RESEARCH REPORT

Leveraging Medicaid to Address Opioid and Substance Use Disorders in Maine

Ten State Policy Options from an Expedited Review

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Executive Summary

Maine is experiencing an unprecedented public health crisis related to the opioid epidemic, ranking among the top 10 states with the highest rates of drug-related overdose deaths in 2017, during which 359 Mainers died from accidental opioid overdose. That same year, 952 babies were born in Maine with neonatal abstinence syndrome owing to in-utero exposure to opioids. Though opioid use disorder has driven the recent spike in mortality, alcohol use disorder remains the most prevalent form of substance use disorder (SUD) in Maine, and survey estimates show substantial unmet needs for substance and opioid use disorder treatments in the state. With a new governor at helm, Maine is refocusing its energies and efforts to reverse these grim statistics, starting with expanding Maine's Medicaid program, MaineCare. With many more low-income adults projected to be covered under the expanded program and gain access to treatment, MaineCare is expected to become an even more dominant payer for SUD services in Maine.

Given the unique opportunity presented by the eligibility expansion, this report provides an overview of the role MaineCare is playing and could play in addressing Maine's opioid epidemic and SUDs more broadly. Over approximately two months, we conducted an expedited review of available public information and data, conducted key informant interviews, and analyzed promising Medicaid initiatives implemented elsewhere to inform Maine's policy debate over effective strategies to address the opioid epidemic and SUDs. Based on this high-level, initial assessment of Maine's SUD treatment landscape, we suggest the following policy options for MaineCare to effectively leverage federal Medicaid expansion funds and explore opportunities for performance-based funding to support these efforts:

1. Maximize the shift of block grant–funded SUD treatment to MaineCare and redirect grant dollars to invest in SUD services, supports, and patients ineligible for MaineCare. This could include SUD services for incarcerated people and funding for supportive housing that serves MaineCare enrollees on medication-assisted treatment, potentially drawing on new strategies for funding programs (e.g., pay for success) that focus on outcomes and help build evidence on effective interventions.

2. Expand SUD treatment capacity through training and mentoring programs for providers, expanding the scope of practice for midlevel practitioners, addressing obstacles to the use of telemedicine/telehealth in MaineCare, and ensuring that reimbursements for different levels of care and services adequately stimulate growth in provider supply and meet the demand for care.

3. Promote methadone maintenance treatment at opioid treatment programs (also called methadone clinics) by addressing its stigma, aligning state counseling requirements in methadone maintenance treatment with federal regulations, expanding the role of experienced opioid treatment program providers in opioid use disorder treatment, and further increasing MaineCare opioid treatment program reimbursement rates to align with established benchmarks.

4. Promote evidence-based treatment for SUD among both health care providers and the public, including by disseminating information about all effective medication-assisted treatment options for alcohol and opioid use disorders and expanding coverage and access to evidence-based recovery supports and services. Greater dissemination of information is especially needed to promote methadone and naltrexone treatments, particularly long-acting injection naltrexone (also called XR-naltrexone), as accessible opioid use disorder treatment options for MaineCare enrollees.

5. Add SUD screening and referral requirements in primary care (including federally qualified health centers), emergency departments, critical access hospitals, psychiatric hospitals, and jails and prison systems for MaineCare beneficiaries, and provide training and support to providers. Require that primary care and other providers use a clinical tool to match patients to the appropriate level of SUD care, which could help with both under- and overutilization of residential or other types of care.

6. Promote best practices among providers and at facilities that care for MaineCare-covered pregnant and postpartum women with an SUD, including universal screening and access to methadone and buprenorphine maintenance treatments for those with opioid use disorder.

7. Use block grant SUD treatment funding to promote and provide all three medication-assisted treatments—methadone maintenance treatment, buprenorphine maintenance treatment, and naltrexone pharmacotherapy—in jails and prisons, and engage MaineCare enrollees in evidence-based care, or support continuity of care, during incarceration.

8. Enroll eligible people involved in the justice system in MaineCare and provide them with supports and services to address health and social needs upon release to minimize barriers to accessing needed services.

9. Redesign MaineCare prescription drug policies related to SUD treatment to promote wide distribution of naloxone to people at risk of overdose and their families and friends, including alternative formulations of naloxone (e.g., autoinjector) that are not widely available.

MaineCare could also evaluate whether the current reliance on brand-name Suboxone products offers Medicaid enrollees the best treatment medication options at the best prices. MaineCare could promote use of less expensive buprenorphine generics, maximize the use of Medicaid prescription drug rebates, and consider promoting wider use of alternative formulations, such as long-acting buprenorphine treatments.

10. Lay groundwork for alternative payment models and value-based payments for SUD treatment services in MaineCare by developing the necessary infrastructure at the state and provider levels.

As Maine mobilizes to address SUD-related morbidity and mortality, MaineCare may be Maine's most important tool to fight the opioid epidemic. However, achieving the maximum benefit from the MaineCare expansion will require addressing current shortcomings of the delivery system and barriers to care, particularly for vulnerable populations affected by SUDs, such as pregnant women, mothers with babies, or people involved in the criminal justice system. By making policy changes and investing in the areas highlighted in this report, MaineCare can leverage its critical role to support the development of a health care delivery system that efficiently and effectively supports Mainers with an SUD in treatment and recovery while making the most of available state and federal funding opportunities. The goal of this report is to prompt discussion among key stakeholders and inform policy and programmatic decisions that affect access to and quality of treatment and recovery services for both MaineCare members and other Mainers with an SUD for whom freed-up block grant and other non-Medicaid funds can now go farther. These discussions extend beyond Maine to other parts of the country grappling with the increased demand for SUD treatment because of the opioid epidemic.

Leveraging Medicaid to Address Opioid and Substance Use Disorders in Maine

Introduction

With a new governor as of January 2019, Maine has renewed its focus on effectively addressing the opioid epidemic and expanding access to treatment and recovery services for substance use disorder (SUD) across the state. Governor Mills' early steps to support opioid-related efforts include (1) expanding MaineCare eligibility to people with incomes up to 138 percent of the federal poverty level;[1] (2) rejecting implementation of work requirements as a condition of MaineCare eligibility, which could have limited MaineCare expansion;[2] (3) creating a position, director of opioid response, to lead state efforts to combat the epidemic;[3] and (4) directing state agencies to implement immediate measures, such as training recovery coaches and distributing naloxone across the state to treat overdose.[4]

With the eligibility expansion, Maine's Medicaid program, MaineCare, is expanding its role as a key source of health insurance coverage for people who have an SUD. Growing evidence demonstrates that in states that expanded Medicaid under the Affordable Care Act (ACA), more people have access to mental and behavioral health services, including SUD treatment for opioid use disorder (OUD), particularly medication-assisted treatment (MAT); more people seeking SUD treatment have insurance coverage (Broaddus, Bailey, and Aron-Dine 2018; Maclean and Saloner 2017; Olfson et al. 2018; Saloner et al. 2017); and Medicaid funding for buprenorphine and naloxone prescriptions related to OUD increased at higher rates than in the nonexpansion states (Broaddus, Bailey, and Aron-Dine 2018; Clemans-Cope, Lynch, et al. 2017; Meinhofer and Witman 2018; Saloner et al. 2018; Sharp et al. 2018; Wen et al. 2017). An estimated 70,000 low-income Mainers could gain coverage with full implementation of the MaineCare expansion (Grady, Mann, and Boozang 2018), bringing total enrollment to over 320,000 people, or almost a quarter of Maine's population (24 percent). As of May 3, 2019, nearly 30 percent of the eligible population, 19,675 people, was enrolled in MaineCare under the expansion eligibility category.[5]

Moreover, the Medicaid program, as a source of funding, leadership, and innovation, is integral to driving health system change. This study, conducted over approximately two months in the spring of 2019, intends to help inform state policy choices to leverage Medicaid dollars and other federal funding opportunities to develop a robust behavioral health care system that can respond to the immediate opioid

crisis and provide comprehensive evidence-based treatment and recovery supports to low-income Mainers with OUD or an SUD in the long term.

The information presented in this report draws on an expedited review of available public information and analysis of data on Maine SUD prevalence, the SUD treatment delivery system, and MaineCare SUD coverage and payment policies. To better understand the current SUD landscape, we also conducted semistructured telephone interviews with more than a dozen key informants, including state officials, SUD treatment providers and representatives, and consumer advocates. Finally, we reviewed existing literature on promising approaches, delivery and payment system innovations, and policy changes that have been introduced in other state Medicaid programs and could inform Maine's efforts to strategically use MaineCare to respond to the current crisis and build a behavioral health system that can withstand future challenges and crises.

Because of the compressed time frame, our review of the relevant material was not exhaustive. This study relies extensively on existing publicly available information and data, including our own analyses of data from readily available sources. Because of the small number of informants we interviewed, some experiences and perspectives may not have been captured, and some findings may not be generalizable. Given the unique opportunity presented by the MaineCare expansion and new state leadership, we aimed to generate a timely initial review of critical issues and policies for policymakers and key health care stakeholders so the state can capitalize, both in the short and long terms, on current policy, federal funding opportunities, and emerging funding models.

The insights from this expedited review are meant to motivate and inform discussions already occurring in state offices and stakeholder convenings across Maine, identify areas that require further exploration to better understand MaineCare's coverage and payment policies and their impacts on Maine's SUD treatment delivery system, and uncover opportunities for innovation and improvement to create a system that responds to the needs of Mainers requiring long-term SUD treatment and recovery support. We also highlight key areas where targeted research, including analyses of current treatment capacity and gaps and of facilitators and impediments to receipt of evidence-based SUD treatment, would be valuable in informing future policy development.

Prevalence of Substance Use Disorders in Maine

Maine is experiencing a public health crisis stemming from the opioid epidemic, occurrence of SUD, and substantial unmet needs for OUD and SUD treatment. The most recent state-level estimates from the National Survey on Drug Use and Health (NSDUH), based on 2015 and 2016, indicate that 88,000 Mainers had an SUD, an estimated 8,000 of whom had a prescription OUD.[6] For comparison, all other New England

states had higher rates of SUD than reported in Maine over the same period. However, NSDUH estimates, which show that 83,000 people in Maine needed but did not receive SUD treatment, likely considerably understate the prevalence of OUD and other SUDs, according to recent research.[7] Over that same period,[8] estimates show that alcohol use disorder was the most prevalent form of SUD in Maine, with 6 percent of Mainers ages 12 and older (about 65,000 people) having an alcohol use disorder in 2015 to 2016 (roughly the same as the neighboring state of similar size, New Hampshire) and more than a third of SUD treatment admissions relating to alcohol use (Hornby Zeller Associates 2018). Data from the Centers for Disease Control and Prevention indicate that Maine has the highest rate of alcohol binge drinking among adults in New England, with 20.2 percent of adults over age 18 reporting having four or more drinks on an occasion during the past 30 days, compared with, for example, 17.8 percent in New Hampshire.[9] Almost 9 percent of deaths among people ages 20 to 64 in Maine are attributable to excessive alcohol consumption (the lowest rate among the New England states), with an average of 241 alcohol-attributable deaths annually among Mainers in this age group (Stahre et al. 2014). Informants noted that many people with OUD also have problems with other substances, such as alcohol and tobacco, and emphasized that providers should broaden their scope from just focusing on OUD to addressing all SUDs diagnosed in a patient. Clinical guidelines recommend treatment for polysubstance use when it occurs among people with OUD, particularly for pregnant women (SAMHSA 2018b).

As one of the top 10 states with the highest rates of drug-related overdose deaths, 4 of which are in New England, Maine recorded 34.3 drug overdose deaths per 100,000 people (424 deaths) in 2017, which was lower than the overdose death rate of 37.0 in New Hampshire, higher than rates in Massachusetts (31.8) and Rhode Island (31.0), and much higher than the national rate of 21.7 deaths per 100,000 people in the same year.[10] Opioids accounted for over 80 percent of drug-related overdose deaths in Maine in 2017, at 359 deaths, compared with 67.8 percent of those deaths across the US (Scholl 2019).

Maine and Connecticut were the only New England states to experience statically significant increases in opioid-related overdose death rates from 2016 to 2017. Among Mainers ages 15 and older, the opioid-related death rate in 2016 was 26.8 deaths per 100,000 people, rising to 31.8 per 100,000 people in 2017—an increase of 18.7 percent in one year—the third-highest opioid-related death rate increase in the nation (Scholl 2019). In comparison, the opioid-related overdose death rate in Connecticut rose by 13.1 percent from 2016 to 2017 (Scholl 2019). Moreover, Maine experienced a decrease of approximately 40 percent in prescription opioid-related deaths, which may suggest that misuse of synthetic drugs, like fentanyl, tramadol, or heroin, increased in the state (Scholl 2019). According to information reported by the Centers for Disease Control and Prevention on counties that meet the reporting threshold, the Maine counties that experienced the highest increase in opioid-related deaths between 2016 and 2017 were Cumberland, Kennebec, Somerset, and York (which are also among the most populated counties in the state), all with an increase of more than 40 percent (Table 1).

