

## State Legislative Responses to the Opioid Crisis: Leading Examples

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**What is the issue?** As the nation faces an epidemic of drug addiction, state lawmakers are faced with the realization that regardless of what happens at the federal level, a crisis of this proportion demands a timely response specific to the needs of their state.

**What is at stake?** Overdose deaths in the U.S. have tripled since 2000, with over 50,000 deaths in 2015 being the highest ever recorded by the Centers for Disease Control and Prevention. The ability of a state to effectively treat addiction and re-integrate patients into the community impacts long-term health care success.

**What do you need to know?** States are taking the lead and exploring the effect of creative solutions to the national problem. This article examines the legislative solutions that are currently the most popularly deployed by states that have taken responsibility for the opioid epidemic or that are trying to prevent its spread, illustrating each state's opportunity to address concerns tailored to the unique resources available to its population.

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# Petersen, Peters, Richard, Whites: Opioid Crisis

## CONTENTS

Introduction .....	32
Limitations of a Provider’s Authority to Prescribe Opiates .....	33
Lower dose recommendations .....	34
States’ response through legislation, guidelines, and recommendations.....	35
The Increased Role of the Prescription Drug Monitoring Program.....	40
Beyond the traditional health care provider .....	43
Putting the data to use.....	44
The Necessity of Diversionary Legal Programs to Access Treatment.....	47
Involuntary Commitment .....	52
How Kentucky Has Reacted.....	56
Non-violent drug offenders.....	59
Self-pay treatment options .....	60
Facility licensure and enhancement.....	62
Provider licensure, credentialing, and telemedicine.....	64
Conclusion .....	68

## Introduction

As the nation faces an epidemic of drug addiction that is now the leading cause of death for Americans under the age of 50,<sup>1</sup> state lawmakers are faced with the realization that regardless of what happens at the federal level, a crisis of this proportion demands a timely response specific to the needs of their state. While many Americans still hope for a cohesive national plan, and the President promised to deliver one through his declaration of a nationwide Public Health Emergency,<sup>2</sup> each state has the opportunity to address concerns tailored to the unique resources available to their populations.

In July 2017, now former Secretary of Health and Human Services, Tom Price, referred to the opioid addiction crisis as “a scourge that knows no bounds.”<sup>3</sup> Overdose deaths in the U.S. have tripled since 2000, with 52,404 deaths in 2015 being the highest ever recorded by the Centers for Disease Control and Prevention (CDC).<sup>4</sup> The CDC has not yet released official statistics for 2016, but experts believe the number of deaths may reach 65,000.<sup>5</sup> It is doubtful, however, that the official statistics capture the scope as examples of underreporting the cause of death and the inconsistency of conducting toxicology tests to determine substances involved in an overdose are acknowledged throughout large metropolitan areas around the country.<sup>6</sup> Those responding to the crisis include front-line organizations distributing overdose-reversal medication, health care organizations proactively providing guidance

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1 Dean Reynolds, *Overdoses Now Leading Cause of Death of Americans Under 50*, CBS NEWS, June 6, 2017, [www.cbsnews.com/news/overdoses-are-leading-cause-of-death-americans-under-50/](http://www.cbsnews.com/news/overdoses-are-leading-cause-of-death-americans-under-50/).

2 Press Release, The White House, President Donald J. Trump is Taking Action on Drug Addiction and the Opioid Crisis (Oct. 26, 2017), available at [www.whitehouse.gov/the-press-office/2017/10/26/president-donald-j-trump-taking-action-drug-addiction-and-opioid-crisis](http://www.whitehouse.gov/the-press-office/2017/10/26/president-donald-j-trump-taking-action-drug-addiction-and-opioid-crisis).

3 Dave Flessner, *Head of Health and Human Services Says Opioid Crisis 'Is Scourge That Knows No Bounds'*, TIMES FREE PRESS, July 6, 2017, [www.timesfreepress.com/news/local/story/2017/jul/06/hhs-secretary-says-opioid-crisis-scourge-knows-no-bounds/436958/](http://www.timesfreepress.com/news/local/story/2017/jul/06/hhs-secretary-says-opioid-crisis-scourge-knows-no-bounds/436958/).

4 CDC, Figure 2: Morphine Milligram Equivalents (MMEs) of Opioids Prescribed Per Capita in 2015 and Change in MMEs Per Capita During 2010-2015, By County—United States, 2010-2015, [www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s\\_cid=mm6626a4\\_e#F2\\_down](http://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s_cid=mm6626a4_e#F2_down).

5 *Id.*

6 Josh Dulaney, *Oklahoma opioid problem may be worse than reported*, NewsOK, <http://newsok.com/oklahoma-opioid-problem-may-be-worse-than-reported/article/5563231> (Sept. 10, 2017).

to their professionals prescribing opioids, and legislators implementing laws that increase checks on access to opioids and access to treatment for those who are addicted to these powerful substances.

States are taking the lead and exploring the effect of creative solutions to the national problem. This article examines the legislative solutions that are currently the most popularly deployed by states that have taken responsibility for the opioid epidemic or that are trying to prevent its spread. Those areas include laws that impact a [prescriber's authority](#), the [increased role of the Prescription Drug Monitoring Programs](#) and [legislators' attempts to impact the opioid crisis by expanding a program's scope](#) to include veterinarians and mandatory participation in the databases. The authors further examine the [diversion of addicted persons from the criminal system to treatment programs](#) and the [increasing utilization of involuntary treatment](#) for addiction services. Finally, the authors take a deep-dive into [Kentucky's comprehensive legislative response](#) as a predictor of avenues that other states may soon be pursuing.

## **Limitations of a Provider's Authority to Prescribe Opiates**

While there is not yet a revised standard of care for the use of opioids for patients living with debilitating pain, the Center for Disease Control and Prevention issued guidelines (Guidelines) in March 2016 for prescribing opioids for chronic pain that have become a model—or at least a starting point—for state initiatives.<sup>7</sup> The CDC Guidelines address patient-centered clinical practices designed to ensure patient access to safer, more effective chronic pain treatment while reducing the risk of opioid use disorder, overdose, and death. The Guidelines focus on three main areas: (i) determining when to initiate or continue opioids for chronic pain, (ii) opioid selection, dosage, duration, follow-up, and discontinuation, and (iii) assessment of risk factors and addressing the dangers of opioid use.<sup>8</sup> In general, the Guidelines depart from prior CDC recommendations by lowering the dosage recommen-

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7 CDC, GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN, available at [www.cdc.gov/drugoverdose/pdf/Guidelines\\_Factsheet-a.pdf](http://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf).

8 The CDC Guidelines are intended for the primary care setting. The Guidelines specifically state they do not apply to active cancer treatment, palliative care, or end-of-life care.

dations, recognizing that there is a risk to all patients of opioid addiction (not just high-risk patients), and providing specific recommendations regarding monitoring and discontinuation.

### Lower dose recommendations

The CDC Guidelines recommend a careful risk-benefit assessment prior to commencing opioid therapy. For example, if the assessment indicates that commencing opioid therapy is in the patient's best interests, the clinician should prescribe immediate-release opioids instead of extended-release/long-acting opioids. Best clinical and risk management practice involves prescribing the lowest effective dosage at the start of treatment—even for cases involving acute pain—and carefully reassessing all risks and benefits when considering an increase of greater than 50 morphine milligram equivalents (MME)/day. The Guidelines recommend that clinicians avoid increasing a dosage to greater than 90 MME/day or carefully justify their decision for titrating a dosage to that higher amount. The Guidelines specifically state that three days or less for a dosage greater than 50 MME/day is often sufficient; rarely will more than seven days be needed.

Ongoing monitoring of the medication's impact on a patient is just as important as the initial determination that opioid therapy is needed. Clinicians should evaluate benefits and harms within one to four weeks of commencing opioid therapy or of any dose escalation, and thereafter every three months. Part of this assessment should include an evaluation for the potential use of other controlled substances through a review of the patient's data for a prescription drug monitoring program (PDMP), as discussed [later](#) in this article. The CDC further recommends that clinicians test for drugs in a patient's urine before starting opioid therapy, followed by an annual assessment of other prescribed medications, controlled prescription drugs, and illicit drugs. Finally, the CDC states that clinicians should avoid prescribing opioid pain medications and benzodiazepines—a type of medication known as tranquilizers—concurrently whenever possible.

The CDC's Guidelines are just that—guidelines and recommendations. They do, however, reflect a carefully developed approach to battling the opioid crisis by addressing one source of addiction: the commencement of prescription pain medications for the treatment of pain and the high potential for unnecessary extended or excessive use. The effectiveness of these Guidelines remains to be seen. The most recent data issued from the CDC in a report on July 6, 2017 (2017 CDC Report) analyzed data on opioid use from 2010 to 2015, which references usage prior to implementation of the March 2016 CDC Guidelines. The 2017 CDC Report revealed a substantial increase in the amount of opioid prescriptions and duration of use.<sup>9</sup> U.S. doctors prescribe three times more opioids than European counterparts, enough for “every American [to] be medicated around the clock for three weeks” according to the acting CDC Director, Anne Schuchat.<sup>10</sup> Schuchat remains optimistic, however, noting that the Guidelines had been downloaded more than 25,000 times since the release of the 2017 CDC Report, indicating an increased awareness of the potential for harm and desire for guidance about how clinicians can avoid perpetuating the opioid crisis.<sup>11</sup>

### States' response through legislation, guidelines, and recommendations

Several states have utilized the CDC's Guidelines as a model for their own efforts to battle the problem. For example, Oregon passed HB 2114 in May 2017, which adopted the Oregon Medical Board's January 2017 publication “Oregon Opioid Prescribing Guidelines: Recommendations for the Safe Use of Opioid Medications.”<sup>12</sup> The Oregon guidelines align very closely with the CDC's Guidelines, encouraging active risk assessment and documentation of the decision to commence opioid therapy, the use of immediate-release opioids instead of extended-release/long-acting opioids, and dosage limits as recom-

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9 Press Release, CDC, Opioid Prescribing is Still High and Varies Widely throughout the U.S. (July 6, 2017), available at [www.cdc.gov/media/releases/2017/p0706-opioid.html](http://www.cdc.gov/media/releases/2017/p0706-opioid.html).

10 Rob Stein, *Opioid Prescriptions Falling But Remain Too High*, CDC Says, NPR, July 6, 2017, available at <https://www.npr.org/sections/health-shots/2017/07/06/535656477/opioid-prescriptions-falling-but-remain-too-high-cdc-says>.

11 *Id.*

12 H.B. 2114 (Or. 2017), available at <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2114>.

mended by the CDC.<sup>13</sup> In addition, the Oregon guidelines address medicinal and recreational use of marijuana, which are allowed by the state. HB 2114 requires that relevant licensing boards notify their licensees by January 2018 about the prescribing authority afforded under these guidelines.

