HOUSE BILL REPORT
SSB 5380

As Reported by House Committee On:
Health Care & Wellness
Appropriations

Title: An act relating to opioid use disorder treatment, prevention, and related services.

Brief Description: Concerning opioid use disorder treatment, prevention, and related services.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Rivers, Frockt, Walsh, Keiser, King, Randall, O'Ban, Conway, Darneille, Saldaña, Das, Dhingra, Hunt, Wilson, C. and Zeiger; by request of Office of the Governor).

Brief History:
Committee Activity:
Health Care & Wellness: 3/19/19, 4/2/19 [DPA];
Appropriations: 4/6/19, 4/8/19 [DPA(APP w/o HCW)].

Brief Summary of Substitute Bill
(As Amended by Committee)

- Modifies the protocols for using medications to treat opioid use disorder.
- Permits pharmacists to partially fill certain prescriptions upon patient request.
- Requires prescribers to discuss the risks of opioids with certain patients and provide the patient with the option to refuse an opioid prescription.
- Establishes new requirements for how electronic health records integrate with the prescription monitoring program (PMP) and how PMP data can be used.
- Requires the Health Care Authority and the Department of Health to partner and work with other state agencies on initiatives that promote a statewide approach in addressing opioid use disorder.
- Permits the Secretary of Health to issue a standing order for opioid reversal medication and requires pharmacists to provide written instructions about responding to an opioid overdose when the medication is dispensed.
- Allows hospital emergency departments to dispense opioid overdose reversal medication when a patient is at risk of opioid overdose.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

- Requires city and county jails to provide medication-assisted treatment to certain individuals with opioid use disorder, if funding is provided.
- Requires certain controlled substances prescriptions to be electronically submitted to pharmacies beginning January 1, 2021.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 13 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Davis, Harris, Jinkins, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Kim Weidenaar (786-7120).

Background:

Opioid Treatment Programs.
The Community Mental Health Services Act provides that: (1) there is no fundamental right to medication-assisted treatment (MAT) for opioid use disorder (OUD); (2) treatment should only be used for participants who are deemed appropriate to need this level of intervention; (3) alternative options, like abstinence, should be considered when developing a treatment plan; (4) the main goal of opiate substitution treatment is total abstinence, but recognizes additional goals of reduced morbidity and restoration of the ability to lead a productive and fulfilling life; and (5) if medications are prescribed, follow up must be included in the treatment plan in order to work towards the primary goal of abstinence.

The Department of Social and Health Services (DSHS) certifies opiate substitution treatment programs.

Medications to Treat Opioid Use Disorder.
Medications used to treat OUD, also referred to as MAT, is a form of treatment which uses medications approved by the United States Food and Drug Administration. Methadone, buprenorphine, and naltrexone are common medications used to treat OUD.

Opioid Overdose Reversal Medication.
A health care practitioner may prescribe, dispense, distribute, and deliver an opioid overdose medication: (1) directly to a person at risk of experiencing an opioid-related overdose; or (2) by collaborative drug therapy agreement, standing order, or protocol to a first responder, family member, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. The practitioner must inform the recipient that as soon as possible after administration, the person at risk of experiencing an overdose should be transported to a hospital or a first responder should be summoned.

Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose medication pursuant to a practitioner's prescription or order. A pharmacist may dispense an opioid overdose medication pursuant to such a prescription and may administer

an opioid overdose medication. The pharmacist must provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention.

The following individuals are not subject to civil or criminal liability or disciplinary action under the Uniform Disciplinary Act for their authorized actions related to opioid overdose medications or the outcomes of their authorized actions if they act in good faith and with reasonable care: practitioners who prescribe, dispense, distribute, or deliver an opioid overdose medication; pharmacists who dispense an opioid overdose medication; and persons who possess, store, distribute, or administer an opioid overdose medication.

Medications can be administered to rapidly restore breathing to an individual experiencing an opioid overdose. Narcan, naloxone, and Evzio are common opioid overdose reversal medications.

