Demanding Better: A Case for Increased Funding and Involvement of State Medical Boards in Response to America's Drug Abuse Crisis

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ABSTRACT: The federal response to the U.S. drug overdose epidemic has largely focused on supply-reduction efforts. Yet, this response has led to serious consequences for patients, prescribers and the public. Specifically, demand-reduction activities have been inadequately prioritized and pursued, and supply-reduction efforts targeted at the prescribers of controlled medications have resulted in reluctance to prescribe medically necessary controlled medications, thereby compromising access to treatment. Meanwhile, overdose death rates have remained tragically high as unabated demand has yielded shifts in the supply of substances of abuse. This article reviews federal responses to the opioid crisis, examining the allocation of federal funding as well as the U.S. Department of Justice's enforcement actions against health care providers. The article then provides recommendations for how state medical boards can be better utilized in responding to the overdose epidemic. These recommendations include requiring that state medical boards be the primary investigators of questions relating to medical need, allocating federal funding to state medical boards, instituting continuing medical education requirements for controlled medication prescribers and expanding screenings for problematic substance use.

Introduction

Many proposed solutions to the U.S. drug overdose epidemic have treated the crisis as primarily a law enforcement issue, rather than a culmination of the shortcomings of social, economic, legal-regulatory, medical, public health, and public safety systems. This response to the issue is incomplete, as it is widely accepted that addiction is a preventable and treatable chronic disease.[1] Some overly aggressive enforcement actions aimed at reducing inappropriate access to prescription opioids have led health care practitioners to fear criminal liability when practicing medicine, causing harm to patients and providers alike. Policymakers are beginning to realize that this enforcement-focused approach has yielded some harmful consequences, chief among them a significant decrease in access to medically necessary treatment for pain, opioid addiction and other conditions that require controlled medications and a corresponding increase in the demand for, and abuse of, illicit drugs.[2]

This article provides an overview of the consequences brought about by the primary federal response to the drug overdose epidemic. It will also highlight the role that state medical boards can play in ensuring that responses to drug abuse, addiction and overdose do not sacrifice access to appropriate medical treatment. Part I presents an overview of recent government action to curtail the prescribing of controlled medications and to prosecute prescribers, as well as the consequences that have resulted from these efforts. Part II establishes that state medical boards are best equipped to serve as the primary authority to review reports of inappropriate prescribing and should be funded accordingly. Part II additionally outlines recommendations for actions that state medical boards can take to promote best practices that ensure that patients have access to individually-appropriate medical care that minimizes the risks of controlled-medication diversion, misuse and abuse and encourages substance-use screenings, interventions and treatment.

Part I: Background

The U.S. Drug Overdose Crisis

Throughout the early 2000s, overdose-related deaths in the United States were on the rise and in November 2011, the Centers for Disease Control and Prevention (CDC) declared that deaths attributable to prescription pain killers had reached "epidemic levels."[3] Recent trends show that overdose deaths in the United States are now more likely to result from illicit substances, such as heroin and fentanyl, than from prescription opioids.[4] According to the CDC, 67,367 drug overdose deaths occurred in 2018.[5] Of those overdose deaths, 15,575 involved prescription opioids.[6] Overdose deaths involving fentanyl and fentanyl analogs numbered 31,335 in 2018.[7] Increased demand for illicit heroin and fentanyl has yielded a spike in overdose deaths involving these substances.[8] Conversely, overdose

deaths related to prescription opioids have been steadily decreasing since 2012.[9]

Additionally, the Drug Enforcement Administration (DEA), an agency within the U.S. Department of Justice (DOJ), has repeatedly warned that drugs sold on the black market are often contaminated with deadly illicit substances (e.g., fentanyl, carfentanil, and related analogs), and that the users of such drugs may not know exactly what substances they have ingested.[10] Demand for, and overdose death-

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rates related to, non-opioid illicit substances, such as cocaine, benzodiazepines and stimulants have also increased.[11] Alcohol and cigarettes are likewise associated with high death rates.[12] Vaping-related injuries and deaths have led to total or partial bans in California, Massachusetts, Michigan, New York, Rhode Island and Washington state.[13] As such, the United States' drug crisis encompasses initiation, abuse, and addiction — in addition to overdoses — and involves far more substances than just prescription drugs, including increasingly lethal illicit substances.

Primary Federal Response

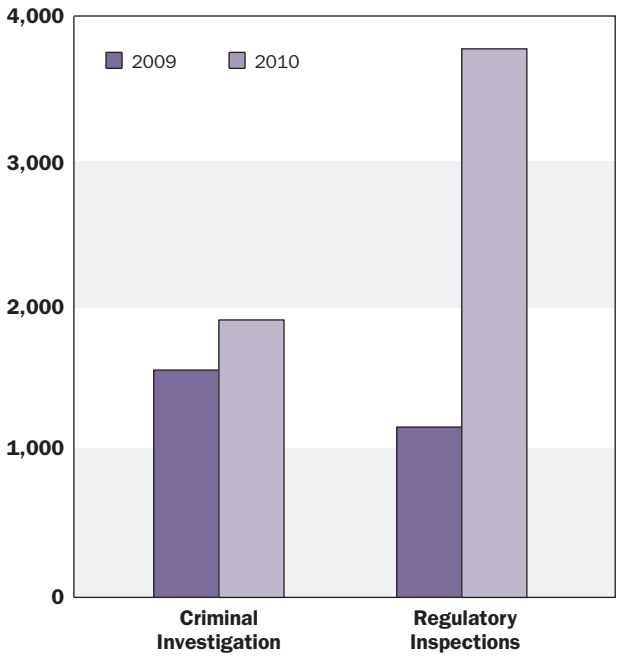
The manner in which the federal government has allocated funding to address the overdose epidemic paints a clear picture of its policy priorities. In drug policy, there are two primary conceptual strategies for addressing drug abuse, addiction and overdose. The first is to reduce the supply of substances of abuse. The second is to reduce the demand for such substances. As defined in the National Drug Control Budget Fiscal Year (FY) 2021 Funding Highlights, "supply-reduction" programs are those related to international drug law enforcement, domestic drug law enforcement and interdiction efforts.[14] "Demand reduction" programs broadly entail prevention and treatment efforts.[15]

Federal drug policy has traditionally prioritized supply reduction over demand reduction. Around October of 2008, supply-reduction efforts were significantly expanded to include inspections, investigations and enforcement actions against prescribers of controlled medications.[16] Figure 1 reflects the impact of this expansion on the number of criminal investigations and administrative inspections conducted over the next two years. From FY 2009 to FY 2010, criminal investigations increased by 21% and administrative inspections increased by 218%.[17]

The federal government has heavily focused its response to the drug overdose epidemic on supply-reduction efforts. Billions of dollars in federal funding have been dedicated to federal, state and local law enforcement responses to the overdose crisis.[18] Some of these dollars have gone towards intense enforcement against prescribers of controlled medications.