Other states have taken a similar but more comprehensive approach. For example, in the Commonwealth of Virginia, the state's Board of Medicine adopted opioid prescription regulations effective March 15, 2017.<sup>14</sup> Similar to the CDC Guidelines, the requirements do not apply to those treating pain associated with cancer; hospice care; palliative care; or inpatient care being provided to hospital, nursing home, or assisted living facility residents. These limitations reflect the need for legislation that reduces diversion and abuse without adversely impacting patient care. Virginia's approach demonstrates that when prescribing limits as mandated by legislation include input from licensing boards and provider organizations, the creation of a more usable framework is likely.

Virginia's regulations emphasize the importance of the clinician's assessment and documentation prior to prescribing opioid medication for either acute or chronic pain. Clinicians are required to take and document the following actions prior to prescribing opioid therapy: (i) consider nonpharmacological and non-opioid medication for the patient, (ii) take a history and physical of the patient, (iii) query the Prescription Drug Monitoring Program, and (iv) assess the risk for abuse. Virginia's rules utilize both a day limit and dosage limit: the prescription may not be for longer than 7 days, or 14 days post-surgical procedure, absent documented "extenuating circumstances."<sup>15</sup> In addition, the clinician must document in the medical records any reason to exceed 50 MME/day.<sup>16</sup> Prior to exceeding 120 MME/day, the clinician is required to document his or her justification or consult with pain management

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13 OR. HEALTH AUTH., PUBLIC HEALTH DIV., OREGON OPIOID PRESCRIBING GUIDELINES: RECOMMENDATIONS FOR THE SAFE USE OF OPIOID MEDICATIONS (2017-2018), available at [www.oregon.gov/obnm/rules/opioidprescribingguidelines.pdf](http://www.oregon.gov/obnm/rules/opioidprescribingguidelines.pdf).

14 18 VA. ADMIN. CODE §§ 85-21-10-170, available at <http://register.dls.virginia.gov/details.aspx?id=6295>.

15 *Id.* § 85-21-40.

16 *Id.* § 85-21-50.

specialists on behalf of the patient.<sup>17</sup> Virginia's approach underscores the necessity for provider education and involvement in statewide policy and regulatory changes. When patients and provider groups are both involved in tackling the opioid crisis, the legal solutions that are created to address one of the most common starting points of opioid addiction—the moment at which opioid therapy is prescribed and commences—may be more palatable and effective.

Under Virginia law, the clinician who is treating chronic pain must—in addition to the above prerequisites—conduct a mental status examination and assessment of the need and risks for his or her patient, which involves consideration of nine factors: (i) the nature and intensity of the pain, (ii) current and past treatments for the pain, (iii) underlying or coexisting conditions, (iv) the effect of pain on the patient's quality of life, (v) psychiatric addiction and substance abuse history of the patient, (vi) any family history of psychiatric addiction and substance abuse, (vii) a urine drug screen or testing to monitor serum medication levels, (viii) a query of the PDMP, and (ix) a request for prior applicable medical records.<sup>18</sup> In addition, the clinician must discuss with the patient in advance appropriate storage and disposal of the medication, as well as an exit strategy, i.e., a plan to help wean the patient off of the medication.<sup>19</sup> Every three months, the clinician should reevaluate the rationale for continuing opioid therapy and evaluate the patient for potential opioid use disorder.<sup>20</sup> Finally, the use of opioid medication for chronic pain requires a “written treatment agreement” that documents the patient's informed consent regarding the risks, benefits, and “alternative approaches prior to the initiation of opioids for chronic pain.”<sup>21</sup> A template treatment agreement is available on the Medical Society of Virginia's website at [www.msv.org/sites/default/files/patientcontrolledagreementtemplatechronicpain.pdf](http://www.msv.org/sites/default/files/patientcontrolledagreementtemplatechronicpain.pdf).

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17 *Id.*

18 *Id.*

19 *Id.* § 85-21-60.

20 *Id.* § 85-21-70.

21 *Id.* § 85-21-80; § 85-21-90.

Virginia's new regulations contain additional requirements, but this brief summary highlights the importance of applying a thoughtful, cautious, and well-documented approach when determining whether opioid therapy is necessary. When establishing such policies and programs, state legislators should consider the burdens on providers and their time limitations in caring for patients, as well as the cost that will be incurred in meeting those policy objectives (e.g., developing the written treatment agreements and requiring periodic office visits). Providers will likely experience a lower capacity of patients overall if they have to see those using opioid therapy more often, thus perhaps exacerbating access problems faced by an already underserved population.

The state of Ohio has taken a slightly different approach by limiting the supply of opioids to a minimum number of days. In March 2017, Gov. John R. Kasich issued an order limiting opiate prescriptions to a seven day supply for adults (five days for minors) suffering from acute pain. These rules were later adopted by the Ohio's Medical Board and Board of Pharmacy, effective August 31, 2017.<sup>22</sup> In addition, clinicians will be required to document a specific diagnosis and procedure code for each prescription and provide a specific reason for exceeding the day limits, if applicable.<sup>23</sup>

The ultimate goal of these state laws is to treat those who legitimately require pain management and opioid therapy without further expanding the addiction and overutilization crisis, but legislation to limit opioid prescriptions is not without controversy.<sup>24</sup> There are concerns that the laws, while well-intended, may have the effect of overreaching and limiting access to this potentially effective form of pain relief.<sup>25</sup> Critics also point out that the

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22 OHIO ADMIN. CODE 4731-11-13, available at [www.registerofohio.state.oh.us/pdfs/4731/0/11/4731-11-13\\_PH\\_RV\\_N\\_RU\\_20170629\\_1329.pdf](http://www.registerofohio.state.oh.us/pdfs/4731/0/11/4731-11-13_PH_RV_N_RU_20170629_1329.pdf).

23 *Id.* 4729-5-30, available at [www.registerofohio.state.oh.us/pdfs/4729/0/5/4729-5-30\\_PH\\_RV\\_A\\_RU\\_20170720\\_1625.pdf](http://www.registerofohio.state.oh.us/pdfs/4729/0/5/4729-5-30_PH_RV_A_RU_20170720_1625.pdf).

24 See, e.g., Christine Vestal, *In States, Some Resistance to New Opioid Limits*, THE PEW CHARITABLE TRUSTS, June 28, 2016, [www.pewtrusts.org/en/research-and-analysis/blogs/state-line/2016/06/28/in-states-some-resistance-to-new-opioid-limits](http://www.pewtrusts.org/en/research-and-analysis/blogs/state-line/2016/06/28/in-states-some-resistance-to-new-opioid-limits).

25 See, e.g., Charlotte Huff, *States Aim to Limit Opioid Prescriptions*, ACP INTERNIST, Oct. 2016, <https://acpinternist.org/archives/2016/10/laws.htm>; Stefan G. Kertesa & Adam J. Gordon, *Strict Limits on Opioid Prescribing Risk the 'Inhuman Treatment' of Pain Patients*, STAT, Feb. 24, 2017, [www.statnews.com/2017/02/24/opioids-prescribing-limits-pain-patients/](http://www.statnews.com/2017/02/24/opioids-prescribing-limits-pain-patients/).

increased documentation and assessments required by clinicians could lead some to avoid opiates as options for patients, even when their use would be appropriate.

Maine provides an excellent example of a state's response to these concerns. In July 2016, Maine became one of the first states to impose prescribing limits on opioid prescriptions and, at the time, was among the strictest in the nation. In addition to requiring providers to check the state PDMP every 90 days,<sup>26</sup> the law required patients to taper down daily doses to no more than 100 MME per day, with exemptions only for cancer patients and those receiving palliative care and end-of-life hospice care.<sup>27</sup> Advocates expressed concern that the requirement was too strict for patients who were struggling with chronic pain, many who were currently using opioid therapy far in excess of the allowed amount. In response, the state legislature amended the law effective July 1, 2017 to clarify that palliative care included management of chronic pain from injury and was not limited to care for those with life-threatening conditions.<sup>28</sup> In making this adjustment, Maine's state legislature recognized that there is not yet a single, ideal way to understand and address the role played by opiate overprescribing in the context of the national crisis.

Other states that have adopted laws or regulations that impose opioid prescribing limits include Arizona, Connecticut, Delaware, Massachusetts, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont. Most limits are set at a supply limit by day, an MME/day, or both.<sup>29</sup> Other states such as Georgia, Hawaii, Indiana, Montana, and Washington have legislation pending. In April 2017, Senators John McCain (R-Ariz.) and Kirsten Gillibrand (D-N.Y.) introduced federal legislation to limit an initial opioid prescription to seven days.<sup>30</sup>

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26 ME. REV. STAT. ANN. tit. 22, § 7253 (2016).

27 *Id.* tit. 32, § 2210.

28 *Id.* (2017).

29 *See, e.g.*, Corey Davis, The Network for Public Health Law Southeastern Region Office & the National Health Law Program, *Appendix B, State-by-State Summary of Opioid Prescribing Regulations and Guidelines*, [www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/appendix-b-state-by-state-summary.pdf](http://www.azdhs.gov/documents/prevention/womens-childrens-health/injury-prevention/opioid-prevention/appendix-b-state-by-state-summary.pdf) (last visited Dec. 12, 2017).

30 Opioid Addiction Prevention Act of 2017, 115th Cong. (1st Sess. 2017), available at [www.mccain.senate.gov/public/\\_cache/files/2cbc29bf-f16c-46d0-b921-06d26caee967/opioid-addiction-prevention-act-of-2017---115th-bill-text.pdf](http://www.mccain.senate.gov/public/_cache/files/2cbc29bf-f16c-46d0-b921-06d26caee967/opioid-addiction-prevention-act-of-2017---115th-bill-text.pdf).

Some states recognize that legally mandated prescription limits can place a significant burden on providers and on a patient's ability to receive medically necessary care. The most significant and immediate effect occurs where physicians with a pattern of overprescribing move out of the regulated state. Patient care is adversely impacted when a community has an insufficient number of qualified providers or alternatives to overprescribing are lacking. State legislators need to listen to all three sides of the health care equation—patients, providers, and payers—if they wish to make effective decisions about prescribing limitations. In addition, where lawmakers legislate medication limits, a concomitant expansion in the use of and reimbursement for alternatives is necessary. Areas for expansion might include non-medical services to help deal with pain, such as occupational and behavioral health counseling and alternative pain treatments like acupuncture, massage, and chiropractic modalities.

