GOVERNORS' RECOMMENDATIONS FOR FEDERAL ACTION TO END THE NATION'S OPIOID CRISIS

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Opioids continue to fuel the worst drug overdose epidemic in our nation's history, claiming the lives of 115 individuals every day and devastating families and communities across the country.[1] Governors have been leading the fight against this deadly epidemic, working across all levels of government as well as with families, health care providers and others in the private sector to save lives, create a pathway to recovery for individuals struggling with addiction and prevent more people from becoming addicted. While progress has been made, the consequences of opioid addiction continue reverberating throughout society, devastating families and overwhelming health care providers, law enforcement and social services, with further downstream impacts on employers and the strength of the nation's workforce.

The federal government is a critical partner in governors' efforts to end the opioid crisis, providing essential resources and flexibility for states to mount a strong public safety response, prevent new cases of addiction and expand access to treatment and recovery services. Governors commend Congress and federal agencies for taking action over the last couple years to provide new funding and address barriers identified by states,[2] such as the lack of evidence-based guidance for opioid prescribing and federal limits on buprenorphine prescribing. More recently, the Administration declared the opioid crisis a nationwide public health emergency and committed to supporting states seeking to provide the full continuum of substance use disorder (SUD) treatment services through Medicaid – an important example of how federal partners can work with states to address specific requests for regulatory relief and flexibility. Governors also applaud the work of the President's Commission on Addiction and Opioids (Commission) for providing a new framework for federal action based on extensive consultation with states and other key stakeholders.[3]

Building on that important work, the nation's governors have come together through the National Governors Association (NGA) to identify additional recommendations for federal action. These recommendations reflect many of the Commission's priorities, including the critical need for state flexibility and significant federal resources to help states and local communities turn the tide on the opioid epidemic. Governors are eager to continue working with Congress and the Administration to strengthen the nation's response and help individuals and communities heal from this crisis.

[1] Centers for Disease Control and Prevention, 2017: https://www.cdc.gov/nchs/products/databriefs/db294.htm
[2] National Governors Association, "Governors' Priorities for Addressing the Opioid Crisis," February 2016: https://www.nga.org/files/live/sites/NGA/files/pdf/2016/1602PrioritiesOpioidCrisis.pdf
[3] President's Commission on Combatting Addiction and the Opioid Crisis, Final Report, November 2017: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-3-2017.pdf

FEDERAL SUPPORT AND COORDINATION

Increase federal support for state efforts to address the opioid crisis, with flexibility for states to meet the needs of their communities. Governors urge Congress and the Administration to increase federal funding to states for opioid/SUD-related activities and streamline the grant process by coordinating application and administrative processes. Increased coordination among federal agencies would reduce the administrative burden for states and federal agencies, freeing up valuable time and resources. As part of this new approach, the duration of federal grants should be extended beyond the typical one- or two-year funding cycle to help states plan and use federal dollars more effectively to address the epidemic. Additionally, federal funding should provide flexibility for states to meet community needs and emerging challenges, such as deadly new fentanyl analogues and the increased risk of infectious diseases, such as HIV and Hepatitis C. Below are additional state priorities for flexible federal funding.

- Evidence-based prevention curricula and programming for youth, particularly in underserved areas.
- Culturally-specific prevention, treatment and recovery services for American Indian/Native American populations and others that have been disproportionately impacted by the addiction epidemic.
- Maintenance and ongoing operation of state prescription drug monitoring programs (PDMPs).
- Analysts and other personnel for fusion centers and other state law enforcement entities responding to the threat of illicit opioids.
- Wider availability of naloxone at the state and local level, particularly for first responders, bystanders, third-parties and pharmacies.
- Data and information sharing initiatives between public health and law enforcement.
- State and local narcotics interdiction efforts and other officer safety programs.
- Capacity building for state medical examiners.
- National Guard Counterdrug activities to assist state public safety and public health surge capacity.
- State correctional health services and post-incarceration reentry services to connect individuals with treatment providers.
- Community-based initiatives that have shown positive outcomes by bringing together law enforcement, intervention and treatment services, prevention programs and recovery providers.