While much of this effort has successfully reduced the number of bad actors who intentionally prescribe and dispense controlled substances in an illegal manner, it has also diminished access to individualized treatments for patients with legitimate medical needs, undermined the expansion of medication-assisted treatment (MAT) and potentially exacerbated the U.S. suicide epidemic. What it has not done is yield significant reductions in drug abuse, addiction or overdoses. In fact, overdose deaths related to illicit substances, such as fentanyl and cocaine, have continued to climb in spite of the government's

Figure 1
Criminal Investigations and Administrative Inspections After 2008 Supply Reduction Expansion



Data Source: U.S. Government Accountability Office. Prescription drug control. https://www.gao.gov/products/gao-11-744. Published August 26, 2011. Accessed February 10, 2020.

supply-reduction efforts.[19] States may also engage in supply-reduction focused enforcement efforts by, for example, revoking the medical licenses of health care practitioners who engage in improper or criminal conduct.[20]

Since 2016, DOJ has received an average of $8.21 billion annually as part of the Federal Drug Control Budget.[21] This funding has been used, in part, to drive the operations of DEA as well as the work of groups like the Organized Crime Drug Enforcement Task Force.[22] In 2017, DOJ began creating multiple new task forces charged with investigating and prosecuting prescribers of controlled medications.[23] It established the Opioid Fraud and Abuse Detection Unit to collect and analyze prescribing and distribution data to identify and charge providers whose data does not fall within DOJ-identified parameters.[24] DOJ also assembled the Prescription Interdiction and Litigation (PIL) Task Force to "aggressively deploy and coordinate all available criminal and civil enforcement tools" against distributors of opioids, such as pharmacies, pain management clinics, drug testing facilities and individual physicians whom it has identified as not distributing, dispensing or prescribing according to its standards.[25] Additionally, DOJ formed and later expanded the Appalachian Regional Prescription Opioid (ARPO) Strike Force to increase enforcement against medical professionals and others involved in illegal prescribing and distribution of opioids.[26]

Through the operation of such task forces, DOJ has aggressively exercised its powers under the federal Controlled Substances Act (CSA) to investigate, raid, and in many cases, prosecute practitioners. Additionally, DOJ has employed extremely broad interpretations of health care fraud statutes to bring fraud charges against prescribers when federal health care funding was used to fill a controlled-medication prescription. On June 28, 2018, alone, DOJ charged 601 defendants for health care fraud and opioid-related conduct. The following year, on April 17, 2019, the ARPO Strike Force charged 60 physicians and pharmacists with illegally prescribing and dispensing opioids in what DOJ described as the "biggest crackdown of its kind in U.S. history."[27] Then, on August 28, 2019, an additional 41 individuals were charged in nine indictments for their involvement in an alleged network of "pill mill" clinics and pharmacies.[28] That same day, DEA also issued Immediate Suspension Orders (ISOs) to seven pharmacies and two providers allegedly involved in dispensing controlled medications without a legitimate medical purpose.[29]

DOJ enforcement actions continued to escalate in 2019. On September 18, 2019, DOJ brought charges against 58 individuals across all four federal districts in Texas for their alleged involvement in Medicare fraud schemes and networks of "pill mill" clinics. Sixteen of the individuals charged were medical professionals, and 20 were charged for opioid diversion.[30] A few days later, on September 24, 2019, a second coordinated law enforcement action of the ARPO Strike Force resulted in charges against 13 individuals across five Appalachian federal districts for alleged offenses relating to the prescribing of controlled medications through "pill mill" clinics.[31] Twelve of the individuals were charged for unlawfully distributing opioids and other controlled substances, 11 of whom were physicians.[32] On September 26, 2019, DOJ charged an additional 48 individuals for their alleged role in submitting fraudulent claims, including 15 medical professionals and 24 individuals who were charged for allegedly diverting opioids.[33]

DOJ's focus on investigating and prosecuting prescribers of controlled medications has compromised access to treatment for individuals with legitimate medical needs. Enforcement efforts have created a chilling effect on prescribers of controlled medications, who are decreasing and altogether ceasing their prescribing out of fear of investigation and prosecution.[34] Evidence of this chilling effect can be found in the nationwide 32% decrease in opioid prescriptions per person from 2008 to 2017.[35]

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Consequently, access to treatment for pain, opioid use disorder (OUD), and other conditions that require controlled medications has deteriorated.[36] Despite the decreases in opioid prescribing and rates of prescription-opioid-related overdose deaths, the federal government remains focused on further restricting the amount of opioids that are distributed, dispensed and prescribed without taking into account those patients who may have a legitimate medical need for such medications. Specifically, the Trump Administration has vowed to reduce the dispensing of prescription opioids by an additional one-third by 2021.[37]