## **The Increased Role of the Prescription Drug Monitoring Program**

The 2017 CDC Report highlights the wide variation in prescribing practices across the nation that are contributing to the crisis.<sup>31</sup> A startling fact can be drawn from the data surrounding the opioid abuse epidemic, namely that many of the opioids killing people are provided not by illegal drug dealers but by medical professionals for the purpose of relieving pain. It is undeniable that illicit street opiates and prescription opioid medications can often be linked, with legitimate prescriptions initiating the addiction, often followed by the person seeking the chemical from illegal sources once the prescription has ended. Sometimes, however, they will resort to “doctor shopping,” i.e., visiting multiple physicians in various ambulatory settings to obtain more of the same opioid medications if the patient's own health care provider is unwilling or unable to renew or refill the prescription. The PDMP makes a significant contribution to fighting the opioid epidemic by preventing and inhibiting doctor shopping.

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31 CDC, Figure 2: Morphine Milligram Equivalents (MMEs) of Opioids Prescribed Per Capita in 2015 and Change in MMEs Per Capita During 2010-2015, By County – United States, 2010-2015, [www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s\\_cid=mm6626a4\\_e#F2\\_down](http://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm?s_cid=mm6626a4_e#F2_down).

PDMPs, or PMPs as they are alternatively known, are utilized by 49 states, as well as Guam and the District of Columbia.<sup>32</sup> Although requirements vary by state, they generally collect data from dispensers and report to authorized users of a state's database the number of prescriptions that have been filled for scheduled drugs for each recipient. Access to the information contained in such databases is typically limited to prescribers and state officials. State pharmacy boards and health departments operate most PDMPs, but a minority relies on professional licensing agencies, law enforcement, state substance abuse agencies, or in the case of Connecticut, the Department of Consumer Protection. All PDMPs monitor at least Schedule II through IV Drugs, with some also monitoring Schedule V and "Drugs of Concern" as designated by an authorized state agency.<sup>33</sup> Because PDMPs are seen as effective tools to reduce drug abuse and diversion through doctor shopping, the 2017 legislative cycle saw a flurry of action across the country to enhance the role of PDMPs in combatting the opioid epidemic.

The completeness of information contained within a PDMP is critical to its success. It is imperative that pharmacies input dispensing information about who is receiving what prescription from which provider, and that prescribers utilize that information as a component of their clinical judgment when determining the most-appropriate course of treatment for the patient. Nonetheless, 18 states and the District of Columbia maintain a voluntary system, with no mandatory enrollment required of either prescribers or dispensers.<sup>34</sup> Still, the majority of state legislatures understand that the sum total is only as good as its parts. For example, recent Georgia and Mississippi legislation tied mandatory PDMP registration to the licensed practitioner's ability to secure or

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32 Missouri is the only state not to have a statewide PDMP, though an Executive Order was issued in July 2017 directing its formulation. PDMP TTAC, *Status of Prescription Drug Monitoring Programs (PDMP)*, available at [www.pdmpassist.org/pdf/PDMP\\_Program\\_Status\\_20170824.pdf](http://www.pdmpassist.org/pdf/PDMP_Program_Status_20170824.pdf).

33 PDMP TTAC, *Drugs Monitored by PDMP*, available at [www.pdmpassist.org/pdf/PDMP\\_Substances\\_Tracked\\_20170824.pdf](http://www.pdmpassist.org/pdf/PDMP_Substances_Tracked_20170824.pdf).

34 PDMP TTAC, *PDMP Mandatory Query by Prescribers and Dispensers*, available at [www.pdmpassist.org/pdf/Mandatory\\_Query\\_20170824.pdf](http://www.pdmpassist.org/pdf/Mandatory_Query_20170824.pdf).

renew a Drug Enforcement Administration (DEA) number.<sup>35</sup> Maine adopted mandatory registration of both prescribers and dispensers in light of “an unprecedented 272 overdose related fatalities.”<sup>36</sup> In an effort to combat the opioid epidemic through ensuring reliable information is accessible to prescribers, Kentucky and North Carolina have each added penalties for failure of pharmacies to comply with reporting requirements, including sanctions and a monetary penalty per offense.<sup>37</sup>

Statutory requirements for submitting and gathering prescription data are of little value if the statutes fail to specify how the data will be used. At least 15 states enhanced their “query” requirements or how a prescriber or dispenser must check the state’s PDMP system for patient information before prescribing a controlled substance. Checking the PDMP for opioid and benzodiazepine prescriptions from other sources is a recommended step in the CDC’s “Checklist for prescribing opioids for chronic pain.”<sup>38</sup> The Arkansas legislature directed licensing boards to adopt regulations requiring prescribers to query the PDMP when prescribing (i) an opioid from Schedules II or III for each time a medication was prescribed to a patient and (ii) a benzodiazepine for the first time.<sup>39</sup> Texas followed suit by naming specific categories of drugs that require a query prior to being prescribed (“opioids, benzodiazepines, barbiturates, or carisoprodol”).<sup>40</sup> Some states (e.g., Georgia, Louisiana, Pennsylvania, and North Carolina) have recognized that requiring a query of *all* controlled substance prescriptions can be burdensome in certain situations. For example, the query

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35 H.B. 249 (Ga. 2017), available at [www.legis.ga.gov/Legislation/20172018/170657.pdf](http://www.legis.ga.gov/Legislation/20172018/170657.pdf)

[hereinafter *H.B. 249*]; H.B. 1032 (Miss. 2017), available at <http://billstatus.ls.state.ms.us/documents/2017/pdf/HB/1000-1099/HB1032SG.pdf>.

36 *Weekly Notices of State Rule-Making: Public Input for Proposed and Adopted Rules*, MAINE.GOV., [www.maine.gov/sos/cec/rules/notices/2017/010417.html](http://www.maine.gov/sos/cec/rules/notices/2017/010417.html) (last visited Nov. 4, 2017).

37 H.B. 314 (Ky. 2017), available at [www.lrc.ky.gov/recorddocuments/bill/17RS/HB314/bill.pdf](http://www.lrc.ky.gov/recorddocuments/bill/17RS/HB314/bill.pdf); H.B. 243 (N.C. 2017), available at [www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf](http://www.ncleg.net/Sessions/2017/Bills/House/PDF/H243v7.pdf) [hereinafter *H.B. 243*].

38 CDC, CHECKLIST FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN, available at [www.cdc.gov/drugoverdose/pdf/PDO\\_Checklist-a.pdf](http://www.cdc.gov/drugoverdose/pdf/PDO_Checklist-a.pdf).

39 S.B. 339, 91st Gen. Assemb., Reg. Sess. (Ark. 2017), available at <ftp://www.arkleg.state.ar.us/Bills/2017R/Public/SB339.pdf>.

40 H.B. 2561 (Tex. 2017), available at <https://legiscan.com/TX/text/HB2561/id/1625193/Texas-2017-HB2561-Enrolled.html> [hereinafter *H.B. 2561*].

requirement may not be applicable to providers of certain specialties if the prescription is for less than a three day supply and contains less than 26 pills,<sup>41</sup> the patient is terminally ill,<sup>42</sup> or when the controlled substance is administered in a hospital.<sup>43</sup> Georgia and South Carolina's legislatures added consequences for those practitioners who fail to query the PDMP, requiring them to be reported to their licensure boards for disciplinary action.<sup>44</sup>

### Beyond the traditional health care provider

An increase in the diversion and misuse of medications prescribed for administration to animals has helped state legislators recognize those who are not considered traditional health care providers also have the ability to prescribe scheduled drugs. For example, doctors of veterinary medicine are now included in many states' PDMP requirements in addition to physicians. The similarity of pain relief medicine for veterinary care has allowed the purchase of animal medications—which are traditionally less monitored, cheaper, and more readily available—by populations that were abusing those medications. Colorado and Texas statutes now allow veterinarians to query PDMP data, though they provide different limitations. Colorado law allows a veterinarian to query the PDMP to the extent the query relates to a current patient/client or if the veterinarian suspects that a client has committed drug abuse or mis-treated an animal. Texas, on the other hand, limits veterinarians' access to the PDMP for prescriptions dispensed to the animal's owner and may not consider the owner's personal prescription history.<sup>45</sup> Nebraska now affirmatively

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41 *H.B. 249.*

42 *Id.*; S.B. 55, Reg. Sess. (La. 2017), available at <https://legiscan.com/LA/text/SB55/id/1633071/Louisiana-2017-SB55-Chaptered.pdf> [hereinafter S.B. 55].

43 *H.B. 249; S.B. 55; H.B. 598*, Reg. Sess. (Pa. 2017), available at [www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2017&sessInd=0&billBody=H&billTyp=B&billNbr=0598&pn=0640](http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=PDF&sessYr=2017&sessInd=0&billBody=H&billTyp=B&billNbr=0598&pn=0640); *H.B. 243.*

44 *H.B. 3824*, 122nd Sess. (S.C. 2017), available at [www.scstatehouse.gov/sess122\\_2017-2018/bills/3824.docx](http://www.scstatehouse.gov/sess122_2017-2018/bills/3824.docx); *H.B. 249.*

45 *S.B. 146*, 70th Gen. Assemb., 2nd Reg. Sess., available at [http://leg.colorado.gov/bills/sb17-146?utm\\_medium=email&utm\\_source=govdelivery](http://leg.colorado.gov/bills/sb17-146?utm_medium=email&utm_source=govdelivery); *H.B. 2561.*

requires veterinarians to report dispensing information.<sup>46</sup> Similarly, where the potential for diversion of medications prescribed by optometrists and dentists has gone unrecognized, tracking their prescriptions may reveal patterns of abuse that ultimately affect drug control policies and regulations in neighboring states.

### Putting the data to use

Perhaps the most interesting impact that these prescription databases have had involves their role in research and quality improvement efforts. A spokesman for the Massachusetts Department of Public Health demonstrated the potential value of utilizing a robust PDMP with the results of the commonwealth's 2015 PDMP Linkage Survey, which found that someone who receives opioids from three or more prescribers within a three-month period is associated with a seven-fold increase in risk of fatal overdose.<sup>47</sup> Thus, recognizing multiple sources of a person's prescriptions in real-time, and preventing more than three prescriptions, has a demonstrable impact on their risk of overdose. Surprisingly, the same study found that only 17 percent of people who died from an opioid overdose had a reported PDMP prescription at the time of death, which leads to the conclusion that the greater risk in prescribing opioids is in opening the gateway to illicit drugs when prescribed opioids are out of reach.<sup>48</sup> Maryland's Department of Health is developing a predictive risk model to identify state-specific factors for overdose and potential points of intervention utilizing the states soon-to-be mandatory PDMP, as well as data sets from the state's chief medical examiner, hospital discharge summaries, adult and youth correctional services, and Medicaid claims.<sup>49</sup>

Effective May 2017, Alaska allows its Pharmacy Board to issue an unsolicited report to a prescriber that compares his or her opioid prescribing practice

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46 L.B. 223, 105th Leg., 1st Sess. (Neb. 2017), available at <http://nebraskalegislature.gov/Floor-Docs/105/PDF/Intro/LB223.pdf>.

