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TO: The Honorable Thomas M. Middleton
Members, Senate Finance Committee
Carolyn Quattrocki, Esquire

FROM: Joseph A. Schwartz, III
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DATE: March 17, 2011

RE: **OPPOSE UNLESS AMENDED** – Senate Bill 883 – *Prescription Drug Monitoring Program*

The Maryland State Medical Society (MedChi), which represents over 7,300 Maryland physicians and their patients, opposes Senate Bill 883 unless amended.

Senate Bill 883 is this year's iteration of a proposal that has been before the General Assembly for a number of years. This legislation establishes a Prescription Drug Monitoring Program (PDMP) in the State Health Department. The "mission" of the Program is to "assist…in…the identification, treatment and prevention of prescription drug abuse and the identification and investigation of unlawful prescription drug diversion." Senate Bill 883 is substantially identical to legislation vetoed by Governor Ehrlich in 2006. Subsequent to that veto, an Advisory Council on Prescription Drug Monitoring was established which included representatives of all stakeholders. That Advisory Council produced a legislative report on December 31, 2009 which is available on the DHMH website:
http://www.dhmh.state.md.us/drugcont/pdf/Final%20Report%20of%20recommendations%20by%20the%20PDM%20Advisory%20Council%2012-31-09.pdf

As in the past, MedChi has multiple objections to Senate Bill 883. However, MedChi wants to acknowledge the efforts of the Health Department and specifically, Deputy Secretary Frances Phillips, and the Governor's Office in the person of Carolyn Quattrocki in proposing changes to the legislation to accommodate certain MedChi concerns. Certain amendments which will be proposed are helpful to resolution. However, MedChi believes that its fundamental objection has not been met.

Since the initial efforts to establish a PDMP in 2006, MedChi has always believed that such programs are costly and inefficient proposals from law enforcement personnel which do little to treat patients who are abusing prescription drugs and will have a chilling effect, particularly on doctors who are involved in pain management. MedChi has always believed that the purpose of the PDMP should be focused on clinical results, not on law enforcement imperatives. MedChi believes that law enforcement personnel should be, at best, secondary parties rather than the primary parties to share PDMP data. The PDMP program in Vermont, for instance, explicitly excludes law enforcement personnel from accessing the data. (Advisory Council Legislative Report at page 18, line 16).

In addition to its philosophical objection to the law enforcement nature of the proposed PDMP, MedChi believes that the creation and expense attendant to a "stand alone" data system is not prudent. This is particularly true when the Maryland Health Care Commission (MHCC) is in the process of establishing a state-wide Health Information Exchange (which will result in patient's health records being available to physicians on a real time basis). The monetary incentives from both the federal government (Medicare or Medicaid) and from the state government (the MHCC regulations) are allowing doctors to switch to EHR systems by providing the necessary capital for same. Virtually everyone involved with Maryland health care is supportive of the work being done by MHCC with respect to the creation of the Health Information Exchange which will allow doctors to have complete records on patients in "real time." Doctors will be able to identify a particular patient who may be "doctor shopping" or otherwise securing prescription drugs. Moreover, Electronic Health Records (EHR) provide a physician with the "full story" on a particular patient and not just a profile of his or her prescriptions. A doctor could review the underlying diagnostic record to see if the prescriptions were justified or not.

EHR systems which allow doctors to see a patient's "full story" are considerably of more value than a computer system which simply identifies certain prescription drugs for any patient. Indeed, MedChi questions whether a "stand alone" PDMP is of any real value in accomplishing the objectives outlined by its proponents. The Advisory Council in its Legislative Report at page 6 concluded as follows: **"However, given the year of other states' experience in operating PDMPs and the voluminous amount of information available, their remains some controversy as to whether these programs are working. No concrete statistics are available to show the programs work; no concrete statistics are available to show the program does not work."** The Advisory

Committee also observed as follows: "**Many states have not seen any significant change in the societal effects of diversion after implementation. Additional economic burdens should not be placed on practitioners and dispensers without some program effectiveness"** (Legislative Report at 48-49).

MedChi continues to believe the goal of a PDMP should be the treatment of addicted patients and that this effort should be integrated with EHR technology and Maryland's soon to be activated Health Information Exchange. MedChi recognizes that Senate Bill 883 establishes a "Multidisciplinary Consultation Team" (Team) to assist the Department with respect to law enforcement or licensing boards seeking information from the PDMP. This is a positive addition to earlier bills. However, MedChi believes that this Team should be granted the explicit authority to examine any information request from a professional licensing board or law enforcement organization and either release the information, in the case of an administrative subpoena, withhold the information, or in the case of a judicial subpoena, ask the court to quash the subpoena.

Moreover, there are several additional items that the legislation should consider including the following:

1. Data should be collected only for Schedule II and Schedule III drugs and/or for specific drugs as determined by the Team at the request of the Secretary;
2. Data should not be collected for Suboxone or other medications that are used for detoxifications and/or addiction treatment;
3. Data should not be collected for a diagnosis of particular concern such as cancer, arthritis, fibromyalgia and others;
4. Law enforcement access to the PDMP data shall be only for an on-going investigation involving a complaint involving the diversion of controlled dangerous substances;
5. Identified PDMP data shall be "read only" and should not be reported, printed or reproduced in electronic form and may not become part of the medical record or a law enforcement document. Such information shall be confined to the "original source" to eliminate errors (for example, the commercial data base known as SureScripts is "read only" and cannot be printed or transferred as a file but may only be viewed on a computer screen);

6. Penalties for the release of information (Section 21-2A-07 of the bill, page 11) should be substantially amended so that prescribers or dispensers who release PDMP information should enjoy the same immunity that state officials are granted;
7. Data should be maintained for a period of one year (not five years) and then "deidentified" for public health and research purposes.

In sum, there is an inherent tension between the clinical monitoring program which MedChi supports and the law enforcement program which some proponents of Senate Bill 883 support. If there is to be a law enforcement component, there must be considerably more protections than currently exist in the legislation.

Again, MedChi believes that the differences between itself and the proponents of the legislation have been narrowed as the result of recent discussions. Unfortunately, these discussions have occurred in the middle of the General Assembly Session when all parties are occupied with multiple issues. MedChi believes that further discussions, undertaken at a less frenzied pace, may ultimately result in legislation which it could support. That time has not yet come and MedChi would urge an unfavorable report on Senate Bill 883.

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