The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Young, Chair
Senator Passidomo, Vice Chair

MEETING DATE: Tuesday, January 16, 2018
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Young, Chair; Senator Passidomo, Vice Chair; Senators Benacquisto, Book, Hukill, Hutson, Montford, and Powell

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 8** Benacquisto (Similar CS/H 21, Compare H 1159, S 458)	Controlled Substances; Authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial renewal; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; requiring certain pain management clinic owners to register approved exemptions with the department; providing requirements for pharmacists and practitioners for the dispensing of controlled substances to persons not known to them; establishing direct-support organizations for specified purposes; requiring a direct-support organization to operate under written contract with the department, etc. HP 01/10/2018 Workshop-Discussed HP 01/16/2018 Fav/CS AP RC	Fav/CS Yeas 8 Nays 0
2	**SB 138** Book (Similar H 937)	Perinatal Mental Health; Citing this act as the "Florida Families First Act"; requiring the Department of Health to create public service announcements to educate the public on perinatal mental health care; revising components that are included in the postpartum evaluation and followup care provided by birth centers to include a mental health screening and the provision of certain information on postpartum depression, etc. HP 01/16/2018 Favorable AHS AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 474** Brandes (Similar H 1339, Compare H 1341, Linked S 476)	Physician Orders for Life-sustaining Treatment; Establishing the Physician Orders for Life-Sustaining Treatment (POLST) Program within the Department of Health; requiring the Agency for Health Care Administration to establish and maintain a database of compassionate and palliative care plans by a specified date; authorizing specified personnel to withhold or withdraw cardiopulmonary resuscitation if presented with a POLST form that contains an order not to resuscitate the patient; requiring the Department of Elderly Affairs, in consultation with the agency, to adopt by rule procedures for the implementation of POLST forms in hospice care, etc. HP 01/16/2018 Favorable AHS AP	Favorable Yeas 6 Nays 2
4	**SB 476** Brandes (Similar H 1341, Compare H 1339, Linked S 474)	Public Records/Compassionate and Palliative Care Plans/Agency for Health Care Administration; Creating an exemption from public records for personal identifying information in compassionate and palliative care plans filed with the Clearinghouse for Compassionate and Palliative Care Plans managed by the Agency for Health Care Administration or its designee; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc. HP 01/16/2018 Fav/CS GO RC	Fav/CS Yeas 8 Nays 0
5	**SB 764** Bean (Identical H 369)	Dental Student Loan Repayment Program; Establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas, etc. HP 01/16/2018 Favorable AHE AP	Favorable Yeas 8 Nays 0
6	**SB 800** Braynon (Identical H 579)	Infectious Disease Elimination Pilot Programs; Citing this act as the “Florida Infectious Disease Elimination Act (IDEA)”; authorizing the Department of Health to establish sterile needle and syringe exchange pilot programs upon request from eligible entities, rather than a single program established in Miami-Dade County, etc. HP 01/16/2018 Favorable AHS AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 906** Young (Similar CS/CS/H 551)	Public Records/Health Care Facilities; Providing an exemption from public records requirements for building plans, blueprints, schematic drawings, and diagrams held by an agency which depict the internal layout or structural elements of certain health care facilities; providing for future legislative review and repeal of the exemption; providing a statement of public necessity, etc. HP 01/16/2018 Fav/CS GO RC	Fav/CS Yeas 8 Nays 0
8	**SB 1134** Rouson (Identical H 6049)	Medical Marijuana Treatment Center Licensure; Revising a requirement that the Department of Health license one applicant who is a member of a certain class to exclude a requirement that the applicant also be a member of the Black Farmers and Agriculturalist Association-Florida Chapter, etc. HP 01/16/2018 Fav/CS AP RC	Fav/CS Yeas 8 Nays 0

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 8
INTRODUCER:	Health Policy Committee; Senator Benacquisto and others
SUBJECT:	Controlled Substances
DATE:	January 17, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			AP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 8 amends various sections of law to increase the regulation, training, and reporting required when prescribing and dispensing controlled substances. The bill:

- Restricts Medicaid managed care plans and health insurers from requiring prior authorization or step therapy or imposing any other conditions as a prerequisite to receiving medication-assisted treatment (MAT) services.
- Requires all prescribing practitioners to complete a two-hour training course on the proper manner to prescribe controlled substances.
- Requires applicable health care regulatory boards to create guidelines for prescribing controlled substances for the treatment of acute pain.
- Limits to no more than three days of opioids listed in Schedule II to treat acute pain as defined. This limit is increased to seven days if determined to be medically necessary by the prescribing practitioner and with proper documentation.
- Requires clinics that are exempt from the requirement to register as a pain management clinic to obtain a certificate of exemption from the DOH.
- Requires pharmacists and dispensing practitioners to verify a patient's identity prior to dispensing controlled substances.
- Conforms an exemption allowing health care practitioners to dispense controlled substances in connection with a surgical procedure to the limits on prescribing established for Schedule II opioid medications.

- Creates an exemption to allow a physician to dispense Schedule II and III controlled substances approved by the United States Food and Drug Administration (FDA) for the MAT of his or her own patients.
- Adds and reschedules substances to the various schedules of controlled substances.
- Substantially rewords the Prescription Drug Monitoring Program (PDMP) with changes including, but not limited to:
  - Including Schedule V controlled substances in the list of drugs that must be reported to the PDMP and eliminating an exemption for reporting controlled substances dispensed to minors under the age of 16;
  - Requiring prescribing practitioners to consult the PDMP before prescribing controlled substances; and
  - Allowing the DOH to coordinate and share Florida's PDMP data with other state's PDMPs.

II. Present Situation:

Opioid Abuse in Florida

Both nationally and in Florida, opioid addiction and abuse has become an epidemic. By nearly every measure, the opioid crisis has become worse in recent years. The Florida Department of Law Enforcement (FDLE) reported that, when compared to 2015, 2016 saw:

- 5,725 (35 percent more) opioid-related deaths;
- 6,658 (24 percent more) individuals died with one or more prescription drugs in their system;[1]
- 3,550 (40 percent more) individuals died with at least one prescription drug in their system that was identified as the cause of death;
- Occurrences of heroin increased by 31 percent and deaths caused by heroin increased by 30 percent;
- Occurrences of fentanyl increased by 80 percent and deaths caused by fentanyl increased by 97 percent;
- Occurrences of methadone (10 percent) and hydrocodone (2 percent) increased. Deaths caused by methadone (40 more) and hydrocodone (9 more) also increased;
- Occurrences of morphine increased by 38 percent and deaths caused by morphine increased by 49 percent;
- Occurrences of oxycodone increased by 28 percent and deaths caused by oxycodone also increased by 28 percent; and
- Occurrences of buprenorphine increased by 90 percent and deaths caused by buprenorphine (14 more) increased.[2]

Additionally, collateral impacts of controlled substance and opioid misuse have increased. For example, between 2007 and 2015 the instance of neonatal abstinence syndrome, an infant

[1] The drugs were identified as either the cause of death or merely present in the decedent. These drugs may have also been mixed with illicit drugs and/or alcohol. These drugs were not necessarily opioids.
[2] FDLE, *Drugs Identified in Deceased Persons by Florida Medical Examiners 2016 Annual Report* (Nov. 2017) https://www.fdle.state.fl.us/MEC/Publications-and-Forms/Documents/Drugs-in-Deceased-Persons/2016-Annual-Drug-Report.aspx (last visited on Jan. 6, 2018).

disorder that occurs when babies are exposed to drugs in the womb before birth, increased by nearly 500 percent from 536 cases to 2,487 cases and overall hospital costs that can be attributed to the opioid crisis have more than doubled between 2010 and 2015 from $460 million to $1.1 billion.[3]

History of the Opioid Crisis

In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and healthcare providers began to prescribe them at greater rates. This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive.[4] Between the early 2000s and the early 2010s, Florida was infamous as the "pill mill capital" of the country. During that time, 93 of the top 100 oxycodone dispensing doctors in the United States were in Florida[5] and, at one point, doctors in Florida bought 89 percent of all the Oxycodone sold in the county.[6]

Between 2009 and 2011, the Legislature enacted a series of reforms to combat prescription drug abuse. These reforms included strict regulation of pain management clinics; creating the PDMP; and stricter regulation on selling, distributing, and dispensing controlled substances.[7] Between 2010 and 2014, deaths from prescription drugs dropped but deaths from illegal opioids, such as heroin, began to rise.[8]As can been seen in the data above, however, more recently deaths from prescription controlled substances are once again on the rise. Early in 2017, the United States Centers for Disease Control and Prevention (CDC) declared the opioid crisis an epidemic and shortly thereafter, on May 3, 2017, Governor Rick Scott signed executive order 17-146 declaring the opioid epidemic a public health emergency in Florida.

The Federal government and many states have mobilized to combat the opioid epidemic. The United States Department of Health and Human Services (HHS) has focused its efforts on five major priorities:

- Improving access to treatment and recovery services;
- Promoting use of overdose-reversing drugs;
- Strengthening our understanding of the epidemic through better public health surveillance;
- Providing support for cutting-edge research on pain and addiction; and
- Advancing better practices for pain management.[9]

Individual states have taken actions to combat the opioid crisis such as increasing the availability of Naloxone and other related medications to prevent overdose deaths, increasing the availability

[3] Florida Behavioral Health Association, *Florida's Opioid Crisis* (Jan. 2017) http://www.fadaa.org/links/Opioid%20Media%20Kit_FINAL.pdf, (last visited on Jan. 6, 2018).
[4] National Institute on Drug Abuse, *Opioid Overdose Crisis*, (Jan. 2018) https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis (last visited on Jan. 6, 2018).
[5] Elaine Silvestrini, *Florida heals from pill mill epidemic*, TAMPA BAY TIMES, Aug. 30, 2014, *available at* http://www.tbo.com/news/crime/florida-heals-from-pill-mill-epidemic-20140830/ (last visited on Jan. 6, 2018).
[6] Lizette Alvarez, *Florida Shutting 'Pill Mill' Clinics*, THE NEW YORK TIMES, Aug. 31, 2011, available at http://www.nytimes.com/2011/09/01/us/01drugs.html (last visited on Jan. 6, 2018).
[7] See chs. 2009-198, 2010-211, and 2011-141, Laws of Fla.
[8] Supra note 3
[9] Supra note 4

and funding of MAT, and establishing stricter guidelines and regulations on the prescribing and dispensing of controlled substances.

Medication-Assisted Treatment

Medication-assisted treatment is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders.[10] Medications including buprenorphine (Suboxone and Subutex), methadone, and extended release naltrexone (Vivitrol) are effective in treating opioid use disorders. Contrary to some beliefs, MAT medications do not substitute one addiction for another since, when properly administered, MAT medications do not cause a high but serve to reduce opioid cravings and withdrawal. Additionally, diversion of buprenorphine is uncommon and when diversion does occur it is primarily used to manage withdrawal symptoms. Patients treated with medications were more likely to remain in therapy compared to patients receiving treatment without medication.[11]

State and Federal Prescribing Guidelines

CDC Prescribing Guidelines

When prescribing opioids, the CDC has established guidelines to reduce the risk of addiction and dependency. These guidelines are applicable to both chronic and acute pain and include:

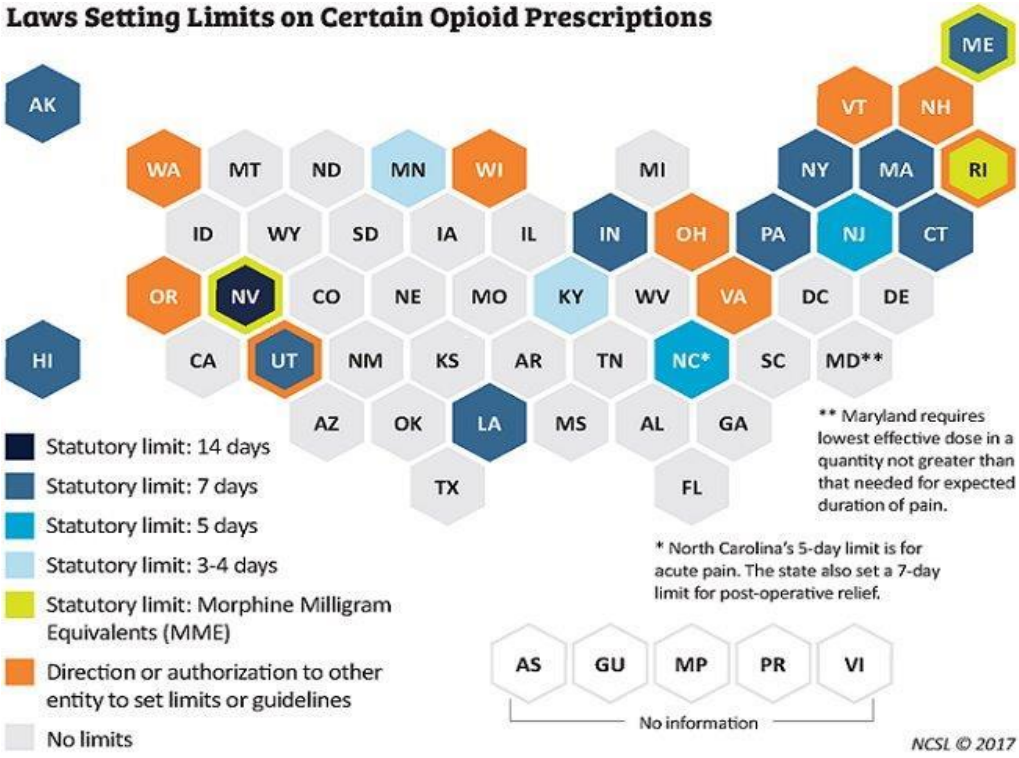
- Not using opioids as first-line therapy.
- Establishing realistic goals for pain and function and discontinuing opioid therapy if the benefits do not outweigh the risks.
- Discussing the risks and benefits with patients before and during opioid therapy.
- Using immediate-release opioids at first and use the lowest effective dose.
- Prescribing short durations for acute pain. The CDC states that, generally, three days or less will be sufficient and more than seven days will rarely be needed.
- Evaluating benefits and harms frequently (within one to four weeks of starting and at least every three months).
- Reviewing PDMP data, use urine drug testing, and avoid prescribing opioids and benzodiazepine concurrently.
- Offering treatment for opioid use disorders.[12]

State Opioid Prescription Limits

Beginning in 2016, more than 30 states have considered at least 130 bills related to opioid prescribing and 24 states have enacted legislation that imposes some type of limit, guideline, or requirement related to opioid prescribing. Most legislation limits first time opioid prescriptions to a certain number of days' supply with seven days being most common. Some states have set limits as low as three days and as high as 14 days. In some cases, states may also set dosage

[10] MAT overview, Substance Abuse and Mental Health Services Administration, available at https://www.integration.samhsa.gov/clinical-practice/mat/mat-overview, (last visited on Jan. 17, 2018).
[11] Effective Treatments of Opioid Addiction, National Institute on Drug Abuse, available at https://www.drugabuse.gov/publications/effective-treatments-opioid-addiction/effective-treatments-opioid-addiction, (last visited Jan. 17, 2018).
[12] CDC Guidelines for Prescribing Opioids for Chronic Pain https://www.cdc.gov/drugoverdose/pdf/guidelines_at-a-glance-a.pdf. (last visited Jan. 10, 2018).

limits using morphine milligram equivalents. Most states also specify that the dosage limits are for acute pain only or exclude chronic pain, palliative care, and cancer treatment.[13] Specific states' laws can be seen on the map below:



Florida's Prescription Drug Monitoring Program

Chapter 2009-197, Laws of Fla., established the PDMP in s. 893.055, F.S. The PDMP uses a comprehensive electronic system/database to monitor the prescribing and dispensing of certain controlled substances.[14] The PDMP became operational on September 1, 2011, when it began receiving prescription data from pharmacies and dispensing practitioners.[15] Dispensers have reported over 232 million controlled substance prescriptions to the PDMP since its inception.[16] Health care practitioners began accessing the PDMP on October 17, 2011.[17] Law enforcement agencies began requesting data from the PDMP in support of active criminal investigations on November 14, 2011.[18]

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[13] Prescribing policies: States Confront Opioid Overdose Epidemic, National Conference of State Legislatures, http://www.ncsl.org/research/health/prescribing-policies-states-confront-opioid-overdose-epidemic.aspx (last visited Jan. 10, 2018). A table of specific legislation is also available at this site under the tab: "Table: Legislation."
[14] Section 893.055(2)(a), F.S.
[15] Florida Dep't of Health, *2012-2013 Prescription Drug Monitoring Program Annual Report* (Dec. 1, 2013), *available at* http://www.floridahealth.gov/reports-and-data/e-forcse/news-reports/_documents/2012-2013pdmp-annual-report.pdf (last visited on Jan. 7, 2018).
[16] Florida Dep't of Health, *2016-2017 Prescription Drug Monitoring Program Annual Report* (Dec. 1, 2017), *available at* http://www.floridahealth.gov/statistics-and-data/e-forcse/funding/2017PDMPAnnualReport.pdf (last visited on Jan. 7, 2017).
[17] *Supra* note 13
[18] *Supra* note 13

Dispensers of controlled substances listed in Schedule II, Schedule III, or Schedule IV[19] must report specified information to the PDMP database by the close of the next business day after dispensing, each time the controlled substance is dispensed. The information required to be reported includes:[20]

- Name of the dispensing practitioner and Drug Enforcement Administration registration number, National Provider Identification, or other applicable identifier;
- Date the prescription is dispensed;
- Name, address, and date of birth of the person to whom the controlled substance is dispensed; and
- Name, national drug code, quantity, and strength of the controlled substance dispensed.[21]

Current law exempts certain acts of dispensing or administering from PDMP reporting:

- A health care practitioner when administering a controlled substance directly to a patient if the amount of the controlled substance is adequate to treat the patient during that particular treatment session.
- A pharmacist or health care practitioner when administering a controlled substance to a patient or resident receiving care as a patient at a hospital, nursing home, ambulatory surgical center, hospice, or intermediate care facility for the developmentally disabled which is licensed in this state.
- A practitioner when administering or dispensing a controlled substance in the health care system of the Department of Corrections.
- A practitioner when administering a controlled substance in the emergency room of a licensed hospital.
- A health care practitioner when administering or dispensing a controlled substance to a person under the age of 16.
- A pharmacist or a dispensing practitioner when dispensing a one-time, 72-hour emergency resupply of a controlled substance to a patient.
- A rehabilitative hospital, assisted living facility, or nursing home dispensing a certain dosage of a controlled substance, as needed, to a patient while the patient is present and receiving care as ordered by the patient's treating physician.[22]

Accessing the PDMP database

Section 893.0551, F.S., makes certain identifying information[23] of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is contained in records

[19] Currently, Florida is one of 16 states that do not require the dispensing of Schedule V controlled substances to be reported to their state's PDMP. For more details please see http://pdmpassist.org/pdf/PDMP_Substances_Tracked_20171205.pdf, (last visited on Jan. 8, 2018).
[20] The specific information reported depends upon the whether the reporter is a pharmacy or practitioner.
[21] *See* s. 893.055(3), F.S.
[22] Section 893.055(5), F.S.
[23] Such information includes name, address, telephone number, insurance plan number, government-issued identification number, provider number, and Drug Enforcement Administration number, or any other unique identifying information or number.

held by the department under s. 893.055, F.S., confidential and exempt from the public records laws in s. 119.07(1), F.S., and in article I, section 24(a) of the State Constitution.[24]

Direct access to the PDMP database is presently limited to medical doctors, osteopathic physicians, dentists, podiatric physicians, advanced registered nurse practitioners, physician assistants, and pharmacists, and their designees.[25] Currently, prescribers are not required to consult the PDMP database before prescribing a controlled substance for a patient, however physicians and pharmacists queried the database more than 3.7 million times in 2012, over 9.3 million times in 2014, over 18.6 million times in 2015, and over 35.8 million times in 2016.[26] Qualified physicians who are issuing physician certifications for the medical use of marijuana under s. 381.986, F.S., are currently required to review the patient's controlled drug prescription history in the PDMP.[27]

Indirect access to the PDMP database is provided to:
- The DOH or certain health care regulatory boards;
- The Attorney General for Medicaid fraud cases;
- Law enforcement agencies during active investigations[28] involving potential criminal activity, fraud, or theft regarding prescribed controlled substances if the law enforcement agency has entered into a user agreement with the DOH;
- Patients, or the legal guardians or designated health care surrogates of incapacitated patients; and
- Impaired practitioner consultants.[29]

Indirect access means the person must request the information from the PDMP manager. After an extensive process to validate and authenticate the request and the requestor, the PDMP manager or support staff provides the specific information requested.[30]

Controlled Substances

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances. The scheduling of substances in Florida law is generally consistent with the Federal scheduling of substances under 21 U.S.C. s. 812:
- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples: heroin and methaqualone.

[24] Section 893.0551(2)(a)-(h), F.S.
[25] Section 893.055(7)(b), F.S.
[26] *Supra* notes 14 and 15.
[27] See s. 381.986(4)(a)5., F.S.
[28] Section 893.055(1)(h), F.S., defines an "active investigation" as an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.
[29] Section 893.055(7)(c)1.-5., F.S.
[30] See s. 893.055(7)(c), F.S., and Rule 64k-1.003, F.A.C.

- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples: cocaine and morphine.
- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples: lysergic acid; ketamine; and some anabolic steroids.
- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples: alprazolam; diazepam; and phenobarbital.
- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples: low dosage levels of codeine; certain stimulants; and certain narcotic compounds.

Pain Management Clinics

A pain management clinic is any facility that either advertises pain management services or a facility where a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.[31] Pain management clinics must register with the DOH and meet provisions concerning staffing, sanitation, recordkeeping, and quality assurance.[32] Certain clinics are exempt from these provisions if they are:

- Licensed as a hospital, ambulatory surgical center, or mobile surgical facility;
- Staffed primarily by surgeons;
- Owned by a publicly-held corporation with total assets exceeding $50 million;
- Affiliated with an accredited medical school;
- Not involved in prescribing controlled substances for the treatment of pain;
- Owned by a corporate entity exempt from federal taxation as a charitable organization;
- Wholly owned and operated by board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or
- Wholly owned and operated by a physician multispecialty practice with physicians holding credentials in pain medicine and who perform interventional pain procedures routinely billed using surgical codes.

All clinics must be owned by at least one licensed physician or be licensed as a health care clinic under part X of ch. 400, F.S., to be eligible for registration as a pain management clinic. Pain management clinics must also designate a physician who is responsible for complying with all the registration and operation requirements designated in ss. 458.3265 or 459.0137, F.S. A pain management clinic may not be owned by, or have a contractual or employee relationship with, a

[31] "Chronic nonmalignant pain" is defined as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain for more than 90 days after surgery. See ss. 458.3265 and 459.0137, F.S.
[32] Sections 458.3265 and 459.0137, F.S. Chapter 458, F.S., is the Medical Practice Act, and Chapter 459, F.S., is the Osteopathic Medical Practice Act. The two sections regulating pain management clinics are substantively identical.

physician who has had his or her Drug Enforcement Administration (DEA) license number revoked, has had his or her application for a license to practice using controlled substances denied by any jurisdiction, or has had any convictions or pleas for illicit drug felonies within the past 10 years.

The DOH is required to conduct an annual inspection of each pain management clinic. Through the inspection, the DOH ensures the following requirements are met:

- The pain management clinic is registered with the DOH and the DOH has been notified of the designated physician;
- Every physician meets the training requirements to practice at the clinic;
- The clinic, including its grounds, buildings, furniture, appliances and equipment, is structurally sound, in good repair, clean, and free from health and safety hazards;
- Storage and handling of prescription drugs complies with ss. 499.0121 and 893.07, F.S.;
- Physicians maintain control and security of prescription blanks and other methods for prescribing controlled substances and report in writing any theft or loss of prescription blanks to the DOH within 24 hours;
- Physicians are in compliance with the requirements for counterfeit-resistant prescription blanks; and
- The designated physician has reported all adverse incidents to the DOH as set forth in s. 458.351, F.S.[33]

The DOH may suspend or revoke a clinic registration or impose administrative fines of up to $5,000 per violation for any offenses against state pain management clinic provisions or related federal laws and rules. If the registration for a pain management clinic is revoked for any reason, the clinic must cease to operate immediately, remove all signs or symbols identifying the facility as a pain management clinic, and dispose of any medication on the premises. The DOH may impose an administrative fine of up to $5,000 per day for a clinic that operates without a registration, unless exempt. No owner or operator of a pain management clinic that had its registration revoked may own or operate another pain clinic for five years after such revocation.[34]

Currently, if a pain clinic meets one of the statutorily approved exemptions from registering with the department, they are not required to register or to show proof of a valid exemption from registration nor are they required to meet any of the requirements set forth above. The determination as to whether the pain clinic meets one of the exemptions is made by the owner of the pain clinic and the department is unaware of which approved exemption the unregistered clinic meets and, without a formal complaint being filed, does not have the authority to inquire. If a clinic no longer qualifies for an exemption they are required to register, however because the department is not aware of clinics that qualify for an exemption from registration and inspection, it is also not aware when the clinic no longer meets the criteria for an exemption from registration.[35]

[33] Department of Health, *Senate Bill 450 Analysis* (2016) (on file with the Senate Committee on Health Policy).
[34] Section 458.3265, F.S. Similar language is found in s. 459.0137, F.S. Related rules are found in Rules 64B8-9 and 64B15-14, F.A.C.
[35] DOH, *Senate Bill 8 Analysis* (Oct. 23, 2017) (on file with the Senate Committee on Health Policy).

In 2010 when pain management clinic registration was first required by law there were 921 registered pain management clinics. At the end of 2016-2017 fiscal year, there were 259. It is indeterminate how many clinics closed voluntarily because they could not meet the more stringent requirements established by law and how many were no longer registered because they self-determined they operated under one of the exemptions outlined earlier in this section.[36]

III. Effect of Proposed Changes:

CS/SB 8 amends and creates various sections of law related to controlled substances.

Sections 1 and 9 amend ss. 409.967 and 627.42392, F.S., respectively, to restrict Medicaid managed care plans and health insurers from requiring prior authorization or step therapy or imposing any other conditions as a prerequisite to receiving MAT services. Section 627.42392, F.S., defines "health insurer" to include health insurers, managed care plans, and health maintenance organizations.

Section 2 creates s. 456.0301, F.S., to require that, if not already required under a licensee's individual practice act, each appropriate board must require each practitioner licensed with the DEA and authorized to prescribe controlled substances to complete a board-approved two-hour continuing education course on prescribing controlled substances when renewing his or her license.[37] Each licensee must submit confirmation of completing the course when applying for licensure renewal and the DOH is prohibited from renewing the license of any practitioner who has failed to complete the course. The course may be offered in a distance learning format and be included within the number of continuing education hours required by law. The course must include:

- Information on the current standards regarding prescribing controlled substances, particularly opiates;
- Alternatives to these standards; and
- Information on the risks of opioid addiction following all stages of treatment in the management of acute pain.

Each board may adopt rules to implement the required course.

Section 3 amends s. 456.072, F.S., to add violations of ss. 893.055 or 893.0551, F.S., relating to the PDMP and the public records exemption for the PDMP, to the list of actions that constitute grounds for disciplinary action against a health care practitioner.

Section 4 amends s. 456.44, F.S., to establish standards for the treatment of acute pain.

