

CALIFORNIA LEGISLATURE



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**Joint Informational Hearing
Senate and Assembly Health Committees
Increasing Access to Treatment and Services in Response to the Opioid Crisis
March 13, 2019 – 10:00 a.m.
State Capitol, Room 112**

The Senate and Assembly Health Committees will hold a joint informational hearing that will focus on the state’s response to the opioid crisis, particularly through the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver and the California Hub and Spoke System (CA H&SS). These two programs have been implemented for four and two years, respectively. Initial evaluations indicate that significant progress is being made throughout the state, both in lowering the number of opioid-related overdose deaths and expanding access to treatment and services for those who experience, or are at risk of experiencing, a substance use disorder (SUD).¹ However, there are continuing challenges, particularly in rural areas of the state. Exploring the future of both projects is timely given that the federal waiver for the DMC-ODS expires in 2020, and it is uncertain if the federal government will provide a third round of funding for the CA H&SS. The Committees will hear testimony from researchers from the University of California, Los Angeles, about both projects and initial outcomes. Stakeholders will also provide perspectives on the implementation of both projects, with one stakeholder focusing on the northern rural area of the state, which has been disproportionately affected by the opioid epidemic. Finally, the Committees will hear from the Department of Health Care Services (DHCS), which administers both the DMC-ODS and CA H&SS; the Department of Public Health (DPH), which has received separate state and federal funding to help address the opioid crisis; and other entities, who will focus on how the state can expand and sustain the vital services that have been made possible through both projects.

¹ <http://www.uclaisap.org/ca-policy/assets/documents/2017-2018%20UCLA%20DMC-ODS%20Evaluation%20Report%2011192018.pdf> and <http://www.uclaisap.org/ca-hubandspoke/docs/reports/CA%20HSS-Evaluation-Annual%20Report-October%202018.pdf>

Background

The opioid epidemic continues to be a national crisis. While general rates of opioid-related overdoses and deaths have been lower in California compared to the rest of the nation, some areas of the state, particularly the rural regions, are experiencing rates that are higher than the overall overdose and death rates of some of the hardest hit areas in the nation.

According to the DPH California Opioid Overdose Surveillance Dashboard, in 2017, there were 2,196 overdose deaths related to all opioids, with 429 overdose deaths related to fentanyl. That same year, there were 4,281 emergency department visits related to opioid overdoses (excluding heroin). The statewide overdose death rate in 2017 was 5.23 per 100,000 residents. However, rural counties experienced as high as almost five times the rate of the statewide average per 100,000 residents: Modoc (23.58); Humboldt (21.03); Mendocino (19.34); Lake (17.02); Shasta (14.06); Lassen (13.91); Yuba (13.15); Del Norte (12.65); Siskiyou (9.97); and, Ventura (9.80). Certain races/ethnicities were also disproportionately affected by opioid-related overdose death rates in 2017. For example, the Native-American population experienced a death rate of 17.59 per 100,000 residents, more than double the rate compared to white (8.90); black (5.77); Latino (3.14); and, Asian (0.97) populations. Additionally, while opioid deaths have historically been highest in the 45-60 year old age group, recent data reflect the second hardest hit group to experience overdose deaths in 2017 is the 25-29 year old age group, which is attributed to the increased presence of fentanyl in California.

In 2017, Californians received about 21.8 million opioid prescriptions. Opioids are a class of narcotic drugs that include medications such as hydrocodone, oxycodone, morphine, and codeine. Taken as prescribed, opioids can be used to manage pain safely and effectively. However, opioids may also produce other effects. According to the National Institute on Drug Abuse (NIDA), some individuals experience a euphoric response to opioid medications since these drugs affect the regions of the brain involving reward response. NIDA states that those who abuse opioids may seek to intensify their experience by taking the drug in ways other than those prescribed. For example, OxyContin is an oral medication used to treat moderate to severe pain through a slow, steady release of the opioid. However, people may crush or dissolve the drug in order to snort or inject it, thereby increasing the risk for serious medical complications. According to DPH, in the past, opioids were prescribed to relieve acute, short-term pain. Today, they are increasingly being used for long-term, chronic pain management which can contribute to addiction and, can lead to long term health consequences, including limitations in daily activity, impaired driving, mental health problems, trouble breathing, overdose, and death.

