Report of CMS Committee on Prescription Drug Abuse
(Action)

Why the board is discussing prescription drug abuse: The Committee on Prescription Drug Abuse met on February 21 for the purpose of identifying and recommending additional mechanisms (legislative, educational, technology based, etc.) that would accelerate current efforts to combat the opioid crisis. Lt. Governor Donna Lynne asked CMS to conduct a short notice, hurry up exercise to identify and recommend additional solutions to accelerate current efforts to combat the opioid crisis. The Lt. Governor's request resulted from her tour of 54 rural counties where opioid misuse and abuse was routinely identified as a crisis issue.

What the Committee discussed on February 21: The meeting was dedicated to a search for possible solutions, preferably consensus solutions.

What the Committee decided on February 21 (<u>Board Action Items</u>):

1. **<u>Schedule II Controlled Substance Partial Fills (ACTION):</u>**

    - That the Committee on Prescription Drug Abuse support the concept of Schedule II Controlled Substance Partial Fills

Please see Attachment 1 for additional background and initial draft legislative specifications (the legislative specifications will be the responsibility of COL-Committee on Prescription Drug Abuse)

<u>Basis for recommendation:</u> Approximately 70 percent of people who misuse opioids report obtaining them from family, friends or on the street – commonly referred to as "diversion."

a. One of the strategies to reduce diversion is to ensure that patients are prescribed the lowest effective dose for the shortest expected duration for expected pain following an acute injury or medical procedure.
b. Some patients, however, may not require medication for the full duration of expected pain.
c. Rather than rely on individuals to safely store and dispose of unwanted and unused medication, patients and prescribers can be empowered to request a partial fill of a Schedule II controlled substance, such as Hydrocodone, Morphine and Oxycodone.
d. Under Section 702 of the federal Comprehensive Addiction and Recovery Act, a pharmacist may partially fill a prescription for a schedule II controlled substance (such as an opioid) if: (1) such partial fills are not prohibited by state law, (2) a partial fill is requested by the patient or

prescribing practitioner, and (3) the total quantity dispensed in partial fillings does not exceed the quantity prescribed.

2. **Ensuring compliance with Substance Use Disorders Essential Health Benefits (EHB) Provision of the Affordable Care Act (ACTION):**

    - That the Committee on Prescription Drug Abuse support the Executive Branch in efforts to ensure that:

        - The Colorado Division of Insurance (DOI) is evaluating and proactively monitoring whether payers are providing the substance use disorder EHB.
        - DOI is enforcing against payers that are not providing this EHB to patients.
        - That payer networks provide adequate access to treatment from an addiction and mental health specialist(s) for patients with substance use disorders in compliance with the EHB.
        - Review current policies in Medicaid and the criminal justice system to determine whether patients with substance use disorders are receiving necessary, evidence-based treatment.

Basis for Recommendation: The federal Affordable Care Act provides that treatment for substance use disorders are an Essential Health Benefit. This means that payers are required to provide the benefit to patients at the same level as other Essential Health Benefits. Payer compliance with this provision of the ACA is imperative.

There is a broad evidence base supporting the benefits of treatment for substance use disorders, but also similar evidence that the treatment often is lacking. To fully address the nation's opioid epidemic, and to reverse the overdose and death attributed to opioids, states must commit resources along the entire continuum – from preventing youth and others from misusing opioids – to ensuring care for those in pain – and for treating those who have a substance use disorder. These are three of the main components to end the nation's opioid epidemic but they typically are not the three main components in state legislative consideration.

An important step in state policy development should be a more aggressive focus on comprehensive treatment efforts. The national increase in heroin- and other opioid-related overdose and death demonstrates the need for greater emphasis and resources on treating patients with substance use disorders with medication assisted treatment (MAT) and concomitant mental health and behavioral and cognitive therapies. These proven methods are evidence-based therapies to reverse the opioid epidemic.