The bill defines the term "acute pain" to mean the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness. The applicable regulatory boards are required to adopt rules establishing guidelines for prescribing controlled substances for acute pain including:

- Evaluating the patient;

[36] Id.
[37] Beginning on January 31, 2019.

- Creating and maintaining a treatment plan;
- Obtaining informed consent;
- Periodic review of the treatment plan;
- Consultation;
- Medical record review; and
- Compliance with controlled substances laws and regulations.

The bill specifies that failure to follow the guidelines is a practice act violation.

The bill also restricts a practitioner from prescribing more than a three-day supply of an opioid listed in Schedule II when treating acute pain except that up to a seven-day supply may be prescribed if:

- The practitioner in his or her professional judgement believes that more than a three-day supply is medically necessary;
- The practitioner indicates "medically necessary" on the prescription; and
- The practitioner adequately documents in the patient's medical record the acute patient's acute condition and lack of alternative treatment options.

Sections 5 and 6 amend ss. 458.3265, and 459.0137, F.S., respectively, to require clinics that are exempt from registration as pain management clinics to obtain a certificate of exemption from the DOH. The bill requires the DOH to adopt an application form in rule for a certificate of exemption. The form must include:

- The name or names under which the applicant does business;
- The address where the pain management clinic is located;
- The specific exemption the applicant is claiming, with supporting documentation; and
- Any other information deemed necessary by the DOH.

The DOH must approve or deny a certificate within 30 days and certificates must be renewed biennially.[38] A certificate holder must prominently display the certificate and make it available to the DOH or board upon request. A new certificate is required for a change of address and certificates are only valid for the applicant, owners, licenses, registrations, certifications, and services provided under the specific exemption claimed. A certificate holder must notify the DOH at least 60 days before any anticipated relocation, name change, or change of ownership. If a pain management clinic ceases to qualify for a certificate of exemption, the certificate holder must notify the DOH within three days and register as a pain management clinic or cease operations.

These sections take effect January 1, 2019.

Sections 7 and 8 amend ss. 465.0155 and 465.0276, F.S., to require pharmacists and dispensing practitioners to confirm a person's identity before dispensing controlled substances to that person if he or she is not personally known to the pharmacist. If the person does not have proper

[38] The DOH may issue initial certificates for three years in order to stagger renewal dates.

identification[39] the dispenser must verify the validity of the prescription and the identity of the patient with the prescriber or his or her agent. This requirement does not apply in an institutional setting or long-term care facility, including, but not limited, to an assisted living facility or a hospital.

Section 8 also amends several provisions in s. 465.0276, F.S., related to the dispensing of controlled substances by health care practitioners. Current law allows health care practitioners who are authorized to prescribe medicinal drugs to dispense such drugs if they are registered with their professional licensing boards. However, current law also restricts such practitioners from dispensing Schedule II or III controlled substances unless there is a specific exemption that allows them to do so. One such exemption allows practitioners to dispense up to a 14-day supply of Schedule II or III controlled substances in connection with the performance of a surgical procedure. The bill amends this exemption to require that practitioners follow the prescribing limits established in section four of the bill when dispensing Schedule II controlled substances under the exemption. The bill also creates a new exemption for practitioners authorized under 21 U.SC. 823[40] to dispense Schedule II or III controlled substances that are approved for MAT by the FDA to their own patients for MAT of opiate addiction.

Section 10 amends s. 893.03, F.S., to add substances to lists of controlled substances as follows:

- Dihydroetorphine, hydrocodone combination products, oripavine, remifentanil, tapentadol, thiafentanil, lisdexamfetamine, and dornabinol (synthetic THC) in oral solution in a drug product approved by the FDA are added to Schedule II.
- Buprenorphine,[41] embutramide, and perampanel are added to Schedule III.
- Alfaxalone, dexfenfluramine, dichloralphenazone, eluxadoline, eszopiclone, fospropofol, lorcaserin, modafinil, petrichloral, sibutramine, suvorexant, tramadol, zaleplon, zolpidem, and zopiclone are added to Schedule IV.
- Not more than .5 milligrams of difenoxin and not less than 25 micrograms of atropine sulfate per dose and any amount of brivaracetum, ezogabine, lacosamide, and pregabalin are added to Schedule V.

These changes conform Florida law with federal law.[42]

Section 11 substantially rewords s. 893.055, F.S., creating the PDMP. Many of the provisions in existing law are reordered. The section:

- Defines the terms:
  - "Active investigation" to mean an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a

[39] The bill defines "proper identification" as an identification that is issued by a state or federal government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B). The verification of health plan eligibility is also considered to be proper identification.
[40] Such practitioners include qualifying physicians (who must be licensed under state law and hold a specialty in addiction treatment or has had specified training) and nurse practitioners and physician assistants who are supervised by, or working in collaboration with, a qualifying physician.
[41] Buprenorphine is rescheduled from Schedule V to Schedule III.
[42] Supra note 33

reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.
    - "Administration" to mean the obtaining and giving of a single dose of controlled substance by a legally authorized person to a patient for her or his consumption.
    - "Controlled substance" to mean a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03 or 21 U.S.C. s. 812. Schedule Vs are added to the reporting requirements. Most states include the dispensing of Schedule V controlled substances in their PDMPS.[43]
    - "Dispense" to mean the transfer of possession of one or more doses of a controlled substance by a dispenser to the ultimate consumer or to his or her agent.
    - "Dispenser" to mean a dispensing health care practitioner, pharmacy or pharmacist licensed to dispense controlled substances in or into this state.
    - "Health care practitioner" or "practitioner" means any practitioner licensed under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, chapter 465, or chapter 466.
    - "Health care regulatory board" has the same meaning as s. 456.001(1), F.S.
    - "Law enforcement agency" to mean the Department of Law Enforcement, a sheriff's office in this state, a police department in this state, or a law enforcement agency of the Federal Government which enforces the laws of this state or the United States relating to controlled substances, and which its agents and officers are empowered by law to conduct criminal investigations and make arrests.
    - "Pharmacy" to include a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, or an Internet pharmacy that is licensed by the department under chapter 465 and that dispenses or delivers controlled substances, including controlled substances to an individual or address in this state.
    - "Prescriber" to mean a prescribing physician, prescribing practitioner, or other prescribing health care practitioner authorized by the laws of this state to order controlled substances.
    - "Program manager" to mean an employee of or a person contracted by the department who is designated to ensure the integrity of the prescription drug monitoring program in accordance with the requirements established in this section.
- Requires the DOH to maintain an electronic system to collect and store controlled substance dispensing information and must release the information as authorized in s. 893.0551, F.S.[44] The system must:
    - Not infringe on legitimate prescribing and dispensing of controlled substances;
    - Be consistent with standards of the American Society for Automation in Pharmacy; and
    - Comply with Health Insurance Portability and Accountability Act (HIPAA) and all other relevant state and federal privacy and security laws and regulations;
- Allows the DOH to collaborate with health care regulatory boards, appropriate organizations, and other state agencies to identify indicators of controlled substance abuse.
- When dispensing a controlled substance to a patient, requires the dispenser to report the following information to the PDMP no later than the close of business the day after the controlled substance was dispensed:

[43] Supra note 13
[44] Section 893.0551, F.S., establishes the public records exemption for information in the PDMP.

  - The name of the prescribing practitioner, his or her DEA registration number, his or her National Provider Identification (NPI), and the date of the prescription.
  - The date the prescription was filled and the method of payment.
  - The full name, address, telephone number, and date of birth of the person for whom the prescription as written.
  - The name, national drug code, quantity, and strength of the controlled substance dispensed.
  - The full name, DEA registration number, DOH pharmacy permit number, and address of the pharmacy where the controlled substance was dispensed or, if dispensed by a practitioner other than a pharmacist, the practitioner's name, address, DEA registration number, DOH license number, and NPI.
  - Whether the drug was dispensed as an initial prescription or a refill and the number of refills ordered;
  - The name of the individual picking up the controlled substance prescription and type of identification provided;
  - Other appropriate identifying information as determined by the DOH in rule;
- Exempts all acts of administration from the reporting requirement.
- Eliminates an exemption for reporting the dispensing of controlled substances to minors under the age of 16.
- Grants direct access to the system to:
  - Prescribers and dispensers and their designees;
  - Employees of the United State Department of Veterans Affairs,[45] United States Department of Defense, or the Indian Health Service who provide health care services pursuant to such employment and who have authority to prescribe controlled substances;
  - The program manager and designated support staff to administer the system. The program manager or designated support staff:
    - The program manager and support staff must complete a level II background screening;
    - May have access to de-identified data in order to calculate performance measures;
    - Must provide the DOH de-identified data for public health care and safety initiatives;
  - The program manager:
    - May provide relevant information to the prescriber and dispenser when determining a pattern that indicates controlled substance abuse;
    - May provide relevant information to law enforcement upon determining a pattern of controlled substance abuse and upon having cause to believe that a violation of controlled substance laws has occurred.
- Grants indirect access to the system to:
  - The DOH and its health care regulatory boards for investigations involving licensees authorized to prescribe or dispense controlled substances. The bill removes access for the DOH's regulatory boards;
  - The Attorney General for Medicaid fraud cases involving prescribed controlled substances;
  - A law enforcement agency during an active investigation of potential criminal activity, fraud, or theft regarding prescribed controlled substances;

[45] Employees of the US Department of Veterans Affairs were allowed access last year in Ch. 2017-169, Laws of Fla.

  - A medical examiner when conducting an authorized investigation to determine the cause of death of an individual;[46]
  - An impaired practitioner consultant who is retained by the DOH to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and has agreed in writing to the consultant's access; and
  - A patient, legal guardian, or designated health care surrogate of an incapacitated patient who submits a written and notarized request including the patient's name, address, phone number, date of birth, and a copy of a government issued photo identification.
- Allows the DOH to enter into a reciprocal agreement or contract to share PDMP information with other states, districts, and territories if their PDMPs are compatible with Florida's.[47] To determine compatibility, the DOH must consider for the other state's, district's, or territory's PDMP:
  - Privacy safeguards and the program's success in protecting patient privacy;
  - The persons who are authorized to view the data collected by the program. Persons and entities in other states who are comparable to those granted access to Florida's PDMP may have access to Florida's PDMP upon approval by the DOH;
  - The schedules of controlled substances monitored;
  - Data reported to the program;
  - Any implementing criteria deemed essential; and
  - The costs and benefits to Florida of sharing prescription information.
- Requires the DOH to assess continued compatibility every four years and requires any agreements with other states to contain the same restrictions as Florida's program and s. 893.0551, F.S.
- Allows the DOH to enter into agreements and contracts to establish secure connections between the PDMP and health care provider's electronic health recordkeeping system.
- Requires all prescribers and dispensers, or their designees, to consult the system before prescribing or dispensing a controlled substance. Prescribers and dispensers are exempt from this requirement if the system is not operational or temporarily cannot be accessed. Any prescriber or dispenser who does not consult the system must document the reason why he or she could not consult the system and may not prescribe or dispense more than a three-day supply of a controlled substance. The DOH is required to issue a non-disciplinary citation pursuant to the procedure in s. 456.077, F.S. to any prescriber or dispenser who fails to consult the system. Under s. 456.077, F.S., the first citation is non-disciplinary and the second and further citations are disciplinary.
- Establishes the penalty of a first degree misdemeanor for any person who willfully and knowingly fails to report the dispensing of a controlled substance to the PDMP.
- Restricts information in the system from being released other than as specified in this section and s. 893.0551, F.S.
- Specifies that the content of the system is informational only.
- Restricts information in the system from being introduced as evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient and exempts the program manager and staff from being required to testify to any findings, recommendations,

[46] This access is newly added.
[47] This authorization to share data is newly added.

evaluations, opinions, or other actions taken in connection with the management of the system.

- Allows a prescriber or dispenser, or his or her designee, to have access to information in the PDMP which relates to his or her patient as needed for the purpose of reviewing the patient's controlled substance prescription history. A prescriber or dispenser acting in good faith is immune from civil, criminal, or administrative liability that might otherwise be incurred or imposed for receiving or using information in the PDMP. The bill specifies that accessing or failing to access information in the system does not create a private cause of action against a prescriber or dispenser.
- Specifies that the PDMP must be funded through federal grants, private funding, or state funds appropriated in the General Appropriations Act. The DOH may not commit funds for the PDMP without ensuring funding is available and may not use funds provided directly or indirectly by prescription drug manufacturers.
- Allows the DOH to establish a direct support organization to raise funds for the PDMP and incorporates an automatic repeal date of October 1, 2027, that is in existing law unless saved from repeal by the Legislature.
- Requires the DOH to conduct or contract for studies to examine the feasibility of enhancing the PDMP for public health initiatives and statistical reporting. Such studies must respect the privacy of patients and be focused on:
  - Improving the quality of health care services and safety by improving the prescribing and dispensing practices for prescription drugs;
  - Taking advantage of advances in technology;
  - Reducing duplicative prescriptions and the overprescribing of prescription drugs; and
  - Reducing drug abuse.
- Requires the DOH to annually report to the Governor and the Legislature on specified performance measures for the PDMP.
- Requires the DOH to adopt rules necessary to implement the section.

Section 12 amends s. 893.0551, F.S., to amend the public records exemption for the PDMP to conform to changes made to s. 893.055, F.S., and to conform the section to the requirement in s. 381.986, F.S., that a qualified physician must check the PDMP prior to issuing a physician certification recommending the medical use of marijuana.

Sections 13-19 amends various sections of law to conform cross references to changes made in the bill.

Section 20 establishes appropriations for the 2018-2019 fiscal year as follows:

- $27,035,360 in nonrecurring funds from the Federal Grants Trust Fund and $15,520,000 in recurring general revenue are appropriated to the Department of Children and Families (DCF) for outpatient, case management, and after care services; residential treatment; MAT, including the purchase and medical use of methadone, buprenorphine, and naltrexone extended-release injectable; peer recovery support; hospital and first responder outreach; and outreach targeted to pregnant women.
- Of the recurring funds appropriated above, the DCF must use $4,720,000 to contract with a nonprofit organization for the distribution of drugs for MAT as follows:
  - $472,000 for methadone;

  - $1,888,000 for buprenorphine; and
  - $2,360,000 for naltrexone extended-release injectable.
- $6 million in recurring general revenue funds are appropriated to the Office of the State Courts Administrator (OSCA) for treatment of substance abuse disorders in individuals involved in the criminal justice system, individuals who have a high likelihood of criminal justice involvement, or who are in court-ordered, community based drug treatment. The OSCA must contract with a non-profit entity to make available the following drugs:
  - $600,000 for methadone;
  - $2.4 million buprenorphine; and
  - $3 million for naltrexone extended-release injectable.
- $5 million of recurring general revenue funds are appropriated to the DOH for the purchase of naloxone to be made available to emergency responders.

Section 21 establishes an effective date of July 1, 2018, unless otherwise specified in the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 8 may have an indeterminate negative fiscal impact on clinics that are required to obtain a certificate of exemption from the requirement to register as a pain management clinic.

The bill may have an indeterminate negative fiscal impact on health care practitioners who are required to attend the additional training established in the bill.

The bill may have an indeterminate fiscal impact on patients due to the supply limits imposed for prescription of opioid medications listed in Schedule II.

The bill may have a negative fiscal impact on the administrative operations of health care providers who are required to consult the PDMP prior to prescribing controlled substances and do not currently do so.

The bill may have a positive fiscal impact on any non-profit entities that contract with the DCF or the OSCA to provide MAT medications pursuant to the appropriation established in the bill.

C. Government Sector Impact:

CS/SB 8 may have an indeterminate negative fiscal impact on the DOH related to increased investigations of unlicensed pain management clinics that may be offset through fees collected for initial issuance and renewal of pain management clinic exemption certificates.[48]

The bill provides appropriations as detailed in the Effects of Proposed Changes section above.

VI. Technical Deficiencies:

CS/SB 8 amends the public records exemption for the PDMP and consolidates access to the PDMP for pharmacists with other health care practitioners on lines 1669-1672. This change is a result of pharmacists being added to the definition of "health care practitioner" in s. 893.055, F.S., by the bill. However, the bill leaves out a reference to s. 893.04, F.S., when allowing access to health care practitioners that is currently incorporated into the access allowed to pharmacists by s. 893.0551(e), F.S. The reference to s. 893.04, F.S., should be added to line 1671 of the bill.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 456.072, 456.44, 458.3265, 459.0137, 465.0155, 465.0276, 627.42392, 893.03, 893.055, 893.0551, 458.331, 459.015, 463.0055, 782.04, 893.13, 893.135, and 921.0022.

This bill creates section 456.0301 and one unnumbered section of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 16, 2018.
The CS makes several substantive changes along with numerous conforming, clarifying, and technical changes. Substantive changes include:

[48] Supra note 28.

- Restricting Medicaid and health insurers from requiring prior authorization for MAT.
- Requiring applicable boards, rather than the DOH, to establish guidelines for prescribing controlled substances to treat acute pain.
- Requiring physicians to maintain treatment plans when prescribing Schedule II opioids for the treatment of acute pain.
- Conforming provisions relating to practitioners dispensing Schedule II and Schedule III controlled substances
- Establishing an exception to allow physicians to dispense MAT drugs to their own patients to treat substance abuse disorders.
- Modifying the definitions of "dispense" and "dispenser" within the PDMP to ensure that out of state dispensers must report controlled substances dispensed into the state.
- Reestablishing indirect access to the PDMP for the DOH's health care regulatory boards.
- Eliminating language stating that the content of the PDMP creates no obligations or legal duties for prescribers, dispensers, pharmacies, or patients.
- Including appropriations:
  - $27,035,360 non-recurring and $15,520,000 recurring to DCF for substance use disorder treatment services. Specifies amounts for specific MAT drugs.
  - $6 million in recurring to the state courts administrator for substance abuse treatment related to the criminal justice system.
  - $5 million to the DOH to purchase naloxone for EMS responders.

B. Amendments:

None.

194134

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
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The Committee on Health Policy (Benacquisto) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem

194134

necessary, the contract must require:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. Each managed care plan must publish any prescribed drug

formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans, and their fiscal agents and intermediaries, may not implement, manage, or require a prior authorization process or step therapy procedures and may not impose any other conditions on recipients as a prerequisite to receiving medication-assisted treatment (MAT) services, as defined in s. 397.311, to treat substance abuse disorders.

5. Managed care plans serving children in the care and custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the

194134

format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 2. Section 456.0301, Florida Statutes, is created to read:

456.0301 Requirement for instruction on controlled substance prescribing.-

(1)(a) If not already required by the licensee's practice act, the appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour continuing education course on prescribing controlled substances as part of biennial license renewal. The course must include information on the current standards for prescribing controlled substances, particularly opiates; alternatives to these standards; and information on the risks of opioid addiction following all stages of treatment in the management of acute pain. The course may be offered in a distance learning format and must be included within the number of continuing education hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement

194134

Administration to prescribe controlled substances who has failed to complete the course. When required by this paragraph, the course must be completed by January 31, 2019, and at each subsequent renewal.

(b) Each such licensee shall submit confirmation of having completed such course when applying for biennial license renewal.

(2) Each board may adopt rules to administer this section.

Section 3. Paragraph (gg) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(gg) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of ~~any provision of~~ this chapter or ss. 893.055 and 893.0551, a violation of the applicable practice act, or a violation of any rules adopted under this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 4. Paragraphs (a) through (g) of subsection (1) of section 456.44, Florida Statutes, are redesignated as paragraphs (b) through (h), respectively, a new paragraph (a) is added to that subsection, subsection (3) is amended, and subsections (4) and (5) are added to that section, to read:

194134

456.44 Controlled substance prescribing.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Acute pain" means the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

194134

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient’s surrogate or guardian if the patient is incompetent. The registrant shall use a written controlled substance agreement between the registrant and the patient outlining the patient’s responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the

treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical

194134

records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient's government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate

use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under

chapter 395.

(4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The applicable boards shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation and maintenance of a treatment plan, obtaining informed consent and agreement for treatment, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).

(5) PRESCRIPTION SUPPLY.-

(a) Except as provided in paragraph (b), a prescription for an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812, for the treatment of acute pain may not exceed a 3-day supply.

(b) Up to a 7-day supply of an opioid described in paragraph (a) may be prescribed if:

1. The practitioner, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient’s pain as an acute medical condition.

2. The practitioner indicates “MEDICALLY NECESSARY” on the prescription.

3. The prescriber adequately documents in the patient’s medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit established in this subsection.

Section 5. Effective January 1, 2019, subsections (2)

194134

through (5) of section 458.3265, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3) and paragraph (a) of present subsection (4) of that section, are amended, and a new subsection (2) is added to that section, to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to

194134

subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain

Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (4) ~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1) must apply for a certificate of exemption on a form adopted in rule by the department. The form must require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) The department must approve or deny the application within 30 days after the receipt of a complete application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A new certificate of exemption is required for a change of address and is not transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must notify the department within 3 days after becoming aware that the clinic no longer qualifies for a certificate of exemption and register as a pain management clinic under subsection (1) or cease operations.

(3) ~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) A physician may not practice medicine in a pain-management clinic, as described in subsection (5) ~~(4)~~, if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as

194134

long as the physician continues to meet the qualifications set forth in the board rules. A physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) ~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Medicine adopted pursuant to subsection (5) ~~(4)~~ unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Medicine.

(5) ~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 6. Effective January 1, 2019, subsections (2) through (5) of section 459.0137, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3) and paragraph (a) of present subsection (4) of that section, are amended, and a new subsection (2) is added to that section, to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology,

194134

or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the


194134

corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (4) ~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the

registration requirements of subsection (1) must apply for a certificate of exemption on a form adopted in rule by the department. The form shall require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) Within 30 days after the receipt of a complete application, the department must approve or deny the application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A new certificate of exemption is required for a change of address and is not transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the

pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must notify the department within 3 days after becoming aware that the clinic no longer qualifies for a certificate of exemption and register as a pain management clinic under subsection (1) or cease operations.

(3)~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) An osteopathic physician may not practice medicine in a pain-management clinic, as described in subsection (5)~~(4)~~, if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Osteopathic Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. An osteopathic physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4)~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Osteopathic Medicine adopted pursuant to subsection (5)~~(4)~~ unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic

194134

Medicine.

(5)~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 7. Section 465.0155, Florida Statutes, is amended to read:

465.0155 Standards of practice.—

(1) Consistent with the provisions of this act, the board shall adopt by rule standards of practice relating to the practice of pharmacy which shall be binding on every state agency and shall be applied by such agencies when enforcing or implementing any authority granted by any applicable statute, rule, or regulation, whether federal or state.

(2)(a) Before dispensing a controlled substance to a person not known to the pharmacist, the pharmacist must require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the pharmacist may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

(b) This subsection does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which

194134

patients are admitted.

(c) As used in this subsection, the term "proper identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 8. Paragraph (b) of subsection (1) of section 465.0276, Florida Statutes, is amended, and paragraph (d) is added to subsection (2) of that section, to read:

465.0276 Dispensing practitioner.—

(1)

(b) A practitioner registered under this section may not dispense a controlled substance listed in Schedule II or Schedule III as provided in s. 893.03. This paragraph does not apply to:

1. The dispensing of complimentary packages of medicinal drugs which are labeled as a drug sample or complimentary drug as defined in s. 499.028 to the practitioner's own patients in the regular course of her or his practice without the payment of a fee or remuneration of any kind, whether direct or indirect, as provided in subsection (4).

2. The dispensing of controlled substances in the health care system of the Department of Corrections.

3. The dispensing of a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure.

a. For a controlled substance listed in Schedule II, the amount dispensed pursuant to this subparagraph may not exceed a 3-day supply unless the criteria in s. 456.44(5)(b) are met, in

which case the amount dispensed may not exceed a 7-day supply.

b. For a controlled substance listed in Schedule III, the amount dispensed pursuant to this ~~the~~ subparagraph may not exceed a 14-day supply.

c. The exception in this subparagraph ~~exception~~ does not allow for the dispensing of a controlled substance listed in Schedule II or Schedule III more than 14 days after the performance of the surgical procedure.

d. For purposes of this subparagraph, the term "surgical procedure" means any procedure in any setting which involves, or reasonably should involve:

(I)~~a.~~ Perioperative medication and sedation that allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal or tactile stimulation and makes intra- and postoperative monitoring necessary; or

(II)~~b.~~ The use of general anesthesia or major conduction anesthesia and preoperative sedation.

4. The dispensing of a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial. For purposes of this subparagraph, the term "approved clinical trial" means a clinical research study or clinical investigation that, in whole or in part, is state or federally funded or is conducted under an investigational new drug application that is reviewed by the United States Food and Drug Administration.

5. The dispensing of methadone in a facility licensed under s. 397.427 where medication-assisted treatment for opiate addiction is provided.

194134

6. The dispensing of a controlled substance listed in Schedule II or Schedule III to a patient of a facility licensed under part IV of chapter 400.

7. The dispensing of controlled substances listed in Schedule II or Schedule III which have been approved by the United States Food and Drug Administration for the purpose of treating opiate addiction including, but not limited to, buprenorphine and buprenorphine combination products, by a practitioner authorized under 21 U.S.C. 823, as amended, to the practitioner's own patients for the medication-assisted treatment of opiate addiction.

(2) A practitioner who dispenses medicinal drugs for human consumption for fee or remuneration of any kind, whether direct or indirect, must:

(d)1. Before dispensing a controlled substance to a person not known to the dispenser, require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the dispenser may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

2. This paragraph does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

3. As used in this paragraph, the term "proper

identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 9. Subsection (5) is added to section 627.42392, Florida Statutes, to read:

627.42392 Prior authorization.—

(5) A health insurer may not require a prior authorization process or step therapy procedure or impose any other conditions on insureds as a prerequisite to receiving medication-assisted treatment (MAT) services, as defined in s. 397.311, to treat substance abuse disorders.

Section 10. Subsections (2), (3), (4), and (5) of section 893.03, Florida Statutes, are amended to read:

893.03 Standards and schedules.—The substances enumerated in this section are controlled by this chapter. The controlled substances listed or to be listed in Schedules I, II, III, IV, and V are included by whatever official, common, usual, chemical, trade name, or class designated. The provisions of this section shall not be construed to include within any of the schedules contained in this section any excluded drugs listed within the purview of 21 C.F.R. s. 1308.22, styled "Excluded Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt Anabolic Steroid Products."

(2) SCHEDULE II.—A substance in Schedule II has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and

abuse of the substance may lead to severe psychological or physical dependence. The following substances are controlled in Schedule II:

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances, whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis:

1. Opium and any salt, compound, derivative, or preparation of opium, except nalmefene or isoquinoline alkaloids of opium, including, but not limited to the following:

a. Raw opium.

b. Opium extracts.

c. Opium fluid extracts.

d. Powdered opium.

e. Granulated opium.

f. Tincture of opium.

g. Codeine.

h. Dihydroetorphine.

i.~~h.~~ Ethylmorphine.

j.~~i.~~ Etorphine hydrochloride.

k.~~j.~~ Hydrocodone and hydrocodone combination products.

l.~~k.~~ Hydromorphone.

m.~~l.~~ Levo-alphacetylmethadol (also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM).

n.~~m.~~ Metopon (methyldihydromorphinone).

o.~~n.~~ Morphine.

p. Oripavine.

q.~~o.~~ Oxycodone.

r.~~p.~~ Oxymorphone.

s.~~q.~~ Thebaine.