TABLE 1
Rates of Opioid-Related Deaths Per 100,000 People in Maine, by County, 2016–17

| | 2016 | | | 2017 | | |
County	Opioid-related deaths	Population ages 15 and older	Crude rate opioid-related deaths	Opioid-related deaths	Population ages 15 and older	Crude rate opioid-related deaths
All counties	301	123,918	26.8	359	1,129,505	31.8
Cumberland	**56**	**246,116**	**22.8**	**82**	**247,289**	**33.2**
York	**54**	**170,688**	**31.6**	**77**	**172,501**	**44.6**
Penobscot	40	129,090	31	49	129,365	37.9
Kennebec	**28**	**101,187**	**27.7**	**50**	**102,443**	**48.8**
Androscoggin	23	87,824	26.2	17	88,043	19.3
Aroostook	14	57,838	24.2	<10	57,593	^
Oxford	10	48,599	20.6	<10	48,855	^
Hancock	15	46,556	32.2	<10	46,722	^
Somerset	**11**	**42,999**	**25.6**	**17**	**42,852**	**39.7**
Knox	<10	33,828	^	<10	33,945	^
Waldo	<10	33,300	^	<10	33,668	^
Sagadahoc	<10	29,681	^	<10	29,784	^
Lincoln	<10	29,528	^	<10	29,580	^
Washington	22	26,534	82.9	14	26,696	52.4
Franklin	<10	25,605	^	<10	25,642	^
Piscataquis	<10	14,545	^	<10	14,527	^

Source: Centers for Disease Control and Prevention Wide-Ranging Online Data for Epidemiologic Research database.
Notes: Crude death rates are suppressed for confidentiality reasons if the county had fewer than 10 deaths. Death rates marked ^ are considered unreliable because the county had fewer than 20 deaths.

Available data from the Maine Attorney General for 2018 suggest that the rate of drug-related fatalities has slowed in Maine over the past year, with 354 total drug overdose deaths in 2018, compared with 417 deaths in 2017, a 15 percent reduction.[11] Over 80 percent of drug-related fatalities involved more than two drugs, including at least one opioid. Nonpharmaceutical fentanyl caused more than two-thirds of drug overdose deaths (77 percent). In 2017, adults between the ages of 26 and 35 had the highest rates of drug-related deaths per 100,000 people among the age groups examined, with the rates growing from 22.1 per 100,000 people in 2013 to 81.5 per 100,000 people in 2017 (Hornby Zeller Associates 2018).

The incidence of psychological distress in Maine aligns with national estimates.[12] According to the latest NSDUH data available for 2015 to 2016, nearly one in five adults reported experiencing mental, behavioral, or emotional problems over the past year (Hornby Zeller Associates 2018). SUD often occurs simultaneously with mental health conditions. In 2016, an estimated 51 percent of all Mainers admitted to SUD treatment also had a diagnosed mental health disorder (Hornby Zeller Associates 2018). Substance use is also associated with suicide; adults with an SUD are more likely than adults without an SUD to think about or plan and attempt suicide (Lipari et al. 2015), and about one in five suicide deaths in the US involves alcohol or drugs (SAMHSA 2016). Between 2016 and 2017, the rate of suicide in Maine increased by 20

percent to 20.5 suicides per 100,000 people, though these data do not indicate how much the increase in suicide may be associated with SUDs (Hornby Zeller Associates 2018).

In 2017, most pregnant women admitted to SUD treatment had OUD, and the share of pregnant women admitted to SUD treatment with a heroin use disorder nearly doubled from about 23 percent in 2013 to 43 percent in 2017 (Hornby Zeller Associates 2018). Among MaineCare members, 6 percent of pregnant women were estimated to have OUD, according to data from the last quarter of 2018 (Maine DHHS 2019b). As the opioid epidemic intensified, the number of infants born with neonatal abstinence syndrome (NAS) grew from 201 in 2006 to 1,024 in 2016 but declined slightly to 952 in 2017.[13] The 2015 rate of 34.7 infants with NAS per 1,000 babies born in Maine hospitals was five times the national average of 6.4 (Maine DHHS 2019b). Moreover, parental substance use was associated with children's removal from their parents' custody in about 60 percent of child custody cases in Maine in 2017.[14]

SUD is disproportionately prevalent in Mainers involved with the criminal justice system. About 67 percent of men and 80 percent of women incarcerated in Maine state prisons were recommended for SUD treatment in 2017.[15] Though about 5,000 adults in Maine are arrested annually for drug-related offenses, mostly for possession (Hornby Zeller Associates 2018), only 254 people participated in one of five adult drug treatment courts in 2017.[16]

Coverage and Funding for Substance Use Disorder Prevention and Treatment

Roughly 60 percent of publicly funded SUD prevention and treatment services in Maine are financed through state and federal funds, with about 40 percent of funding coming from the MaineCare program (both federal and state share) in state fiscal years 2016–17 (Figure 1).[17] Non-MaineCare dollars from the state general fund and Fund for a Healthy Maine (i.e., tobacco settlement funds) covered a considerable share of publicly funded SUD prevention and treatment services (31 percent). The remaining sources of public funding include the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant and various other federal grants from SAMHSA and the Centers for Disease Control and Prevention, including Medicare and the recent State Targeted Response to the Opioid Crisis Grants.[18]

FIGURE 1

Maine's Public Spending on Substance Use Disorder Treatment and Prevention, by Funding Source, State Fiscal Years 2016–17
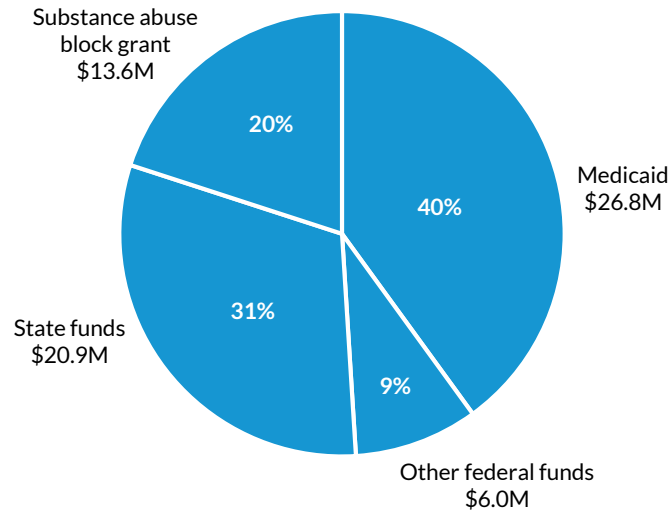
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Source: "Maine Uniform Application FY 2018/2019 - State Behavioral Health Assessment and Plan: Substance Abuse Prevention and Treatment Block Grant," Maine Department of Health and Human Services, January 19, 2018, https://www.maine.gov/dhhs/samhs/grants/documents/SAPTBG-1-19-18.pdf.

Notes: Dollar amounts are based on projections of Maine expenditures for substance use prevention and treatment services, including state administrative costs, for fiscal years 2016 to 2017 (July 1, 2015–June 30, 2017).

MaineCare's Role in Coverage of Substance Use Disorder Services

Many people with OUD or SUD were ineligible for MaineCare coverage before the 2019 eligibility expansion, partly because of tightened MaineCare eligibility rules implemented in the early 2010s. Though MaineCare covers comprehensive SUD services and all three medications approved by the Food and Drug Administration to treat OUD, before the expansion, most people enrolled in MaineCare were either children or enrolled in the aged, blind, and disabled category. These two eligibility categories comprised 82 percent of over 283,000 MaineCare enrollees in December 2017, and the remaining enrollees were parents with dependent children and pregnant women (15 percent) and people enrolled under limited optional eligibility categories (3 percent), such as women with breast or cervical cancer or people with HIV/AIDS.[19]

Not only was Maine five years behind most other states in adopting the ACA Medicaid expansion, but its pre-ACA Medicaid eligibility expansions had been rolled back under the previous state administration. As one informant put it, "just as every other state was expanding, we were actually retracting." Facing budgetary pressures, the state significantly limited MaineCare eligibility in 2012 and 2013, which primarily affected childless adults covered through the waiver program and parents, whose income eligibility

threshold was cut from 200 percent of the federal poverty level to 105 percent of the federal poverty level.[20] These changes reportedly left as many as 20,000 people without coverage,[21] with another 25,000 people dropped from MaineCare in January 2014, many of whom had behavioral health needs.[22] And though Maine voters approved MaineCare expansion through a ballot measure in November 2017,[23] former Governor LePage continued to block the expansion,[24] and his administration sought and received approval from the Centers for Medicare & Medicaid Services (CMS) to implement work requirements for certain MaineCare beneficiaries,[25] which if implemented would likely push more MaineCare members off the program.[26]

Because of restrictive MaineCare eligibility policies under the previous administration, many Mainers seeking SUD treatment services, until recently, were un- or underinsured, and their treatment was covered by various state and federal funding sources described above, administered by Maine's Office of Substance Abuse and Mental Health Services. Several informants observed that MaineCare eligibility cuts "eroded" the behavioral health system, which, according to one informant, was already underresourced. Coupled with generally low reimbursement rates for behavioral health services (from MaineCare and other public sources), many SUD treatment providers struggled to keep afloat as a growing share of their patients dropped MaineCare and became uninsured. The Maine Center for Economic Policy estimated that the share of uninsured Mainers receiving inpatient hospital treatment for mental health and SUDs increased from 19 percent in 2010 to 33 percent in 2014, likely because people with MaineCare coverage, who have disproportionate levels of mental health and SUDs, became uninsured.[27]

A large body of evidence demonstrates positive effects of Medicaid expansion on coverage rates, improved access to care and utilization of services, greater affordability of care, and improved health outcomes (Antonisse et al. 2018). In addition, many studies suggest that states expanding Medicaid under the ACA may experience budget savings and revenue gains from increased economic activity (Antonisse et al. 2018). With implementation of the Medicaid expansion, MaineCare's role in financing SUD services is bound to become more prominent, because a significantly larger share of people accessing SUD treatment will be eligible for MaineCare. With renewed efforts by Maine's new administration to address the opioid epidemic, many informants hoped to see a positive impact on the behavioral health system. Some even believed that MaineCare expansion was critical to providing a much-needed boost to behavioral health providers.

With the enhanced federal match for the cost of SUD and other health care services used by the expansion enrollees, some of the state funding that currently supports SUD services for the un- and underinsured population could be freed up for other strategies to address the opioid epidemic and SUD generally. For example, one study found that when Montana expanded Medicaid, federal Medicaid dollars replaced state and federal block grant funding previously used to cover treatment for uninsured Montanans

with an SUD (Grady, Bachrach, and Boozang 2017). Indeed, Manatt's analysis of state budget impacts from the MaineCare expansion suggest that the state could save an estimated $15.1 million in 2019 by expanding MaineCare, of which 45 percent, or about $6.8 million, would come from shifting a portion of the cost of mental health and substance use services from the state general fund to MaineCare (Grady, Mann, and Boozang 2018). Moreover, Maine has directed most of the federal funding flowing to states for targeted response to the opioid epidemic to MAT for the uninsured, similar to other states that have not expanded Medicaid.[28] As MaineCare increasingly finances SUD treatment, federal funding from the opioid emergency grants could be redirected to support workforce development; prevention activities; wraparound recovery supports, such as housing or transportation; and evaluation to identify outcome-based strategies with the greatest potential to improve SUD prevention, identification, treatment, and recovery rates. However, the state should closely examine its current non-Medicaid federal block grant and state spending on SUD treatment and prevention to determine what resources can be reprogrammed for other SUD-related purposes. Developing a clear plan for reinvesting the freed-up funds can help keep dollars in the SUD system, as opposed to being directed into other state priorities.

MaineCare-Covered Substance Use Disorder Services

Under the ACA, states are required to provide Medicaid expansion enrollees with a comprehensive benefit package, the Alternative Benefit Plan, that must include SUD and mental health benefits, and coverage limitations must not be more restrictive than those for physical health coverage. Accordingly, the Maine Department of Health and Human Services submitted a state plan amendment to add the Alternative Benefit Plan for the expansion population and received CMS approval in early April 2018.[29] According to state officials, the Alternative Benefit Plan provides the same benefits for the expansion population as MaineCare currently covers for the nonexpansion population, including SUD services. Despite the rather comprehensive SUD benefits package described below, key informants reported that access to these services has been limited by provider capacity constraints and other barriers to care, such as lack of transportation.

MaineCare benefits cover SUD treatment and some recovery services. As of April 2019, MaineCare covers at least one SUD service within the five broad levels of care defined by the American Society for Addiction Medicine's (ASAM's) continuum of care, described below.[30] Though no MaineCare benefit is specifically designed for SUD prevention, key informants noted that some SUD prevention activities may be included as part of targeted case management. SUD prevention activities are mostly managed and overseen by the Maine Center for Disease Control and Prevention and funded through state and federal sources other than Medicaid.[31] Within the realm of SUD prevention, MaineCare has implemented guidelines for prescribing opioids for pain management,[32] and the agency has collaborated with Maine's Office of

Substance Abuse and Mental Health Services on implementation of Maine's prescription drug monitoring program, which allows the state to monitor prescriptions of controlled substances and prescribing practices. In response to the opioid epidemic, Maine is one of the few states in the nation that has strengthened its prescription drug monitoring program by requiring electronic prescribing and requiring prescribers and dispensers to check the prescription drug monitoring program database.[33]

EARLY INTERVENTION (ASAM LEVEL 0.5)

MaineCare covers Screening, Brief Intervention, and Referral to Treatment (SBIRT) service, an evidence-based approach commonly used by primary care providers and other practitioners to identify and provide initial intervention to patients with or at risk of developing an SUD.[34] Informants were not sure how much providers use SBIRT in practice, though one informant speculated that the availability of MaineCare reimbursement for SBIRT incentivizes, albeit modestly, primary care providers to screen their patients for SUD. Informants noted that some primary care providers, particularly in remote, rural communities, may lack referral partnerships with behavioral health providers or social services organizations, which could deter some from screening for SUD and other needs (i.e., if providers cannot refer patients for help). In addition, MaineCare covers OUD screening specifically.[35]

Most MaineCare members are enrolled in the primary care case management program, but primary care providers are not required to manage behavioral health and SUD services, meaning members may access these services without a referral from their primary care provider.[36] At least one informant noted that this could present a barrier to care, because MaineCare members may struggle to find information about and navigate available SUD treatment options. And with a considerable share of the state classified as a health professional shortage area, many MaineCare members may find it difficult to access primary care or specialty services.[37] Several informants pointed out Maine's 2-1-1 hotline service, which helps callers identify and access available health and human services programs in their community, as a potential referral source for SUD services.[38] However, the 2-1-1 covers an array of services (e.g., help with preparing tax returns), and staff responding to inquires may not be sufficiently trained to help clients navigate services for complex issues such as substance use. One key informant, for example, said that sometimes the 2-1-1 service refers people to provider associations rather than actual service providers. Another key informant thought the lack of easily accessible and reliable information on where to get SUD treatment services was a "major problem" in Maine.