- *NOTE: Many states highlighted issues with sustainability, coordination, and flexibility of funds. This recommendation draws on the President's Commission recommendation to block grant funding at the federal level, to improve coordination and reduce burden on states. This is also augmented by the need for funding flexibility, with several examples suggested by Hawaii, Minnesota, Washington, and Vermont.*

Improve coordination within and across federal agencies involved in responding to the opioid crisis. Federal agencies are essential partners for governors working on the front lines of the opioid epidemic. Increased coordination and communication within and between federal agencies involved in those efforts would help improve coordination on the ground, avoid duplicative efforts and streamline grant requirements, freeing up valuable time and resources at the state level needed to mount an effective response to the opioid epidemic. This could be facilitated by an inter-agency task force or an existing entity empowered to bring executive agency leadership together regularly to enhance federal agency coordination and planning.

- *NOTE: Many states have highlighted this issue, particularly as more federal agencies have become engaged in providing funding and technical assistance to states. The coordinating entity could be situated in the White House or an agency – so long as it is truly empowered to serve its role.*

DATA AND INFORMATION SHARING

Align 42 CFR Part 2 with the Health Insurance Portability and Accountability Act (HIPAA). Protecting patient records is critical, particularly for those who have or are undergoing treatment for substance use disorder given the negative consequences of stigma often attributed to those individuals. However, federal privacy rules impede care coordination and threaten patient safety by prohibiting substance use disorder treatment providers from fully participating in electronic health information exchange, leaving treating providers without the full picture of a patient's history. Current restrictions on the ability of opioid treatment programs to report medications dispensed to their state PDMP limit providers' ability to prevent overdose and diversion, as well as potentially deadly medication interactions. Congress should pass legislation aligning 42 CFR with HIPAA, to bring substance use disorder information into alignment with the privacy protections governing other types of health data.

- *NOTE: A similar recommendation was included in NGA's 2016 priorities and the Commission's report. Aligning 42 CFR Part 2 with HIPAA is also the goal of H.R.3545, the Overdose Prevention and Patient Safety Act. Proposed changes to 42 CFR Part 2 have historically garnered strong resistance from some advocates.*

Require interoperability between electronic health records (EHRs) and state PDMPs. PDMPs are an important care management tool which allow clinicians to screen for opioid misuse, identify "doctor shoppers" and prevent medication interactions. The U.S. Department of Health and Human Services Office of the National Coordinator (ONC) has led several initiatives to improve the interoperability of EHRs and PDMPs, however, additional action is needed to make PDMPs more easily accessible to clinicians. Through the certification process, ONC should require that EHR vendors make their systems interoperable with all state PDMPs. ONC should also maintain Meaningful Use incentives for providers connecting to their state's PDMP.

- *NOTE: PDMP-EHR integration is a challenge frequently raised by states. State officials have highlighted the need for ONC to act to maintain meaningful use incentives for providers using the PDMP.*

Strengthen data monitoring initiatives and information sharing environments at the state level between public health and public safety. States routinely face regulatory and legal barriers to expanding state drug data systems and providing real-time information sharing across all sectors. The administration should issue guidance to facilitate more open data sharing environments that enable real-time surveillance, ensure that state PDMPs incorporate naloxone deployment data from all sources (e.g. Department of Transportation's (DOT) Emergency Medical Technician (EMT) overdose database) and reduce existing barriers to appropriate data sharing arrangements between public health and law enforcement. Further, Congress should provide the Department of Justice with increased federal funding to provide trainings and technical assistance that support state law enforcement and public health data and information sharing initiatives. For example, increased federal efforts can help establish new and/or enhance existing state-level drug monitoring initiatives and overdose fatality review teams between law enforcement and public health.

PREVENTION AND EARLY INTERVENTION

Develop an evidence-based national education and awareness campaign to promote prevention and reduce stigma associated with SUD. Governors applaud the President's announcement of a national advertising campaign to prevent youth and others from abusing opioids and illicit substances. Awareness-raising campaigns such as those utilized to reduce youth tobacco use need to be replicated with respect to opioids. Critically, this campaign should also address the misperception and stigma surrounding addiction that can prevent many individuals from seeking help. It is important that

the public recognize addiction as a treatable chronic condition, requiring the sustained, multifaceted approach typical in managing any chronic disease.