3. Prescription Drug Monitoring Program (ACTION)

- That the Committee on Prescription Drug Abuse support CMS working in the 2017 General Assembly and in coordination with the Executive Branch to identify and appropriate the neccessary funds to upgrade the PDMP into a highly functional clinical tool.

Total PDMP queries, state and national:

	PDMP queries		
State	**2014**	**2015**	**Rate of change**
California	3,553,551	6,174,394	74%
Colorado	682,600	898,000	32%
Kentucky	4,991,810	5,498,298	10%
New York	16,811,126	18,145,982	8%
Ohio	7,500,000	10,500,000	40%
Tennessee	5,062,732	6,442,965	27%
National	60,721,868	84,979,298	40%

Basis for Recommendation: The Colorado PDMP is inadequately funded and the lack of funding directly impacts the functionality and use of the system at the point of care. In addition, prescribers alone assume the role of funding Colorado's PDMP. In 2016, the AMA conducted a national survey of every state PDMP administrator and authority to help determine the usage of PDMPs. First, the data show that the effects of a mandate in these states vary in terms of long-term rate of sustained increase. Kentucky, New York, Ohio and Tennessee enacted mandates prior to 2014.

It is important to note that New York and Kentucky require use for every prescription; and while Ohio and Tennessee both require use prior to an initial opioid prescription, Ohio requires a subsequent check every 90 days while Tennessee is once per year. The precise reasons for these differences likely include, among other things, the fact that Ohio and Tennessee physicians consistently report the PDMP is easy to use, has relevant data, and helps them in their practices.

New York and Kentucky physicians also report that the PDMPs are largely helpful, but the every-time requirement has been a challenge, and the technology of the Kentucky PDMP is cited by some physicians as a common hurdle, including minutes delays to retrieve data, which by themselves, might seem inconsequential, but for a busy practice, "minutes" add up to hours, which can take important time away from actual patient care.

A second common theme to the increase in use in New York, Ohio, Tennessee and California (which only enacted a mandate in 2016) is the

considerable funding allocated to support the technology. This funding generally exceeds $1 million per year to maintain the PDMP database and staff it appropriately. These states each have made long-term commitments to funding that does not exist in other states. Thus, while the total usage in Colorado may be lower than some might prefer, it is critical to look at the functionality of the PDMP, which is directly related to the usability and funding as well as the integration and collaboration of physicians and other health care professionals. While this has occurred in differing degrees in many of the above states, Tennessee's high use of the PDMP (note: only a 1x/per year requirement after the initial check) is likely due to the close collaboration between the medical and public health communities and the state government.

Some of the surrounding policies that many states, including those referenced in the above tables have enacted include supporting multiple delegate access to the PDMP, 24-hour or less reporting by pharmacies and other dispensers to the PDMP, and streamlined registration by health care professionals to the PDMP. The latter policy has been largely achieved by states tying state licensing renewals to PDMP registration to help ensure a seamless registration process.

4. **<u>Opioid Prescribing Continuing Medical Education (ACTION):</u>**

    - That the Committee on Prescription Drug Abuse achieve the following continuing medical education goals in 2017:
        - Partner with the Colorado Consortium for Prescription Drug Abuse Prevention, COPIC, CU School of Public Health, CPMG, CPEP, Pinnacol Assurance, specialty societies and others to accelerate responsible opioid prescribing CME courses to Colorado physicians
        - Dedicate the September-October issue of Colorado Medicine to Colorado's opioid misuse and abuse crisis and provide practical "To Do's" for readers.

<u>Basis for Recommendation:</u> There are robust continuing medical education (CME) safe opioid prescribing offerings currently available to Colorado physicians. By way of example, in 2016, CMS certified 39 CME programs that covered pain management, prescription drug/opioid abuse, and other substance abuse with 179 physicians and 634 others participated in these programs. Also, in the past 4 years, COPIC has provided opioid CME to an estimated 2000 physicians.

