CALIFORNIA SENATE OFFICE OF RESEARCH

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Federal Update

OPIOID ABUSE THE FOCUS OF FEDERAL COMPREHENSIVE ADDICTION AND RECOVERY ACT

Responding to the nation's opioid abuse and heroin epidemic, Congress passed and President Obama signed bipartisan legislation, the Comprehensive Addiction and Recovery Act (CARA), in July 2016 (S.524 (Whitehouse), 114th Congress 2015–16). This measure was the result of three years of collaboration among the country's law enforcement, first responders, scientists, policy makers, and impacted families. [1] Advocates have praised the legislation as an essential policy shift to recognize addiction as a disease rather than merely a crime or law enforcement issue.[2]

A Centers for Disease Control and Prevention (CDC) study released in January 2016 states that drug overdose-related deaths increased by 137 percent between 2000 and 2014, with a 200 percent increase in the rate of overdose deaths involving opioids.[3] The study found that opioids were involved in 28,647 deaths in 2014, of which 4,521 were in California.

Among other things, the legislation seeks to expand access to treatment by allowing nurses and physician assistants to administer medication to help fight addiction[4] and creates the nation's first mandate for doctors to cross-check a patient's opioid history with prescription drug monitoring programs (see more details on this below).

CARA FUNDING

Total funding for the measure, which was estimated by Senate Democrats and the administration at approximately $900 million, was not included in the bill and is necessary to expand the treatment program nationally. Senate Democrats had been pushing to include the funding in the original legislation, but Senate Republicans argued that the funding would have to go through the regular appropriations process. The legislation did authorize and appropriate nearly $120 million, through offsets, for community-based grants, comprehensive response grants administered by the

Department of Justice (DOJ), and the reauthorization of the National All Schedules Prescription Electronic Reporting system[5] to ensure proper monitoring of opioid prescriptions.

CONTINUING RESOLUTION TO FUND CARA

On September 29, 2016, Congress passed and the President signed a Continuing Resolution (CR) to fund the federal government from October 1, 2016, through December 9, 2016, that specifically includes funding for CARA within DOJ and the Department of Health and Human Services (HHS). A CR can fund agencies at the previous fiscal year (FY) levels only (in this case, FY 2016), so any new programs that require funding must be specifically mentioned. The CR allocates $37 million ($17 million to HHS and $20 million to DOJ). The CR does not specify how the funding will be spent within the agencies, and the agencies likely will wait until December at the earliest to start putting funding plans in place.

Addendum, October 13, 2016: U.S. Sen. Ron Wyden (D-OR), Ranking Member of the Senate Finance Committee, recently released a report by Democratic committee staff calling for more CARA funding. The report, "Dying Waiting for Treatment: The Opioid Use Disorder Treatment Gap and the Need for Funding," describes the country's need for more treatment of substance use. California is one of several states highlighted in the report, which is available at http://www.finance.senate.gov/imo/media/doc/101116%20Opioid%20Treatment%20Gap%20Report%20Final.pdf.

OTHER FEDERAL EFFORTS RELATED TO THE OPIOID EPIDEMIC

In March 2015, the Obama Administration announced a three-part targeted initiative aimed at reducing prescription opioid and heroin-related abuse and overdoses. Since that time, the administration has taken several steps to implement the initiative. Significantly, HHS increased the patient limit from 100 to 275 for physicians prescribing the semisynthetic opioid buprenorphine[6] under medication-assisted treatment, commonly referred to as MAT (see endnote 4 for an explanation on how CARA further expanded upon this), and CDC released final opioid prescribing guidelines for primary care physicians addressing opioids' use for chronic pain.[7] In addition, HHS announced that for FY 2017, the Department will provide $94 million in mandatory funding for substance abuse service expansion under community health centers with a focus on MAT for opioid use disorders.[8]

For FY 2016, $237 million was dedicated to HHS to address the opioid epidemic through grants administered competitively to the states to help combat prescription drug abuse. Of the $179 million that was awarded to the states in FY 2016, California received grants totaling $14 million.[9]

The administration also announced that it would be taking further action by launching more than a dozen new studies on pain treatment and opioid misuse.[10] Later this year, the U.S. Surgeon General is expected to release a sweeping report to address opioid abuse, accompanied by a national awareness campaign.[11] The efforts are meant to increase awareness of consumers and patients, and reduce the pressure some doctors may feel when prescribing opioid pain medications.