Require prescribers to register with their state prescription drug monitoring program (PDMP) and complete evidence-based training on pain management and substance use disorder upon receiving or renewing their Drug Enforcement Administration (DEA) registration. Attaching new requirements to DEA registration would help ensure health care providers have the tools and education needed to safely treat individuals with pain. State experience shows that requiring PDMP registration encourages prescribers to use the PDMP to prevent and identify opioid misuse and diversion. Though federal law requires health care providers to complete training and apply for a waiver to prescribe buprenorphine for opioid use disorder, federal rules do not include a similar education requirement for providers registering with the DEA to prescribe the opioid pain relievers that have fueled this deadly opioid epidemic. It is critical that any new federal education requirement feature evidence-based guidance regarding pain management and substance use disorder, including the Centers for Disease Control and Prevention's opioid prescribing guideline.

- *NOTE: This recommendation was carried over from NGA's 2016 priorities. The Commission's report similarly calls for training as a condition of DEA licensure.*

Continue building the evidence base for non-pharmacological treatments for pain and provide guidance to state Medicaid programs regarding best practices for covering these services. Nonpharmacologic interventions for pain treatment, such as acupuncture, cognitive behavioral therapy, mindfulness meditation and physical therapy are important tools in the management of chronic pain. While there is growing evidence to support the efficacy of these and other nonpharmacologic interventions, additional research is needed to better understand their role in managing pain, identify clinical best practices and develop new, non-addictive treatment options. Governors encourage the Department of Health and Human Services (HHS) to enhance its role in those efforts by investing in additional research and evaluation of non-pharmacological therapies for pain, as well as guidance to assist states in making appropriate coverage decisions in Medicaid and other state-administered health programs.

- *Note: The lack of effective alternative pain treatments has been highlighted by many states and health care providers. The Commission's report recommends additional resources for efforts underway to new, non-opioid pain relievers (as well as to develop additional MAT options).*

TREATMENT AND RECOVERY

Allow state Medicaid programs to offer the full continuum of evidence-based care, including residential treatment. As the largest source of coverage for behavioral health services, including treatment for opioid use disorder, Medicaid plays a critical role in helping states address the opioid crisis. The Institutions for Mental Diseases (IMD) exclusion generally prohibits state Medicaid programs from receiving federal reimbursement for adults between 21 and 65 receiving mental health or substance use disorder treatment in a residential treatment facility with more than 16 beds. This arcane federal policy, while well intentioned, limits states' ability to provide the full continuum of clinically appropriate care for Medicaid enrollees with SUD. Governors encourage the Administration to continue working with states to expedite approval of IMD waivers while also recognizing the need for a permanent, statutory solution to resolve this issue for all states. To that end, governors urge Congress to enact legislation that would create an exception to the IMD exclusion for individuals receiving SUD treatment.

- *NOTE: This recommendation was carried over from the NGA's 2016 priorities. The White House Commission's report recommends expedited approval for state waivers to address IMD, rather than eliminating it altogether. A bill to eliminate the IMD exclusion, the Road to Recovery Act (H.R.2938), has*

been endorsed by the Bipartisan Heroin Task Force, a group led by Representatives Tom MacArthur (R-NJ), Annie Kuster (D-NH), Brian Fitzpatrick (R-PA), and Donald Norcross (D-NJ).

Fully Enforce the Mental Health Parity and Addiction Equity Act (MHPAEA). MHPAEA built on the Mental Health Parity Act by requiring health insurers and group health plans to provide the same level of benefits for substance use and mental health as they do for medical/surgical care. While parity is a requirement under federal law, enforcement remains a challenge for state and federal regulators. Governors urge the federal government, through HHS, to strengthen federal oversight and ensure parity violations do not limit access to substance use disorder treatment.