- Recommendations on Pending State Legislation

a. SB17-074: Concerning the creation of a pilot program in certain areas of the state that experience high levels of opioid addiction to award grants to increase access to medication assisted addiction treatment: Support with amendments from Colorado Pain Society
b. SB17-146: Concerning access to the electronic PDMP: Support with amendment to allow funding to improve the PDMP and to allow pharmacists to contribute financially to maintenance and operation of the program

Issues pending consideration before the Committee:

1. Use Technology to Voluntarily Improve PDMP Usage and DORA/CDC Guideline Adherence

Objectives:

- Double the Colorado physician "PDMP check rate" (number of physician (or physician delegate) queries divided by the total number of opioid prescriptions dispensed) within 12 months
- Improve Colorado physicians guideline adherence rate (CDC or DORA Quad Regulator Policy) by at least 20% within 12 months

Tactics:

- The state will appropriate $500,000 to support/create a pilot program to give every willing opioid prescriber in Colorado access to a computer program for one year that will substantially simplify PDMP checks and compliance with CDC and DORA Quad Reg guidelines.
- The prescriber (or their staff) will have the option to use any or all of the following guideline-adherent functions:
    - Rapid PDMP Checks (completed in 15 seconds, help with interpretation, automatic daily rechecks, automatic alerts about new issues)
    - Risk Assessment (using ORT- Opioid Risk Tool)
    - Urine Drug Testing (helps with ordering and interpreting results)
    - Patient Symptom Monitoring (via an app the patients use)
    - Generates Patient Opioid Contracts
    - Measures Patient Pain/Function
- The choice of which guideline functions to use with any given patient is completely up to the prescriber.
- The program is available to use on any platform the physician chooses (desktops, laptops, tablets, smartphones, etc.)
- The pilot will allow any licensed opioid prescriber in Colorado (including Physicians, PAs, NPs, Dentists, and Veterinarians) unlimited access to the program for at least one year (this could be extended in future years).

- The prescribers who elect to use the program will be required to complete an short online training course that details effective implementation of the CDC/Quad Reg guidelines and an overview of how to use the computer program.
- CMS will aggressively promote the program through all possible channels in cooperation with the various Colorado specialty societies.
- CMS will work to get other healthcare stakeholders in Colorado (e.g. COPIC, payers, hospitals, etc.) to promote the program.
- The state will mandate that all payers in Colorado shall reimburse prescribers for newly-created E/M codes for appropriate management of acute and/or chronic opioid addiction/management.
    - Note: The Colorado Division of Workers Compensation has already implemented use of similar codes
- Program will start July 1, 2017

OpiSafe by RxAssurance:

- OpiSafe is an evidence-based computer program that simplifies PDMP checks and makes it much easier for prescribers to understand and follow the opioid management guidelines (CDC, Colorado Quad Reg/DORA)

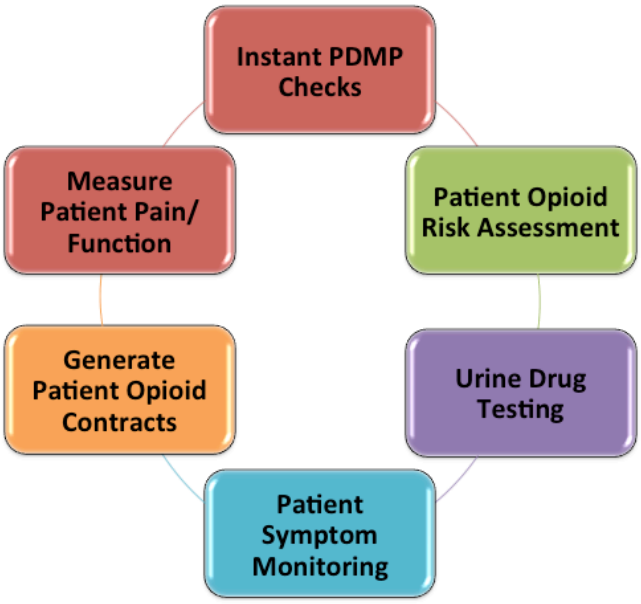
- OpiSafe works on any electronic platform including desktops, laptops, tablets, smartphones, etc.

