MAINE MEDICAL ASSOCIATION

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TESTIMONY OF THE MAINE MEDICAL ASSOCIATION

IN SUPPORT OF

L.D. 1646, AN ACT TO PREVENT OPIATE ABUSE BY STRENGTHENING THE CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

AND

L.D. 1648, AN ACT TO AMEND THE LAWS GOVERNING THE CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM AND TO REVIEW LIMITS ON THE PRESCRIPTION OF CONTROLLED SUBSTANCES

Joint Standing Committee on Health & Human Services
Room 209, Cross State Office Building
Wednesday, March 16, 2016, 1:00 p.m.

Good afternoon Senator Brakey, Representative Gattine, and Members of the Joint Standing Committee on Health & Human Services. I am Gordon Smith of East Winthrop and I am pleased to testify on these two bills on behalf of the Maine Medical Association which I serve as Executive Vice President. As you know, the Association represents the interests of nearly 4000 Maine physicians, medical students, and residents and its mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens. Consistent with this mission, the Association supports the provisions in L.D. 1648 and can give qualified support to L.D. 1646 subject to a number of caveats and amendments.

The Maine Medical Association has been at the forefront of the battle against prescription drug abuse for more than thirty years. In the 1980's, we used data from the American Medical Association to provide an early warning system (DAWN) to prescribers. Ten years later we began a series of educational programs to respond to the problems that long-acting opioids were bringing to rural Maine. I recall doing a program with a DEA agent in Presque Isle around 2002 and since that time, with grant funding from the Office of Substance Abuse (now OSAMHS), we have provided more than fifty such programs ranging from one hour of education to four hours, including a three and one-half hour program and webinar delivered at and from our offices in Manchester last Friday. About 70 prescribers participated in that particular program. The previous evening more than 200 prescribers attended regional forums arranged by

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Quality Counts to discuss MAT in primary care practices. We also, through a contract with MaineCare, provide a module on appropriate prescribing for pain that is delivered across the state by our academic detailing staff. For three years, the Board of Licensure in Medicine contracted with us to operate a Chronic Pain Program which included on-line exams and personal visits to practices. We also have been a founding member of the board of the Maine Opiate Collaborative established by the U.S. Attorney, the Attorney General, and the Commissioner of Public Safety. You know of much of the work of the three Task Forces that work under the auspices of the Collaborative. MMA is the grantee of funds from two foundations to support the community Forums being held in each Public Health District encouraging the public to come together to discuss the impact of the opioid/heroin epidemic on their families, their schools, their employers, law enforcement, and their communities. It is neither a cliché nor an overstatement to state that the current epidemic is tearing at the very fabric of our society and threatens the culture and the quality of life that we have prided ourselves on as Mainers. We congratulate the Governor and Senator Katz and the co-sponsors for presenting these bills which are intended to address, in a limited way, the scourge of prescription drug abuse which is among the causes of the heroin crisis in our state and across New England and the nation. I say "in a limited way" because even though the bills are very broad in their scope, they deal with only one part of a very complicated problem.

The two proposals before you cover the same general areas but there are important differences which you have already heard testimony about. Before I discuss what we like or dislike about each proposal, I want to make some brief cautionary remarks highlighting a theme that you will hear repeatedly this afternoon. While there are some provisions in both bills that impose administrative and regulatory burdens on all prescribers of controlled substances, it is not these burdens that physicians we have heard from object to. In fact, the majority are, perhaps reluctantly, supportive of the educational mandates, the mandate to move to electronic prescribing (with appropriate and necessary waiver provisions), and even the mandatory use of the Prescription Monitoring Program (PMP). What is clearly bothering them is the aspect of L.D. 1646 (and potentially 1648) that puts you, as a legislator, in the exam room between the prescriber and the patient. With the notable exception of Representative Hymanson, you are not physicians. That being the case, you should be very cautious about practicing medicine and intruding on the clinical judgment of physicians and other prescribers. To the extent that aberrant practices result in outliers on the spectrum of health care professionals, traditionally the potential harm to patients as a result has been handled by the licensing boards. This approach is continued in Senator Katz' bill. The Governor's bill sets arbitrary and very strict standards for the amount and duration of pain medication that can be prescribed, potentially leaving thousands of patients with unrelieved pain. As written, there are no exceptions for pain from cancer, end-of-life care, palliative care, or for post-surgical care in a trauma setting. If you go down this road, appropriate exceptions should be written into the law and our discussions with representatives from the Governor's office lead us to believe that the Governor would