47 Harold Rogers, Prescription Drug Monitoring Program Regional Meeting [slides] (Oct. 25, 2017), available at [www.pdmpassist.org/pdf/25-C\\_Young.pdf](http://www.pdmpassist.org/pdf/25-C_Young.pdf).

48 *Id.*

49 B. Casey Lyons, Kirsten Madison, Brendan Saloner, PRECOG: Predictive Risk Model to Combat Overdose Grant [slides] (Sept. 6, 2017), available at [www.pdmpassist.org/pdf/06-E2\\_Lyons\\_Madison\\_Saloner.pdf](http://www.pdmpassist.org/pdf/06-E2_Lyons_Madison_Saloner.pdf).

with others in the same occupation and similar specialty.<sup>50</sup> This data allows providers the opportunity to reflect on their prescribing patterns without the pressure to defend their decisions. More time is needed to determine if Alaska's program is more impactful than North Carolina's, which has taken a more punitive approach by notifying both the prescriber and his or her licensure board of "behavior that increases the risk of diversion."<sup>51</sup> To date, Maine is the only state that has authorized the release of information to a hospital's chief medical officer for the purpose of utilizing the information in its evaluation of hospital-employed physicians.<sup>52</sup> Although the data regarding a provider's prescribing patterns is a "drop in the bucket" in terms of information that hospitals collect to determine the appropriateness of care, it is nevertheless a valuable piece of information. Physicians who show patterns of over-prescribing are likely to attract the type of patient who has fallen into an opioid addiction; these patients pose a significant challenge on many levels for hospitals given the patient's lack of a payer source, noncompliance with treatment recommendations, and other severe health complications. Missouri's Gov. Eric Greitens issued an Executive Order in July 2017 that will make it the last state to implement a PDMP. The Executive Order grants the administering agency more powers than is typical, providing Missouri's Department of Health and Senior Services (DHSS) authority to investigate criminal activities of controlled substances that are being inappropriately prescribed, dispensed, or obtained.

The future success of PDMPs lies in states expanding the program's application to all sources of prescribers—as seen in laws regulating veterinarians, optometrists, and dentists—and in enforcing mandatory participation of querying and reporting. According to the CDC, states that have previously "enhance(d)" PDMP with required reporting or querying saw "promising

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50 H.B. 159, 30th Leg. (Alaska 2017), available at [www.akleg.gov/basis/Bill/Text/30?Hsid=HB0159Z](http://www.akleg.gov/basis/Bill/Text/30?Hsid=HB0159Z).

51 H.B. 243.

52 L.D. 184, 128th Leg., 1st Reg. Sess. (Me. 2017), available at <https://legislature.maine.gov/legis/bills/getPDF.asp?paper=HP0140&item=1&snum=128>.

results” measured in the form of substantial decreases of MME per capita.<sup>53</sup> Mandatory querying is not likely to occur until access to PMDPs is integrated into electronic medical records and health systems begin creating a standard of care to use it as a resource. Mandatory querying is not likely to be viewed favorably by the medical community, as indicated by a UC Davis California PDMP User Survey which found that while 81% of physicians and 76% of pharmacists agree that clinicians *should* check the state’s PDMP prior to writing a controlled substance prescription, only 23% of physicians and 39% of pharmacists thought it should become a requirement to do so.<sup>54</sup> Physicians already feel they spend more time on the computer than with the patient, and some say that the length of time it takes to log into multiple programs is a significant reason for not accessing the PDMP. The University of Colorado’s emergency department is currently using a pilot program, funded by a federal grant, to link its electronic medical record with the state’s PDMP.<sup>55</sup> Researchers are trying to determine if improving ease of access by preventing the need to exit the EMR platform to access a separate website with a separate login will increase PDMP use, and whether such improved access and use has a positive correlation to improved patient results.

States implementing or enhancing PDMP use should focus on the importance of educating providers about how to effectively use the system and how to document their use in patient records. Providers may be more compliant and receptive about a PDMP’s requirements if they understand how the information can protect both provider and patients from the risks of abuse and misuse of opioid medications. Feedback from providers is necessary to improve this support system and make it less burdensome. Attorneys and

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53 *Opioid Overdose: State Successes*, CDC, [www.cdc.gov/drugoverdose/policy/successes.html](http://www.cdc.gov/drugoverdose/policy/successes.html) (last visited Nov. 4, 2017).

54 Tina Farales et al., California PDMP Enhancement, Analysis, and Response Initiative [slides] (Sept. 6-8, 2017), available at [www.pdmpassist.org/pdf/06-E1\\_Farales.pdf](http://www.pdmpassist.org/pdf/06-E1_Farales.pdf).

55 Alexandra Wilson Pecci, *State Opioid Database Links with EHR in Pilot Program*, HEALTHLEADERS MEDIA, Mar. 14, 2017, available at [www.healthleadersmedia.com/technology/state-opioid-database-links-ehr-pilot-program?nopaging=1#](http://www.healthleadersmedia.com/technology/state-opioid-database-links-ehr-pilot-program?nopaging=1#).

policy makers must work with provider and patient groups to bring the concerns of those populations to the forefront, assuring that legislation does not erode the end goal of appropriate patient care.

## **The Necessity of Diversionary Legal Programs to Access Treatment**

“Diversion” is a term used in the context of the opioid epidemic in two distinct and equally important ways. The first way is the actual diversion of the medication, resulting in their nonmedical and illegal use by a person or persons for whom the medications were not prescribed, and for purposes for which they were not prescribed, thereby resulting in their illegal use, abuse, and ultimately, addiction and associated crimes.<sup>56</sup> In terms of policies responsive to the opioid epidemic, “diversion” connotes unlawful, high risk behavior that dictates a quick response that relies on regulatory and police powers in the interest of public safety and patient well-being. On the other hand, diversion is also used to describe a community initiative or state policy that attempts to ameliorate some of the devastating effects of opioid addiction by providing treatment as an alternative to incarceration. In this context, diversion connotes a policy alternative to punitive measures against providers that may result in fewer providers offering necessary and appropriate pain management services to their patient populations.

Why are legal diversion programs relevant to health care lawyers in 2017? The answer lies in our roles as interpreters and advisors to diverse stakeholders in our local communities, states, and nation about the responsibilities, risks, and scopes of authority in the face of the opioid epidemic. Stakeholders who possess a wide range of skills sets include behavioral health and primary care

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56 An example of this approach is provided in “The Prescription Opioid Epidemic: An Evidence-Based Approach” published after lengthy analysis by a multidisciplinary group gathered by the Johns Hopkins Bloomberg School of Public Health in which attention was focused on provider behavior and data gathering and no mention was made of diversion of addicts to treatment as an alternative. JOHNS HOPKINS BLOOMBERG SCH. OF PUB. HEALTH, THE PRESCRIPTION OPIOID EPIDEMIC: AN EVIDENCE-BASED APPROACH (Nov. 2015), available at [www.wcc.sc.gov/Documents/Narc%20Use%20Adv%20Comm/ARook%20Comments/2015%20John%20Hopkins%20opioid-epidemic-report.pdf](http://www.wcc.sc.gov/Documents/Narc%20Use%20Adv%20Comm/ARook%20Comments/2015%20John%20Hopkins%20opioid-epidemic-report.pdf) [hereinafter JOHNS HOPKINS REPORT].

clinicians, hospitals and clinics, pain management providers, pharmacies, regulators at all levels of government, law enforcement, prosecutors, defense counsel, judges and policymakers.

The opioid epidemic exists in a setting fraught with barriers to treatment.<sup>57</sup> Remedies and responses, both procedural and substantive, currently vie for a role in resolving the opioid addiction problem. This is the setting in which a wide range of health care attorneys and practices find themselves—in-house counsel to facilities, clinics and other provider entities, government agencies, district attorneys, the judiciary, licensure boards, and other regulatory agencies. A thorough understanding of the relevant laws and alternatives for properly serving those struggling with opioid addiction and adequate communication between the stakeholders is critical to effectively addressing the national opioid crisis.

Mandated or permissible treatment programs are of great importance to legal counsel because they impact behavioral health facilities and other providers by offering a treatment-focused alternative to life-limiting prosecution and incarceration. Treatment<sup>58</sup> and diversionary programs (pre- and post-booking) go hand in hand in the quest to decriminalize opioid addiction. Legislative schemes range from providing sentencing alternatives at the time of conviction to providing sanctions as alternatives to revocation, thereby reducing the likelihood of recidivism while providing treatment, housing, and jobs. These concerns are patient-focused, but provider-focused concerns also exist in state and federal enforcement programs.

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57 In addition to payment and scarcity issues, providers are increasingly reticent to treat patients with addictions and other behavioral health diagnoses. In the face of the continuing stigma of mental illness, those addicted find themselves caught in the criminal justice system for violations that may in actuality be acts of living for them such as trespass, prohibited public displays and the like. See HAZELDEN BETTY FORD FOUND., INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDERS (July 2017), available at [www.hazeldenbettyford.org/articles/emerging-drug-trends/involuntary-commitment](http://www.hazeldenbettyford.org/articles/emerging-drug-trends/involuntary-commitment) [hereinafter HAZELDEN REPORT].

58 See, e.g., MASS. GEN. LAWS ch. 123, § 8(b), available at <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter123/Section8> (treatment of committed persons with antipsychotic medication; petition; notice; hearing; guardian).

In support of state legislative action, the U.S. Department of Justice, in a September 2016 memorandum, directed each U.S. Attorney “to consult with local stakeholders—including those outside the law enforcement community—[to] draft a district-specific strategy that incorporates the three pillars”—prevention, enforcement, and treatment.<sup>59</sup> The memorandum includes action items focused on using scarce resources to investigate and prosecute cases posing the greatest threats; enhancing regulatory enforcement for providers prescribing, dispensing, and distributing controlled substances; fostering information sharing; and promoting treatment options throughout the criminal justice system.