- OpiSafe does all the following:
    - PDMP Checks (in 15 seconds, automatic daily rechecks, automatic alerts about new issues)
    - Risk Assessment (using ORT- Opioid Risk Tool)
    - Urine Drug Testing (helps with ordering and interpreting results)
    - Patient Symptom Monitoring (via an app the patients use)
    - Generates Patient Opioid Contracts
    - Measures Patient Pain/Function

- Prescribers can use just the PDMP checker, or turn on any or all of the other functions

- It takes about 3 minutes to learn how to use the simple version of OpiSafe

- OpiSafe helps the prescriber understand how to implement the guidelines and how to interpret the information generated by the PDMP, from Urine Drug Tests, etc.



RxAssurance is a leading digital health IT company that is based here in Colorado. OpiSafe was created by physicians and pharmacists to simplify compliance with Colorado state and national opioid prescribing guidelines. The OpiSafe program is currently available to prescribers in 41 states (with additional states being added monthly).

What the CMS President explained to the Committee and guests:

From the time Governor Hickenlooper determined that reducing opioid misuse and abuse in Colorado would be one of his winnable battles, we have been and will continue to work with him to win this battle. CMS has been fully committed to giving the Governor our full cooperation and support in this worthwhile and overdue effort.

I have been fully briefed on the conversation between our representatives and the Lt. Governor and I see her invitation as a great opportunity. It is my hope that we seize this opportunity to accelerate the progress that is already underway. The board of directors meets on March 10 and I have already cleared time on the agenda for a critical report from this Committee.

I will not take your valuable time to outline all that we have done to address the crisis, but I must emphasize that this has and will continue to be a substantial focus and critical task for our medical society.

In approving our fiscal year 2016-2017 operational plan, the board of directors not only approved a robust project plan for this Committee, it noted in the preamble that prescription drug abuse would remain a top priority.

I want to personally thank Dr. Rob Valuck for his dedication to the effort in reducing opioid abuse and misuse. There is perhaps no one in Colorado who has put more time in on the effort than Dr. Valuck as Chair of the Governor's Colorado Consortium for Prescription Drug Abuse Prevention. It has been our pleasure to serve as a member of the Consortium and to work with Dr. Valuck and the many other dedicated volunteers.

Members Present (representing a quorum)

John Hughes, MD, Chair
Lynn Parry, MD, Chair, Council on Ethical and Judicial Affairs
Kathryn Mueller, MD, Colorado Division of Workers Compensation
Steven Wright, MD, Colorado Pain Society
Elizabeth Grace, MD
Mathew Szvetezv, MD
Doug Hemler, MD, Rocky Mountain Pain Society
Tom Kurt, MD,
Alan Lembitz, MD, COPIC
John Sacha, MD
Lee Newman, MD, Colorado School of Public Health
Eleanor Jensen, DO

Guests Present

Larry Wolk, MD, Executive Director, Colorado Department of Public Health and the Environment
Kyle Brown, Ph.D, Policy Advisor, Office of the Governor
Stuart Gottesfeld, MD, Colorado ACOG
Phillip Keppeler, MD, Colorado ACOG
Zach Wachtl, MD, CAFP
Donald Strader, MD, Colorado ACEP
Benjamin Murphy, MD Colorado ACEP
Eric Verzemnieks, MD, Colorado ACEP
Jeremiah Bartley, MD Mile High Medical Society
Rachael Duncan, PharmD, Colorado ACEP
Liz Lowdermilk, MD Colorado Psychiatric Society
Jonathan Clapp, MD, Colorado Pain Society
Roland Flores, MD, Colorado Society of Anesthesiologist
Rick May, MD
Robert Valuck, Ph.D., Colorado Consortium for Prescription Drug Abuse Prevention
Daniel Blaney-Koen, JD, American Medical Association