2. Any salt, compound, derivative, or preparation of a substance which is chemically equivalent to or identical with any of the substances referred to in subparagraph 1., except that these substances shall not include the isoquinoline alkaloids of opium.

3. Any part of the plant of the species *Papaver somniferum, L.*

4. Cocaine or ecgonine, including any of their stereoisomers, and any salt, compound, derivative, or preparation of cocaine or ecgonine, except that these substances shall not include ioflupane I 123.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

1. Alfentanil.

2. Alphaprodine.

3. Anileridine.

4. Bezitramide.

5. Bulk propoxyphene (nondosage forms).

6. Carfentanil.

7. Dihydrocodeine.

8. Diphenoxylate.

9. Fentanyl.

10. Isomethadone.

11. Levomethorphan.
12. Levorphanol.
13. Metazocine.
14. Methadone.
15. Methadone-Intermediate,4-cyano-2-dimethylamino-4,4-diphenylbutane.
16. Moramide-Intermediate,2-methyl-3-morpholoino-1,1-diphenylpropane-carboxylic acid.
17. Nabilone.
18. Pethidine (meperidine).
19. Pethidine-Intermediate-A,4-cyano-1-methyl-4-phenylpiperidine.
20. Pethidine-Intermediate-B,ethyl-4-phenylpiperidine-4-carboxylate.
21. Pethidine-Intermediate-C,1-methyl-4- phenylpiperidine-4-carboxylic acid.
22. Phenazocine.
23. Phencyclidine.
24. 1-Phenylcyclohexylamine.
25. Piminodine.
26. 1-Piperidinocyclohexanecarbonitrile.
27. Racemethorphan.
28. Racemorphan.
29. Remifentanil.
30.~~29.~~ Sufentanil.
31. Tapentadol.
32. Thiafentanil.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or

194134

preparation which contains any quantity of the following substances, including their salts, isomers, optical isomers, salts of their isomers, and salts of their optical isomers:

1. Amobarbital.

2. Amphetamine.

3. Glutethimide.

4. Lisdexamfetamine.

5.~~4.~~ Methamphetamine.

6.~~5.~~ Methylphenidate.

7.~~6.~~ Pentobarbital.

8.~~7.~~ Phenmetrazine.

9.~~8.~~ Phenylacetone.

10.~~9.~~ Secobarbital.

(d) Dronabinol (synthetic THC) in oral solution in a drug product approved by the United States Food and Drug Administration.

(3) SCHEDULE III.—A substance in Schedule III has a potential for abuse less than the substances contained in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. The following substances are controlled in Schedule III:

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant or stimulant effect on the nervous system:

1. Any substance which contains any quantity of a derivative of barbituric acid, including thiobarbituric acid, or any salt of a derivative of barbituric acid or thiobarbituric acid, including, but not limited to, butabarbital and butalbital.

2. Benzphetamine.

3. Buprenorphine.

4.~~3.~~ Chlorhexadol.

5.~~4.~~ Chlorphentermine.

6.~~5.~~ Clortermine.

7. Embutramide.

8.~~6.~~ Lysergic acid.

9.~~7.~~ Lysergic acid amide.

10.~~8.~~ Methyprylon.

11. Perampanel.

12.~~9.~~ Phendimetrazine.

13.~~10.~~ Sulfondiethylmethane.

14.~~11.~~ Sulfonethylmethane.

15.~~12.~~ Sulfonmethane.

16.~~13.~~ Tiletamine and zolazepam or any salt thereof.

(b) Nalorphine.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following controlled substances or any salts thereof:

1. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

2. Not more than 1.8 grams of codeine per 100 milliliters

or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

3. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

4. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients that are not controlled substances.

5. Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

6. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

7. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

For purposes of charging a person with a violation of s. 893.135 involving any controlled substance described in subparagraph 3. or subparagraph 4., the controlled substance is a Schedule III controlled substance pursuant to this paragraph but the weight of the controlled substance per milliliters or per dosage unit

881 is not relevant to the charging of a violation of s. 893.135.
882 The weight of the controlled substance shall be determined
883 pursuant to s. 893.135(6).
884 (d) Anabolic steroids.
885 1. The term "anabolic steroid" means any drug or hormonal
886 substance, chemically and pharmacologically related to
887 testosterone, other than estrogens, progestins, and
888 corticosteroids, that promotes muscle growth and includes:
889 a. Androsterone.
890 b. Androsterone acetate.
891 c. Boldenone.
892 d. Boldenone acetate.
893 e. Boldenone benzoate.
894 f. Boldenone undecylenate.
895 g. Chlorotestosterone (Clostebol).
896 h. Dehydrochlormethyltestosterone.
897 i. Dihydrotestosterone (Stanolone).
898 j. Drostanolone.
899 k. Ethylestrenol.
900 l. Fluoxymesterone.
901 m. Formebulone (Formebolone).
902 n. Mesterolone.
903 o. Methandrostenolone (Methandienone).
904 p. Methandranone.
905 q. Methandriol.
906 r. Methenolone.
907 s. Methyltestosterone.
908 t. Mibolerone.
909 u. Nortestosterone (Nandrolone).

v. Norethandrolone.
w. Nortestosterone decanoate.
x. Nortestosterone phenylpropionate.
y. Nortestosterone propionate.
z. Oxandrolone.
aa. Oxymesterone.
bb. Oxymetholone.
cc. Stanozolol.
dd. Testolactone.
ee. Testosterone.
ff. Testosterone acetate.
gg. Testosterone benzoate.
hh. Testosterone cypionate.
ii. Testosterone decanoate.
jj. Testosterone enanthate.
kk. Testosterone isocaproate.
ll. Testosterone oleate.
mm. Testosterone phenylpropionate.
nn. Testosterone propionate.
oo. Testosterone undecanoate.
pp. Trenbolone.
qq. Trenbolone acetate.
rr. Any salt, ester, or isomer of a drug or substance described or listed in this subparagraph if that salt, ester, or isomer promotes muscle growth.

2. The term does not include an anabolic steroid that is expressly intended for administration through implants to cattle or other nonhuman species and that has been approved by the United States Secretary of Health and Human Services for such

194134

administration. However, any person who prescribes, dispenses, or distributes such a steroid for human use is considered to have prescribed, dispensed, or distributed an anabolic steroid within the meaning of this paragraph.

(e) Ketamine, including any isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.

(f) Dronabinol (synthetic THC) in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration.

(g) Any drug product containing gamma-hydroxybutyric acid, including its salts, isomers, and salts of isomers, for which an application is approved under s. 505 of the Federal Food, Drug, and Cosmetic Act.

(4)(a) SCHEDULE IV.—A substance in Schedule IV has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation, are controlled in Schedule IV:

1. Alfaxalone.

2.~~(a)~~ Alprazolam.
3.~~(b)~~ Barbital.
4.~~(c)~~ Bromazepam.
5.~~(iii)~~ Butorphanol tartrate.
6.~~(d)~~ Camazepam.
7.~~(jjj)~~ Carisoprodol.
8.~~(e)~~ Cathine.
9.~~(f)~~ Chloral betaine.
10.~~(g)~~ Chloral hydrate.
11.~~(h)~~ Chlordiazepoxide.
12.~~(i)~~ Clobazam.
13.~~(j)~~ Clonazepam.
14.~~(k)~~ Clorazepate.
15.~~(l)~~ Clotiazepam.
16.~~(m)~~ Cloxazolam.
17. Dexfenfluramine.
18.~~(n)~~ Delorazepam.
19. Dichloralphenazone.
20.~~(p)~~ Diazepam.
21.~~(q)~~ Diethylpropion.
22. Eluxadoline.
23.~~(r)~~ Estazolam.
24. Eszopiclone.
25.~~(s)~~ Ethchlorvynol.
26.~~(t)~~ Ethinamate.
27.~~(u)~~ Ethyl loflazepate.
28.~~(v)~~ Fencamfamin.
29.~~(w)~~ Fenfluramine.
30.~~(x)~~ Fenproporex.

194134

31.~~(y)~~ Fludiazepam.
32.~~(z)~~ Flurazepam.
33. Fospropofol.
34.~~(aa)~~ Halazepam.
35.~~(bb)~~ Haloxazolam.
36.~~(cc)~~ Ketazolam.
37.~~(dd)~~ Loprazolam.
38.~~(ee)~~ Lorazepam.
39. Lorcaserin.
40.~~(ff)~~ Lormetazepam.
41.~~(gg)~~ Mazindol.
42.~~(hh)~~ Mebutamate.
43.~~(ii)~~ Medazepam.
44.~~(jj)~~ Mefenorex.
45.~~(kk)~~ Meprobamate.
46.~~(ll)~~ Methohexital.
47.~~(mm)~~ Methylphenobarbital.
48.~~(nn)~~ Midazolam.
49. Modafinil.
50.~~(oo)~~ Nimetazepam.
51.~~(pp)~~ Nitrazepam.
52.~~(qq)~~ Nordiazepam.
53.~~(rr)~~ Oxazepam.
54.~~(ss)~~ Oxazolam.
55.~~(tt)~~ Paraldehyde.
56.~~(uu)~~ Pemoline.
57.~~(vv)~~ Pentazocine.
58. Petrichloral.
59.~~(ww)~~ Phenobarbital.

194134

60.~~(xx)~~ Phentermine.
61.~~(yy)~~ Pinazepam.
62.~~(zz)~~ Pipradrol.
63.~~(aaa)~~ Prazepam.
64.~~(o)~~ Propoxyphene (dosage forms).
65.~~(bbb)~~ Propylhexedrine, excluding any patent or proprietary preparation containing propylhexedrine, unless otherwise provided by federal law.
66.~~(ccc)~~ Quazepam.
67. Sibutramine.
68.~~(ccc)~~ SPA[(-)-1 dimethylamino-1, 2 diphenylethane].
69. Suvorexant.
70.~~(fff)~~ Temazepam.
71.~~(ddd)~~ Tetrazepam.
72. Tramadol.
73.~~(ggg)~~ Triazolam.
74. Zaleplon.
75. Zolpidem.
76. Zopiclone.
77.~~(hhh)~~ Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) SCHEDULE V.—A substance, compound, mixture, or preparation of a substance in Schedule V has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.

194134

(a) Substances controlled in Schedule V include any compound, mixture, or preparation containing any of the following limited quantities of controlled substances, which must ~~shall~~ include one or more active medicinal ingredients that ~~which~~ are not controlled substances in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the controlled substance alone:

1. Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.

2. Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.

3. Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.

4. Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

5. Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

6. Not more than 0.5 milligrams of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

(b) Unless a specific exception exists or unless listed in another schedule, any material, compound, mixture, or preparation that contains any quantity of the following substances is controlled in Schedule V:

1. Brivaracetam.

2. Ezogabine.

3. Lacosamide.

4. Pregabalin ~~Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound,~~

~~mixture, or preparation containing any of the following narcotic drugs and their salts: Buprenorphine~~.

(c) Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers: Pyrovalerone.

Section 11. Section 893.055, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 893.055, F.S., for present text.)

893.055 Prescription drug monitoring program.—

(1) As used in this section, the term:

(a) "Active investigation" means an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.

(b) "Administration" means the obtaining and giving of a single dose of a controlled substance by a legally authorized person to a patient for her or his consumption.

(c) "Controlled substance" means a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03 or 21 U.S.C. s. 812.

(d) "Dispense" means the transfer of possession of one or more doses of a controlled substance by a dispenser to the ultimate consumer or to his or her agent.

(e) "Dispenser" means a dispensing health care practitioner, pharmacy, or pharmacist licensed to dispense controlled substances in or into this state.

(f) "Health care practitioner" or "practitioner" means any practitioner licensed under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, chapter 465, or chapter 466.

(g) "Health care regulatory board" has the same meaning as s. 456.001(1).

(h) "Law enforcement agency" means the Department of Law Enforcement, a sheriff's office in this state, a police department in this state, or a law enforcement agency of the Federal Government which enforces the laws of this state or the United States relating to controlled substances and whose agents and officers are empowered by law to conduct criminal investigations and make arrests.

(i) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, or an Internet pharmacy that is licensed by the department under chapter 465 and that dispenses or delivers controlled substances to an individual or address in this state.

(j) "Prescriber" means a prescribing physician, prescribing practitioner, or other prescribing health care practitioner authorized by the laws of this state to order controlled substances.

(k) "Program manager" means an employee of or a person contracted by the department who is designated to ensure the integrity of the prescription drug monitoring program in accordance with the requirements established in this section.

(2)(a) The department shall maintain an electronic system

194134

to collect and store controlled substance dispensing information and shall release the information as authorized in this section and s. 893.0551. The electronic system must:

1. Not infringe upon the legitimate prescribing or dispensing of a controlled substance by a prescriber or dispenser acting in good faith and in the course of professional practice.

2. Be consistent with standards of the American Society for Automation in Pharmacy.

3. Comply with the Health Insurance Portability and Accountability Act as it pertains to protected health information, electronic protected health information, and all other relevant state and federal privacy and security laws and regulations.

(b) The department may collaborate with professional health care regulatory boards, appropriate organizations, and other state agencies to identify indicators of controlled substance abuse.

(3) For each controlled substance dispensed to a patient in the state, the following information must be reported by the dispenser to the system as soon thereafter as possible but no later than the close of the next business day after the day the controlled substance is dispensed unless an extension or exemption is approved by the department:

(a) The name of the prescribing practitioner, the practitioner’s federal Drug Enforcement Administration registration number, the practitioner’s National Provider Identification (NPI) or other appropriate identifier, and the date of the prescription.

(b) The date the prescription was filled and the method of payment, such as cash by an individual, insurance coverage through a third party, or Medicaid payment. This paragraph does not authorize the department to include individual credit card numbers or other account numbers in the system.

(c) The full name, address, telephone number, and date of birth of the person for whom the prescription was written.

(d) The name, national drug code, quantity, and strength of the controlled substance dispensed.

(e) The full name, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued pharmacy permit number, and address of the pharmacy or other location from which the controlled substance was dispensed. If the controlled substance was dispensed by a practitioner other than a pharmacist, the practitioner's full name, address, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued license number, and National Provider Identification (NPI).

(f) Whether the drug was dispensed as an initial prescription or a refill, and the number of refills ordered.

(g) The name of the individual picking up the controlled substance prescription and type and issuer of the identification provided.

(h) Other appropriate identifying information as determined by department rule.

All acts of administration of controlled substances are exempt from the reporting requirements of this subsection.

194134

(4) The following must be provided direct access to information in the system:

(a) A prescriber or dispenser or his or her designee.

(b) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of employment.

(c) The program manager or designated program and support staff may have access to administer the system.

1. In order to calculate performance measures pursuant to subsection (14), the program manager or program and support staff members who have been directed by the program manager to calculate performance measures may have direct access to information that contains no identifying information of any patient, physician, health care practitioner, prescriber, or dispenser.

2. The program manager or designated program and support staff must provide the department, upon request, data that does not contain patient, physician, health care practitioner, prescriber, or dispenser identifying information for public health care and safety initiatives purposes.

3. The program manager, upon determining a pattern consistent with the department's rules established under subsection (16), may provide relevant information to the prescriber and dispenser.

4. The program manager, upon determining a pattern consistent with the rules established under subsection (16) and

194134

having cause to believe a violation of s. 893.13(7)(a)8., (8)(a), or (8)(b) has occurred, may provide relevant information to the applicable law enforcement agency.

The program manager and designated program and support staff must complete a level II background screening.

(5) The following entities may not directly access information in the system, but may request information from the program manager or designated program and support staff:

(a) The department and its health care regulatory boards, as appropriate, for investigations involving licensees authorized to prescribe or dispense controlled substances.

(b) The Attorney General for Medicaid fraud cases involving prescribed controlled substances.

(c) A law enforcement agency during active investigations of potential criminal activity, fraud, or theft regarding prescribed controlled substances.

(d) A medical examiner when conducting an authorized investigation under s. 406.11, to determine the cause of death of an individual.

(e) An impaired practitioner consultant who is retained by the department under s. 456.076 to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant’s access to and review of such information.

(f) A patient or the legal guardian or designated health care surrogate of an incapacitated patient who submits a written and notarized request that includes the patient’s full name,

address, phone number, date of birth, and a copy of a government-issued photo identification.

(6) The department may enter into a reciprocal agreement or contract to share prescription drug monitoring information with another state, district, or territory if the prescription drug monitoring programs of other states, districts, or territories are compatible with the Florida program.

(a) In determining compatibility, the department shall consider:

1. The safeguards for privacy of patient records and the success of the program in protecting patient privacy.

2. The persons authorized to view the data collected by the program. Comparable entities and licensed health care practitioners in other states, districts, or territories of the United States, law enforcement agencies, the Attorney General's Medicaid Fraud Control Unit, medical regulatory boards, and, as needed, management staff that have similar duties as management staff who work with the prescription drug monitoring program as authorized in s. 893.0551 are authorized access upon approval by the department.

3. The schedules of the controlled substances that are monitored by the program.

4. The data reported to or included in the program's system.

5. Any implementing criteria deemed essential for a thorough comparison.

6. The costs and benefits to the state of sharing prescription information.

(b) The department shall assess the prescription drug

monitoring program's continued compatibility with the other state's, district's, or territory's program every 4 years.

(c) Any agreement or contract for sharing of prescription drug monitoring information between the department and another state, district, or territory shall contain the same restrictions and requirements as this section or s. 893.0551, and the information must be provided according to the department's determination of compatibility.

(7) The department may enter into agreements or contracts to establish secure connections between the system and a prescribing or dispensing health care practitioner's electronic health recordkeeping system. The electronic health recordkeeping system owner or license holder will be responsible for ensuring that only authorized individuals have access to prescription drug monitoring program information.

(8) A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance.

(a) The duty to consult the system does not apply to a prescriber or dispenser or designee of a prescriber or dispenser if the system is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure.

(b) A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system under this subsection shall document the reason he or she did not consult the system in the patient's medical record or prescription

194134

record, and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.

(c) The department shall issue a citation pursuant to the procedure in s. 456.077 to any prescriber or dispenser who fails to consult the system as required by this subsection.

(9) A person who willfully and knowingly fails to report the dispensing of a controlled substance as required by this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(10) Information in the prescription drug monitoring program's system may be released only as provided in this section and s. 893.0551. The content of the system is intended to be informational only. Information in the system is not subject to discovery or introduction into evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient arising out of matters that are the subject of information in the system. The program manager and authorized persons who participate in preparing, reviewing, issuing, or any other activity related to management of the system may not be permitted or required to testify in any such civil or administrative action as to any findings, recommendations, evaluations, opinions, or other actions taken in connection with management of the system.

(11) A prescriber or dispenser, or his or her designee, may have access to the information under this section which relates to a patient of that prescriber or dispenser as needed for the purpose of reviewing the patient's controlled drug prescription history. A prescriber or dispenser acting in good faith is immune from any civil, criminal, or administrative liability

that might otherwise be incurred or imposed for receiving or using information from the prescription drug monitoring program. This subsection does not create a private cause of action, and a person may not recover damages against a prescriber or dispenser authorized to access information under this subsection for accessing or failing to access such information.

(12)(a) All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants, private funding applied for or received by the state, or state funds appropriated in the General Appropriations Act. The department may not:

1. Commit funds for the monitoring program without ensuring funding is available; or

2. Use funds provided, directly or indirectly by prescription drug manufacturers to implement the program.

(b) The department shall cooperate with the direct-support organization established under subsection (15) in seeking federal grant funds, other nonstate grant funds, gifts, donations, or other private moneys for the department if the costs of doing so are immaterial. Immaterial costs include, but are not limited to, the costs of mailing and personnel assigned to research or apply for a grant. The department may competitively procure and contract pursuant to s. 287.057 for any goods and services required by this section.

(13) The department shall conduct or participate in studies to examine the feasibility of enhancing the prescription drug monitoring program for the purposes of public health initiatives and statistical reporting. Such studies shall respect the privacy of the patient, the prescriber, and the dispenser. Such

194134

studies may be conducted by the department or a contracted vendor in order to:

(a) Improve the quality of health care services and safety by improving prescribing and dispensing practices for controlled substances;

(b) Take advantage of advances in technology;

(c) Reduce duplicative prescriptions and the overprescribing of controlled substances; and

(d) Reduce drug abuse.

(14) The department shall annually report on performance measures to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1. Performance measures may include, but are not limited to, the following outcomes:

(a) Reduction of the rate of inappropriate use of controlled substances through department education and safety efforts.

(b) Reduction of the quantity of controlled substances obtained by individuals attempting to engage in fraud and deceit.

(c) Increased coordination among partners participating in the prescription drug monitoring program.

(d) Involvement of stakeholders in achieving improved patient health care and safety and reduction of controlled substance abuse and controlled substance diversion.

(15) The department may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized for the prescription drug monitoring program.

(a) As used in this subsection, the term "direct-support organization" means an organization that is:

1. A Florida corporation not for profit incorporated under chapter 617, exempted from filing fees, and approved by the Department of State.

2. Organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, and invest, in its own name, securities, funds, objects of value, or other property, either real or personal; and make expenditures or provide funding to or for the direct or indirect benefit of the department in the furtherance of the prescription drug monitoring program.

(b) The State Surgeon General shall appoint a board of directors for the direct-support organization.

1. The board of directors shall consist of no fewer than five members who shall serve at the pleasure of the State Surgeon General.

2. The State Surgeon General shall provide guidance to members of the board to ensure that moneys received by the direct-support organization are not received from inappropriate sources. Inappropriate sources include, but are not limited to, donors, grantors, persons, prescription drug manufacturers, or organizations that may monetarily or substantively benefit from the purchase of goods or services by the department in furtherance of the prescription drug monitoring program.

(c) The direct-support organization shall operate under written contract with the department. The contract must, at a minimum, provide for:

1. Approval of the articles of incorporation and bylaws of the direct-support organization by the department.

2. Submission of an annual budget for the approval of the department.

3. The reversion, without penalty, to the department's grants and donations trust fund for the administration of the prescription drug monitoring program of all moneys and property held in trust by the direct-support organization for the benefit of the prescription drug monitoring program if the direct-support organization ceases to exist or if the contract is terminated.

4. The fiscal year of the direct-support organization, which must begin July 1 of each year and end June 30 of the following year.

5. The disclosure of the material provisions of the contract to donors of gifts, contributions, or bequests, including such disclosure on all promotional and fundraising publications, and an explanation to such donors of the distinction between the department and the direct-support organization.

6. The direct-support organization's collecting, expending, and providing of funds to the department for the development, implementation, and operation of the prescription drug monitoring program as described in this section. The direct-support organization may collect and expend funds to be used for the functions of the direct-support organization's board of directors, as necessary and approved by the department. In addition, the direct-support organization may collect and provide funding to the department in furtherance of the

194134

prescription drug monitoring program by:

a. Establishing and administering the prescription drug monitoring program's electronic system, including hardware and software.

b. Conducting studies on the efficiency and effectiveness of the program to include feasibility studies as described in subsection (13).

c. Providing funds for future enhancements of the program within the intent of this section.

d. Providing user training of the prescription drug monitoring program, including distribution of materials to promote public awareness and education and conducting workshops or other meetings, for health care practitioners, pharmacists, and others as appropriate.

e. Providing funds for travel expenses.

f. Providing funds for administrative costs, including personnel, audits, facilities, and equipment.

g. Fulfilling all other requirements necessary to implement and operate the program as outlined in this section.

7. Certification by the department that the direct-support organization is complying with the terms of the contract in a manner consistent with and in furtherance of the goals and purposes of the prescription drug monitoring program and in the best interests of the state. Such certification must be made annually and reported in the official minutes of a meeting of the direct-support organization.

(d) The activities of the direct-support organization must be consistent with the goals and mission of the department, as determined by the department, and in the best interests of the

state. The direct-support organization must obtain written approval from the department for any activities in support of the prescription drug monitoring program before undertaking those activities.

(e) The direct-support organization shall provide for an independent annual financial audit in accordance with s. 215.981. Copies of the audit shall be provided to the department and the Office of Policy and Budget in the Executive Office of the Governor.

(f) The direct-support organization may not exercise any power under s. 617.0302(12) or (16).

(g) The direct-support organization is not considered a lobbying firm within the meaning of s. 11.045.

(h) The department may permit, without charge, appropriate use of administrative services, property, and facilities of the department by the direct-support organization, subject to this section. The use must be directly in keeping with the approved purposes of the direct-support organization and may not be made at times or places that would unreasonably interfere with opportunities for the public to use such facilities for established purposes. Any moneys received from rentals of facilities and properties managed by the department may be held in a separate depository account in the name of the direct-support organization and subject to the provisions of the letter of agreement with the department. The letter of agreement must provide that any funds held in the separate depository account in the name of the direct-support organization must revert to the department if the direct-support organization is no longer approved by the department to operate in the best interests of

194134

the state.

(i) The department may adopt rules under s. 120.54 to govern the use of administrative services, property, or facilities of the department or office by the direct-support organization.

(j) The department may not permit the use of any administrative services, property, or facilities of the state by a direct-support organization if that organization does not provide equal membership and employment opportunities to all persons regardless of race, color, religion, gender, age, or national origin.

(k) This subsection is repealed October 1, 2027, unless reviewed and saved from repeal by the Legislature.

(16) The department shall adopt rules necessary to implement this section.

Section 12. Section 893.0551, Florida Statutes, is amended to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(1) For purposes of this section, the terms used in this section have the same meanings as provided in s. 893.055.

(2) The following information of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is contained in records held by the department under s. 893.055 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Name.

194134

(b) Address.

(c) Telephone number.

(d) Insurance plan number.

(e) Government-issued identification number.

(f) Provider number.

(g) Drug Enforcement Administration number.

(h) Any other unique identifying information or number.

(3) The department shall disclose such ~~confidential and exempt~~ information to the following persons or entities upon request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(a) A health care practitioner, or his or her designee, who certifies that the information is necessary to provide medical treatment to a current patient in accordance with ss. 893.05 and 893.055.

(b) A qualified physician, to review a patient's controlled drug prescription history before issuing a physician certification pursuant to s. 381.986.

(c) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of such employment.

(d) The program manager and designated support staff for administration of the program, and to provide relevant information to the prescriber, dispenser, and appropriate law enforcement agencies, in accordance with s. 893.055.

(e) The department for investigations involving licensees

194134

authorized to prescribe or dispense controlled substances. The department may request information from the program but may not have direct access to its system. The department may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.

(f) ~~(a)~~ The Attorney General or his or her designee when working on Medicaid fraud cases involving prescribed controlled substances ~~prescription drugs~~ or when the Attorney General has initiated a review of specific identifiers of Medicaid fraud or specific identifiers that warrant a Medicaid investigation regarding prescribed controlled substances ~~prescription drugs~~. The Attorney General's Medicaid fraud investigators may not have direct access to the department's system ~~database~~. The Attorney General or his or her designee may disclose to a criminal justice agency, as defined in s. 119.011, only the ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for the information.

(g) ~~(b)~~ The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a practitioner, pharmacist, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a specific controlled substances investigation for prescription drugs involving a designated person. The health care regulatory boards may request information from the department but may not have direct access to its database. The health care regulatory boards may provide


194134

to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.

(h) ~~(c)~~ A law enforcement agency that has initiated an active investigation involving a specific violation of law regarding prescription drug abuse or diversion of prescribed controlled substances and that has entered into a user agreement with the department. A law enforcement agency may request information from the department but may not have direct access to its system ~~database~~. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for such information.

(i) A district medical examiner or associate medical examiner, as described in s. 406.06, pursuant to his or her official duties, as required by s. 406.11, to determine the cause of death of an individual. Such medical examiners may request information from the department but may not have direct access to the system.