While diversion programs exist within the criminal justice system,<sup>60</sup> they are inextricably linked to behavioral health care providers by facilitating participation in mandated treatment programs as alternatives to criminal sentences. In such diversion programs, the focus is on the treatment related to the behavior<sup>61</sup> that resulted in the individual’s arrest, and the objectives are avoidance of prosecution, conviction, and a criminal record.<sup>62</sup> Another objective is to provide relief to overburdened local courts and law enforcement. These programs may be operated by police departments, courts, district attorney offices, or outside agencies. The experience has thus far demonstrated improved outcomes as well as cost savings.<sup>63</sup> Such is the case in the Law Enforcement Assisted Diversion Program (LEAD) in Seattle and King County, where “a coalition of law enforcement, public health, city and county officials, community stakeholders and private-sector supporters” designed a pre-booking

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59 Memorandum for Heads of Department Components from the Attorney Gen. 1 (Sept. 21, 2016), available at [www.justice.gov/opioidawareness/file/896776/download](http://www.justice.gov/opioidawareness/file/896776/download) [hereinafter *Memorandum*].

60 New Hampshire specialty courts, both Superior and Circuit, offer programs for offenders with substance abuse or mental health diagnoses that include linking offenders with services. *Drug and Mental Health Courts*, NEW HAMPSHIRE JUDICIAL BRANCH, [www.courts.state.nh.us/drugcourts/](http://www.courts.state.nh.us/drugcourts/) (last visited Nov. 5, 2017).

61 *Memorandum*, at 8.

62 *Id.* at 8–9.

63 EXEC. OFFICE OF THE PRESIDENT OF THE UNITED STATES, FY 2017 BUDGET AND PERFORMANCE SUMMARY: COMPANION TO THE NATIONAL DRUG CONTROL POLICY 14 (Dec. 2016), available at [https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/fy2017\\_budget\\_summary-final.pdf](https://obamawhitehouse.archives.gov/sites/default/files/ondcp/policy-and-research/fy2017_budget_summary-final.pdf).

diversion program that empowered “street level public safety personnel” to make decisions about arrests and to keep persons with substance use disorders out of the criminal justice system.<sup>64</sup> Other attempts to expand the diversion concept include “Ban the Box” campaigns or “fair chance policies” designed to minimize the stigma that can hurt an individual’s chances for securing employment and housing following treatment and/or incarceration.<sup>65</sup>

With their knowledge of admissions, consent and privacy, and recidivism, counsel for hospitals and clinics providing behavioral health services are uniquely qualified to effectively participate in state and community efforts to divert from incarceration “nonviolent individuals whose low-level criminal behavior stems from their drug addiction.”<sup>66</sup> It is patently clear that providers treating addicted patients must be free to provide those services without fear or risk of investigation and prosecution. The fall-out from punitive policies can be observed in the context of responses and pro-activities on the part of provider licensing boards in a number of states. In Oklahoma, for example, the board regulating pharmacists is known for helping providers through post-suspension assistance and counseling services following investigation and imposition of restrictions. The nursing board, however, is widely thought to be a highly punitive board that prosecutes aggressively. For licensing boards responding to incidences of criminal diversion of opioids by providers, the challenge is to strike a balance between protection of the public and fair treatment of licensed providers. In this context, it is critical that state licensing boards be supportive of federal, state, and local policies and programs with a

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64 *Seattle-King County Police Diversion Program*, NLC, [www.nlc.org/resource/seattle-king-county-police-diversion-program](http://www.nlc.org/resource/seattle-king-county-police-diversion-program) (last visited Nov. 5, 2017) (LEAD stakeholders have contracted with a service provider to treat LEAD participants).

65 On May 5, 2017, the Governor of Pennsylvania announced that a Fair Chance Hiring Policy for state agencies will “Ban the Box” and remove criminal history questions from non-civil service employment applications for agencies under the Governor’s office. The policy took effect on July 1, 2017. Press Release, Governor Wolf, Governor Wolf ‘Bans the Box’ on State Employee Applications (May 5, 2017), available at [www.governor.pa.gov/gov-wolf-bans-the-box-on-state-employee-applications/](http://www.governor.pa.gov/gov-wolf-bans-the-box-on-state-employee-applications/). Tallahassee had adopted a “Ban the Box” policy as part of its municipal hiring guidelines in 2015.

66 NAT’L LEAGUE OF CITIES & NAT’L ASS’N OF CTYS., A PRESCRIPTION FOR ACTION: LOCAL LEADERSHIP IN ENDING THE OPIOID CRISIS 36, available at [http://opioidaction.org/wp-content/uploads/2017/01/NACo-NLC\\_JointOpioidReport\\_FINAL\\_12.15.16.pdf](http://opioidaction.org/wp-content/uploads/2017/01/NACo-NLC_JointOpioidReport_FINAL_12.15.16.pdf).

focus on cooperation between every agency and entity that is involved in addressing the opioid epidemic. A forward-looking goal that includes enhanced patient care, appropriate remediation for addicts and criminal offenders, and educating the public may allow a state to more quickly reach benchmarks for success in responding to both types of diversion.

Agency and non-profit treatment programs designed to divert addicts from the criminal justice system may offer services of providers who are employed, independently contracted, or both.<sup>67</sup> A risk management or compliance perspective requires that all providers remain educated and aware of changes in federal, state, and even local requirements regarding treatment; maintenance of records; reporting/communication requirements with regulatory agencies like the DEA, state narcotics, and licensure agencies; rules of the local court; law enforcement; and the confidentiality rigors of the recently revised 42 C.F.R. Part 2.<sup>68</sup> Concurrently, academicians and clinicians continue to work on achieving sufficient, clear outcome data that can provide empirical proof regarding the success of current policies and programs.<sup>69</sup> It is impossible to discuss diversion programs without giving proper recognition to the special skills of lawyers in advocating for both client providers and patients, educating stakeholders about current laws and alternatives, and taking steps to provide relief to the overburdened system.

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67 Health care counsel will recognize important opportunities for counsel focused on risk avoidance for providers. Indeed, inclusion of such knowledge and experience represents a component in state-of-the-art compliance plans for behavioral health providers. The authors note that communities may experience future attempts to assign responsibility to providers and others for failing to facilitate such alternatives for patients in the face of charges and convictions and the attendant hardships.

68 Health Insurance Portability & Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, available at [www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf](http://www.gpo.gov/fdsys/pkg/PLAW-104publ191/pdf/PLAW-104publ191.pdf) and amendments thereto; 42 C.F.R. pt. 2, available at [www.ecfr.gov/cgi-bin/text-idx?rgn=div5;no\\_de=42%3A1.0.1.1.2](http://www.ecfr.gov/cgi-bin/text-idx?rgn=div5;no_de=42%3A1.0.1.1.2); Confidentiality of Substance Use Disorder Patient Records, 82 Fed. Reg. 6052, 6115 (Jan. 18, 2017) (to be codified at 42 C.F.R. pt. 2).

69 HAZELDEN REPORT. It is interesting to note that the Johns Hopkins Report does not include recommendations related to diversion. The report does note that PDMP data could be used effectively by law enforcement to identify “doctor shopper” rings and pill mills. JOHNS HOPKINS REPORT, at 29.

## Involuntary Commitment

All states provide for involuntary commitment for treatment where patients present sufficient potential harm<sup>70</sup> as established by reliable and substantial evidence in the context of proper procedures under applicable state statutes.<sup>71</sup> While these statutory schemes were designed for patients with mental health disorders, they were not historically relied upon to serve patients with substance use disorders.<sup>72</sup> In fact, some state statutes did not define or interpret mental illness to also refer to substance abuse.<sup>73</sup> In 2016, the National Alliance for Model State Drug Laws analyzed state laws to determine which states offered involuntary commitment for individuals with alcoholism or substance use disorder.<sup>74</sup> While it determined that over half of the states had such laws,<sup>75</sup>

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70 The concept of danger to self or others is most commonly understood for other types of mental illnesses. Such procedures are well-established in U.S. hospitals. The proscriptions associated with the Emergency Medical Treatment and Labor Act (EMTALA) have also been applied to such cases. In Oklahoma, state statutes provide for emergency detention for a period of 120 hours where the individual is evaluated and found to present a danger to self or others. OKLA. STAT. tit. 43A § 5-206(2). Oklahoma mental health statutes provide for emergency detention and treatment for mentally ill and drug- and alcohol-dependent persons. A hearing on the petition for involuntary commitment must be held within that period of time.

71 See, e.g., the Ohio voluntary admission statute. OHIO REV. CODE ANN. §§ 5122.05 (involuntary admission), 5122.11 (court-ordered treatment of a mentally ill person), *available at* <http://codes.ohio.gov/orc/5122>.

72 See Colorado website which states that “...no one can be committed because he or she is an alcoholic or drug abuser” *Mental Health Emergency Hold/Involuntary Commitment*, COLO. DEP’T OF HUMAN SERVS., [www.colorado.gov/pacific/cdhs/mental-health-emergency-holdinvoluntary-commitment](http://www.colorado.gov/pacific/cdhs/mental-health-emergency-holdinvoluntary-commitment) (last visited Nov. 7, 2017).

73 HAZELDEN REPORT at 2. According to the HAZELDEN REPORT, 37 states and the District of Columbia allow for involuntary commitment for patients with both substance use disorder, alcoholism, or both. Of these 38 jurisdictions, five have placed commitment for substance use disorders on par with psychiatric disorders, while the remaining jurisdictions offer separate commitment provisions for these types of patients. *Id.* at 2-3.

74 NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS, [www.namsdl.org/](http://www.namsdl.org/) (last visited Nov. 7, 2017). An example is provided by the statutory definition of “Initial assessment” under Oklahoma law: “Initial assessment (medical necessity review) means the examination of a person, either in person or via telemedicine, who appears to be a mentally ill person, an alcohol-dependent person, or a drug-dependent person and a person requiring treatment, whose condition is such that it appears that emergency detention may be warranted by a licensed mental health professional at a facility approved by the Commissioner of Mental Health and [citation] emergency detention of the person is warranted . . .”. OKLA. STAT. tit. 43A § 5-206(2).

75 Thirteen states have no provision for involuntary commitment at all for individuals with substance abuse disorders. HAZELDEN REPORT, at 3.

a clinical review a year earlier had suggested that having such a statutory scheme did not necessarily guarantee its use.<sup>76</sup> This may be a result of reticence on the part of judges to rely on new procedures, or it may signal a general lack of awareness by courts, law enforcement, providers, and even families of the alternatives and scope of authority under an expanded statutory scheme. Continuing and updated education on these alternatives is of paramount importance when dealing with patients addicted to opioids.<sup>77</sup>

Our growing understanding of substance abuse has moved some federal and state policymakers forward with programs that serve rather than penalize and, as a result, state and local governments are scrambling to catch up and better understand the impact of placing substance use disorders on par with other psychiatric disorders in terms of involuntary treatment. One such response comes from states seeking to make it easier to involuntarily commit an individual in need of such treatment.<sup>78</sup> In facilitating treatment without prior patient authorization, whether it be for outpatient or inpatient care, these programs seek to identify those who present a high risk of criminogenic behavior. The underlying objective is to provide families, providers, and

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<sup>76</sup> *Id.* at 4.