State Opioid Response Plan.
Several state agency members of the Department of Health (DOH) Opioid Response Workgroup developed a statewide plan for opioid response. On September 30, 2016, the Governor signed Executive Order 16-09 Addressing the Opioid Use Public Health Crisis formally directing activities and state agencies to act in accordance with the Washington State Opioid Response Plan. In November 2016, state agency members revised the Washington State Opioid Response Plan to align with the executive order and activities directed by federal grants received in 2016. The workgroup meets quarterly and updates the plan annually.

Prescription Monitoring Program.
The DOH maintains a prescription monitoring program (PMP) to monitor the prescribing and dispensing of all Schedule II, III, IV, and V controlled substances. Each time one of these drugs is dispensed, the dispenser must electronically submit the following information to the PMP:

- a patient identifier;
- the drug dispensed;
- the dispensing date;
- the quantity dispensed;
- the prescriber; and
- the dispenser.

Prescribers are not required to query the PMP prior to prescribing a controlled substance. Generally, prescription information submitted to the DOH is confidential; however, data in the PMP may be accessed by:

- a person authorized to prescribe or dispense a controlled substance or legend drug for the purpose of providing medical or pharmaceutical care for his or her patients;
- a person requesting his or her own PMP information;
- a health professional licensing, certification, or regulatory agency;
- an appropriate law enforcement or prosecutorial official;
- an authorized practitioner of the DSHS or the Health Care Authority regarding Medicaid recipients;

- the Director of the Department of Labor and Industries (or designee) regarding workers' compensation claimants;
- the Secretary of the Department of Corrections (DOC) (or designee) regarding offenders in the custody of the DOC;
- an entity under grand jury subpoena or court order;
- personnel of the DOH for administration of the PMP or the Uniform Controlled Substances Act;
- certain medical test sites licensed by the DOH;
- a health care facility or entity for the purpose of providing medical or pharmaceutical care to the patients of the facility or entity if the facility or entity is licensed by the DOH or operated by the federal government or federally recognized Indian tribe, and the facility or entity is a trading partner with the Health Information Exchange (HIE);
- a health care provider group of five or more providers for the purpose of providing medical or pharmaceutical care to the patients of the provider group if all of the providers in the group are licensed and the provider group is a trading partner with the HIE;
- the local health officer of a local health jurisdiction for the purposes of patient follow-up and care coordination following a controlled substance overdose event; and
- the coordinated care electronic tracking program, often referred to as the seven best practices in emergency medicine.

Opioid Prescribing Rules.
In 2017 the Legislature passed Engrossed Substitute House Bill 1427 requiring the Medical Quality Assurance Commission; the Board of Osteopathic Medicine and Surgery; the Nursing Care Quality Assurance Commission; the Dental Quality Assurance Commission; and the Podiatric Medical Board to adopt new rules for prescribing opioids by January 1, 2019. The rules establish prescribing and documentation guidelines for varying pain levels acute, perioperative, subacute, and chronic and require PMP checks, documentation justifying a prescription, one hour of opioid prescribing continuing education, and providing the patient with resources regarding risks of opioid use and how to safely dispose of the drugs. The rules do not apply to palliative care, in-patient hospital care, procedural medications, and cancer related treatments.

Criminal Justice Treatment Account.
The state funds substance use disorder treatment for certain offenders of the criminal justice system.

Emergency Medications at Hospital Pharmacies.
A hospital may allow prepackaged emergency medications for patients being discharged from the emergency department to be prescribed by practitioners with prescriptive authority and distributed by these practitioners and registered nurses when: (1) community pharmacies and outpatient hospital services are not available within 15 miles by road; or (2) in the judgment of a practitioner and consistent with hospital policies, the patient has no reasonable ability to reach a local community or outpatient pharmacy.

The director of the hospital pharmacy must develop policies and procedures regarding the types of emergency medications to be prepackaged and the criteria under which prepackaged emergency medications may be prescribed and distributed, in addition to other requirements.

