AMA
AMERICAN MEDICAL ASSOCIATION

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Fraser Cobbe
Executive Director
Florida Orthopaedic Society
1215 E. Robinson Street
Orlando, FL 32801

Dear Mr. Cobbe:

On behalf of the American Medical Association (AMA) and our physician and student members, I am writing to provide brief analysis of state policy interventions to limit opioid prescriptions. As you review this letter and the attached information, there are a few overarching considerations:

- The nature of the opioid epidemic is changing. While death due to prescription opioids remains unacceptably high, death due to heroin and illicit fentanyl are now the main drivers of opioid-related mortality.
- States with and without prescribing restrictions have each seen opioid-related mortality increases and decreases, respectively.

More than 20 states thus far have enacted some type of restriction or limit on the amount of opioids prescribed to a patient. Typically, these limits are focused on the "initial prescription" for an opioid analgesic and/or benzodiazepine. The limits mainly address the initial prescription for acute, non-cancer pain, such as pain associated with sudden injury requiring treatment in an emergency department or related to minor surgical procedures. Most states have pursued a restriction on the total number of days while a few have implemented specific restrictions on daily morphine milligram equivalent (MME) doses.

Within every new state law, and regulations implementing those statutes, are exceptions to the specific day limit or MME threshold. Common exceptions to the prescribing limits for acute pain include:

- Cancer care, including care associated with cancer-related illnesses;
- Hospice and end-of-life care;
- Palliative care;
- Opioids administered in a medical, assisted living or skilled nursing facility;
- Care for a substance use disorder; and
- Situations that do not fall within a recognized exception but are detailed within the patient's medical record as requiring a greater dose or quantity than the stated threshold.

It remains to be seen, however, how states are interpreting "initial prescription." The following scenario underscores the potential challenges:

> Patient Joe goes to the emergency department for a sports injury. He is seen by Dr. Kate, who examines Joe, reviews an x-ray and determines that Joe has a broken arm. Kate casts the arm, prescribes a five day course of an opioid analgesic and refers Joe to an orthopaedic surgeon. Four days later, Joe sees the surgeon, Dr. Ken, who recommends surgery and schedules it at his next opening—10 days away. Joe, who is still experiencing pain, asks Dr. Ken for a new prescription to last until the surgery. Can Dr. Ken prescribe more than seven days? On one hand, this is a new prescription given that Dr. Ken has never prescribed to Joe. But on the other hand, this is an ongoing care situation. And the surgery is more than seven days in the future. What does Dr. Ken do? The answer depends on the interpretation of "initial"—and whether there are applicable exceptions in the state law.

This scenario underscores the inherent challenges in attempting to legislate the nuances of medical care, which is why the AMA supports guidelines developed and endorsed by medical associations and relevant medical journals. The AMA has collected more than 300 educational and other resources on a new opioid microsite: www.end-opioid-epidemic.org. Should the State of Florida pursue hard prescribing thresholds, it is critical that both the statute and implementing regulations avoid rigid thresholds that do not account for the realities of patient care.

In the AMA's state and national advocacy, we urge policymakers to focus on legislative interventions that will lead to two primary outcomes regarding the nation's opioid overdose and death epidemic: (1) Reducing opioid-related harms—particularly overdose and death; and (2) Improving access to treatment.

Generally, a review of representative states (Table 1) shows a continuing increase of rates of mortality across the three major opioid categories—regardless of state prescribing restrictions. And while the chart below only shows a limited number of states, it is representative of the fact that the nature of the epidemic is changing from one driven by prescription opioids to one driven by illicit fentanyl and heroin. Prescription opioid mortality remains unacceptably high, but other than a few, limited examples, including Florida, mortality continues to rise in this category. It is not clear why some states have seen slight decreases and other variations in prescription opioid-related mortality, but they, too, have seen increases in illicit fentanyl and heroin-related death.