<sup>77</sup> In writing about the appropriateness on balance and the need for involuntary commitment for opioid addiction, one parent argued against stipulations as unnecessary:

She said the reality is that a civil commitment requires a concerted effort on the part of the person petitioning the court, and that it is generally pursued only as a last resort—after the disorder and risk have clearly grown severe and grave. ‘Families who have filed [an involuntary treatment petition] have done so only in desperate situations, after multiple overdoses and the loss of home, job, children, car, insurance, self-esteem and hope . . . . The only thing left to lose is their loved one’s life. That is the right the family is trying to protect—their loved one’s right to live.

*Id.*

<sup>78</sup> S.B. 390 (Ala. 2017) (involuntary commitment of individuals for assessment, treatment, stabilization and protective custody by law enforcement under certain conditions), available at <https://legiscan.com/AL/text/SB390/id/1598915/Alabama-2017-SB390-Introduced.pdf>; MD. HEALTH-GEN. CODE ANN §10-620 et seq. (2017) (setting standards for involuntary admissions and petitions for emergency evaluation in Maryland); S.B. 220 (N.H. 2017), available at [https://legiscan.com/NH/text/SB220/id/1486971/New\\_Hampshire-2017-SB220-Introduced.html](https://legiscan.com/NH/text/SB220/id/1486971/New_Hampshire-2017-SB220-Introduced.html) (definition of mental illness for purposes of mental health services) [hereinafter S.B. 220]; and S.B. 5811 (Wash. 2017), available at <http://lawfilesexet.leg.wa.gov/bien-nium/2017-18/Pdf/Bills/Senate%20Bills/5811.pdf#page=1> (expansion of use of involuntary treatment alternative as a way to combat heroin addiction).

facilities the tools they need to serve the patient's best interests, especially given the nature of the disease, i.e., substance abuse, and the existing stigma attached to it, which continues to inhibit patients from securing much needed addiction services. Behavioral health care managers and their lawyers are familiar with the risks associated with attempts to transport, transfer, or admit a patient to a health care facility when the patient is unwilling or out of control. A court order requiring treatment may be a viable mechanism for enabling families and providers to secure services for the individual in need.<sup>79</sup> For example, treatment non-adherence, a history of multiple hospitalizations, or violence toward self or others can trigger a court order under New York's Assisted Outpatient Treatment (AOT) program.<sup>80</sup>

Two states, New Hampshire<sup>81</sup> and Maryland,<sup>82</sup> have gone a step further and considered involuntary commitment policies that apply specifically to opioid use. This represents a more focused and aggressive effort to offer commitment as a treatment alternative. Such policy changes must be translated into specific procedures to maximize compliance and mitigate risk to facilities and other providers. If a state wishes to expand its statutory scheme in this way, the state will need to consider a number of factors, such as the level of training and licensure required to evaluate a patient for forced treatment, the mechanisms required to ensure privacy and confidentiality to the maximum degree possible while still serving evaluative and care coordination purposes, identifying the

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79 See, e.g., HAZELDEN BETTY FORD FOUND., INVOLUNTARY COMMITMENT FOR SUBSTANCE USE DISORDERS (July 2017), available at [www.hazeldenbettyford.org/articles/emerging-drug-trends/involuntary-commitment](http://www.hazeldenbettyford.org/articles/emerging-drug-trends/involuntary-commitment). Lawyers providing behavioral health counsel are familiar with the risks associated with attempting to transport, transfer, and admit a patient who is unwilling or out of control. See 18 VA. ADMIN. CODE § 85-21-40.

80 Section 9.60 of the New York Mental Hygiene Law (1999) is known as "Kendra's Law." N.Y. MENTAL HYG. LAW § 9.60. The goal is to provide care rather than to punish. Kendra's Law was enacted on a trial basis and has been temporarily re-authorized twice. Currently debate centers around the value of making the law permanent. S. Eide, *Assisted Outpatient Treatment in New York State: The Case for Making Kendra's Law Permanent*, Manhattan Institute (Apr. 27, 2017), available at [www.manhattan-institute.org/html/assisted-outpatient-treatment-nys-case-making-kendras-law-permanent-10229.html](http://www.manhattan-institute.org/html/assisted-outpatient-treatment-nys-case-making-kendras-law-permanent-10229.html). Oklahoma law provides an example of a state allowing outpatient treatment orders by a judge as part of the mental health docket without the benefit of enforcement provisions.

81 S.B. 220.

82 H.B. 1009 (Md. 2017) (withdrawn).

proper persons for filing such a petition, and documentation of facts supporting the necessity of sacrificing the patient's freedom in light of the risks—to the patient and others—associated with not undergoing treatment. In adopting such expanded policies, states also will likely find themselves grappling with issues related to confidentiality,<sup>83</sup> absence of consent,<sup>84</sup> and continuity of care.<sup>85</sup>

With the emergence of unique approaches aimed at helping opioid abusers get the help they need, all levels of government throughout the country are also attempting to balance and maintain substantive and procedural due process for its most vulnerable citizens, such as the right to counsel and the right to receive the petition and be present at the hearing. Attorneys practicing in the behavioral health space are in a unique position to provide much needed guidance to [the numerous stakeholders](#) mentioned earlier in this article. Because providers do not shed the attributes and responsibilities of their unique relationships with patients, and indeed the alternatives for disposition discussed in this article may increase future risks for providers, they must be able to access education and guidance from legal counsel who are prepared to interpret responsibilities and options in this changing environment as well as patient rights. Another unique program, as mentioned [earlier](#) in this article, is the “Ban the Box” campaign, also referred to as the “fair-chance policy,” which helps individuals

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83 HIPAA applies, as does the more rigorous 42 C.F.R. pt. 2, which applies solely to substance use disorders. For a thorough comparison of these two statutory schemes in light of recent revisions to 42 C.F.R. pt. 2, see Am. Health Lawyers Ass'n, *Member Briefing: 42 C.F.R. Part 2 in Retrospective: The 30-Year Journey of the Alcohol and Drug Abuse Treatment Confidentiality Regulation* (2017). Confidentiality issues are broadened by programs such as an evidence-based approach to drug abuse intervention endorsed by SAMHSA known as the Screening, Brief Intervention and Referral to Treatment (SMIRT) program that promotes universal screening. Telemedicine as a solution, particularly in provider-scarce rural areas, also raises unique confidentiality concerns and unique state regulatory structures. See U.S. Department of Agriculture Distance Learning and Telemedicine grants.

84 But note the argument made by some families and providers that the loss of freedom and some degree of privacy for some period of time pales in comparison to the risk of death, injury, and destruction.

85 Post-commitment treatment does not appear to be mandated in any state. In Oklahoma, for example, an order for outpatient treatment is commonly given under 43A O.S. § 5-416 (eff. 11/1/16) but the statutes do not provide for enforcement or for funds to support enforcement activities.

convicted of drug offenses secure employment and housing upon release from jail and to minimize the stigma associated with a conviction.<sup>86</sup>

## **How Kentucky Has Reacted**

The Commonwealth of Kentucky was hard hit by the opioid addiction crisis. Treating behavioral health conditions quickly and effectively was challenging. Patients were geographically scattered given the mostly rural and agricultural nature of the state, and poverty and the stigma of needing behavioral health care made patients reluctant to seek care. In Kentucky, as in many states, cost, access to health care, and the stigma associated with behavioral health care are the three largest barriers to treatment. Kentucky's legislative response to the need for treatment was two-fold, encompass additional licensures for facilities and providers and recognize the need to enhance treatment options and treatment flexibility across the state.

The state's coal mining industry and focus on manual jobs such as farming created a relatively young population with complaints of physical pain and injuries. A large portion of this population resided in Eastern Kentucky and depended on Medicaid or relied on other federal health care programs to treat their job-related injuries. High utilization of prescriptions by physicians and low availability of alternative medications or lifestyle options may have contributed to the population having become dependent on opiates. "Pill mills"—medical clinics that have a reputation for writing a large number of prescriptions in a short period of time were noted in many rural—and urban—areas throughout the state.

In 2012 the Speaker of the Kentucky House of Representatives passed House Bill 1, which amended Kentucky Revised Statute Sections 218A.172 and 218A.205. The new laws, collectively referred to as "The Pill Mill Bill", were enacted to eradicate pill mills across the Commonwealth.<sup>87</sup> Aspects of the bill included prescribing restrictions, monitoring of patients via drug screening

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86 Tallahassee adopted this program in January 2015 for its municipal hiring guidelines. SAMHSA, long a proponent of early diversion, awarded the City of Knoxville a law enforcement grant in 2013.

87 Ky. REV. STAT. § 218A.172.

tests, mandatory use by physicians of the Kentucky All Schedule Prescription Electronic Reporting System (KASPAR),<sup>88</sup> and enhanced reporting mechanisms for professional oversight organizations and law enforcement.<sup>89</sup> The primary focus of the bill, however, was to enhance addiction treatment options for persons who were overusing or abusing prescription medication. In response to the legislation, opioid prescriptions in Kentucky went down 11 percent between 2013 and 2015, according to the Pew Research Center.<sup>90</sup> Even with the decrease, however, Kentucky providers still prescribed more than 10.6 million controlled substances between June 2015 and July 2016, according to the Kentucky Office of Drug Control Policy's 2016 report.<sup>91</sup> Interestingly, the bill drafters had recognized that the new laws might have the unintended consequence of limiting availability or accessibility to opioids, and that such reduction in supply might actually increase the number of patients who become addicted. As predicted, Kentucky saw an increase in patients seeking addiction treatment. The prescription restrictions—while well-intended—created a measurable increase in persons suffering from opiate addiction, and the state now faced a shortage of treatment providers.

Kentucky struggled with a high need, high risk population for which it was not adequately prepared to treat. Medical experts say that while limiting prescriptions can help prevent future drug abuse, it does little to help those who are already in the midst of an addiction.<sup>92</sup> This was evident in Kentucky where the existing providers and care facilities struggled with how to recognize, diagnose, and treat a patient population that was currently struggling with addiction. The legislature sought input from law enforcement, provider

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88 *Id.* § 218A.202.

89 *Id.* § 218A.205.

90 See, e.g., Christine Vestal, *In States, Some Resistance to New Opioid Limits*, THE PEW CHARITABLE TRUSTS, June 28, 2016, [www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/06/28/in-states-some-resistance-to-new-opioid-limits](http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2016/06/28/in-states-some-resistance-to-new-opioid-limits).

