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Henry Skinner, MD
President, Maine Association of Psychiatric Physicians
Thursday February 21, 2019

Good afternoon Senators Breen and Gratwick, Representatives Gattine and Hymanson, and distinguished members of the Joint Committee on Appropriations and Financial Affairs and Health and Human Services. My name is Henry Skinner, M.D. and I am grateful for your consideration of my testimony in support of The Supplemental Budget. While I am Chief Medical Officer of Tri-County Mental Health Service and Chair of Psychiatry at Central Maine HealthCare, I address you today in my role as President of the Maine Association of Psychiatric Physicians.

Everyone has their own sense of how the Government should spend taxpayer money. I think "efficiently" is at the top of many people's list. Now where is this more important than in the largest department, DHHS. Unfortunately, I think that Maine lacks a "system" of behavioral health care. Rather, we have a hodgepodge of services and programs. One of the most constructive activities of the waning days of the previous administration was to contract for a review of Children's Behavioral healthcare services, which was fulfilled capably by Public Consulting group (PCG). The advocacy of Disability Rights Maine was instrumental in bringing this to fruition. I am hoping that the Department will also see fit to conduct a similar review of Adult Behavioral Health Services (including mental health, substance abuse and developmental disabilities services) and develop a comprehensive and integrated strategic

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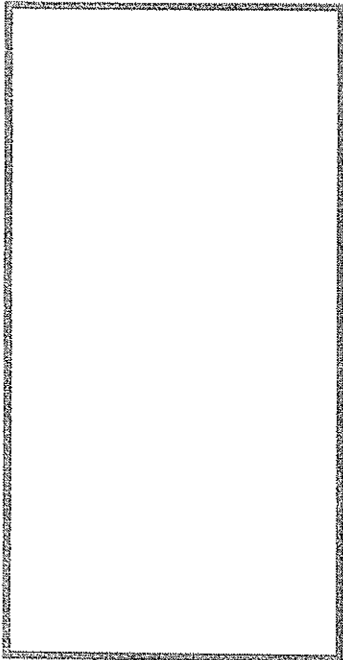

plan for efficiently and effectively delivering the right kinds of services to the right kinds of people. It would be well worth the investment.

Please keep in mind that behavioral health interventions don't just help Mainers feel better. They help Mainers participate better in themselves, their families, and in the economy. They become better students, better parents, and better employees.

Thank you very much for your consideration of these points in everything you do to make Maine "The Way it Should Be."

Dr. Skinner

Maine Medical Association

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Distributed to the Joint Standing Committees on Appropriations & Financial Affairs and

Health & Human Services

in support of

Part B of LR 2406, the Governor's SFY 2019 Supplemental Budget Proposal

by the Maine Medical Association on behalf of Mark Publicker, M.D.

2/21/19

ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

Proven Clinical and Cost Effectiveness of Medications to Treat Opioid Use Disorder

Key Points

- Physicians have classified opioid use disorder as a chronic disease.
- The FDA has approved three medications for opioid use disorders: methadone, buprenorphine, and naltrexone.
- All three medications have undergone rigorous FDA trials and are proven to be effective in treating opioid use disorder.
- At adequate doses, these medications block the "high" of taking opioids.
- Studies have clearly shown that methadone and buprenorphine are cost-effective.
- While no cost-effectiveness studies have been performed on injectable naltrexone, preliminary cost analysis studies justify further research.

While all three medications are both clinically and cost effective for the treatment of opioid use disorders, research has found they are underutilized in American healthcare.

The opioid epidemic is one of the most important problems facing our country's citizens and our nation's budget. Overdose deaths are now comparable to the number of deaths caused by motor vehicle crashes, and the societal costs of opioid misuse is estimated to be above $55 billion per year.

Over the past few decades, physicians and researchers have classified addiction as a chronic disease identified by a cluster of cognitive, behavioral and physiological symptoms. As with other chronic diseases, medication can be an important component of a treatment regimen.

The FDA has approved three medications for the treatment of opioid use disorder: methadone, buprenorphine, and naltrexone. Despite the growing opioid epidemic, these medications remain underutilized, which raises two important questions:

1. Are these medications clinically effective for people with opioid use disorder?
2. Is the use of medication as a component of treatment financially pragmatic for treating opioid use disorder?

