HB 838

Department of Legislative Services

Maryland General Assembly
2026 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 838 (Delegate Cullison, *et al.*)
Health Finance

State Board of Pharmacy - Prescriber-Pharmacist Agreements

This bill authorizes a pharmacist to enter into a prescriber-pharmacist agreement to treat an opioid use disorder (OUD) using controlled dangerous substances (CDS) drug therapy if the pharmacist (1) individually registers with both the Maryland Office of Controlled Substances Administration (OCSA) and the federal Drug Enforcement Agency; (2) completes any required training; and (3) follows a specified protocol. A protocol authorizing CDS drug therapy must require the pharmacist to request relevant data from the Prescription Drug Monitoring Program (PDMP) before initiating or modifying CDS drug therapy. The bill also adds licensed certified midwives to the definition of "authorized prescriber," thereby authorizing licensed certified midwives to enter into therapy management contracts. The bill repeals specified authorizations and requirements related to prescriber-pharmacist agreements. **The bill takes effect July 1, 2026.**

Fiscal Summary

State Effect: Maryland Department of Health (MDH) general fund expenditures increase by $58,600 in FY 2027 for personnel and a one-time only software update. Future year expenditures reflect ongoing costs. MDH general fund revenues increase by approximately $72,000 in FY 2027 from CDS registration fees. Future year revenues reflect growth in CDS registration applications and renewal fees beginning in FY 2030.

(in dollars)	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
GF Revenue	$72,000	$7,200	$7,200	$79,200	$14,400
GF Expenditure	$58,600	$49,000	$51,500	$54,000	$56,400
Net Effect	$13,400	($41,800)	($44,300)	$25,200	($42,000)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate increase; (-) = indeterminate decrease

Local Effect: None.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: The bill repeals the requirement for a prescriber who enters into a prescriber-pharmacist agreement to submit a copy of the agreement and any subsequent modifications to the health occupations board that regulates the prescriber. The bill also repeals the authorization for a health occupations board to enter into an agreement with the Board of Pharmacy that requires authorized prescribers to submit documentation to the Board of Pharmacy that otherwise would be required to be submitted to the health occupations board that regulates the prescriber.

However, a licensed pharmacist who enters into a prescriber-pharmacist agreement must still submit a copy of the agreement and any subsequent modifications to the Board of Pharmacy.

Current Law:

Prescriber-pharmacist Agreements

The Drug Therapy Management Program permits an authorized prescriber (a licensed physician, licensed podiatrist, or certified advanced practice nurse with prescriptive authority) and a pharmacist to enter a therapy management contract that specifies treatment protocols that may be used to provide care to a patient. A pharmacist may authorize certain patient care measures related to monitoring or improving the outcomes of drug or device therapy based on disease-specific, mutually agreed-upon protocols. Those measures include ordering laboratory tests or initiating, modifying, continuing, or discontinuing drug therapy. A protocol may not authorize acts that exceed the scope of practice of the parties in the therapy management contract, and it must prohibit the substitution of a chemically dissimilar drug product for the product prescribed, unless permitted in the contract.

Generally, an authorized prescriber who has entered a prescriber-pharmacist agreement must submit a copy of the agreement and any subsequent modifications made to the agreement or protocol to the health occupations board that oversees the prescriber. A health occupations board may enter an agreement with the Board of Pharmacy that would require authorized prescribers to submit documentation to the Board of Pharmacy instead of the health occupations board that oversees the prescriber.

A licensed pharmacist who enters a prescriber-pharmacist agreement must submit a copy of the agreement and any subsequent modifications made to the agreement or protocols to the Board of Pharmacy.

A pharmacist is authorized to enter into a prescriber-pharmacist agreement if the pharmacist (1) is licensed; (2) has a Doctor of Pharmacy degree or equivalent training; (3) is approved by the Board of Pharmacy to enter into a prescriber-pharmacist agreement with an authorized prescriber; and (4) meets any other requirements established by Maryland regulations (COMAR 10.34.29.04).

Prescription Drug Monitoring Program

Chapter 166 of 2011 established PDMP to assist with the identification and prevention of prescription drug abuse and the identification and investigation of unlawful prescription drug diversion. PDMP must monitor the prescribing and dispensing of CDS schedules II through V and naloxone medication. In general, PDMP data (1) are confidential, privileged, and not subject to discovery, subpoena, or other means of legal compulsion in civil litigation; (2) are not public records; and (3) may not be disclosed to any person, subject to specified exceptions. One of the specified exceptions requires that PDMP disclose prescription monitoring data to a dispenser, or a licensed health care practitioner authorized by the dispenser, in connection with the dispensing of a monitored prescription drug.

Opioid Use Disorders

For more information about OUD and the opioid crisis in the State, please see **Appendix – Opioid Crisis**.