~~(f) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(7)(c)4.~~

(j) ~~(h)~~ An impaired practitioner consultant who has been authorized in writing by a participant in, or by a referral to, the impaired practitioner program to access and review information as provided in s. 893.055(5)(e) ~~893.055(7)(c)5~~.

(k) A patient or the legal guardian or designated health

care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(5)(f).

(4) If the department determines consistent with its rules that a pattern of controlled substance abuse exists, the department may disclose such confidential and exempt information to the applicable law enforcement agency in accordance with s. 893.055. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that is specific to a violation of s. 893.13(7)(a)8., s. 893.13(8)(a), or s. 893.13(8)(b).

(5) Before disclosing ~~confidential and exempt~~ information to a criminal justice agency or a law enforcement agency pursuant to this section, the disclosing person or entity must take steps to ensure the continued confidentiality of all ~~confidential and exempt~~ information. At a minimum, these steps must include redacting any nonrelevant information.

(6) An agency or person who obtains any ~~confidential and exempt~~ information pursuant to this section must maintain the confidential and exempt status of that information and may not disclose such information unless authorized by law. Information shared with a state attorney pursuant to paragraph (3)(f) ~~(3)(a)~~ or paragraph (3)(h) ~~(3)(c)~~ may be released only in response to a discovery demand if such information is directly related to the criminal case for which the information was requested. Unrelated information may be released only upon an order of a court of competent jurisdiction.

(7) A person who willfully and knowingly violates this

194134

section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 13. Effective January 1, 2019, paragraphs (pp) and (qq) of subsection (1) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(pp) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of

194134

another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 458.3265(3) ~~458.3265(2)~~.

(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 458.3265(3) ~~458.3265(2)~~.

Section 14. Effective January 1, 2019, Paragraphs (rr) and (ss) of subsection (1) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a

license or disciplinary action, as specified in s. 456.072(2):

(rr) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo

contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 459.0137(3) ~~459.0137(2)~~.

(ss) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 459.0137(3) ~~459.0137(2)~~.

Section 15. Paragraph (b) of subsection (4) of section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ocular pharmaceutical agents.—

(4) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon. A certified optometrist may not administer or prescribe:

(b) A controlled substance for the treatment of chronic nonmalignant pain as defined in s. 456.44(1)(f) ~~456.44(1)(c)~~.

Section 16. Paragraph (a) of subsection (1) of section 782.04, Florida Statutes, is amended to read:

782.04 Murder.—

(1)(a) The unlawful killing of a human being:

1. When perpetrated from a premeditated design to effect the death of the person killed or any human being;

2. When committed by a person engaged in the perpetration of, or in the attempt to perpetrate, any:

a. Trafficking offense prohibited by s. 893.135(1),

b. Arson,

c. Sexual battery,

d. Robbery,

e. Burglary,

f. Kidnapping,

g. Escape,

h. Aggravated child abuse,

i. Aggravated abuse of an elderly person or disabled adult,

j. Aircraft piracy,

k. Unlawful throwing, placing, or discharging of a destructive device or bomb,

l. Carjacking,

m. Home-invasion robbery,

n. Aggravated stalking,

o. Murder of another human being,

p. Resisting an officer with violence to his or her person,

q. Aggravated fleeing or eluding with serious bodily injury or death,

r. Felony that is an act of terrorism or is in furtherance of an act of terrorism, including a felony under s. 775.30, s. 775.32, s. 775.33, s. 775.34, or s. 775.35, or

s. Human trafficking; or

3. Which resulted from the unlawful distribution by a

194134

person 18 years of age or older of any of the following substances, or mixture containing any of the following substances, when such substance or mixture is proven to be the proximate cause of the death of the user:

a. A substance controlled under s. 893.03(1);

b. Cocaine, as described in s. 893.03(2)(a)4.;

c. Opium or any synthetic or natural salt, compound, derivative, or preparation of opium;

d. Methadone;

e. Alfentanil, as described in s. 893.03(2)(b)1.;

f. Carfentanil, as described in s. 893.03(2)(b)6.;

g. Fentanyl, as described in s. 893.03(2)(b)9.;

h. Sufentanil, as described in s. 893.03(2)(b)30. ~~893.03(2)(b)29.~~; or

i. A controlled substance analog, as described in s. 893.0356, of any substance specified in sub-subparagraphs a.-h.,

is murder in the first degree and constitutes a capital felony, punishable as provided in s. 775.082.

Section 17. Paragraphs (a), (c), (d), (e), (f), and (h) of subsection (1), subsection (2), paragraphs (a) and (b) of subsection (4), and subsection (5) of section 893.13, Florida Statutes, are amended to read:

893.13 Prohibited acts; penalties.—

(1)(a) Except as authorized by this chapter and chapter 499, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s.

194134

893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302 or a public or private elementary, middle, or secondary school between the hours of 6 a.m. and 12 midnight, or at any time in, on, or within 1,000 feet of real property comprising a state, county, or municipal park, a community center, or a publicly owned recreational facility. As used in this paragraph, the term "community center" means a facility operated by a nonprofit community-based organization for the provision of recreational, social, or educational services to the public. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The defendant

194134

must be sentenced to a minimum term of imprisonment of 3 calendar years unless the offense was committed within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

This paragraph does not apply to a child care facility unless the owner or operator of the facility posts a sign that is not less than 2 square feet in size with a word legend identifying the facility as a licensed child care facility and that is posted on the property of the child care facility in a conspicuous place where the sign is reasonably visible to the public.

(d) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public or private college, university, or other postsecondary educational institution. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s.

194134

893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(e) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance not authorized by law in, on, or within 1,000 feet of a physical place for worship at which a church or religious organization regularly conducts religious services or within 1,000 feet of a convenience business as defined in s. 812.171. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

194134

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(f) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public housing facility at any time. As used in this section, the term "real property comprising a public housing facility" means real property, as defined in s. 421.03(12), of a public corporation created as a housing authority pursuant to part I of chapter 421. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(h) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or

194134

within 1,000 feet of the real property comprising an assisted living facility, as that term is used in chapter 429. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(2)(a) Except as authorized by this chapter and chapter 499, a person may not purchase, or possess with intent to purchase, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

194134

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, a person may not purchase more than 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. A person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Except as authorized by this chapter, a person 18 years of age or older may not deliver any controlled substance to a person younger than 18 years of age, use or hire a person younger than 18 years of age as an agent or employee in the sale or delivery of such a substance, or use such person to assist in avoiding detection or apprehension for a violation of this chapter. A person who violates this subsection with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Imposition of sentence may not be suspended or deferred, and the person so convicted may not be placed on probation.

(5) A person may not bring into this state any controlled

substance unless the possession of such controlled substance is authorized by this chapter or unless such person is licensed to do so by the appropriate federal agency. A person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 18. Paragraphs (c) and (f) of subsection (1) of section 893.135, Florida Statutes, are amended to read:

893.135 Trafficking; mandatory sentences; suspension or reduction of sentences; conspiracy to engage in trafficking.—

(1) Except as authorized in this chapter or in chapter 499 and notwithstanding the provisions of s. 893.13:

(c)1. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of any morphine, opium, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 4 grams or more of any mixture containing any such

194134

substance, but less than 30 kilograms of such substance or mixture, commits a felony of the first degree, which felony shall be known as "trafficking in illegal drugs," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $100,000.

c. Is 28 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $500,000.

2. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of hydrocodone, as described in s. 893.03(2)(a)1.k. ~~893.03(2)(a)1.j.~~, codeine, as described in s. 893.03(2)(a)1.g., or any salt thereof, or 14 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in hydrocodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 50 grams, such person

shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 50 grams or more, but less than 200 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 200 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

3. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 7 grams or more of oxycodone, as described in s. 893.03(2)(a)1.q. ~~893.03(2)(a)1.o.~~, or any salt thereof, or 7 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in oxycodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 7 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 25 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 25 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

194134

d. Is 100 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

4.a. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of:

(I) Alfentanil, as described in s. 893.03(2)(b)1.;

(II) Carfentanil, as described in s. 893.03(2)(b)6.;

(III) Fentanyl, as described in s. 893.03(2)(b)9.;

(IV) Sufentanil, as described in s. 893.03(2)(b)30. ~~893.03(2)(b)29.~~;

(V) A fentanyl derivative, as described in s. 893.03(1)(a)62.;

(VI) A controlled substance analog, as described in s. 893.0356, of any substance described in sub-sub-subparagraphs (I)-(V); or

(VII) A mixture containing any substance described in sub-sub-subparagraphs (I)-(VI),

commits a felony of the first degree, which felony shall be known as "trafficking in fentanyl," punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. If the quantity involved under sub-subparagraph a.:

(I) Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and shall be ordered to pay a fine of $50,000.

(II) Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of

imprisonment of 15 years, and shall be ordered to pay a fine of $100,000.

(III) Is 28 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years, and shall be ordered to pay a fine of $500,000.

5. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the first degree felony of trafficking in illegal drugs. A person who has been convicted of the first degree felony of trafficking in illegal drugs under this subparagraph shall be punished by life imprisonment and is ineligible for any form of discretionary early release except pardon or executive clemency or conditional medical release under s. 947.149. However, if the court determines that, in addition to committing any act specified in this paragraph:

a. The person intentionally killed an individual or counseled, commanded, induced, procured, or caused the intentional killing of an individual and such killing was the result; or

b. The person’s conduct in committing that act led to a natural, though not inevitable, lethal result,

such person commits the capital felony of trafficking in illegal

drugs, punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

6. A person who knowingly brings into this state 60 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 60 kilograms or more of any mixture containing any such substance, and who knows that the probable result of such importation would be the death of a person, commits capital importation of illegal drugs, a capital felony punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

(f)1. Any person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment utilized in the manufacture of amphetamine or methamphetamine, commits a felony of the first degree, which felony shall be known as "trafficking in amphetamine," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

194134

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and the defendant shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 200 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years, and the defendant shall be ordered to pay a fine of $100,000.

c. Is 200 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 calendar years and pay a fine of $250,000.

2. Any person who knowingly manufactures or brings into this state 400 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment used in the manufacture of amphetamine or methamphetamine, and who knows that the probable result of such manufacture or importation would be the death of any person commits capital manufacture or importation of amphetamine, a capital felony punishable as provided in ss. 775.082 and 921.142. Any person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

Section 19. Paragraphs (b) through (e) and (g) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking

chart.—

(3) OFFENSE SEVERITY RANKING CHART

(b) LEVEL 2

Florida Statute	Felony Degree	Description
379.2431 (1)(e)3.	3rd	Possession of 11 or fewer marine turtle eggs in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)4.	3rd	Possession of more than 11 marine turtle eggs in violation of the Marine Turtle Protection Act.
403.413(6)(c)	3rd	Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.
517.07(2)	3rd	Failure to furnish a prospectus meeting requirements.
590.28(1)	3rd	Intentional burning of lands.

	784.05(3)	3rd	Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.
2226			
	787.04(1)	3rd	In violation of court order, take, entice, etc., minor beyond state limits.
2227			
	806.13(1)(b)3.	3rd	Criminal mischief; damage $1,000 or more to public communication or any other public service.
2228			
	810.061(2)	3rd	Impairing or impeding telephone or power to a dwelling; facilitating or furthering burglary.
2229			
	810.09(2)(e)	3rd	Trespassing on posted commercial horticulture property.
2230			
	812.014(2)(c)1.	3rd	Grand theft, 3rd degree; $300 or more but less than $5,000.
2231			
	812.014(2)(d)	3rd	Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage

			of dwelling.
2232			
	812.015(7)	3rd	Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.
2233			
	817.234(1)(a)2.	3rd	False statement in support of insurance claim.
2234			
	817.481(3)(a)	3rd	Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.
2235			
	817.52(3)	3rd	Failure to redeliver hired vehicle.
2236			
	817.54	3rd	With intent to defraud, obtain mortgage note, etc., by false representation.
2237			
	817.60(5)	3rd	Dealing in credit cards of another.
2238			
	817.60(6)(a)	3rd	Forgery; purchase goods, services with false card.
2239			
	817.61	3rd	Fraudulent use of credit cards

			over $100 or more within 6 months.
2240			
	826.04	3rd	Knowingly marries or has sexual intercourse with person to whom related.
2241			
	831.01	3rd	Forgery.
2242			
	831.02	3rd	Uttering forged instrument; utters or publishes alteration with intent to defraud.
2243			
	831.07	3rd	Forging bank bills, checks, drafts, or promissory notes.
2244			
	831.08	3rd	Possessing 10 or more forged notes, bills, checks, or drafts.
2245			
	831.09	3rd	Uttering forged notes, bills, checks, drafts, or promissory notes.
2246			
	831.11	3rd	Bringing into the state forged bank bills, checks, drafts, or notes.
2247			
	832.05(3)(a)	3rd	Cashing or depositing item with

		intent to defraud.
843.08	3rd	False personation.
893.13(2)(a)2.	3rd	Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs other than cannabis.
893.147(2)	3rd	Manufacture or delivery of drug paraphernalia.

(c) LEVEL 3

Florida Statute	Felony Degree	Description
119.10(2)(b)	3rd	Unlawful use of confidential information from police reports.
316.066 (3)(b)-(d)	3rd	Unlawfully obtaining or using confidential crash reports.
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.

316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.

328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
379.2431 (1)(e)5.	3rd	Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)6.	3rd	Possessing any marine turtle species or hatchling, or parts thereof, or the nest of any marine turtle species described in the Marine Turtle Protection Act.
379.2431 (1)(e)7.	3rd	Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.

2271			
	400.9935(4)(a) or (b)	3rd	Operating a clinic, or offering services requiring licensure, without a license.
2272			
	400.9935(4)(e)	3rd	Filing a false license application or other required information or failing to report information.
2273			
	440.1051(3)	3rd	False report of workers' compensation fraud or retaliation for making such a report.
2274			
	501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
2275			
	624.401(4)(a)	3rd	Transacting insurance without a certificate of authority.
2276			
	624.401(4)(b)1.	3rd	Transacting insurance without a certificate of authority; premium collected less than $20,000.
2277			
	626.902(1)(a) &	3rd	Representing an unauthorized

(b)		insurer.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(5)(b)	2nd	Computer offense devised to

			defraud or obtain property.
2286			
	817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
2287			
	817.233	3rd	Burning to defraud insurer.
2288			
	817.234 (8)(b) & (c)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
2289			
	817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
2290			
	817.236	3rd	Filing a false motor vehicle insurance application.
2291			
	817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.
2292			
	817.413(2)	3rd	Sale of used goods as new.
2293			
	828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or

194134

			death.
2294			
	831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
2295			
	831.29	2nd	Possession of instruments for counterfeiting driver licenses or identification cards.
2296			
	838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
2297			
	843.19	3rd	Injure, disable, or kill police dog or horse.
2298			
	860.15(3)	3rd	Overcharging for repairs and parts.
2299			
	870.01(2)	3rd	Riot; inciting or encouraging.
2300			
	893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs).

2301			
	893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of university.
2302			
	893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of public housing facility.
2303			
	893.13(4)(c)	3rd	Use or hire of minor; deliver to minor other controlled substances.
2304			
	893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
2305			
	893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.

2306			
	893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
2307			
	893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
2308			
	893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
2309			
	893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner’s practice.
2310			
	893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner’s practice to assist a patient, other person, or owner of an animal in obtaining a controlled

		substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47 (1)(a)1. & 2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.721	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

194134

(d) LEVEL 4

Florida Statute	Felony Degree	Description
316.1935(3)(a)	2nd	Driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
499.0051(1)	3rd	Failure to maintain or deliver transaction history, transaction information, or transaction statements.
499.0051(5)	2nd	Knowing sale or delivery, or possession with intent to sell, contraband prescription drugs.
517.07(1)	3rd	Failure to register securities.

517.12(1)	3rd	Failure of dealer, associated person, or issuer of securities to register.
784.07(2)(b)	3rd	Battery of law enforcement officer, firefighter, etc.
784.074(1)(c)	3rd	Battery of sexually violent predators facility staff.
784.075	3rd	Battery on detention or commitment facility staff.
784.078	3rd	Battery of facility employee by throwing, tossing, or expelling certain fluids or materials.
784.08(2)(c)	3rd	Battery on a person 65 years of age or older.
784.081(3)	3rd	Battery on specified official or employee.

784.082(3)	3rd	Battery by detained person on visitor or other detainee.
784.083(3)	3rd	Battery on code inspector.
784.085	3rd	Battery of child by throwing, tossing, projecting, or expelling certain fluids or materials.
787.03(1)	3rd	Interference with custody; wrongly takes minor from appointed guardian.
787.04(2)	3rd	Take, entice, or remove child beyond state limits with criminal intent pending custody proceedings.
787.04(3)	3rd	Carrying child beyond state lines with criminal intent to avoid producing child at

			custody hearing or delivering to designated person.
2338			
	787.07	3rd	Human smuggling.
2339			
	790.115(1)	3rd	Exhibiting firearm or weapon within 1,000 feet of a school.
2340			
	790.115(2)(b)	3rd	Possessing electric weapon or device, destructive device, or other weapon on school property.
2341			
	790.115(2)(c)	3rd	Possessing firearm on school property.
2342			
	800.04(7)(c)	3rd	Lewd or lascivious exhibition; offender less than 18 years.
2343			
	810.02(4)(a)	3rd	Burglary, or attempted burglary, of an unoccupied structure; unarmed; no assault or battery.
2344			

	810.02(4)(b)	3rd	Burglary, or attempted burglary, of an unoccupied conveyance; unarmed; no assault or battery.
2345			
	810.06	3rd	Burglary; possession of tools.
2346			
	810.08(2)(c)	3rd	Trespass on property, armed with firearm or dangerous weapon.
2347			
	812.014(2)(c)3.	3rd	Grand theft, 3rd degree $10,000 or more but less than $20,000.
2348			
	812.014 (2)(c)4.-10.	3rd	Grand theft, 3rd degree, a will, firearm, motor vehicle, livestock, etc.
2349			
	812.0195(2)	3rd	Dealing in stolen property by use of the Internet; property stolen $300 or more.
2350			
	817.505(4)(a)	3rd	Patient brokering.
2351			
	817.563(1)	3rd	Sell or deliver

			substance other than controlled substance agreed upon, excluding s. 893.03(5) drugs.
2352			
	817.568(2)(a)	3rd	Fraudulent use of personal identification information.
2353			
	817.625(2)(a)	3rd	Fraudulent use of scanning device, skimming device, or reencoder.
2354			
	817.625(2)(c)	3rd	Possess, sell, or deliver skimming device.
2355			
	828.125(1)	2nd	Kill, maim, or cause great bodily harm or permanent breeding disability to any registered horse or cattle.
2356			
	837.02(1)	3rd	Perjury in official proceedings.
2357			
	837.021(1)	3rd	Make contradictory statements in official

			proceedings.
2358			
	838.022	3rd	Official misconduct.
2359			
	839.13(2)(a)	3rd	Falsifying records of an individual in the care and custody of a state agency.
2360			
	839.13(2)(c)	3rd	Falsifying records of the Department of Children and Families.
2361			
	843.021	3rd	Possession of a concealed handcuff key by a person in custody.
2362			
	843.025	3rd	Deprive law enforcement, correctional, or correctional probation officer of means of protection or communication.
2363			
	843.15(1)(a)	3rd	Failure to appear while on bail for felony (bond estreature or bond jumping).
2364			

194134

847.0135(5)(c)	3rd	Lewd or lascivious exhibition using computer; offender less than 18 years.
874.05(1)(a)	3rd	Encouraging or recruiting another to join a criminal gang.
893.13(2)(a)1.	2nd	Purchase of cocaine (or other s. 893.03(1)(a), (b), or (d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).
914.14(2)	3rd	Witnesses accepting bribes.
914.22(1)	3rd	Force, threaten, etc., witness, victim, or informant.
914.23(2)	3rd	Retaliation against a witness, victim, or informant, no bodily injury.
918.12	3rd	Tampering with jurors.

934.215	3rd	Use of two-way communications device to facilitate commission of a crime.

(e) LEVEL 5

Florida Statute	Felony Degree	Description
316.027(2)(a)	3rd	Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.
316.1935(4)(a)	2nd	Aggravated fleeing or eluding.
316.80(2)	2nd	Unlawful conveyance of fuel; obtaining fuel fraudulently.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving

			personal injury; leaving scene.
2383			
	379.365(2)(c)1.	3rd	Violation of rules relating to: willful molestation of stone crab traps, lines, or buoys; illegal bartering, trading, or sale, conspiring or aiding in such barter, trade, or sale, or supplying, agreeing to supply, aiding in supplying, or giving away stone crab trap tags or certificates; making, altering, forging, counterfeiting, or reproducing stone crab trap tags; possession of forged, counterfeit, or imitation stone crab trap tags; and engaging in the commercial harvest of stone crabs while license is suspended or revoked.
2384			
	379.367(4)	3rd	Willful molestation of a commercial harvester’s spiny lobster trap, line, or buoy.
2385			
	379.407(5)(b)3.	3rd	Possession of 100 or more undersized spiny lobsters.
2386			
	381.0041(11)(b)	3rd	Donate blood, plasma, or organs

			knowing HIV positive.
2387			
	440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
2388			
	440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
2389			
	440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
2390			
	624.401(4)(b)2.	2nd	Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than $100,000.
2391			
	626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
2392			
	790.01(2)	3rd	Carrying a concealed firearm.
2393			
	790.162	2nd	Threat to throw or discharge destructive device.
2394			
	790.163(1)	2nd	False report of bomb,

		explosive, weapon of mass destruction, or use of firearms in violent manner.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms, ammunition, or electronic weapons or devices.
796.05(1)	2nd	Live on earnings of a prostitute; 1st offense.
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years of age.
800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years of age or older.
806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more

			but less than $50,000.
812.015(8)		3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
812.019(1)		2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)		3rd	Robbery by sudden snatching.
812.16(2)		3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.		2nd	Communications fraud, value $20,000 to $50,000.
817.234(11)(b)		2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
817.2341(1), (2)(a) & (3)(a)		3rd	Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity.
817.568(2)(b)		2nd	Fraudulent use of personal

			identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.
2410			
	817.611(2)(a)	2nd	Traffic in or possess 5 to 14 counterfeit credit cards or related documents.
2411			
	817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device, skimming device, or reencoder.
2412			
	825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
2413			
	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
2414			
	827.071(5)	3rd	Possess, control, or intentionally view any

			photographic material, motion picture, etc., which includes sexual conduct by a child.
2415			
	839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
2416			
	843.01	3rd	Resist officer with violence to person; resist arrest with violence.
2417			
	847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18 years or older.
2418			
	847.0137 (2) & (3)	3rd	Transmission of pornography by electronic device or equipment.
2419			
	847.0138 (2) & (3)	3rd	Transmission of material harmful to minors to a minor by electronic device or equipment.
2420			
	874.05(1)(b)	2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.

194134

874.05(2)(a)	2nd	Encouraging or recruiting person under 13 years of age to join a criminal gang.
893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000

			feet of university.
2425			
	893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
2426			
	893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of public housing facility.
2427			
	893.13(4)(b)	2nd	Use or hire of minor; deliver to minor other controlled substance.
2428			
	893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

(g) LEVEL 7

Florida Statute	Felony Degree	Description
316.027(2)(c)	1st	Accident involving death, failure to stop; leaving scene.
316.193(3)(c)2.	3rd	DUI resulting in serious bodily injury.
316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
402.319(2)	2nd	Misrepresentation and

			negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
2438			
	409.920 (2)(b)1.a.	3rd	Medicaid provider fraud; $10,000 or less.
2439			
	409.920 (2)(b)1.b.	2nd	Medicaid provider fraud; more than $10,000, but less than $50,000.
2440			
	456.065(2)	3rd	Practicing a health care profession without a license.
2441			
	456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
2442			
	458.327(1)	3rd	Practicing medicine without a license.
2443			
	459.013(1)	3rd	Practicing osteopathic medicine without a license.
2444			

 194134

460.411(1)	3rd	Practicing chiropractic medicine without a license.
461.012(1)	3rd	Practicing podiatric medicine without a license.
462.17	3rd	Practicing naturopathy without a license.
463.015(1)	3rd	Practicing optometry without a license.
464.016(1)	3rd	Practicing nursing without a license.
465.015(2)	3rd	Practicing pharmacy without a license.
466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
467.201	3rd	Practicing midwifery without a license.
468.366	3rd	Delivering respiratory care services without a

			license.
2453			
	483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
2454			
	483.901(7)	3rd	Practicing medical physics without a license.
2455			
	484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
2456			
	484.053	3rd	Dispensing hearing aids without a license.
2457			
	494.0018(2)	1st	Conviction of any violation of chapter 494 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
2458			
	560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by a money services business.

560.125(5)(a)	3rd	Money services business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver license or identification card; other registration violations.
775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.

194134

782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
782.071	2nd	Killing of a human being or unborn child by the operation of a motor vehicle in a reckless manner (vehicular homicide).
782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.
784.045(1)(a)2.	2nd	Aggravated battery; using

		deadly weapon.
784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
784.048(7)	3rd	Aggravated stalking; violation of court order.
784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
784.081(1)	1st	Aggravated battery on specified official or employee.
784.082(1)	1st	Aggravated battery by

		detained person on visitor or other detainee.
784.083(1)	1st	Aggravated battery on code inspector.
787.06(3)(a)2.	1st	Human trafficking using coercion for labor and services of an adult.
787.06(3)(e)2.	1st	Human trafficking using coercion for labor and services by the transfer or transport of an adult from outside Florida to within the state.
790.07(4)	1st	Specified weapons violation subsequent to previous conviction of s. 790.07(1) or (2).
790.16(1)	1st	Discharge of a machine gun under specified circumstances.
790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.

194134

790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
790.23	1st,PBL	Possession of a firearm by a person who qualifies for the penalty enhancements provided for in s. 874.04.
794.08(4)	3rd	Female genital mutilation; consent by a parent, guardian, or a person in custodial authority to a victim younger than 18

			years of age.
2489			
	796.05(1)	1st	Live on earnings of a prostitute; 2nd offense.
2490			
	796.05(1)	1st	Live on earnings of a prostitute; 3rd and subsequent offense.
2491			
	800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim younger than 12 years of age; offender younger than 18 years of age.
2492			
	800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years of age; offender 18 years of age or older.
2493			
	800.04(5)(e)	1st	Lewd or lascivious molestation; victim 12 years of age or older but younger than 16 years; offender 18 years or older; prior conviction for specified sex offense.

806.01(2)	2nd	Maliciously damage structure by fire or explosive.
810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
810.02(3)(e)	2nd	Burglary of authorized emergency vehicle.
812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more or a semitrailer deployed by a law enforcement officer; property stolen while causing other property damage; 1st degree grand theft.

194134

812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
812.014(2)(b)4.	2nd	Property stolen, law enforcement equipment from authorized emergency vehicle.
812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other

			weapon.
2507			
	817.034(4)(a)1.	1st	Communications fraud, value greater than $50,000.
2508			
	817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
2509			
	817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
2510			
	817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
2511			
	817.2341 (2)(b) & (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
2512			
	817.535(2)(a)	3rd	Filing false lien or other unauthorized document.