- *NOTE: A similar recommendation was included in the Commission's report.*

Provide state Medicaid programs flexibility to cover SUD and mental health services for individuals in custody prior to conviction and up to 30 days prior to release from prison or jail. Expanding access to evidence-based SUD and mental health services for justice-involved populations is a critical strategy for reducing opioid and other drug overdose deaths. SUD and mental illness are often co-occurring and significantly more prevalent among people in correctional settings. Moreover, individuals leaving incarceration and re-entering the community are at a dramatically higher risk of dying from a drug-related overdose. Medicaid coverage of SUD and mental health services for Medicaid-eligible individuals who are incarcerated pending disposition or nearing release would greatly enhance continuity of care and reduce a host of adverse outcomes, such as recidivism, emergency department visits and drug overdose. Governors urge CMS to use its authority under Section 1115 of the Social Security Act to grant states partial waivers of the inmate exclusion that would otherwise bar states from receiving federal Medicaid funding in these circumstances.

- *NOTE: Several states suggested Medicaid could play a role in covering targeted services for individuals while they are incarcerated.*

Ensure Medicare covers methadone for opioid use disorder in outpatient settings. The opioid crisis affects individuals of all age groups, including older adults. In 2016, one in three Medicare Part D enrollees received an opioid prescription and nearly 90,000 were found to be "serious risk" of opioid misuse or overdose, according to the HHS Office of Inspector General.[4] CDC found a 33 percent increase in older adult deaths from heroin between 2014 and 2015.[5] While Medicare covers methadone for opioid use disorder in inpatient settings, Medicare does not cover methadone provided in the community at opioid treatment programs – creating a significant barrier to treatment for many older adults. HHS should revise Medicare coverage requirements, to ensure that all Medicare individuals have access to methadone treatment for opioid use disorder if needed.

- *NOTE: A similar recommendation was included in the Commission's report.*

Recognize substance use disorder treatment facilities as approved sites for the National Health Service Corps program. The Health Resources and Services Administration (HRSA) administers the National Health Service Corps (NHSC) program, which awards scholarships and loan repayment to primary care providers in eligible disciplines. The NHSC supports over 10,400 medical, dental and behavioral health professionals who provide care to individuals at approved sites in urban, rural and frontier areas. Primary care and mental health clinics are approved sites for this program, while facilities providing substance use disorder treatment services are not. With the increasing demand

[4] HHS Office of Inspector General, "Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing," July 2017: https://oig.hhs.gov/oei/reports/oei-02-17-00250.pdf

[5] Centers for Disease Control and Prevention, "Increases in Drug and Opioid-Involved Overdose Deaths — United States, 2010–2015," December 2016: https://www.cdc.gov/mmwr/volumes/65/wr/mm655051e1.htm

for substance use disorder treatment, more professionals are needed to provide MAT and other behavioral health interventions. HRSA should expand the definition of approved sites to include substance use disorder treatment facilities, to increase access to care for individuals with addiction while also serving as a recruitment and retention opportunity for the field.

- *NOTE: A similar recommendation was included in the Commission's report.*

Promote universal substance use disorder screening for pregnant women and comprehensive standards for treating neonatal abstinence syndrome. HHS should issue guidance encouraging universal screening of pregnant women as part of comprehensive obstetric care, as recommended by the American College of Obstetricians and Gynecologists and American Society of Addiction Medicine.[6]

Provide guidance to hospitals on treating individuals experiencing an overdose. Admission to the hospital after an overdose creates an important opportunity to connect individuals with treatment and recovery services. Many states and communities have developed programs to dispatch peer recovery coaches to emergency departments (EDs) following an overdose, where they begin linking individuals with medication-assisted treatment (MAT) and other needed services in their community. Some hospitals are even ensuring the connection to treatment by initiating MAT in the ED. HHS could expand this and other hospital interventions by providing guidance on best practices for care following an overdose.

- *NOTE: This recommendation has been highlighted by states and other national experts.*

Permit medical residents to prescribe buprenorphine under an institutional DEA registration number. Currently, medical residents and other physicians must apply for a federal waiver in order to prescribe buprenorphine. DEA should remove this requirement for medical residents, who practice under physician supervision. Doing so would expand access to buprenorphine and help more residents learn how to manage individuals with opioid addiction.