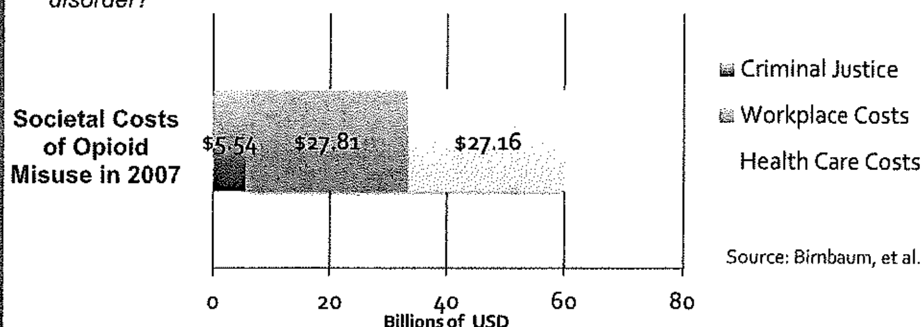
A recent comprehensive review of the literature found that the answer to both these questions is unequivocally – YES.

The review by the Treatment Research Institute showed that the use of these medications for the treatment of opioid use disorder is both clinically and cost effective.

CLINICAL EFFECTIVENESS

Methadone: Methadone, the most thoroughly researched medication, blocks the "high" of taking opioids, suppresses withdrawal symptoms and curbs cravings.

Methadone has been clinically proven to reduce opioid use more than (1) no treatment, (2) outpatient treatment without medication, (3) outpatient treatment with placebo medication, and (4) detoxification only. Additionally, methadone has proven to reduce several opioid use related health problems, including HIV/AIDS and is associated with decreased use of more intensive medical services, such as utilization of Emergency Department and inpatient hospital services.



Proven Clinical and Cost Effectiveness of Medications to Treat Opioid Use Disorder

Buprenorphine: Buprenorphine and methadone have similar track records of success for treating opioid use disorder. Like methadone, buprenorphine also blocks the "high" of taking opioids, suppresses withdrawal symptoms and curbs cravings.

Buprenorphine treatment provides two key benefits over methadone: there is less risk of overdose from buprenorphine, and it can be prescribed in a physician's office rather than through a specialized treatment center.

Naltrexone: The newest of the three medications, naltrexone, can be taken orally (daily) or extended release injection (monthly). Like methadone and buprenorphine, naltrexone binds to opioid receptors in the brain, blocking a patient's ability to get "high" from opioids. Unlike methadone or buprenorphine, however, naltrexone does not produce euphoria even when not given at adequate dose; it has no withdrawal symptoms or abuse potential. Naltrexone is also approved by the FDA as a treatment for alcohol use disorder. While naltrexone's effectiveness is clear, its oral version has low retention rates, and its depot injection is the most expensive of the opioid use disorder medications. Further, no studies of injectable naltrexone's cost effectiveness have yet been performed.

COST EFFECTIVENESS

Research has shown that methadone and buprenorphine are both cost-effective interventions for the treatment of opioid use disorder; compared to other opioid treatment interventions, these medications result in greater improvements at a lower overall cost as well as reduced medical costs related to reductions in hospital inpatient and emergency department visits.

Methadone: The most thoroughly researched drug for opioid use disorder. Various studies have shown clinically and statistically significant reductions in opioid misuse and opioid use-related incidence of infectious diseases and crimes with averted costs ranging from two to four times the costs of methadone per year. A 2008 study showed that reductions in robbery alone justified the costs associated with outpatient methadone treatment (Basu et al., 2008). However, it must be stressed that cost-offsets for methadone pertain to its use for longer term maintenance therapy, as it does not have long-term benefit when used for detoxification only.

Buprenorphine: Fewer cost-effectiveness studies have been completed on buprenorphine to date. Buprenorphine-naloxone direct medication costs can be hundreds of dollars a month versus anywhere from $0.50 to $2.50 per dose for methadone. However, the clinical effects of the two medications on reductions of opioid misuse and opioid use-related health and social problems are quite comparable. An Australian Treatment Outcome Study (ATOS; Ross et al., 2003; Shanahan et al., 2003) showed that two-years of maintenance costs approximately $5,000 as compared to $11,000 for residential rehabilitation and $52,000 for prison.

Naltrexone: Due to its relatively recent FDA approval (2010), extended release, injectable naltrexone is the least studied of the three medications. Oral naltrexone is inexpensive, but high patient attrition rates are common. Injectable naltrexone, on the other hand, shows promise in cost-analysis studies, but no cost-effectiveness studies have been conducted yet. Injectable naltrexone is also the most expensive of these medications, at approximately $700 per monthly dose.