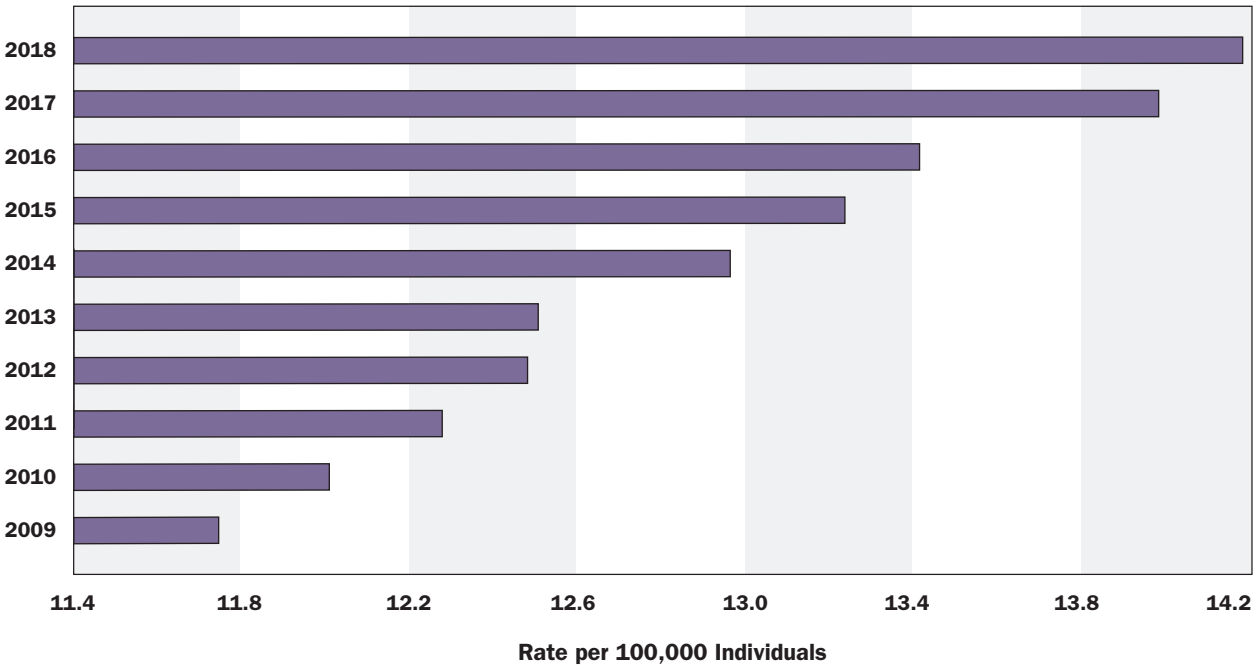
When raids of prescribers occur, patients who may have been stable on a course of treatment for years often find themselves unable to access their medications. When opioid dosing is reduced suddenly or drastically, patients may be placed in the position of either going into withdrawal or seeking alternative relief. As such, patients may turn to risky street drugs and could unintentionally ingest lethal substances, such as illegal fentanyl. This impact has been evidenced by the changes in drug overdose mortality curves over the past several years. As mortality rates related to prescription-opioid-involved overdoses have declined, there has been an accompanying sharp increase in mortality rates due to illicit substances, such as heroin and fentanyl.[38]

Further complicating the overdose crisis, DOJ's aggressive enforcement actions have undermined efforts to expand access to opioid addiction treatment. Fear of audits and investigations (particularly when unannounced), as well as possible prosecution, has prevented many diligent health care providers from prescribing MAT, specifically buprenorphine for the treatment of OUD, which has, in turn, restricted patient access to treatment. Prescribers have cited numerous reasons for their reluctance to incorporate MAT into their practice, including burdensome regulatory requirements and increasing regulatory and law enforcement scrutiny of practitioners who do provide such treatment.[39] Moreover, the fundamental misunderstanding of the use of MAT as simply substituting one drug for another has exacerbated the stigma attached to addiction treatment, further discouraging practitioners from integrating MAT into their practices.[40]

Additionally, the intense enforcement approach has potentially exacerbated suicide rates. Suicide rates have steadily increased in the United States since 2008 (Figure 2).[41] It is now the nation's tenth leading cause of death, resulting in more than 48,000 deaths in 2018, the most recent year with available data.[42] Notably, the undertreatment of conditions that require controlled medications has correlated with an increase in suicide. Research has found that an inability to access controlled medications for the treatment of pain has resulted in suicides.[43] A survey of over 3,100 pain patients found that over 40% of respondents had considered suicide as a result of poorly treated pain.[44]

To date, DOJ has used its enforcement authority under the CSA to justify its investigations and prosecutions of health care practitioners, determining that if the treating physician is not following standards or falling within data parameters that DOJ deems acceptable, then the physician is consequently

Figure 2
Suicide Rates in the United States By year 2009–2018



Data Source: American Foundation for Suicide Prevention. https://afsp.org/suicide-statistics.

violating the CSA by not prescribing for a legitimate medical purpose or by practicing outside of the usual course of professional practice.[45] Yet, medical experts frequently speak of "the art and science of medicine."[46] The art of medicine is the individual physician's interpretation of the science, based upon his or her training, expertise and experience. This method facilitates the individualization of treatment and may yield controlled medication prescribing decisions that deviate from the legal or regulatory standard that DOJ may apply. Nevertheless, prescriptions outside the bounds of such standard can often be for legitimate medical needs and issued in the usual course of practicing the art of medicine in accordance with science.

Additionally, the circumstances that policymakers consider to be indicative of diversion or abuse may actually be indicative of curtailed access to treatment. A recent judicial review and dissolution of an ISO issued to a West Virginia pharmacy highlights that practices that DOJ considers to be "red flags" may actually be explained by patients' difficulty accessing their medically necessary controlled medications. In an October 2019 opinion from the U.S. District Court for the Southern District of West Virginia, Judge Joseph Goodwin explained that the "red flags" at issue, such as multiple prescriptions written by prescribers outside of West Virginia and patients traveling great distances to have their prescriptions filled at the pharmacy, may have been due to shortages of available local MAT providers, the high number of required monthly appointments with MAT providers in West Virginia, or a lack of health insurance coverage for MAT, rather than drug abuse or diversion.[47] Judge Goodwin further explained that opioid addiction cannot be solved "solely through criminal law enforcement," and that "[w]hen the government uses tools that were chiefly developed to crackdown on illegal drugs to impede the lawful prescription of substances for MAT," it may erect barriers to medically necessary treatment.[48] DOJ's crackdown on prescription opioids has curtailed access to MAT and may be exacerbating the very problem that it is intended to fix.