Report of Daniel Blaney-Koen, JD, American Medical Association
Please see Attachment 2

Attachment 1: <u>Schedule II Controlled Substance Partial Fills</u>: Background and initial draft legislative specifications

The federal, bipartisan Comprehensive Addiction and Recovery Act (CARA) was enacted in 2016 includes:

- Authorizing state grants to increase access to naloxone
- Authorizing state grants to expand the availability of medication-assisted treatment (MAT)
- Expands the total number of patients that physicians can treat with in-office buprenorphine from 100 to 275
- Allows nurse practitioners and PAs to treat patients with buprenorphine for substance use disorders (with additional training)
- Authorizes a grant program to help treat pregnant and post-partum women who have an opioid use disorder
- Authorizes state grants to enhance a state-based PDMP
- Other provisions to help states to fight the opioid epidemic.

The following proposal can serve as a starting point for the Council on Legislation to consider transitioning the concept to a legislative reality.

<u>Legalize authorization for Schedule II Partial Fill:</u>

a. Authorize prescriptions for a Schedule II controlled substance to be partially filled if—
    i. The partial fill is requested by the patient or the practitioner who wrote the prescription; and
    ii. The total quantity dispensed in all partial fillings does not exceed the total quantity prescribed.
b. Require the pharmacist to retain the original prescription at the pharmacy where the prescription was first presented and the partially filled prescription dispensed.
c. Require that any subsequent fills occur at the pharmacy that initially dispensed the partial fill subject to the following:
    i. Any subsequent amount shall be filled within 30 days after the date on which the prescription is written
    ii. The original prescription becomes null and void 30 days after the date on which the prescription is written.

<u>Notification to the Prescriber of a Partial Fill:</u>

a. The pharmacist shall only record in the state prescription drug monitoring program the partial fill actually dispensed.

b. The pharmacist shall notify the prescribing practitioner of the partial fill and of the amount actually dispensed by one of the following:
    i. A notation in the interoperable electronic health record of the patient;
    ii. Electronic or facsimile transmission;
    iii. A notation in the patient's record maintained by the pharmacy which shall be accessible to the practitioner upon request.

Insurance Coverage (this starting point should be worked out with assistance of pharmacy and health plans):

a. A person who presents a prescription for a partial fill pursuant to this Act shall be required to pay the required cost sharing and/or co-pay as required by the person's insurance coverage for the first partial fill.
b. A health plan or other payer shall not require the patient to pay any additional cost-sharing for subsequent partial fills of the original prescription.
c. Under no circumstances shall a person be required to pay more in total cost-sharing for partial fills than would be required to pay for the original prescription.

Attachment 2: Report of Daniel Blaney-Koen, JD, AMA

Memo to: Colorado Medical Society

Date: February 20, 2017

From: Daniel Blaney-Koen, JD

Subject: Comparison of state policy interventions and measures relating to opioid epidemic

DRAFT

The purpose of this letter is to clarify the experience of state legislative action and other policy interventions with respect to prescribing limits, prescription drug monitoring programs (PDMPs), continuing medical education, naloxone-access policies and reversing the nation's opioid epidemic. The American Medical Association (AMA) has worked with dozens of states and national stakeholders such as the National Governors Association and National Association of Attorneys General to better understand the relationship between legislative and other efforts to and reducing opioid-related harms, including overdose and death.

The AMA's analysis, and state experience, shows that measures designed to reduce opioid supply have one clear effect: that is, they reduce opioid supply. The AMA's analysis of policies to require physicians and other health care

professionals use PDMPs also have one clear outcome: they increase use of PDMPs. And the outcome of requiring physicians and other health care professions to take content-specific education has one clear effect: physicians and other health care professionals take content-specific education. On the other hand, the AMA's analysis of policies designed to increase access to naloxone also shows one clear outcome: thousands of lives saved.