POLICY IMPLICATIONS

Opioid use disorder has reached epidemic levels in the United States. Since 1990, there has been exponential growth in opioid-related hospitalizations, overdoses, and deaths. Medications for the treatment of opioid use disorder have proven to be both clinically and cost-effective, but are seriously underutilized despite epidemic growth in the number and severity of opioid-related deaths. Better physician training and more facilitative policies for medication for the treatment of opioid use disorder could reduce mortality with substantial cost savings.

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Medications for the Treatment of Opioid Use Disorder: Public/Private Policies

Key Points

- Overdose rates from opioid pain relievers are now at an epidemic level.
- Non-medical use of opioid pain relievers cost US health insurers approximately $55 billion annually.
- Systematic barriers including 'fail first', non-evidence based dosage limitations, and arbitrary prior authorization requirements serve to limit access to life saving medications.
- There is an overwhelming need for medications for the treatment of opioid use disorder however federal regulations limit qualified physicians from providing these desperately needed services.

A recent study finds that dosage/duration limitations, prior authorization, prescription limitations, lack of coverage, and utilization management policies limit accessibility to medication for the treatment of opioid use disorder.

Use of illegal opioids such as heroin and the non-medical use of certain prescription opioid pain medications, such as oxycodone, have risen to epidemic levels, with rates continuing to soar. Deaths from opioid overdose have tripled since 1990 and are now comparable to deaths resulting from motor vehicle accidents in persons under age 65 (Centers for Disease Control, 2011).

Additionally, in 2010, DAWN estimated that approximately 2.3 million emergency room visits resulted from drug misuse or abuse; 51 percent involved nonmedical use of pharmaceuticals.

FDA approved medications for the treatment of opioid use disorder, including methadone, buprenorphine and naltrexone are effective, safe and cost-effective yet continue to be underutilized and inaccessible under both Medicaid and private insurance.

Systematic implementation of medications for the treatment of opioid use disorder will reduce the risk of death from opioid overdose, lower the rates of diseases associated with intravenous drug use, and lower health plan and societal costs.

Further, the American Society of Addiction Medicine 2013 surveys found that access to these lifesaving medications is hampered by multiple barriers.

WHAT ARE THE BARRIERS TO THESE LIFE SAVING MEDICATIONS?

In both the public and private insurance markets payers have enacted time consuming and often dangerous utilization management barriers with little to no medical basis.

Polices such as "Fail First" (also referred to as "Step Therapy"), complex prior authorization requirements and dosage limitations serve to prevent patients from full access to methadone, buprenorphine and naltrexone. Further, provider prescribing restrictions including limits on numbers of patients and prior authorization further prevent these lifesaving medications from full utilization.

Dosage/Duration Limitations: Both public and private insurance providers frequently employ dosage and/or duration limitations when covering medications for the treatment of opioid use disorder that may not correspond to clinically recommended dosages of the medication. Further, in some cases, public insurance has placed lifetime limitations on these medications – unlike other lifesaving medications, with one northeast state establishing a 24 month lifetime limit for methadone.

Additionally, 11 states have implemented lifetime limits on prescriptions for buprenorphine, and a total of 14 states have established a maximum daily dose of buprenorphine after six months or more of therapy, ranging from 8 to 16 mg. These dosage limitations seem to have no medical basis and do not correspond to established clinical guidelines for the safe usage of buprenorphine. Further, sharp dosage limitations for buprenorphine may result in serious medical effects including miscarriages among pregnant women. Because dose limitations are frequently below the FDA-approved range, it is unclear whether they are safe and effective.

Prior Authorization: Prior authorization requires that a patient meet various criteria (as verified by their prescriber) in order for prescriptions to be approved. Such criteria vary between states and private insurers and can range from requirements for counseling to "active participation in a comprehensive rehabilitation program that includes psychosocial support." While counseling and/or psychosocial intervention combined with medication has been found to be extremely beneficial to those suffering from opioid use disorders, insurers have increasingly required such services while failing to provide coverage for such treatments concurrently with use of medications. The health plans' policies for coverage are not often easily available to the prescriber or patient. Additionally, once approved prior authorizations often are subject to time limitations on the use of the medication, such as 3 months. Unlike medications for other chronic conditions, prior authorization requirements are common among medications for the treatment of opioid use disorder and often require days or weeks for approval, while patients remain at-risk for relapse, overdose or death.

