CMS Comments on Draft Interim Study Legislation

Date: September 24, 2018

To: 2018 Interim Study Committee on Opioid and Other Substance Abuse Disorders (Interim Study)

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Liaisons to the 2018 Interim Study on Opioid and Other Substance Abuse Disorders

Re: Draft Interim Study Legislation: Comments from CMS Committee on Prescription Drug Abuse

The Colorado Medical Society (CMS) Committee on Prescription Drug Abuse (Committee) met on Tuesday, September 18, 2018 to review and discuss the five bills currently under the Interim Study's consideration. Our committee reports to the CMS Council on Legislation and to the board of directors. The committee members wish to express their deep appreciation for your thoughtful work and consideration of their discussion outlined below on each of the five bills. Please let us know if you have questions or need additional information.

Bill #1: Treatment of Opioid and Substance Use Disorders

Comment: In a 2017 survey of CMS members, 42% reported that they did not know where to refer a patient for substance use disorders. Numbers were even higher for referral of Medicaid patients. One committee member stated that bill # 1 is a potential game changer because it will not only provide a much-needed referral source for physicians but also be helpful in identifying the access gaps in Colorado.

The committee voted to recommend CMS support of this bill.

Bill #2: Substance Use Disorders Recovery

Comment: The Committee voted to recommend CMS support for this bill.

Bill #3: Harm Reduction Substance Use Disorders.

- **Extends from 9-1-2021 to 9-1-2024 the repeal of the requirements on prescribers to query the PDMP prior to prescribing a second fill for an**

opioid unless the person receiving the prescription meets certain requirements

Comments: Committee members expressed concern that if the 2018 agreement is extended that medical professional organization leaders will be reluctant to promote future legislative agreements with colleagues. The following rationale is provided for this concern.

While recognizing that much work needs to be done to reverse the opioid crisis and despite the fact the prescribing of opioids were declining and PDMP checks were increasing, Committee members worked diligently to garner support from colleagues and specialty and component medical societies for 2018 legislation, SB 22, Clinical Measures for Safer Opioid Prescribing. The legislation was a carefully crafted agreement between physicians, the Hickenlooper Administration, and the members of the 2017 Interim Study on Opioid and Other Substance Abuse Disorders. It was drawn specifically to address the major issue referred to as "*The Medicine Cabinet"* problem. In response to the bill's passage, physician organizations have doubled down on continuing medical education focused mainly on prescribing for acute pain. This is in addition to Colorado Medical Board educational initiatives and those of the Colorado Consortium for Prescription Drug Abuse Prevention. In part, medicine's support for SB 22 was predicated on the provision repealing the prescribing and PDMP mandates in three years because:

a. There is no gold standard among the states for prescription opioid fill limits. There is a lack of evidence regarding appropriate duration of opioid pain medication for non-surgery related acute conditions, or the efficacy of such legislation;

b. The Colorado Consortium for Prescription Drug Abuse Prevention can study the impact on the opioid prescribing and PDMP mandates and recommend new state policy in 2020, if indicated;

c. Once the PDMP is integrated seamlessly into electronic medical records providing a one-click check, a statutory PDMP mandate will not be needed; and,

d. Maintaining prescribing limitation mandates in law does not allow for the evolving practice of medicine as new scientific research becomes available.

- **Allows school districts and nonpublic schools to develop a policy by which schools are authorized to obtain a supply of opiate antagonists and school employees are trained to administer opiate antagonists to individuals at risk of experiencing a drug overdose**

Comment: The Committee voted to recommend CMS support for this section of the bill.

- **Prohibits a pharmacist from dispensing an opioid unless the prescription for the opioid was sent electronically to the pharmacist or pharmacy where the pharmacist practices**

  Comment: CMS opposed a similar measure in the 2018 Legislature. CMS conducted an all-member survey from July 24 through August 20, 2018, on the issue of health care costs. This survey revealed, with a margin of error of plus or minus 4.3% at the 95th confidence level that:

  a. Significant percentages of CMS physicians are implementing (or have specific plans to implement) various technologies, systems or strategies to contain costs while ensuring quality:
  b. Nearly all (87%) say they have an electronic health record, including 97% of those in practices with 51 or more physicians and 93% of those in practices with 11-50 physicians.
  c. Fully 82% have e-prescribing in their practice, including 89% among those practices with more than 11 physicians.

