Latest Opioid Abuse Bill Contains Over 100 Provisions But No Far-Reaching Pharmacy Mandates

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It may be cynical to wonder whether the huge substance abuse prevention bill that Congress passed in October 2018 will be any more effective than the Comprehensive Addiction and Recovery Act (CARA) that was passed two years ago. That was CARA 1.0. Now comes CARA 2.0. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (aka the SUPPORT for Patients and Communities Act) passed the House and Senate overwhelmingly and was highlighted by both parties as an example of important bipartisan legislation that last session’s deeply divided Congress could pass. But the reason for the bipartisan support was that the SUPPORT bill consisted of 120 separate bills, mostly minor in impact, which individual congressmen and senators, who are sponsors of those sections, could use on the 2018 campaign trail to show how much they were accomplishing in Washington.

Some of the bill’s provisions have distant effective dates. The drug management plans (DMPs) authorized by CARA 1.0 for Medicare Part D plans that wanted to voluntarily establish them have now been made mandatory, but they will not go into effect until January 1, 2022. The bill also mandates DMPs for state Medicaid programs.

Aside from mandating DMPs and a few other provisions, the new opioid bills is light on provisions affecting pharmacists and pharmaceuticals. In a blog post, Thomas Menighan, BSPharm, Executive Vice President and Chief Executive Officer of the American Pharmacists Association (APhA), said, “The fact that the opioids bill doesn’t contain Medicare Part B coverage of pharmacists’ opioid-related services is a major disappointment and missed opportunity for our patients.”

Paul Abramowitz, Chief Executive Officer of the American Society of Health-System Pharmacists (ASHP), called the bill a “landmark” piece of legislation and highlighted sections including Section 1011, Assessing Barriers to Opioid Use Disorder Treatment and Chapter 2, Empowering Pharmacists in the Fight Against Opioid Abuse. Both of those started out as separate bills sponsored and co-sponsored by individual representatives or senators, as did most of the provisions. The Assessing provision calls for a study of the barriers in the Medicaid program to providing buprenorphine, naloxone, and buprenorphine–naloxone for the treatment of substance use disorders, and will include an analysis of pharmacists’ dispensing of these medications. The Empowering provision charges the U.S. Department of Health and Human Services with developing and disseminating programs and materials to inform pharmacists how to decline to fill a prescription for a controlled substance that seems fraudulent, forged, or questionable.

The section of the bill addressing state-run Prescription Drug Monitoring Programs (PDMPs) is similarly underwhelming. These are state-run databases that physicians and pharmacists can check to avoid issuing a prescription to someone who should not be receiving opioids because of possible or probable abuse. Only some states require physicians and pharmacists to check PDMPs, and even then, the requirement is ignored more than it is adhered to, based on testimony given to Congress (see our June 2018 issue).

As SUPPORT was moving through Congress, the National Association of Chain Drug Stores (NACDS) advocated for a nationwide PDMP solution to harmonize state PDMPs. The bill includes no such provision. Instead, the bill says that the Centers for Disease Control and Prevention (CDC), which has current grant- ing authority for PDMPs, may provide technical assistance and award grants in order to improve PDMPs, promote new approaches for responding to emerging public health crises, and improve overdose data reporting. This is, in effect, a shuffling of current CDC grants with no new money authorized.

Michelle Cope, Director, Federal and State Public Policy at NACDS, says, “The bill contains some provisions which make changes to existing grant programs at the CDC which we think will facilitate cooperation among grant administrators, the states, and the office of the national coordinator to standardize PDMPs and facilitate interoperability with health information technology.”

Among the provisions touted by NACDS is one that requires physicians to electronically transmit prescriptions for schedule II, III, IV, or V controlled substances to pharmacists, except where a multitude of exceptions come into play. Cope explains that those exceptions will not come into play very often.

She adds that pharmacies are already set up to receive controlled substance prescriptions electronically. While many physicians already take advantage of e-prescribing, many have not updated their electronic health records systems to comply with the Drug Enforcement Administration’s requirement for “securely” transmitting controlled substance e-prescriptions. The bill says physicians will have to do so by January 1, 2021. The e-prescribing provision applies only to Medicare Advantage and Part D plans, and not to Medicaid, employer plans, or marketplace plans.

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Cope explains that New York State already requires what the SUPPORT mandates and that New York has seen a decrease in doctor shopping and prescription fraud as a result.

SUPPORT provided plenty of support for candidates running for re-election to Congress in 2018. It remains to be seen, then, whether this new bill will be any more effective than its predecessor, which looks in retrospect like a public relations (political) gesture with the publication on November 29, 2018, of the CDC’s annual statistics on death in the U.S. Drug overdoses set another annual record in 2017, with 70,237 overdoses reported compared to 63,632 overdoses the year before.