MaineCare members with multiple physical, mental, and behavioral chronic health conditions are eligible to enroll in primary and behavioral health homes, which coordinate and manage care for members across all health care services.[39] Key informants emphasized that as part of the program, health home providers are responsible for assessing each member's health and social service needs, including screening for mental health and substance use conditions and linking members to appropriate care. Maine has also

developed an opioid health home program to care for members with OUD, to link medication-assisted treatment with primary and behavioral health care and an array of services designed to address members' clinical and nonclinical needs.[40] (See the SUD treatment delivery system section below for more information on opioid health homes.)

Regarding identification and intervention services, behavioral health care providers can bill MaineCare for comprehensive assessments that include evaluation of the patients' medical and psychosocial needs to determine the appropriate type and intensity of treatment.[41]

TREATMENT (ASAM LEVELS 1 TO 4)

MaineCare-covered services include outpatient and intensive outpatient services delineated under Section 65 of the MaineCare Benefits Manual.[42] SUD residential services are covered under Section 97 of the MaineCare Benefits Manual, and though Medicaid cannot cover room and board, the covered clinical costs for people in residential care include clinically managed, low-intensity residential services (halfway house services); clinically managed, population-specific, high-intensity residential programs; clinically managed, high-intensity residential services; and medically monitored intensive inpatient services. MaineCare also covers medically managed intensive inpatient services for mental health and/or SUD treatment delivered in psychiatric residential treatment facilities,[43] but this benefit is limited to MaineCare members under age 21 who require this level of service because of mental illness, an SUD, or severe emotional disturbance.[44]

Partial hospitalization services are currently not covered for SUD but are a covered benefit for adults with serious mental illness or children with serious emotional disturbance.[45]

MAT with all three Food and Drug Administration–approved drugs for OUD are also covered, including methadone and several formulations of buprenorphine and naltrexone. Despite the well-established efficacy of methadone maintenance treatment and widespread use across the United States and the world (box 1), interviews with key informants revealed that MAT may not be particularly promoted and appears widely stigmatized in Maine. (See the Maine SUD treatment delivery system section for more details.)

Methadone Maintenance Treatment Is Effective; It Is Not "Replacing One Addiction with Another"

Evidence of methadone maintenance treatment effectiveness is extensive and shows that it (1) significantly reduces illicit opioid use, based on a wide body of research including a recent Cochrane systematic review (Mattick et al. 2014); (2) reduces HIV and hepatitis transmission (Karki et al. 2016; Schuckit 2016); (3) significantly reduces the death rate associated with OUD (Sordo et al. 2017), by approximately 50 percent (Schuckit 2016); (4) reduces involvement with the criminal justice system (Schuckit 2016); (5) has been found to be superior to buprenorphine treatment in retaining people with OUD in treatment (Mattick et al. 2014); and (6) is safe for women who are pregnant or breastfeeding (SAMHSA 2018b).

Expanding the use of methadone maintenance treatment in Maine may also help reduce the high OUD-related mortality rate in Maine, because methadone is associated with decreased mortality, similar to buprenorphine treatment (Sordo et al. 2017). Further, this treatment has been successful in treating people with OUD in an environment inundated with illicit fentanyl (Stone et al. 2018).

MaineCare also covers naloxone, a medication to reverse drug overdose, in the form of the Narcan nasal spray, which is a preferred drug and limited to two units per 28 days. The brand-name Evzio autoinjection device and injectable naloxone are covered but nonpreferred naloxone formulations that require prior authorization.[46] No MaineCare policy currently covers naloxone for friends or relatives obtaining prescriptions on a member's behalf.[47] Naloxone coverage is the only harm-reduction benefit currently available in MaineCare.[48]

Additional SUD-related services covered by MaineCare include medication management services and urine drug screenings, which are recommended or required when receiving MAT. MaineCare also reimburses services provided via telehealth, but according to our initial assessment, few SUD treatment providers seem to use telehealth to deliver treatment.[49]

RECOVERY

MaineCare covers targeted case management services for members with an SUD, which include comprehensive assessment and periodic reassessment to determine service needs, development of an individual care plan, referral and assistance with obtaining needed services, and follow-up activities to ensure the individual care plan is implemented and addresses the member's needs.[50]

The opioid health home program covers some recovery services, including comprehensive biopsychosocial assessment. Peer recovery coaches are required members of the opioid health home team. There are no training or certification requirements for opioid health home peer recovery coaches; anyone in recovery from SUD and willing to identify his or herself as such to the opioid health home clients qualifies

him or her to become a peer recovery coach. In contrast, training is required for peer support specialists working with patients who have mental health conditions.[51] In addition, one required opioid health home service is providing referrals and assisting members in accessing available community supports and social services that promote recovery, including transportation assistance, housing, and employment services.[52] Outside the opioid health home program, MaineCare does not cover peer supports for SUD or other recovery services, such as relapse prevention and recovery maintenance therapies.[53] However, emerging evidence shows that peer recovery coaches can improve treatment initiation and recovery for opioid use disorder (Krawczyk et al. 2018; Powell et al. 2019; Scott et al. 2018).

COVERAGE OF SERVICES FOR VULNERABLE POPULATIONS WITH SUBSTANCE USE DISORDERS

Pregnant and postpartum women. Pregnant women with an SUD are eligible for targeted case management, and those with OUD can enroll in MaineCare's opioid health homes. MaineCare covers home visits for families with a child ages 2 and under enrolled in MaineCare if the household has a history of problematic substance use.[54] Home visit services are provided by a registered nurse or other trained professional who may deliver up to two and a half hours of direct services in the home per family per month.[55] According to key informants, there is currently no MaineCare eligibility category for infants born with NAS. However, MaineCare is pursuing the Maternal Opioid Misuse model cooperative agreement that would allow the state to design and test a coordinated care model for pregnant and postpartum women with OUD and infants born with NAS.[56]

    Criminal justice–involved population. MaineCare covers inpatient care provided to incarcerated people and those in hospitals, intermediate care facilities for people with intellectual disabilities, nursing facilities, and juvenile psychiatric facilities (Maine DHHS 2019a). MaineCare eligibility is suspended, rather than terminated, for enrollees who become incarcerated, which eliminates the need to submit a new application and allows immediate access to needed health care upon reentry. However, in 2018, no MaineCare outreach and assistance strategies facilitated enrollment for eligible but not enrolled people before release.[57] However, key informants told us that the Office for Family Independence within Maine's Department of Health and Human Services, which determines eligibility for all applications to MaineCare and other social welfare programs, is actively engaging with Maine Department of Corrections to develop policies and procedures that would allow MaineCare eligibility determinations and applications to be processed upon admission into state correctional facilities. Enrollment in the program upon admission would allow providers to bill MaineCare for authorized inpatient services provided to incarcerated people and facilitate seamless reactivation of enrollment upon release from a correctional facility. Maine Department of Corrections recently began partnering with a community provider of buprenorphine treatment to assess people with SUDs and provide referrals to treatment within 30 days of release to

facilitate transition to MAT. (Consistent with federal regulations, these assessment and referral services are not covered by MaineCare.)

Per Governor Mills's executive order number 2,[58] Maine Department of Corrections and several Maine counties are preparing to pilot MAT in prisons and jails. Because federal rules prevent Medicaid from covering SUD treatment for incarcerated people, these MAT pilots will be financed primarily from funds managed by Maine's Office of Substance Abuse and Mental Health Services. MaineCare covers SUD treatment services, including MAT, for members participating in drug treatment courts,[59] and key informants noted a recent emphasis on ensuring that services for eligible people are billed to MaineCare.

Maine's Substance Use Disorder Treatment Delivery System

MaineCare provides SUD services, particularly for OUD, to MaineCare enrollees through a delivery system that focuses on low-intensity outpatient care, with less emphasis on services provided through intensive outpatient, residential, and hospital inpatient settings; opioid treatment programs (OTPs, also known as methadone clinics); and other facilities specializing in SUD treatment. Key informants were concerned about capacity constraints related to SUD care generally, but particularly for programs that serve Mainers with high levels of need that may require residential treatment.

Data presented below in figures 2 and 3 and tables 2 through 7 describe the SUD treatment delivery system in Maine and are from various sources, including the 2017 state profile for Maine from the National Survey of Substance Abuse Treatment Services (N-SSATS), an annual survey of private, local government, federal, and tribal facilities providing substance use treatment (SAMHSA 2018a). In the 2017 N-SSATS, the survey response rate in Maine was 88.2 percent. Among the 199 substance use treatment facilities included in the survey, 11,801 clients were in substance use treatment on March 31, 2017. To assess potential availability of MAT across the state, table 4 shows tabulations of prescribers with buprenorphine waivers from the Drug Enforcement Administration Active Controlled Substances Act Registrants Database by county.[60] We provide estimates of waivered prescribers per 1,000 people ages 15 and older because we did not have access to data needed to estimate how many patients are being seen by waivered prescribers, who likely do not treat their maximum number of patients under their Drug Enforcement Administration waiver.

Substance Use Disorder Treatment Facilities in Maine

According to data from N-SSATS, the number of substance use treatment facilities in Maine increased in 2011 and then remained relatively stable until a drop in 2017 (Figure 2). However, the total number of

patients at a substance use treatment facility increased from 10,621 in 2016 to 11,801 in 2017 (SAMHSA 2017, 2018a).

Number of Maine Substance Use Treatment Facilities Reporting to N-SSATS, by Type of Care, 2010–17
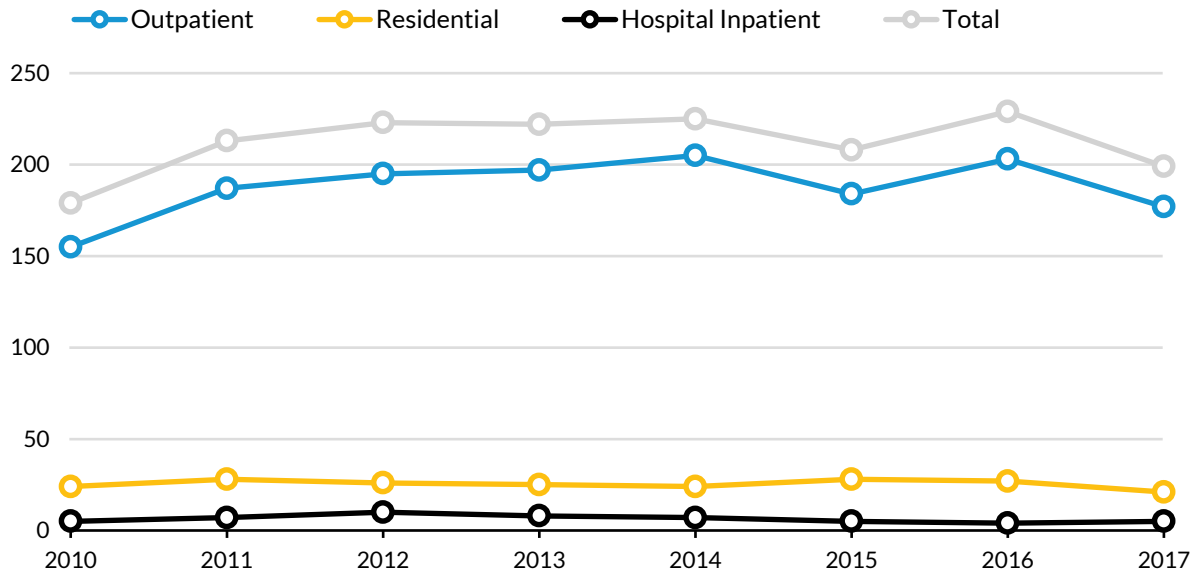
Source: National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality.

Notes: N-SSATS = National Survey of Substance Abuse Treatment Services. Facilities may provide more than one type of care. Reflects facilities as of March 31, 2017. Residential facilities are nonhospital residential facilities.

In table 2, we present the share of Maine SUD facilities that accept MaineCare patients by type of care; however, we did not assess SUD treatment provider network adequacy or analyze MaineCare claims data to examine MaineCare members' access to these services.

TABLE 2

Maine Substance Use Treatment Facilities Reporting to N-SSATS
That Accept MaineCare, by Type of Care, 2017

	All facilities	Facilities accepting MaineCare	
	Number	Number	Percent
Outpatient	**177**	**145**	**81.9**
Regular	172	142	82.6
Intensive	44	37	84.1
Day treatment/partial hospitalization	7	6	85.7
Detoxification	9	6	66.7
Medication-assisted treatment	47	38	80.9
Residential (nonhospital)	**21**	**16**	**76.2**
Fewer than 30 days	5	3	60.0
30 days or more	19	14	73.7
Detoxification	-	-	-
Hospital inpatient	**5**	**5**	**100.0**
Treatment	3	3	100.0
Detoxification	5	5	100.0
Total	**199**	**163**	**81.9**

Source: National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality.
Notes: N-SSATS = National Survey of Substance Abuse Treatment Services. Facilities may provide more than one type of care. Reflects facilities as of March 31, 2017. Government funds may come from the local, state, or federal level.

