Maine’s New Opioid Prescribing Law & the Opioid Crisis: Implications for Providers

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Facing the Opioid Crisis Today

- Opioid abuse epidemic gains attention of state and federal policymakers throughout 2015
- About a half dozen relevant bills submitted for consideration by the 127th Maine Legislature during the 2016 session
- Opioid abuse issue has substantial political energy behind it; legislative action seemed certain from the session’s start
- MMA and other advocates sought health care practitioner licensing board regulatory action rather than legislative intrusion into the physician-patient relationship
- Finally, preventing legislative action not a realistic strategy; MMA and other advocates successfully moderated LePage Administration proposal through lengthy negotiations
Key Bills in 2016 Session

- **LD 1537, An Act To Combat Drug Addiction through Enforcement, Prevention, Treatment and Recovery** (PL 2015, Chapter 378) - submitted by Speaker of the House and President of the Senate
- **LD 1646, An Act To Prevent Opiate Abuse by Strengthening the Controlled Substances Prescription Monitoring Program** (PL 2015, Chapter 488) - introduced by the Governor to provide limits on the prescription of opioids
- **LD 1648, An Act To Amend the Laws Governing the Controlled Substances Prescription Monitoring Program and To Review Limits on the Prescription of Controlled Substances** - introduced by Sen. Roger Katz (R-Kennebec) as an alternative to LD 1646; did not pass, but some concepts included in final version of LD 1646
Overview of Chapter 488

- Effective 90 days after adjournment, though some provisions have other timeframes specified (~July 29th)
- Components include:
  - Required PMP check for prescribers and dispensers
  - Prescribing limits on MMEs per day
  - Prescribing limits on length of scripts
  - Exception for emergency rooms, inpatient hospitals, long-term care facilities, or residential care facilities
  - Exception for medication-assisted treatment for substance use disorder
  - Exception for active and aftercare cancer treatment, palliative care, and end-of-life and hospice care
  - Other exceptions may be determined by rule
  - Mandatory CME
  - Mandatory electronic prescribing
Key Definitions

• **Acute pain**
  - Normal, predicted physiological response to a noxious chemical or thermal or mechanical stimulus.
  - Typically associated with invasive procedures, trauma and disease and is usually time-limited.

• **Chronic pain**
  - Persists beyond the usual course of an acute disease or healing of an injury.
  - May or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.
• **Prescriber**
  - Licensed health care professional with authority to prescribe controlled substances
  - Includes veterinarians

• **Administer**
  - Action to apply prescription drug directly to a person
  - Does not include delivery, dispensing, or distribution of a prescription drug for later use
Key Definitions

• Palliative care
  - Patient-centered, family-focused medical care that optimizes quality of life by anticipating, preventing, and treating suffering caused by medical illness or physical injury or condition that substantially affects quality of life
  - Addresses physical, emotional, social, and spiritual needs
  - Facilitates patient autonomy and choice of care
  - Provides access to information
  - Discusses patient’s goals for treatment and treatment options, including hospice care
  - Manages pain and symptoms comprehensively
Key Definitions

**Serious illness**
- Medical illness or physical injury or condition that substantially affects quality of life for more than a short period of time
- Includes, but is not limited to, Alzheimer’s disease and related dementias, lung disease, cancer and heart, renal or liver failure
Prescriber Responsibilities

• Required PMP check
  - Upon initial prescription of benzodiazepine or opioid medication
  - Every 90 days following

• Exception
  - No PMP check is required for benzodiazepine or opioid medication directly administered in an emergency room setting, an inpatient hospital setting, a long-term care facility, or a residential care facility
Prescriber Responsibilities

• **Electronic Prescribing**
  - Beginning July 1, 2017, prescribers with the capability to electronically prescribe must prescribe all opioid medication electronically
  - A waiver may be available in some circumstances

• **Continuing Education**
  - A prescriber must complete 3 hours of CME on the prescription of opioid medication every 2 years as a condition of prescribing opioid medication
• Morphine Milligram Equivalents (MMEs)
  - New opioid patients after effective date of law (~July 29th)
    • May not prescribe any combination of opioid medication in an aggregate amount of more than 100 MMEs per day
  - Existing opioid patients with active prescription in excess of 100 MMEs per day as of effective date of law (“Legacy patients”)
    • From effective date of law (~July 29th) until July 1, 2017, may not prescribe any combination of opioid medication in an aggregate amount of more than 300 MMEs per day
  - Exception for medical necessity documented in the medical record until January 1, 2017 or the effective date of DHHS rulemaking on exceptions, whichever is later
Prescription Limits

• **Acute Pain**
  - Script may not be written for more than 7-day supply within a 7-day period

• **Chronic Pain**
  - Script may not be written for more than 30-day supply within a 30-day period

• Scripts may be renewed without limit based on medical necessity

• Limits apply only to opioid medications
Prescription Limit Exceptions

• When prescribing for:
  - Active or aftercare cancer treatment
  - Palliative care
  - End-of-life and hospice care
  - Medication-assisted treatment for substance use disorder
  - Other circumstances determined by rulemaking

• When directly ordered or administrated in:
  - An emergency room
  - An inpatient hospital
  - A long-term care or residential care facility
Deadlines

• Effective date is 90 days after adjournment (~July 29th)

• January 1, 2017
  - Mandatory checks of the PMP
  - Limits on scripts for acute and chronic pain

• July 1, 2017
  - Mandatory electronic prescribing
  - Patients with active prescriptions in excess of 100 MMEs must be tapered to an aggregate amount of 100 MMEs or less per day

• December 31, 2017
  - CME requirement
Penalties

• Civil violation
• Subject to fine of $250 per incident up to a maximum of $5000 per calendar year
• But, no penalties may be imposed for violating prescribing limits until PMP enhancements are implemented
Other Provisions

- Prescription Monitoring Program (PMP)
  - PMP data access by certain hospital and pharmacy staff and a province of Canada
  - Automatic registration of pharmacists and veterinarians
  - "Enhancements" to PMP
    - "Dosage converter" to/from MME
    - Automatic distribution of de-identified peer data to prescribers annually
    - Improved delegation to non-prescriber staff
    - Improved speed and communication
- DHHS and Bureau of Insurance reporting requirements
Questions?

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