According to the federal Department of Health and Human Services, from January 2017 through August 2018, the amount of opioids prescribed in the nation dropped by 21%. During the same time, the number of prescriptions filled for naloxone hydrochloride (naloxone, a federally approved medication to reverse opiate overdose) increased by 264%, and the number of

prescriptions for buprenorphine (one form of medication federally approved for use in medication-assisted treatment [MAT] for opioid addiction) rose 16%.

DMC-ODS Waiver

According to DHCS, the DMC-ODS is a five-year pilot program approved by the Centers for Medicare and Medicaid Services (CMS) in 2015 under the Section 1115 Bridge to Reform Demonstration Waiver to test a new method for the organized delivery of health care services for Medi-Cal-eligible individuals with an SUD. Elements of the DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) criteria for SUD treatment services; increased control and accountability; greater administrative oversight; utilization controls to improve care and efficient use of resources; evidence-based practices in SUD treatment; and, increased coordination with other systems of care.

“Continuum of care” refers to a treatment system in which clients enter treatment at a level appropriate to their needs and then step up to more intense treatment, or down to less intense treatment, as needed. These levels should be thought of not as discrete levels of care but rather as points in a continuum of treatment services. ASAM criteria established five main levels in a continuum of care for SUD treatment:

- Level 0.5: Early intervention services;
- Level 1: Outpatient services;
- Level 2: Intensive outpatient/partial hospitalization services (Level 2 is subdivided into levels 2.1 and 2.5);
- Level 3: Residential/Inpatient services (Level 3 is subdivided into levels 3.1, 3.3, 3.5, and 3.7); and,
- Level 4: Medically managed intensive inpatient services.

In addition to the levels of care described by ASAM, outpatient treatment can be broken down into four sequential stages that clients work through, regardless of the level of care at which they enter treatment: 1) treatment engagement; 2) early recovery; 3) maintenance; and 4) community support.

After the initial approval of the five-year pilot program, which expires in 2020, counties could opt in to the DMC-ODS by submitting an implementation plan for approval by DHCS and CMS. After approval of a plan, a county contracts with DMC-certified providers or offers county-operated services to provide all services available through the DMC-ODS. Counties are also permitted to contract with managed care plans to offer services to beneficiaries. In addition to

standard DMC benefits², counties that opt into the program are required to provide, among other requirements: recovery services to support an individual's recovery efforts, including counseling, education and job skills, and linkages to housing, transportation, and case management services; comprehensive assessment and periodic reassessment, referral services, and patient advocacy, such as linkages to physical and mental health care; and, physician consultation services, which are provided to DMC-certified physicians who seek expert advice on designing treatment plans for complex cases involving DMC-ODS beneficiaries.

According to the California Health Care Foundation (CHCF), as of December 2018, 40 of California's 58 counties had submitted implementation plans to participate in the DMC-ODS. The following 22 counties are now providing services: Alameda, Contra Costa, Imperial, Los Angeles, Marin, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Ventura, and Yolo. CHCF states that currently participating counties represent 75% of the state's Medi-Cal population, and that once all 40 counties begin providing services, nearly 97% of Medi-Cal beneficiaries will have access to DMC-ODS services. Of the 22 counties currently providing services, none are among those identified as having overdose and death rates of up to five times above the statewide average. The 18 counties that have not yet opted into the DMC-ODS are: Amador, Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lake, Madera, Mariposa, Mono, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

CA H&SS

The federal government has responded to the opioid crisis by awarding billions of dollars since 2017 in the form of opioid-related grants to states to support a comprehensive response to the epidemic and to expand access to treatment and recovery support services.