Among Maine SUD treatment facilities responding to the N-SSATS, the residential settings report higher utilization than the national average (table 3). Informants were particularly concerned about access to residential care and other programs to serve high-needs patients in Maine. This concern is consistent with data that indicate that SUD treatment clients in Maine are much less likely than those across the US to receive treatment in a residential or inpatient setting (data not shown; SAMHSA 2018a), implying that some patients may not get residential care because there are no available slots. Some informants noted that MaineCare reimbursement rates for SUD services provided in residential settings are much lower than those for mental health services provided in residential facilities. (See the MaineCare payment policies section for more details.) Increased residential treatment capacity—or in other service settings, such as OTPs, that provide higher-level services and supports—could help rebalance Maine's disproportionate use of low-intensity outpatient care among people receiving SUD treatment. At the time of this study, the Office of MaineCare Services was soliciting public input and drafting a Section 1115 waiver application to CMS to provide reimbursement for SUD services delivered in large residential facilities with more than 16 beds, which CMS calls "institutions for mental disease."[61] If approved by CMS, this provision would expand capacity for residential treatment, which, according to some informants, could significantly improve access to SUD treatment.

TABLE 3

Selected Measures of Maine Substance Use Treatment Facilities Reporting to N-SSATS, 2017

	Residential (nonhospital)	Hospital inpatient (offering detoxification or treatment)
Number of facilities	17	3
Number of clients	213	39
Number of designated beds (for substance use treatment)	216	52
Utilization rate of designated substance use treatment beds	98.6 (US = 93.9)	75.0 (US = 98.3)
Average number of designated substance use treatment beds per facility	13	17

Source: National Survey of Substance Abuse Treatment Services, Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality.

Notes: N-SSATS = National Survey of Substance Abuse Treatment Services. Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question. Number of clients as of March 31, 2017. Substance use treatment clients may also occupy nondesignated beds, but the denominator of the utilization rates only includes designated beds.

Non–Substance Use Disorder Facilities Providing Substance Use Disorder Treatment

In addition to state-licensed SUD facilities, primary care providers and hospitals may provide SUD services, but many primary care providers and hospitals are reportedly not treating patients for SUDs. Maine has 20 federally qualified health centers with more than 70 sites statewide.[62] It appears that only a handful currently offer SUD services, including those that participate in the opioid health home program, though one key informant noted that federally qualified health centers are increasingly providing MAT. Another informant, however, thought community health centers were not stepping up sufficiently, characterizing them as "a dramatically underutilized resource" in addressing the opioid epidemic, along with critical access hospitals. Of the 36 hospitals in Maine, 33 are acute care hospitals with emergency departments, 16 of which have been designated as critical access hospitals.[63] Key informants reported that with federal funding, efforts to screen for SUD and initiate buprenorphine treatment for emergency department patients with OUD have increased, with five or six hospitals already having implemented buprenorphine induction and more than a dozen planning to do so by the end of the year. It is unclear how many of Maine's 16 critical access hospitals are among this group.

Waivered Buprenorphine Prescribers for Opioid Use Disorder Treatment in Maine

To assess potential availability of buprenorphine treatment across the state, we tabulated Drug Enforcement Administration data showing 768 waivered prescribers, with between 9 and 245 prescribers in every county (Table 4). The counties with the fewest prescribers per 1,000 people ages 15 and older (0.31 or less) are Aroostook, Oxford, Sagadahoc, and York, and the counties with the most prescribers per 1,000 people ages 15 and older (1.01 or higher) are Cumberland and Kennebec. Even in areas with higher numbers

of prescribers per capita, patients may still experience treatment gaps because they cannot access MAT. According to key informants, many waivered prescribers in Maine do not treat as many patients as permitted by their waiver and some may not treat any patients, an issue that has been observed in other states (Breen and Fiellin 2018). . Informants cited factors such as low reimbursement rates and high rates of uncompensated care (i.e., for un- and underinsured patients), lack of training and education around MAT, and stigma and lack of understanding that SUD is a chronic illness that may prevent primary care providers from practicing to full capacity once they are waivered to prescribe buprenorphine. Some informants also noted that bureaucratic "red tape" burdens (e.g., the waiver training requirements, Drug Enforcement Administration oversight) may keep some primary care providers from obtaining waivers. Several informants also noted that lack of partnerships with behavioral health providers to refer patients with greater care needs, as well as limited or no available wraparound social services to support patients in treatment and recovery (e.g., transportation, job training, housing, peer recovery specialist), deter some waivered prescribers from taking on more patients with OUD.

TABLE 4

**Buprenorphine-Waivered Prescribers in Maine, by Provider Type,
Patient Limit, and County in January 2019**

	Physicians with			NPs/PAs with			
County	30-patient limit	100-patient limit	275-patient limit	30-patient limit	100-patient limit	Total	Waivered prescribers per 1,000 people ages 15 and older
Androscoggin	23	7	1	9	0	40	0.5
Aroostook	10	1	3	3	1	18	0.3
Cumberland	145	37	19	37	7	245	1.0
Franklin	2	6	0	3	2	13	0.5
Hancock	16	8	1	6	2	33	0.7
Kennebec	46	26	7	26	10	115	1.1
Knox	12	8	0	4	0	24	0.7
Lincoln	8	5	1	5	0	19	0.6
Oxford	5	7	1	0	1	14	0.3
Penobscot	47	31	3	27	8	116	0.9
Piscataquis	7	1	1	3	0	12	0.8
Sagadahoc	5	2	0	2	0	9	0.3
Somerset	12	2	0	6	1	21	0.5
Waldo	8	8	0	3	0	19	0.6
Washington	7	4	1	8	0	20	0.7
York	25	7	6	11	1	50	0.3
All	378	160	44	153	33	768	0.7

Source: Urban Institute analysis of Drug Enforcement Administration Active Controlled Substances Act Registrants Database from the National Technical Information Service and American Community Survey population estimates.
Notes: NP = nurse practitioner. PA = physician assistant. Waivered provider counts as of January 2019 and county population estimates as of 2017.

Ninety-seven percent of SUD treatment patients receive care in an outpatient setting, which is a slightly higher rate than that for patients across the US (91 percent; table 5). A far higher share of Mainers seen in outpatient settings for SUD receives outpatient MAT than the national average (50 percent versus 35 percent). This relatively high rate of MAT among those in outpatient SUD treatment may partially owe to Maine, like Vermont, having developed a higher level of buprenorphine treatment capacity than other states by 2012, which was relatively early in the opioid epidemic (Jones et al. 2015). This may have also put Maine ahead of the curve in destigmatizing buprenorphine treatment among patients and providers.

TABLE 5

Type of Care Received by Clients at Maine Substance Use Treatment Facilities Reporting to N-SSATS, 2017

| Type of Care	Maine		United States
	Number	Percent	Percent
Outpatient	**11,482**	**97.3**	**91.3**
Regular	4,974	42.1	44.2
Intensive	527	4.5	9.9
Day treatment/partial hospitalization	39	0.3	1.7
Detoxification	30	0.3	0.9
Medication-assisted treatment	5,915	50.1	34.7
Residential	**257**	**2.2**	**7.4**
Fewer than 30 days	39	0.3	2.4
30 days or more	215	1.8	4.2
Detoxification	3	*	0.8
Hospital inpatient	**62**	**0.5**	**1.3**
Treatment	18	0.2	0.7
Detoxification	44	0.4	0.6
Total	**11,801**	**100.0**	**100.0**

Source: Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality.
Notes: N-SSATS = National Survey of Substance Abuse Treatment Services. Reflects clients as of March 31, 2017.

Trends in MaineCare-Covered Prescriptions to Treat Opioid Use Disorder and Overdose

Prescriptions for all three medications—buprenorphine, naltrexone, and naloxone—approved by the Food and Drug Administration for OUD and overdose treatment increased over time, according to Medicaid State Drug Utilization Data (figure 3).[64] From 2010 to 2017, the annual number of MaineCare-covered buprenorphine prescriptions for OUD increased from over 48,000 to over 82,000, naltrexone prescriptions increased slightly but stayed under 2,000, and naloxone prescriptions rose from zero to a few hundred. Though these Medicaid data and analysis do not capture methadone treatment, informants reported that methadone treatment is not widely promoted in Maine. The previous administration reportedly favored buprenorphine over methadone because of the perceived lower rates of diversion and risk of overdose,[65] which may explain Maine's relative emphasis on buprenorphine treatment.

FIGURE 3

**Number of MaineCare-Reimbursed Prescriptions for Treating
Opioid Use Disorder and Overdose, 2010–17**
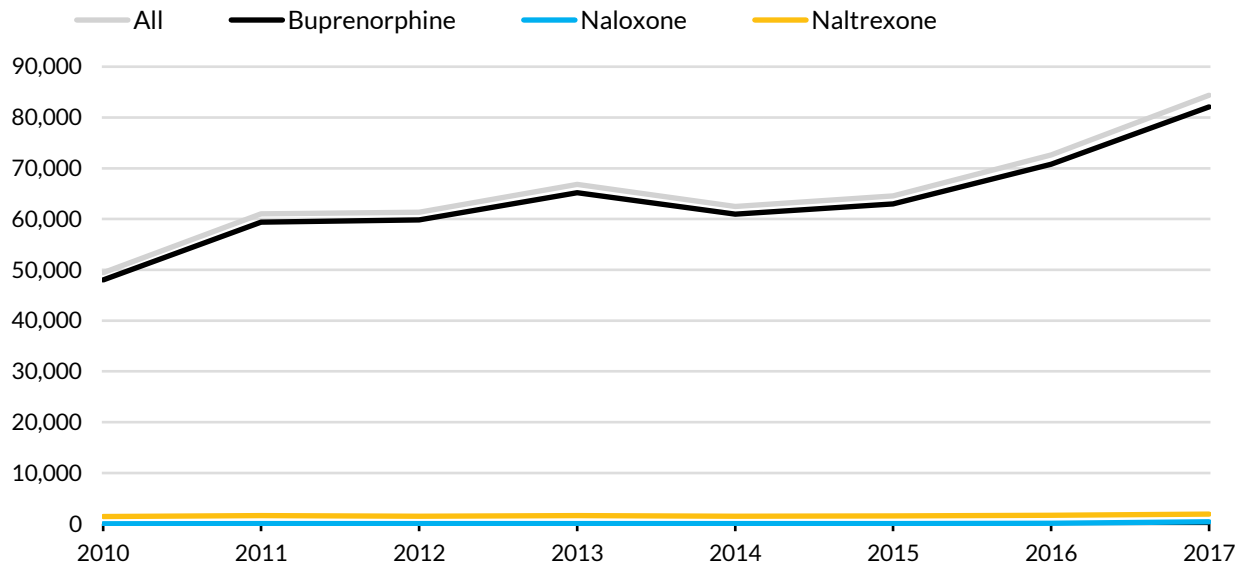
Source: Urban Institute analysis of Medicaid State Drug Utilization Data from the Centers for Medicare & Medicaid Services.

MaineCare-covered buprenorphine prescriptions for OUD were almost entirely (90 percent) for the brand-name drug Suboxone (table 6), which represented a much higher share of buprenorphine treatment in Maine than in Medicaid across all states, where generic buprenorphine prescriptions were much more common, likely because it typically costs less than brand-name buprenorphine.[66] Through various Medicaid drug rebate agreements, the manufacturers of Suboxone may offset federal and state costs of prescriptions to Medicaid patients, but these rebate amounts are not publicly available. Per capita prescriptions for buprenorphine treatment (per 1,000 MaineCare enrollees ages 12 and older) grew from 216 in 2010 to 404 in 2017.[67]

TABLE 6

**MaineCare Prescriptions of Buprenorphine or Buprenorphine/Naloxone Products
for Treating Opioid Use Disorder, Third Quarter of 2017 to Second Quarter of 2018**
Brand name and generic

Brand-name/generic buprenorphine medications used in MaineCare-funded BMT	Active ingredients	Number of MaineCare prescriptions	Percent of BMT prescriptions
Suboxone	Buprenorphine/naloxone	74,002	90
Generic	Buprenorphine/naloxone	2,166	3
Generic	Buprenorphine	6,206	8
Zubsolv	Buprenorphine/naloxone	28	<0.1
Bunavail	Buprenorphine/naloxone	13	<0.1

Source: Urban Institute analysis of Medicaid State Drug Utilization Data from the Centers for Medicare & Medicaid Services, available at https://www.urban.org/policy-centers/health-policy-center/projects/tracking-medicaid-covered-prescriptions-treat-opioid-use-disorder.
Note: BMT = buprenorphine maintenance treatment.

MaineCare's Opioid Health Homes

Opioid health homes were established by the Maine legislature in 2017 to provide an integrated care delivery model focused on whole-person OUD treatment.[68] Opioid health homes provide evidence-based MAT and related services (e.g., counseling, peer support, drug screenings) integrated with a range of required health home services that include care management and coordination, health promotion, comprehensive transitional care, inclusion of patients and families in care, and connections to community resources and social support services. In Maine, the opioid health home program for MaineCare beneficiaries went into effect on October 1, 2017,[69] though the program initially began enrolling uninsured Mainers in the spring of the same year. Enrollee eligibility criteria include having OUD and risk of developing another chronic condition. Members opt into enrollment (e.g., patients are presented with program information and must select to participate). Opt-in enrollment was less effective in opioid health home programs implemented in other states than the opt-out approach, under which eligible patients are automatically enrolled in the program (Clemans-Cope, Wishner, et al. 2017).

