AMA
AMERICAN MEDICAL ASSOCIATION

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Bruce M. Smoller, MD
AMA Delegation Representative
Gene Ransom
Chief Executive Officer
MedChi, The Maryland State Medical Society
1211 Cathedral Street
Baltimore, MD 21201-5516

Dear Dr. Smoller and Gene:

On behalf of the American Medical Association (AMA) and our physician and student members, I want to thank you for your recent letters concerning multiple aspects of the nation's opioid epidemic and drug benefits. As described in more detail below, the AMA—through our state and federal advocacy and the work of the AMA Opioid Task Force—is working on each of the issues you raised in your correspondence.

First, we strongly agree that there needs to be much greater access to non-opioid therapies for patients with pain, including the pharmacologic alternatives to opioids you mention in your letter. We further agree that administrative barriers, including step therapy and prior authorization, pose significant barriers for physicians. AMA advocacy, therefore, will seek reforms that include having non-opioid pharmacologic options on the lowest cost-sharing tiers in formularies. We will also advocate that utilization management protocols, if used, should be used sparingly to make access to these non-opioid alternatives affordable and timely. Moreover, we believe that insurance commissioners, Medicaid directors and other appropriate regulatory entities should take increased action to review payer formularies to ensure that patients have timely and affordable access to these non-opioid alternatives. The AMA would be very pleased to join MedChi, The Maryland State Medical Society (MedChi) in direct advocacy to support these goals.

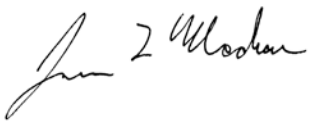
Additionally, we are aligned with you on the need to address conflicts of interest for physicians and other health care providers on formulary review boards. For nearly two years, we were engaged with the National Association of Insurance Commissioners (NAIC) as they developed model legislation on the prescription drug benefit. Our advocacy to the NAIC during this time included a request to incorporate a strong conflict of interest policy for pharmacy and therapeutic (P&T) committees into their model bill. While the final NAIC model bill did require that P&T committees have a conflict of interest policy, we believe the NAIC's language falls short. As such, we are in the process of developing our own model language to prevent such conflicts and establish other patient protections in the pharmacy benefit to ensure that patients have access to the most appropriate and effective prescriptions to meet their health care needs. We will be circulating our model language to you and other members of the Federation in early 2019.

With respect to the issue of including methadone in a state prescription drug monitoring program (PDMP), I first want to commend MedChi for its efforts to encourage PDMP use, which has resulted, in Maryland, in an increase from 537,000 queries in 2014 to nearly 2 million in 2017. I recognize that this increase is due to many factors, but it also is a mark that Maryland physicians are seeing its utility as a helpful tool to assist with clinical decision making. I also want to note that in Maryland, methadone-related overdose has remained stable for more than a decade, and was lower (197 deaths in 2016) than at its peak (201 deaths) in 2007.

At the same time, death related to heroin, illicit fentanyl and opioid analgesics have all greatly increased. This is not to suggest that methadone-related mortality is acceptable, but to point out two things. First, the data is not clear whether patients who died from a methadone-related cause received the medication for pain or for treatment of a substance use disorder (SUD). Methadone for pain should be included in the Maryland PDMP. Methadone for treatment of an SUD, however, is subject to a broader set of privacy rules that I would be happy to direct my staff to discuss in much greater detail. I want to also point out that while methadone for SUD treatment may not be in the PDMP, we urge physicians to ask their patients about their complete drug history. Successful medical care requires ongoing collaboration between patients and physicians. Patients contribute to the collaborative effort when they are truthful and forthcoming with their physicians and strive to express their concerns clearly. Physicians likewise should encourage patients to raise questions or concerns. It follows that physicians should encourage patients to provide as complete a medical history as they can, including providing information about past illnesses, medications, hospitalizations, family history of illness and other matters relating to present health. This certainly includes a current history of prescriptions used to treat a SUD.

To continue this discussion, please contact Daniel Blaney-Koen, JD and Emily Carroll, JD, in the AMA's Advocacy Resource Center. Daniel can be reached at daniel.blaney-koen@ama-assn.org and (312) 464-4954, and Emily can be reached at emily.carroll@ama-assn.org or (312) 464-4967.

Sincerely,



James L. Madara, MD

cc: Willarda Edwards, MD