Prescribing Limitations: In addition to barriers that prevent patient access to both information and medications, practitioners are also burdened with additional federal prescribing restrictions that are only applied to medications for the treatment of opioid use disorder. Under DATA 2000, physicians must be trained to become qualified; only qualified physicians are permitted to prescribe buprenorphine for the treatment of opioid use disorder once they meet certain criteria. Once that criterion is met, however, prescribers are limited to treating only 100 patients (Drug Addiction Treatment Act of 2000). In a recent survey, 43% of DATA-waived ASAM members reported the 100-patient prescribing limit as a barrier to treatment.

Lack of Coverage: Methadone may be provided for the treatment of opioid dependence only through a licensed specialty treatment program. Many public and private health plans exclude coverage for this life-saving treatment, neglecting to offer a needed level of care for treating opioid use disorder. Further, benefit classification can present significant barriers as well. Naltrexone, for example, is often covered as a medical benefit rather than a prescription benefit, which results in significant coverage issues for both patients and providers

Fail First: Fail First requires that a patient attempt (and presumably fail) less costly therapies prior to receiving coverage for a targeted medication. While matching patients with appropriate medications is extremely important, written utilization management and/or drug utilization review committee notes often show primarily financial, rather than quality management or patient life-saving concerns as justification for use of Fail First policies.

POLICY IMPLICATIONS

As the Affordable Care Act rolls out in 2014, millions of previously uncovered patients will have access to coverage for substance abuse treatment. As such, both public and private insurers will see an increase in demand for evidence-based and cost-saving treatment for opioid use disorder. Further, health plans will be called upon to make coverage and utilization management requirements and approval processes more consistent, equitable and comprehensible to the average patient and provider. Arbitrary restrictions that serve as barriers to provider and patient access to medication for the treatment of opioid use disorder must be lifted in order to safely, efficiently and properly combat the ever increasing opioid epidemic.

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LR 2406 An Act to Make Supplemental Appropriations and Allocations for the Expenditures of State Government and to Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2019

Testimony on Support

February 21, 2019

Senator Breen, Representative Gattine and members of the Committee on Appropriations and Financial Affairs, my name is Lisa Harvey-McPherson and I am here today providing testimony on behalf of Northern Light Acadia Hospital to speak in support of Sections B and C of this bill.

PART B SUMMARY
This Part repeals the limited lifetime maximum coverage and reimbursement of 24 months under the MaineCare program for buprenorphine and naloxone combination drugs for the treatment of addiction.

PART C SUMMARY
This Part repeals the limited lifetime maximum reimbursement of 24 months under the MaineCare program for methadone for the treatment of addiction

Northern Light Acadia Hospital, located in Bangor, is a regional specialty center providing behavioral health and substance use disorder treatment services for adults and children living in northern and eastern Maine. The hospital offers the only not for profit Methadone outpatient program in Maine and also offers a daily dosing Suboxone program in Maine caring for individuals as they enter into recovery needing a higher level of supportive services.

The limited lifetime maximum coverage regulations resulted in a prior authorization process for those in need of longer term medication assisted therapy to support ongoing recovery from substance use disorder. In preparing for the hearing today I worked with staff at Acadia to learn more about the prior authorization process and how often authorizations are rejected by the State. On an annual basis Northern Light Acadia Hospital averages approximately 300 prior authorization requests including initial authorizations and continued treatment beyond 24 months. Of those authorization requests for continued treatment, we have not had any requests denied. What we do experience is a high level of bureaucratic inefficiencies as the information requested by the State often times was submitted with the original prior authorization documents, the request for information sought on subsequent authorization requests is often already on file, and/or the authorization is approved for a shorter duration than one (1)

year and thus needs to be redone at the end of said timeframe. We also receive requests for information that is not required on prior authorization form that has been completed by professional staff. All of this results in a highly inefficient process that costs time and money to achieve 100% approval of the need for ongoing treatment.

We thank Governor Mills for her proposal to eliminate these artificial barriers to treatment and ongoing recovery for individuals in our care.

Thank you.