The program had a slow rollout, with only a handful of providers serving about 50 MaineCare members and 5 uninsured people between October 2017 and February 2018.[70] According to key informants, the cumbersome program rules and low reimbursement rates for the opioid health homes may have contributed to initial low provider interest. Among other states that have implemented the opioid health home program, Maryland also experienced a slow program rollout, attributed in part to providers' perceived high burden of program implementation (Clemans-Cope, Wishner, et al. 2017). However, MaineCare has recently revised the opioid health home program rules and substantially modified and increased reimbursement rates.[71] These changes have apparently increased provider participation; as of March 2019, 26 organizations with 49 locations appeared to participate in the program, an increase from 16 organizations and 33 locations in

January 2019.[72] A range of providers can serve as opioid health homes, and only a few OTPs participate, which is a substantial departure from other states with opioid heath home programs, such as Maryland, Rhode Island, and Vermont, where OTPs are central to the program, and in some states, the only provider type permitted to participate (Clemans-Cope, Wishner, et al. 2017). State officials reported that following the expansion of the program in early 2019, the opioid health homes served about 800 MaineCare members and 200 uninsured patients with OUD in April 2019. The number of enrollees will likely continue to grow with MaineCare expansion and increased provider participation. One of the directives in the governor's executive order number 2 is to evaluate the opioid health home program "to determine if it is the best model" for MaineCare members with OUD.[73]

Methadone Maintenance Treatment at Opioid Treatment Programs

Table 7 shows OTPs in Maine by county[74] and whether they accept MaineCare patients. According to key informants, eight of these programs accept MaineCare patients, though our review of OTPs' websites indicates that nine do. All 10 offer methadone maintenance treatment, and the two Health Care Resource Centers and the four Discovery House OTPs also offer buprenorphine maintenance treatment. OTPs, also called methadone clinics in Maine, have operated in a challenging environment and faced numerous obstacles over the past decade, including legislative and regulatory challenges, MaineCare reimbursement cuts, and efforts to eliminate MaineCare coverage of methadone.[75] For example, as part of MaineCare service cuts in early 2013, a prior authorization requirement to continue treatment past 24 months was put in place for MAT with methadone and buprenorphine.[76] However, several informants recounted that these measures were not "a hard limit" or necessarily a barrier to continue treatment, because MaineCare approved nearly all prior authorization requests. In fact, some informants contended that the time limit was envisioned as an opportunity to encourage providers to discuss weaning and achieving treatment goals with clients. However, because these policies could obstruct continuous MAT for some patients and were perceived as an administrative burden for providers, time limits and prior authorization requirements for MAT treatment were removed from MaineCare in February 2019.[77] MaineCare also increased reimbursement rates for methadone treatment retroactive to August 1, 2018.

Former Governor LePage openly criticized methadone clinics, which may have fueled stigma and public opposition to methadone maintenance treatment.[78] And informants suggested that OTPs are not fully integrated in Maine's SUD treatment delivery landscape, even though MaineCare covers methadone maintenance treatment and OTPs serve several thousand patients, including about 3,000 MaineCare patients, at a given time.[79] Informants indicated that methadone maintenance treatment is not well publicized in Maine, and patients learn about it mostly through word of mouth because referrals from health care providers, community-based organizations, or the criminal justice system are rarely to OTPs. However,

one methadone clinic reportedly established productive relationships with primary care providers and social services agencies in the community by actively engaging health care and community organizations and received referrals from community partners. Several informants interviewed for the report emphasized Suboxone delivered through primary care as a major way to expand access to MAT in Maine, and though methadone maintenance treatment is covered by MaineCare, it is not necessarily promoted.

One informant emphasized that OUD patients need treatment choices that include both buprenorphine and methadone maintenance therapy: "It's like any kind of treatment or any kind of medication, it is not a one-size-fits-all for any patient. Some patients do much better with Suboxone, and some people do better with methadone." Informants also reported that state regulations for counseling requirements in methadone clinics are burdensome, conflict with federal requirements, and were responsible for some patients not being retained in treatment. Coupled with low OTP reimbursement in MaineCare, these challenges have likely limited the OTP expansion in Maine, as discussed further in the MaineCare payment policies section.

TABLE 7
Opioid Treatment Programs Accepting MaineCare Patients

Opioid treatment program	Accepting MaineCare?	County
Health Care Resource Centers Lewiston	Yes	Androscoggin
Health Care Resource Centers Portland	Yes	Cumberland
Acadia Healthcare	Yes	Penobscot
Discovery House Comprehensive Treatment Center of Waterville	Yes	Kennebec
Discovery House Comprehensive Treatment Center of South Portland	Yes	Cumberland
Discovery House Comprehensive Treatment Center of Bangor	Yes	Penobscot
Discovery House Comprehensive Treatment Center of Calais	Yes	Washington
CAP Quality Care	Yes	Cumberland
Penobscot County Metro Treatment Center (Colonial Management Group)	Yes	Penobscot
Rockland Metro Treatment Center (Colonial Management Group)	No	Knox

Sources: Key informant interviews and Substance Abuse and Mental Health Services Administration's Opioid Treatment Program Directory, available at https://dpt2.samhsa.gov/treatment/directory.aspx.
Note: Colonial Management Group owns and operates Penobscot County and Rockland Metro Treatment Centers.

MaineCare Payment Policies

Covered health care services delivered to MaineCare members are largely reimbursed on a fee-for-service basis, using a fee schedule developed by the Maine Department of Health and Human Services' rate-setting unit, which develops payment rates and methodologies for services provided by various agencies within the Department of Health and Human Services, including MaineCare.[80] Since 2011, MaineCare has implemented several value-based payment programs, including Accountable Communities (an accountable

care organization model) and health homes, which collectively serve 113,000 (roughly 44 percent) MaineCare members.[81]

Except for the opioid health home program, SUD services are reimbursed on a fee-for-service basis. Table 8 lists current and pending as of July 1, 2019, MaineCare rates for SUD services. Most current rates reflect a 2 percent increase relative to 2018 rates, with some exceptions, most notably a 36 percent increase in the weekly reimbursement rate for methadone treatment providers. At the time of this project, MaineCare was seeking and anticipating receiving approval from CMS to make the payment increases retroactive to August 1, 2018, to boost provider payment rates. SUD treatment providers and other informants generally considered payment levels from MaineCare and other public sources for care of the uninsured inadequate. Many informants thought low reimbursement rates contributed to widespread workforce shortages and exacerbated treatment access and capacity issues.

Even with the rate hike in 2019, some informants were still concerned by low payment rates for methadone clinics. Because of budgetary pressures, MaineCare reimbursement rates for methadone clinics were cut from $80 per patient per week to $72 per patient per week in 2010, and two years later, the rates were further lowered to $60 per patient per week as part of the MaineCare eligibility and service cuts.[82] According to one informant, methadone clinics struggled to operate under such low reimbursement rates, particularly as the bundle of services they had to offer grew (the service package includes assessment and development of a treatment plan, behavioral counseling, medication administration, and drug use testing).[83] Quality of patient care, including retention and other outcomes, reportedly suffered. For example, methadone clinics had to increase counselor caseloads from 50 patients per one counselor to sometimes as many as 150 patients per counselor. Informants indicated that low reimbursement rates from MaineCare also limited clinics' ability to hire new staff and expand capacity to meet the growing demand for services as the opioid epidemic worsened. One of the methadone clinics ultimately closed, owing in part to low reimbursement.[84] Though the payment level for methadone clinics has increased to $81.74 per patient per week in 2019, the largest payment increase among SUD services, one informant pointed out that accounting for inflation and the expanded bundle of services, the rate should be around $140 per patient per week to adequately cover the cost of care. Reportedly, the current administration is open to further increasing MaineCare rates for methadone maintenance treatment.

Some informants also noted discrepancies between payment levels for comparable SUD and mental health services, particularly much lower rates for SUD care provided in inpatient and residential facilities than those for mental health care in similar settings. However, for other services, payment rates for SUD treatment are similar or higher than those for mental health treatment (Table 89).

TABLE 8

MaineCare Fee Schedule for Substance Use Disorder Services, 2019

Service (ASAM level)	Code and rate as of 1/1/19[a]	Code and rate effective 7/1/19
Nonhospital inpatient detox and treatment (3.7 and 3.5)	H0010, $217.88/day	H0010, $217.48/day
Residential treatment (3.3)[b]	H2036 HF, $224.87/day for type I H2034 HF, $119.87 for type II	H2036 HF, $224.44/day for type I H2034 HF, $119.65/day for type II
Adolescent residential treatment	H2036 HA, $188.02 day	H2036 HA, $187.67 day
Halfway house	H2034, $106.30/day	H2034, $106.09/day
Extended care	H2036, $117.11/day	H2036, $116.89 /day
Intensive outpatient (2.1)	H0015, $102.18/day	H0015, $102.00/day
Personal care (substance abuse shelter services)	T1020 HF, $56.97/day	T1020 HF, $56.87/day
Individual and group therapy - substance abuse agency	H0004, $21.46/15 min. (individual) H0004 HQ, $9.20/15 min. (group)	H0004, $21.42/15 min. (individual) H0004 HQ, $9.18/15 min. (group)
Non–master's level licensed alcohol and drug abuse counselor	H0004, $20.44/15 min. (individual) H0004 HQ, $8.69/15 min. (group)	H0004, $20.40/15 min. (individual) H0004 HQ, $8.67/15 min. (group)
Certified alcohol and drug abuse counselor	H0004, $14.81/15 min. (individual) H0004 HQ, $7.16/15 min. (group)	H0004, $14.79/15 min. (individual) H0004 HQ, $7.14/15 min. (group)
Case management for adults with substance use disorder	T1017 HF, $21.99/15 min.	T1017 HF, $21.95/15 min.
Assessment and placement	**H2000, $21.46/15 min.**	**H2000, $21.42/15 min.**
Non–master's level licensed alcohol and drug abuse counselor	H2000, $20.44/15 min.	H2000, $20.40/15 min.
Certified alcohol and drug abuse counselor	H2000, $14.81/15 min.	H2000, $14.79/15 min.
Medication-assisted treatment with methadone	H0020, $81.74/week[c]	H0020, $81.60/week
Medication management services	H2010, $66.11/15 min.[d]	H2010, $65.26/15 min.
Screening, Brief Intervention, Referral, and Treatment	99408, $60.60/15 to 30 min. 99409, $117.00/over 30 min.	
Opioid use disorder screening	G9584, $3.37	
Presumptive drug test(s)[e, f]		
By direct optical observation	80305, $8.41/day	
By instrument-assisted direct optical observation	80306, $11.22/day	
By instrument chemistry analyzers, chromatography, or mass spectrometry	80307, $44.89/day	
Definitive drug test[f]		
1–7 drug class(es)	G0480, $82.36/test	
8–14 drug classes	G0481, $112.69/test	
15–21 drug classes	G0482, $143.04/test	
22 or more drug classes	G0483, $177.71/test	

Sources: "Chapter III – Allowances for Services," in *Chapter 101: MaineCare Benefits Manual* (Augusta, ME: Maine Department of Health and Human Services), accessed June 10, 2019, https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s080.docx; "Opioid Use Disorder Screening Code Opened and Upcoming Value-Based Purchasing Management System (VMS) Portal Transition," Maine Department of Health and Human Services, June 1, 2018, https://content.govdelivery.com/accounts/MEHHS/bulletins/1f44ac9.

Notes: ASAM = American Society for Addiction Medicine. min. = minute. Substance abuse agency = licensed SUD treatment facility.

[a] Unless otherwise noted, current rates reflect a 2 percent increase retroactive to August 1, 2018, pending CMS approval.

[b] Residential rehabilitation type II will provide a structured therapeutic environment for members who are on a waiting list for treatment or have either completed or otherwise do not need detoxification services. The primary objectives of residential rehabilitation type II are to stabilize the member, provide continuity of treatment, and enable the member to develop an appropriate supportive environment, remain substance free, and develop linkages with community services. Room and board costs are not reimbursed at the rates for all private nonmedical institution substance use treatment services.

[c] The reimbursement for medication-assisted treatment with methadone includes a 36 percent increase from $60 per patient per week, retroactive to August 1, 2018, pending CMS approval.

[d] The reimbursement for this service includes a 15 percent increase retroactive to August 1, 2018, pending CMS approval.

[e] Drug tests are qualitative presumptive tests for any drug class, device, or procedure and include sample validation when performed.

[f] The reimbursement for this service has not changed recently.

TABLE 9

MaineCare Payment Rates for Selected Substance Use Disorder and Mental Health Services, 2019

Service	Substance use disorder rate and code	Mental health rate and code
Individual therapy	$42.92/30 min. (H0004, 2 x $21.46/15 min.)	$23.90/30 min. (90832)
Group therapy	$18.40/30 min. (H0004 HQ, 2 x $9.20/15 min.)	$20.88 (90853)
Targeted case management	$21.99/15 min. (T1017 HF)	$21.99/15 min. (T1017 UC)
Assessment	$21.46/15 min. (H2000)	$21.46/15 min. (H2000 - mental health agency)
Inpatient	$4,898 per discharge in a distinct substance use unit in an acute care noncritical access hospital	$6,438.72 per discharge in a distinct psychiatric unit in an acute care noncritical access hospital; $15,161.43 per discharge in a rehabilitation hospital
Residential[a]	$224.87 per diem for type I (H2036 HF)	$485.72 per diem that covers medical, clinical, and direct care
Health home	Tiered payments ranging from $408.37 to $2,217.76 per member per month based on level of care at an opioid health home[b]	$394.40 per member per month at a behavioral health home

Source: "Chapter III – Allowances for Services," in *Chapter 101: MaineCare Benefits Manual* (Augusta, ME: Maine Department of Health and Human Services), accessed June 10, 2019, https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s080.docx.
Notes: min. = minute. Mental health agency = licensed mental health facility.
[a] Residential treatment rate does not include room and board.
[b] See table 10 for more payment details.

As mentioned above, MaineCare has implemented several value-based payment initiatives, including the opioid health home program. When opioid health homes began operating in 2017, the payment rate for care provided to MaineCare members was set at $496 per member per month for providers prescribing medication, and the payment level for providers dispensing medication was set at $1,000 per member per month.[85] However, as described earlier, provider participation in the program was low. In response, MaineCare made program changes per emergency rule in November 2018 that were adopted in March 2019.[86] One of the most significant changes included revisions to the payment methodology and introduction of tiered per member per month rates for opioid health home providers. Based on the level of care a patient needs and whether opioid health homes also provide coordinated case management, reimbursement rates range from slightly more than $400 per member per month to over $2,200 per member per month, with the medications billed and paid separately (table 10).[87]

Though provider participation has increased in the opioid health home program, at least one informant thought provider requirements were overly complex and burdensome to effectively engage

more provider types, especially primary care providers. Indeed, to qualify for opioid health home reimbursement, providers must meet 10 requirements each month, including a provision of a minimum of five prescribed services.[88] One key informant emphasized that requirements for level of services were not flexible enough to account for needs of patients in the maintenance phase, who many not benefit from all the services required as part of the program, and that participating in the program could then become burdensome for both providers and patients. More information is needed from opioid health home providers to get their perspectives on administrative burden associated with delivering and getting paid for services or other aspects of the program. State officials emphasized the need to evaluate the opioid health home model to determine whether it meets its objectives regarding improved access to and quality of OUD care.