- *NOTE: Recommendation was included in NGA's 2016 priorities.*

Permit Advanced Practice Registered Nurses (APRNs) to prescribe buprenorphine. CARA expanded buprenorphine prescribing privileges to nurse practitioners and physician assistants for five years, until October 1, 2021, addressing a key barrier to evidence-based MAT. To further expand the treatment workforce and better respond the growing need for services, governors encourage Congress to extend those privileges to all APRN roles – certified nurse practitioner, clinical nurse specialist, registered nurse anesthetist and nurse midwife – without the October 1, 2021 deadline for obtaining the required federal waiver.

Use authority under the public health emergency declaration to swiftly remove barriers to prescribing buprenorphine via telehealth. The Ryan Haight Online Pharmacy Consumer Protection Act prohibits providers from prescribing buprenorphine to individuals via telehealth, creating a barrier to care for individuals in rural areas who may not otherwise have access to an MAT provider. Governors urge the Administration to act quickly in addressing this challenge under the nationwide public health emergency declaration, which allows the HHS secretary, in coordination with the Drug Enforcement Administration (DEA), to carve out exceptions under the law. Governors encourage these agencies to work expeditiously to issue guidance on the policy and encourage providers to use telehealth to reach individuals in rural and other underserved areas. Given the time-limited nature of the public health

[6] The American College of Obstetricians and Gynecologists, "Committee Opinion: Opioid Use and Opioid Use Disorder in Pregnancy," August 2017: https://www.acog.org/-/media/Committee-Opinions/Committee-on-Obstetric-Practice/co711.pdf?dmc=1&ts=20171108T1550067088

emergency, Congress and the Administration should also pursue a permanent fix to ensure these individuals can continue receiving needed MAT services after the declaration expires.

ENHANCING SUPPORT FOR PUBLIC SAFETY

Prioritize federal support for state efforts that address justice-involved populations at risk from the opioid epidemic. The federal government has recently been doing a lot to support state efforts to provide criminal justice medication assisted treatment, treatment alternatives to incarceration, diversion programs, training for first responders on the use of drugs and devices to reverse the effects of opioids and, particularly for rural areas, support for heroin and fentanyl drug task forces. For example, Comprehensive Opioid Abuse Program (COAP) and Edward Byrne Memorial Justice Assistance (JAG) funding streams through the Department of Justice (DOJ) offer critical resources for state and local law public safety entities to address the epidemic, provide the full range of alternatives to criminal justice interventions, and strengthen new and ongoing partnerships with public health and other entities to tackle core issues that increase the addiction risk for vulnerable populations.

However, as noted in the "Federal Support and Coordination" section, additional assistance is needed. Increased JAG funding for state and local narcotic interdiction efforts and officer safety programs is needed. Further, Congress should both increase funding and emphasize the role of preparing for and connecting individuals to community-based treatment for programs that support state reentry efforts, such as DOJ's Second Chance Act and Residential Substance Abuse Treatment (RSAT) programs. In particular, federal efforts through the National Institute of Corrections (NIC), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of Justice Programs (OJP) to bolster the capacity of state correctional health services and post-incarceration transition services to develop and provide MAT for justice-involved populations (e.g. correctional settings, outpatient treatment programs, drug courts) require increased congressional funding..

Expand assistance to and enhance the capacity of our Nation's laboratories. More assistance is needed to sustain the mission of supporting state and local forensic communities, such as accelerating state crime laboratory testing to identify and share real-time drug data. Forensic medical practitioners, medicolegal investigators, and experts of the medicolegal investigations community play a vital role in helping governors and states navigate the contours of the epidemic. Additional federal coordination and funding for state medical examiner offices would strengthen the nation's understanding of the epidemic and allow for a more targeted public safety and public health response by states.

Increase federal efforts to detect and prevent dangerous synthetic drugs like fentanyl and carfentanil from being shipped and disseminated throughout the United States. Bad actors in countries overseas violate U.S. customs laws and regulations by shipping drugs directly through the U.S. postal system, which does not require advance electronic customs data for the vast majority of mail entering the United States. Federal efforts to strengthen electronic customs regulations would assist state efforts to combat synthetic drugs and traffickers. Federal agencies can also develop better chemical screening devices to detect fentanyl and other synthetic opioids, which is critical for enhancing detection efforts by state and local law enforcement agencies.