be supportive of these exceptions. And when considering the average daily dosages, please give consideration to the thousands of existing patients who are on medication which currently exceeds the 100 morphine milligram equivalent. In fact, from PMP data, we know that over 1200 patients exceeded 300 MME on a daily basis as of the end of 2015. So, imagine how many patients would need to be tapered or have their particular medication, which may have been working for them for years, changed or otherwise adjusted. No doubt, such a change would be good medicine for many, but not all. And how do you know? It may be reasonable, at least initially, to grandfather those patients who are in this situation and to focus on any opioid medication for a new patient or a new opioid script for an existing patient.

Should you decide to establish in law the duration of a script or limit the average daily dosage, please bear in mind that each and every patient is different. They come in many different shapes and sizes. *Indeed, one size does not fit all.* A patient weighing two hundred pounds has different dosage needs than a patient weighing a hundred pounds. The reason we prefer L.D. 1648 to 1646 is our belief that during a reasonable period of time, the licensing boards could come up with appropriate standards of practice that would have appropriate exceptions and be better tailored than what we can do with you and the Governor's Office between now and Friday. Statutes can be a very blunt instrument. *What you essentially have in front of you is a sledgehammer when what you need is the precision of a surgeon's knife.*

Continuing on this "go-slow" theme, please remember that the vast majority of patients receiving pain medication are legitimate pain patients. Many have multiple medical issues ranging from amputations to rheumatoid arthritis. And, the vast majority of prescribers are conscientious, compassionate health professionals who are trying to meet their patient's needs without putting them at risk for addiction. It is truly a shame that you may need to risk harming patients and intentionally impose administrative barriers on prescribers because of the poor practices of a few. But, such is the nature of public policy and legislation.

I have gone on long enough about the dangers inherent in the bills and the need to go slow. I will move on to the major substantive provisions in each bill.

1. **Enhancing immunity for prescribers who share relevant information to law enforcement.** MMA supports. Really a no-brainer. With all the emphasis on HIPAA and patient privacy, the physicians and other prescribers need as much protection as possible when then step forward and breach patient confidentiality in order to protect the public. Patients can be very quick to file a complaint with the licensing board or even bring a malpractice case in such situations so the additional layer of protection is warranted and appreciated.

2. **Mandatory education.** All physicians are already required to have thirty hours of so-called category one CME (Continuing Medical Education) every two years. So long as the education mandate in the bill is part of this process and applies

only to physicians who prescribe controlled substances, MMA can support it. We would recommend that at least three hours of the thirty hours be devoted to this topic. We do not think DHHS needs to approve the courses as there are already very stringent requirements through the Accreditation Council on CME which is a national accrediting body. And, most of the other prescribers, such as APRNs, Physician Assistants, Dentists, and Podiatrists have similar requirements.