TABLE 10

MaineCare Per Member Per Month Payment Rates for Opioid Health Homes

Service/level of care	Effective 4/11/17	Effective 11/27/18[a]
Providing a prescription	$496.00	
Administration	$1,000.00	
Provides comprehensive care management services and transitional care		
Intensive outpatient		$2,217.76
Intermediate/stabilization		$1,045.01
Maintenance		$662.68
Does not provide comprehensive care management services and transitional care		
Intensive outpatient		$1,963.45
Intermediate/stabilization		$790.70
Maintenance		$408.37

Source: "Chapter III – Allowances for Services," in *Chapter 101: MaineCare Benefits Manual* (Augusta, ME: Maine Department of Health and Human Services), accessed June 10, 2019, https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s080.docx.
Note: [a] New opioid health home rates are pending Centers for Medicare & Medicaid Services approval.

Neither the fee-for-service reimbursement or per member per month payments for SUD services currently include incentives or bonuses for meeting quality or other outcomes. Though providers interviewed for this report generally agreed that tying payments to patient outcomes and other measures could improve quality of care, they also noted that most SUD treatment providers in Maine lack infrastructure and administrative capacity to effectively track and report metrics.

Outside the SUD treatment delivery system, MaineCare has implemented quality incentive payments in the primary care case management program, but to date, no measure has focused on screening for SUD or mental health conditions.[89] Quality measures for the Accountable Communities

program, which serves over 55,000 MaineCare members, include several behavioral health metrics, one of which evaluates patients for risk of opioid misuse,[90] but it is an elective measure.[91]

Opportunities for Leveraging MaineCare's Role in Substance Use Disorder Treatment, Coverage, Access, and Improvement

Because of the recent Medicaid expansion in Maine, MaineCare is likely to become an even more dominant payer for SUD treatment services, and demand for SUD treatment will likely substantially increase in Maine, where provider capacity is already constrained.[92] MaineCare can shape the SUD landscape by emphasizing and expanding access to cost-effective, high-quality SUD treatment services and supports. Based on a quick topline assessment of MaineCare's current programs and policies and the existing SUD treatment delivery system, we have identified strategically important areas that Maine policymakers and stakeholders may wish to consider as part of the overall efforts to strengthen the state's response to the opioid crisis. To promote and inform debate in developing effective solutions, we propose 10 initial policy options designed to maximize MaineCare's impact on SUDs and the SUD treatment delivery system, focusing on OUD treatment. The options leverage Medicaid dollars, other federal funding, and innovative funding models to achieve the greatest impact on SUD prevalence and treatment rates and could reshape the behavioral health care system so it better responds to future challenges and crises. Below, we expand on these policy options, and we highlight innovative delivery and payment approaches for enhancing SUD and OUD treatment capacity and quality that have been implemented in other state Medicaid programs and could complement Maine's existing SUD initiatives, based on our initial assessment.

1. **Maximize the shift of block grant–funded SUD treatment to MaineCare and redirect grant dollars to invest in SUD services, supports, and patients ineligible for MaineCare. This could include SUD services for incarcerated people and funding for supportive housing that serves MaineCare enrollees on MAT, potentially drawing on new strategies for funding programs (e.g., pay for success) that focus on outcomes and help build evidence on effective interventions.**

Many SUD services for people who are newly covered by MaineCare were financed with state tobacco settlement, state general fund, or federal block grant funds. In addition, federal funds currently directed at the opioid crisis are temporary; MaineCare funding is sustainable to address SUDs in the long run

(Grady et al. 2018). Though a sizable uninsured population will still need SUD services funded outside MaineCare,[93] the federal government will finance 94 percent and 90 percent of the Medicaid services used by newly eligible and enrolled adults in 2019 and 2020, respectively. By enrolling newly eligible adults with an SUD in MaineCare, the state can leverage federal Medicaid funds for treatment, freeing up funding for critical services and supports that cannot be covered by MaineCare. Engaging SUD treatment providers in MaineCare enrollment efforts could be particularly effective for people in SUD treatment, many of whom may be in hard-to-reach populations, such as those who do not have a regular primary care provider. The SUD treatment provider community could conduct MaineCare enrollment "in-reach" activities, such as screening for MaineCare eligibility at check-in, with uninsured patients they already serve (Artiga, Rudowitz, and Tolbert 2016).[94]

Maine could invest the savings from shifting some costs for SUD services from the state general fund to MaineCare in services, supports, and patients that cannot be covered under Medicaid, such as SUD services for incarcerated people or funding for supportive housing that serves MaineCare enrollees on MAT (e.g., the Housing First model). Interventions that are not reimbursable under Medicaid can provide community resources, housing, food, and population health programs critical to supporting people in SUD treatment and recovery. For example, block grants and other non-Medicaid funds have been used to provide permanent supportive housing to Medicaid enrollees with mental health conditions and/or SUDs in several states, including Arizona, Louisiana, and Pennsylvania (Paradise and Ross 2017), and these housing interventions have shown reductions in total health care costs.[95] However, MaineCare could also consider a Section 1115 waiver demonstration that includes support for services that address social determinants of health. For example, CMS recently approved a waiver that will allow North Carolina to pilot interventions to address issues such as lack of housing and food insecurity.[96]

Another strategy that could increase the availability of critical community resources, such as affordable housing or public transportation, is using public-private financing partnerships, including pay for success approaches or community financing mechanisms, to pool resources. Under a pay for success contract, a private investor or group of investors would fund community resources that are integrated with clinical services or new recovery support services covered by MaineCare up front. For instance, the Denver Supportive Housing Social Impact Bond Initiative leveraged Medicaid reimbursement for behavioral and physical health care services, local and state housing resources, and funding from private investors to create a supportive housing program for 250 chronically homeless adults with mental health and SUD conditions.[97] The investor would be repaid, with interest, by the Maine government if certain outcomes were achieved, such as reduced SUD-related emergency department

visits and hospitalizations, days of incarceration, or foster care placements. If additional savings are achieved for the state and local governments, they can be reinvested to sustain these resources over the long term. To be successful, metrics for a pay for success contract will likely need to consider savings across systems, including health, criminal justice, and child welfare, and levels of government. The goal of the pay for success model is to secure upfront funding for promising programs, build strong evidence on intervention effectiveness, ensure public funds reward demonstrated outcomes, promote data sharing and cross-agency collaboration on strategic priorities, and identify cost-effective solutions.

2. **Expand SUD treatment capacity through training and mentoring programs for providers, expanding the scope of practice for midlevel practitioners, addressing obstacles to use of telemedicine/telehealth in MaineCare, and ensuring that reimbursements for different levels of care and services adequately stimulate growth in provider supply and meet the demand for care.**

The opioid crisis and growing demand for treatment have brought workforce challenges into focus, including training and recruiting new professionals into the addiction medicine field, as well as barriers primary care providers experience integrating MAT into their practices. A portion of expansion-related SUD savings could be redirected to workforce development strategies to support and train existing providers and attract new SUD treatment providers, including training on the provision of culturally and linguistically appropriate SUD care. In addition, several informants suggested that mentoring by other waivered buprenorphine prescribers could lead more health care professionals to obtain a waiver or increase prescribing for those already waivered. Some states have funded such mentoring programs or provided financial incentives to increase the number of waivered prescribers (Hinde et al. 2018). The hub-and-spoke model is promising for providing support to primary care providers (spokes) through specialized treatment providers (hubs),[98] such as OTPs, and has been associated with increased rates of waivered prescribers (Brooklyn and Sigmon 2017). Though midlevel practitioners may bill MaineCare for SUD services, including outpatient services and MAT, Maine could consider expanding the scope of practice for midlevel practitioners, such as by allowing licensed alcohol and drug abuse counselors to diagnose patients, as has been done in nearby Massachusetts, New Hampshire, and Vermont.[99]

MaineCare could address obstacles to use of telemedicine/telehealth for SUD treatment, including provision of buprenorphine treatment, to expand access to treatment to patients in rural and remote areas. For example, Washington State has implemented a telemedicine pilot, Flex Care, allowing patients in rural coastal Washington, who previously had no access to MAT for their OUD, to receive MAT via telehealth (SAMHSA 2018c). Similar initiatives have been implemented in Missouri and West Virginia (The Pew Charitable Trusts 2018). One informant reported that it may be challenging to

identify an appropriate Health Insurance Portability and Accountability Act–compliant platform for web-based visits that are compatible with any internet-ready device (i.e., devices that do not require Wi-Fi access). They also noted the difficulty of coordinating appropriate high-quality drug testing (e.g., saliva drug testing) and medication adherence (e.g., pill counts) via telehealth without strong guidance and support. Recent efforts at the US Department of Health and Human Services and the Drug Enforcement Administration have affirmed the federal government's commitment to expand buprenorphine-based MAT,[100] and under the SUPPORT Act, the federal government must release guidance to states within one year of the bill enactment to promote MAT treatment delivered via telehealth for Medicaid enrollees.[101]

Finally, MaineCare could invest in increasing SUD treatment provider capacity by increasing payment rates to providers of cost-effective, high-quality SUD treatment services and supports. For example, increased reimbursement rates for SUD treatment providers in Virginia led to substantial growth in both providers accepting Medicaid patients and the number of Medicaid members receiving SUD treatment.[102] MaineCare reimbursement levels to providers are perhaps the most important tool in ensuring adequate SUD treatment capacity, as recognized by recent and planned changes to reimbursements for some providers (e.g., opioid health homes and OTPs). MaineCare payment levels for some SUD services (e.g., residential care) are currently reimbursed at lower rates than comparable mental health services. Because stakeholders reported that treatment capacity is lacking for residential SUD treatment, MaineCare could incentivize increasing capacity by reviewing rules governing this treatment option and paying higher rates. Rate increases for residential SUD care could be accompanied by requirements to offer evidence-based treatments, including MAT, and a plan to measure residential care outcomes.

When considering value-based payment reforms, MaineCare could first evaluate whether provider payment rates sufficiently incentivize provider participation in MaineCare, including adequate capacity across all levels of services and treatments for MaineCare enrollees.[103] At the time of this study, the Maine legislature was considering a bill to establish a MaineCare reimbursement rate review process and the MaineCare Independent Rate Commission.[104]

3. **Promote methadone maintenance treatment at OTPs by addressing its stigma, aligning state counseling requirements in methadone maintenance treatment with federal regulations, expanding the role of experienced OTP providers in OUD treatment, and further increasing MaineCare OTP reimbursement rates to align with established benchmarks.**

Maine has recently taken steps to eliminate certain restrictions on methadone and buprenorphine maintenance treatments in MaineCare,[105] including prior authorization for treatment initiation and for continuation after 24 months of treatment.[106] Yet informant interviews suggest that MaineCare is not fully leveraging methadone maintenance treatment or OTPs to address the opioid epidemic. Reducing the stigma surrounding methadone maintenance treatment is likely a prerequisite to increasing its accessibility, as well as other treatment options. Public awareness campaigns, educating the health care workforce, family therapy and engaging family members in care, and community meetings have been cited as promising stigma-reduction strategies for SUD treatment (Woo et al. 2017). Maine could leverage and expand its Community Opioid Overdose Response ECHO project to educate communities about the effectiveness of methadone maintenance treatment and other evidence-based MAT in reducing opioid overdose deaths.[107]

Engaging OTPs to play a larger role in MaineCare's opioid health home program and supporting methadone maintenance treatment as a key piece of the OUD treatment landscape more generally may improve patient outcomes, as evidenced by other states' experiences.[108] State regulations for counseling requirements in methadone maintenance treatment could also be replaced with the federal counseling requirements, which informants felt were more consistent with high-quality care and would likely retain more patients in treatment.

Maine could also consider raising the reimbursement rates for methadone maintenance treatment. MaineCare's OTP reimbursement rates may not be sufficient to ensure adequate capacity for methadone maintenance treatment, a highly cost-efficient treatment approach for OUD. MaineCare's bundled payments for MAT provided by OTPs, at the new rate of $81.74 per patient per week, is, according to one key informant, "a great place to start, but we are definitely not where we need to be yet." The new rate is substantially lower than recent TRICARE cost estimates from the US Department of Defense for methadone treatment in an OTP (including medication and integrated psychosocial and medical support services with daily visits), which is $126 per patient per week (Department of Defense 2016).[109] The TRICARE rate is a recognized benchmark for OTP reimbursement and is used to determine new Medicare rates for OTPs.[110] One informant reported that MaineCare adopting the TRICARE rate at OTPs would help provide high-quality care, retain staff, and support the higher staff-patient caseload requirements that will go into effect in January 2020, particularly as OTPs in Maine are required to provide a higher level of counseling than per federal regulations (though this state requirement could be removed, as discussed above). The higher reimbursement rates would allow OTPs to hire and retain qualified staff that can provide a higher level of care, such as licensed clinical alcohol and drug counselors and certified clinical supervisors. A potential pay for success project to consider

would involve providing start-up funding to open new OTP clinics and/or supplement MaineCare OTP reimbursement.

Maine could also consider requiring OTPs to provide all three MAT medications—methadone maintenance treatment, buprenorphine maintenance treatment, and naltrexone pharmacotherapy—to effectively accommodate patients with varying needs and responsiveness to treatments. The share of clients at OTPs that receive buprenorphine maintenance treatment or naltrexone pharmacotherapy is lower in Maine than in Vermont, for example, particularly for buprenorphine maintenance treatment (SAMHSA 2018a).