In November 2019, the U.S. District Court for the District of Massachusetts reversed a verdict of criminal CSA liability of former executives and managers of Insys Therapeutics Inc. for actions that encouraged the prescribing and dispensing of a controlled sub-lingual fentanyl spray.[49] In reversing the verdict, the court held that the defendants' actions did not meet the requisite intent to establish criminal liability under the CSA.[50] In its interpretation of the CSA, the court stated that "a practitioner becomes a criminal not when he is a bad or negligent physician, but when he ceases to be a physician at all."[51] Criminal liability under the CSA requires that "the physician not only intentionally distributed drugs, but that he intentionally acted as a pusher rather than a medical professional."[52] As such, the court found that, even though the defendants did intend to try to sell as much of the controlled medication as possible, there was no evidence that the defendants intended that the health care practitioners with whom they worked prescribe the medication to patients who did not need it, or otherwise "abdicate entirely their role as healthcare providers."[53] Consequently, the defendants did not have the requisite intent for criminal liability under the CSA, and the verdict was reversed.[54]

Part II: Recommendations

Aggressive law enforcement actions against prescribers of controlled medications have generated harmful consequences for both patients and health care practitioners. Many practitioners are reluctant to treat patients with controlled medications "due in part to concerns and undue burdens of investigation and prosecution by drug enforcement."[55] Even where DOJ actions do not lead to any arrests or prosecutions, raids and investigations disrupt practices, lead to temporary office closures and cause lasting reputational damage to practitioners.[56] As a result, patients who need controlled medications to treat their conditions are left without adequate access to treatment, leaving those with OUD at risk of overdose and death, and those with pain potentially at risk of suicide.[57]

Most policymakers and law enforcement professionals lack the medical and public health knowledge that must be part of the national response to the drug abuse, addiction and overdose crises. In fact, one regulatory authority that does possess such medical and public health expertise has been largely overlooked: the state medical board. State medical boards should be empowered to serve as the primary investigator that makes the initial determination on questions related to medical need and patient care, including the prescribing of controlled medications. Such an approach has the potential to improve the individualization of medical care; prevent controlled medication diversion and risk of substance use disorder (SUD); improve transparency and fairness for prescribers; and help curtail the drug abuse, addiction and overdose crisis.

Recommendation 1: Strengthen the role of state medical boards in responding to accusations of improper prescribing.

State legislatures have the authority to regulate the practice of medicine under the states' plenary police power.[58] They can use the authority to revoke physicians' and physician assistants' licenses if the physician or physician assistant (PA) has been found guilty of improper or unlawful conduct. Such revocations are intended to protect the public health and safety, rather than to punish the physician or PA.[59] DOJ's aggressive-enforcement approach has compromised the states' ability to oversee the practice of medicine in this manner. State medical boards should have exclusive authority to handle allegations of inappropriate prescribing and other physician or PA conduct related to medical need and patient care before state or federal law enforcement is permitted to investigate.[60] After their investigation and determination, boards could then refer the case to the appropriate law enforcement authority if they determine that it is advisable to conduct a criminal investigation. Boards' medical expertise and thorough understanding of standards of care equip them better than police and prosecutors to determine whether medical professional actions are inappropriate and potentially criminal. Medical boards are also better suited to foresee and address the medical consequences of actions that cause a medical provider to discontinue treating his or her patients.

BOARDS' MEDICAL EXPERTISE AND THOROUGH UNDERSTANDING OF STANDARDS OF CARE EQUIP THEM BETTER THAN POLICE AND PROSECUTORS TO DETERMINE WHETHER MEDICAL PROFESSIONAL ACTIONS ARE INAPPROPRIATE AND POTENTIALLY CRIMINAL.

Prescriber Confidence

Establishing medical boards as the exclusive initial investigative authority in cases of alleged inappropriate prescribing would help to alleviate the chilling effect that zealous federal law enforcement actions have had on controlled medication prescribers. It would provide prescribers with relief from the fear that they must satisfy DOJ's interpretations of appropriate prescribing or risk being raided without notice, prosecuted and imprisoned, or losing their life savings to cover legal costs. This approach would protect patients, prescribers and the public by educating and rehabilitating — rather than raiding and prosecuting — prescribers whose actions may be improper. It would still permit the prosecution of prescribers who commit intentionally wrongful or reckless acts by providing for referral from medical boards to law enforcement of suspected criminal activity.

Additionally, the ability of boards to appoint specialists in pain, SUD treatment, psychiatry and other medical practices that often require controlled medication prescribing better accounts for medical standards of care and the art of medicine in the context of investigations and adjudication of allegations against controlled medication prescribers. As a result, this approach would create a fairer process, more appropriate and precise assessments of standards and conduct and less of a chilling effect on the prescribing of controlled substances when medically appropriate.

Regulatory Process Rights

A critical benefit of the medical-boards-first approach is that it would better protect the regulatory process rights of physicians and PAs than DOJ's enforcement actions. State medical boards generally provide physicians and PAs with notice of a complaint. Practitioners against whom complaints are made are typically given a hearing in which they have the opportunity to respond with the assistance of legal counsel before any adverse disciplinary action is taken.[61] DOJ, on the other hand, has employed a far less transparent approach, often utilizing surprise inspections, raids, undercover investigations and informants and closed-door grand jury proceedings.[62] The agency may choose to allow problematic behavior to remain unabated throughout its investigation in order to ensure that there is sufficient evidence to support a conviction under the CSA. As a result, DOJ can report high win rates.[63]

Relying on state medical boards to conduct medical investigations would also work against the stigmas surrounding individuals treated for conditions like pain, addiction, anxiety and attention deficit hyperactivity disorder (ADHD) by ensuring that practitioners who prescribe controlled medications are not unjustly regarded as criminals and are afforded the same rights to regulatory process as other health care practitioners accused of improper medical conduct.

By no means does the recommendation that state medical boards possess primary investigative authority suggest that states or the federal government would "go easy" on medical professionals who endanger patients and the public. Depending on the

facts of a particular situation, it is possible that a board might take a strict approach to investigation and enforcement, including revocation of a medical license and referring potentially criminal conduct to state or federal law enforcement. The potential that a board could revoke a license to practice and refer the practitioner for additional investigation by law enforcement would still provide a strong deterrent effect without many of the detrimental consequences of the current approach.

The greater transparency afforded by providing notice to the physician or PA of an allegation of improper medical conduct can lead to a speedier remedy to such conduct than the current approach affords. One concern about providing notice is that it is not optimal given the increased risk of the destruction of evidence, which could hinder criminal prosecution. Some boards have addressed this problem by shortening or eliminating the notice requirement. For example, Texas allows its medical board to temporarily suspend or restrict a medical license without notice or hearing, if (1) it immediately provides the license holder with notice of the suspension or restriction, and (2) a disciplinary panel hearing on the temporary suspension or restriction is scheduled for the earliest possible date after 10 days' notice of the hearing.[64] Such a policy can be utilized when there is reason to believe evidence may be intentionally lost, damaged or destroyed.

