MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
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2022 SESSION
POSITION PAPER

BILL NO: **SB 984**

COMMITTEE: **Senate Finance Committee**

POSITION: **Support**

TITLE: SB 984 - Public Health – State Designated Exchange – Health Data Utility

BILL ANALYSIS

Senate Bill 984 (SB 984) establishes a health data utility operated by the State Designated health information exchange (HIE). SB 984 requires the Maryland Department of Health ("MDH"), pharmacy dispensers, nursing homes and electronic health networks to submit certain data to the State Designated HIE. Prescription drug dispensers, including retail, specialty, and institutional pharmacies, are required to electronically submit information to the health data utility after dispensing. The health data utility must make select information available to providers and health officials for public health interventions and health equity. The Maryland Health Care Commission (MHCC) is required to develop regulations governing information shared by the utility. On or before January 1, 2024, MDH, MHCC, and the State Designated HIE must report to the General Assembly on the revenue sources to fund the health data utility.

POSITION AND RATIONALE

The Maryland Health Care Commission supports SB 984 and the amendments offered by the Chesapeake Regional Information System for Our Patients (CRISP).

This legislation would formalize many of the roles that the State Designated HIE (CRISP) took on during the COVID-19 Public Health Emergency (PHE). CRISP proved its value as an essential information sharing hub during the PHE. CRISP technical capabilities and the trust in which it is held by many stakeholders makes it well-suited to serve as a health data utility in Maryland.

The MHCC and the Health Services Cost Review Commission competitively selected CRISP as the State Designated HIE in 2009. The State Designated HIE supports clinical care through information exchange among providers with caregiving with a patient. Prior to the start of the pandemic CRISP-developed applications supported Maryland hospitals performance under the Total Cost of Care (TCOC) Model and physicians' participation in value-based programs, including the Maryland Primary Care Program (MDPCP) and care transformation initiatives launched by HSCRC.

Beginning with the onset of the PHE in March 2020, CRISP has played an essential part in the State's response to the COVID-19 pandemic and that work continues today. CRISP developed applications were critical to COVID-19 disease reporting, COVID-19 test scheduling, test result reporting, and contacting tracing. CRISP served as a data enclave for hospital and nursing home capacity monitoring and planning. When vaccines became available, CRISP applications and data infrastructure supported vaccine distribution, scheduling, and uptake monitoring. These new capabilities were developed even as longstanding CRISP provider-facing applications including patient alerts and encounter notifications continued to evolve and advance. SB 984 formalizes CRISP role as a health data utility and enables the organization to support continuing and future public health interventions including COVID-19 surges, other health care emergencies, and routine public health data operations. As important, SB 984 formalizes CRISP role in supporting health care transformation initiatives through deeper integration of provider data that will improve care delivery, address health disparities, improve quality, and enable conformance with the TCOC Model.

The bill establishes a dispensed prescription drug repository (or repository) that coupled with the long-standing controlled dangerous substances (CDS) information, the repository will enable providers to have access to comprehensive patient medication histories of patients under their care. This repository will build on an existing framework offering savings to the funders. In 2011, the State established a prescription drug monitoring program (PDMP) to monitor CDS prescribing and dispensing.[1] The PDMP primarily assists providers and public health efforts by the Maryland Department of Health (MDH) to identify and reduce prescription drug abuse of CDS Schedules II through V.[2] The law requires dispensers to report prescription fill information for CDS drugs dispensed to a patient or a patient's agent in Maryland.[3] CRISP, the State Designated Health Information Exchange, collects and securely stores this information, which is made available to providers and for public health activities under certain circumstances.

Provider access to complete and accurate medication history can minimize the potential for medication errors and inadvertent omissions, while improving efficiencies in care delivery. Providers access to comprehensive medication history has great potential to increase patient safety by improving the medication reconciliation process that will reduce medication

[1] The PDMP is authorized under Health-General Article, Section 21-2A, Annotated Code of Maryland (Chapter 166, 2011). PDMP regulations can be found under Code of Maryland Regulations (COMAR) 10.47.07.
[2] The PDMP also assists federal, State, and local law enforcement agencies, health occupations licensing boards and certain MDH agencies in the investigation of illegal CDS diversion, health care fraud, illegitimate professional practice, and other issues.
[3] The law includes reporting exemptions to the PDMP for the following: 1) a licensed hospital pharmacy that only dispenses a monitored prescription drug for direct administration to an inpatient of the hospital; 2) an opioid treatment service program; 3) a veterinarian licensed under Agriculture Article, Title 2, Subtitle 3, Annotated Code of Maryland, when prescribing controlled substances for animals in the usual course of providing professional services; 4) a pharmacy issued a waiver permit under COMAR 10.34.17.03 that provides pharmaceutical specialty services exclusively to persons living in assisted living facilities, comprehensive care facilities, and developmental disabilities facilities; and 5) dispensing to hospice inpatients, provided that the dispensing pharmacy has applied for and been granted a waiver by the Department pursuant to §G of COMAR 10.47.07.03.

prescribing errors.[4] Medication errors are among the most common causes of morbidity and mortality in hospitals.[5, 6] This particularly holds true for hospital emergency departments, the origin of at least half of all hospital admissions in Maryland and the nation.[7, 8, 9] Studies find that inaccuracies in medication histories account for upwards of 50 to 70 percent of admitted patients; over one quarter of these errors are attributable to incomplete information at the time of admission.[10] Medication discrepancies lead to interrupted or inappropriate drug therapy during and after a hospitalization. This can result in adverse drug events (ADEs); half of preventable ADEs occurring within 30 days of discharge are due to medication discrepancies.[11] Medication reconciliation is a key component of patient safety in any health care setting.[12] Manual medication reconciliation processes often require lengthy conversations with patients and/or their caregivers along with multiple calls to pharmacies. SB 984 will address hurdles in care delivery and patient safety due to a missing or incomplete medication history.

