An Act To Save Lives by Establishing the Low Barrier Opioid Treatment Response Program

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, opioid use disorder has reached epidemic proportions and threatens the lives and well-being of many Maine residents; and

Whereas, existing modalities and strategies for treatment of opioid use disorder are insufficient to end the epidemic of this disorder in Maine; and

Whereas, existing services are especially inadequate to address the impact of opioid use disorder on those experiencing or having experienced unstable housing, minimal or no employment, unreliable transportation, lack of insurance coverage, use of multiple substances, frequent hospitalization or prior overdoses; and

Whereas, failure to provide timely treatment to those most at risk of overdose death from opioid use leads to unnecessary loss of life and tragic dislocations of family life, while imposing substantial additional costs on the State due to related increases in incarcerations, hospital admissions and foster care for children affected by parental use of opioids; and

Whereas, a low barrier, rapid access treatment system delivered and coordinated by Maine's community health centers will provide an essential component of an improved array of responses to this epidemic; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore,

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 22 MRSA §259, sub-§1, ¶B, as amended by PL 2015, c. 267, Pt. JJJ, §1, is further amended to read:

B. Six hundred ninety-nine thousand, one hundred fifty dollars in fiscal year 2001-02 to federally qualified health centers to support the infrastructure of these programs in providing primary care services to underserved populations. Forty-four thousand, two hundred fifty dollars must be provided to each federally qualified health center with an additional $8,850 for the 2nd and each additional site operated by a federally qualified health center. For the purposes of this paragraph, "site" means a site or sites operated by the federally qualified health center within its scope of service that meet all health center requirements, including providing primary care services, regardless of patients' ability to pay, 5 days a week with extended hours. If there is not sufficient funding to meet the formula in this paragraph, the $699,150 must be allocated in proportion to the formula outlined in this paragraph; ~~and~~

Sec. 2. 22 MRSA §259, sub-§1, ¶C, as enacted by PL 2015, c. 267, Pt. JJJ, §1, is amended to read:

C. Five hundred thousand dollars, beginning with fiscal year 2015-16 and continuing each fiscal year thereafter, to support access to primary medical, behavioral health and dental services to residents of the State in rural and underserved communities and to assist with provider recruitment and retention. Twenty-five thousand dollars must be provided to each federally qualified health center.; and

Sec. 3. 22 MRSA §259, sub-§1, ¶D is enacted to read:

D. Four hundred thousand dollars, beginning with fiscal year 2019-20 and continuing each fiscal year thereafter, to support pilot implementation and operation of the Low Barrier Opioid Treatment Response Program established in section 2354, to be allocated by the department to those federally qualified health centers approved to participate in the pilot and subsequent implementation. The funds provided pursuant to this paragraph are in addition to and do not alter or amend the purposes or the allocation of the funds provided pursuant to paragraph C.

Sec. 4. 22 MRSA §2354 is enacted to read:

§ 2354. Low Barrier Opioid Treatment Response Program

1. Program establishment. The Low Barrier Opioid Treatment Response Program, referred to in this section as "the program," is established in the department to provide resources for federally qualified health centers, referred to in this section as "community health centers," to develop and deploy low barrier, rapid access treatment models to treat opioid use disorder. The program must provide low barrier, rapid access to treatment for those persons typically unable to obtain timely treatment and at greatest risk of opioid overdose, including but not limited to persons affected by unstable housing, minimal or no employment, unreliable transportation, use of multiple substances associated with addiction or chronic overuse, frequent hospitalization, prior overdoses or a lack of health insurance coverage for substance use treatment services.

2. Program components. The program must include:

A. Support for clinic infrastructure to reduce barriers to access to treatment, including incentives for community health centers to support additional qualified providers in obtaining waivers to provide medication-assisted therapy services and support for each community health center to identify and compensate an individual within that community health center to help implement the program;

B. Support for community health centers to incentivize providers to accept increased call responsibilities and to see greater numbers of patients with opioid use disorders;

C. A statewide program of anti-stigma training that includes providers, staff and community health center patient-led boards;

D. Support for the development and implementation of a standardized induction practice across all participating community health centers;

E. Increasing the availability of naloxone hydrochloride to community health centers and training community health center personnel on the emergency administration of naloxone hydrochloride; and

F. Strategies to increase the number of providers willing to issue prescriptions for medication-assisted therapy services in a manner that facilitates rapid access to treatment.