State Revenues: OCSA advises that a CDS registration costs $120 for a three-year registration period. Based on current participation in drug therapy management programs, OCSA estimates that about 600 pharmacists may initially apply for CDS registration under the bill. As the program continues, OCSA anticipates about 60 new applicants annually in subsequent years.

Thus, OCSA estimates that general fund revenues from CDS registration fees may increase by up to $72,000 in fiscal 2027. Assuming about 60 applicants annually in subsequent years and renewal applications beginning in fiscal 2030, general fund revenues increase by $79,200 in fiscal 2030 and by $14,400 in fiscal 2031.

State Expenditures: OCSA advises that the anticipated increase in applications may require additional staff, as well as a one-time $1,750 programming expenditure to update the online database portal. Thus, MDH general fund expenditures increase by $58,635 in

fiscal 2027, which reflects the cost to hire one part-time (50%) administrative specialist to process increased applications for CDS registrations and the one-time only programming expenses. It includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	0.5
Salary and Fringe Benefits	$48,438
One-time Programming Expenses	1,750
Operating Expenses	8,447
Total FY 2027 State Expenditures	**$58,635**

Future year expenditures reflect a full salary with annual increases and employee turnover as well as annual increases in ongoing operating expenses.

Small Business Effect: Pharmacists at small business pharmacies may enter into new prescriber-pharmacist agreements under the bill but must obtain specified registrations and training.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced within the last three years.

Designated Cross File: SB 562 (Senator Gile) - Finance.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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Appendix – Opioid Crisis

Opioid Overdose Deaths

Between April 2016 and April 2025, nearly 23,000 individuals died from overdose in Maryland, with approximately 88% of the deaths involving opioids. During the same period, approximately 780,000 individuals died from overdoses nationally, with 72.2% of those fatalities involving opioids. Since 2021, there has been a gradual decrease in overdose deaths both in Maryland and nationally. According to preliminary data covering April 2024 through April 2025, overdose deaths have decreased in both the United States and Maryland by approximately 26% and 33%, respectively.

In Maryland, disparities in overdose fatalities persist across race, age, gender, and jurisdiction. Statewide, Black men, particularly those aged 55 and older, have the highest overdose fatality rate, which is nearly double that of white men, the group with the second highest overdose fatality rate. Across race groups, more than twice the number of males die by overdose compared to females, and individuals aged 55 and older comprise the highest number of overdose deaths among each race and gender category except for white females. The Maryland Overdose Response Advisory Council voted in June 2024 to reinstate the Racial Disparities in Overdose Task Force to study the causes of racial disparities and recommend solutions.

Although opioid overdose fatalities are problematic statewide, Baltimore City is disproportionately impacted. Between calendar 2018 and 2022, Baltimore City experienced an overdose fatality rate nearly twice that of any other U.S. city. According to the Maryland Department of Health (MDH), there were 1,296 overdose-related fatalities across the State from October 2024 to September 2025, of which 536 occurred in Baltimore City, representing approximately 41% of the State's total overdose fatalities but just 9% of the State's population.

Maryland Actions to Address the Opioid Crisis

Legislative Response: The General Assembly has passed legislation to address the opioid crisis, including prevention, treatment, overdose response, and prescribing guidelines.

- Chapters 573 and 574 of 2017 expand drug education in public schools to include heroin and opioid addiction prevention; require local boards of education to require each public school to store overdose-reversing medication; and require institutions of higher education that receive State funding to establish a policy that addresses heroin and opioid addiction and prevention.

- Chapter 570 of 2017 requires a health care provider to prescribe the lowest effective dose of an opioid and a quantity that is no greater than that needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance, with specified exceptions.

- Chapters 215 and 216 of 2018 require a health care provider to advise a patient of the benefits and risks of a prescribed opioid or co-prescribed benzodiazepine.

- Chapter 537 of 2019 establishes the Opioid Restitution Fund (ORF), a special fund to retain revenues received by the State relating to specified opioid judgments or settlements, which may be used only for opioid-related programs and services.

- Chapter 82 of 2022 requires MDH to adopt a reporting system to monitor the prescribing of medications to treat opioid use disorders (OUDs), identify and reach out to prescribers who regularly prescribe nonpreferred medications, and identify barriers to individuals who need medication to treat an OUD to obtaining the medication in a timely manner.

- Chapter 224 of 2022 requires the Prescription Drug Monitoring Program to monitor the dispensing of naloxone and maintain confidentiality of naloxone data.

- Chapter 239 of 2022 broadens existing requirements and protections relating to the administration or provision of naloxone to encompass any opioid overdose reversal drug approved by the U.S. Food and Drug Administration (FDA) and authorizes specified providers and organizations across the State to offer naloxone free of charge to individual community members.

