2018 Legislation Impacting Prescription Drug Monitoring Programs (PDMPs)

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Summary of 2018 Bills and Regulations

2018 saw the introduction of more than 260 state and federal bills related to prescription drug monitoring programs (PDMPs) and the proposal of 141 regulations, including topics ranging from mandatory query provisions to the inclusion of opioid antagonist and medical marijuana dispensing in PDMP databases. Of the bills and regulations introduced, 5 federal bills became law, 79 state bills were enacted, and 94 state regulations were adopted.

Federal Legislative Changes

Four of the five federal bills that passed during the 2017–2018 legislative session are of particular interest to PDMPs. The first, H.R. 5515, requires the Secretary of Defense to establish and maintain a program known as the Military Health System Prescription Drug Monitoring Program. The Military Health System PDMP is to be comparable to state PDMPs and applicable to designated controlled substances prescriptions under the military pharmacy benefits program, and it must include a special emphasis on drugs provided through facilities of the uniformed services. The law further requires the Secretary to establish procedures for the bidirectional sharing of information between the Military Health System PDMP and state PDMPs. There is no set time period within which the Military Health System PDMP is to become operational.

The second bill of interest is H.R. 6, the SUPPORT for Patients and Communities Act. This law amends the Social Security Act and provides that the state agency administering the state Medicaid plan may have reasonable access, as determined by the state, to the state PDMP to the extent that such state agency is permitted to access the PDMP under state law. It further allows the state agency to facilitate access to the PDMP for and share PDMP information with any provider enrolled under the state plan to provide services to Medicaid beneficiaries and any managed care entity that has a contract with the state to the same extent allowed under state law.

The bill further requires that by October 1, 2021, states shall require each covered provider (meaning a health care provider participating in the state Medicaid plan) to query a qualified PDMP for a patient before prescribing a controlled substance to such patient. Under this section, a “qualified prescription drug monitoring program” is one that facilitates access by a Medicaid participating provider and facilitates integration of PDMP information into the workflow of the provider, which may include the electronic system the provider uses to prescribe controlled substances.

In addition, H.R. 6 provides that the Centers for Disease Control and Prevention (CDC) may carry out and expand any evidence-based prevention activities and award grants to any state, locality, or Indian tribe for purposes of carrying out such activities. Evidence-based prevention activities include encouraging authorized users to register with and use the PDMP; improving the ease of use of PDMPs; providing a mechanism for the PDMP to notify users of any potential misuse or abuse of controlled substances by a patient; encouraging analysis of PDMP data; enhancing
interoperability between the PDMP and health information technology systems; encouraging and facilitating interstate data sharing; enhancing data collection and quality; and providing prescriber and dispenser practice tools, including prescriber insight reports.

Finally, H.R. 6 includes provisions for the Secretary, each fiscal year and acting through the Director of the CDC, to provide support to states and localities for the purpose of improving the efficiency and use of PDMPs. Beginning on page 169 of the bill, Section 7162 sets out the purposes for which grant funds can be used, including establishment and implementation, maintenance, and improvements to a PDMP. As a condition of receiving grant funds, the state or locality must have legislation or regulations in place to provide for the implementation of a PDMP and to permit the imposition of appropriate penalties for the unauthorized use or disclosure of PDMP information. Additional conditions for funding include a requirement that states receiving support under this section establish a program to notify practitioners and dispensers of information that will help identify and prevent unlawful diversion; a requirement that states report on interoperability between other states and federal agencies, health information technology systems, such as electronic health records, e-prescribing systems, and health information exchanges; and a requirement that states provide the Secretary with aggregate information to enable the Secretary to evaluate the success of state PDMPs. Further, states receiving grants shall facilitate prescribers and dispensers to use the PDMP and educate prescribers and dispensers on the benefits of using it.

