



ARMA
ARIZONA MEDICAL
ASSOCIATION

AOMA
Arizona Osteopathic Medical Association

Arizona Department of Health Services
150 North 18th Avenue, Suite 200
Phoenix, AZ 85007

Dear Dr. Christ,

On behalf of Arizona physicians, the Arizona Medical Association, and the Arizona Osteopathic Medical Association, we respectfully submit feedback on the preliminary legislative solutions proposed in the Arizona Department of Health Services' (ADHS) Opioid Action Plan.

Thank you for your leadership and for your Department employees' tireless efforts to address the opioid epidemic. We are deeply concerned about the growth and prevalence of opioid abuse/misuse and related fatalities from overdoses. Through your leadership and collective support of physicians, providers, patients, payers and communities, we can all make a difference.

Ending this opioid epidemic requires a multi-faceted approach to address the root causes of the problem that include changing the culture of medicine and pain management, the delivery of healthcare, ceasing the flow of illicit drugs, and preventing and treating addictive behaviors. We should ensure at the forefront of these efforts access to high-quality treatment for those with a substance use disorder. To adequately address the epidemic and the resulting death rates, Arizona must prioritize funding to ensure adequate access to providers and treatment programs.

We urge ADHS and policymakers to be exceptionally careful considering these sweeping changes to the delivery of healthcare to patients. It is virtually impossible to legislate the care of individual patients since each patient has unique needs and responds differently to varying types and levels of treatment. Laws seldom keep pace with changes in evidence-based medicine. Thus, it is imperative we ensure that legislative solutions account for unintended consequences, are adaptable to changes, and do not create unnecessary barriers to care or harm vulnerable patients. It is especially important in the context of the opioid epidemic as the consequences could result in illicit use, death, and suicide. The worst possible outcomes.

As your legislative recommendations are preliminary, please also consider our recommendations preliminary. We are in the midst of studying these proposals thoroughly with physicians. Additional evidence-based research and data are rapidly

emerging about opioids and pain management so policies can quickly become outdated and a barrier to progress. We know additional issues and information will emerge that will necessitate stakeholder meetings and further consideration. Below we have highlighted the key legislative proposals that directly deal with the doctor-patient relationship, the regulation of physician behavior and patient care.

Five-day limit on all first fills for opioid naïve patients for all payers

We have serious concerns about unintended consequences of broadly applying a five-day limit to all patients. In order to avoid harm to vulnerable patients, we must develop a comprehensive list of exemptions for conditions and situations. Some examples include hospice and palliative care, oncology, post-surgical discharge, neonatal abstinence syndrome patients and highly vulnerable patients with limited ability to receive follow-up care. An exception for appropriately documented medical discretion must be included in any policies to ensure a system that supports the best patient care possible.

We also note that Arizona's opioid prescriptions have decreased every year since 2013 – a 10 percent decrease total. In addition, deaths from prescription opioids are trending down compared to the staggering increases in death from heroin and fentanyl. Thus, as we work together to reduce the state's opioid supply, it is clear that physicians and other prescribers already are taking action on this front.

We therefore urge you to collect data and learn from the experiences in implementation of the initial fill limitation for AHCCCS and state employee patients before this is considered for all patients. We further urge an appropriate review of emerging data from policies reducing opioid prescribing in a variety of surgical settings. The policy should also be flexible as best practices and prescribing guidelines change and new data and research inform clinical situations.

We also seek clarification how this requirement would be imposed on commercial payers. Most states that have imposed prescribing limits have placed them on prescribers, while payers and pharmacy benefit management companies have instituted their own proprietary dispensing and coverage policies. We seek consistency so that providers, dispensers and payers all are working under the same criteria to help minimize patient care disruptions.

Require a limit (and tapering down) of doses to less than 90 MME (taper down would occur over years, exemptions for specific situations would be in statute)

We strongly oppose putting any kind of dose-strength limitation in state law. Furthermore, it is virtually impossible to specifically legislate an appropriate taper. Every patient is unique and there is no universally accepted threshold for what is acceptable for every situation. Some complex pain patients can be properly cared for and managed by appropriate providers with higher dosages that allow them to manage pain and be active members of society and our economy. In addition, imposing this type of a requirement on healthcare delivery would create arbitrary subclasses of patients and likely result in unnecessary and disproportionate patient suffering.