- Chapter 408 of 2024 requires MDH to report until 2026 on (1) current opioid overdose reversal drugs approved by the FDA and (2) whether MDH has added each current FDA-approved opioid overdose reversal drug to a standing order.

- Chapter 764 of 2024 expands the Public Access Automated External Defibrillator (AED) Program to include an initiative to locate up to two doses of naloxone with each AED in a public building.

- Chapter 886 of 2024 requires hospitals, beginning January 1, 2025, to establish protocols to provide appropriate care for patients admitted for opioid-related conditions, including overdose, possess specified medication for the treatment of

OUD, and treat a patient who presents in an emergency room for opioid-related overdose or emergency medical condition, as specified.

- Chapter 759 of 2025 establishes a Buprenorphine Training Grant Program to support counties in training paramedics in administering buprenorphine.

Maryland has a statewide standing order for opioid overdose reversal drugs that authorizes any Maryland-licensed pharmacist to dispense unlimited prescriptions and refills of naloxone and devices for its administration to any individual, as specified. A pharmacist must provide consultation with the individual regarding the naloxone dosage that is most appropriate, select and dispense two doses of naloxone, and provide directions for use. If a patient cannot afford naloxone or related copayments, or does not wish to use insurance coverage, pharmacists are instructed to refer them to the nearest Overdose Response Program, a community organization providing overdose prevention education and supplies, where individuals can obtain a naloxone kit free of charge.

Opioid Manufacturer and Distributor Settlements: In October 2020, the U.S. Department of Justice announced a global resolution of its criminal and civil investigations of opioid manufacturer Purdue Pharma. After multiple rejected settlements and appeals, Purdue agreed to a $7.4 billion national settlement that was approved by a federal judge in November 2025.

The State was part of several other settlements, including ones with McKinsey & Company, Johnson & Johnson, Walmart, Walgreens, Allergan, Teva, and Publicis Health. All settlement revenues are allocated to ORF, as described below.

Opioid Restitution Fund: Through the end of fiscal 2025, Maryland has received more than $245.8 million from opioid settlements. By October 2038, the State is projected to receive more than $670.8 million in opioid settlement revenue, which is split between local jurisdictions and ORF.

While each Maryland county will receive block grant funding through ORF, Baltimore City will receive ORF funds from just one settlement, as it opted out of all other settlements to pursue separate litigation in pursuit of higher award amounts. As of September 2025, Baltimore City has announced nearly $580 million in separate settlement awards, with additional settlements in progress.

Under the National Opioid Settlement, Maryland's settlement revenues are directed into four distinct funding streams for expenditure; the amount in each stream must ultimately reach a specified percentage of total awards, with only 75% flowing through ORF, as follows:

- **Local Direct Funds (25%):** Direct payments from settlement administrators to participating subdivisions. As of the end of fiscal 2025, this accounts for approximately $53.6 million in revenues paid directly to local jurisdictions.
- **Targeted Abatement Grant Funds (45%):** Funds deposited into ORF that must be used for formula-based grants for participating subdivisions. As of the end of fiscal 2025, this accounts for approximately $97.0 million in ORF revenues.

- **State Discretionary Abatement Fund (15%):** Funds that must be made available for competitive grants. As of the end of fiscal 2025, this accounts for approximately $38.0 million in ORF revenues.

- **State Allocation Funds (15%):** Funds that may be spent at the State's discretion, within allowable parameters. As of the end of fiscal 2025, this accounts for approximately $57.3 million in ORF revenues.

Generally, legislative mandates and initiatives are funded with State Allocation Funds. Through the end of fiscal 2025, $14.4 million of the $57.3 million in State Allocation Funds received has been expended; another $34.5 million is allocated for future spending through 2038. Thus, approximately $8.4 million of State Allocation Funds received remains available for future discretionary spending. In addition, the Maryland Office of Overdose Response (MOOR) anticipates receiving an additional $64.7 million in State Allocation Funds through 2038.

Recent legislative initiatives funded through this revenue stream include co-location of naloxone with AED units (per Chapter 764); operating and personnel expenses for the Office of the Attorney General's Opioids Enforcement Unit related to investigation and enforcement of opioid settlements (per Chapters 700 and 701 of 2025); and development of an interactive dashboard to report on settlement revenue and the use of ORF (per Chapters 690 and 691 of 2025). Other current uses of this funding include salaries for MOOR staff and the Opioid Policy Advisor in the Lieutenant Governor's Office and a Medicaid waiver for medications for opioid use disorder (MOUD). Additionally, provisions in the fiscal 2026 budget temporarily expanded the allowable uses of ORF to supplement general funds for the buprenorphine initiative under the Behavioral Health Administration and MOUD in correctional and pre-trial detention facilities.