The last two federal bills of interest are S.2372 and S.3479. Senate bill 2372 creates a new federal statute that requires states to allow access to PDMP information by Veterans Administration (VA)-employed health care providers and their delegates. It further provides that no state may prevent VA-employed licensed health care providers or their delegates from accessing the state PDMP; nor shall any state deny or revoke the license, registration, or certification of a VA-employed health care provider or delegate who otherwise meets the state’s qualifications for holding a license, registration, or certificate on the basis that the provider or delegate queried or received data from the PDMP. Under this statute, a “licensed health care provider” is defined as a provider employed by the Department of Defense who is licensed, certified, or registered within any state to fill or prescribe medications within the scope of his or her practice as a department employee. A “delegate” is a person or automated system accessing the PDMP at the direction or under the supervision of a licensed health care provider. In S.2372, these requirements are limited to a “national network of state-based prescription drug monitoring programs,” which means an “interconnected nationwide system that facilitates the transfer of state PDMP data across state lines.” Senate bill 3479 amended the statute to include individual state and regional PDMPs.

**State Legislative Changes**

It is generally accepted that mandatory query and mandatory registration requirements increase utilization of state PDMPs by health care practitioners. At the end of 2017, 41 states had mandatory query requirements in place for prescribers and/or dispensers. One year later, that
number has grown to 45 states with the addition of Hawaii, Iowa, Oregon, and South Dakota. Hawaii now requires that practitioners query the PDMP prior to prescribing a Schedule II–IV controlled substance, while Iowa requires practitioners to query the PDMP prior to prescribing an opioid. The provisions in Oregon and South Dakota are more limited. The Oregon requirement applies only to pharmacists with authority to prescribe pseudoephedrine products who must query the PDMP prior to issuing such a prescription. The South Dakota regulation provides that the standards for documentation of patient care for nurse practitioners and nurse midwives prescribing controlled substances for the treatment of chronic, non-cancer pain include documentation that the appropriate state PDMPs were accessed.

In addition, five states (Arizona, Connecticut, Florida, Mississippi, and Virginia) that previously only required prescribers to query the PDMP now also require certain dispensers to query the PDMP. Arizona, Mississippi, and Virginia now specifically include pharmacists, while the Florida provision applies to all dispensers, and the Connecticut provision applies only to medical marijuana dispensaries.

A further 25 states (Alabama, Alaska, Arkansas, Colorado, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Nevada, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, Washington, West Virginia, and Wisconsin) amended already existing mandatory query provisions and/or passed legislation or regulations adding additional types of practitioners, such as dentists, optometrists, advanced practice registered nurses, and physician assistants, to those required to query the PDMP.

As of December 2017, 38 states had mandatory registration provisions in place requiring prescribers and/or dispensers to register with the PDMP. That number grew to 42 in 2018 with the passage of legislation or regulations in Iowa, North Dakota, Washington, and Wyoming. In addition, Indiana and Oregon, which previously only required dispensers to register, now require practitioners to register with the PDMP. An additional 12 states (Alabama, Alaska, Arkansas, Arizona, Connecticut, Georgia, Illinois, Kentucky, Massachusetts, New Mexico, Ohio, and South Dakota) passed legislation or regulations that require other types of practitioners to register with the PDMP.

Twenty-three states (Alabama, Alaska, Arizona, Delaware, Florida, Georgia, Indiana, Illinois, Iowa, Louisiana, Maryland, Massachusetts, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, South Carolina, Utah, Virginia, West Virginia, Wisconsin, and Wyoming) modified or added additional authorized recipients of PDMP data to their existing laws. Examples of new authorized recipients include state epidemiologists; medical examiners and medical examiner investigators; consultant pharmacists; drug court officials; prescribers and dispensers employed by the Department of Defense, Department of Veteran’s Affairs, and Indian Health Service; tribal law enforcement officials; and Opioid Fatality Review Committees.

Twelve states (Alaska, Arizona, Georgia, Idaho, Illinois, Iowa, Maryland, New Jersey, New Mexico, Rhode Island, Washington, and Wisconsin) added or modified their laws regarding the use of
delegates. Arizona now allows pharmacy technician trainees, pharmacy technicians, and pharmacy interns who work in the same facility as the supervising dispenser to act as delegates. Georgia law no longer requires that delegates be licensed or registered with a state licensing or regulatory board, while Illinois allows both licensed and non-licensed personnel to act as delegates.

