Department of Legislative Services

Maryland General Assembly
2018 Session

FISCAL AND POLICY NOTE
Enrolled - Revised

Senate Bill 522 (Senator Klausmeier, *et al.*)

Education, Health, and Environmental Affairs Health and Government Operations

Health Care Providers - Opioid and Benzodiazepine Prescriptions - Discussion of Benefits and Risks

This bill requires a health care provider, when prescribing an opioid, to advise the patient of the benefits and risks associated with the opioid. Additionally, when co-prescribing a benzodiazepine with an opioid, a health care provider must advise the patient of the benefits and risks associated with the benzodiazepine and the co-prescription of the benzodiazepine. A violation of the bill's provisions is grounds for disciplinary action by the appropriate health occupations board.

Fiscal Summary

State Effect: The bill is not expected to materially affect State finances or operations, as discussed below.

Local Effect: None.

Small Business Effect: Minimal.

Analysis

Current Law: Chapter 570 of 2017 requires a health care provider, on treatment for pain and based on the clinical judgment of the provider, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance (CDS). An exception is provided if the opioid is prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. The dosage, quantity, and

duration of a prescribed opioid must be based on an evidence-based clinical guideline for prescribing a CDS that is appropriate for the health care delivery setting for the patient, the type of health care services required by the patient, and the age and health status of the patient. A violation of these requirements is grounds for disciplinary action by the appropriate health occupations board.

Chapter 570 also expressed the intent of the General Assembly that the State Board of Dental Examiners, the State Board of Nursing (BON), the State Board of Physicians, and the State Board of Podiatric Medical Examiners work to educate practitioners to ensure that Maryland residents are aware of the risks associated with opioid drugs, including the risks of dependence, addiction, and overdose, and the dangers of taking an opioid drug with alcohol, benzodiazepines, and other depressants.

Background: Between January 1 and August 31, 2017, 2.5 million prescriptions for opioids were dispensed in Maryland.

Prescription Drug Monitoring Program (PDMP): Chapter 166 of 2011 established PDMP to assist with the identification and prevention of prescription drug abuse and the identification and investigation of unlawful prescription drug diversion. PDMP must monitor the prescribing and dispensing of Schedule II through V CDS. Since July 1, 2017, all CDS dispensers have been required to register with PDMP. Beginning July 1, 2018, a prescriber must (1) request at least the prior four months of prescription monitoring data for a patient before initiating a course of treatment that includes prescribing or dispensing an opioid or a benzodiazepine; (2) request prescription monitoring data for the patient at least every 90 days until the course of treatment has ended; and (3) assess prescription monitoring data before deciding whether to prescribe or dispense – or continue prescribing or dispensing – an opioid or a benzodiazepine. A prescriber is not required to request prescription monitoring data if the opioid or benzodiazepine is prescribed or dispensed to specified individuals and in other specified circumstances.

Federal Guidelines on Prescribing Opioids: In 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued guidelines for prescribing opioids for chronic pain. According to CDC**,** long-term opioid use often begins with treatment of acute pain. When 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. Three days or less will often be sufficient; more than seven days will rarely be needed. Because physical dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days, limiting days of opioids prescribed should also minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms and reduces the likelihood of physical dependence. Furthermore, prescriptions with fewer days' supply minimize the number of pills available for unintentional or intentional diversion.

For information on the State's opioid crisis, please refer to the **Appendix – Opioid Crisis**.

State Fiscal Effect: General and/or special fund revenues may increase minimally from the imposition of disciplinary fines for violations of the bill's requirements for the State Board of Physicians, the State Board of Dental Examiners, BON, and the State Board of Podiatric Medical Examiners.

BON notes that nursing professional associations and continuing education unit (CEU) providers have been offering courses in safe prescribing practices for several years, and that renewal of national certifications for advanced practice registered nurses requires extensive CEUs in this area.

Additional Information

Prior Introductions: None.

Cross File: HB 653 (Delegate K. Young, *et al.*) - Health and Government Operations.