Summary of Amended Bill:

Opioid Use Disorder Treatment.
The state declares that substance use disorders are medical conditions and should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence. This includes using medications approved by the United States Food and Drug Administration (FDA) for the treatment of opioid use disorder (OUD). Providers must inform patients with OUD and substance use disorder of options to access FDA approved medications for the treatment of OUD and substance use disorder. Opioid use disorder treatment programs may order, possess, dispense, and administer opioid overdose reversal medication and medications approved by the FDA to treat OUD. Registered nurses and licensed practical nurses may dispense up to a 31-day supply of FDA approved medications to patients receiving OUD treatment.

Medicaid and all state regulated plans must provide coverage of at least one prescription drug, without prior authorization, within the drug class of substance use disorder—opioid partial agonists as established under Washington's Medicaid preferred drug list.

Opioid Use Disorder Treatment for Pregnant and Parenting Individuals.
Opioid treatment programs that provide services to individuals who are pregnant must provide information about the effects opioid use and OUD medication may have on their baby. The Department of Health (DOH) must adopt rules requiring all opioid treatment programs to educate pregnant individuals about the risks to the parent and the fetus of not treating OUD. If a pregnant Medicaid client is identified at risk for OUD, the Health Care Authority (HCA), through the managed care organizations, must provide outreach to the individual. The HCA is required to provide recommendations to the Office of Financial Management by October 1, 2019, on how to better support individuals with OUD who have recently given birth, and newborns of individuals with OUD.

Opioid Prescribing.
Pharmacists are permitted to partially fill a Schedule II controlled substance prescription. The partial fill must be requested by the patient or the prescribing practitioner, and the total quantity dispensed in all partial fillings must not exceed the quantity prescribed. By January 1, 2020, the boards and commissions for the various prescribers must adopt or amend their rules to require opioid prescribers to inform patients of their right to refuse opioid prescriptions. If a patient indicates a desire to not receive an opioid, the prescriber must document the patient's request and avoid ordering or prescribing opioids for the patient. The DOH must update its patient materials to reflect a patient's right to refuse an opioid prescription or order.

When prescribing an opioid for the first time during a patient's course of outpatient treatment, practitioners must have a discussion with the patient about the risks of opioids, and about pain management alternatives, and provide patients with a warning statement created by the DOH. Practitioners must document the discussion in the patient's health record. The DOH

must review the science, data, and best practices regarding the use of opioids and their associated risks and update the warning as needed.

Electronic prescription systems are no longer required to be approved by the Pharmacy Commission. Pharmacists in charge are no longer required to establish or verify policies to ensure integrity and confidentiality of prescription information electronically transmitted, which employees no longer have to sign and comply with.

Beginning January 1, 2021, prescriptions for controlled substances must be communicated to pharmacies electronically, except for:

- prescriptions issued by veterinarians;
- prescriptions issued for a patient of a long-term care facility or hospice program;
- when the electronic system is unavailable due to temporary technological or electronic failure;
- prescriptions issued that are intended for dispensing outside of Washington;
- when a prescriber and pharmacist are employed by the same entity;
- prescriptions that cannot be accomplished electronically due to federal laws;
- prescriptions that require compounding;
- standing orders, collaborative drug therapy agreements, or prescriptions issued in response to a public health emergency;
- prescriptions issued under a drug research protocol;
- where a delay would adversely impact the patient; or
- prescriptions issued by a prescriber who has received a waiver from the DOH.

Prescription Monitoring Program.
Dispensers are required to submit the necessary prescription information to the prescription monitoring program (PMP) no later than one business day after the date the prescription is dispensed, or as required by DOH rule, whichever is sooner. By January 1, 2021, all health care facilities, entities, offices, or provider groups with at least 10 providers must demonstrate that their federally certified electronic health record (EHR) system can fully integrate with the PMP. The DOH must develop a waiver process for the integration requirement for facilities, entities, offices, or provider groups due to economic hardship, technological limitations that are not reasonably in the control of the practitioner, or other exceptional circumstance.

Electronic health record vendors that are fully integrated with the PMP are prohibited from charging an ongoing fee or a fee based on the number of transactions. The total costs for integration must not impose unreasonable costs on any health care providers and must be consistent with industry pricing.