91 COMMONWEALTH OF KENTUCKY JUSTICE & PUBLIC SAFETY CABINET, 2016 COMBINED ANNUAL REPORT, KENTUCKY OFFICE OF DRUG CONTROL POLICY AND KENTUCKY AGENCY FOR SUBSTANCE ABUSE POLICY (Feb. 2016), available at <https://odcp.ky.gov/Reports/2016%20annual%20report.pdf>.

92 Daniel Desrochers, *3-Day Limit on Painkiller Prescriptions Among New Laws Taking Effect Thursday*, LEXINGTON HERALD-LEADER, June 28, 2017, available at [www.kentucky.com/news/politics-government/article158710024.html](http://www.kentucky.com/news/politics-government/article158710024.html) [hereinafter *3-Day Limit on Painkiller Prescriptions Among New Laws Taking Effect Thursday*].

organizations such as the Kentucky Board of Medical Licensure (KBML), and the state Department of Medicaid in implementing legislation to address the provider shortage and the increasing number of patients seeking treatment.

During this same time period (2011-2014), Kentucky was a Medicaid expansion state under Patient Protection and Affordable Care Act (ACA) and shifted from traditional Medicaid to a Medicaid managed care model. A significant portion of the population was covered by federal health care programs, and it was clear that the response to the addiction crisis needed to include mandates on coverage. As part of that response, the initial and ongoing managed care organization (MCO) contracts under Medicaid managed care included a mandate for addiction treatment. The MCOs in Kentucky are required to provide behavioral health care, specifically for substance abuse disorders, as part of the services provided.<sup>93</sup>

The substance abuse disorder services that are included for Medicaid and Medicare members under the Centers for Medicare and Medicaid Services (CMS) guidelines and under the Kentucky State Plan and Kentucky regulations are as follows:

- screening, assessment, crisis intervention, mobile crisis, residential crisis;
- stabilization, day treatment (for minors), peer support;
- parent/family peer support, intensive outpatient program, individual outpatient;
- therapy, group outpatient therapy, family outpatient therapy, collateral outpatient;
- therapy, partial hospitalization, residential services for substance use disorder; and
- Screening, Brief Intervention and Referral to Treatment (SBIRT).<sup>94</sup>

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93 907 Ky. ADMIN. REGS. 17:005.

94 KENTUCKY DEPARTMENT OF MEDICAID Q & A 1 (2014), available at [www.chfs.ky.gov/NR/rdonlyres/9E3C2325-1B94-4284-B944-62963A293AF8/0/MACBinderSection13Miscellaneous111915.pdf](http://www.chfs.ky.gov/NR/rdonlyres/9E3C2325-1B94-4284-B944-62963A293AF8/0/MACBinderSection13Miscellaneous111915.pdf).

The medications approved include vivitrol, methodone, and buprenorphine. Commercial insurers track the federal payer options in most cases.

## Non-violent drug offenders

Criminal activity is often tied to addiction. The legislative response in Kentucky has therefore also included the creation and expansion of services for offenders. Kentucky has operated a drug court program since 1996, with structured “best practices” and guidelines to use when offering non-violent drug offenders a route to recovery as an alternative to incarceration.<sup>95</sup> Until 2015, drug court options did not include patients who were using Medication-Assisted Treatment (MAT) to achieve treatment and recovery goals.<sup>96</sup> Abstinence-based programs were the only options available to drug court members. As more people began understanding that addiction was a disease rather than a criminal activity, the court system in turn responded to a joint medical and legal response to the addiction crisis. Kentucky’s success was due in part to the active involvement of patient advocacy and provider-focused groups in educating lawmakers. During all facets of the lawmaking process, advocacy groups and organizations such as the State Board of Medical Licensure had the opportunity to participate during hearings, which gave lawmakers a better understanding of the potential impact and possible unintended consequences that the proposed legislation might create. Even with this measured approach, however, amendments to the initial law were required in two following legislative sessions. Two “clean up” bills refined the law and the related administrative regulations once actual practice of the law revealed what parts were working well and what parts were proving unworkable. Kentucky’s legislature’s ongoing

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95 KENTUCKY DRUG COURT: THE TEN KEY COMPONENTS, available at [https://courts.ky.gov/courtprograms/drugcourt/Documents/AOC\\_DC\\_10Keys.pdf](https://courts.ky.gov/courtprograms/drugcourt/Documents/AOC_DC_10Keys.pdf).

96 Ryland Barton, *Amid Federal Pressure, Kentucky Drug Courts Look Into Expanding Addiction Treatment*, WKMS JIVE HOUSE, Feb. 26, 2015, available at <http://wkms.org/post/amid-federal-pressure-kentucky-drug-courts-look-expanding-addiction-treatment>; Jason Cherkis, *Kentucky Reforms Drug Court Rules To Let Heroin Addicts Take Prescribed Meds*, HUFFPOST, Apr. 17, 2015, available at [www.huffingtonpost.com/2015/04/17/heroin-addiction-kentucky\\_n\\_7088270.html](http://www.huffingtonpost.com/2015/04/17/heroin-addiction-kentucky_n_7088270.html).

response to the opioid crisis serves as a reminder that lawmakers should ensure ample discussion time before implementing legal changes and remain flexible and open-minded about amending laws or regulations when problems arise. There is no “ultimate” solution to this crisis, but rather a system of amendments that is intended to positively impact all affected populations.

Kentucky’s drug court program uses a team approach of collaboration between judges, specialty program staff, prosecutors, defense counsel, treatment professionals, and other community agencies that provides wraparound services such as job training, temporary housing, and public assistance. The patient-participants engage in mandatory treatment, counseling, community service, random urine screens, and probation and parole monitoring for a period not less than six months. The expansion of services to include the greater variety of treatment options expanded the options available for remediation of minor criminal charges due to addiction. The program is believed to be highly successful and the recidivism rate indicates the continuing success. Legislation granting Kentucky’s Administrative Office of the Court discretion in operating drug courts supports both the drug court program and the pilot SMART (Supervision, Monitoring, Accountability, Responsibility, and Treatment) program, which provides similar care for parolees.

### **Self-pay treatment options**

Kentucky also had to contend with issues being created by self-pay clinics, which treat a large number of patients with a quick monthly visit and a prescription for the patient’s medication of choice. Kentucky has a large number of self-pay treatment options that operate outside the federal payer system and which can charge patients up to \$500 a month for outpatient treatment, not including any prescription or drug screening costs. Self-pay patients do not receive the protections afforded to those who are covered by insurance in terms of receiving appropriate referrals, long-term support, consistency of

care, and adequacy of treatment. While some self-pay clinics provide mental health services and behavior modification in addition to physician visits and prescriptions, not all of them adhere to those best practices.

Concerns were raised that these self-pay treatment options were charging Medicaid members cash for the doctor's visit and care, and then charging Medicaid for the medications and drug screens performed by third party entities. This practice resulted in the payer covering only those limited parts of treatment without allowing the payer to review the care provided. As a result, commercial payers amended their member contracts, requiring that prescribers enroll with the carrier in order for the care to be covered. In addition, many payer contracts strictly limited coverage of out-of-network care to eliminate coverage of the mandatory drug screen or the medication ordered by a non-participating provider—Kentucky insurance statutes allowed that type of payer independence in contracting.<sup>97</sup>

Federal payers reacted in a similar fashion. Pursuant to state law, Kentucky amended its administrative regulations and required that any physician treating a Medicaid member must be credentialed with CMS and with the Kentucky Department of Medicaid Services, which tracks the CMS requirement found at Section 455.410 “Enrollment and Screening of Providers.”<sup>98</sup> States imposing limits on payment or frequency of care need to ensure that the practical impact of those changes is tracked. Effectiveness is not always linear, and unintended consequences can hamper the positive effect that was intended by any law. Credentialing and licensure mandates on health care providers will help the state access data that would not otherwise be available or provided by “cash only” medical practices.

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97 Ky. REV. STAT. ch. 304.

98 Letter from Lee Guice, Dir., Div. of Policy & Operations, Dep't for Medicaid Servs., to Ordering, Referring, Prescribing Providers (Feb. 1, 2017), available at [www.kymmis.com/kymmis/pdf/20170201\\_ORP\\_Letter.pdf](http://www.kymmis.com/kymmis/pdf/20170201_ORP_Letter.pdf).

## Facility licensure and enhancement

With increased controls on prescriptions and significant limitations placed on over-prescribers, the number of patients suffering from substance addiction in Kentucky continued to grow. “Legislating care” became the goal of elected officials. In 2017, Kentucky State Representative Kimberly P. Moser offered a bill that focused on recovery and treatment for addicts, but it failed to pass the Senate on the final day of this year’s legislative session.<sup>99</sup> Similar bills are being advocated for future legislative sessions. Other legislative and administrative responses regarding access include amendments that covered facility licensure, removal of barriers, and creating new or expanded treatment options. Currently, Kentucky offers residential care and outpatient care (bi-weekly or monthly), as well as intensive outpatient care, which includes counseling and support three hours/day, three days/week. Long-term residential care is most often coupled with abstinence in Kentucky, while the shorter term 30-90 day programs often incorporate MAT.

### *Relaxing CON regulations*

An insufficient number of “brick and mortar” facilities became an issue for Kentucky. As a result, statutes regarding Certificate of Need (CON) legislation were amended so that addiction care and treatment providers were not required to obtain a CON for services.<sup>100</sup> This allowed for new clinics and treatment centers to open more rapidly. In addition, certain categories of providers that operated under existing CON regulations were allowed to increase the number of beds they could offer. These providers included community mental health centers, licensed free-standing residential substance use disorder treatment programs, residential treatment facilities or licensed psychiatric inpatient beds, and outpatient behavioral health treatment centers.<sup>101</sup> The purpose of the amendments was to ensure that treatment providers could quickly expand services to sufficiently meet the demands of a growing substance abuse patient population.

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<sup>99</sup> *3-Day Limit on Painkiller Prescriptions Among New Laws Taking Effect Thursday.*

<sup>100</sup> KY. REV. STAT. § 216B.020.

<sup>101</sup> *Id.*

*Other provider types that provide opioid addiction services*

Kentucky licenses Alcohol or Drug Treatment Entities (AODE) to treat patients who have commercial insurance or are self-pay. State administrative regulations govern the licensure of AODEs,<sup>102</sup> which must meet certain physical plant, staff educational, and experiential requirements.<sup>103</sup> An AODE may provide inpatient, outpatient, and intensive outpatient services<sup>104</sup> and is reimbursed through private or commercial insurance or on a patient self-pay basis. AODE care is not, however, covered by federal health care programs. In 2014, the state therefore created a new provider facility type known as a Behavioral Health Services Organizations (BHSO) that could treat Medicaid and Medicare members. A BHSO is similar to an AODE in structure and operations. Facilities may request and receive both AODE and BHSO licensures simultaneously or elect to form an AODE first and accept commercial payer insureds to support the facility while applying for BHSO licensure, which—like AODE licensure—is governed by Kentucky’s administrative regulations.<sup>105</sup> The Kentucky Department of Medicaid Services allows for reimbursement from Medicaid for BHSOs.<sup>106</sup>

Separate licensure is required for another provider type called Residential Crisis Stabilization Units (RCSU), which provide crisis management and short-term detoxification services.<sup>107</sup> RCSUs can be freestanding or part of an existing facility. Patients who are treated at RCSUs are referred to further outpatient or inpatient treatment in most cases.