For prescribers whose conduct is improper, yet not intentionally wrongful, mere notice of a complaint may be adequate to alter behavior, improving health and safety nearly immediately. Therefore, even if a chance of evidence loss does exist, immediately reducing risks to patients and the public health and safety outweighs the possibility that some bad actors may not be punished as harshly.

Recommendation 2: Appropriate federal funding for state medical boards.

To implement this policy change, Congress should authorize and appropriate federal funding for state medical boards to address the drug overdose crisis. Federal agencies and states have received billions of dollars in federal funding to address the drug overdose epidemic, typically with consistent year-to-year increases.[65] For example, the enacted version of the FY 2020 National Drug Control Budget will distribute $35.6 billion among various federal agencies to support the response to the drug overdose crisis.[66] This budget reflects the key drug policy priorities of the Trump Administration and roughly matches funding levels from prior fiscal years.[67]

From 2003 through 2016, the ratio of federal funding for supply-reduction versus demand-reduction initiatives was roughly three to two.[68] Supply-reduction programs received a total of $192.92 billion over this time frame, for an average amount of $13.78 billion per year.[69] Demand-reduction programs, on the other hand, only received $127.18 billion over that same time frame, giving these efforts a yearly average of $9.08 billion.[70] Put another way, of all federal funding given to supply and demand-reduction efforts from 2003 through 2016, supply-reduction efforts received around 60%.

Yet, drug overdose deaths increased sharply year to year over the same period of time. Total drug overdose deaths rose by an average of 7.34% each year, climbing from 25,785 in 2003 to 63,632 in 2016.[71] Overdose deaths related to opioids (both prescription and illicit) increased across the board, from 13,706 in 2003 to 43,491 in 2016.[72] The greatest increases were seen in overdose deaths related to fentanyl, which increased at a staggering average annual rate[73] of 27.24% from 2003 through 2016, and those related to heroin, which had an average annual increase of 17.86%.

After 2016, a shift in the approach of the federal government occurred in the form of increased funding allocated to demand-reduction programs. After receiving no more than 42.82% of available funds each year from 2003 through 2016, demand-reduction programs received 49.14% of available funds from 2017 through 2018.[74] By comparison, from 2017 through 2018, supply-reduction programs received 50.86% of available funding, a significantly lower percentage than the amount that these programs received from 2003 through 2016.[75] This change in proportionate funding reflects the urgency that the federal government felt to address overdoses involving prescription and illicit opioids. By necessity, demand-reduction initiatives have been more singularly focused on problematic opioid use, rather than substance abuse more broadly.

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U.S. drug overdose death data reported by CDC (Figure 3) shows a marked change in drug overdose

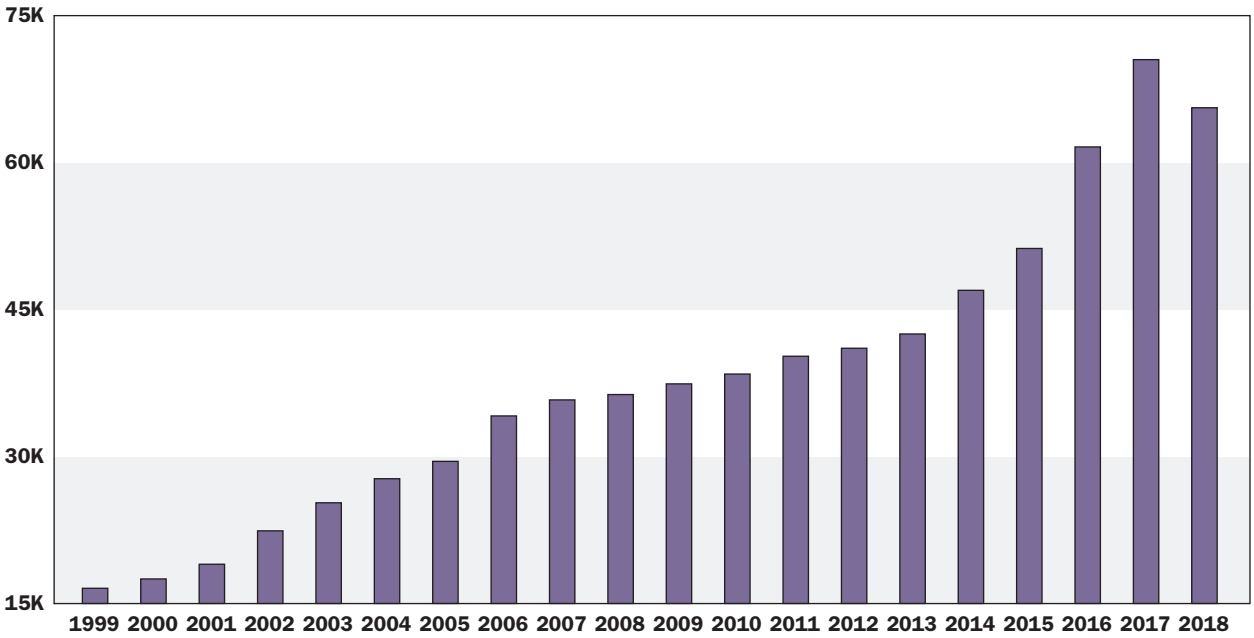
death rates from 2017 to 2018 as compared to 2003 through 2016.[76]

One significant aspect of this change was a decline in all drug overdose deaths and opioid-involved overdose deaths from 2017 to 2018. Additionally, the average annual growth rate of total drug overdose deaths slowed from 7.34% per year in 2003 through 2016 to 3.15% per year in 2017 through 2018 (Figure 4).[77] Similarly, the average annual growth rate in overdose deaths involving opioids (prescription and illicit) slowed from 9.74% per year to 5.49% per year.[78] Not all rates decreased, however. For example, the average annual growth rate for overdose deaths involving fentanyl slightly increased from 27.24% per year in 2003 through 2016 to 28.36% per year in 2017 through 2018. More strikingly, there was a significant change in the average annual growth rate of overdose deaths involving cocaine and other stimulants. These deaths grew by an average of 9.47% each year from 2003 through 2016 and increased to a rate of 24.06% from 2017 to 2018. The absence of such a drastic shift in the rate of overdose deaths related to cocaine and other stimulants could be attributed in part to the fact that these substances were largely being addressed only by supply-reduction efforts.