The DOH must:

- collaborate with health professional and facility associations, EHR vendors, and other stakeholders to assess the current status of EHR and PMP integration;
- provide recommendations for improving integration among small and rural health providers including establishing a financial assistance program;
- conduct security assessments of other commonly used platforms for integrating EHR and PMP; and

- evaluate options to identify patients in the PMP who do not wish to receive opioids or patients who have had an opioid-related overdose.

Prescription Monitoring Program data may be provided to:
- a health professional licensing, certification, or regulatory agency or entity for use in legal proceedings regarding the license;
- the HCA director, or designee, for Medicaid recipients and members of the HCA's self-funded and self-insured health plans;
- DOH personnel to assess the public health impacts of OUD and to identify possible interventions;
- a licensed, certified or accredited behavioral health facility;
- public or private entities for statistical research, or educational purposes after removing any unique identifiers;
- the Washington State Medical Association for use solely in its coordinated quality improvement program;
- the Department of Social and Health Services (DSHS), the Department of Labor and Industries, and the HCA for data analysis and research approved by Washington State Institutional Review Board for public health purposes to improve the prevention or treatment of substance use disorders; and
- the largest health professional associations representing each of the prescribing professions for the purposes of quality improvement.

The DOH may also enter into agreements to exchange PMP data with PMPs in other states.

State Opioid Response Plan.
The Secretary of the DOH is responsible for coordinating the statewide response plan and must work in partnership with the HCA to execute the plan. State agencies shall promote positive outcomes associated with the accountable communities of health, local law enforcement, and human service collaborations to address OUD. In addition the work already underway by the State Opioid Response Plan, the HCA, and the DOH are provided with additional directives.

The HCA is authorized to:
- work with other state agencies and stakeholders to develop value-based payment strategies for the ongoing care of persons with opioid and other substance use disorders;
- promote the use of medication assisted treatment (MAT) and other evidence-based strategies to address the opioid epidemic and by January 1, 2020, prioritize state resources be provided to treatment settings that allow patients to use MAT while engaging in services;
- seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis;
- partner with the DSHS, Department of Corrections, the DOH, and the Department of Children, Youth, and Families to develop a statewide approach to leveraging Medicaid funding to treat OUD and provide emergency overdose treatment;
- replicate effective approaches to broaden outreach and patient navigation with allied OUD community partners;
- work with the DOH to promote coordination between OUD treatment providers;

- work with stakeholders to develop a set of recommendations for the Governor and the Legislature regarding a standard set of services needed to support individuals with OUD in treatment programs and identify what is needed to implement the recommendations;
- partner with the DOH and other state agencies to replicate effective approaches for linking individuals who have had a non-fatal overdose with treatment opportunities, including connecting them to certified peer counselors;
- implement a law enforcement assisted diversion program in two or more geographic areas of the state;
- work with the DOH and managed care organizations to promote access to OUD medications at state-certified opioid treatment centers, and encourage the distribution of naloxone to patients who are at risk of an opioid overdose;
- work with the DOH, the accountable communities of health, and community stakeholders to develop a plan for coordinating purchasing and distributing opioid overdose reversal medication; and
- recommend coverage options for non-pharmacologic treatment options for acute, subacute, and chronic non-cancer pain.

The DOH is authorized to:

- display on its website a warning statement about the risks of opioids and information about the safe disposal of opioids;
- ensure training is available electronically and in a variety of media identifying a person suffering from an opioid-related overdose and the use of opioid overdose reversal medication;
- establish an electronic emergency medical services data system for all licensed ambulance and aid services to report patient encounter data including data on suspected drug overdoses to engage individuals in treatment or other support services through peer professionals, patient navigators, outreach workers, and other professionals as appropriate;
- work with state agencies to develop a plan to increase outreach and education about opioid overdoses to non-English speaking communities and submit the plan with to the appropriate legislative committees by July 1, 2020;
- coordinate with the HCA on a strategy to rapidly deploy a response team to a local community identified as having a high number of fentanyl-related or other drug overdoses; and
- work with the HCA to reduce barriers and promote the use of medication treatment therapies for OUD in emergency departments and same-day referrals to treatment programs.

Opioid Overdose Reversal Medication.