4. **Promote evidence-based treatment for SUD among both health care providers and the public, including by disseminating information about all effective medication-assisted treatment options for alcohol use disorder and OUD and expanding coverage and access to evidence-based recovery supports and services. Greater dissemination of information is especially needed to promote methadone and naltrexone treatments, particularly long-acting injection naltrexone (also called XR-naltrexone), as accessible OUD treatment options for MaineCare enrollees.**

In addition to buprenorphine and methadone maintenance treatment, naltrexone treatment, and particularly long-acting injection XR-naltrexone, could be promoted as a treatment option for OUD in MaineCare, as evidence supports its efficacy, particularly as an alternative for patients with OUD receiving no pharmacotherapy. Though some informants reported that Mainers with OUD preferred Suboxone treatment to naltrexone treatment, many people with OUD do not receive any treatment, and some may not want buprenorphine or methadone maintenance treatment if offered it. Evidence suggests that XR-naltrexone is a good treatment option for some patients because it blocks both opioids' and alcohol's effects and helps maintain abstinence in highly motivated patients (Schuckit 2016). Naltrexone treatment has been shown to be far more effective than abstinence approaches and has similar outcomes to buprenorphine maintenance treatment if patients successfully initiate XR-naltrexone after 7 to 10 days of abstinence from opioids, which is a considerable hurdle for many patients (Lee et al. 2018). Naltrexone does not require special waivers to prescribe, and it is covered by MaineCare without restrictions.

There are efforts in Maine to expand the number and use of recovery coaches, but peer recovery coach services are not covered by MaineCare outside the opioid health home program. Expanding the MaineCare benefits package to include peer recovery coaches could ensure these efforts' long-term sustainability, and MaineCare could develop requirements and regulations to ensure that recovery

coaches and patient navigators promote evidence-based treatment. Several states have incorporated peer recovery support services in Medicaid,[111] as well as smart phone–based recovery supports.[112] Recovery coaches and technology could also be leveraged in a pay for success payment system to help meet provider quality targets, and the bonus payments could be structured to support the cost of recovery coaches and other evidence-based recovery interventions (London et al. 2018).

5. **Add SUD screening and referral requirements in primary care (including federally qualified health centers), emergency departments, critical access hospitals, psychiatric hospitals, and jails and prison systems for MaineCare beneficiaries, and provide training and support to providers. Require that a clinical tool be used by primary care and other providers to match patients to the appropriate level of SUD care, which could help with both under- and overutilization of residential or other types of care.**

MaineCare could require SUD screening in primary care as several other states do,[113] which could involve including SBIRT as a quality measure in the primary care case management payment incentive program and encouraging federally qualified health centers to implement SBIRT, because most centers already provide or link patients to specialty care and community resources. Identifying existing patients who have an SUD, including OUD, could help reduce stigma associated with SUD and SUD treatment and motivate primary care practices to offer MAT or develop referral relationships with waivered buprenorphine prescribers and specialized SUD treatment providers (Hinde et al. 2018). Hospitals are at the frontlines of dealing with drug-related overdoses and—in addition to ongoing efforts to implement buprenorphine induction in emergency departments and hospitals, including critical access and psychiatric hospitals—could screen all patients for SUD and provide brief intervention or refer patients to appropriate treatment. The screening and referral requirements could be extended to Maine jails and prisons, as a disproportionate share of the criminal justice–involved population has an SUD and/or OUD.

Development of new protocols, availability of evidence-based screening tools, training on protocols and tools, and support are necessary to overcome barriers for health care providers and hospital staff, including lack of both familiarity with screening tools and training on how to manage positive screening results. For example, Oregon designated SBIRT as an incentive measure for its Medicaid Coordinated Care Organizations (a program similar to Maine's Accountable Communities) and launched a website with SBIRT training materials and resources to support primary care providers and emergency departments in implementation.[114] The Massachusetts Bureau of Substance Abuse Services partnered with Boston University to train hospital staff and facilitate integration of SBIRT in emergency department care.[115] MaineCare could leverage its experience integrating primary and specialty care

through the health home programs and assemble and disseminate best practices and lessons learned on how to effectively implement screenings and establish referral and follow-up care processes. The state could also support establishing referral relationships among different providers and service organizations; for example, Colorado used funding from its State Innovation Model Initiative to develop the Regional Health Connectors program to facilitate connections between local clinical and community organizations (Caldwell 2018).

MaineCare could also require that primary care, behavioral health, SUD care, and other providers use a clinical tool to match patients to the appropriate level of care, which could help with both under- and overutilization of residential or other types of care. Many states use the ASAM criteria for evaluating the appropriate level of care for Medicaid enrollees seeking SUD services, and under Section 1115 Medicaid demonstration waivers, CMS requires that states implement evidence-based treatment guidelines, such as those published by ASAM.[116]

6. **Promote best practices among providers and at facilities that care for MaineCare-covered pregnant and postpartum women with an SUD, including universal screening and access to methadone and buprenorphine maintenance treatments for those with OUD.**

Pregnant women with an SUD and their infants are at high risk for poor maternal and infant health outcomes. MaineCare could support and incentivize primary care and hospital providers universally screening pregnant women for substance use and other risk factors and referring them to treatment (Wexelblatt et al. 2015). To improve outcomes for women and their children, MaineCare should also implement policies that ensure access to recommended MAT and other services during pregnancy and birth hospitalization and after pregnancy.

MaineCare could require that care for MaineCare-covered pregnant and postpartum women with an SUD be consistent with current best practices, including encouraging prenatal care providers to screen for SUD; providing or referring pregnant women to SUD treatment; and initiating maternal OUD treatment during birth hospitalization and continuing that treatment after hospital discharge through referrals to supports and services (SAMHSA 2018b).[117] MaineCare could also ensure that recommended perinatal hospital screenings are covered and reimbursed adequately, including for (1) use of tobacco, alcohol, and other drugs or a history of SUD or SUD treatment; (2) depression and anxiety; (3) trauma and violence; (4) infectious disease; (5) food or housing insecurity; and (6) safe living environments. MaineCare can also ensure that additional best practices regarding perinatal hospital care for women with OUD or an SUD, such as contraceptive counseling and methods (e.g., long-acting

reversible contraceptives) and breastfeeding support, which can decrease the need for infant pharmacologic therapy (Grossman et al. 2017), are covered and reimbursed adequately.

MaineCare could also require that all facilities that care for MaineCare-covered infants with NAS, including residential pediatric recovery centers, provide care consistent with current best practices, including decreased use of pharmacologic treatment for infants; use of effective nonpharmacologic treatments, such as breastfeeding and "rooming-in" (keeping the infant and mother together during the birth hospitalization); and decreased use of the neonatal intensive care unit (SAMHSA 2018b), which have all been associated with reduced hospital costs (Grossman et al. 2017; Holmes et al. 2016).

Finally, MaineCare could leverage the new SUPPORT Act provisions that permit Medicaid programs to pay for prenatal and postpartum care provided to women in SUD treatment at institutions for mental disease and health care services provided to infants born with NAS in residential pediatric recovery centers.[118]

7. **Use block grant SUD treatment funding to promote and provide all three medication-assisted treatments—methadone maintenance treatment, buprenorphine maintenance treatment, and naltrexone pharmacotherapy—in jails and prisons, and to engage MaineCare enrollees in evidence-based care, or support continuity of care, during incarceration.**

Maine's MAT pilots in jails and prisons are promising programs for providing needed SUD treatment to justice system–involved people. However, to improve postrelease outcomes, MaineCare could ensure that people have access to all three types of MAT, as has been done in Rhode Island.[119] Recent meta-analyses of all three MAT types delivered in correctional settings show that use of all types of MAT is associated with greater engagement in treatment and reduction in opioid use after release (Moore et al. 2019). Making all three MAT modalities available in Maine's correctional facilities would also optimize MaineCare's role in supporting the criminal justice system–involved population by facilitating continuity of care for this high-risk group if they are already on MAT when they become incarcerated and following reentry into the community. If methadone maintenance treatment is expanded as a treatment option in jails, adequate methadone maintenance treatment capacity and accessibility after release is critical.

8. **Enroll eligible people involved in the justice system in MaineCare and provide them with supports and services to address health and social needs upon release to minimize barriers to accessing needed services.**

As described earlier, processes for enrolling eligible people involved in the criminal justice system in MaineCare are being developed, but other states' experiences demonstrate that enrolling justice

system–involved people in Medicaid is often insufficient to ensure access to care and improve health outcomes (Jannetta et al. 2018). In addition to better linking MaineCare and the criminal justice system, it will be important to consider whether MaineCare is maximizing its funding of SUD treatment in drug courts or pretrial for eligible enrollees, which may reduce incarceration rates. Enrollment approaches for the justice system–involved population could include (1) providing dedicated call center services; (2) enhancing application assistance, such as providing discharge rosters and lists of drug court participants to the eligibility and enrollment assisters; and (3) identifying people with high medical needs to ensure MaineCare enrollment before release (Grady, Bachrach, and Boozang 2017).

Emerging strategies to facilitate access to health care and social services after release include (1) building data exchanges between jail or prison and community health care providers to facilitate timely "in-reach" and seamless transitions in care, including exchanging health information and medical records before release while protecting patient data confidentiality; (2) training primary care providers and specialists to work with justice system–involved people; and (3) linking people to housing and other social services after release, including using peer support specialists to help those reentering navigate health care and community resources (Guyer et al. 2019).

MaineCare could also assess whether covered services include all treatments and drug screening tests used by prebooking diversion programs and drug treatment court participants and could consider altering drug court tests to fit medically funded services if needed. Because many justice system–involved people may be eligible for MaineCare after expansion, if the benefit package includes all types of treatments, screens, and tests used by Maine's drug courts, federal matching funds can cover these services instead of other state, local, and federal funds, freeing up these resources for other purposes (Grady, Bachrach, and Boozang 2017).

9. **Redesign MaineCare prescription drug policies related to SUD treatment to promote wide distribution of naloxone to people at risk of overdose and their families and friends, including alternative formulations of naloxone (e.g., autoinjector) that are not widely available. MaineCare could also evaluate whether the current reliance on brand-name Suboxone products offers Medicaid enrollees the best treatment medication options at the best prices. MaineCare could promote use of less expensive buprenorphine generics, maximize the use of Medicaid prescription drug rebates, and consider wider use of alternative formulations, such as long-acting buprenorphine treatments.**

Even in the most recent data available from 2017, we found very few MaineCare-covered prescriptions for naloxone, a lifesaving medication that can reverse the effects of an opioid overdose (Boyer 2012).

Narcan nasal spray is preferred in MaineCare (Miller 2018). The auto-injector formulation of naloxone, Evzio, is nonpreferred in MaineCare and is likely not widely available. In addition, MaineCare could consider a generic version of Evzio that is expected to be available shortly (Facher 2018). Prescribing naloxone to MaineCare enrollees in formulations not readily available through other programs could be promoted by, for example, requiring that it be coprescribed to patients at high risk of overdose, per recently released guidelines from the US Department of Health and Human Services. Maine allows pharmacists to dispense naloxone by standing order without a prescription.[120] But because MaineCare coverage of naloxone could decrease out-of-pocket costs for enrollees for formulations that are not offered through free naloxone distribution programs, MaineCare could play an essential role in achieving adequate distribution of naloxone to people at risk of overdose and their family and friends. Access would be further enhanced by implementing a policy that would allow family or friends to obtain a naloxone prescription on behalf of a MaineCare member.

In addition, the brand-name drug Suboxone constitutes nearly all MaineCare-covered buprenorphine prescriptions for OUD in Maine, but generic buprenorphine prescriptions to treat OUD are much more common across all states.[121] MaineCare could review prescription drug coverage policies to ensure that generic drugs are available when appropriate (e.g., for new patients starting pharmacotherapy, not patients stable in recovery) and expand options for treatment medications at the best price. The state could also ensure that MaineCare maximizes Medicaid rebates in drug purchasing, including the drug manufacturer rebates through the Medicaid Drug Rebate Program,[122] rebates related to price increases greater than inflation (The Pew Charitable Trusts 2018), supplemental drug rebate pools, and additional rebates for innovator drugs.[123] In addition, MaineCare could consider promoting wider use of alternative formulations, such as long-acting buprenorphine treatments Sublocade (buprenorphine extended-release monthly injection) and Probuphine (buprenorphine extended-release six-month implant). These long-acting formations may be particularly helpful to patient populations with transportation and other treatment barriers.

10. **Lay groundwork for alternative payment models and value-based payments for substance use disorder treatment services in MaineCare by developing the necessary infrastructure at the state and provider levels.**

MaineCare payment methodologies and provider payment levels could be updated to support and incentivize quality, cost-effective, evidence-based SUD care. But to successfully do so, the state should consider increasing provider payment rates as discussed above, because a recent study showed that providers are reluctant to participate in value-based payment systems when they believe the Medicaid base payment rates are too low, leaving no room for risking part of the reimbursement (Marks et al.

2018). In addition, Maine should evaluate providers' readiness to adopt value-based payment arrangements, including having infrastructure at both state and provider levels to track and report outcomes to enable such payment models; key informants recounted that many SUD treatment providers currently lack time, resources, and technology to track and report metrics. Before experimenting with alternative payment approaches, MaineCare should address common barriers to adopting value-based payments, such as updates to technology and billing systems, provider training, and start-up funding so providers can make necessary practice changes or hire additional staff. A pay for success approach could provide access to up-front, start-up capital to help providers build data capacity to efficiently coordinate care and collect and report outcomes data.