Information Source(s): Maryland Department of Health; U.S. Centers for Disease Control and Prevention; Department of Legislative Services

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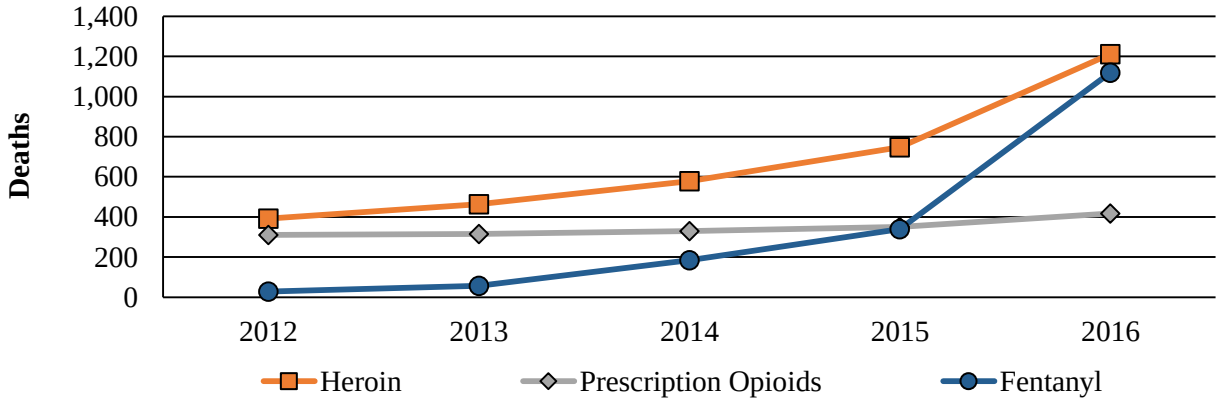
Appendix – Opioid Crisis

Opioid Overdose Deaths

The rate of opioid-related deaths continues to rise at an alarming rate. As seen in **Exhibit 1**, between 2015 and 2016, prescription opioid-related deaths in Maryland increased by 19% (from 351 to 418), heroin-related deaths increased by 62% (from 748 to 1,212), and fentanyl-related deaths increased by 229% (from 340 to 1,119). Between January and June 2017, there were 799 deaths related to fentanyl, a 70% increase over the same time period for 2016, and 46 deaths related to carfentanil, a drug used as an elephant tranquilizer, a substance which first appeared as a cause of death in April 2017.

Exhibit 1
Total Number of Drug-related Intoxication Deaths
By Selected Substances in Maryland
2012-2016



Source: Maryland Department of Health

Federal Actions to Address the Opioid Crisis

In 2016, the Comprehensive Addiction and Recovery Act authorized over $181 million annually, and the 21st Century Cures Act (CURES Act) authorized up to $970 million to be distributed through the State Targeted Response to the Opioid Crisis Grants. The grants are to be used by states to increase access to treatment and reduce unmet treatment needs and opioid-related overdose deaths. In 2017, Maryland received a two-year, $20 million grant for the prevention and treatment of opioid abuse. In March 2017, President Donald J. Trump signed an executive order establishing the President's Commission on Combating Drug Addiction and the Opioid Crisis. The commission issued

a final report in November 2017, with 56 recommendations, including a recommendation for federal block grant funding for state activities relating to opioids and substance use disorders. The full report can be found here: https://www.whitehouse.gov/ondcp/presidents-commission

Maryland Actions to Address the Opioid Crisis

The General Assembly passed several comprehensive acts during the 2017 session to address the State's opioid crisis, which addressed prevention, treatment, overdose response, and prescribing guidelines.