Regulate pain management clinics to prohibit “pill mill” activities

We strongly support curtailing illegal “pill mill” activities through regulation. We also support efforts to identify outliers to help determine whether they have practices (e.g. oncology) with understandable prescribing patterns, whether they need additional education, or whether other interventions are necessary. However, it is important that any criteria used to subject physicians to additional regulations is carefully designed so responsible physicians, who by virtue of the type of medicine they practice treat higher numbers of patients who suffer from pain, are not unduly and unnecessarily impacted. This is the type of analysis undertaken in the peer review process, and we welcome the opportunity to work with you to implement this in a meaningful way.

Require e-prescribing for Schedule II controlled substances

We understand e-prescribing is a powerful tool to help reduce fraudulent prescriptions. It is also relatively new and still quite expensive for physicians, and accessibility and costs are not yet conducive for widespread adaptation. We are concerned about the inconsistent availability of this technology through the different vendors to all physicians, especially in rural areas. In addition, this could be an onerous expense for physicians who infrequently prescribe Schedule II medications. We strongly recommend that a requirement like this be flexible with exemptions and include a long lead time for implementation to ensure that the technology is widely available and cost-effective. We also believe that imposing the requirement on all Schedule II drugs in the onset is overly broad to address the opioid epidemic.

Eliminate dispensing of controlled substances by prescribers

We understand the concerns about opioid misuse related to inappropriate dispensing by physicians. We should carefully consider all of the circumstances and situations for prescribers needing to dispense medications to patients. We must avoid unintended consequences of prohibiting dispensing in remote rural communities, home visits to vulnerable patients, or other special circumstances where dispensing a medication is the most viable option for patients with limited or no mobility.

Require at least 3 hours of opioid-related CME for all professions that prescribe/dispense opioids

Our organizations have been actively providing and promoting CME on opioid prescribing for many years and we will continue to assist physicians to learn about best practices for responsible prescribing of opioids and pain management. We are not opposed to additional provider CME on opioid prescribing and addiction. However, it is unnecessary and unfair to impose this mandate on physicians who do not have a DEA registration or have never prescribed Schedule II medications and should be exempt. Furthermore, while the practice of medicine and the need for CME changes as issues emerge, the laws often do not keep pace and are difficult to change. Therefore, we recommend a policy like this have a sunset date so its need can be reevaluated in the future and modified if necessary.

Insurance Prior Authorization Practices & Increasing Access to Care

We strongly support a thorough review of the prior authorization laws and other barriers to patient care and non-pharmacological pain management therapies. Physicians and patients in Arizona are often subjected to insurance company restrictions and/or limitations to essential services that prevent or delay the recovery of patients. As policymakers seek to limit the availability of opioids, it is imperative that we make it easier to access alternatives, including substance abuse treatment. The current prior authorization system must be addressed to ensure the system is transparent, fair and efficient for patient care.

In addition, access to medically assisted treatment (“MAT”) is critical in addressing the opioid epidemic. Barriers to access need to be broken down. Insurers should be prohibited from requiring prior authorizations of MAT for opioid use disorder. In addition, all payers should be required to cover all three forms of MAT on their formularies and coverage at the lowest cost sharing tier. Finally, we need to ensure network adequacy for MAT and ensure network providers are accepting new patients.

Require pharmacists to check the PMP prior to dispensing an opioid or benzodiazepine

We support this change and believe pharmacists can play an important role in reviewing the PMP for fraudulent or unusual activity related to opioid abuse or misuse.

Enact a Good Samaritan law to allow bystanders to call 911 for a potential overdose

We strongly support enacting a Good Samaritan law to prevent life threatening or fatal overdose.

Thank you for the opportunity to provide feedback on the preliminary legislative solutions proposed in the ADHS Opioid Action Plan. We look forward to working closely with you to ensure that we address the root causes of the opioid epidemic while preventing unintended consequences.

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