3. **Mandatory PMP use.** L.D. 1648 puts this into the licensing boards as part of amendments to Joint Rule 21. This makes sense to us as the Board of Licensure in Medicine and the Board of Osteopathic Licensure already regulate this area. L.D. 1646 imposes a mandate to check the PMP at the time of any new prescription for an opioid or benzodiazepine and then for every 90 days thereafter as long as the prescription is renewed. There are no exceptions. If you prefer the approach in 1646, we would suggest looking at some exceptions where the PMP check would not be warranted (hospice care, small dosages, etc). And, we believe that subsequent checking into the PMP should be every six months, rather than every 90 days. There is no evidence that checking the PMP frequently actually decreases inappropriate prescribing, but it is one tool, along with urine screens, controlled substances agreements, and random pill counts, that help physicians and other prescribers to determine if patients are being honest with them. In reviewing responses from our members regarding this issue, the most frequent comment we received was that the PMP did not work very well. Staff changes frequently (the program is presently without a coordinator and the next one hired will be the fifth in ten years) and the program has been chronically underfunded. I sit on the PMP Advisory Committee and am aware that a number of activities are going on intended to improve the program, including issuance of a new RFP for potential vendors. And, I understand that a recent federal grant has been received that can also be used to improve the program. Needless to say, if prescribers are going to be mandated to use it, the State should do its part to ensure that the program is state of the art and robust. Currently, it is not.

4. **Electronic Prescribing.** Most of our members responded that they supported a mandate to prescribe opioids electronically, so long as waivers could be sought for instances in which it was not possible to do it (no broadband) or circumstances do not permit it (palliative care physician sees patient in their home). In the interest of time, I will not go further with this. I also know that you will receive lots of information on this topic from the pharmacy community. Suffice it to say, the federal laws have been changed to permit it and the Board of Pharmacy enacted rules allowing it so long as the transmissions were consistent with the federal rule. But, the federal rule is complicated and compliance is expensive. Only one state, New York, has required it and their mandate has been delayed for a year and is only now getting close to the

effective date. And, I understand that New York is now facing thousands of waiver requests as many prescribers and pharmacies are not ready. So, as I have stated repeatedly during my testimony, go slow. Electronic prescribing of opioids would be helpful and reduce the administrative hassles noted above if limits are put on the number of days a script can be written for. But, very little electronic prescribing of opioids (as opposed to non-scheduled drugs) is currently being done in the state and you should examine what the barriers to electronic prescribing are (mostly economics, I suspect).

5. **Limits on daily dose (100 morphine milligram equivalents).** As noted above, our physicians object the most strongly to this limitation as they believe it will be harmful and dangerous to patients who exceed the limit now. This would include several thousand patients. The limit itself of 100 MME should be reviewed for appropriateness and existing patients should be grandfathered. There are many other ways to encourage both patients and physicians to reduce their prescribing of opioids. Or, use the approach in L.D. 1648 and let the licensing boards review this with the possibility of establishing a different limit with appropriate exceptions. We have also thought about a hybrid approach wherein you would set an appropriate limit now, with appropriate exceptions but it would be subject to a sunset provision once the licensing Boards amended Joint Rule Chapter 21 and imposed a different practice standard.

6. **Limits on scripts to 3 days for acute pain and 15 days for chronic pain.** Nearly universally, physicians do not believe that these limits are reasonable. Many have suggested 7 to 10 days for acute and 30 for chronic pain. We would prefer to have the licensing boards establish the limits after reviewing the experience with the MaineCare limits established three years ago. And, if the MaineCare limits are pointed to as a positive step, why not stick with those limits (15 days for acute pain, 30 days for chronic but subject to a number of other conditions such as trying alternatives to opioids first).

There are many other aspects of the bills that I could discuss, such as penalties and enforcement, the need for a full evaluation component to any mandates that are implemented and the need for the PMP to furnish more information to the prescribers, particularly reports comparing their prescribing with their peer group. But, I am aware of the time constraints of testimony and am also aware that many others will be bringing up these issues. So, in the interest of time, I will, mercifully, conclude by thanking you for your time and attention. You have a very difficult job to do here and I don't envy you for one minute. I would be happy to answer any questions that you have.