817.611(2)(b)	2nd	Traffic in or possess 15 to 49 counterfeit credit cards or related documents.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.
825.103(3)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $10,000 or more, but less than $50,000.
827.03(2)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
837.05(2)	3rd	Giving false information

			about alleged capital felony to a law enforcement officer.
838.015		2nd	Bribery.
838.016		2nd	Unlawful compensation or reward for official behavior.
838.021(3)(a)		2nd	Unlawful harm to a public servant.
838.22		2nd	Bid tampering.
843.0855(2)		3rd	Impersonation of a public officer or employee.
843.0855(3)		3rd	Unlawful simulation of legal process.
843.0855(4)		3rd	Intimidation of a public officer or employee.
847.0135(3)		3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.

194134

847.0135(4)	2nd	Traveling to meet a minor to commit an unlawful sex act.
872.06	2nd	Abuse of a dead human body.
874.05(2)(b)	1st	Encouraging or recruiting person under 13 to join a criminal gang; second or subsequent offense.
874.10	1st,PBL	Knowingly initiates, organizes, plans, finances, directs, manages, or supervises criminal gang-related activity.
893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly

			owned recreational facility or community center.
2532			
	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~, within 1,000 feet of property used for religious services or a specified business site.
2533			
	893.13(4)(a)	1st	Use or hire of minor; deliver to minor other controlled substance.
2534			
	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
2535			
	893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
2536			
	893.135 (1)(c)1.a.	1st	Trafficking in illegal drugs, more than 4 grams,

		less than 14 grams.
893.135 (1)(c)2.a.	1st	Trafficking in hydrocodone, 14 grams or more, less than 28 grams.
893.135 (1)(c)2.b.	1st	Trafficking in hydrocodone, 28 grams or more, less than 50 grams.
893.135 (1)(c)3.a.	1st	Trafficking in oxycodone, 7 grams or more, less than 14 grams.
893.135 (1)(c)3.b.	1st	Trafficking in oxycodone, 14 grams or more, less than 25 grams.
893.135 (1)(c)4.b.(I)	1st	Trafficking in fentanyl, 4 grams or more, less than 14 grams.
893.135 (1)(d)1.a.	1st	Trafficking in phencyclidine, 28 grams or more, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, 200 grams or more, less than 5

			kilograms.
2544			
	893.135(1)(f)1.	1st	Trafficking in amphetamine, 14 grams or more, less than 28 grams.
2545			
	893.135 (1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
2546			
	893.135 (1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
2547			
	893.135 (1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
2548			
	893.135 (1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
2549			
	893.135 (1)(m)2.a.	1st	Trafficking in synthetic cannabinoids, 280 grams or more, less than 500 grams.
2550			

2551	893.135 (1)(m)2.b.	1st	Trafficking in synthetic cannabinoids, 500 grams or more, less than 1,000 grams.
2552	893.135 (1)(n)2.a.	1st	Trafficking in n-benzyl phenethylamines, 14 grams or more, less than 100 grams.
2553	893.1351(2)	2nd	Possession of place for trafficking in or manufacturing of controlled substance.
2554	896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
2555	896.104(4)(a)1.	3rd	Structuring transactions to evade reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
	943.0435(4)(c)	2nd	Sexual offender vacating permanent residence;

			failure to comply with reporting requirements.
2556			
	943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
2557			
	943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
2558			
	943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
2559			
	943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.
2560			
	944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.

944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification; providing false registration information.
985.4815(10)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.
985.4815(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
985.4815(13)	3rd	Sexual offender; failure

194134

to report and reregister; failure to respond to address verification; providing false registration information.

Section 20. For the 2018-2019 fiscal year:

(1)(a) The nonrecurring sum of $27,035,360 from the Federal Grants Trust Fund, and the recurring sum of $15,520,000 from the General Revenue Fund are appropriated to the Department of Children and Families. These funds shall be used for the following services to address opioid and other substance abuse disorders: outpatient, case management, and after care services; residential treatment; medication-assisted treatment, including the purchase and medical use of methadone, buprenorphine, and naltrexone extended-release injectable; peer recovery support; hospital and first responder outreach; and outreach targeted to pregnant women.

(b) From a total of $4,720,000 of the recurring general revenue funds specified in paragraph (a), the Department of Children and Families shall contract with a nonprofit organization for the distribution and associated costs for the following drugs as part of its medication assisted treatment program for substance abuse disorders:

1. $472,000 for methadone;

2. $1,888,000 for buprenorphine; and

3. $2,360,000 for naltrexone extended-release injectable.

(2) The recurring sum of $6 million from the General

194134

Revenue Fund is appropriated to the Office of the State Courts Administrator for treatment of substance abuse disorders in individuals involved in the criminal justice system, individuals who have a high likelihood of criminal justice involvement, or who are in court-ordered, community-based drug treatment. The Office of the State Courts Administrator shall use the funds to contract with a non-profit entity for the purpose of distributing the medication. The Office of the State Courts Administrator shall make available the following drugs:

(a) $600,000 for methadone;

(b) $2.4 million for buprenorphine; and

(c) $3 million for naltrexone extended-release injectable.

(3) The recurring sum of $5 million from the General Revenue Fund is appropriated to the Department of Health for the purchase of naloxone to be made available to emergency responders.

Section 21. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2018.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to controlled substances; amending s. 409.967, F.S.; prohibiting managed care plans and their fiscal agents or intermediaries from imposing certain requirements or conditions on recipients as a prerequisite to receiving medication-assisted

treatment (MAT) services to treat substance abuse disorders; creating s. 456.0301, F.S.; authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial license renewal; providing exceptions; providing course requirements; prohibiting the Department of Health from renewing a license of a prescriber under specified circumstances; requiring a licensee to submit confirmation of course completion; providing for each licensing board requiring such continuing education course to include hours of completion with the total hours of continuing education required in certain circumstances; authorizing rulemaking; amending s. 456.072, F.S.; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; amending s. 456.44, F.S.; defining the term “acute pain”; requiring the applicable boards to adopt rules establishing certain guidelines for prescribing controlled substances for acute pain; providing that failure of a practitioner to follow specified guidelines is grounds for disciplinary action; limiting opioid drug prescriptions for the treatment of acute pain to a specified period under certain circumstances; authorizing prescriptions for such opioids for an extended period if specified requirements are met; amending ss. 458.3265 and 459.0137, F.S.; requiring

194134

certain pain management clinic owners to register approved exemptions with the department; requiring certain clinics to obtain certificates of exemption; providing requirements for such certificates; requiring the department to adopt rules necessary to administer such exemptions; amending ss. 465.0155 and 465.0276, F.S.; providing requirements for pharmacists and practitioners for the dispensing of controlled substances to persons not known to them; defining the term "proper identification"; amending s. 627.42392, F.S.; prohibiting a health insurer from imposing certain requirements or conditions on insureds as a prerequisite to receiving medication-assisted treatment (MAT) services to treat substance abuse disorders; amending s. 893.03, F.S.; conforming the state controlled substances schedule to the federal controlled substances schedule; amending s. 893.055, F.S.; revising and providing definitions; revising requirements for the prescription drug monitoring program; authorizing rulemaking; requiring the department to maintain an electronic system for certain purposes which meets specified requirements; requiring certain information to be reported to the system by a specified time; specifying direct access to system information; authorizing the department to enter into reciprocal agreements or contracts to share prescription drug monitoring information with certain entities; providing requirements for such agreements; authorizing the department to enter into agreements or

contracts for secure connections with practitioner electronic systems; requiring specified persons to consult the system for certain purposes within a specified time; providing exceptions to the duty of specified persons to consult the system under certain circumstances; authorizing the department to issue citations to specified entities for failing to meet certain requirements; prohibiting the failure to report the dispensing of a controlled substance when required to do so; providing penalties; authorizing the department to enter into agreements or contracts for specified purposes; providing for the release of information obtained by the system; allowing specified persons to have direct access to information for the purpose of reviewing the controlled drug prescription history of a patient; providing prescriber or dispenser immunity from liability for review of patient history when acting in good faith; providing construction; prohibiting the department from specified uses of funds; requiring the department to conduct or participate in studies for specified purposes; requiring an annual report to be submitted to the Governor and Legislature by a specified date; providing report requirements; authorizing the department to establish a certain direct-support organization for specified purposes; defining the term "direct-support organization"; requiring a direct-support organization to operate under written contract with the department; providing contract requirements;

194134

requiring the direct-support organization to obtain written approval from the department for specified purposes; authorizing the department to adopt certain rules relating to resources used by the direct-support organization; providing for an independent annual financial audit by the direct-support organization; providing that copies of such audit be provided to specified entities; providing for future repeal of provisions relating to the direct-support organization; requiring the department to adopt rules to implement the system; amending s. 893.0551, F.S.; revising provisions concerning the release of information held by the prescription drug monitoring program; amending ss. 458.331, 459.015, 463.0055, 782.04, 893.13, 893.135, and 921.0022, F.S.; correcting cross-references; conforming provisions to changes made by the act; providing appropriations; providing effective dates.

By Senator Benacquisto

27-00673-18 20188__

A bill to be entitled

An act relating to controlled substances; creating s. 456.0301, F.S.; authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial renewal; providing exceptions; providing course requirements; prohibiting the department from renewing a license of a prescriber under specified circumstances; requiring a licensee to submit confirmation of course completion; providing for each licensing board requiring such continuing education course to include hours of completion with the total hours of continuing education required in certain circumstances; authorizing rulemaking; amending s. 456.072, F.S.; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; amending s. 456.44, F.S.; defining the term "acute pain"; providing for the adoption of standards of practice for the treatment of acute pain; providing that failure of a practitioner to follow specified guidelines is grounds for disciplinary action; limiting opioid prescriptions for the treatment of acute pain to a specified period under certain circumstances; authorizing prescriptions for such opioids for an extended period if specified requirements are met; amending ss. 458.3265 and 459.0137, F.S.; requiring certain pain management clinic owners to register approved exemptions with the

department; requiring certain clinics to obtain certificates of exemption; providing requirements for such certificates; authorizing rulemaking relating to specified exemptions; amending ss. 465.0155 and 465.0276, F.S.; providing requirements for pharmacists and practitioners for the dispensing of controlled substances to persons not known to them; defining the term "proper identification"; amending s. 893.03, F.S.; conforming the state controlled substances schedule to the federal controlled substances schedule; amending s. 893.055, F.S.; revising and providing definitions; revising requirements for the prescription drug monitoring program; authorizing rulemaking; requiring the department to maintain an electronic system for certain purposes to meet specified requirements; requiring certain information to be reported to the system by a specified time; specifying direct access to system information; authorizing the department to enter into reciprocal agreements or contracts to share prescription drug monitoring information with certain entities; providing requirements for such agreements; authorizing the department to enter into agreements or contracts for secure connections with practitioner electronic systems; requiring specified persons to consult the system for certain purposes within a specified time; providing exceptions to the duty of specified persons to consult the system under certain circumstances; authorizing the department to issue

nondisciplinary citations to specified entities for failing to meet certain requirements; prohibiting the failure to report the dispensing of a controlled substance when required to do so; providing penalties; authorizing the department to enter into agreements or contracts for specified purposes; providing for the release of information obtained by the system; allowing specified persons to have direct access to information for the purpose of reviewing the controlled drug prescription history of a patient; providing prescriber or dispenser immunity from liability for review of patient history when acting in good faith; providing construction; prohibiting the department from specified uses of funds; authorizing the department to conduct or participate in studies for specified purposes; requiring an annual report to be submitted to the Governor and Legislature by a specified date; providing report requirements; providing exemptions; establishing direct-support organizations for specified purposes; defining the term "direct-support organization"; requiring a direct-support organization to operate under written contract with the department; providing contract requirements; requiring the direct-support organization to obtain written approval from the department for specified purposes; authorizing rulemaking; providing for an independent annual financial audit by the direct-support organization; providing that copies of such audit be provided to

specified entities; providing for future repeal of provisions relating to the direct-support organization; amending s. 893.0551, F.S.; revising provisions concerning release of information held by the prescription drug monitoring program; amending ss. 458.331, 459.015, 463.0055, 782.04, 893.13, 893.135, and 921.0022, F.S.; correcting cross-references; conforming provisions to changes made by the act; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 456.0301, Florida Statutes, is created to read:

456.0301 Requirement for instruction on controlled substance prescribing.-

(1)(a) If not already required by the licensee's practice act, the appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour continuing education course on prescribing controlled substances as part of biennial renewal. The course must include information on the current standards regarding for prescribing controlled substances, particularly opiates, alternatives to these standards, and information on the risks of opioid addiction following all stages of treatment in the management of acute pain. The course may be offered in a distance learning format and must be included within the number of continuing education

hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement Administration to prescribe controlled substances that has failed to complete the course. When required by this paragraph, the course shall be completed by January 31, 2019, and at each subsequent renewal.

(b) Each such licensee shall submit confirmation of having completed such course when applying for biennial renewal.

(c) Each licensing board that requires a licensee to complete an educational course pursuant to this subsection may include the hours required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(2) Each board may adopt rules to administer this section.

Section 2. Paragraph (gg) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(gg) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter or ss. 893.055 and 893.0551, a violation of the applicable practice act, or a violation of any rules adopted under this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such

a pattern from billing records, data, or any other information obtained by the department.

Section 3. Paragraphs (a) through (g) of subsection (1) of section 456.44, Florida Statutes, are redesignated as paragraphs (b) through (h), respectively, a new paragraph (a) is added to that subsection, subsection (3) is amended, and subsections (4) and (5) are added to that section, to read:

456.44 Controlled substance prescribing.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Acute pain" means the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall

also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant shall use a written controlled substance agreement between the registrant and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric

disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient’s government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant’s full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a

mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians,

the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

(4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The department shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation of a treatment plan, obtaining informed consent and agreement for treatment, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).

(5) PRESCRIPTION SUPPLY.-

(a) Except as provided in paragraph (b), a prescription for a Schedule II opioid, as defined in s. 893.03 or 21 U.S.C. s. 812, for the treatment of acute pain must not exceed a 3-day supply.

(b) An up to 7-day supply of an opioid described in paragraph (a) may be prescribed if:

1. The practitioner, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient’s pain as an acute medical condition.

2. The practitioner indicates "MEDICALLY NECESSARY" on the prescription.

3. The prescriber adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the 3-day supply limit established in this subsection.

Section 4. Effective January 1, 2019, subsections (2) through (5) of section 458.3265, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) are amended, and a new subsection (2) is added to that section, to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-

management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (4)~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1), must apply for a certificate of exemption on a form adopted in rule by the department. The form shall require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) Within 30 days after the receipt of a complete application, the department must approve or deny the application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A certificate of exemption is not movable or transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must immediately notify the department and register as a pain management clinic under subsection (1).

(3)~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) A physician may not practice medicine in a pain-management clinic, as described in subsection (5)~~(4)~~, if the

pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. A physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) ~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Medicine adopted pursuant to subsection (5) ~~(4)~~ unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Medicine.

(5) ~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 5. Effective January 1, 2019, subsections (2) through (5) of section 459.0137, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) are amended, and a new subsection (2) is added to that section, to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

(a)1. As used in this section, the term:

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical

services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location

based upon an annual inspection and evaluation of the factors described in subsection (4) ~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1), must apply for a certificate of exemption on a form adopted in rule by the department. The form shall require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) Within 30 days after the receipt of a complete application, the department must approve or deny the application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A certificate of exemption is not movable or transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory

exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must immediately notify the department and register as a pain management clinic under subsection (1).

(3) ~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) An osteopathic physician may not practice medicine in a pain-management clinic, as described in subsection (5) ~~(4)~~, if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Osteopathic Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. An osteopathic physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) ~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Osteopathic Medicine adopted pursuant to subsection (5) ~~(4)~~

unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic Medicine.

(5)~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 6. Section 465.0155, Florida Statutes, is amended to read:

465.0155 Standards of practice.—

(1) Consistent with the provisions of this act, the board shall adopt by rule standards of practice relating to the practice of pharmacy which shall be binding on every state agency and shall be applied by such agencies when enforcing or implementing any authority granted by any applicable statute, rule, or regulation, whether federal or state.

(2)(a) Before dispensing a controlled substance to a person not known to the pharmacist, the pharmacist must require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the pharmacist may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

(b) This subsection does not apply in an institutional

setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

(c) As used in this subsection, the term "proper identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 7. Paragraph (d) is added to subsection (2) of section 465.0276, Florida Statutes, to read:

465.0276 Dispensing practitioner.—

(2) A practitioner who dispenses medicinal drugs for human consumption for fee or remuneration of any kind, whether direct or indirect, must:

(d)1. Before dispensing a controlled substance to a person not known to the dispenser, require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the dispenser may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

2. This paragraph does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

3. As used in this paragraph, the term "proper

identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 8. Subsections (2), (3), (4), and (5) of section 893.03, Florida Statutes, are amended to read:

893.03 Standards and schedules.—The substances enumerated in this section are controlled by this chapter. The controlled substances listed or to be listed in Schedules I, II, III, IV, and V are included by whatever official, common, usual, chemical, trade name, or class designated. The provisions of this section shall not be construed to include within any of the schedules contained in this section any excluded drugs listed within the purview of 21 C.F.R. s. 1308.22, styled "Excluded Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt Anabolic Steroid Products."

(2) SCHEDULE II.—A substance in Schedule II has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. The following substances are controlled in Schedule II:

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances, whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis:

1. Opium and any salt, compound, derivative, or preparation of opium, except nalmefene or isoquinoline alkaloids of opium, including, but not limited to the following:

a. Raw opium.

b. Opium extracts.

c. Opium fluid extracts.

d. Powdered opium.

e. Granulated opium.

f. Tincture of opium.

g. Codeine.

h. Dihydroetorphine.

i.~~h.~~ Ethylmorphine.

j.~~i.~~ Etorphine hydrochloride.

k.~~j.~~ Hydrocodone and hydrocodone combination products.

l.~~k.~~ Hydromorphone.

m.~~l.~~ Levo-alphacetylmethadol (also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM).

n.~~m.~~ Metopon (methyldihydromorphinone).

o.~~n.~~ Morphine.

p. Oripavine.

q.~~o.~~ Oxycodone.

r.~~p.~~ Oxymorphone.

s.~~q.~~ Thebaine.

2. Any salt, compound, derivative, or preparation of a substance which is chemically equivalent to or identical with any of the substances referred to in subparagraph 1., except that these substances shall not include the isoquinoline alkaloids of opium.

3. Any part of the plant of the species *Papaver somniferum*,

L.

4. Cocaine or ecgonine, including any of their stereoisomers, and any salt, compound, derivative, or preparation of cocaine or ecgonine, except that these substances shall not include ioflupane I 123.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

1. Alfentanil.

2. Alphaprodine.

3. Anileridine.

4. Bezitramide.

5. Bulk propoxyphene (nondosage forms).

6. Carfentanil.

7. Dihydrocodeine.

8. Diphenoxylate.

9. Fentanyl.

10. Isomethadone.

11. Levomethorphan.

12. Levorphanol.

13. Metazocine.

14. Methadone.

15. Methadone-Intermediate,4-cyano-2-dimethylamino-4,4-diphenylbutane.

16. Moramide-Intermediate,2-methyl-3-morpholoino-1,1-diphenylpropane-carboxylic acid.

17. Nabilone.

18. Pethidine (meperidine).

19. Pethidine-Intermediate-A,4-cyano-1-methyl-4-phenylpiperidine.

20. Pethidine-Intermediate-B,ethyl-4-phenylpiperidine-4-carboxylate.

21. Pethidine-Intermediate-C,1-methyl-4- phenylpiperidine-4-carboxylic acid.

22. Phenazocine.

23. Phencyclidine.

24. 1-Phenylcyclohexylamine.

25. Piminodine.

26. 1-Piperidinocyclohexanecarbonitrile.

27. Racemethorphan.

28. Racemorphan.

29. Remifentanil.

30.~~29.~~ Sufentanil.

31. Tapentadol.

32. Thiafentanil.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers, optical isomers, salts of their isomers, and salts of their optical isomers:

1. Amobarbital.

2. Amphetamine.

3. Glutethimide.

4. Lisdexamfetamine.

5.~~4.~~ Methamphetamine.

6.~~5.~~ Methylphenidate.

7.~~6.~~ Pentobarbital.

8.~~7.~~ Phenmetrazine.

9.~~8.~~ Phenylacetone.

10.~~9.~~ Secobarbital.

(d) Dronabinol (synthetic THC) in oral solution in a drug product approved by the United States Food and Drug Administration.

(3) SCHEDULE III.—A substance in Schedule III has a potential for abuse less than the substances contained in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. The following substances are controlled in Schedule III:

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a depressant or stimulant effect on the nervous system:

1. Any substance which contains any quantity of a derivative of barbituric acid, including thiobarbituric acid, or any salt of a derivative of barbituric acid or thiobarbituric acid, including, but not limited to, butabarbital and butalbital.

2. Benzphetamine.

3. Buprenorphine.

4.~~3.~~ Chlorhexadol.

5.~~4.~~ Chlorphentermine.

6.~~5.~~ Clortermine.

7. Embutramide.

8.~~6.~~ Lysergic acid.

9.~~7.~~ Lysergic acid amide.

10.~~8.~~ Methyprylon.

11. Perampanel.

12.~~9.~~ Phendimetrazine.

13.~~10.~~ Sulfondiethylmethane.

14.~~11.~~ Sulfonethylmethane.

15.~~12.~~ Sulfonmethane.

16.~~13.~~ Tiletamine and zolazepam or any salt thereof.

(b) Nalorphine.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following controlled substances or any salts thereof:

1. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

2. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

3. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

4. Not more than 300 milligrams of hydrocodone per 100

milliliters or not more than 15 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients that are not controlled substances.

5. Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

6. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

7. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

For purposes of charging a person with a violation of s. 893.135 involving any controlled substance described in subparagraph 3. or subparagraph 4., the controlled substance is a Schedule III controlled substance pursuant to this paragraph but the weight of the controlled substance per milliliters or per dosage unit is not relevant to the charging of a violation of s. 893.135. The weight of the controlled substance shall be determined pursuant to s. 893.135(6).

(d) Anabolic steroids.

1. The term "anabolic steroid" means any drug or hormonal substance, chemically and pharmacologically related to testosterone, other than estrogens, progestins, and corticosteroids, that promotes muscle growth and includes:

a. Androsterone.
b. Androsterone acetate.
c. Boldenone.
d. Boldenone acetate.
e. Boldenone benzoate.
f. Boldenone undecylenate.
g. Chlorotestosterone (Clostebol).
h. Dehydrochlormethyltestosterone.
i. Dihydrotestosterone (Stanolone).
j. Drostanolone.
k. Ethylestrenol.
l. Fluoxymesterone.
m. Formebulone (Formebolone).
n. Mesterolone.
o. Methandrostenolone (Methandienone).
p. Methandranone.
q. Methandriol.
r. Methenolone.
s. Methyltestosterone.
t. Mibolerone.
u. Nortestosterone (Nandrolone).
v. Norethandrolone.
w. Nortestosterone decanoate.
x. Nortestosterone phenylpropionate.
y. Nortestosterone propionate.
z. Oxandrolone.
aa. Oxymesterone.
bb. Oxymetholone.
cc. Stanozolol.

dd. Testolactone.

ee. Testosterone.

ff. Testosterone acetate.

gg. Testosterone benzoate.

hh. Testosterone cypionate.

ii. Testosterone decanoate.

jj. Testosterone enanthate.

kk. Testosterone isocaproate.

ll. Testosterone oleate.

mm. Testosterone phenylpropionate.

nn. Testosterone propionate.

oo. Testosterone undecanoate.

pp. Trenbolone.

qq. Trenbolone acetate.

rr. Any salt, ester, or isomer of a drug or substance described or listed in this subparagraph if that salt, ester, or isomer promotes muscle growth.

2. The term does not include an anabolic steroid that is expressly intended for administration through implants to cattle or other nonhuman species and that has been approved by the United States Secretary of Health and Human Services for such administration. However, any person who prescribes, dispenses, or distributes such a steroid for human use is considered to have prescribed, dispensed, or distributed an anabolic steroid within the meaning of this paragraph.

(e) Ketamine, including any isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation.

(f) Dronabinol (synthetic THC) in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration.

(g) Any drug product containing gamma-hydroxybutyric acid, including its salts, isomers, and salts of isomers, for which an application is approved under s. 505 of the Federal Food, Drug, and Cosmetic Act.

(4)(a) SCHEDULE IV.—A substance in Schedule IV has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation, are controlled in Schedule IV:

1. Alfaxalone.

2.~~(a)~~ Alprazolam.

3.~~(b)~~ Barbital.

4.~~(c)~~ Bromazepam.

5.~~(iii)~~ Butorphanol tartrate.

6.~~(d)~~ Camazepam.

7.~~(jjj)~~ Carisoprodol.

8.~~(e)~~ Cathine.

9.~~(f)~~ Chloral betaine.

10.~~(g)~~ Chloral hydrate.
11.~~(h)~~ Chlordiazepoxide.
12.~~(i)~~ Clobazam.
13.~~(j)~~ Clonazepam.
14.~~(k)~~ Clorazepate.
15.~~(l)~~ Clotiazepam.
16.~~(m)~~ Cloxazolam.
17. Dexfenfluramine.
18.~~(n)~~ Delorazepam.
19. Dichloralphenazone.
20.~~(p)~~ Diazepam.
21.~~(q)~~ Diethylpropion.
22. Eluxadoline.
23.~~(r)~~ Estazolam.
24. Eszopiclone.
25.~~(s)~~ Ethchlorvynol.
26.~~(t)~~ Ethinamate.
27.~~(u)~~ Ethyl loflazepate.
28.~~(v)~~ Fencamfamin.
29.~~(w)~~ Fenfluramine.
30.~~(x)~~ Fenproporex.
31.~~(y)~~ Fludiazepam.
32.~~(z)~~ Flurazepam.
33. Fospropofol.
34.~~(aa)~~ Halazepam.
35.~~(bb)~~ Haloxazolam.
36.~~(cc)~~ Ketazolam.
37.~~(dd)~~ Loprazolam.
38.~~(ee)~~ Lorazepam.

39. Lorcaserin.

40.~~(ff)~~ Lormetazepam.

41.~~(gg)~~ Mazindol.

42.~~(hh)~~ Mebutamate.

43.~~(ii)~~ Medazepam.

44.~~(jj)~~ Mefenorex.

45.~~(kk)~~ Meprobamate.

46.~~(ll)~~ Methohexital.

47.~~(mm)~~ Methylphenobarbital.

48.~~(nn)~~ Midazolam.

49. Modafinil.

50.~~(oo)~~ Nimetazepam.

51.~~(pp)~~ Nitrazepam.

52.~~(qq)~~ Nordiazepam.

53.~~(rr)~~ Oxazepam.

54.~~(ss)~~ Oxazolam.

55.~~(tt)~~ Paraldehyde.

56.~~(uu)~~ Pemoline.

57.~~(vv)~~ Pentazocine.

58. Petrichloral.

59.~~(ww)~~ Phenobarbital.

60.~~(xx)~~ Phentermine.

61.~~(yy)~~ Pinazepam.

62.~~(zz)~~ Pipradrol.

63.~~(aaa)~~ Prazepam.

64.~~(o)~~ Propoxyphene (dosage forms).

65.~~(bbb)~~ Propylhexedrine, excluding any patent or proprietary preparation containing propylhexedrine, unless otherwise provided by federal law.

66.~~(ccc)~~ Quazepam.

67. Sibutramine.

68.~~(ccc)~~ SPA[(-)-1 dimethylamino-1, 2 diphenylethane].