MaineHealth

MaineHealth Member Organizations:

Franklin Community Health Network
LincolnHealth
MaineHealth Care At Home
Maine Behavioral Healthcare
Memorial Hospital
Maine Medical Center
NorDx
Pen Bay Medical Center
Southern Maine Health Care
Synernet
Waldo County General Hospital
Western Maine Health

Part of the MaineHealth Family:

MaineHealth Accountable Care Organization

MaineHealth Affiliates:

MaineGeneral Health
Mid Coast-Parkview Health
New England Rehabilitation Hospital of Portland
St. Mary's Health System

Testimony of Dr. Donald McNally
Addiction Psychiatrist at Maine Behavioral Healthcare
To the Joint Standing Committee on Appropriations and Financial Affairs
In Strong Support of Parts B and C of the Governor's Proposed Supplemental Budget
February 21, 2019

Senator Breen, Representative Gattine and Distinguished Members of the Joint Standing Committee on Appropriations and Financial Affairs, My name is Dr. Donald McNally and I am sorry that I am not able to deliver this testimony in person, but my patients must take precedent. Please accept this testimony in strong support of the elimination of eliminating the arbitrary time limit and prior authorization process both in duration and for treatment with buprenorphine for Opioid Use Disorder (OUD). I am an addiction psychiatrist currently employed by Maine Behavioral Healthcare in our "hub" in Biddeford. I hold board certification in two specialties with the American Board of Psychiatry and Neurology: Psychiatry and Addiction Psychiatry

As you know, the United States and the State of Maine are facing an opioid epidemic that is the worst drug crisis in our nation's history. People are dying of opioid overdose at a terrifying and increasing rate; I strongly believe that expanding access and eliminating existing barriers to medication-assisted treatment (MAT) is imperative to battling this deadly crisis in Maine. Research shows that as barriers to accessing MAT drop, so does the rate of opioid overdose deaths. MAT has been shown to significantly improve an individual's functionality and health, help people maintain recovery, reduce crime and overall healthcare costs.

However, onerous, arbitrary and complex lifetime limits and related prior authorization processes can hinder access to these life-saving treatments resulting in potential serious adverse outcomes. Opioid use disorder is a brain disease, and there is absolutely no evidence to suggest that treatment is no longer needed at the end of two years. In addition, we have encountered significant challenges in which prior authorization is required for the prescribing of Subutex to pregnant women. Maine's lifetime limit on the coverage and reimbursement for buprenorphine and naloxone and the prior authorization requirements for pregnant women are capricious, dangerous and fail to meet basic clinical guidelines for care. Should you proceed in passing this bill, Maine would join other states like Pennsylvania and New Jersey, who recently eliminated the prior authorization process, and move to the forefront of improving outcomes in OUD.

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In the past I have often provided counterarguments in my testimony to the common opposing views, however there is no evidence-based or valid reason to delay ongoing access to medically appropriate treatment. The prior authorization process and lifetime limit adds to stigma and it may be inadvertently contributing to the current crisis.

I want to provide a real life example of the limits the prior authorization requirement for pregnant women can place on an individual and their path to recovery. Recently, late on a Friday afternoon a young female in her early third trimester of pregnancy presented to my office in need of ongoing MAT treatment. She was recently discharged from a facility that had been providing her MAT. She was discharged directly to her appointment to have her MAT continued under my care. Ongoing MAT was medically indicated as opioid withdrawal in the third trimester (even from Suboxone and buprenorphine) can cause premature labor imperiling the life of both the mother and the unborn child. Given the late hour abutting a weekend, the MaineCare authorization would not be reviewed until Monday. This left a patient with a pair of unfortunate choices: she could pay out of pocket for a medically indicated treatment for the next three days or present to the Emergency Department to access ongoing care. The patient hung her head in tears after emptying her purse on our waiting room floor, she was currently living on a couch and did not have access to any money – it did not matter that the total cost of her medications for the weekend would be $11.00 - she just didn't have it. While she sat motionless our staff quickly jumped into action and used clinic funds to enable her to afford the medication until the prior authorization could be reviewed Monday.

Fortunately, poor outcomes were avoided this time, but the existing restrictions on accessing MAT could have had dangerous (and potentially lethal) consequences to both the mother and her unborn baby as well as unnecessary costs to the healthcare system as an ED visit would have cost one hundred times more than the cost of the medication. This is just one example of many in which the current process has impeded necessary and potentially lifesaving treatment. On a more day to day basis when patients present and want to stabilize and obtain sobriety, they often require frequent dose changes that require prior authorizations for each dose change. This can at times leave patients waiting sometimes days during critical times in their treatment without medications. Without medication, the risk of relapse in the first thirty days is nearly 100% in published studies. Additionally, even after two years and cessation of treatment relapse rates can be in the 80% range which speaks to the necessity of eliminating the two year restriction.