AMA support for policies to reverse the nation's opioid epidemic

The AMA supports the use of effective PDMPs to help better inform physicians' decision-making when considering whether to prescribe a controlled substance. When fully integrated into a physician's practice, including providing relevant, real-time information at the point of care, PDMPs are widely considered important clinical tools.

Similarly, for many reasons, physicians and other health care professionals have been increasingly more judicious in making prescribing decisions – particularly with respect to opioid analgesics. The AMA supports the practice that physicians should only prescribe opioid analgesics when the intended benefits outweigh the risks. And when a physician begins a course of opioid therapy, the AMA supports the CDC recommendation to start low and go slow.

Enhancing a physician's continuing medical education (CME), moreover, regarding pain management, recognizing signs of misuse, and treating patients with a substance use disorder are among those skills that should begin during medical school. As a physician's career progresses, the AMA encourages physicians to continue to enhance their education to best support their specialty and patient population. It is challenging for content-specific CME to fulfill all of these goals for all physicians.

The AMA has worked to help support naloxone access laws and policies across the United States. Nearly every state now has such a law, many of which are based on an AMA model bill. New efforts to increase access to naloxone include using statewide standing orders, supporting federal grants to states, and support for physicians to co-prescribe naloxone to patients at risk of overdose. Were it not for these efforts, it is likely there would be thousands more dead and harmed from opioid-related overdose.

Brief review of key policy measures and opioid-related mortality

The data currently do not show that prescribing restrictions, mandates to use a PDMP, or content-specific CME have a positive effect on opioid-related mortality. This is not to discredit the utility of making more informed prescribing decisions, using PDMPs or taking CME. The AMA supports each of these practices as

important components of reversing the nation's opioid epidemic. The AMA also supports greatly enhanced access to treatment for substance use disorders as well as increased access to non-opioid and non-pharmacologic pain care. The addition of these latter two policies and practices, unfortunately, have not had the state legislative focus as the primary three policy interventions.

Brief data review

For the purposes of this memo, relevant data from six states will be reviewed: California, Colorado, Kentucky, New York, Ohio and Tennessee.

Table 1: State policy interventions and heroin and total opioid-related deaths

State	CME mandate?	PDMP mandate?	Opioid-related prescribing restrictions?	Naloxone access law(s)?	Heroin deaths, CDC (2012-2015)	Total opioid-related deaths,CDC (2012-2015)
California	Yes – one-time 12 hours in pain management or treatment of terminally ill and dying patients	Yes – upon the initial prescription of CS II-IV and every 4 months (2016)	Under legislative consideration	Yes	2012: 362 2013: 486 2014: 561 2015: 593	2012: 1,719 2013: 1,948 2014: 2,024 2015: 2,018
Colorado	No	Under legislative consideration	Under legislative consideration	Yes	2012: 91 2013: 120 2014: 156 2015: 159	2012: 407 2013: 433 2014: 525 2015: 495
Kentucky	Yes – 4.5 hours related to the KY PDMP, pain, addiction disorders or a combination	Yes – prior to any prescription for an opioid analgesic; exceptions (2013)	Under legislative consideration	Yes	2012: 143 2013: 215 2014: 228 2015: 310	2012: 673 2013: 665 2014: 729 2015: 885
New York	Yes – 3-hour course on pain management, palliative care and addiction	Yes – prior to any prescription of CS II-IV (2013)	Yes – 7-day limit for an CS II-IV for acute pain; exceptions (2016)	Yes	2012: 616 2013: 666 2014: 825 2015: 1,058	2012: 1,530 2013: 1,681 2014: 1,739 2015: 2,166
Ohio	Yes – limited to pain management clinics	Yes – prior to a prescription for all controlled substances and every 90 days; exceptions (2013)	No – a "press pause" Ohio recommended guideline requires review when opioid MME =/> 80 (2013)	Yes	2012: 696 2013: 998 2014: 1,208 2015: 1,444	2012: 1,355 2013: 1,630 2014: 2,106 2015: 2,698
Tennessee	Yes – two hours on controlled prescribing to include Dept. of Health prescribing guidelines	Yes – prior to a prescription for an opioid analgesic or benzodiazepine and every once/year (2013)	When opioid MME is 120mg & benzodiazepines used for mental health, provider shall refer to a mental health professional to assess necessity of benzodiazepine.	Yes	2012: 50 2013: 68 2014: 148 2015: 205	2012: 723 2013: 767 2014: 863 2015: 1,038

