F I S C A L I M P A C T R E P O R T

SPONSOR Martinez **ORIGINAL DATE** 2/08/16 **LAST UPDATED** 2/13/16 **HB**

SHORT TITLE Opioid Prescription Monitoring **SB** 263/aSJC

ANALYST Liu

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY16	FY17	FY18	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total		$240.0	$120.0	$360.0	Recurring	Board of Pharmacy Operating Budget
Total		$98.0	$98.0	$196.0	Recurring	Federal Funds

(Parenthesis ( ) Indicate Expenditure Decreases)

Relates to HB 241, HB 277, SB 100, SB 191, SB 262

SOURCES OF INFORMATION
LFC Files

Responses Received From
Regulation and Licensing Department (RLD)
Board of Nursing (BON)
Department of Health (DOH)
Human Services Department (HSD)
Medical Board (MB)

SUMMARY

Synopsis of SJC Amendment

The Senate Judiciary Committee amendment to Senate Bill 263:

- strikes requirements for practitioners to check the state's prescription monitoring program before "administering" an opioid;
- requires the practitioner to check the PMP and similar reports from "adjacent" states, rather than any other state, if applicable;
- removes "pharmacist" from the definition of practitioner;
- exempts practitioners from checking the PMP and similar reports before prescribing or dispensing an opioid for first-time patients if the supply for the opioid prescription is four days or less;

- exempts practitioners from checking the PMP when prescribing an opioid to a patient in a nursing facility or in hospice care; and
- allows professional licensing boards to promulgate rules for checking the PMP at a greater frequency than the bill requires.

Synopsis of Original Bill

Senate Bill 263 amends the New Mexico Drug, Device and Cosmetic Act, requiring any practitioner (except veterinarians and euthanasia technicians) to check the state's prescription monitoring program (PMP) before prescribing, administering, or dispensing an opioid. The bill also requires the practitioner to check the PMP and similar reports from another state, if applicable, at least every three months for individuals on chronic opioid therapy. The practitioner will document the receipt and review of PMP reports in the patient's medical record. Professional licensing boards will enforce these provisions for each category of practitioner that is licensed or authorized to prescribe, administer, or dispense opioids.

FISCAL IMPLICATIONS

RLD and the Board of Pharmacy (BOP) are currently pursuing a contract to host the PMP through Appriss, a major technology provider for PMPs across the nation. The contract is expected to cost $120 thousand initially to migrate the database from state servers to the Appriss system and $10 thousand each month for technical support. BOP will need one additional FTE to assist with the registration of practitioners and other issues related to PMP operation. The new PMP employee will be paid by an existing federal grant up to four years. BOP's average FTE cost is approximately $98 thousand per year. Funding for Appriss and the PMP employee (after the grant period expires) will come from the BOP fund.

SIGNIFICANT ISSUES

RLD operates a PMP that allows prescribers, pharmacists, regulators, and law enforcement agencies to monitor and manage prescriptions for opiates to patients to prevent abuse, duplication, or waste. New Mexico regulations require prescribers and pharmacists to employ the PMP as part of the process of writing and filling prescriptions. PMP utilization is poor if each professional licensing board promulgates different rules for PMP usage. (http://www.nmpmp.org/).

To be fully effective, PMPs must be used extensively by practitioners. According to DOH, PMP usage is low in New Mexico. Between July and December 2015, providers used the PMP for only approximately 30 percent of patients prescribed opioids and only 12 percent of patients had reports requested by the practitioner who prescribed the opioid. Currently, all of New Mexico's professional licensing boards for providers authorized to prescribe controlled substances require PMP use. However, requirements for use differ significantly by board. For example, the Board of Nursing requires a PMP check for each initial controlled substance prescription, and nurse practitioners have the highest required rate of PMP checks.

According to BOP, this bill was presented and supported during the board's meeting on January 25, 2016, with the caveat that pharmacists would be exempted from reviewing the PMP report each time an opioid was dispensed. BOP requests that "pharmacists" be specifically listed as one of the practitioners exempted in the bill.

PERFORMANCE IMPLICATIONS

According to DOH, addressing the rate of deaths due to drug overdose is a highly-prioritized performance measure for the agency.

