

To: Washington Representatives/State-Federal Contacts
CC: Health Policy Advisors, Criminal Justice Policy Advisors
From: Melinda Becker
Re: NGA Survey on Federal Recommendations to Address Prescription Drug Abuse

Across the country, states are confronted by the growing epidemic of prescription drug abuse. To address this issue, states are utilizing their authority to protect the public health and regulate the practice of the health professions while recognizing that progress may require changes at the federal level.

NGA is seeking state input on federal barriers identified during its policy academy on prescription drug abuse discussed below. Each state is encouraged to coordinate with its health policy and criminal justice policy advisors and other policy leads, as necessary, to respond to the enclosed survey.

Please send one submission per state to Melinda Becker (mbecker@nga.org; 202-624-5336) by close of business on Monday, September 23rd.

BACKGROUND

In September 2012, the NGA Center for Best Practices launched a year-long policy academy to support governors in their efforts to develop and implement an effective response to the prescription drug abuse epidemic. Governor Bentley and Governor Hickenlooper co-chaired the initiative, which included five other states: Arkansas, Kentucky, New Mexico, Oregon and Virginia.

In addition to developing state-level strategies, participants identified several areas where federal barriers are hindering state efforts to address prescription drug abuse. NGA is now seeking input from all states to inform its federal agenda on this issue. Below please find the proposed recommendations and accompanying survey questions.

SURVEY OF PROPOSED RECOMMENDATIONS

- 1. Recommendation: Amend the Controlled Substances Act to make any substance containing hydrocodone a Schedule II drug.** Currently, products containing 15 mg per dosage unit of hydrocodone or less are classified as Schedule III drugs. Reclassifying all hydrocodone combinations as Schedule II substances would impose additional restrictions on the prescribing and sale of hydrocodone combination products that, if misused, may lead to addiction.
 - a. Does your state see a need to further restrict access to hydrocodone combination products such as Vicodin?
 - Using examples and data from your state as much as possible, please explain why these products should or should not be classified as Schedule II substances.
 - b. Would up-scheduling hydrocodone products limit abuse of these substances without substantially affecting access for patients seeking them for legitimate use?
 - Please explain how this proposal would impact (1) efforts to prevent abuse and diversion of hydrocodone products and (2) access for patients, particularly in rural and/or medically underserved areas.
 - c. Please provide additional comments or feedback drawing on your state's experience.
- 2. Recommendation: Amend the Drug Addiction Treatment Act of 2000 (DATA 2000) to alter current limits on the number of patients a physician can have on opioid therapy at one time.** Under DATA 2000, physicians are prohibited from prescribing Suboxone to more than 30 patients in the first year and 100 patients each year thereafter. This limitation restricts patient access to Suboxone and other buprenorphine-based products needed for medication-assisted treatment.
 - a. Has your state identified a need to adjust or remove the cap on the number of patients that a physician can treat with buprenorphine-based products at one time?
 - Using examples and data from your state as much as possible, please explain why this limitation should or should not be changed.
 - b. Is there evidence from your state to show that limiting the number of patients a physician can treat with Suboxone at one time has created major barriers for patients seeking treatment for opioid addiction?
 - c. Please provide additional comments or feedback drawing on your state's experience.
- 3. Recommendation: Amend 42 CFR Part 2 to allow without a patient's prior consent (1) prescriber access to patient substance abuse treatment records and (2) integration of treatment information with electronic medical records and prescription drug monitoring programs.** 42 CFR Part 2, known as the Confidentiality of Alcohol and Drug Abuse Patient Records Regulation, prohibits substance abuse treatment programs from providing identifying information about patients without written consent. As a result, prescribers lack access to substance abuse and medication histories and may inadvertently prescribe medications that interact dangerously with those taken by patients to treat addiction.

- a. Has your state found a need for prescribers to have access to their patients' substance abuse treatment records?
 - Using examples and data from your state as much as possible, please explain why prescribers should or should not have access to substance abuse treatment records.
- b. Please provide additional comments or feedback drawing on your state's experience.

4. Recommendation: Request clearer guidance from the Drug Enforcement Administration (DEA) and more flexibility in the forthcoming final rule on disposal of controlled substances. The proposed rule governing safe disposal of controlled substances, issued in December 2012, takes a step in the right direction by providing guidance to ultimate users and establishing additional disposal options. However, states have expressed concern that the proposed regulations lack clarity on certain existing methods of disposal (e.g., flushing and mixing controlled substances with coffee grounds) and do not provide adequate flexibility.

- a. Does your state have concerns about DEA's proposed regulations on disposal of controlled substances?
 - If so, please explain these concerns and illustrate how the proposed rule would affect your state's efforts to promote safe disposal of controlled substances. Please also indicate whether any official(s) in your state submitted formal comments on the proposed rule.
- b. What changes, if any, should DEA consider before issuing the final rule?

5. Has your state encountered other federal barriers to addressing prescription drug abuse and diversion? If so, please explain.