U.S. DRUG OVERDOSE DEATH DATA REPORTED BY CDC SHOWS A MARKED CHANGE IN DRUG OVERDOSE DEATH RATES FROM 2017 TO 2018 AS COMPARED TO 2003 THROUGH 2016.

This data, while not sufficient to provide evidence of clear causation, at the very least indicates that the allocation of additional funding to opioid-focused demand-reduction (i.e., treatment and prevention programs) in 2017 and 2018 may have had an immediate and significant impact on the rate of overdose deaths involving opioids. For instance, in 2017, the Substance Abuse and Mental Health Service Administration (SAMHSA) offered nearly half a billion dollars via the State Targeted Response to the Opioid Crisis grant, which helped states address the opioid crisis by "increasing access to treatment, reducing unmet treatment need and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder."[79] Likewise, in 2018, SAMHSA announced a $930 million State Opioid Response grant opportunity to help states expand their prevention, treatment and recovery services, including MAT, and to improve retention in care.[80]

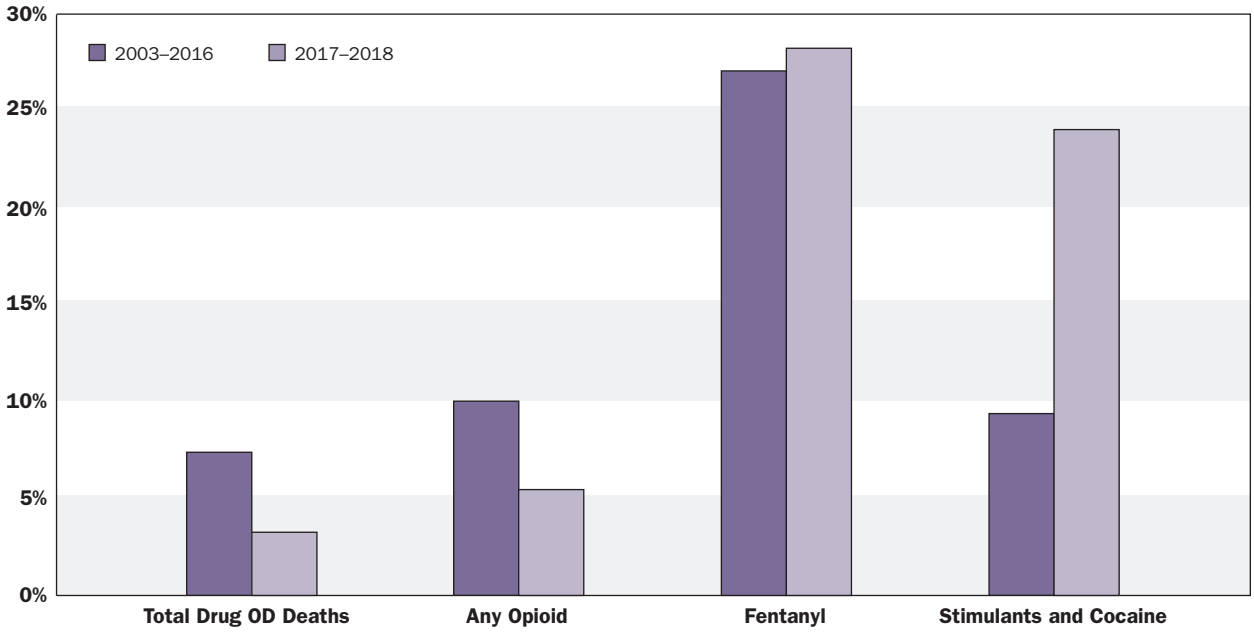
Figure 3
Drug Overdose Deaths in the United States
Number of deaths in thousands (K) by year



Data Source: National Center for Health Statistics. https://www.cdc.gov/nchs/data/databriefs/db356_tables-508.pdf.

Figure 4

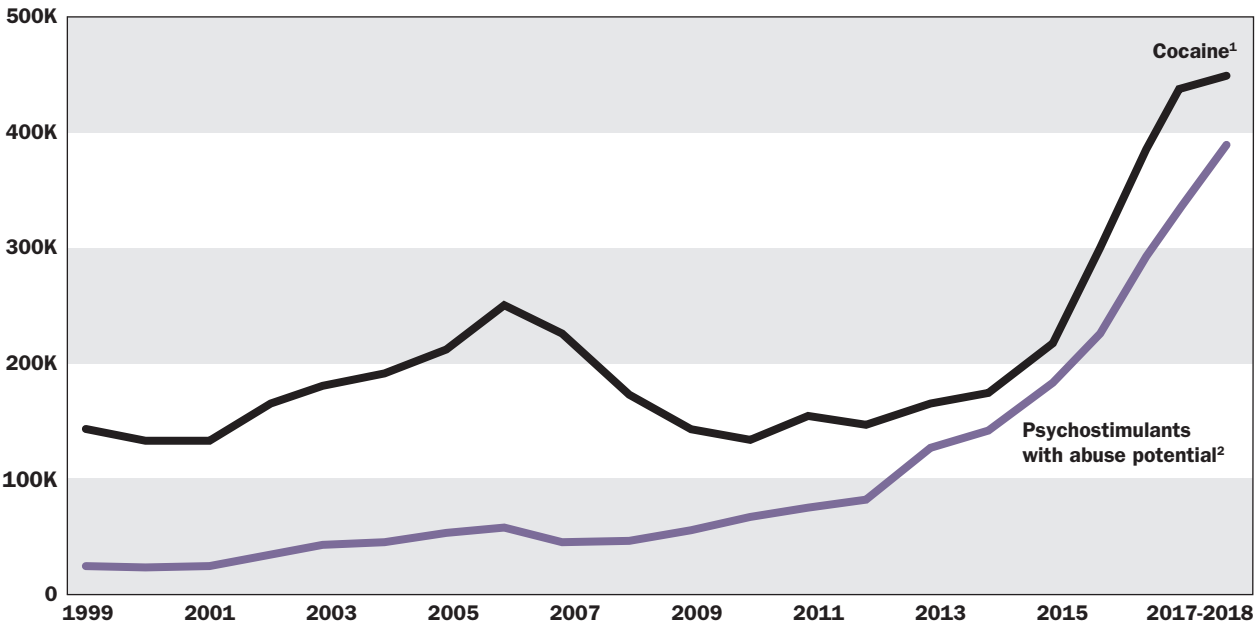
Average Annual Growth Rate in Overdose Deaths 2003–2016 vs. 2017–2018 By drug type



Data Source: Centers for Disease Control and Prevention. Data brief 356. Drug overdose deaths in the United States, 1999-2018. https://www.cdc.gov/nchs/data/databriefs/db356_tables-508.pdf#page=3. Accessed February 10, 2020.