As you can see below, Florida's mortality rates due to prescription opioids are down from 2012, yet increased from 2014 to 2015. At the same time, death from illicit fentanyl and heroin has more than tripled. The reasons for these trends demand greater attention—and ensuring increased access to high quality treatment is even more imperative. As we have advocated for years, unless and until policymakers provide the necessary resources to ensure access to high quality treatment for pain and for substance use disorders, the AMA is deeply concerned that the epidemic will only continue to worsen.

Table 1: Opioid-related mortality[1] and relationship with PDMP mandates and prescribing restrictions

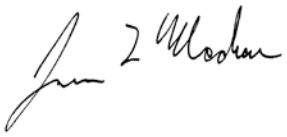
	Natural and Semisynthetic Opioids (e.g. oxycodone, hydrocodone)				Synthetic Opioids, other than Methadone (e.g. fentanyl)				Heroin				Prescribing Restriction	Date
	2012	2013	2014	2015	2012	2013	2014	2015	2012	2013	2014	2015		
Arizona	326	253	290	298	36	52	57	72	101	146	197	247	Yes	2017
California	965	1039	1047	1019	146	176	194	229	362	486	561	593	No	n/a
Colorado	223	221	259	259	52	67	80	64	91	120	156	159	No	n/a
Florida	**850**	**751**	**697**	**789**	**162**	**200**	**343**	**610**	**101**	**181**	**344**	**567**	**No**	**n/a**
Georgia	300	309	388	435	61	80	174	284	40	67	153	222	No	n/a
Kentucky	391	349	344	382	70	76	179	323	143	215	228	310	Yes	2017
Maine	61	64	80	102	15	23	62	116	12	16	38	52	Yes	2016
Massachusetts	171	179	178	225	67	98	453	949	246	288	469	634	Yes	2016
New Hampshire	56	62	81	63	24	30	151	285	39	67	98	78	No	n/a
New Jersey	217	231	245	237	38	57	111	243	304	383	424	508	Yes	2017
New Mexico	179	209	223	160	37	23	66	42	104	89	139	156	No	n/a
New York	616	644	608	705	164	210	294	668	516	666	825	1058	Yes	2016
Ohio	499	518	618	690	139	167	590	1234	696	998	1208	1444	Yes	2017
Pennsylvania	358	406	411	460	99	108	217	429	323	409	503	663	Yes	2017
Rhode Island	72	80	70	95	12	32	82	137	30	65	66	45	Yes	2016
Tennessee	491	524	554	643	77	99	132	251	50	68	148	205	No	n/a
Texas	480	452	471	473	121	112	157	186	367	369	425	523	No	n/a
Utah	328	358	367	357	59	58	68	62	84	122	110	127	Yes	2017
Vermont	27	37	21	25	NSD	17	21	33	10	20	33	33	Yes	2017
Virginia	276	297	323	276	89	125	176	270	121	206	253	353	Yes	2017
Washington	332	269	288	261	59	59	62	65	177	205	289	303	Yes	2012
West Virginia	348	341	363	356	89	98	122	217	63	144	163	194	No	n/a
United States	**11134**	**11342**	**12159**	**12728**	**2628**	**3105**	**5544**	**9549**	**5925**	**8257**	**10574**	**12957**		

[1] See "Opioid Overdose Deaths by Type of Opioid" available at http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-type-of-opioid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

We understand why policymakers and payers have focused on limiting opioid prescribing, but we urge an equal focus on improving the quality of care for patients with pain. The objective should be to improve the number of pain patients whose pain is well controlled without needing high doses of opioids for lengthy periods of time. Achieving that would be true quality improvement, and it is a mistake to approach a reduction in opioid prescribing alone as the goal—particularly when that has been occurring nationwide for the past several years. The policy objective should focus both on how well patients' pain is controlled and what therapies are being used to manage pain. It is not acceptable to focus all the attention on reducing opioid prescribing if the result is to increase patient suffering.

The AMA would be pleased to provide additional information to help the physicians of Florida. If we can be of further assistance, please contact Daniel Blaney-Koen, JD, Senior Legislative Attorney, Advocacy Resource Center at daniel.blaney-koen@ama-assn.org or (312) 464-4954.

Sincerely,



James L. Madara, MD

cc Florida Medical Association