

Department of Legislative Services
Maryland General Assembly
2017 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1278

(Delegate Pena-Melnyk, *et al.*)

Health and Government Operations

Public Health - Health Care Facilities and Health Care Systems - Availability of Buprenorphine Prescribers

This bill requires each health care facility that is not part of a health care system and each health care system to make available to patients the services of at least one health care provider who is authorized under federal law to prescribe buprenorphine for every 100 patients. For the purpose of calculating the number of health care providers required, the health care facility or health care system must use the average number of patients provided health care services per day in the immediately preceding calendar year. A health care facility or health care system may contract with a health care provider who is authorized under federal law to prescribe buprenorphine.

Fiscal Summary

State Effect: Potential significant increase in general fund expenditures for State hospitals to meet the bill's requirements, as discussed below. Medicaid expenditures (60% federal funds, 40% general funds) also increase, to the extent the bill results in additional buprenorphine prescriptions that are covered by Medicaid. Federal matching revenues increase correspondingly.

Local Effect: Potential significant increase in expenditures for local health departments (LHDs) to meet the bill's requirements, as discussed below. Revenues are not affected.

Small Business Effect: Potential meaningful for specified small business health care facilities that must meet the bill's required provider-patient ratio.

Analysis

Bill Summary: “Health care facility” means a hospital, a federally qualified health center, an outpatient mental health clinic, an outpatient addiction treatment provider, and an LHD.

Current Law:

Buprenorphine Prescription

Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates. Buprenorphine was the first medication to treat opioid addiction that is permitted to be prescribed or dispensed in physician’s offices.

Under the federal Controlled Substances Act, a qualifying practitioner may apply for a waiver from the annual registration requirement for dispensing or prescribing Schedule III, IV, or V narcotic drugs for maintenance or detoxification treatment, including buprenorphine, if the practitioner submits a notice to the U.S. Secretary of Health and Human Services of the practitioner’s intent to dispense such drugs. A waiver may be obtained for the treatment of up to 30 patients at one time. However, one year after the practitioner submits the initial notice, the physician may submit a second notice of the need and intent to treat up to 100 patients.

Through new regulations, effective August 8, 2016, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) increased the maximum number of patients a qualifying practitioner may treat at one time from 100 patients to 275, subject to renewal every three years. According to SAMHSA, licensed physicians who have had a waiver to treat 100 patients for at least one year are eligible for the increased limit if they (1) hold additional specified credentials; (2) practice in a qualifying practice setting; (3) have not had their Medicare enrollment and billing privileges revoked; and (4) have not violated the federal Controlled Substances Act. Additionally, practitioners with a current waiver to treat up to 100 patients but who are not otherwise eligible to apply for a waiver for the increased limit may request a temporary increase for up to 275 patients to address emergency situations, which is valid for up to six months. To the extent possible, SAMHSA will consult with appropriate governmental authorities to determine if the emergency situation justifies the increase. An “emergency situation” is one where an existing substance use disorder system is overwhelmed or unable to meet the existing need for MAT as a direct consequence of a clear precipitating event, which must have an abrupt onset (*e.g.*, practitioner incapacity, natural or human-caused disaster, or a drug use outbreak).

Comprehensive Addiction and Recovery Act

President Barack Obama signed the Comprehensive Addiction and Recovery Act (CARA) on July 22, 2016. The law authorizes over \$181 million each year in new funding. Among other provisions, CARA:

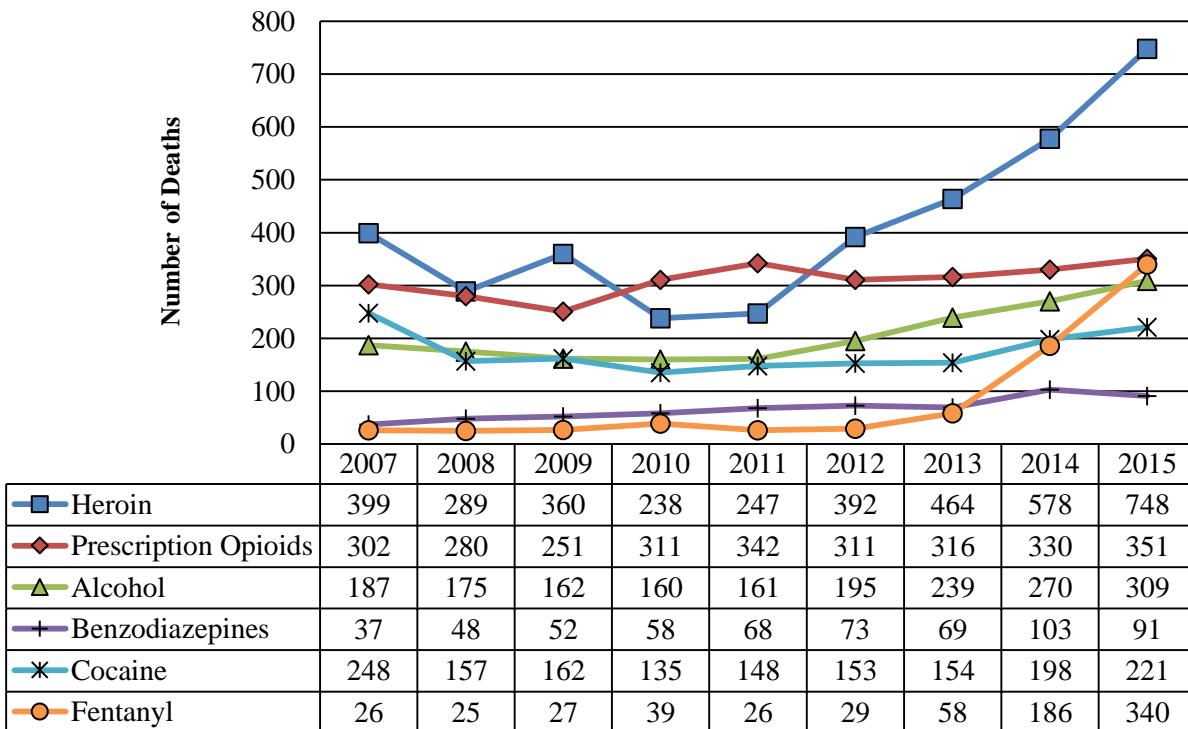
- authorizes grants to federally qualified health centers, opioid treatment programs, and practitioners who offer office-based MAT to expand access to naloxone through co-prescribing;
- reauthorizes funding for the National All Schedules Prescription Electronic Reporting Act for states to improve or maintain a prescription drug monitoring program;
- directs the U.S. Secretary of Health and Human Services to develop recommendations regarding education programs for opioid prescribers;
- authorizes grants to states to expand evidence-based MAT in areas with high rates of opioid and heroin use;
- authorizes grants to state substance abuse agencies to carry out pilot programs for nonresidential treatment of pregnant and postpartum women; and
- authorizes grants to states to implement integrated opioid abuse response initiatives, including expanding availability of MAT and behavioral therapy for opioid addiction.