3. Implementation; pilot. The department shall initially implement the program as a pilot project and shall subsequently expand the program to all community health centers in accordance with this subsection.

A. The pilot project must be operated by at least 3 community health centers selected on the basis of applications demonstrating interest in implementing the program and capacity to implement the program. The department shall strive to approve applications of community health centers of varying sizes and as geographically diverse as practicable given the pool of applicants. The department may phase in selected elements of the program over the course of the pilot project. Community health centers participating in the pilot project shall collect information on and report to the department the number of patients served in the program and, for each patient served:

(1) Emergency department utilization and hospital admissions;

(2) Time elapsed between first patient encounter and delivery of services in the program; and

(3) Any other outcome and quality indicators that the department may specify after consultation with participating health centers, without duplicating other existing reporting requirements.

B. After review of the data reported during the pilot project, the department shall expand the program to include all community health centers, on a schedule and with such financial support as the department determines to be appropriate and sufficient to address the statewide need for the program.

4. Reimbursement. The department shall modify and supplement the reimbursement of community health centers provided under section 3174-V to the extent necessary to implement this section.

5. Rules. The department shall adopt routine technical rules pursuant to Title 5, chapter 375, subchapter 2-A to implement the provisions of this section.

Sec. 5. Review of barriers. In conjunction with review of the reports provided pursuant to the Maine Revised Statutes, Title 22, section 2354, subsection 3, paragraph A, the Department of Health and Human Services and representatives of federally qualified health centers shall examine the extent to which existing structures for reimbursement and delivery of services by federally qualified health centers and other providers may hamper or facilitate access to opioid use disorder treatment and develop proposed changes to address identified barriers, reduce unnecessary costs and enhance coordination between other providers and federally qualified health centers in serving persons at risk of opioid overdose. The

department, with input from providers, shall present a report with the findings under this section to the Joint Standing Committee on Health and Human Services no later than January 15, 2020. The report must address the effectiveness of the implementation of the pilot project established pursuant to Title 22, section 2354, subsection 3, the schedule for full implementation and the extent of any additional funding needed to accomplish full implementation.

Sec. 6. Appropriations and allocations. The following appropriations and allocations are made.

HEALTH AND HUMAN SERVICES, DEPARTMENT OF

Community Health Center Investment Fund

Initiative: Provides funds to establish and implement a pilot project for a low barrier, rapid access treatment program for opiate use disorder and other substance use disorders to be delivered by Maine's federally qualified health centers under the department's direction and in collaboration with other health care providers, with funds in addition to Medicaid reimbursement distributed to health centers pursuant to the Maine Revised Statutes, Title 22, section 259.

GENERAL FUND	**2019-20**	**2020-21**
All Other	$400,000	$400,000
GENERAL FUND TOTAL	$400,000	$400,000

Emergency clause. In view of the emergency cited in the preamble, this legislation takes effect when approved.

SUMMARY

This bill requires the Department of Health and Human Services to establish the Low Barrier Opioid Treatment Response Program in Maine's federally qualified health centers to improve the availability of medication-assisted treatment and enhance the effectiveness and sustainability of acute care responses to persons in urgent need of treatment for substance use disorders, including opioid use disorder. The department is required to implement the program on a pilot basis initially and expand the program statewide after reviewing initial outcomes of the pilot.

It also directs the department and representatives of federally qualified health centers to examine the extent to which existing structures for reimbursement and delivery of services by federally qualified health centers and other providers may hamper or facilitate access to opioid use disorder treatment and develop proposed changes to address identified barriers, reduce unnecessary costs and enhance coordination between federally qualified health centers and other providers serving persons at risk of opioid overdose. The department is required to report findings on these subjects and on initial pilot implementation of the Low Barrier Opioid Treatment Response Program to the Joint Standing Committee on Health and Human Services no later than January 15, 2020.