Maine Medical Association

Resolution #2 RE: Actions in Response to Opioid Problem

Submitted by the MMA Board of Directors

Approved September 12, 2015

Whereas, Maine, like other states across the nation, has experienced an increase in substance abuse in recent decades;

Whereas, in recent years opioid abuse has increased considerably;

Whereas, heroin abuse has increased significantly in recent years as prescription drug abuse has declined;

Whereas, the abuse of opioids, including heroin, resulted in the premature death of 208 Mainers through overdose in 2014, the highest ever recorded in Maine;

Whereas, recent information released by the Attorney General suggests that 2015 overdose deaths will exceed even those in 2014;

Whereas, in state fiscal year 2015, 8% of all babies born in the state were born with narcotics in their developing systems, greatly exceeding the national average;

Whereas, in three years MaineCare has seen a 45% reduction in the number of opioid pills prescribed, but during the same period commercial insurers saw a 5% increase;

Whereas, the Maine Medical Association in the past 15 years has committed an increasing amount of resources to addressing the challenges of prescription drug abuse; and

Whereas, in addition to the actions called for in a Resolution passed in 2014, the Maine Medical Association continues to engage in a multi-pronged strategy, including education and advocacy, to engage members in the fight against drug abuse in all forms;

Therefore, be it Resolved, that the Maine Medical Association, while convened for its 163rd Annual Meeting, shall direct its Board of Directors to take the following actions:

1. Encourage physicians to become certified buprenorphine prescribers;
2. Support the work of the U.S. Attorney's office in organizing three work groups on drug abuse prevention, treatment and law enforcement;
3. Encourage use of the Prescription Monitoring Program;
4. Continue advocacy for the dedication of sufficient resources for medication assisted therapy in order to assist individuals with substance use disorders to get coverage and treatment;
5. Continue advocacy for changes in law aimed at making naloxone universally available;
6. Seek participation in grants and contracts which address the epidemic of drug abuse in our state; and

7. Continue the Maine Medical Association's longstanding initiatives to educate physicians and the public about principles of responsible pain management.

Maine Medical Association
Resolution #1 RE: MMA Support for Responsible Pain Management Programs
Submitted by Kevin Flanigan, MD, MBA, Past President Maine Medical Association, Medical Director Office of MaineCare Services
September 6, 2014

WHEREAS, the Maine Medical Association's Mission Statement has three key objectives: to promote public health, to advance quality and the support of physicians, and

WHEREAS, the United States Centers for Disease Control and Prevention has recently published a report identifying Maine as having the highest rate of long-acting opioid medication prescribing per capita, and

WHEREAS, the misuse, abuse, diversion, and overdose deaths due to opioid medications continues to be a serious problem in Maine, and

WHEREAS, ACUTE pain, by definition time limited, can be successfully managed with opioid medications, and

WHEREAS, there is very limited evidence in the literature supporting the use of opioid medications for the treatment of chronic pain, and

WHEREAS, there is now an accepted evidence base for the use of treatment options such as Cognitive Behavioral Therapy, Physical Therapy, Occupational Therapy and Osteopathic Manipulative Treatment as effective interventions for the management of chronic pain, and

WHEREAS, MaineCare has successfully partnered with stakeholders in developing a Pain Management Program, which has resulted in a nearly 50% reduction in the number of controlled substances dispensed to MaineCare members and

WHEREAS, the evidence supports the use of these treatment options for the management of chronic pain.

NOW, THEREFORE BE IT RESOLVED that the Maine Medical Association **support physicians** and other prescribers in utilizing treatment options for the management of chronic pain other than opioid medication, and

BE IT FURTHER RESOLVED that the Maine Medical Association work towards **improving the quality** of care for the people of Maine who suffer from pain through advocacy for the use of a Pain Management Program and discourage the use of opioids when other evidenced based options exist, and

BE IT FURTHER RESOLVED that the Maine Medical Association will **promote the health of all Maine citizens** by advocating for the availability of Pain Management Program coverage

by all insurers so that there are fewer opioids available to potential misuse, abuse or diversion, and

BE IT FURTHER RESOLVED that the Maine Medical Association adopt a one year goal of a reduction in the dispensing of opioid medications for chronic pain in the State of Maine by 25% through its efforts of advocating for the use of other evidenced based treatment options along with advocating for a shift in the goal of pain treatment from one of pain free to one of maximum function.