There are several conclusions that can be drawn from Table 1. First, with the exception of Colorado, each of these states have enacted or promulgated policy interventions focused on CME, PDMPs and opioid prescribing. Second, each of

these states have seen an increase, often staggering, in heroin-related mortality. Yet, Colorado and California have both seen decreases, albeit very small, in total opioid-related mortality. California policymakers, however, recently enacted a PDMP mandate and are debating the merits of restrictions on opioid prescribing. Kentucky, New York, Ohio and Tennessee each are among the states that have had the CME, PDMP and opioid prescribing mandates for the greatest length of time. Perhaps it is too early to suggest what effect they will have on opioid-related mortality, but current data do not support the conclusion that these mandates have a positive effect in reversing opioid-related mortality.

It is important, however, to dive deeper into the effects of these mandates. Specifically, what effect do they have on opioid prescribing and PDMP use? And how do those effects reflect national trends?

Table 2. Total opioid prescriptions, state and national

	Total opioid prescriptions				
State	**2013**	**2014**	**2015**	**Rx per capita**	**Rate of change**
California	21,047,372	20.561,933	18,666,608	0.5	-12.8%
Colorado	3,678,624	3,637,189	3,471,691	0.6	-6.0%
Kentucky	4,997,389	4,900,964	4,471,521	1.0	-11.8%
New York	10,957,729	10,450,786	10,164,060	0.5	-7.8%
Ohio	11,261,528	10,794,642	9,955,858	0.9	-13.1%
Tennessee	8,525,017	8,239,110	7,800,947	1.2	-9.3%
National	251,814,805	244,462,567	227,780,915	0.7	-10.6%

This data from QuintilesIMS (formerly IMS Health) shows two clear trends for the selected states, which also applies to nearly every state in the nation. First, from 2013 to 2015, there has been a significant decrease in prescriptions of opioid analgesics. Second, from 2014-2015, every state in the nation saw a decrease – even in states like Colorado, which has a lower per capita prescribing rate compared to the national average. In other words, the nation's physicians have adopted the AMA and the nation's medical societies calling on physicians to be more judicious in their prescribing of opioids – without legislative declarations or mandates to do so. This has been the case in all of the Northeastern states that have recently enacted restrictive prescribing measures (e.g. MA, ME, NH, NY, RI, VT), as it is in states with recommended guidelines (e.g. OH) and mandates (KY, OH).

Table 3. Total PDMP queries, state and national

	PDMP queries		
State	**2014**	**2015**	**Rate of change**
California	3,553,551	6,174,394	74%
Colorado	682,600	898,000	32%
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In 2016, the AMA conducted a national survey of every state PDMP administrator and authority to help determine the usage of PDMPs. First, the data show that the effects of a mandate in these states vary in terms of long-term rate of sustained increase. Kentucky, New York, Ohio and Tennessee enacted mandates prior to 2014. It is important to note that New York and Kentucky require use for every prescription; and while Ohio and Tennessee both require use prior to an initial opioid prescription, Ohio requires a subsequent check every 90 days while Tennessee is once per year. The precise reasons for these differences likely include, among other things, the fact that Ohio and Tennessee physicians consistently report the PDMP is easy to use, has relevant data, and helps them in their practices. New York and Kentucky physicians also report that the PDMPs are largely helpful, but the every-time requirement has been a challenge, and the technology of the Kentucky PDMP is cited by some physicians as a common hurdle, including minutes delays to retrieve data, which by themselves, might seem inconsequential, but for a busy practice, "minutes" add up to hours, which can take important time away from actual patient care.