Figure 5

Age-Adjusted Drug Overdose Death Rates Involving Stimulants by Type of Stimulant — United States, 1999–2018 Deaths per 100,000 (100K)



[1] Significant increasing trend from 1999 through 2006, decreasing trend from 2006 through 2012, and increasing trend from 2012 through 2018 with different rates of change over time, $p < 0.05$.

[2] Significant increasing trend from 1999 through 2005, 2008 through 2012, and 2012 through 2018 with different rates of change over time, $p < 0.05$.

NOTES: Deaths are classified using the International Classification of Diseases, 10th Revision. Drug-poisoning (overdose) deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Drug overdose deaths involving selected drug categories are identified by specific multiple-cause-of-death codes: cocaine, T40.5; and psychostimulants, T43.6. Deaths may involve multiple drugs. The percentage of drug overdose deaths that identified the specific drugs involved varied by year, with ranges of 75%–79% from 1999 through 2013 and 81%–92% from 2014 through 2018. Access data table for Figure 4 at: https://www.cdc.gov/nchs/data/databriefs/db356_tables-508.pdf#4. Source: NCHS, National Vital Statistics System, Mortality
Figure Source: cdc.gov/nchs/products/databriefs/db356.htm.

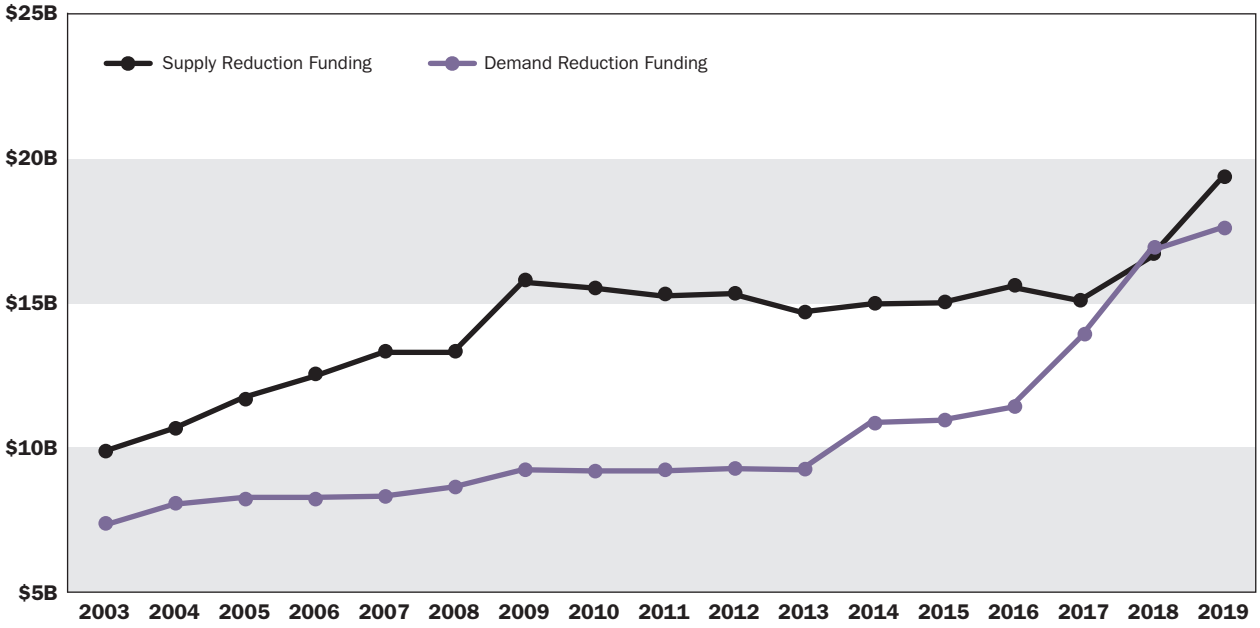
Every state proposed specific efforts to address demand-reduction in 2017 and 2018 under these grant programs. For example, in 2017, Massachusetts proposed to expand office-based opioid treatment programs to at least seven new community-based sites and re-entry treatment and recovery support services for inmates prior to their release from incarceration. Such services included MAT induction, treatment and recovery planning and post-release linkages to services and recovery support, case management and recovery coaching.[81] In 2018, Maryland proposed to use SAMHSA funds to improve access to and enhance services for individuals with OUD by "reducing unmet treatment need, creating links to somatic health care, [and] designing of primary and secondary prevention methods with an emphasis on peer and other recovery support."[82]

The average yearly amount of supply-reduction funding in 2017 and 2018 was only marginally higher than the average yearly funding from 2003 through 2016.[83] Further, there was no decrease in the average annual growth rate of overdose deaths from 2003 through 2016. This dynamic may suggest that these types of programs are less cost effective than demand-reduction initiatives in addressing the nation's overdose epidemic. Indeed, the most significant change in funding from 2003 through 2016 to 2017 through 2018 was that the proportion of funding given to demand-reduction programs came closer to 50%.

If one accepts these premises, then a next logical step would be to continue to appropriate more federal funding to demand-reduction programs and to keep supply-reduction funding at its current level. In FY 2017 and FY 2018, it appeared as though Congress would do just that, with demand-reduction efforts receiving 49.14% of available funds during those years and supply-reduction efforts receiving 50.86%. In fact, dating back to FY 2003, FY 2018 marked the first time that demand-reduction funding was higher than supply-reduction funding (Figure 6). The very next year, however, Congress reverted to disproportionate funding in favor of supply-reduction programs, an approach that proved to be ineffective at reducing overdose death rates from 2003 through 2016. In FY 2019, demand-reduction efforts received 47.75% of available funds (down from 50.40% the year prior) and supply-reduction efforts received 52.25% (up from 49.60% the year prior).