69. Suvorexant.

70.~~(fff)~~ Temazepam.

71.~~(ddd)~~ Tetrazepam.

72. Tramadol.

73.~~(ggg)~~ Triazolam.

74. Zaleplon.

75. Zolpidem.

76. Zopiclone.

77.~~(hhh)~~ Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) SCHEDULE V.—A substance, compound, mixture, or preparation of a substance in Schedule V has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.

(a) Substances controlled in Schedule V include any compound, mixture, or preparation containing any of the following limited quantities of controlled substances, which shall include one or more active medicinal ingredients which are not controlled substances in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the controlled substance alone:

1. Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.

2. Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.

3. Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.

4. Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

5. Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

6. Not more than 0.5 milligrams of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

7. Brivaracetam.

8. Ezogabine.

9. Lacosamide.

10. Pregabalin.

~~(b) Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs and their salts: Buprenorphine.~~

(b) ~~(c)~~ Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers: Pyrovalerone.

Section 9. Section 893.055, Florida Statutes, is amended to read:

(Substantial rewording of section. See

s. 893.055, F.S., for present text.)

893.055 Prescription drug monitoring program.—

(1) As used in this section, the term:

(a) "Administration" means the obtaining and giving of a single dose of medicinal drugs by a legally authorized person to a patient for her or his consumption.

(b) "Active investigation" means an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.

(c) "Controlled substance" means a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03 or 21 U.S.C. s. 812.

(d) "Dispense" means the transfer of possession of one or more doses of a medicinal drug by a health care practitioner to the ultimate consumer or to his or her agent.

(e) "Dispenser" means a dispensing health care practitioner or pharmacist licensed to dispense medicinal drugs in this state.

(f) "Health care practitioner" or "practitioner" means any practitioner licensed under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, chapter 465, or chapter 466.

(g) "Health care regulatory board" means any board or commission as defined in s. 456.001(1).

(h) "Law enforcement agency" means the Department of Law Enforcement, a sheriff's office in this state, a police department in this state, or a law enforcement agency of the

Federal Government which enforces the laws of this state or the United States relating to controlled substances, and which its agents and officers are empowered by law to conduct criminal investigations and make arrests.

(i) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, or an Internet pharmacy that is licensed by the department under chapter 465 and that dispenses or delivers medicinal drugs, including controlled substances to an individual or address in this state.

(j) "Prescriber" means a prescribing physician, prescribing practitioner, or other prescribing health care practitioner authorized by the laws of this state to order medicinal drugs.

(k) "Program manager" means an employee of or a person contracted by the department who is designated to ensure the integrity of the prescription drug monitoring program in accordance with the requirements established in this section.

(2)(a) The department shall maintain an electronic system to collect and store controlled substance dispensing information and shall release the information as authorized in s. 893.0551. The electronic system must:

1. Not infringe upon the legitimate prescribing or dispensing of a controlled substance by a prescriber or dispenser acting in good faith and in the course of professional practice.

2. Be consistent with standards of the American Society for Automation in Pharmacy (ASAP).

3. Comply with the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to protected health

information (PHI), electronic protected health information (EPHI), and all other relevant state and federal privacy and security laws and regulations.

(b) The department may collaborate with professional health care regulatory boards, appropriate organizations, and other state agencies to identify indicators of controlled substance abuse.

(c) The department shall adopt rules necessary to implement this subsection.

(3) For each controlled substance dispensed to a patient in the state, the following information must be reported by the dispenser to the system as soon thereafter as possible but no later than the close of the next business day after the day the controlled substance is dispensed unless an extension or exemption is approved by the department:

(a) The name of the prescribing practitioner, the practitioner's federal Drug Enforcement Administration registration number, the practitioner's National Provider Identification (NPI) or other appropriate identifier, and the date of the prescription.

(b) The date the prescription was filled and the method of payment, such as cash by an individual, insurance coverage through a third party, or Medicaid payment. This paragraph does not authorize the department to include individual credit card numbers or other account numbers in the system.

(c) The full name, address, telephone number, and date of birth of the person for whom the prescription was written.

(d) The name, national drug code, quantity, and strength of the controlled substance dispensed.

(e) The full name, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued pharmacy permit number, and address of the pharmacy or other location from which the controlled substance was dispensed. If the controlled substance was dispensed by a practitioner other than a pharmacist, the practitioner's full name, address, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued license number, and National Provider Identification (NPI).

(f) Whether the drug was dispensed as an initial prescription or a refill, and the number of refills ordered.

(g) The name of the individual picking up the controlled substance prescription and type and issuer of the identification provided.

(h) Other appropriate identifying information as determined by department rule.

(i) All acts of administration of controlled substances are exempt from the reporting requirements of this section.

(4) The following shall have direct access to information in the system:

(a) An authorized prescriber or dispenser or his or her designee.

(b) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of employment.

(c) The program manager or designated program and support staff may have access to administer the system.

1. The program manager or designated program and support staff must complete a level II background screening.

2. In order to calculate performance measures pursuant to subsection (14), the program manager or program and support staff members who have been directed by the program manager to calculate performance measures may have direct access to information that contains no identifying information of any patient, physician, health care practitioner, prescriber, or dispenser.

3. The program manager or designated program and support staff must provide the department, upon request, data that does not contain patient, physician, health care practitioner, prescriber, or dispenser identifying information for public health care and safety initiatives purposes.

4. The program manager, upon determining a pattern consistent with the department's rules established under paragraph (2)(b), may provide relevant information to the prescriber and dispenser.

5. The program manager, upon determining a pattern consistent with the rules established under paragraph (2)(b) and having cause to believe a violation of s. 893.13(7)(a)8., (8)(a), or (8)(b) has occurred, may provide relevant information to the applicable law enforcement agency.

(5) The following entities may not directly access information in the system, but may request information from the program manager or designated program and support staff:

(a) The department for investigations involving licensees

authorized to prescribe or dispense controlled substances.

(b) The Attorney General for Medicaid fraud cases involving prescribed controlled substances.

(c) A law enforcement agency during active investigations of potential criminal activity, fraud, or theft regarding prescribed controlled substances.

(d) A medical examiner when conducting an authorized investigation under s. 406.11, to determine the cause of death of an individual.

(e) An impaired practitioner consultant who is retained by the department under s. 456.076 to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant's access to and review of such information.

(f) A patient or the legal guardian or designated health care surrogate of an incapacitated patient who submits a written and notarized request that includes the patient's full name, address, phone number, date of birth, and a copy of a government-issued photo identification. A legal guardian or health care surrogate must provide the same information if he or she submits the request.

(6) The department may enter into a reciprocal agreement or contract to share prescription drug monitoring information with another state, district, or territory if the prescription drug monitoring programs of other states, districts, or territories are compatible with the Florida program.

(a) In determining compatibility, the department shall consider:

1. The safeguards for privacy of patient records and the success of the program in protecting patient privacy.

2. The persons authorized to view the data collected by the program. Comparable entities and licensed health care practitioners in other states, districts, or territories of the United States, law enforcement agencies, the Attorney General's Medicaid Fraud Control Unit, medical regulatory boards, and, as needed, management staff that have similar duties as management staff who work with the prescription drug monitoring program as authorized in s. 893.0551 are authorized access upon approval by the department.

3. The schedules of the controlled substances that are monitored by the program.

4. The data reported to or included in the program's system.

5. Any implementing criteria deemed essential for a thorough comparison.

6. The costs and benefits to the state of sharing prescription information.

(b) The department must assess the prescription drug monitoring program's continued compatibility with the other state's, district's, or territory's program periodically.

(c) Any agreement or contract for sharing of prescription drug monitoring information between the department and another state, district, or territory shall contain the same restrictions and requirements as this section or s. 893.0551, and the information must be provided according to the department's determination of compatibility.

(7) The department may enter into agreements or contracts

to establish secure connections between the system and a prescribing or dispensing health care practitioner's electronic health recordkeeping system. The electronic health recordkeeping system owner or license holder will be responsible for ensuring that only authorized individuals have access to prescription drug monitoring program information.

(8) A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance.

(a) The duty to consult the system does not apply to a prescriber or dispenser or designee of a prescriber or dispenser if the system is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure.

(b) A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system under this subsection shall document the reason he or she did not consult the system in the patient's medical record or prescription record, and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.

(c) The department shall issue a nondisciplinary citation to any prescriber or dispenser who fails to consult the system as required by this subsection.

(9) A person who willfully and knowingly fails to report the dispensing of a controlled substance as required by this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(10) Information in the prescription drug monitoring program's system may be released only as provided in this subsection and s. 893.0551. The content of the system is intended to be informational only and imposes no obligations of any nature or any legal duty on a prescriber, dispenser, pharmacy, or patient. Information in the system shall be provided in accordance with s. 893.13(7)(a)8. and is not subject to discovery or introduction into evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient arising out of matters that are the subject of information in the system. The program manager and authorized persons who participate in preparing, reviewing, issuing, or any other activity related to management of the system may not be permitted or required to testify in any such civil or administrative action as to any findings, recommendations, evaluations, opinions, or other actions taken in connection with management of the system.

(11) A prescriber or dispenser, or his or her designee, may have access to the information under this section which relates to a patient of that prescriber or dispenser as needed for the purpose of reviewing the patient's controlled drug prescription history. A prescriber or dispenser acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for receiving or using information from the prescription drug monitoring program. This subsection does not create a private cause of action, and a person may not recover damages against a prescriber or dispenser authorized to access information under this subsection for accessing or failing to access such information.

(12)(a) All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants, private funding applied for or received by the state, or state funds appropriated in the General Appropriations Act. The department may not:

1. Commit funds for the monitoring program without ensuring funding is available; or

2. Use funds provided, directly or indirectly by prescription drug manufacturers to implement the program.

(b) The department shall cooperate with the direct-support organization established under subsection (15) in seeking federal grant funds, other nonstate grant funds, gifts, donations, or other private moneys for the department if the costs of doing so are immaterial. Immaterial costs include, but are not limited to, the costs of mailing and personnel assigned to research or apply for a grant. The department may competitively procure and contract pursuant to s. 287.057 for any goods and services required be this section.

(13) The department shall conduct or participate in studies to examine the feasibility of enhancing the prescription drug monitoring program for the purposes of public health initiatives and statistical reporting. Such studies shall respect the privacy of the patient, the prescriber, and the dispenser. Such studies may be conducted by the department or a contracted vendor in order to:

(a) Improve the quality of health care services and safety by improving the prescribing and dispensing practices for prescription drugs;

(b) Take advantage of advances in technology;

(c) Reduce duplicative prescriptions and the overprescribing of prescription drugs; and

(d) Reduce drug abuse.

(14) The department shall annually report on performance measures to the Governor, the President of the Senate, and the Speaker of the House of Representatives by the department each December 1. Performance measures may include, but are not limited to, the following outcomes:

(a) Reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts.

(b) Reduction of the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit.

(c) Increased coordination among partners participating in the prescription drug monitoring program.

(d) Involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug abuse and prescription drug diversion.

(15) The department may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized for the prescription drug monitoring program.

(a) As used in this subsection, the term "direct-support organization" means an organization that is:

1. A Florida corporation not for profit incorporated under chapter 617, exempted from filing fees, and approved by the Department of State.

2. Organized and operated to conduct programs and

activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, and invest, in its own name, securities, funds, objects of value, or other property, either real or personal; and make expenditures or provide funding to or for the direct or indirect benefit of the department in the furtherance of the prescription drug monitoring program.

(b) The State Surgeon General shall appoint a board of directors for the direct-support organization.

1. The board of directors shall consist of no fewer than five members who shall serve at the pleasure of the State Surgeon General.

2. The State Surgeon General shall provide guidance to members of the board to ensure that moneys received by the direct-support organization are not received from inappropriate sources. Inappropriate sources include, but are not limited to, donors, grantors, persons, or organizations that may monetarily or substantively benefit from the purchase of goods or services by the department in furtherance of the prescription drug monitoring program.

(c) The direct-support organization shall operate under written contract with the department. The contract must, at a minimum, provide for:

1. Approval of the articles of incorporation and bylaws of the direct-support organization by the department.

2. Submission of an annual budget for the approval of the department.

3. The reversion, without penalty, to the department's grants and donations trust fund for the administration of the

prescription drug monitoring program of all moneys and property held in trust by the direct-support organization for the benefit of the prescription drug monitoring program if the direct-support organization ceases to exist or if the contract is terminated.

4. The fiscal year of the direct-support organization, which must begin July 1 of each year and end June 30 of the following year.

5. The disclosure of the material provisions of the contract to donors of gifts, contributions, or bequests, including such disclosure on all promotional and fundraising publications, and an explanation to such donors of the distinction between the department and the direct-support organization.

6. The direct-support organization's collecting, expending, and providing of funds to the department for the development, implementation, and operation of the prescription drug monitoring program as described in this section. The direct-support organization may collect and expend funds to be used for the functions of the direct-support organization's board of directors, as necessary and approved by the department. In addition, the direct-support organization may collect and provide funding to the department in furtherance of the prescription drug monitoring program by:

a. Establishing and administering the prescription drug monitoring program's electronic system, including hardware and software.

b. Conducting studies on the efficiency and effectiveness of the program to include feasibility studies as described in

subsection (13).

c. Providing funds for future enhancements of the program within the intent of this section.

d. Providing user training of the prescription drug monitoring program, including distribution of materials to promote public awareness and education and conducting workshops or other meetings, for health care practitioners, pharmacists, and others as appropriate.

e. Providing funds for travel expenses.

f. Providing funds for administrative costs, including personnel, audits, facilities, and equipment.

g. Fulfilling all other requirements necessary to implement and operate the program as outlined in this section.

7. Certification by the department that the direct-support organization is complying with the terms of the contract in a manner consistent with and in furtherance of the goals and purposes of the prescription drug monitoring program and in the best interests of the state. Such certification must be made annually and reported in the official minutes of a meeting of the direct-support organization.

(d) The activities of the direct-support organization must be consistent with the goals and mission of the department, as determined by the department, and in the best interests of the state. The direct-support organization must obtain written approval from the department for any activities in support of the prescription drug monitoring program before undertaking those activities.

(e) The direct-support organization shall provide for an independent annual financial audit in accordance with s.

215.981. Copies of the audit shall be provided to the department and the Office of Policy and Budget in the Executive Office of the Governor.

(f) The direct-support organization may not exercise any power under s. 617.0302(12) or (16).

(g) The direct-support organization is not considered a lobbying firm within the meaning of s. 11.045.

(h) The department may permit, without charge, appropriate use of administrative services, property, and facilities of the department by the direct-support organization, subject to this section. The use must be directly in keeping with the approved purposes of the direct-support organization and may not be made at times or places that would unreasonably interfere with opportunities for the public to use such facilities for established purposes. Any moneys received from rentals of facilities and properties managed by the department may be held in a separate depository account in the name of the direct-support organization and subject to the provisions of the letter of agreement with the department. The letter of agreement must provide that any funds held in the separate depository account in the name of the direct-support organization must revert to the department if the direct-support organization is no longer approved by the department to operate in the best interests of the state.

(i) The department may adopt rules under s. 120.54 to govern the use of administrative services, property, or facilities of the department or office by the direct-support organization.

(j) The department may not permit the use of any

administrative services, property, or facilities of the state by a direct-support organization if that organization does not provide equal membership and employment opportunities to all persons regardless of race, color, religion, gender, age, or national origin.

(k) This subsection is repealed October 1, 2027, unless reviewed and saved from repeal by the Legislature.

Section 10. Section 893.0551, Florida Statutes, is amended to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(1) For purposes of this section, the terms used in this section have the same meanings as provided in s. 893.055.

(2) The following information of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is contained in records held by the department under s. 893.055 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Name.

(b) Address.

(c) Telephone number.

(d) Insurance plan number.

(e) Government-issued identification number.

(f) Provider number.

(g) Drug Enforcement Administration number.

(h) Any other unique identifying information or number.

(3) The department shall disclose such ~~confidential and~~

~~exempt~~ information to the following persons or entities upon request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(a) A health care practitioner, or his or her designee, who certifies that the information is necessary to provide medical treatment to a current patient in accordance with ss. 893.05 and 893.055.

(b) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of such employment.

(c) The program manager and designated support staff for administration of the program, and to provide relevant information to the prescriber, dispenser, and appropriate law enforcement agencies, in accordance with s. 893.055.

(d) The department for investigations involving licensees authorized to prescribe or dispense controlled substances. The department may request information from the program but may not have direct access to its system. The department may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.

(e) ~~(a)~~ The Attorney General or his or her designee when working on Medicaid fraud cases involving prescribed controlled substances ~~prescription drugs~~ or when the Attorney General has initiated a review of specific identifiers of Medicaid fraud or

specific identifiers that warrant a Medicaid investigation regarding prescribed controlled substances ~~prescription drugs~~. The Attorney General's Medicaid fraud investigators may not have direct access to the department's system ~~database~~. The Attorney General or his or her designee may disclose to a criminal justice agency, as defined in s. 119.011, only the ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for the information.

~~(b) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a practitioner, pharmacist, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a specific controlled substances investigation for prescription drugs involving a designated person. The health care regulatory boards may request information from the department but may not have direct access to its database. The health care regulatory boards may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.~~

(f) ~~(c)~~ A law enforcement agency that has initiated an active investigation involving a specific violation of law regarding prescription drug abuse or diversion of prescribed controlled substances and that has entered into a user agreement with the department. A law enforcement agency may request information from the department but may not have direct access to its system ~~database~~. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only

~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for such information.

(g) A medical examiner or associate medical examiner, as defined in s 406.06, pursuant to his or her official duties, as required by s. 406.11, to determine the cause of death of an individual. A medical examiner may request information from the department but may not have direct access to the system.

~~(f) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(7)(c)4.~~

(h) An impaired practitioner consultant who has been authorized in writing by a participant in, or by a referral to, the impaired practitioner program to access and review information as provided in s. 893.055(6)(e) ~~893.055(7)(c)5.~~

(i) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(6)(f).

(4) If the department determines consistent with its rules that a pattern of controlled substance abuse exists, the department may disclose such confidential and exempt information to the applicable law enforcement agency in accordance with s. 893.055. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that is specific to a violation of s. 893.13(7)(a)8., s. 893.13(8)(a), or s. 893.13(8)(b).

(5) Before disclosing ~~confidential and exempt~~ information

to a criminal justice agency or a law enforcement agency pursuant to this section, the disclosing person or entity must take steps to ensure the continued confidentiality of all ~~confidential and exempt~~ information. At a minimum, these steps must include redacting any nonrelevant information.

(6) An agency or person who obtains any ~~confidential and exempt~~ information pursuant to this section must maintain the confidential and exempt status of that information and may not disclose such information unless authorized by law. Information shared with a state attorney pursuant to paragraph (3)(e) ~~(3)(a)~~ or paragraph (3)(f) ~~(3)(c)~~ may be released only in response to a discovery demand if such information is directly related to the criminal case for which the information was requested. Unrelated information may be released only upon an order of a court of competent jurisdiction.

(7) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 11. Paragraphs (pp) and (qq) of subsection (1) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(pp) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason

to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 458.3265(3) ~~458.3265(2)~~.

(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 458.3265(3) ~~458.3265(2)~~.

Section 12. Paragraphs (rr) and (ss) of subsection (1) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(rr) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of

adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 459.0137(3) ~~459.0137(2)~~.

(ss) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 459.0137(3) ~~459.0137(2)~~.

Section 13. Paragraph (b) of subsection (4) of section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ocular pharmaceutical agents.—

(4) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon. A certified optometrist may not administer or prescribe:

(b) A controlled substance for the treatment of chronic nonmalignant pain as defined in s. 456.44(1)(f) ~~456.44(1)(e)~~.

Section 14. Paragraph (a) of subsection (1) of section 782.04, Florida Statutes, is amended to read:

782.04 Murder.—

(1)(a) The unlawful killing of a human being:

1. When perpetrated from a premeditated design to effect the death of the person killed or any human being;

2. When committed by a person engaged in the perpetration of, or in the attempt to perpetrate, any:

a. Trafficking offense prohibited by s. 893.135(1),

b. Arson,

c. Sexual battery,

d. Robbery,

e. Burglary,

f. Kidnapping,

g. Escape,

h. Aggravated child abuse,

i. Aggravated abuse of an elderly person or disabled adult,

j. Aircraft piracy,

k. Unlawful throwing, placing, or discharging of a destructive device or bomb,

l. Carjacking,

m. Home-invasion robbery,

n. Aggravated stalking,

o. Murder of another human being,

p. Resisting an officer with violence to his or her person,

q. Aggravated fleeing or eluding with serious bodily injury or death,

r. Felony that is an act of terrorism or is in furtherance of an act of terrorism, including a felony under s. 775.30, s. 775.32, s. 775.33, s. 775.34, or s. 775.35, or

s. Human trafficking; or

3. Which resulted from the unlawful distribution by a person 18 years of age or older of any of the following substances, or mixture containing any of the following substances, when such substance or mixture is proven to be the proximate cause of the death of the user:

a. A substance controlled under s. 893.03(1);

b. Cocaine, as described in s. 893.03(2)(a)4.;

c. Opium or any synthetic or natural salt, compound, derivative, or preparation of opium;

d. Methadone;

e. Alfentanil, as described in s. 893.03(2)(b)1.;

f. Carfentanil, as described in s. 893.03(2)(b)6.;

g. Fentanyl, as described in s. 893.03(2)(b)9.;

h. Sufentanil, as described in s. 893.03(2)(b)30. ~~893.03(2)(b)29.~~; or

i. A controlled substance analog, as described in s.

893.0356, of any substance specified in sub-subparagraphs a.-h.,

is murder in the first degree and constitutes a capital felony, punishable as provided in s. 775.082.

Section 15. Paragraphs (a), (c), (d), (e), (f), and (h) of subsection (1), subsection (2), paragraphs (a) and (b) of subsection (4), and subsection (5) of section 893.13, Florida Statutes, are amended to read:

893.13 Prohibited acts; penalties.—

(1)(a) Except as authorized by this chapter and chapter 499, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a child care

facility as defined in s. 402.302 or a public or private elementary, middle, or secondary school between the hours of 6 a.m. and 12 midnight, or at any time in, on, or within 1,000 feet of real property comprising a state, county, or municipal park, a community center, or a publicly owned recreational facility. As used in this paragraph, the term "community center" means a facility operated by a nonprofit community-based organization for the provision of recreational, social, or educational services to the public. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The defendant must be sentenced to a minimum term of imprisonment of 3 calendar years unless the offense was committed within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

This paragraph does not apply to a child care facility unless

the owner or operator of the facility posts a sign that is not less than 2 square feet in size with a word legend identifying the facility as a licensed child care facility and that is posted on the property of the child care facility in a conspicuous place where the sign is reasonably visible to the public.

(d) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public or private college, university, or other postsecondary educational institution. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(e) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance not authorized

by law in, on, or within 1,000 feet of a physical place for worship at which a church or religious organization regularly conducts religious services or within 1,000 feet of a convenience business as defined in s. 812.171. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(f) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public housing facility at any time. As used in this section, the term "real property comprising a public housing facility" means real property, as defined in s. 421.03(12), of a public corporation created as a housing authority pursuant to part I of chapter 421. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(h) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising an assisted living facility, as that term is used in chapter 429. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any

other penalty prescribed by law.

(2)(a) Except as authorized by this chapter and chapter 499, a person may not purchase, or possess with intent to purchase, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, a person may not purchase more than 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. A person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Except as authorized by this chapter, a person 18 years of age or older may not deliver any controlled substance to a person younger than 18 years of age, use or hire a person younger than 18 years of age as an agent or employee in the sale or delivery of such a substance, or use such person to assist in avoiding detection or apprehension for a violation of this

chapter. A person who violates this subsection with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Imposition of sentence may not be suspended or deferred, and the person so convicted may not be placed on probation.

(5) A person may not bring into this state any controlled substance unless the possession of such controlled substance is authorized by this chapter or unless such person is licensed to do so by the appropriate federal agency. A person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable

as provided in s. 775.082 or s. 775.083.

Section 16. Paragraphs (c) and (f) of subsection (1) of section 893.135, Florida Statutes, are amended to read:

893.135 Trafficking; mandatory sentences; suspension or reduction of sentences; conspiracy to engage in trafficking.—

(1) Except as authorized in this chapter or in chapter 499 and notwithstanding the provisions of s. 893.13:

(c)1. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of any morphine, opium, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 4 grams or more of any mixture containing any such substance, but less than 30 kilograms of such substance or mixture, commits a felony of the first degree, which felony shall be known as "trafficking in illegal drugs," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $100,000.

c. Is 28 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $500,000.

2. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of hydrocodone, as described in s. 893.03(2)(a)1.k. ~~893.03(2)(a)1.j.~~, codeine, as described in s. 893.03(2)(a)1.g., or any salt thereof, or 14 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in hydrocodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 50 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 50 grams or more, but less than 200 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 200 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

3. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 7 grams or more of oxycodone, as described in s. 893.03(2)(a)1.q. ~~893.03(2)(a)1.o.~~, or any salt thereof, or 7 grams or more of any mixture

containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in oxycodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 7 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 25 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 25 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 100 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

4.a. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of:

(I) Alfentanil, as described in s. 893.03(2)(b)1.;

(II) Carfentanil, as described in s. 893.03(2)(b)6.;

(III) Fentanyl, as described in s. 893.03(2)(b)9.;

(IV) Sufentanil, as described in s. 893.03(2)(b)30. ~~893.03(2)(b)29.~~;

(V) A fentanyl derivative, as described in s. 893.03(1)(a)62.;

(VI) A controlled substance analog, as described in s.

893.0356, of any substance described in sub-sub-subparagraphs (I)-(V); or

(VII) A mixture containing any substance described in sub-sub-subparagraphs (I)-(VI),

commits a felony of the first degree, which felony shall be known as "trafficking in fentanyl," punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. If the quantity involved under sub-subparagraph a.:

(I) Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and shall be ordered to pay a fine of $50,000.

(II) Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years, and shall be ordered to pay a fine of $100,000.

(III) Is 28 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years, and shall be ordered to pay a fine of $500,000.

5. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the first degree felony of trafficking in illegal drugs. A person who has been convicted of the first degree felony of trafficking

in illegal drugs under this subparagraph shall be punished by life imprisonment and is ineligible for any form of discretionary early release except pardon or executive clemency or conditional medical release under s. 947.149. However, if the court determines that, in addition to committing any act specified in this paragraph:

a. The person intentionally killed an individual or counseled, commanded, induced, procured, or caused the intentional killing of an individual and such killing was the result; or

b. The person's conduct in committing that act led to a natural, though not inevitable, lethal result,

such person commits the capital felony of trafficking in illegal drugs, punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

6. A person who knowingly brings into this state 60 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 60 kilograms or more of any mixture containing any such substance, and who knows that the probable result of such importation would be the death of a person, commits capital importation of illegal drugs, a capital felony punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to

pay the maximum fine provided under subparagraph 1.

(f)1. Any person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment utilized in the manufacture of amphetamine or methamphetamine, commits a felony of the first degree, which felony shall be known as "trafficking in amphetamine," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and the defendant shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 200 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 7 years, and the defendant shall be ordered to pay a fine of $100,000.

c. Is 200 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 calendar years and pay a fine of $250,000.