A second common theme to the increase in use in New York, Ohio, Tennessee and California (which only enacted a mandate in 2016) is the considerable funding allocated to support the technology. This funding generally exceeds $1 million per year to maintain the PDMP database and staff it appropriately. These states each have made long-term commitments to funding that does not exist in other states. Thus, while the total usage in Colorado may be lower than some might prefer, it is critical to look at the functionality of the PDMP, which is directly related to the usability and funding as well as the integration and collaboration of physicians and other health care professionals. While this has occurred in differing degrees in many of the above states, Tennessee's high use of the PDMP (note: only a 1x/per year requirement after the initial check) is likely due to the close collaboration between the medical and public health communities and the state government.

Some of the surrounding policies that many states, including those referenced in the above tables have enacted include supporting multiple delegate access to the PDMP, 24-hour or less reporting by pharmacies and other dispensers to the PDMP, and streamlined registration by health care professionals to the PDMP. The latter policy has been largely achieved by states tying state licensing renewals to PDMP registration to help ensure a seamless registration process.

Treatment:

The next important step in state policy development, however, must be to more aggressively focus on comprehensive treatment efforts. In each of the above states – and in states across the nation – patients are increasingly dying from heroin-related overdose. While Kentucky, Ohio and Tennessee are generally

viewed as three states where heroin-related overdose is particularly staggering, the national increase in heroin- and other opioid-related overdose and death has increased the need for greater emphasis and resources on treating patients with substance use disorders with medication assisted treatment and concomitant mental health and behavioral and cognitive therapies. These proven methods are evidence-based therapies to reverse the opioid epidemic.

Yet, most state legislative efforts continue to focus on mandates for CME, PDMP use and opioid analgesic prescribing restrictions. These policies may – in the future – demonstrate different results than the data currently show. However, the AMA also is deeply concerned that the legislative focus on limiting access to opioid analgesics will push some patients to find other forms of pain relief for two reasons. First, the AMA has heard of increasing reports of physicians no longer treating chronic – or acute – pain with opioid analgesics due to increased state, federal and private payer barriers to providing appropriate pain care. As a result, patients often have nowhere to turn for pain relief except diverted drugs, heroin, or illicit fentanyl. Even with exemptions on new restrictions to prescribing opioids for cancer-related pain and pain relief for hospice and palliative care, the AMA is deeply concerned about the unintended consequences of policies to universally restrict opioid analgesics – particularly when the data show that physicians already have taken measures to reduce opioid prescribing.

Second, the heavy focus on restricting access to opioid analgesics has tended to limit state legislative efforts to further support access to MAT. This includes efforts to remove prior authorization, step therapy and other payer utilization management tools for MAT. Thankfully, the New York attorney general recently reached agreements with national payers Anthem and Cigna, who will no longer require prior authorization for MAT. And Aetna also recently announced that it will end its prior authorization policies for MAT. These are promising developments, and the AMA urges all payers to adopt these policies.

One final point about further areas for state policy efforts regarding MAT and comprehensive access to treatment for substance use disorders. Specifically, states should review current policies in Medicaid and the criminal justice system to determine whether patients with substance use disorders are receiving necessary, evidence-based treatment. There is a broad evidence base supporting the benefits of such treatment, but also similar evidence that the treatment often is lacking. To fully address the nation's opioid epidemic, and to reverse the overdose and death attributed to opioids, states must commit resources along the entire continuum – from preventing youth and others from misusing opioids – to ensuring care for those in pain – and for treating those who have a substance use disorder. These are three of the main components to end the nation's opioid epidemic, but as discussed above, they typically are not the three main components in state legislative consideration.