescribers and opioid treatment program (OTP) locations



SOURCE: DEA; SAMHSA. Updated 07 Sept 2020.