State Prescription Drug Monitoring Programs

CDC recommends that states use Prescription Drug Monitoring Programs (PDMPs) as a state-level intervention tool to improve painkiller prescribing practices with a focus on high-risk patients, as well as prescribers who deviate from accepted medical practice. While the CR is not specific on funding, prior reports indicate that approximately $13 million will be dedicated to PDMPs through DOJ.

California's Controlled Substance Utilization Review and Evaluation System (CURES) is the oldest PDMP in the nation. CURES is an electronic tracking program that reports all pharmacy (and specified types of prescriber) dispensing of controlled drugs by drug name, quantity, prescriber, patient, and pharmacy. The database contains approximately 400 million entries of controlled substance prescriptions dispensed in California. Through the recently updated system, CURES 2.0, prescribers can receive daily informational alerts about patients who reach various prescribing thresholds, based on patterns indicative of at-risk patient behavior, which can be used to determine whether action by the prescriber is necessary.

Recent Related Legislation in California

ACR 26 (Levine), Chapter 16, Statutes of 2015: March 2015 was proclaimed the Prescription Drug Abuse Awareness Month in California due to the significant rise in drug overdose related deaths.

SB 833 (Committee on Budget and Fiscal Review–Health), Chapter 30, Statutes of 2016, Budget Act of 2016, subject to an appropriation, awarded funding to local health

departments and agencies to support or establish programs to provide Naloxone[12] to first responders and at-risk opioid users.

SB 482 (Lara), Chapter 708, Statutes of 2016, requires a health care provider, narrowly defined as someone who is authorized to prescribe, order, administer, or furnish a controlled substance, to consult CURES before prescribing a Schedule II, III, or IV drug to a patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient, with certain exemptions.

Written by Elizabeth Dietzen Olsen, Kim Flores, and Janelle Miyashiro. The California Senate Office of Research is a nonpartisan office charged with serving the research needs of the California State Senate and assisting Senate members and committees with the development of effective public policy. The office was established by the Senate Rules Committee in 1969. For more information, please visit **http://sor.senate.ca.gov** or call **(916) 651-1500.**

1 http://www.addictionpolicy.org/single-post/2016/07/25/Statement-on-the-President-Signing-CARA-into-Law.

2 http://www.nytimes.com/2016/07/14/us/politics/senate-opioid-addiction-bill.html?_r=0.

3 http://www.cdc.gov/drugoverdose/data/statedeaths.html.

4 CARA amends the Controlled Substances Act to permit nurse practitioners and physician assistants (NPs and PAs) to receive a waiver from Substance Abuse and Mental Health Services Administration to dispense Food and Drug Administration-approved drugs for treatment for up to 30 patients in the first year and up to 100 patients after the first year (previously the Obama Administration through regulations had only increased patient limits for physician's administering buprenorphine). However, because California requires NPs and PAs to practice under the supervision of a physician, the physician would also need to obtain a waiver. https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/20160706JES.pdf.

5 http://www.nasper.org/.

6 http://www.samhsa.gov/medication-assisted-treatment/treatment/buprenorphine.

7 Issue brief "Opioid Policy Developments," Thorn Run Partners, May 3, 2016.

8 Federal Funds Information for States Issue Brief 16–43, September 13, 2016, HHS Awards FY 2016 Funds to Address Opioid Epidemic.

9 Ibid.

10 https://www.whitehouse.gov/the-press-office/2016/07/06/fact-sheet-obama-administration-takes-more-actions-address-prescription.

11 Issue brief "Opioid Policy Developments," Thorn Run Partners, May 3, 2016. http://www.surgeongeneral.gov/news/2015/10/unite-to-face-addiction-remarks.html.

12 Naloxone blocks or reverses the effects of opioids and is used to treat a narcotic overdose in an emergency situation. See https://www.drugs.com/naloxone.html.