To support a transition toward value-based payment models for SUD treatment, MaineCare could consider piloting pay for performance reimbursement, which builds on the fee-for-service structure by incorporating value-based incentives (or penalties) associated with meeting (or failing to meet) performance measures related to care quality, cost, and outcomes. Provider payments could be linked directly to specific quality indicators, with outcomes borrowed from already developed alternative payment models for addiction treatment, such as the share of patients who filled and used the medications prescribed to initiate treatment or the risk-adjusted average number of opioid-related emergency department visits per patient (ASAM 2018). MaineCare has already implemented similar outcomes-based approaches in the primary care case management and behavioral health home programs. For providers, pay for performance typically does not require as much technology and assumption of financial risk as other alternative payment models, so it could help providers develop the necessary systems and processes that could later support adopting more sophisticated value-based payment approaches, such as those in New York's Medicaid program.[124]

Recommendations for Further Research

As part of our expedited review, we identified important gaps in knowledge around SUD prevalence in Maine, the state's SUD treatment delivery system, and MaineCare SUD coverage and payment policies that could inhibit policymakers and other stakeholders in Maine as they try to combat the opioid epidemic and improve outcomes for MaineCare enrollees with OUD or other SUDs. High-priority analyses that could be carried out with minimal new data collection include the following:

1. Though informants identified treatment capacity as a critical barrier to care, no detailed assessment has evaluated Maine's current treatment capacity across the ASAM spectrum or for the full range of evidence-based treatment; information was also lacking on how MaineCare

reimbursements affect providers' capacity to serve MaineCare patients and provide access to evidence-based SUD treatment and supports.

2. Though many stakeholders promote buprenorphine treatment in Maine, little is known about the outcome and spending trajectories for MaineCare enrollees receiving MAT. What is the association between treatment/retention and key outcomes, such as health care spending, emergency department visits, and hospitalizations, among different subgroups (e.g., adolescents, pregnant women) of MaineCare enrollees receiving MAT by treatment type?

3. Estimates based on Maine data suggest that a substantial share of MaineCare enrollees who need treatment for SUD do not receive it.[125] But what share of MaineCare enrollees get screened for SUD in primary care, are referred to treatment, and receive treatment is unknown, and barriers and facilitators to implementing these services more widely have not been identified.

4. Despite the importance of providing evidence-based care for pregnant women with OUD and their infants at risk for NAS, because of high health and social risks and the high cost of care, little or no information is available on how many pregnant and postpartum women with OUD and infants with NAS in MaineCare get recommended care.[126]

5. Though the risk of overdose death is very high for people with OUD after release from incarceration, these risks are dramatically decreased for those receiving MAT, particularly methadone maintenance treatment. However, no systematic assessment has evaluated the barriers and facilitators to (1) implementing all three evidence-based OUD treatment medications in Maine jails and prisons; (2) continuity of care, including hand-off to community providers; and (3) supports and services after release.

6. An estimated two-thirds or more of people involved with the criminal justice system in Maine need SUD treatment, but it is unclear whether MaineCare is leveraging the opportunities to enroll and provide evidence-based care and support services to justice system–involved populations.[127]

Conclusion

Maine is facing a crisis of SUD-related morbidity and mortality. The MaineCare expansion positions the program to be the state's primary payer for SUD treatment services and thus Maine's most important tool to address substance use. However, achieving maximum benefit from the MaineCare expansion

will require addressing challenges described in this report, including provider shortages and payment rates and methodologies that do not incentivize optimal care. In addition to the current emergency department initiative to engage patients with OUD in buprenorphine treatment, other policies are necessary to promote SUD screening and treatment initiation. These policies could (1) offer a range of evidence-based treatment choices at critical junctures (e.g., during primary care visits, involvement with the criminal justice system, or birth or other hospitalization); (2) address stigma and barriers to methadone maintenance treatment; and (3) increase use of generic and long-acting formulations of buprenorphine/naloxone products for treating enrollees with OUD, which could improve the effectiveness and efficiency of SUD treatment in MaineCare. By investing in these areas, MaineCare can leverage its critical role in supporting the development of a treatment delivery system that works best for enrollees, improving their health and well-being while making the most of available state and federal funds.

Notes

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98 For example, Vermont developed a hub-and-spoke model as part of its opioid health home program, which includes OTPs, or hubs, that serve more clinically complex patients and office-based opioid treatment providers, or spokes, that focus on less complex patients. The hub-and-spoke model allows OTPs to focus on high-need, clinically complex patients who are on methadone treatment or buprenorphine; more stable, low-risk patients are diverted to spoke providers who administer buprenorphine (Clemans-Cope, Wishner, et al. 2017).

99 "Map of State Policies," Scope of Practice Policy, accessed June 7, 2019, http://scopeofpracticepolicy.org/map-state-policies/.

100 "Telemedicine and Prescribing Buprenorphine for the Treatment of Opioid Use Disorder," US Department of Health and Human Services, accessed June 7, 2019, https://www.hhs.gov/opioids/sites/default/files/2018-09/hhs-telemedicine-hhs-statement-final-508compliant.pdf.

101 Substance Use–Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, H.R. 6, 115th Cong. (2018).

102 Virginia increased Medicaid reimbursement rates for SUD treatment providers who follow research-guided treatment as part of their Addiction and Recovery Treatment Services launched in April 2017, which also expanded benefits such as for detox, residential treatment, and peer supports; see "1115 Demonstration Extension Application," Virginia Department of Medical Assistance Services, accessed June 7, 2019, http://www.dmas.virginia.gov/files/links/1803/Virginia%201115%20Waiver%20Application%209.19.2018%20final%20for%20comment%20v2.pdf. Payment in Virginia's Addiction and Recovery Treatment Services demonstration was increased so that Medicaid rates equaled or exceeded commercial insurers' rates; Medicaid rates were increased by 50 percent for SUD case management and quadrupled for SUD partial hospitalization, intensive outpatient services, and the counseling component of MAT (MACPAC 2017). An independent evaluation found that in the first year of the Addiction and Recovery Treatment Services demonstration, the number of outpatient SUD treatment providers billing Medicaid increased by 173 percent, including 848 buprenorphine prescribers treating Medicaid enrollees with OUD, and enrollees receiving SUD treatment services increased by 57 percent compared with the previous year. Other states have recently enhanced Medicaid SUD treatment provider payment rates to increase access to substance use treatment for Medicaid enrollees, including Idaho (Antonisse, Rudowitz, and Gifford 2018), New Jersey (see "Governor Christie Announces Expansion of Behavioral Health Homes," State of New Jersey Office of the Governor, April 7, 2016,

https://dspace.njstatelib.org/bitstream/handle/10929/43158/GovernorNewsroom20160407_3.pdf?sequence=1&isAllowed=y.), and Washington.

[103] The Medicaid and CHIP Payment and Access Commission recently published a framework for evaluating Medicaid provider payment policy (MACPAC 2015).

[104] Legis. Doc. 1288, 129 Leg., 1st Spec. Sess. (Me. 2019).

[105] Scott Thistle, "Supplemental Budget Supports Medication-Assisted Treatment for Substance Use Disorder," CentralMaine.com.

[106] "Initial Methadone Treatment Authorization Form," MaineCare, accessed June 7, 2019, https://mainecare.maine.gov/Provider%20Forms/Authorizations%20and%20Referrals/MTC%20Entry%20Form_Updated.pdf; "Request for Continued Methadone Treatment," MaineCare, accessed June 7, 2019, https://mainecare.maine.gov/Provider%20Forms/Authorizations%20and%20Referrals/MTC%20Continued%20Stay%20Form_Updated.pdf.

[107] "Northern New England Practice Transformation Network: Community Opioid Overdose Response (COOR) ECHO in Maine," Maine Quality Counts, accessed June 7, 2019, http://mainequalitycounts.org/wp-content/uploads/2018/11/COOR-ECHO-Infographic.pdf.

[108] Other states have done more to leverage experienced methadone maintenance treatment providers at OTPs to address the opioid epidemic. Medicaid opioid health homes in Maryland, Rhode Island, and Vermont have placed experienced OTP treatment providers as the hubs of their opioid health home programs and have leveraged relationships and trust between OTP providers and patients with promising outcomes (Clemans-Cope, Wishner, et al. 2017). The University of Vermont's recent study of the Medicaid SUD health home model, which uses OTPs as hubs and office-based opioid treatment as spokes, found positive impacts for participants, including significant reductions in opioid, alcohol, and other illicit drug use; reductions in emergency department visits; and fewer police stops, arrests, and reported days of illegal activity (Rawson 2017).

[109] TRICARE; Mental Health and Substance Use Disorder Treatment, 81 Fed. Reg. 32 61068 (Sept. 2, 2016) (codified at 32 CFR 199). This rate is scheduled to be updated annually using the Medicare update factor used for other mental health care services under TRICARE (i.e., the Inpatient Prospective Payment System update factor). "The daily projected per diem costs ($18/day) will be converted to a weekly per diem rate of $126 ($18/day × 7 days) and billed once a week to TRICARE using the Healthcare Common Procedure Coding System code H0020, 'Alcohol and/or drug services; methadone administration and/or service'" (Department of Defense 2016).

[110] COMBAT Act of 2018, H.R. 5080, 115th Cong. (2018).

[111] Virginia used the Section 1115 waivers to implement recovery peer support services in its Medicaid program; see "1115 Demonstration Extension Application," Virginia Department of Medical Assistance Services. Maine could consider other models and strategies for expanding recovery supports. For example, Vermont finances community health teams, with recovery coaches and other preventive services, by charging health insurers an assessment fee of $17,500 per 1,000 members; see "Budget Document: State Fiscal Year 2016," Department of Vermont Health Access, Agency of Human Services, accessed June 7, 2019, http://dvha.vermont.gov/budget-legislative/sfy201602042015.pdf. Preliminary findings suggest that Vermont's program has improved care and reduced enrollee costs (Bielaszka-DuVernay 2011).

[112] In Kansas, Medicaid is piloting recovery support through the Addiction-Comprehensive Health Enhancement Support System, a smart phone application that helps patients with an SUD maintain treatment and recovery goals through connections with treatment providers and support groups. See "Health Plan Highlights for 2019," KanCare, accessed June 6, 2019, https://www.kancare.ks.gov/docs/default-source/consumers/choosing-a-plan/2019-vas-final-long-version-for-website---english-10-09.pdf?sfvrsn=b8224d1b_8.

113 For example, Indiana, Maryland, Minnesota, and Ohio use initial health screens to identify new enrollees who are receiving treatment or counseling for SUD, mental health, or other behavioral health issues (Center for Health Care Strategies 2009).

114 "SBIRT Oregon," Oregon Health & Science University, accessed June 7, 2019, https://www.sbirtoregon.org/.

115 "Massachusetts ED SBIRT Initiative," Boston University School of Public Health BNI ART Institute, accessed June 5, 2019, http://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-hospital-emergency-department/.

116 Brian Neale, "Re: Strategies to Address the Opioid Epidemic," Centers for Medicare & Medicaid Services, November 1, 2017, https://www.urban.org/sites/default/files/publication/99479/navigating_work_requirements_in_safety_net_programs_0.pdf.

117 "Obstetric Care for Women with Opioid Use Disorder," Council on Patent Safety in Women's Health Care, accessed June 5, 2019, https://safehealthcareforeverywoman.org/patient-safety-bundles/obstetric-care-for-women-with-opioid-use-disorder/.

118 Substance Use–Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, H.R. 6, 115th Cong. (2018).

119 In 2016 and 2017, Rhode Island's corrections facilities started offering methadone, buprenorphine, and naltrexone to incarcerated people with OUD, depending on the medication deemed most appropriate, and the outcomes showed a dramatic decrease in overdose deaths among recently incarcerated people (Green et al. 2018). Connecticut also has programs to offer MAT options. A recent meta-analytic summary of MATs delivered in correctional settings supports the use of methadone, buprenorphine, and naltrexone in MAT, showing that access to all three types of MAT increased treatment engagement and reduced opioid use after release (Moore et al. 2019). Evidence was particularly strong for methadone treatment because of many randomized controlled trials with methadone maintenance treatment, and buprenorphine and naltrexone studies, though less common, were also promising.

120 "About PDAPS," Legal Science LLC, accessed June 6, 2019, http://pdaps.org/about.

121 "Tracking Medicaid-Covered Prescriptions to Treat Opioid Use Disorder," Urban Institute.

122 Brian Neale, "Re: Strategies to Address the Opioid Epidemic," Centers for Medicare & Medicaid Services.

123 "State Prescription Drug Resources," Medicaid.gov, accessed June 5, 2019, https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/index.html; "Medicaid Drug Rebate Program," Medicaid.gov, accessed June 5, 2019, https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html.

124 New York's Medicaid program has undertaken value-based payment reform with different options for providers and managed care organizations to transition to value-based payment arrangements, started under the Delivery System Reform Incentive Payment program, part of a 1115 waiver demonstration (New York State Department of Health 2017). New York Medicaid intends for 80 percent of Medicaid payments to be value based by the end of fiscal year 2020 (Johnson, Kahn, and Friedman 2018). Policy options are described in the state's value-based payment resource library, available at https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/.

125 "2016–2017 NSDUH State-Specific Tables," Substance Abuse and Mental Health Services Administration, accessed June 7, 2019, https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables.

126 This could include an analysis of (1) the care provided to MaineCare-covered pregnant and postpartum women with OUD and other SUDs and infants with NAS using birth records and Medicaid claims data—including the timing of OUD/SUD diagnoses, timing and duration of appropriate treatment, subsequent infant and maternal

outcomes, and health care costs—combined with assessments of how much hospitals use evidence-based protocols and clinical guidelines when caring for women with OUD and their infants; (2) practitioner's suggestions on how to improve quality of care and outcomes for women and their children to foster stakeholder buy-in and consensus; and (3) adoption of and adherence to evidence-based practices.

[127] This could include a qualitative study of barriers and facilitators to enrolling eligible justice system–involved people in MaineCare and providing people with supports and services to address health and social needs upon release, during pretrial, and/or during probation or parole.

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