California has received two grants that are administered by DHCS. The State Targeted Response (STR) to the Opioid Crisis grant was received in 2017 for a period between May 2017 and April 2019. The \$90 million STR grant supports DHCS's MAT Expansion Project 1.0, which includes the CA H&SS, the Tribal MAT project, and various prevention and treatment activities. The State Opioid Response (SOR) grant was received in 2018 for a period between September 2018 and September 2020. The \$140 million SOR grant supports DHCS's MAT Expansion Project 2.0,³ which includes increasing access to MAT, reducing unmet treatment need, and reducing opioid-related overdose deaths through prevention, treatment, and recovery services.

² DMC is a benefit available to all Medi-Cal-eligible individuals who have an SUD diagnosis. Available services include: narcotic treatment program services; outpatient drug-free treatment services; individual and group counseling; day care rehabilitative services, perinatal residential SUD services, and naltrexone treatment services. Per state regulations, room and board are prohibited from being reimbursable through DMC.

³ https://www.dhcs.ca.gov/services/Documents/MAT2.0_SAC.pdf

According to DHCS, the CA H&SS is a way to improve, expand, and increase access to MAT services throughout the state, particularly in rural regions that have historically lacked SUD services and that have experienced the highest opioid-related overdose rates. The CA H&SS helps to increase the total number of physicians, physician assistants, and nurse practitioners prescribing buprenorphine (those who have received a federal Drug Addiction Treatment Act of 2000 [DATA 2000] waiver⁴), which increases the availability of MAT services for those with SUDs.

All “hubs” are current DHCS-licensed Narcotic Treatment Programs (NTPs) or Medication Units (MUs), serving as the specialized addiction centers of expertise, and work closely with other clinical service providers that serve as the “spokes” to build a treatment network that meets community needs. Patients are able to move between hubs and spokes based on clinical severity. Hubs are generally responsible for outreach, treatment services, data collection and performance measures, reports, evaluation, training, invoices, and subcontracting. Spokes consist of either a federally waived prescriber who prescribes and/or administers buprenorphine, or one or more federally waived prescribers and a MAT team that consists of a licensed health practitioner and/or licensed behavioral health professional to perform duties that do not require a prescribing license. Spokes provide ongoing care for patients with milder SUDs, managing both induction and maintenance, and have access to a dedicated MAT team. Spokes can refer more complex patients to the hub in their region to stabilize patients. NTPs and MUs cannot operate as spokes.

The CA H&SS was modeled after a successful program in Vermont. According to DHCS, utilizing regionalized Learning Collaboratives, ongoing training, and mentorship opportunities will ensure that the CA H&SS addresses the opioid crisis through a collaborative effort of stakeholders to achieve the primary goals of preventing overdose and treating SUDs as a chronic disease while improving access to MAT services in both rural and urban regions by increasing the availability and utilization of buprenorphine statewide.

Prescription Opioid Misuse and Overdose Prevention Workgroup

DPH and several state partners convened the Prescription Opioid Misuse and Overdose Prevention (POMOP) Workgroup in the spring of 2014. This workgroup is currently exploring opportunities to improve collaboration and expand joint efforts among state entities and other partners working to address the opioid epidemic. Initial workgroup discussions have focused on information sharing about existing efforts and roles, identification of challenges, and potential opportunities for partnership. Participants in the workgroup include: DPH, DHCS, California Health and Human Services Agency, Department of Education, California Conference of Local Health Officers, CHCF, County Health Executives Association of California, Emergency

⁴ <https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver>

Medical Services Authority, Department of Motor Vehicles, Department of Corrections and Rehabilitation, Covered California, Department of Justice, Department of Managed Health Care, Division of Workers Compensation, CalPERS, the Office of Statewide Health Planning and Development, UC Davis Medical Center, United States Health and Human Services Agency, Drug Enforcement Administration, California Board of Nursing, California Board of Pharmacy (BOP), Dental Board of California, and Medical Board of California (MBC). In September 2015, DPH announced that the federal Centers for Disease Control and Prevention (CDC) awarded more than \$3.7 million over four years to enhance the state's multi-agency effort to prevent deaths and injuries caused by opioid misuse. Specifically, the grant to DPH was intended to improve safe prescribing of opioid painkillers. California was one of only 16 states to receive the prevention-strategy funding from the CDC.