I implore you to vote in support of the elimination of prior authorizations in regards to treatment with MAT so that we can truly take a step towards ending the opioid epidemic. Please do not hesitate to contact me with any further questions or other information in regards to my position on the issue. Thank you for your time and consideration.

References

CDC Medication-Assisted Treatment for Opioid Use Disorder Study (MAT Study)
https://www.cdc.gov/opioids/Medication-Assisted-Treatment-Opioid-Use-Disorder-Study.html

American Medical Association: Leadership Viewpoints – MAT
https://www.ama-assn.org/advocacy/leadership-viewpoints/landmark-deal-medication-assisted-treatment-model-nation

Verrill Dana LLP
Attorneys at Law

Joint Standing Committee on Appropriations and Financial Affairs
Joint Stand Committee on Health and Human Services

LR 2406, Budget Part C, 24-Month Limit on Medication Assisted Treatment Utilizing Methadone under the MaineCare Program

Testimony of James I. Cohen on behalf of the Coalition to Ensure Fair Access to Opioid Addiction Treatment

February 21, 2019

Members of the Joint Standing Committees of Appropriations and Financial Affairs and Health and Human Services, my name is Jim Cohen of Verrill Dana, LLP, and I am here today on behalf of a Coalition of outpatient providers of Medication Assisted Treatment utilizing Methadone, and we speak in strong ***support*** of ***Part C of LR 2406*** which repeals the 24-month lifetime limit on Medication Assisted Treatment utilizing Methadone under the MaineCare program.

Our Coalition. The Coalition to Ensure Fair Access to Opioid Addiction Treatment is comprised of four providers who operate eight clinics in Maine serving approximately 4000 individuals, 3000 of whom are MaineCare eligible. Coalition members operate three clinics in Greater Portland, one in Lewiston, one in Waterville, two in Bangor, and one in Calais. Our eight clinics are the only clinics offering MAT using Methadone to MaineCare eligible patients. We advocate for sensible policies governing treatment to ensure that Maine people not only have access to quality opioid use disorder treatment, but also that treatment services can become available in locations in Maine beyond the areas currently served – like York County, or Western Maine, the Mid Coast, or Northern Maine, where there are no clinics serving MaineCare eligible patients, despite great need.

Medication Assisted Treatment Utilizing Methadone Is Effective. MAT utilizing Methadone has been used effectively as a treatment for opioid use disorder in this country for over 50 years. The treatment has been utilized in Maine since the mid-1990s.

- MAT utilizing Methadone is particularly effective for individuals who are severely addicted or who are pregnant. It is considered the "gold standard" for treating opioid use disorder.

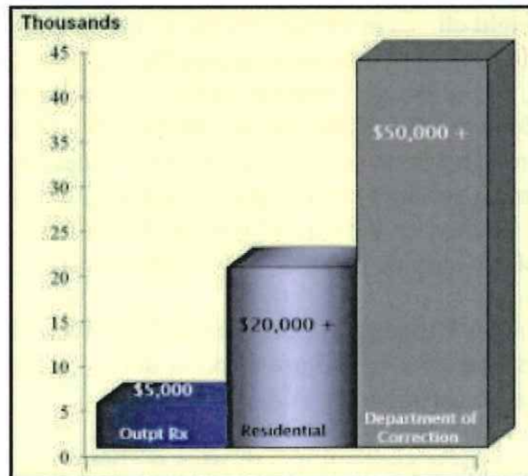
FACING ADDICTION IN AMERICA
The Surgeon General's Report on Alcohol, Drugs, and Health

Surgeon General: Methadone Treatment Works; Evidence-Based

- "Long-term methadone maintenance treatment for opioid use disorders has been shown to be more effective than short-term withdrawal management, and it has demonstrated improved outcomes for individuals (including pregnant women and their infants) with opioid use disorders. Studies have also indicated that methadone reduces deaths, HIV risk behaviors, and criminal behavior associated with opioid drug seeking."
- "More than 40 years of research support the use of methadone as an effective treatment for opioid use."