Three states (Iowa, Montana, and Rhode Island) changed their data reporting interval requirements in 2018 so that dispensing data in all three states is now required to be reported within one business day, bringing the total number of states with daily reporting requirements to 45 and leaving only California (weekly), Hawaii (weekly), Oregon (72 hours), Puerto Rico (15 days), and Guam (14 days) with data reporting intervals greater than one business day.

California passed legislation in 2018 that now explicitly allows the sharing of PDMP data across state lines leaving Hawaii and Guam the only programs without legislative authority to share data with other states.

Finally, ten states (Colorado, Florida, Georgia, Illinois, Maryland, Massachusetts, New Jersey, South Carolina, Texas, and Utah) passed legislation that in some way addressed the integration of PDMP data with electronic health records, electronic pharmacy systems, or health information exchanges.

Reporting of Additional Information to Prescription Drug Monitoring Programs

Increasingly, states have begun requiring that information in addition to data on controlled substance prescriptions be reported to or shared with the state PDMP. The most common information required to be reported includes the dispensing of medical marijuana products, including cannabidiol oil and THC-A; the dispensing or administration of opioid antagonists such as naloxone; and information regarding fatal and nonfatal overdoses. In 2018, 16 states (Connecticut, Delaware, Idaho, Illinois, Iowa, Kentucky, Maryland, North Dakota, Oklahoma, Rhode Island, South Carolina, Utah, Virginia, Washington, West Virginia, and Wyoming) passed legislation or regulations that require the reporting of non-prescription information to the PDMP.

Connecticut, Illinois, North Dakota, Oklahoma, Utah, and Virginia now require that information regarding the dispensing of medical marijuana be reported to the PDMP. In Connecticut and Utah, that onus falls on the dispensary. In Illinois, the dispensary enters data into a state verification system; the data is then reviewed by the Department of Public Health and electronically forwarded to the PDMP. The PDMP is required to make a notation on the patient’s prescription record that he or she is entitled to the lawful medical use of cannabis. North Dakota regulation provides that the department shall submit data regarding usable marijuana to the PDMP. In Oklahoma, both medical marijuana dispensaries and registered medical marijuana physicians are charged with the collection and reporting of data. In Virginia, that information is required to be reported by the pharmaceutical processor.
With the passage of laws in Idaho, Iowa, Rhode Island, South Carolina, Virginia, West Virginia, and Wyoming, there are now 12 states that require information regarding the dispensing or administration of opioid antagonists be reported to or shared with the state PDMP. Delaware, Kentucky, and Maryland now include information regarding fatal and/or nonfatal overdoses in their state PDMPs.

Illinois requires that the PDMP alert a patient’s prescriber if he or she is discharged from any medical facility with an ICD-10 code related to a sport or accident injury and is dispensed a controlled substance on discharge. The alert to the patient’s prescriber is required to include information regarding the risk of addiction and an urge to follow the CDC guidelines or the treatment guidelines of the prescriber’s profession related to that patient’s specific injury.

Rhode Island allows patients to sign a voluntary non-opioid directive indicating that they should not be prescribed, offered, or administered an opioid and provides that the directive be recorded in both the patient’s electronic health record and the PDMP.

Finally, Washington adopted multiple regulations across various medical disciplines (including osteopathic physicians, advanced practice registered nurses, and podiatrists) requiring that a patient receiving long-term opioid therapy for chronic pain enter into a written treatment agreement with his or her health care provider. The treatment agreement must include written authorization for the health care provider to release the agreement to other practitioners so that those other practitioners can report any violations of the treatment agreement to the treating health care provider and to the PDMP.

**Resources**

Additional information regarding all legislation and regulations introduced and enacted in 2018 can be found at [http://www.pdmpassist.org/content/statutes-and-regulations](http://www.pdmpassist.org/content/statutes-and-regulations). PDMP issue-specific maps and charts can be found on the PDMP Training and Technical Assistance website located at [http://www.pdmpassist.org/content/pdmp-maps-and-tables](http://www.pdmpassist.org/content/pdmp-maps-and-tables).