In March 2017, DPH sent a letter to health care providers offering resources in addressing issues with prescribing opioids to patients, including strategies for assisting high-risk patients, local addiction recovery resources, and opioid prescribing guidelines. DPH recommended that providers work with patients who may already be showing signs of addiction. Some recommendations included weaning patients off higher opioid doses and maintaining communication with them. DPH also recommended referring patients to treatment programs and considering treatment options other than opioids for pain. These recommendations are similar to guidelines recommended by the CDC and the MBC, which released revised prescribing guidelines in November 2014.⁵ Although primarily intended to address the use of opioids in the long-term treatment of chronic pain, the guidelines briefly discussed opioid use for acute pain, stating that opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies likely will not provide adequate pain relief. When opioid medications are prescribed for treatment of acute pain, the number dispensed should be for a short duration and no more than the number of doses needed based on the usual duration of pain severe enough to require opioids for that condition. Long and intermediate duration-of-action opioids or extended-release/long-acting opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted. The MBC guidelines also referenced the American College of Emergency Physicians recommendations that emergency department patients with acute back pain or chronic non-cancer pain only be given opioids when indicated and in the lowest practical dose for a limited duration (generally less than a week), and that the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

⁵ http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

In the 2016 guidelines for prescribing opioids for chronic pain,⁶ the CDC reported that an estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) received an opioid prescription. In 2012, health care providers nationally wrote 259 million prescriptions for opioid pain medication, enough for every adult in the U.S. to have an opioid prescription. The CDC states that rates of opioid prescribing vary greatly across states in ways that cannot be explained by the underlying health status of the population, highlighting the lack of consensus among clinicians on how to use opioid pain medication. These guidelines highlight scientific research that has identified high-risk prescribing practices that have contributed to the overdose epidemic, such as high-dose prescribing, overlapping opioid and benzodiazepines, and extended-release/long-acting opioids for acute pain. Similar to DPH's letter to providers/prescribers, the CDC guidelines recommend when opioids are used for acute pain clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. The guidelines suggest that three days or less is often sufficient, and that more than seven days will rarely be needed. The CDC guidelines also suggest that clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose are present, such as history of overdose, history of an SUD, higher opioid doses, and concurrent benzodiazepine use. For pregnant women, the guidelines suggest that clinicians and patients together carefully weigh risks and benefits when initiating opioid therapy for chronic pain during pregnancy. Both CDC and MBC guidelines are nonspecific as to prescribing recommendations for youth, and, in fact, the CDC states the recommendations in their guidelines are intended for patients 18 years of age and older.

Legislative Action

Over the past several years, the Legislature has introduced a myriad of bills to help address the opioid crisis in California. These bills range from licensing and treatment requirements to prescription drug misuse and overdose prevention and safe storage issues. A sampling of the bills enacted follows:

- AB 395 (Bocanegra, Chapter 223, Statutes of 2017), modified among other things, the specific controlled substances authorized for use in narcotic replacement therapy to include MAT.
- AB 1751 (Low, Chapter 478, Statutes of 2018), provided a framework for the Controlled Substance Utilization Review and Evaluation Systems' Prescription Drug Monitoring Program to connect with other states that comply with California's patient privacy and data security standards.