- MAT utilizing Methadone is the most regulated and tightly controlled form of opioid use disorder treatment. Treatment must be provided from a federally licensed clinic that offers medication management, counseling, drug screening, and medical assessment services all under one roof. Treatment is daily, until patients have been successful in treatment for many months, and counseling is mandated.
- The relapse rate for individuals with opioid use disorder is high, but individuals who remain in treatment with MAT utilizing Methadone until they are stable and able to voluntarily leave treatment have a much lower rate of relapse.
- While individuals are in treatment they are much less likely to use illegal drugs or commit crimes, by a wide margin; are more likely to be with their dependent children; are more likely to be employed; and are less likely to have psychiatric or emergency room admissions. In short, it is better for patients, and for society, when individuals are in treatment.

Treatment saves money. Study after study demonstrates that every dollar invested in treatment saves money in other areas, such as law enforcement, health care, and child protective services. MAT utilizing Methadone, which is an outpatient service, is particularly cost-effective as compared to other treatment modalities.



Comparison of Annual Costs

No evidence supports limiting duration of medication-assisted treatment. Very simply, there is no scientific evidence supporting the establishment of a lifetime limit on medication assisted treatment, whether through Suboxone or Methadone. To the contrary, the evidence is very clear that, while a person is in treatment, their outcomes are improved, the negative impact on society is reduced, and the likelihood of eventual recovery is greater. Moreover, the very existence of a lifetime limit is a barrier to treatment as patients are fearful of committing to treatment when there is even a small risk that treatment might be involuntarily terminated.

Lifetime Caps on Treatment in Maine: A study in ineffectiveness. In 2012, the Maine Legislature passed legislation adopting a 24-month lifetime cap on MAT treatment, subject to prior authorization. The legislation passed despite the absence of evidence supporting the proposal, and the absence of any proponents for the bill. Here is a brief timeline of Maine's actual experience with this limitation:

- **Fall 2012**: Statute authorizing 24-Month Cap goes into effect. Bill directs stakeholder rulemaking process to implement.
- **Winter 2013:** Following many months of cordial stakeholder meetings, DHHS adopts a streamlined process (literally, a 2-page checklist) for prior approval to allow patients to receive MAT treatment beyond 24 months. For the next 3 years, virtually no MAT patients utilizing Methadone were denied prior authorization – for appropriate medical reasons. The time burden on providers was modest, but not debilitating.
- **November 2016:** DHHS adopts new rules governing the prior authorization process which adds new paperwork burden for providers, without evidence, and over the objection of public commenters. Unlike the 2013 rules, the 2016 rules were not established through a collaborative stakeholder process. The new rules now require clinicians to spend about 40 minutes per patient in order to request prior authorization, and another 10-15 minutes of time to deal with deferrals or submission errors (about 20% of all applications). For larger clinics where prior authorization is required for about 50 patients per month, this translates into 22 hours/week (+/-) in paperwork, equal to about 0.5 FTE that could otherwise have contributed to direct patient care. Notwithstanding this time burden, the vast majority of patients received prior authorization.
- **December 2018 (approx.):** Very recently, without any public process, DHHS adopted new, rigid standards for prior authorization. The new standards require 100% attendance at counseling, 100% attendance at medication appointments, and 0% illicit drug use. These standards are not consistent with sound medical practice. Under these new standards, there has been an increase in denials of prior authorization, and more patients have received limited approvals for 6 months rather than 1 year. Under the new standards, patients who are making substantial progress may not be able to remain in treatment even though they are making progress, and leaving treatment will bring substantial harm to themselves, their families, and society.

Repeal of the 24-Month Limit will SAVE time and money. For most of its existence, the 24-month limit has – in practical reality -- not limited how long a patient was in treatment since prior authorization was being based on medical science, and denials were extremely rare. At the same time, the 24-month cap has been effective in diverting already limited resources away from treatment and into paperwork, which has contributed to staff turnover and a reduction in available counseling services for patients. In short, repeal of this ill-advised standard will do one important thing: allow providers to devote more time to treatment, and less time to paperwork that serves no purpose. For the State, removing this needless bureaucracy – including the internal staff that has to receive and review the paperwork -- will save taxpayers money.

Additionally, under the new rigid standards that showed up in the last several months, denials of prior authorization remain rare, but for the few who are denied treatment, the harm to patients, their families, and society will be enormous. Under these new standards, repeal of the 24-month limit will save lives, keep families together, reduce crime, and improve Maine's shrinking labor pool.

Conclusion. The time has come to end the failed 24-month cap. The time is now to pass Part C of this Supplemental Budget. Thank you, and we would be happy to answer any questions that you may have.