Chapters 571 and 572 of 2017, the Heroin and Opioid Prevention Effort and Treatment Act, among other things, require (1) the Behavioral Health Administration to establish crisis treatment centers that provide individuals in a substance use disorder crisis with access to clinical staff, requiring at least one center be established by June 1, 2018; (2) the Maryland Department of Health (MDH) to establish and operate a toll-free health crisis hotline; (3) certain health care facilities and systems to make available to patients the services of health care providers who are trained and authorized under federal law to prescribe opioid addiction treatment medications, including buprenorphine; (4) each hospital, by January 1, 2018, to have a protocol for discharging a patient who was treated for a drug overdose or identified as having a substance use disorder; (5) the Governor's proposed budget for fiscal 2019 through 2021 to include specified rate adjustments for community behavioral health providers; (6) the Department of Public Safety and Correctional Services and MDH to develop a plan to increase the provision of substance use disorder treatment, including medication assisted treatment, in prisons and jails; (7) the authorization of the provision of naloxone through a standing order and that MDH establish guidelines to co-prescribe naloxone to high-risk individuals; and (8) the expansion of private insurance coverage for opioid use disorders by prohibiting certain carriers from applying a pre-authorization requirement for a prescription drug when used for treatment of an opioid use disorder and that contains methadone, buprenorphine, or naltrexone.

Chapters 573 and 574 of 2017, the Heroin and Opioid Education and Community Action Act (Start Talking Maryland Act), require (1) the State Board of Education to expand an existing program in public schools to encompass drug addiction and prevention education that specifically includes instruction related to heroin and opioid addiction and prevention and information relating to the lethal effect of fentanyl; (2) each local board of education to establish a policy requiring each public school to obtain and store naloxone and other overdose-reversing medication to be used in an emergency situation; (3) each local board of education or local health department to hire a sufficient number of community action officials or develop and implement a program that provides community relations and education functions that coordinate forums and conduct public relations efforts; and (4) specified institutions of higher education in Maryland to establish a policy that

addresses heroin and opioid addiction and prevention, including awareness training for incoming students, obtaining and storing naloxone, and campus police training.

Chapter 570 of 2017 requires a health care provider, on treatment for pain and based on the provider's clinical judgment, to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance (CDS). The Act establishes that the quantity limitations do not apply to opioids prescribed to treat a substance-related disorder; pain associated with a cancer diagnosis; pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or chronic pain. A violation of the Act is grounds for disciplinary action by the appropriate health occupations board.

In January 2017, Governor Lawrence J. Hogan issued an executive order establishing an Opioid Operational Command Center (OOCC) to facilitate collaboration between State and local public health, human services, education, and public safety entities to combat the heroin and opioid crisis. OOCC will (1) develop operational strategies to continue implementing the recommendations of the Governor's Heroin and Opioid Emergency Task Force; (2) collect, analyze, and facilitate the sharing of data relevant to the epidemic from State and local sources; (3) develop a memorandum of understanding among State and local agencies that provides for the sharing and collection of health and public safety information and data relating to the heroin and opioid epidemic; (4) assist and support local agencies in the creation of opioid intervention teams; and (5) coordinate the training of and provide resources for State and local agencies addressing the threat to the public health, security, and economic well-being of the State.

In March 2017, Maryland became the first state to declare a state of emergency for the opioid crisis, activating the Governor's emergency management authority and enabling increased and more rapid coordination between the State and local jurisdictions. In conjunction with the declaration, Governor Hogan included a supplemental budget appropriation of $10 million, part of a $50 million, five-year commitment to address the State's heroin and opioid epidemic.

In July 2017, $22 million was appropriated for fiscal 2018, including $10 million in CURES Act funding, to be used for prevention, treatment, and enforcement activities. Prevention efforts include distribution of opioid intervention teams for each jurisdiction, a public awareness campaign, funding to train community teams on overdose response and linking to treatment, a pilot program to create school-based teams for early identification of the problems related to substance use disorders, and distribution of opioid information to health care facilities and providers that offer treatment. Enforcement initiatives include funding to disrupt drug trafficking organizations for the heroin coordinator program and to increase MDH's regulatory oversight of CDS. Treatment funding will be used to expand treatment beds and implement a tracking system to identify available beds; improve access to naloxone; establish a 24-hour crisis center in Baltimore City; expand use of peer

recovery support specialists; expand Screening, Brief Intervention, and Referral to Treatment to hospitals and parole, probation, and correctional facilities; increase access to medication-assisted treatment; expand law enforcement diversion programs; and improve the State's crisis hotline.