Notably, the FY 2019 and FY 2020 National Drug Control Budgets do not direct any funding to state

Figure 6
Supply-Reduction vs. Demand-Reduction Funding
By year, 2003–2019 in billions of dollars (B)



Data Source: Office of National Drug Control Policy. National drug control strategy FY 2021 funding highlights. https://www.whitehouse.gov/wp-content/uploads/2020/02/FY-2021-National-Drug-Control-Budget-Highlights.pdf. Published February 2020. Accessed February 10, 2020; Office of National Drug Control Policy. FY 2015 budget performance and performance summary. https://obamawhitehouse.archives.gov/sites/default/files/ondcp/about-content/fy2015_summary.pdf. Published July 2014. Accessed February 10, 2020

medical boards under any of their priorities, nor does any such funding appear in the FY 2021 proposal.[84] We recommend that Congress fund demand-reduction efforts at higher levels moving forward. From FY 2018 (the last year that demand-reduction programs received the majority of available funds) to the enacted FY 2020 totals, funding for supply-reduction programs has increased by $953.9 million. We recommend that this increase be fully redirected to demand-reduction efforts. Should these funds be added to the funding already enacted for FY 2020, it would amount to a total increase in funding for demand-reduction efforts of $2.31 billion from what was given in FY 2018. We recommend that, of this total increase, 33.5 percent (roughly $775 million) should be directed to state medical boards to investigate and act upon allegations of inappropriate controlled medication prescribing practices. This funding would drastically bolster medical boards' ability to address accusations of improper prescribing in a fairer, consistent, streamlined, and more transparent way, thus aiding both supply-reduction and demand-reduction efforts.

Recommendation 3: Medical boards should support mandatory education for controlled medication prescribers.

Controlled medications, by legal definition, pose a higher risk of diversion, misuse and abuse than non-controlled prescription medications. As such, health care practitioners have a higher duty to be knowledgeable about these risks and the best practices for minimizing them. Mandatory education for controlled medication prescribers on how to create proper treatment plans that involve controlled medications and how to recognize signs of diversion, misuse, abuse and addiction may help equip prescribers to satisfy the greater duty associated with prescribing controlled medications.

States may require continuing medical education (CME) for licensed health care practitioners. Some states currently have laws that mandate some degree of continuing education related to prescribing controlled medications. For example, Arizona, Delaware, New Hampshire and Vermont all require physicians who are registered with DEA to prescribe controlled medications to complete *at least* two hours of CME in controlled substances or opioid prescribing practices per licensing period.[85]

CME requirements could be a powerful tool to ensure a more complete and accurate understanding of the risks, potential benefits and responsibilities associated with controlled-medication prescribing. Mandatory controlled medication prescriber education should include safe prescribing practices; screening, interventions and treatment or referral to treatment protocols; and MAT for the treatment of OUD. If controlled medication prescriber education were mandatory and included such information, it would be reasonable to expect both supply-reduction and demand-reduction effects. Supply-reduction effects would include fewer medications prescribed without medical necessity and less diversion. Demand-reduction effects would include an increase in screenings, interventions and treatment for SUDs in primary care and other settings as providers gained a more complete understanding of their duties and best practices.

Recommendation 4: State medical boards should endorse expanded screenings for problematic substance use.

As the regulators of medical practice for their respective states, medical boards serve as a persuasive authority not just on the oversight of the medical profession, but also on broader state health and safety policy, including, for example, health insurance coverage and health care in criminal justice settings. Therefore, boards are well-positioned to take a leadership role in advancing the state-level adoption of recommendations from federal organizations and addiction treatment experts regarding the need for screenings for problematic substance use. The U.S.

CME REQUIREMENTS COULD BE A POWERFUL TOOL TO ENSURE A MORE COMPLETE AND ACCURATE UNDERSTANDING OF THE RISKS, POTENTIAL BENEFITS AND RESPONSIBILITIES ASSOCIATED WITH CONTROLLED-MEDICATION PRESCRIBING.

Preventive Services Task Force has issued a draft recommendation that all adults be screened for illicit drug use in primary care settings when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.[86] Moreover, addiction treatment experts recommend that primary care, pain medicine, emergency medicine, psychiatry, obstetrics and surgery practitioners implement routine screening for problematic substance use.[87] Screenings for SUDs should also be a part of the law enforcement intake processes, ideally being conducted before an individual's arrest and booking.[88] Per the National Conference of State Legislatures, as of 2017, 23 states have statutorily authorized

diversion programs for defendants charged with a drug offense or who have substance use needs.[89]

To increase access to screenings for SUD, practitioners should be assured that they will receive payment for their services. The Patient Protection and Affordable Care Act (ACA) made notable strides to increase access to preventive mental health care and SUD treatment by requiring such services be covered as an essential health benefit (EHB).[90] However, the ACA does not specify which services must be covered, leaving the states and insurance companies with the discretion to decide what types of screenings and services will be covered. Medical boards should encourage coverage of and fair payment for such screenings in their states.

PRIORITIZING A LAW ENFORCEMENT-LED RESPONSE TO THE DRUG OVERDOSE EPIDEMIC HAS YIELDED UNINTENDED CONSEQUENCES, INCLUDING AN INCREASING DEMAND FOR ILLICIT SUBSTANCES...

Conclusion

Prioritizing a law enforcement-led response to the drug overdose epidemic has yielded unintended consequences, including an increasing demand for illicit substances; prescriber reluctance; decreased access to treatment for pain, OUD and other conditions that require controlled medications; and pain-related suicides. As policymakers begin to address these consequences, state medical boards should be advocates for policies that minimize the risk of drug diversion, misuse and abuse; ensure consistent and fair regulation of the practice of medicine; and do not curtail access to individualized treatment. To date, state medical boards have been an underutilized resource, but as primary investigators of questions of medical need and patient care, they have the potential to yield meaningful change that would improve the lives of patients, practitioners and the public at large. ■

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