The Secretary of the DOH, or designee, is authorized to issue a standing order for opioid reversal medication to any person at risk of experiencing an opioid related overdose or any person or entity in a position to assist a person at risk of experiencing an opioid-related overdose. Prescribers and dispensers are authorized to provide opioid overdose reversal medication pursuant to a standing order or a collaborative drug therapy agreement to any person at risk of experiencing an opioid overdose or to any person in a position to assist a person at risk of experiencing an opioid overdose. When a pharmacist dispenses an opioid

overdose reversal medication, the pharmacist must provide written instructions on the proper response to an opioid-related overdose which must include seeking medical attention.

Hospital emergency departments may dispense opioid overdose reversal medication when the practitioner determines the patient is at risk of an opioid overdose and it is authorized by the hospital's policies and procedures. The Pharmacy Commission prescription labeling requirements do not apply to opioid overdose reversal medications dispensed, distributed, or delivered from an emergency department.

Criminal Justice.
Any region or county that uses state criminal justice treatment account funds to support a therapeutic court must allow therapeutic court participants to use all medication approved by the FDA for the treatment of OUD as deemed medically appropriate. If treatment resources are not available or accessible within the jurisdiction, the HCA's designee must assist the court in acquiring the resource.

Subject to appropriated funds or approval of a Section 1115 demonstration waiver to fund opioid treatment medications to persons in the custody of jails, city and county jails in Washington provide medication for the treatment of OUD to individuals in the custody of the jail who were receiving medication for the treatment of OUD pursuant to a valid prescription immediately before incarceration or at least 30 days before release when treatment is determined to be medically appropriated, to the extent funds are allocated. City and county jails must make reasonable efforts to directly connect incarcerated individuals receiving medication for the treatment of OUD to an appropriate provider or treatment site.

The Department of Corrections is required to develop policies to prioritize treatment services based on available grant funding and funds appropriated specifically for opioid use disorder treatment.

Amended Bill Compared to Substitute Bill:

The amended bill:

- removes requirements that the Department of Health (DOH) study a number of issues related to integration of the prescription monitoring program (PMP) into electronic health records (EHRs) in Washington;
- states that it is the intent of the Legislature that a person with opioid use disorder should be provided with a well-coordinated plan of interventions based on evidence while preserving the patient voice, rather than a patient must be provided with a well-coordinated plan of interventions based on evidence while preserving the patient voice;
- changes the requirement that the Health Care Authority (HCA) must replicate effective treatment approaches such as the opioid hub and spoke treatment networks to broaden outreach and patient navigation, so that the HCA may replicate these approaches;
- modifies the requirements on city and county jails:
    - to provide medication assisted treatment (MAT) to persons in custody who were receiving medication for the treatment of opioid use disorder before incarceration or provide medication to persons in custody 30 days before

release if treatment is determined to be medically necessary, so that jails must only provide MAT to the extent that funding is provided through either an appropriation or approval of a Section 1115 waiver; and
        - to make every possible effort to directly connect incarcerated individuals receiving medication for the treatment of opioid use disorder to an appropriate provider or treatment site before release; instead, city and county jails are required to only make reasonable efforts to connect incarcerated individuals to an appropriate provider or treatment site.
- adds physician assistants to the definition of "prescribing professions" for purposes of the PMP, allowing the largest health professional association representing each of the prescribing professions to include physician assistants in the prescriber feedback reports; and
- requires:
    - dispensers to submit certain controlled substances prescriptions electronically beginning January 1, 2021;
    - entities or facilities with ten or more providers to integrate EHRs with the PMP beginning January 1, 2021, unless the DOH grants a waiver;
    - the Department of Corrections to develop policies to prioritize services based on available grant funding and funds appropriated specifically for opioid use disorder treatment; and
    - Medicaid and all state regulated plans to provide coverage of at least one prescription drug, without prior authorization, within the drug class of substance use disorder—opioid partial agonists as established in the Medicaid preferred drug list.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 16, relating to requiring certain controlled substances prescriptions to be transmitted to pharmacies electronically, which takes effect January 1, 2021. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) This bill is substantially similar to the House bill the committee passed out unanimously. The provision that was in the House version that requires offices with 11 or more providers to integrate their electronic health records with the prescription monitoring program (PMP) should be added back into this version of the bill. The Department of Corrections is also requesting a small technical change in relation to its responsibilities, and there is support to add in the provisions that only required city and county jails to provide medication assisted treatment (MAT) if funding is provided as is included in the House version.