Leverage the long-standing and institutional relationships between the White House Office of National Drug Control Policy (ONDCP) and state and local law enforcement. ONDCP plays an invaluable role at the national level in setting drug strategy, reducing drug use and its consequences, and encouraging strong collaboration between public health and public safety. For example, ONDCP's long-standing efforts to support High Intensity Drug Trafficking Areas and Drug Free Communities have provided states with critical resources throughout the opioid epidemic. ONDCP should also continue to convene and engage additional federal and non-federal agencies (e.g. CDC,

SAMHSA, state public health entities, etc.), with the goal of better understanding the priorities of both public health and public safety entities at all levels of government.

Strengthen support for regional High Intensity Drug Trafficking Areas (HIDTAs) and state law enforcement efforts to address the supply of illicit opioids. Since 1988, HIDTAs have provided essential support for states to forge stronger linkages between public health and safety professionals. With continued and/or additional federal support, innovative partnerships at the state and local level could be scaled up and replicated nationwide. Governors strongly urge the White House Office of National Drug Control Policy to continue to support the development of these public health and safety networks among regional HIDTAs. As fentanyl spreads, more HIDTAs across the country can play a critical role in fortifying personnel, intelligence, and data efforts by state law enforcement. State fusion centers and other state law enforcement entities require additional personnel and analysts from federal grant dollars. As cartels and drug distributors continue to change the supply of illicit opioids, states must continue to have representation on intergovernmental task forces and require grant funding to be flexible to meet the dynamic challenges in their own operating environment, such as direct investments in state and local narcotic interdiction initiatives and resources for officer safety. Further, the role of HIDTA should be expanded to allow for it to provide more robust assistance to state and local law enforcement led prevention efforts.

Ensure that state law enforcement priorities are incorporated into larger federal supply reduction efforts. For example, DOJ's Task Force on Crime Reduction and Public Safety proposes to examine violent crime, which often derives from transnational criminal organizations involved in illicit opioid distribution. Future DEA and Organized Crime Drug Enforcement Task Forces (OCDETF) Program) supply reduction priorities and strategies should incorporate concerns and key issues from state law enforcement, particularly those engaged on illicit opioid distribution. Such federal and state priorities should target transnational criminal organizations and violent gangs. Federal support for supply reduction efforts should prioritize both emerging and existing markets. Additionally, reinforce DEA's ability to regulate opioid distributors it suspects of misconduct.

Support research, development, and court admissibility of a simple, accurate and cost-effective roadside testing method for drugged driving. States have struggled to develop and implement an effective roadside test for the presence of controlled substances. The rise in the number of people with substance use disorders, together with the decriminalization, medical use, and legalization of marijuana has caused a corresponding increase in the number of drivers under the influence of controlled substances and motor vehicle fatalities. Without an effective way to test for the presence of these drugs, the risk to the motoring public is substantial and growing.

Increase support for National Guard Counterdrug Program. Governors and states partner with the Counterdrug Program to leverage their skills and resources (e.g. operational case support, intelligence support, technical support, reconnaissance missions, and specialized equipment) to assist wider state and local efforts to address illicit drugs and transnational threats. The National Guard can strengthen state efforts to reduce exposure to trauma, implement comprehensive prevention strategies, and provide screening support and services for service personnel and families with substance use disorders. Increased support for the program will allow greater program capacity, provide states with funds to partner with local agencies and community groups and augment state use of this program to cut illicit drug supply.

Embrace law enforcement's greater role in education efforts and prevention strategies. As the opioid epidemic has worsened, law enforcement officials are increasingly engaged in comprehensive educational and prevention activities in schools and communities. Such efforts must continue to be coordinated with existing prevention programs in schools and avoid increasing stigma and fear around punitive approaches for those who need access to treatment. Federal support for state law enforcement to engage in educational activities, such as DEA's 360 Strategy, should be expanded. Increasing police

prevention and intervention efforts in schools requires new and additional resources to support training for officers in school and community engagement and other educational activities.