  This data does not distinguish between e-prescribing for controlled substances and legend (non-narcotic) drugs and this should be explored. A representative of Denver Health explained that there are technology authorization issues with resident physician e-prescribing of controlled substances and that representatives of teaching hospitals should be consulted. Similar concerns were voiced by a physician practicing with the Colorado Permanente Medical Group. The same issue had previously been pointed out about locum tenens covering rural health care facilities (a locum tenens physician is a physician who works in the place of the regular physician when that physician is absent, or when a hospital/practice is short-staffed).

  The committee asked CMS leaders to conduct a flash survey of members to determine: (1) The response of physicians to an e-prescribing mandate; (2) Whether members with e-prescribing capability are currently e-prescribing controlled substances and if not, why; (3) The response of physicians who currently do not have e-prescribing in their practice; (4) Costs associated with an e-prescribing mandate; and (5) The ability to sort the data by specialty, type of practice and location (rural/urban). This information will be provided to the Interim Study members as soon as it is available.

  The committee has delayed a recommendation on this section of the bill until additional member data is available.

- **Requires department of revenue to adopt rules to expediate the issuance of ID cards to individuals with substance use disorders who require an ID card to enter treatment**

  Comment: The committee voted to recommend CMS support this section of the bill.

- **Requires a person or entity that makes an automated external defibrillator available to the public to also make an opiate antagonist available to the public**

  Comment: The committee voted to recommend CMS support for this section of the bill.

Bill #4: Prevention of Opioid and Other Substance Use Disorders

- **Requires health care providers, not including physicians, who have prescriptive authority to complete substance use disorder training as a condition of licensure**

  Comment: Although physicians are not included in the current draft, the committee offers the following comments.

  1. CMS conducted an all-member survey from September 6 through 25, 2017, with a margin of error is ±3.8% at the 95% confidence level that demonstrated:
     a. Fully 70% of all CMS physicians report that they have had CME regarding opioids in at least the past 2-3 years;
     b. Physicians in Internal Medicine (88%), Family Medicine (84%) and Emergency Medicine (83%) are more likely to say they have had CME in the past 2-3 years; and,
     c. Physicians have a mixed reaction to the idea of mandating the number of required hours of CME, with 39% supporting and 39% opposing "mandating the number of required hours for CME regarding prescribing opioids as part of licensure for physicians in Colorado."

  2. The 2018 Legislature upon recommendation of the 2017 Interim Study on Opioid and Other Substance Abuse Disorders appropriated $750,000 to the Colorado Consortium for Prescription Drug Abuse Prevention for provider and other educational purposes. This appropriation was part of HB-18-1003 that directed the Consortium to perform: (1) Provider education on safe opioid prescribing; (2) Community based naloxone training; and, (3) Law enforcement-based naloxone training.

The Consortium has already used the provider education portion of the funds for rounding out a robust curriculum of provider education and logistical details including outreach. The Consortium is currently talking with large health systems, such as Centura, SCL Health and others about collaborating on provider education events and programs using the state funding to reach thousands of physicians (for example, the Consortium estimates that Centura Health has 3,300 primary care physicians they want to train, with details currently under discussion). Colorado is taking an effective approach; state funding; a willing medical community and an effective Consortium effort. Colorado Medicine will continue to feature opioid educational columns through 2019. Component or county medical societies continue to promote and sponsor opioid educational seminars for their members.

We urge the Interim Study to continue recommending funding to the Consortium for provider education and for public awareness, such as safe disposal. The Consortium is on the right track with larger scale needed.

3. Voluntary uptake of continuing medical education continues to accelerate. In addition to the consortium and the Colorado Medical Board CME advertising, education of surgical groups and other specialties that prescribe for acute pain have been conducted and-or planned. The July-August issue of Colorado Medicine was dedicated to reversing the opioid crisis. The September-October issue included two additional segments.

4. Committee members suggest that a mandate will not accelerate training and may cause a backlash with a profession that already sees the opioid issue as a crisis, is taking ownership and making changes in their strategies for treating pain with fewer opioids and alternatives to opioids entirely.

5. The committee is interested in learning from proponents of mandatory CME about the desired outcomes they are trying to achieve. By understanding the desired outcomes, additional discussions would be desired. There may be alternative ways to achieve the desired outcomes.

The committee prefers to have more information on a mandatory CME provision before making a recommendation on this section of the bill.