2. Any person who knowingly manufactures or brings into this state 400 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing

amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment used in the manufacture of amphetamine or methamphetamine, and who knows that the probable result of such manufacture or importation would be the death of any person commits capital manufacture or importation of amphetamine, a capital felony punishable as provided in ss. 775.082 and 921.142. Any person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

Section 17. Paragraphs (b), (c), and (e) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

(b) LEVEL 2

Florida Statute	Felony Degree	Description
379.2431 (1)(e)3.	3rd	Possession of 11 or fewer marine turtle eggs in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)4.	3rd	Possession of more than 11 marine turtle eggs in violation of the Marine Turtle Protection

		Act.
403.413(6)(c)	3rd	Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.
517.07(2)	3rd	Failure to furnish a prospectus meeting requirements.
590.28(1)	3rd	Intentional burning of lands.
784.05(3)	3rd	Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.
787.04(1)	3rd	In violation of court order, take, entice, etc., minor beyond state limits.
806.13(1)(b)3.	3rd	Criminal mischief; damage $1,000 or more to public communication or any other public service.
810.061(2)	3rd	Impairing or impeding telephone or power to a dwelling;

		facilitating or furthering burglary.
810.09(2)(e)	3rd	Trespassing on posted commercial horticulture property.
812.014(2)(c)1.	3rd	Grand theft, 3rd degree; $300 or more but less than $5,000.
812.014(2)(d)	3rd	Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage of dwelling.
812.015(7)	3rd	Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.
817.234(1)(a)2.	3rd	False statement in support of insurance claim.
817.481(3)(a)	3rd	Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.
817.52(3)	3rd	Failure to redeliver hired

		vehicle.
817.54	3rd	With intent to defraud, obtain mortgage note, etc., by false representation.
817.60(5)	3rd	Dealing in credit cards of another.
817.60(6)(a)	3rd	Forgery; purchase goods, services with false card.
817.61	3rd	Fraudulent use of credit cards over $100 or more within 6 months.
826.04	3rd	Knowingly marries or has sexual intercourse with person to whom related.
831.01	3rd	Forgery.
831.02	3rd	Uttering forged instrument; utters or publishes alteration with intent to defraud.
831.07	3rd	Forging bank bills, checks, drafts, or promissory notes.

831.08	3rd	Possessing 10 or more forged notes, bills, checks, or drafts.
831.09	3rd	Uttering forged notes, bills, checks, drafts, or promissory notes.
831.11	3rd	Bringing into the state forged bank bills, checks, drafts, or notes.
832.05(3)(a)	3rd	Cashing or depositing item with intent to defraud.
843.08	3rd	False personation.
893.13(2)(a)2.	3rd	Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs other than cannabis.
893.147(2)	3rd	Manufacture or delivery of drug paraphernalia.

(c) LEVEL 3

Florida Statute	Felony Degree	Description
119.10(2)(b)	3rd	Unlawful use of confidential information from police reports.
316.066 (3)(b)-(d)	3rd	Unlawfully obtaining or using confidential crash reports.
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.
319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.

319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the Inland Protection Trust Fund.
379.2431 (1)(e)5.	3rd	Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.

379.2431 (1)(e)6.	3rd	Possessing any marine turtle species or hatchling, or parts thereof, or the nest of any marine turtle species described in the Marine Turtle Protection Act.
379.2431 (1)(e)7.	3rd	Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.
400.9935(4)(a) or (b)	3rd	Operating a clinic, or offering services requiring licensure, without a license.
400.9935(4)(e)	3rd	Filing a false license application or other required information or failing to report information.
440.1051(3)	3rd	False report of workers' compensation fraud or retaliation for making such a report.
501.001(2)(b)	2nd	Tampers with a consumer product or the container using

		materially false/misleading information.
624.401(4)(a)	3rd	Transacting insurance without a certificate of authority.
624.401(4)(b)1.	3rd	Transacting insurance without a certificate of authority; premium collected less than $20,000.
626.902(1)(a) & (b)	3rd	Representing an unauthorized insurer.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than

		structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.
812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(5)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
817.233	3rd	Burning to defraud insurer.
817.234 (8)(b) & (c)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
817.236	3rd	Filing a false motor vehicle

		insurance application.
817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.
817.413(2)	3rd	Sale of used goods as new.
828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
831.29	2nd	Possession of instruments for counterfeiting driver licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police dog or horse.

860.15(3)	3rd	Overcharging for repairs and parts.
870.01(2)	3rd	Riot; inciting or encouraging.
893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs).
893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of university.
893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of public housing facility.

893.13(4)(c)	3rd	Use or hire of minor; deliver to minor other controlled substances.
893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
893.13(7)(a)10.	3rd	Affix false or forged label to package of controlled substance.
893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an

		animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.
893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
893.13(8)(a)3.	3rd	Knowingly write a prescription for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.

944.47 (1)(a)1. & 2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.721	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

(e) LEVEL 5

Florida Statute	Felony Degree	Description
316.027(2)(a)	3rd	Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.
316.1935(4)(a)	2nd	Aggravated fleeing or eluding.
316.80(2)	2nd	Unlawful conveyance of fuel; obtaining fuel fraudulently.
322.34(6)	3rd	Careless operation of motor

		vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
379.365(2)(c)1.	3rd	Violation of rules relating to: willful molestation of stone crab traps, lines, or buoys; illegal bartering, trading, or sale, conspiring or aiding in such barter, trade, or sale, or supplying, agreeing to supply, aiding in supplying, or giving away stone crab trap tags or certificates; making, altering, forging, counterfeiting, or reproducing stone crab trap tags; possession of forged, counterfeit, or imitation stone crab trap tags; and engaging in the commercial harvest of stone crabs while license is suspended or revoked.
379.367(4)	3rd	Willful molestation of a commercial harvester’s spiny lobster trap, line, or buoy.

379.407(5)(b)3.	3rd	Possession of 100 or more undersized spiny lobsters.
381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
624.401(4)(b)2.	2nd	Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than $100,000.
626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
790.01(2)	3rd	Carrying a concealed firearm.

790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of bomb, explosive, weapon of mass destruction, or use of firearms in violent manner.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms, ammunition, or electronic weapons or devices.
796.05(1)	2nd	Live on earnings of a prostitute; 1st offense.
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years of age.
800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years of age or older.
806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent

		to damage any structure or property.
812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
812.019(1)	2nd	Stolen property; dealing in or trafficking in.
812.131(2)(b)	3rd	Robbery by sudden snatching.
812.16(2)	3rd	Owning, operating, or conducting a chop shop.
817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.
817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
817.2341(1), (2)(a) & (3)(a)	3rd	Filing false financial statements, making false entries of material fact or

			false statements regarding property values relating to the solvency of an insuring entity.
2296			
	817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.
2297			
	817.611(2)(a)	2nd	Traffic in or possess 5 to 14 counterfeit credit cards or related documents.
2298			
	817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device, skimming device, or reencoder.
2299			
	825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
2300			
	827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which

		includes sexual conduct by a child.
827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or death.
843.01	3rd	Resist officer with violence to person; resist arrest with violence.
847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18 years or older.
847.0137 (2) & (3)	3rd	Transmission of pornography by electronic device or equipment.
847.0138 (2) & (3)	3rd	Transmission of material harmful to minors to a minor by electronic device or equipment.

874.05(1)(b)	2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.
874.05(2)(a)	2nd	Encouraging or recruiting person under 13 years of age to join a criminal gang.
893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.

893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of university.
893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of public housing facility.
893.13(4)(b)	2nd	Use or hire of minor; deliver to minor other controlled

substance.

893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

Section 18. Except as otherwise provided in this act, this act shall take effect July 1, 2018.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Rules, *Chair*
Judiciary, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Regulated Industries

JOINT COMMITTEE:
Joint Legislative Budget Commission

SENATOR LIZBETH BENACQUISTO
27th District

January 4, 2018

The Honorable Dana Young
Senate Health Policy, Chair
316 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 8- An act relating to controlled substances

Dear Madam Chair:

Please allow this letter to serve as my respectful request to agenda SB 8, Relating to controlled substances, for a public hearing at your earliest convenience.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

Lizbeth Benacquisto
Senate District 27

Cc: Sandra Stovall

REPLY TO:
❒ 2310 First Street, Unit 305, Fort Myers, Florida 33901 (239) 338-2570
❒ 400 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5027

Senate's Website: *www.flsenate.gov*

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 8
Bill Number (if applicable)

194134
Amendment Barcode (if applicable)

Topic Controlled Substances

Name Brittany Beane

Job Title

Address
Street

Phone

Email JLFL@gmail.com

City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Junior Leagues of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

SB 8
Bill Number (if applicable)

194134
Amendment Barcode (if applicable)

Topic Opioids

Name Mark Fontaine

Job Title Executive Director

Address 2868 Mahan Drive
Street

Phone 878-2196

Tallahassee FL 32308
City *State* *Zip*

Email mfontaine@fadaa.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Alcohol + Drug Abuse Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

8
Bill Number (if applicable)

194134
Amendment Barcode (if applicable)

Topic Opioids

Name Andrew Fay

Job Title Special Counsel

Address PL 01
Street

Tallahassee
City *State* *Zip*

Phone 850-245-0155

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Office of the Attorney General

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

SB-08
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Opioid

Name Teresa Miller

Job Title Parent

Address 3608 W Corona St
Street
Tampa
City *State* *Zip*

Phone

Email tmiller@stoprxdrugabuse.org

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing N/A

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/16/18
Meeting Date

SB 08
Bill Number (if applicable)

Topic Opioids

Amendment Barcode (if applicable)

Name Ellen Snelling

Job Title Parent Volunteer

Address 521 Lantern Circle
Street
Temple Terrace FL 33617
City *State* *Zip*

Phone 813-731-2696

Email er.snelling@verizon.net

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

8
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave #240
Street

Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Surgeons

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

8
Bill Number (if applicable)

Topic Controlled Substances

Amendment Barcode (if applicable)

Name Amy Mercer

Job Title Executive Director

Address 2636 Mitcham Dr
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 219 3631

Email amercer@fpca.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Police Chiefs Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

8
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Opioids

Name Jennifer Ernst

Job Title Chief Operating Officer

Address 1700 Education Ave
Street

Phone 941-889-8048

Punta Gorda FL 33950
City *State* *Zip*

Email Jernst@cbhcfl.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Charlotte Behavioral Health Care, Inc.

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-2018	8
Meeting Date	*Bill Number (if applicable)*

Topic Controlled Substances — *Amendment Barcode (if applicable)*

Name Erin Choy

Job Title Immediate Past President

Address 404 E. Sixth Avenue (*Street*) — Phone 5616354168

Tallahassee (*City*) FL (*State*) 32303 (*Zip*) — Email erin.choy@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Junior Leagues of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 8
Bill Number (if applicable)

Topic CONTROLLED SUBSTANCES

Amendment Barcode (if applicable)

Name BILL BUNKLEY

Job Title PRESIDENT

Address PO BOX 341644 Phone 813.264.2977
Street

TAMPA FL 33694 Email
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA ETHICS AND RELIGIOUS LIBERTY COMMISSION

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 8
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Ashley Norse, MD

Job Title FMA Vice Speaker

Address 1430 Piedmont Dr. E.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850 224-6496

Email anorse@ath.net

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

Jan. 16, 18 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 8

Meeting Date *Bill Number (if applicable)*

Topic _____ *Amendment Barcode (if applicable)*

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Speaking: ☐ For ☐ Against ☐ Information Waive Speaking: ☐ In Support ☒ Against

(The Chair will read this information into the record.)

Representing FL Orthopedic Society

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

8
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name THAD LOWREY

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing OPERATION PAR

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

0008
Bill Number (if applicable)

Topic Controled Substances

Amendment Barcode (if applicable)

Name Devon West

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Broward County

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

0008
Bill Number (if applicable)

Topic Controlled Substances

Amendment Barcode (if applicable)

Name Candice Ericks

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Palm Beach County

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

Waive in support

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

8
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Controlled Substances

Name Alisa LaPolt

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing National Alliance on Mental Illness - Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 8
Bill Number (if applicable)

Topic Controlled Substances

Amendment Barcode (if applicable)

Name Joe Anne Hart

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Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/16/18
Meeting Date

538
Bill Number (if applicable)

Topic OPIATE Bill

Amendment Barcode (if applicable)

Name AARON WOTH, MD

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CAPE Coral FL 33990
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Email

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FCEP FLORIDA COLLEGE of EMERGENCY PHYSICIANS.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

8

Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name DARREN Duchene

Job Title Long-Acting Naltrexone Program Director

Address Florida Alcohol + Drug Abuse Assoc. Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing _____

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/16/18
Meeting Date

SB 8
Bill Number (if applicable)

[redacted]
Amendment Barcode (if applicable)

Topic Opioids

Name Natalie Kelly

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Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Association of Managing Entities

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/11/18
Meeting Date

SB8
Bill Number (if applicable)

Topic SB8

Amendment Barcode (if applicable)

Name Shane Messer

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Council for Behavioral Healthcare

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 138
INTRODUCER:	Senator Book
SUBJECT:	Perinatal Mental Health
DATE:	January 12, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 138 directs the Department of Health (DOH) to establish two toll-free perinatal mental health care hotlines by January 1, 2019: one for the general public and one for health care providers. The public hotline must provide basic information on postpartum depression and perinatal care; and may refer the caller to a local qualified provider. The provider hotline must provide information to assist a provider in addressing the mental health of pregnant or postpartum patients. The DOH must also encourage obstetrical and mental health providers to attend continuing education on perinatal mental health care; and must create public service announcements on perinatal mental health care.

The bill also expands the statutory responsibilities of birth centers and hospitals to require additional infant and maternal postpartum evaluations and follow-up, including, a maternal mental health assessment, information on postpartum depression, and the telephone number of the DOH public perinatal mental health care hotline.

The bill takes effect July 1, 2018.

II. Present Situation:

Perinatal Mental Health Care and Child Birth

Perinatal Mental Health Care

The Florida Legislature has not defined the term *perinatal*, although it is used throughout the statutes in connection with *perinatal* intensive care units, and maternal and fetal morbidity and mortality. The Merriam-Webster Dictionary defines *perinatal* as occurring in, concerning with,

or being in the period around the time of birth.[1] *Perinatal mental health care* is thus mental health care occurring in, concerned with, and around child birth.

Perinatal Anxiety Disorders

There are four major mood and anxiety disorders that may affect women in the perinatal period:

- Bipolar Disorder (formerly Manic Depressive Disorder);
- Panic Disorder;
- Obsessive Compulsive Disorder; and
- Depression.[2]

Depression interferes with daily life and may last for weeks or months. Depression is a common and serious illness. A recent Center for Disease Control and Prevention (CDC) survey showed that about one in ten reproductive age women, between the ages of 18 to 44, experienced symptoms of major depression.[3] Most women, even those with the most severe forms of depression, can get better with treatment.[4]

Recent studies suggest that approximately 10 to 16 percent of women experience clinically significant depression during pregnancy.[5] Particularly vulnerable are those women with histories of psychiatric illness who discontinue psychotropic medications during pregnancy. A recent study estimated that women who discontinued medication were five times as likely to relapse as compared to women who maintained treatment.[6]

While depression can occur among women with a healthy pregnancy and birth, the following experiences may put some women at a higher risk for perinatal depression:

- Symptoms of depression during or after a previous pregnancy;
- History of depression or bipolar disorder;
- Family history of depression;
- Stressful event before, during, or shortly after childbirth such as job loss, death of loved one, domestic violence, or personal illness;

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[1] Merriam-Webster Dictionary - On Line, *available at* https://www.merriam-webster.com/dictionary/perinatal (last visited Jan. 8, 2018).

[2] Altshuler, M.D., Lori L., Hendrick, M.D., Victoria & Cohen, M.D., Lee S., *An Update on Mood and Anxiety Disorders During Pregnancy and the Postpartum Period*, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC181144/pdf/i1523-5998-002-06-0217.pdf (last visited Jan. 8, 2018).

[3] Journal of Women's Health, *Depression and treatment among U.S. pregnant and nonpregnant women of reproductive age, 2005-2009* (August 21, 2012), *available at* https://www.ncbi.nlm.nih.gov/pubmed/22691031 (last visited Jan. 9, 2018); Center for Disease Control and Prevention, *Depression Among Women,* (Dec. 13, 2017), *available at* https://www.cdc.gov/reproductivehealth/depression/index.htm (last visited January 8, 2018).

[4] *See Supra* note 3.

[5] Massachusetts Center for Women's Mental Health, *Depression During Pregnancy is Often Not Treated,* (Feb. 10, 2007), *available at* https://womensmentalhealth.org/posts/depression-during-pregnancy-is-often-not-treated/ (last visited Jan. 8, 2018); Florida Department of Health, *After Pregnancy*, http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/after-pregnancy.html (last viewed Jan. 9, 2018); *See also Supra* note 2. This United States Center for Disease Control and Prevention funded study indicated that 12 to 16 percent of new mothers experience postpartum depression.

[6] New Research, Psychiatric Disorders During Pregnancy, by Massachusetts Center for Women's Mental Health, *Relapse of Major Depression during Pregnancy* (April 22, 2006) *available at* https://womensmentalhealth.org/posts/243/ (last visited Jan. 8, 2018).

- Medical complications during childbirth such as premature delivery or infant with medical problems;
- Mixed emotion about pregnancy;
- Lack of emotional support from spouse, partner, family, or friends; or
- Alcohol or drug abuse problems.[7]

Postpartum Blues vs. Depression

The *postpartum blues*, or the "*baby blues,"* are common feelings experienced by approximately 75 to 80 percent of women in the first 10 days following childbirth; and include mood swings, crying spells, and feelings of sadness, fear, anger, irritability, or anxiety and usually go away within a few days to one to two weeks after childbirth. [8]

Postpartum depression is a major depressive episode that also affects women after childbirth and also commonly occurs within one and four weeks of delivery.[9] Postpartum depression can affect any woman regardless of age, race, ethnicity, or economic status.[10] Postpartum depression causes women to experience more intense feelings of depression and intensified feelings of sadness, fear, anger, anxiety, or despair that prevent them from being able to perform their activities of daily living.[11] Postpartum depression may begin shortly before, or any time after child birth, but commonly begins one to four weeks after child birth,[12] and can persist up to a year or more after giving birth.[13] Because of the severity of the symptoms, postpartum depression usually requires treatment.[14]

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[7] National Institute of Mental Health, *Postpartum Depression Facts* https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/postpartum-depression-brochure_146657.pdf (last visited Jan. 9, 2018).

[8] Florida Department of Health, After Pregnancy, *The "Baby Blues" and Postpartum Depression, available at* http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/after-pregnancy.html (last visited Jan. 9, 2018); Center for Disease Control and Prevention, *Depression Among Women*, (Dec. 13, 2017) *available at* https://www.cdc.gov/reproductivehealth/depression/index.htm (last visited Jan. 8, 2018); Fitelson, E; Kim, Sarah; Scott-Baker, A.; and Leicht, K; International Journal of Women's Health, *Treatment of postpartum depression: clinical, psychological and pharmacological options*, (Dec. 30, 2010) *available at* https://www.ncbi.nlm.nih.gov/pubmed/?term=Leight%20K%5BAuthor%5D&cauthor=true&cauthor_uid=21339932 (last visited Jan. 9, 2018).

[9] American Psychiatric Association*; Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Washington DC, 1994, p. 386.

[10] *See supra* note 10.

[11] United States Center for Disease Control and Prevention, *Maternal Depression*, (May 23, 2017) *available at* https://www.cdc.gov/features/maternal-depression/index.html (last visited Jan. 9, 2018).

[12]*See supra* note 10; *see also* Fitelson, E; Kim, Sarah; Scott-Baker, A.; and Leicht, K; International Journal of Women's Health, *Treatment of postpartum depression: clinical, psychological and pharmacological options* (Dec. 30, 2010), *available at* https://www.ncbi.nlm.nih.gov/pubmed/?term=Leight%20K%5BAuthor%5D&cauthor=true&cauthor_uid=21339932 (last visited Jan. 9, 2018).

[13] Fitelson, E; Kim, Sarah; Scott-Baker, A.; and Leicht, K; International Journal of Women's Health, *Treatment of postpartum depression: clinical, psychological and pharmacological options*, (Dec. 30, 2010) *available at* https://www.ncbi.nlm.nih.gov/pubmed/?term=Leight%20K%5BAuthor%5D&cauthor=true&cauthor_uid=21339932 (last visited Jan. 9, 2018).

[14] Center for Disease Control and Prevention, *Depression Among Women*, (Dec. 13, 2017) *available at* https://www.cdc.gov/reproductivehealth/depression/index.htm (last visited Jan. 8, 2018).

Regulation of Perinatal Mental Health Care and Child Birth Settings

At least three state agencies have responsibilities related to the regulation and delivery of perinatal mental health care and child birth. The Department of Children and Families (DCF) evaluates, researches, plans, and recommends to the Governor and the Legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders.[15] The DCF also oversees and contracts for the delivery of mental health services funded with certain federal and state funds through the Substance Abuse and Mental Health (SAMH) program office.

The Agency for Health Care Administration (AHCA) regulates hospitals and birthing centers. [16] The DOH is responsible for the state's public health system;[17] and is the agency designated by the legislature to administer and provide maternal and child health services.[18] Healthy Start, for example, provides the following services to expectant and new mothers:

- Periodic prenatal care for low or medium risk pregnant patients;
- Referrals for higher risk pregnancy patients;
- Periodic medical examinations and nutrition counseling, including the benefits of breast feeding;
- Pediatric primary care, programs subject to the availability of funds;
- Prenatal and infant health care, subject to the availability of funds, including:
  - Case identification;
  - Risk factor assessment;
  - Case management;
  - Home health care; and
  - Childbirth and parenting education.[19]

The goal of Healthy Start is to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes. Healthy Start legislation provides for universal risk screening of all Florida's pregnant women and newborn infants to identify those at risk of poor birth, health, and developmental outcomes. The range of Healthy Start services available to pregnant women, infants and children up to age 3 include:

- Information, referral and ongoing care coordination and support to assure access to needed services;
- Psychosocial, nutritional, and smoking cessation counseling;
- Childbirth, breastfeeding, and parenting support and education; and
- Home visiting.[20]

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[15] Section 394.453, F.S.
[16] Sections 395.003 and 383.301, F.S.
[17] Section 381.001, F.S.
[18] Section 383.011, F.S. *See also* Department of Health, *Programs and Services*, http://www.floridahealth.gov/programs-and-services/index.html, (last visited Jan. 9, 2018). Some of the programs the DOH administers or provides to mothers and children include Breastfeeding, Birth Certificates, Children's Medical Services (CMS), Florida's Children's Medical Services Managed Care Plan, Drowning Prevention, Early Steps, Healthy Start, Kid Care, Lead Poisoning, Newborn Screening, School Health Program (available in all 67 counties), Sudden Unexpected Infant Death, and WIC nutrition program.
[19] See Department of Health, *Healthy Start*, http://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html (last visited Jan. 8, 2018).
[20] *See supra* note 19.

Care for postpartum women under the Healthy Start program includes a nondescript examination within six weeks of delivery.[21]

The DOH does not provide or perform mental health services.[22] The DOH, through its county health departments and other state programs,[23] refer clients in need of mental health services to providers in local areas;[24] and though its web site provides information on, *The "Baby Blues" and Postpartum Depression.*[25]

The DOH contracts for the provision of a toll-free Family Health Line[26] to provide consumers with information on community resources, pregnancy, prenatal care, childbirth, breastfeeding, family planning, infant and toddler care, parenting, smoking cessation, substance abuse and the Medicaid Family Planning Waiver Program. That hotline received 10,011 calls,[27] and information is available to callers in English, Spanish and Haitian Creole.[28]

Childbirth Settings

The Legislature has recognized the need for a person to have the freedom to choose the manner, cost, and setting for childbirth.[29] There are three potential settings from which a women may *choose* for childbirth: at home (other non-licensed location), at a licensed birthing center, or at a hospital.[30]

The home delivery setting for childbirth is not regulated, like birthing centers and hospitals; but the practices of physicians, physician assistants (PAs),[31] Advanced Registered Nurse Practitioners (ARNPs), Certified Nurse Midwives (CNMs), and Licensed Midwives (LMs) who may attend a women during a home delivery, are licensed and regulated by the DOH.[32]

A licensed physician may attend any birth in any setting, including home delivery, if he or she can do so with reasonable skill and safety, and within the standard of care.[33] A physician may also delegate any delivery to his or her PA.[34] There are no specific laws or administrative rules

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[21] Agency for Health Care Administration, *Medicaid Contract No. FP###*, (Effective Feb. 1, 2017) p. 20, *available at* http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2017-02-01/02-01-17_EXHIBIT_II-A_MMA.pdf (last visited Jan. 8, 2018).
[22] Department of Health, *Senate Bill 138 Analysis* (August 15, 2017) (on file with the Senate Committee on Health Policy).
[23] Department of Health, *Programs and Services*, http://www.floridahealth.gov/programs-and-services/index.html, (last visited Jan. 9, 2018).
[24] *See supra* note 22.
[25] Department of Health, *After Pregnancy*, http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/after-pregnancy.html (last viewed Jan. 9, 2018).
[26] Department of Health, *Family Health Line*, http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/family-health-line.html (last visited Jan. 9, 2018).
[27] *See supra* note 22; the hotline costs $17,532.62 per month or $210,391 per year.
[28] *See supra* note 26.
[29] *See* s. 467.002, F.S.
[30] *See* chs. 383 and 467, F.S., Rules 59A-11 and 64B24-7, F.A.C.
[31] *See* ss. 458.347 and 459.022, F.S.
[32] *See supra* note 31.
[33] *See* ss. 458.347 and 459.022, F.S
[34] *See* ss. 458.347 and 459.022, F.S. See also Rules 64B8-30.001 and 64B15-6.001, F.A.C.

that address the required perinatal care required for a patient choosing home delivery by physicians and PAs.[35]

Section 464.012(4)(b), F.S., permits a ARNP-CNM to perform a postpartum examination, to the extent authorized by an established protocol with a supervising physician, but does not specify that a perinatal mental health assessment is to be included in that examination; or at any time during the perinatal period for a home delivery.

Licensed birth centers are places, outside of the home or hospital, where women with normal, uncomplicated, low risk pregnancies may choose to have their babies.[36] Sections 383.330 through 383.335, F.S., establish minimum standards of care for birth centers.[37] Birth centers are licensed by the AHCA, but the clinical staff of the birth centers must be physicians, ARNP-CNMs, or LMs; and are licensed and regulated by the DOH.

In order for a pregnant women to be accepted for childbirth by a licensed birth center she must be initially determined to be at low maternal risk and be regularly evaluated throughout the pregnancy to assure that she remains at low risk for poor pregnancy outcome.[38] The women must receive specific prenatal,[39] intrapartum,[40] and postpartum care,[41] but regulatory rules do not include specific mental health screening, or education, for prenatal or postpartum depression.

The mother and infant must be discharged from the licensed birth center within 24 hours of birth, except under unusual circumstances.[42] A postpartum examination of the mother is required to be performed within 72 hours after delivery, and must include, at a minimum:
- Interval history;
- Blood pressure measurement; and
- Observation of the breasts, perineum and abdomen.[43]

A second postpartum examination is required at four to six weeks postpartum, and must include all of the above, and:
- Weight;
- Hemoglobin or hematocrit; and,
- Bi-manual pelvic examination.[44]

At some point during the postpartum period the mother must also be counseled regarding:
- Breast feeding;
- Perineal care;
- Family planning;

[35] *See* chs. 458 and 459, F.S., and Rules 64B8-9 and 64B15-14, F.A.C.
[36] Section 383.302(2), F.S.
[37] Section 383.309(1), F.S.
[38] Rule 59A-11.009, F.A.C.
[39] Rule 59A-11.012, F.A.C.
[40] Rule 59A-11.013, F.A.C.
[41] Rule 59A-11.016, F.A.C.
[42] Section 383.318, F.S., and Rule 59A-11.016(6), F.A.C.
[43] Rule 59A-11.016(6), F.A.C.
[44] *See* chs. 383 and 467, F.S., Rules 59A-11 and 64B24-7, F.A.C.