Section 303 of CARA expands office-based treatment by allowing nurse practitioners and physician assistants to prescribe buprenorphine for opioid addiction for five years (until October 1, 2021). Physician assistants and nurse practitioners must complete 24 hours of training to be eligible for a waiver to prescribe buprenorphine and must be supervised by or work with a qualifying physician if required by state law. Section 303 also specifies the training components for qualifying physicians. Additionally, office-based treatment practitioners must have the capacity (including necessary training) to either provide directly, or by referral, all drugs approved by the U.S. Food and Drug Administration for the treatment of opioid use disorders, including for maintenance, detoxification, overdose reversal, and relapse prevention.

Background: According to the Department of Health and Mental Hygiene's (DHMH) 2016 report, *Drug and Alcohol-Related Intoxication Deaths in Maryland*, drug- and alcohol-related intoxication deaths in Maryland increased for the fifth year in a row, totaling 1,259 deaths in 2015 – a 21% increase since 2014 and an all-time high. Of all intoxication deaths, 1,089 deaths (86%) were opioid-related, including deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl. Opioid-related deaths increased by 23% between 2014 and 2015 and have more than doubled since 2010. Heroin- and fentanyl-related deaths have risen particularly sharply. The number of

heroin-related deaths increased by 29% between 2014 and 2015 and has more than tripled between 2010 and 2015. The number of fentanyl-related deaths increased by 83% between 2014 and 2015 and has increased nearly twelvefold since 2012. **Exhibit 1** shows trends in drug- and alcohol-related intoxication deaths in Maryland from 2007 through 2015.

Exhibit 1
Total Number of Drug- and Alcohol-related Intoxication Deaths
By Selected Substances in Maryland
2007-2015



Source: Department of Health and Mental Hygiene

Preliminary data from DHMH indicates that the number of intoxication deaths increased at an even steeper rate in 2016, with 1,468 deaths from January through September 2016 compared to 904 deaths during the same period in 2015 (a 62% increase). Additionally, for January through September 2016, the number of heroin-related deaths increased 72% and the number of fentanyl-related deaths increased nearly fourfold compared to the same period in 2015.

State Expenditures: The bill includes hospitals in the definition of “health care facility.” Therefore, to the extent State hospitals do not already have a provider authorized under federal law to prescribe buprenorphine for every 100 patients, general fund expenditures

increase, potentially significantly, either for hospitals to have providers obtain authorization under federal law (including any required training) or to contract with a qualified provider. The extent of any impact depends on how many providers each hospital must have in order to meet the bill's required provider-patient ratio. The Department of Legislative Services (DLS) additionally notes that some State hospitals may not treat substance use as part of their routine or authorized functions. Specifically, the State's two chronic disease hospitals (Western Maryland Hospital Center and Deer's Head Hospital Center) provide chronic care and treatment to patients in need of acute rehabilitation (at a level greater than that available at a nursing home), long-term nursing care, and inpatient and outpatient renal dialysis services. Thus, the bill's requirements may fall outside the scope of certain facilities.

Local Expenditures: The bill also includes LHDs in the definition of "health care facility." Therefore, to the extent LHDs do not already have a provider authorized under federal law to prescribe buprenorphine for every 100 patients, expenditures increase, potentially significantly, either for LHDs to have providers obtain authorization under federal law (including any required training) or to contract with a qualified provider. As at the State level, the extent of any impact depends on how many providers each LHD must have in order to meet the bill's required provider-patient ratio. DLS again notes that some LHDs may not treat substance use as part of their routine or authorized functions; thus, the bill's requirements may fall outside the scope of certain LHDs.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): American Society of Addiction Medicine; Maryland Association of County Health Officers; Department of Health and Mental Hygiene; Substance Abuse and Mental Health Services Administration; Department of Legislative Services

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