- **Allows medical examiners access to the PDMP if the information released by the PDMP is specific to an individual who is the subject of an autopsy conducted by the medical examiner and the individual's death or injury occurred under unusual, suspicious or unnatural circumstances.**

Comment: The committee is conceptually supportive of this provision but asked CMS staff to determine the current definition of "medical examiner" and what level of confidentiality would be applied to such access.

The committee deferred a recommendation on this section until additional information is available.

- **Amends the definition of "abuse" for the purpose of the "Child Protection Act of 1987" to mean newborn children who are born affected by substance exposure and who present factors that threaten the newborn child's health or welfare.**

  Comment: The committee seeks more information to understand the intent and impact of this section before making a final recommendation. Concerns were expressed about the provision having the effect of punishing pregnant women who are dealing with an opioid-use disorder. Committee members want to understand this provision fully before recommending a CMS position.

- **Creates the prenatal screening, brief intervention, and referral to treatment pilot program to gather data concerning pregnant women with substance use disorders and infants who are affected by substance use prior to birth**

  Comment: The committee voted to recommend CMS support for this section of the bill.

- **Appropriates money to expand the household medication take-back program to include a process for the safe collection and disposal of medication injection devices**

  Comment: The committee voted to recommend CMS support for this section of the bill.

- **Requires HCPF to implement a grant program to refer persons with substance use disorders who have tested positive for hepatitis C or HIV and have used injectable drugs to treatment for substance use and MH issues**

  Comment: The committee supports this section of the bill in concept.

- **Requires an increase in public awareness of safe use, storage and disposal of antagonist drugs**

  Comment: The committee voted to recommend CMS support for this section of the bill.

- **Requires Office of Behavioral Health to administer a pilot program to integrate substance use disorder and medication-assisted treatment with obstetric and gynecological health care**

  Comment: The committee supports this section of the bill conceptually and seeks input from the Colorado Chapter of the American College of Obstetrics and Gynecology.

- **Increases appropriations for distribution to local public health agencies in an amount sufficient to fund local activities relating to opioid and other substance use disorders.**

  Comment: The committee voted to recommend CMS support for this section of the bill.

Bill #5: Substance Use Disorder Treatment in the Criminal Justice System

Comment: The committee recommended that CMS support this bill.

Final Comment:

As a point of reference, the Committee wishes to once again provide CMS recommendations previously submitted to the Interim Study.

The following recommendations are respectfully submitted for consideration by the Opioid and Other Substance Use Disorders Study Committee:

1. **Increase access to care and decrease use of opioids:** Strive to create a practice environment that promotes the efficacy and safety of a multi-modal approach to treating pain. Avoid or limit as much as possible use of opioid pain medications.

   - **Multi-modal:** A multi-modal approach to managing pain is essential. Components of this approach include:
     - *Decrease exposure to opioids from the start*: Increase access to and funding for non-medication pain treatment options like physical therapy, massage, acupuncture, and pain psychology therapy;
     - *Help with chronic pain*: For patients with chronic pain, increase access to safer abuse-deterrent opioids and atypical opioids like tapentadol, buprenorphine buccal films and transdermal patches. Ensure access to appropriate interventional procedures.
     - *Care when needed:* Ensure access to substance use disorder treatment and support high risk patients by making sure that they have ready access to Naloxone.

- **Decrease use of opioids when appropriate:** Continue to work on reducing doses when appropriate or switching to atypical or alternatives to opioids. Promote the use of best practice guidelines and prescribing of the safest and most effective pain regimen for patients.

2. **Ensure that insurance coverage works for opioid addicted patients:**

   - **Break down barriers to care:** Improve access to treatment of patients who have pain or are addicted by removing health plan prior authorization or step therapy requirements.
   - **Network adequacy:** Develop and promote health plan network adequacy standards specifically related to ensuring that insured patients addicted to opioids have adequate access to a multi-modal approach to care.

3. **Health care workforce**: Lack of available behavioral health addiction treatment and other pain management specialists that addicted patients can be referred to is a critical concern for Colorado physicians as demonstrated in CMS member surveys. Shoring up this workforce need is essential. Augmenting those specialists through more use of and collaboration with primary care physicians is an excellent opportunity to expand access to care. Appropriate medical education on the treatment of opioid addicted patients should be easily available to primary care physicians, as should the ability to co-locate and co-manage addicted patients with other behavioral and mental health clinicians. This team-based approach has been shown to work but it will require sufficient funding that currently does not exist for most primary care practices.

Copies to:

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