⁶ <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>

- AB 2086 (Gallagher, Chapter 274, Statutes of 2018), allowed prescribers of controlled substances to review a list of patients for whom they are listed as being the prescriber.
- AB 2256 (Santiago, Chapter 259, Statutes of 2018), authorized a pharmacy or wholesaler to furnish naloxone or other opioid antagonists to law enforcement agencies, under specified conditions.
- AB 2487 (McCarty, Chapter 301, Statutes of 2018), added opioid addiction training as a continuing medical education requirement for certain physicians in order to increase the availability of buprenorphine treatment.
- AB 2760 (Wood, Chapter 324, Statutes of 2018), required a prescriber of opioids to offer a co-prescription of naloxone to a patient identified as being at risk for opioid-related overdose based on the presence of specified conditions.
- AB 2789 (Wood, Chapter 438, Statutes of 2018), required that by 2022 all prescriptions be submitted electronically, with limited exceptions.
- AB 2859 (Caballero, Chapter 240, Statutes of 2018), increased safe storage practice requirements to prevent access to prescription drugs in the home by children and adolescents.
- AB 1748 (Mayes, Chapter 557, Statutes of 2016), authorized school nurses and other trained personnel to use naloxone or another opioid antagonist to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an opioid-related overdose. AB 1748 also authorized pharmacies to furnish naloxone, without a prescription, to a school district, county office of education, or charter school.
- AB 1535 (Bloom, Chapter 326, Statutes of 2014), authorized pharmacists to furnish naloxone without a prescription, pursuant to standardized procedures developed by the BOP and MBC.
- SB 823 (Hill, Chapter 781, Statutes of 2018), required DHCS to adopt the ASAM treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for DHCS-licensed adult alcoholism or drug abuse recovery or treatment facilities (RTFs).
- SB 992 (Hernandez, Chapter 784, Statutes of 2018) made various changes to current law for RTFs to improve client treatment and provide DHCS more oversight authority over RTFs.
- SB 1045 (Weiner and Stern, Chapter 845, Statutes of 2018), created in Los Angeles, San Diego, and San Francisco Counties, until January 1, 2024, a new conservatorship process for

individuals who are incapable of caring for their own health and well-being due to a serious mental illness and SUD.

Naloxone Distribution Project

In 2016, DPH received one-time funding of \$3 million through the State Budget Act to initiate a Naloxone Distribution Project (NDP). Through the NDP, various entities, including harm reduction organizations, emergency medical services, syringe exchange programs, and other community-based organizations received naloxone for distribution to those with an SUD or those in a position to assist an individual experiencing opioid-related overdose.

After the initial state funding to DPH was expended, DHCS began to administer the NDP through its federal grants. The NDP aims to address the opioid crisis by reducing opioid overdose deaths by providing free naloxone. Since October 2018, qualified organizations and entities, as well as individuals with a valid prescription, have been able to request free naloxone from DHCS through a standing order issued by DPH's State Public Health Officer. Some of the eligible organizations and entities include: first responders, emergency medical services, fire authorities, law enforcement, courts and criminal justice partners, veterans organizations, homeless programs, schools and universities, libraries, religious entities, and community organizations. DHCS allocated \$20 million from its SOR federal grant to support the NDP, and since October 2018 has distributed 100,000 units of naloxone, with a majority of the units being distributed to the regions with the highest opioid-related overdose deaths.⁷

Conclusion

This joint informational hearing presents an opportunity for the Legislature, stakeholders, and the public to hear about the progress made in addressing the opioid crisis through projects that, according to recent evaluations, have provided critical and life-saving services for those with SUDs throughout the state. There have been challenges in the implementation of these projects early on, as may be expected with pilot projects. However, it appears that some significant progress has been made in addressing the opioid-related overdose and death rates, and there have been many who have worked hard to design innovative service delivery projects to provide services for historically hard-to-treat patients. Through existing projects and the renewal of the DMC-ODS waiver, California has an opportunity to improve SUD services in the future. This hearing will explore what opportunities and challenges need to be addressed in order for California to increase access and expand services to individuals with SUDs.

⁷ https://www.dhcs.ca.gov/services/Documents/MAT2.0_SAC.pdf