Finally, the state’s Community Mental Health Centers (CMHCs) are heavily involved in substance abuse treatment. CMHCs are private, nonprofit organizations serving residents of designated multicounty regions across the state. Amendments to CON laws and regulations have helped CMHCs increase the

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102 902 KY. ADMIN. REGS. 20:160.

103 908 KY. ADMIN. REGS. 1:370.

104 *Id.*

105 902 KY. ADMIN. REGS. 20:430; *id.* 20:440.

106 907 KY. ADMIN. REGS. 15:025; KY. REV. STAT. §§ 194A.030(2), 194A.050(1), 205.520(3).

107 902 KY. ADMIN. REGS. 20:440.

number of patients they can treat. The continuing expansion of CMHCs by the Kentucky state government will help assure that even the most rural patients have access to care.

### Provider licensure, credentialing, and telemedicine

Kentucky has also responded to the overwhelming number of patients requiring substance abuse treatment through an expansion of provider types who can be credentialed to provide those services. Expanding the provider network is a critical component of sufficiently addressing patient care need and volume. All payers in Kentucky, whether they are commercial payers or federal health care programs, cover Screening, Brief Intervention and Referral to Treatment (SBIRT) assessment of patients who may suffer from addiction.<sup>108</sup> Family physicians, primary care physicians, and hospital providers who do not treat for substance addiction are encouraged to perform the covered evaluation and refer patients to providers who specialize in such care.

#### *Licensed clinical alcohol and drug counselors*

Kentucky Administrative Regulation (KAR) 35:010 concerns the credentialing of licensed clinical alcohol and drug counselors (LCADC), registered alcohol and drug peer support specialists, certified alcohol and drug counselors, licensed clinical alcohol and drug counselor associates, and peer support specialists. This provider type is new in Kentucky, having graduated its first class in 2015. State statute and regulations govern licensure and oversight of LCADC personnel. Changes in Kentucky's administrative regulations have also permitted applicants for certification as alcohol and drug counselors to substitute part of their work experience with a degree in a related field, such as addictions, counseling, psychology, psychiatric nursing, or social work.

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108 CMS, SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) SERVICES (Mar. 2017), available at [www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT\\_Factsheet\\_ICN904084.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf); ANTHEM BLUE CROSS & BLUE SHIELD MEDICAID, SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT (SBIRT) (Dec. 2016), available at [https://mediproviders.anthem.com/Documents/KYKY\\_CAID\\_PU\\_SBIRT.pdf](https://mediproviders.anthem.com/Documents/KYKY_CAID_PU_SBIRT.pdf).

Approval of educational substitution is based on education relative to the delivery of alcohol and other drug counseling.<sup>109</sup> For example, if an applicant's educational degree is in a related field, the degree may be substituted for a certain number of hours of work experience (note, however, that a bachelor's degree in an unrelated field does not qualify for substitution of hours). This regulatory change allowed highly qualified individuals to obtain LCADC licensure without having to take on additional coursework.

In 2015, Kentucky's legislature expanded certification and licensure for LCADCs, requiring both commercial and federal payers to reimburse for that level of care.<sup>110</sup> Currently, the Medicaid fee schedule for provider categories does not include LCADCs or other non-bachelor level degrees.<sup>111</sup> While commercial carriers may be reimbursing for care provided by LCADCs, the Kentucky Department of Medicaid Services (DMS) has yet to list them as providers who will be reimbursed by Medicaid for their addiction treatment services; additional legislative mandates may be required to advance that. Managed care organizations are not required to pay for all care that is reimbursed by DMS to a CMHC and do not as of yet reimburse for LCADC care unless it is provided as part of a per diem payment to a licensed facility.<sup>112</sup>

### *Targeted case managers*

Targeted case management is another avenue used by case managers to help patients access appropriate care providers and stay on track for care and rehabilitation. Targeted case managers screen for addiction and monitor ongoing treatment, including placement and counseling. Inpatient care for the substance abuse disorder population is paid for under targeted case management, but not for outpatient treatment with the exception of CMHC staff, who are reimbursed for the targeted case management services they render on an

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109 201 KY. ADMIN. REGS. 35:075.

110 KY. REV. STAT. § 309.084; *id.* § 309.0813(1).

111 BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES INPATIENT (FACILITY) FEE SCHEDULE (June 2016), available at <http://chfs.ky.gov/NR/rdonlyres/5F888306-0400-4FC1-91D1-530BC7A554CD/0/BHandSUFeeScheduleIPFrev612016r1.pdf>.

112 907 KY. ADMIN. REGS. 1:045(13).

outpatient basis.<sup>113</sup> Targeted case management covered by federal payers has been extended to patients with dual diagnoses or co-occurring mental health and substance abuse disorders. Private and commercial insurance may also cover case management services, including coverage for outpatient care. State law modifications in Kentucky permits an expansion of the case manager provider type so that in addition to physicians, case managers may be registered nurses or have a masters or bachelor's degree in social work with a set number of years of professional experience.<sup>114</sup>

### *Telemedicine*

Daily check-ins, patient assessment, crisis management, and counseling services via telemedicine is a key service that can expand care available to addicted patients by increasing access and decreasing cost or the stigma often associated with seeking behavioral health care services. Some commercial and private payers cover telemedicine services, which has expanded availability of services. Kentucky law requires parity in reimbursement for telemedicine and traditional in-person care. Current statutes and regulations governing Kentucky's Medicaid reimbursement for telemedicine covers a limited class of providers for certain services provided via telehealth. Otherwise, such reimbursement is strictly limited.<sup>115</sup> DMS and the legislature are currently crafting modifications to existing law to expand coverage and options for telehealth services. Those amendments will be considered in the 2018 legislative session. Currently, CMHCs are permitted to bill for the widest variety of telemedicine services;<sup>116</sup> however, when it comes to BHSO entities and other substance use disorder (SUD) providers, DMS has not approved much by way of telemedicine counseling, assessment, or other aspects of care.<sup>117</sup> Proposed statutory and

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113 *Id.*

114 907 KY. ADMIN. REGS. 4:1440.

115 KY. REV. STAT. § 205.559.

116 Daniel Desrochers, *3-Day Limit on Painkiller Prescriptions Among New Laws Taking Effect Thursday*, LEXINGTON HERALD-LEADER, June 28, 2017, available at [www.kentucky.com/news/politics-government/article158710024.html](http://www.kentucky.com/news/politics-government/article158710024.html).

117 907 KY. ADMIN. REGS. 3:170.

regulatory changes should amend those limitations and increase the types of care for which telemedicine is reimbursable.

Kentucky has made great strides to address the opioid crisis, but as is the case with many—if not all—other states struggling with this epidemic, there is still much to do. The tension that exists between patients, providers, and payers regarding the different approaches to care is evident in Kentucky. For example, abstinence treatment, with or without counseling, was initially highly favored by many of the state's hardest hit regions while medication was disfavored and looked upon as “replacing one addiction with another.” While Kentucky was an early adopter of the drug naloxone, a medication designed to quickly address the immediate risk of death due to overdose,<sup>118</sup> the state has nevertheless been slower to recognize that both medication assisted treatment and abstinence can be effective for different types of patients.

Despite the tension, Kentucky continues to monitor the need for care and proactively address necessary changes to state law so that this vulnerable patient population remains covered. The state legislature has enacted new laws or modifications to existing laws combatting addiction for each of the past five legislative sessions and that progress is expected to continue in the 2018 session. In 2017, for example, new legislation amended the state law on prescription drug monitoring to require prompt reporting of controlled substances prescribed by any entity, including hospital emergency departments.<sup>119</sup> Recent legislation also now requires that courts and prosecutors transmit data on drug convictions (of persons possessing controlled substances illegally, abusing controlled substances, or prescribing controlled substances improperly) to the state's Cabinet for Health and Family Services so that this division of state government can track those actions.<sup>120</sup>

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118 Jason Cherkis, *How Kentucky Embraced a Life-Saving Drug for Opioid Addicts*, HUFFPOST, Aug. 18, 2015, available at [www.huffingtonpost.com/entry/kentucky-heroin-addicts\\_us\\_55d2b574e4b07addcb43e481](http://www.huffingtonpost.com/entry/kentucky-heroin-addicts_us_55d2b574e4b07addcb43e481).

119 KY. REV. STAT. § 218A.202, amended by H.B. 314 (Ky. 2017).

120 KY. REV. STAT. § 218A.202, amended by S.B. 32 (Ky. 2017).

## Conclusion

As the opioid epidemic continues to generate deadly statistics, state legislatures will be called upon to be ever diligent and creative in their responses. The national legislative response includes a bill passed in 2015, the 21st Century Cures Act,<sup>121</sup> which makes approximately \$1 billion in funding available to help states combat the opioid epidemic. Federal payers such as Medicare and Medicaid must begin providing comprehensive coverage for substance abuse disorder and not limit the options to a less than therapeutic maximum of treatment days. The Mental Health Parity and Addiction Equity Act<sup>122</sup> (MHPAEA) also aims to make it easier for those with mental health and substance use disorders to secure the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services. The MHPAEA requires coverage for mental health and substance use disorders to be no more restrictive than coverage that is generally available for medical/surgical conditions, but enforcement of this ambiguous provision is lacking. Despite federal recognition of the need for treatment, states still struggle with specific patient demographics, geographical and economic barriers to access to care, the stigma associated with seeking such care, a shortage of qualified providers, and insufficient resources to implement the proven strategies such as MAT and a central PDMP to combat the scourge of the opioid crisis.

While eradication of the opioid epidemic remains a significant goal for the future of our states and communities, the scope of the crisis is increasingly clear. The debate over the best and most effective ways to proceed will continue at the state level and, while each state will respond in its own unique way, it is imperative that states learn from the experiences of other states in terms of effective—and ineffective—program components and program design. State and federal lawmakers also must continue using their resources and authority to effect the most change if, as a nation, we are to successfully fight this epidemic. **J**

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121 Pub. L. No. 114-255.

122 Pub. L. No. 110-343.



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