The MHCC recognized that requiring reporting of non-CDS pharmacy information for care management purposes could raise concerns among consumers and dispensers. The MHCC began planning for this use case several years ago. The MHCC workgroup convened to study electronic prescription record systems for care management in 2019. The MHCC released the final report from that workgroup in July 2019.[13] Among the issues the workgroup considered were privacy protections required for a prescription record system, including the ability of consumers to choose not to share prescription data and the procedures to ensure the prescription data are used in a manner that is compliant with State and federal privacy requirements. The workgroup recommended that an electronic prescription record system should ensure patient privacy through an opt-out process and to define certain classifications of medications that would be excluded from the electronic prescription record system.

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[4] Medication reconciliation is a process of creating the most accurate list possible of all medications that a patient is taking — including drug name, dosage, frequency, and route. More information is available at: www.ihi.org/Topics/ADEsMedicationReconciliation/Pages/default.aspx.

[5] The Mayo Clinic defines medication errors as mistakes in prescribing, dispensing, and administering medications.

[6] Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn LT, Corrigan JM, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Washington (DC): National Academies Press (US); 2000. 2, Errors in Health Care: A Leading Cause of Death and Injury. Available at: www.ncbi.nlm.nih.gov/books/NBK225187/.

[7] Percent of hospital admissions originating from the ED in Maryland: FY 2017 (56.68 percent), FY 2018 (56.63 percent), FY 2019 through March (56.53 percent).

[8] Schuur JD, Venkatesh AK. The growing role of emergency departments in hospital admissions. N Engl J Med. 2012;367(5):391-393.

[9] Tamblyn R, Poissant L, Huang A, et al. Estimating the information gap between emergency department records of community medication compared to on-line access to the community-based pharmacy records. J Am Med Inform Assoc. 2014; 21(3):391–398.

[10] Agency for Healthcare Research and Quality, *Medication Reconciliation: Whose Job Is It?*, 2007. Available at: psnet.ahrq.gov/webmm/case/158/medication-reconciliation-whose-job-is-it.

[11] Salameh L, Abu Farha R, Basheti I. Identification of medication discrepancies during hospital admission in Jordan: Prevalence and risk factors. *Saudi Pharmaceutical Journal*. 2018;26(1):125-132. Available at: www.sciencedirect.com/science/article/pii/S1319016417301688.

[12] Barnsteiner JH. Medication Reconciliation. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 38. Available at: www.ncbi.nlm.nih.gov/books/NBK2648/.

[13] House Bill 115, Electronic Prescription Records System available at: https://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_EPRS_Rpt_072219.pdf.

In 2021, MHCC worked with stakeholders to operationalize the workgroup recommendations. HB 1022/SB 748 (Public Health – State Designated Exchange – Clinical Information) requires HIEs registered with MHCC to implement consent registries and integrate those registries with a consent registry maintained by CRISP.[14] Stronger patient protections including a unified consent registry provide an appropriate balance between patient privacy and benefits to patients and providers of expanding access to medication histories.

The MHCC is prepared to develop regulations required by SB 984. The MHCC has successfully collaborated with stakeholders to construct data collection and privacy regulations. In 2011, legislation passed that required MHCC to adopt regulations governing the privacy and security of electronic protected health information obtained or released through an HIE.[15, 16] The MHCC is already working with payers, providers, and consumers to update the HIE privacy and security regulations (COMAR 10.25.18) to reflect recent changes in federal law, evolving patient-privacy best practices and the Maryland legislation adopted in 2021 (HB 1022/SB 748) with safeguarding HIE data and ensuring patients have a voice to the extent technically feasible.[17]

For these reasons, the Commission asks for a favorable report on SB 984 and on the amendments offered by CRISP.

Note: The Maryland Health Care Commission is an independent State agency, and the position of the Commission may differ from the position of the Maryland Department of Health.

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[14] Chapter 791 of the 2021 Laws of Maryland, www.mgaleg.maryland.gov/2021RS/chapters_noln/Ch_791_sb0748T.pdf

[15] Md. Code Ann., Health-Gen. §§4-301, 4–302.2, 4–302.3, and 4–302.4 (2011).

[16] PHI means all individually identifiable health information, including demographic data, that relates to the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual, and that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual, held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

[17] COMAR 10.25.18, Health Information Exchanges: *Privacy and Security of Protected Health Information*. Also available at: dsd.state.md.us/coma/SubtitleSearch.aspx?search=10.25.18.