ADMINISTRATIVE IMPLICATIONS

This bill will increase use of the PMP database but affect user access as technical issues arise. Currently, the database is hosted on a state IT server managed by RLD staff. Additional usage will necessitate third-party technical support (i.e. Appriss) or additional agency FTE.

RELATIONSHIP

This bill relates to HB 241 and its duplicate, SB 191. HB 241 and SB 191 require DOH to provide educational materials on opioid overdose on its website, require insurers to cover abuse dependent formulations of opioids, and require the Department of Corrections to consider medication assisted treatment for persons under the department's supervision.

This bill relates to SB 100, which requires health care providers with the authority to prescribe opioids to complete an overdose prevention education program, requires health care providers and pharmacists to counsel patients on overdose risks, and allows retail pharmacies to dispense naloxone, an overdose reversal medication.

This bill relates to HB 277 and its duplicate, SB 262. HB 277 and SB 262 allow the authorized possession, storage, distribution, prescription, and administration of naloxone. The bills also provide limited immunity from civil and criminal liability.

TECHNICAL ISSUES

This bill amends the New Mexico Drug, Device and Cosmetic Act. Authorization for the PMP is found in the New Mexico Controlled Substances Act. The PMP is for the reporting of controlled substances only. This bill should instead amend the New Mexico Controlled Substances Act.

According to RLD, there are rules and regulations concerning practitioners that "distribute" medications. A distinction between "dispense" and "distribute" is defined in the Pharmacy Act and Controlled Substances Act. "Distribute" should be added to the legislation.

According to BON, the term "administers" (page 2, line 13 and 24) may create an unintended burden on registered nurses and licensed practical nurses who frequently administer opioids as part of their practice. As the bill is written, nurses in hospitals and hospices administering opioids as part of the necessary and appropriate care of patients would have to check the PMP multiple times a shift. If the word "administers" is omitted, the obligation to check the PMP would still remain for prescribing providers.

OTHER SUBSTANTIVE ISSUES

This bill will require hospital staff to review a PMP report prior to administering an initial dose of an opiate. According to RLD, a recent report shows that individuals presented with an overdose of an opiate that did not result in death are 90 percent more likely to go and repeat the

process, which could result in death. A PMP report should be required for patients prescribed certain drug combinations. Overdose death rates increase substantially for patients prescribed an opiate and a benzodiazepine. Rates increase even more if patients are prescribed an opiate, a benzodiazepine, and the muscle relaxant, carisoprodol, simultaneously. Hospital personnel should be required to review PMP reports for opioid overdose patients. Hospital personnel could then notify the prescribing practitioner about any misuse of the medication prescribed.

DOH and RLD are conducting a wide range of activities to reduce prescription drug abuse, with funding from the federal Centers for Disease Control and Prevention and, and with collaboration from HSD's Behavioral Health Services Division, where the State Opiate Treatment Authority program and the Office of Substance Abuse Prevention are housed.

Forty eight states have similar PMP databases, and 22 states require providers to consult the PMP under certain circumstances. The intent of the PMP is to reduce the inappropriate use of multiple prescribers and multiple pharmacies by patients to acquire controlled substances, and to reduce inappropriate prescribing.
(www.namsdl.org/prescription-monitoring-programs.cfm)
(http://www.pdmpexcellence.org/sites/all/pdfs/Briefing%20on%20PDMP%20Effectiveness%203rd%20revision.pdf).

Other states faced with low PMP utilization have increasingly mandated PMP use. Recent mandates for practitioner PMP use in Kentucky, Tennessee, and New York have been associated with declines in opioid prescribing and inappropriate patient use of multiple providers.
(http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%20revised_a.pdf).

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

According to DOH, New Mexico had the second highest drug overdose death rate in the U.S. in 2014, and many of those deaths were attributed to prescription and illicit opioids. New Mexico's age-adjusted drug overdose death rate more than tripled from 1990 through 2014, increasing from 7.6 per 100 thousand population in 1990 to 26.4 in 2014. During 2014, 540 New Mexicans died of drug overdose, according to the DOH Bureau of Vital Records and Health Statistics. The number of deaths in 2014 was the highest number of deaths from drug overdose since tracking of drug overdose began.
(www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w)

SL/jo/al