This bill is a good comprehensive approach to deal with the terrible issue of the opioid epidemic. The electronic prescribing provisions are a good step and should be expanded in the future.

Although most of the bill contains a lot of positives, integration requirements are a big issue for many providers, and they appreciate that it is not required under this version of the bill. There is no opposition to integration, the opposition is to the timeline and with whom practices are required to integrate. Integrating with the current system is very costly. If the integration requirement is added back into this bill, a waiver for economic hardship like that included for electronic prescribing should also be added for integration.

(Opposed) This bill requires jails to provide MAT without funding, but actual and sufficient funding is necessary. Otherwise it is an unfunded mandate. The requirement to provide MAT is great policy and is supported by many jails. Currently jails that can afford it generally provide MAT. However, a number of jails in the state are already making significant cuts and cannot book many crimes because they do not have the resources. Medication assisted treatment requires significant staff time. The jails encourage these requirements, but need adequate resources to do it.

(Other) Some jails are already providing MAT, but some of the smaller ones are struggling. While it is good policy, section 33 from the House bill, which provides funding and some protection for the jails, should be added to this version of the bill.

The House bill requires electronic transmission of controlled substance prescriptions, which will be required by Medicare in 2021. Accordingly this bill should incorporate the House version of this section and align with the federal requirements.

Checking the PMP is vital, and so this bill should include a firm deadline to require integration between electronic health records in the state and the PMP. While some are suggesting that integration would cost $100,000, this figure comes from a single pilot study that was conducted in 2012 in Indiana for Emergency Departments. Integration is feasible for small practices. There are 25 practices that have already integrated, 40 percent of which have only a single site. There already is an exemption for practices with less than 11 providers, which is quite reasonable.

Persons Testifying: (In support) Jason McGill, Office of the Governor; Mark Johnson, Washington Retail Association; Katie Kolan, Washington Medical Association; Dave Arbaugh, OCHIN; Lisa Thatcher, Washington State Hospital Association; Emily Lovell, Washington State Dental Association; and Devon Connor-Green, Advanced Register Nurse Practitioners United of Washington.

(Opposed) Juliana Roe, Washington State Association of Counties; and James McMahan, Washington Association of Sheriffs and Police Chiefs.

(Other) Sharon Swanson, Association of Washington Cities; Jim Hedrick, Walgreens; and Kelly Richburg, Office of the Attorney General.

Persons Signed In To Testify But Not Testifying: None.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 32 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Cody, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Jinkins, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Schmick, Senn, Springer, Stanford, Steele, Sullivan, Sutherland, Tarleton, Tharinger and Ybarra.

Staff: Andy Toulon (786-7178).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The Appropriations Committee recommended changing the requirement for health care facilities, entities, offices, or provider groups to demonstrate that their federally certified electronic health record system can fully integrate with the Prescription Monitoring Program (PMP) by January 1, 2021, from applying to such entities with at least 10 "providers" to such entities with at least 10 "prescribers." The language regarding a Department of Health waiver process related to integration of data to and from the PMP is clarified to apply to specified circumstances that are not reasonably in the control of the "facilities, entities, offices, or provider groups" rather than circumstances that are not reasonably in the control of the "practitioner." Requirements for Medicaid and state regulated health plans to provide coverage without prior authorization of at least one prescription drug within the drug class of "substance use disorder-opioid partial agonists" are removed.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available. New fiscal note requested April 3, 2019.

Effective Date of Amended Bill: This bill takes effect 90 days after adjournment of the session in which the bill is passed, except for section 16, relating to requiring certain controlled substances prescriptions to be transmitted to pharmacies electronically, which takes effect January 1, 2021.

Staff Summary of Public Testimony:

(In support) None.

(Opposed) None.

Persons Testifying: None.

Persons Signed In To Testify But Not Testifying: None.