- Signs of common complications;
- Activities and exercises;
- Sex relations;
- Care and feeding of the newborn; and
- Changing family relationships.[45]

None of the required postpartum examinations or counseling for mothers utilizing licensed birth centers require any type of mental health screening or education on postpartum depression. However, if complications occur during the postpartum period, which could include postpartum depression, a consultation or referral must be made to the appropriate source for secondary or tertiary care.[46]

Hospitals are regulated by the AHCA under ch. 395, F.S. Within the context of the bill, the only statutory requirement for a hospital providing birthing services is that women using the facility for child birth must receive instruction on safe sleep practices and possible causes of Sudden Unexpected Infant Death (SUID) in the hospital's instruction on newborn care.[47] There are no other statutory or administrative requirements that a hospital providing birthing services mandate its medical staff perform any type of postpartum mental health assessment, follow-up care, or postpartum depression education.

III. Effect of Proposed Changes:

SB 138 may be cited as the, *Florida Families First Act*. It creates s. 383.014, F.S., which directs the DOH to establish by January 1, 2019, and maintain, two perinatal mental health care toll-free hotlines, one accessible to the general public, and one for health care providers, as defined in s. 408.07, F.S.[48] The hotline for general public access must:

- Provide basic information on postpartum depression and perinatal care;
- May recommend that the caller or patient be further evaluated by a qualified health care provider; and
- May refer a caller or patient to an appropriate health care provider in the caller's or patient's local area.

The hotline for health care providers must:

- Provide information to assist health care providers in addressing the mental health of a pregnant or postpartum patient;
- Maintain and offer contact information for health care providers throughout the state who have experience in caring for pregnant or postpartum patients; and
- Compile resources to encourage the efficient and coordinated care of pregnant or postpartum patients.

[45] *See* chs. 383 and 467, F.S., Rules 59A-11 and 64B24-7, F.A.C.
[46] *See* chs. 383 and 467, F.S., Rules 59A-11 and 64B24-7, F.A.C.
[47] Section 395.1053, F.S.
[48] Section 408.07(25),F.S., defines *health care providers* as those licensed under chs. 458 (allopathic doctor & PA), 459 (osteopathic doctor & PA), 460 (chiropractor), 461(podiatrist), 463 (optometrist), 464 (nurses), 465 (pharmacist), 466 (dentist and hygienist), 483, 484, 486, 490, 491, or 468, parts I (speech & language pathologists & audiologists), III (occupational therapists), IV (radiological technicians), V (respiratory therapists), or X (dietician and nutritionist).

The bill requires the DOH to create public service announcements (PSAs) to educate the public on perinatal mental health care, and the PSAs must include the telephone number of the public perinatal mental health care hotline.

The DOH must also encourage mental health care providers, and health care providers who conduct postpartum evaluations or treat postpartum patients, to attend continuing medical education courses on perinatal mental health care.

The bill amends s. 383.318, F.S., to require licensed birth centers to provide the following additional postpartum services and follow-up care:
- A maternal postpartum assessment that includes mental health screening;
- Information on postpartum depression; and
- The telephone number of the public perinatal mental health care hotline.

The bill amends s. 395.1053, F.S., to require hospitals providing birthing services to provide similar postpartum education and care services to that of birthing centers, including:
- Physical examination of the infant;
- Metabolic screening tests required by s. 383.14, F.S.;[49]
- Referral to sources for pediatric care;
- Maternal postpartum assessment that incorporates mental health screening;
- Information on postpartum depression and the telephone number of the perinatal mental health care hotline established in s. 383.014, F.S.;
- Instruction in child care, including immunization and breastfeeding; in addition to information on safe sleep practices and possible causes of Sudden Unexpected Infant Death;
- Family planning services; and
- Referral to secondary or tertiary care, as indicated.

The bill takes effect July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[49] Section 383.14, F.S., requires the DOH to screen newborns for metabolic disorders before becoming one week of age. Currently the DOH screens for 53 total conditions. Department of Health, *Newborn Screening*, http://www.floridahealth.gov/programs-and-services/childrens-health/newborn-screening/index.html (last visited Jan. 8, 2018). Babies born in a hospital must be tested for metabolic disorders between 24 and 48 hours after birth. Babies discharged before 24 hours after birth must be tested before discharge, and again between 24 hours and five days after birth. Rule 64C-7.002, F.A.C.

C. Trust Funds Restrictions:

None

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Hospitals and birthing centers may incur additional costs due to the mandated evaluations and follow-up care, which would likely be billed to patients, insurers, and Medicaid.

C. Government Sector Impact:

SB 138 requires the DOH to establish and maintain two telephone hotlines, one for the public and one for providers. The DOH estimates that the cost of the two hotlines created by this bill would be $775,920 for the first year, and $259,320 for the second year. The estimated cost to the DOH for the public service announcements and promotional/ educational materials is $380,600 in year one and $42,500 in year two. The total estimated cost is $1,156, 520 in year one, and $301,820 in year two.[50]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.318 and 395.1053.

This bill creates section 383.014 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

[50] *See supra* note 22.

B. Amendments:

None.

By Senator Book

32-00046-18 2018138__

A bill to be entitled

An act relating to perinatal mental health; providing a short title; creating s. 383.014, F.S.; requiring the Department of Health to establish and maintain a toll-free hotline accessible to the general public and a toll-free hotline accessible to health care providers; requiring the department to create public service announcements to educate the public on perinatal mental health care; requiring the department to encourage certain health care providers to attend continuing medical education courses on perinatal mental health care; amending s. 383.318, F.S.; revising components that are included in the postpartum evaluation and followup care provided by birth centers to include a mental health screening and the provision of certain information on postpartum depression; amending s. 395.1053, F.S.; requiring hospitals that provide birthing services to provide the same postpartum evaluation and followup care that is required to be provided by birth centers; providing an effective date.

WHEREAS, the Alachua County Perinatal Mental Health Coalition released its 2017 Maternal Mental Health Needs Assessment, which found that perinatal mental illness is the leading health complication related to pregnancy and birth, and

WHEREAS, as many as 1 in 5 mothers nationally will experience Perinatal Mood and Anxiety Disorder (PMD), and

WHEREAS, as many as 1 in 10 fathers will also experience

symptoms of PMD, and

WHEREAS, Florida loses approximately $900 million annually because of the failure to recognize and treat perinatal mental illnesses, and

WHEREAS, approximately 44,000 Florida babies are born to a parent experiencing a perinatal mental illness, and those babies may experience social, emotional, and cognitive detriments if their affected parents do not have access to proper care or receive treatment, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Florida Families First Act."

Section 2. Section 383.014, Florida Statutes, is created to read:

383.014 Perinatal mental health care.—By January 1, 2019, the Department of Health shall:

(1) Establish and maintain a perinatal mental health care toll-free hotline, accessible to the general public, which:

(a) Provides basic information on postpartum depression and perinatal care;

(b) May recommend that a caller or patient be further evaluated by a qualified health care provider; and

(c) May refer a caller or patient to an appropriate health care provider in the caller's or patient's local area.

(2) Establish and maintain a perinatal mental health care provider toll-free hotline for health care providers, as defined in s. 408.07, which:

(a) Provides information to assist health care providers in addressing the mental health of a pregnant or postpartum patient;

(b) Maintains and offers the contact information of health care providers throughout the state who have experience in caring for pregnant or postpartum patients; and

(c) Compiles resources to encourage the efficient and coordinated care of pregnant or postpartum patients.

(3) Create public service announcements (PSAs) to educate the public on perinatal mental health care. The PSAs must include the telephone number of the perinatal mental health care hotline established in subsection (1).

(4) Encourage mental health care providers, and health care providers who conduct postpartum evaluations or treat postpartum patients, to attend continuing medical education courses on perinatal mental health care.

Section 3. Subsection (3) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following ~~shall be provided, which shall include~~:

(a) Physical examination of the infant.

(b) Metabolic screening tests required by s. 383.14.

(c) Referral to sources for pediatric care.

(d) Maternal postpartum assessment that incorporates mental health screening.

(e) Information on postpartum depression and the telephone

number of the perinatal mental health care hotline established in s. 383.014.

(f) ~~(e)~~ Instruction in child care, including immunization, breastfeeding, safe sleep practices, and possible causes of Sudden Unexpected Infant Death.

(g) ~~(f)~~ Family planning services.

(h) ~~(g)~~ Referral to secondary or tertiary care, as indicated.

Section 4. Section 395.1053, Florida Statutes, is amended to read:

395.1053 Postpartum care and education.—A hospital that provides birthing services shall provide a postpartum evaluation and followup care that includes all of the following:

(1) Physical examination of the infant.

(2) Metabolic screening tests required by s. 383.14.

(3) Referral to sources for pediatric care.

(4) Maternal postpartum assessment that incorporates mental health screening.

(5) Information on postpartum depression and the telephone number of the perinatal mental health care hotline established in s. 383.014.

(6) Instruction in child care, including immunization, breastfeeding, ~~incorporate information on~~ safe sleep practices, and ~~the~~ possible causes of Sudden Unexpected Infant Death ~~into the hospital's postpartum instruction on the care of newborns~~.

(7) Family planning services.

(8) Referral to secondary or tertiary care, as indicated.

Section 5. This act shall take effect July 1, 2018.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Subcommittee on the Environment and Natural Resources, *Chair*
Appropriations
Appropriations Subcommittee on Health and Human Services
Education
Environmental Preservation and Conservation
Health Policy
Rules

SENATOR LAUREN BOOK
Democratic Leader Pro Tempore
32nd District

August 28, 2017

Chair Dana Young
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair Young,

I respectfully request that you place SB 138, relating to Perinatal Mental Health, on the agenda of the Committee on Health Policy at your earliest convenience.

Should you have any questions or concerns, please feel free to contact my office or me. Thank you in advance for your consideration.

Thank you,

Lauren Book

Senator Lauren Book
Senate District 32

cc: Sandra Stovall, Staff Director
Celia Georgiades, Administrative Assistant

REPLY TO:
❒ 967 Nob Hill Road, Plantation, Florida 33324 (954) 424-6674
❒ 202 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5032

Senate's Website: *www.flsenate.gov*

JOE NEGRON
President of the Senate

ANITERE FLORES
President Pro Tempore

412-K
4:00

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-2018
Meeting Date

SB 138
Bill Number (if applicable)

Topic PERINATAL MENTAL HEALTH

Amendment Barcode (if applicable)

Name STEPHEN R. LOIAN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date	Bill Number (if applicable)
	SB 138

Topic SB 138 - FL Families First Act

Amendment Barcode (if applicable)

Name Dr. Heather Flynn

Job Title FSU College of Medicine

Address 1115 West Call St
Street

Phone 850 645 7367

Tallahassee FL 32306
City *State* *Zip*

Email Heather.flynn@med.fsu.edu

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/10/18
Meeting Date

SB 138
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Perinatal mental Health

Name Lauren DePaola, LCSW

Job Title Owner, Postpartum Wellness + Family Counseling

Address 17698 NW 181 Street
Street

Phone 352-278-2558

Morriston FL 32668
City *State* *Zip*

Email laurendepaolalcsw@yahoo.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Maternal Mental Health Collaborative

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date	Bill Number (if applicable)
	138

Amendment Barcode (if applicable)

Topic Bill 138

Name Lawsha Wetherington

Job Title Executive Director

Address 3137 Lookout Trail (Street)

Tallahassee FL 32309 (City / State / Zip)

Phone 850-727-9461

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing March of Dimes

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

138
Bill Number (if applicable)

Topic Perinatal Mental Health

Amendment Barcode (if applicable)

Name Christina Herdt

Job Title Owner/Operator of Christina's Cakes, LLC

Address 3909 Reserve Dr, Apt 1516
Street

Tallahassee FL 32311
City *State* *Zip*

Phone 850-320-5255

Email Christina.herdt@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Self

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

138
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Perinatal Mental Health

Name Doug Bell

Job Title

Address 119 S Monroe
Street

Phone 205 9000

TLH FL
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

138
Bill Number (if applicable)

Topic Perinatal Mental Health

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title Exec. Director

Address PO Box 961
Street

Phone 850-671-4445

Tallahassee
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing National Alliance of Mental Illness

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

138
Bill Number (if applicable)

Topic Perinatal Mental Health

Amendment Barcode (if applicable)

Name Barbara DeLane

Job Title N/S

Address 1625 E Brevard St
Street

Tall FL 32308
City *State* *Zip*

Phone 251-4382

Email barbaradelane1@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL NOW National Organization for Women

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 138
Bill Number (if applicable)

Topic Perinatal Mental Health

Amendment Barcode (if applicable)

Name Aimee Diaz Lyon

Job Title

Address 119 South Monroe Street #200 *Street*

Phone 850-205-9000

Tallahassee FL 32301 *City* *State* *Zip*

Email aimee.diazlyon@mhdfirm.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Psychiatric Society

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date	Bill Number (if applicable)
	138

Topic SB 138 Florida Families first act

Amendment Barcode (if applicable)

Name Amanda Dibley

Job Title

Address 2181 Portsmouth Circle (Street)

Phone 850 363 9267

Tallahassee FL 32311 (City / State / Zip)

Email amandaddibley@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing SB 138 - Florida families first Act

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

138
Bill Number (if applicable)

Topic PERINATAL CARE

Amendment Barcode (if applicable)

Name CHAKO VALERO

Job Title STATE POLICY DIRECTOR

Address 8235 NE 83RD AVE
Street

Phone 786 442 8199

Miami FL 33138
City *State* *Zip*

Email CHAKO@LATINAINSTITUTE.ORG

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL LATINA ADVOCACY NETWORK

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

138
Bill Number (if applicable)

Topic Amy Kimmell 2 Perinatal Mental Health

Amendment Barcode (if applicable)

Name

Job Title

Address
Street

Phone

Tallahassee FL
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Tallahassee Postpartum

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

138
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic SB 138

Name Rebecca Hartley-Woods

Job Title Stay at home mother

Address _____ Phone _____
Street

_____ Email _____
City State Zip

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing _____

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 474
INTRODUCER:	Senator Brandes
SUBJECT:	Physician Orders for Life-sustaining Treatment
DATE:	January 12, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 474 recognizes a Physician Order for Life Sustaining Treatment (POLST) and establishes a Clearinghouse for Compassionate and Palliative Care Plans (clearinghouse) for state residents as a central registry for advance directives for health care. The Agency for Health Care Administration (AHCA) is directed to establish and maintain the registry, either independently or through a national or private clearinghouse. Plans are required to be electronically accessible. The AHCA is also directed to disseminate information about the clearinghouse once available.

The bill also provides requirements for the contents of the POLST form and its proper execution, and addresses the relationship of a POLST with other advance directives. The Department of Health (DOH) is required to develop the form by rule.

A separate public records exemption bill, CS/SB 476, is linked to SB 474.

The effective date of the bill is July 1, 2018.

II. Present Situation:

End of Life Decision-Making

Individuals may express their end of life health care decisions through one or more different mechanisms such as formal or informal discussions with a health care provider or a loved one or through one of several recognized legal documents. Such discussions may occur because of an individual's particular medical condition, age, or as part of an annual medical examination. Sometimes, the conversation may be the result of a recent hospitalization and the health care provider seeks guidance from the patient or the patient's caregiver about how to treat the

individual's condition next, such as when and if to change to comfort (palliative or hospice) care rather than care that is aimed at a cure for the patient's illness.[1]

Florida law defines an advance directive as any witnessed, oral statements or written instructions that express a person's desires about any aspect of his or her future health care, including the designation of a health care surrogate, a living will, or an anatomical gift.[2] Designation of a health care surrogate, a living will, or an anatomical gift each serve different purposes and have their own unique requirements and specifications under the law.

One type of advance directive, a "do not resuscitate order" (DNRO) results in the withholding of cardiopulmonary resuscitation (CPR) from an individual if a DNRO is presented to the health care professional treating the patient. For the DNRO to be valid, it must be on the form adopted by the DOH, signed by the patient's physician and by the patient, or if the patient is incapacitated, the patient's health care surrogate or proxy, court-appointed guardian, or attorney in fact under a durable power of attorney.[3] Florida's DNRO form is printed on yellow paper.[4] It is the responsibility of the Emergency Medical Services provider to ensure that the DNRO form or the patient identification device, which is a miniature version of the form, accompanies the patient.[5] A DNRO may be revoked by the patient at any time, if signed by the patient, or the patient's health care surrogate, proxy, court-appointed guardian or a person acting under a durable power of attorney.[6]

Not available in Florida, a Physician Order for Life-Sustaining Treatment (POLST), documents a patient's health care wishes in the form of a physician order for a variety of end of life measures, including CPR.[7] A DNRO is limited only to the withholding of CPR. The POLST form can only be completed by a physician and is then provided to the patient to be kept secured in a visible location for emergency personnel.[8] It is suggested that the form be completed when an individual has a serious illness or frailty, regardless of age, as the POLST serves as a medical order for a current, life-threatening illness where the patient has a life expectancy of a year or less.[9] The POLST is intended to express the patient's treatment wishes when the patient is unable to speak for himself or herself during a medical crisis.

Other states' POLST forms include questions relating to what level of care is wanted for CPR (attempt or do not attempt); medical intervention (comfort only, limited additional intervention, or full treatment); and artificially administered nutrition (none, trial, or long-term). Many POLST forms also include information on how to void the authorization before the expiration date, contact information for the surrogate, and information about the medical professionals who may

---

[1] Information from Your Family Doctor: *End of Life Choices for Families,* Am Fam Physician, 2004 Aug 15; 70(4): 725-726, https://www.aafp.org/afp/2004/0815/p725.html (last visited: Dec. 22, 2017).
[2] *See* s. 765.101, F.S.
[3] *See* ss. 395.1041, 400.142, 400.487, 400.605, 400.6095, 401.35, 401.45, 429.255, 429.73, and 7665.205, F.S.
[4] Rule 64J-2.018, F.A.C.
[5] Id.
[6] Id.
[7] POLST.ORG, *About the National POLST Paradigm,* http://www.polst.org/about-the-national-polst-paradigm/ (last visited Jan. 8, 2018).
[8] POLST.ORG, *FAQ,* http://www.polst.org/advance-care-planning/faq/ (last visited Dec. 22, 2017).
[9] POLST.ORG, *POLST v. Advance Directives,* http://www.polst.org/advance-care-planning/polst-and-advance-directives/ (last visited Dec. 22, 2017).

have completed the form. At least 22 other states have implemented or endorsed a POLST program, with California, Oregon and West Virginia being identified as having mature programs.[10]

In comparison to a POLST, an advance directive's purpose is to give instructions on the appointment of a health care representative, express intentions for future treatment or health care, or for an anatomical gift.[11] Florida law allows such advance directives to be expressed in writing or by an oral designation of another person to make health care decisions upon that person's incapacity.[12]

A living will is another mechanism used by individuals to express life-prolonging wishes through a written document or a witnessed oral statement.[13] Any competent adult may make a living will or written declaration, at any given time, to address the providing, withholding, or withdrawing of life-prolonging procedures should that individual have a terminal or end-stage condition.[14] A living will requires the signature of the individual in the presence of two witnesses, one of whom is not the spouse nor a blood relative. It becomes the individual's responsibility to notify health care providers about the living will, so it can be made a part of the individual's medical record.

The statute also provides a suggested form, but in all capital letters, makes clear that a living will does not need to follow the form to be accepted as part of the patient's medical records.[15] Many non-profit organizations also make similar advance directive forms easily available online or in hard copy formats for the designation of health care surrogates or the creation of living wills.[16]

Effective January 1, 2016, advance care planning (ACP) services from physicians and other health care professionals was available as a separate billed service covered by Medicare.[17] If a Medicare beneficiary wants to discuss advance care planning at his or her first annual visit with a physician and then any updates during any subsequent annual wellness visit, physicians and other health care professionals may provide the service during those visits and bill Medicare separately for it. Such services can be provided in both facility and non-facility settings. Previous to this date, ACP services could only be billed as part of another visit; it could not be the sole reason for the physician visit.[18] Providers must also notify their patients if they are unwilling to follow the individual's wishes as expressed in an advance directive document.

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[10] POLST.ORG, *Programs in Your State*, http://www.polst.org/programs-in-your-state/ (last visited Dec. 22, 2017).
[11] *See* s. 765.101, F.S.
[12] *See* s. 765.101(2), F.S.
[13] *See* s. 765.101(13), F.S.
[14] Section 765.302, F.S.
[15] Section 765.303, F.S.
[16] *See* Aging with Dignity, *Five Wishes – Florida*, https://www.agingwithdignity.org/Florida, (last visited: Dec. 22, 2017); Florida Health Care Association, http://www.fhca.org/consumers/health_care_advanced_directives/, (last visited: Dec. 22, 2017); and AARP-Florida, http://www.caringinfo.org/files/public/ad/Florida.pdf (last visited: Dec. 22, 2017).
[17] 42 CFR 410.15.
[18] Henry J. Kaiser Family Foundation, *10 FAQs: Medicare's Role in End of Life Care*, http://kff.org/medicare/fact-sheet/10-faqs-medicares-role-in-end-of-life-care/ (last visited Jan. 8, 2018).

Clearinghouse for Compassionate and Palliative Care Plans

In addition to the availability of the POLST form, several states also have registries for the collection of advance directives.
The Oregon Legislature followed its POLST form creation with its registry in July 2009.[19] Overseen by the Oregon Health Authority, the Oregon POLST Registry received more than 55,000 POLST forms via fax, eFax, mail, electronic files transfer, or other secure messaging means in 2015.[20] In total, Oregon's registry had an estimated 300,000 forms representing almost 200,000 registrants as of the end of 2015.[21]

An individual is not required to send a completed POLST form to the registry. If an individual does not want his or her form in the registry, the Oregon POLST form contains an "opt-out" box that can be checked.[22] When a POLST form is submitted to the registry by the primary care physician, the individual receives a confirmation letter in return, a magnet, and a set of stickers with their registry identification number for future access.[23] The number is to be given to the individual's primary care physician and the magnet and stickers put in prominent places, including something the person might usually carry with them. Beginning in January 2018, Naturopathic Physicians became authorized to sign POLST forms.

West Virginia has its WV e-Directive Registry which makes advance directives, DNROs, West Virginia Physician Orders for Scope of Treatments (POSTs), living wills, and medical powers of attorney available online 24/7 to health care practitioners and facilities when the individual specifically opts in to the registry. While the registry is currently under re-construction, providers must make a request for information via fax sheet and records are distributed between 8:00 a.m. and 4:00 p.m. via a toll-free fax number.[24] Usually, the e-Directive Registry accepts new forms through its direct upload process online or toll-free fax.[25]

Idaho's Health Care Directives Registry is offered through its Secretary of State's office. Individuals may submit several types of health care directive documents, including a Physician Order for Scope of Treatment (POST) form, living will, or durable power of attorney for health care.[26] Documents can be submitted online to the Secretary of State or via the mail. Once registration is confirmed, individuals receive a wallet sized registration card with an individualized filing number and password and information about using the registry.[27]

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[19] Oregon POLST Registry 2015 Annual Report, http://polst.org/wp-content/uploads/2016/09/2015OregonPOLSTRegistryAnnualReport.pdf, p. 5, (last visited Jan. 2, 2018).
[20] Id at 7.
[21] Id at 20.
[22] POLST Oregon, http://www.or.polst.org/registry-resources (last visited Dec. 22, 2017).
[23] Id.
[24] West Virginia Center for End-of-Life Care, *e-Directive Registry, Request for Release of Records from the WV e-Directive Registry*, http://wvendoflife.org/media/1113/registry-treating-provider-release-of-information-rev-july2017.pdf (last visited Dec. 27, 2017).
[25] West Virginia Center for End-of-Life Care, *Introducing the WV E-Directive Registry*, *http://wvendoflife.org/for-providers/e-directive-registry/* (last visited: Dec. 27, 2017).
[26] Idaho Secretary of State, *Health Care Directive Registry*, https://sos.idaho.gov/hcdr/index.html (last visited Dec. 22, 2017).
[27] Id.

New York utilizes a secure web-based application for its electronic Medical Orders for Life-Sustaining Treating (eMOLST) forms. The forms can be printed for the medical record and then stored and linked to the electronic eMOLST registry. The forms can be accessed by emergency medical services, hospitals, nursing homes, and most all health care providers in the community via the online portal.[28] The eMOLST form may also be used for minor patients.[29]

III. Effect of Proposed Changes:

Physician Orders for Life-Sustaining Treatment (POLST) Program (Section 1)

The bill creates s. 401.451, F.S., the Physician Order for Life-Sustaining Treatment (POLST) program, within the DOH. The DOH is directed to implement and administer the program and to collaborate with the AHCA on the implementation and operation of the Clearinghouse for Compassionate and Palliative Care plans (clearinghouse).

Under s. 401.451, F.S., definitions are provided for the following terms:

- "Advance directive" means the same as in s. 765.101, F.S.;[30]
- "Agency" means the Agency for Health Care Administration;
- "Clearinghouse for Compassionate and Palliative Care Plans" [31] or "clearinghouse" means the same as in s. 408.064, F.S.,[32](which is created in this bill);
- "End-stage condition" means the same as in s. 765.101, F.S.;[33]
- "Examining physician" means a physician who examines a patient who wishes, or whose legal representative wishes, to execute a POLST form; who attests to the patient's or the patient's representative's ability to make and communicate health care decisions; who signs the POLST form; and who attests to the patient's or the patient's legal representative's execution of the POLST form;
- "Health care provider" means the same as in s. 408.07, F.S.;
- "Legal representative" means a patient's legally authorized health care surrogate or proxy as provided in ch. 765, F.S., a patient's court-appointed guardian as provided in ch. 744, F.S., who has been delegated authority to make health care decisions on behalf of the patient; an attorney in fact under a durable power of attorney as provided in ch. 709, F.S., who has been

[28] eMOLST - Electronic Medical Orders for Life Sustaining Treatment in New York State, *available at* http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/emolst (last visited Dec. 22, 2017).
[29] Medical Orders for Life Sustaining Treatment - Professionals (FAQS), *available at* http://www.compassionandsupport.org/index.php/for_professionals/molst_training_center/frequently_asked_questions/molst_faqs_page_1 (last visited Dec. 22, 2017).
[30] "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of ch. 765, F.S.
[31] "Compassionate and palliative care plan" means any end-of-life document or medical care directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, an order not to resuscitate, a physician order for life-sustaining treatment, or a health care surrogate designation.
[32] "Clearinghouse" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to s. 408.064, F.S.
[33] "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

delegated authority to make health care decisions on behalf of the patient, or a patient's parent if the patient is a minor;
- "Order not to resuscitate " means an order issued pursuant to s. 401.45(3), F.S.; and
- "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to s. 401.451, F.S., which specifies a patient with an end stage condition and provides directives for that patient's medical treatment under certain conditions.

The bill establishes specific duties for the DOH for the POLST program. These duties include the requirement to:
- Adopt rules to implement and administer the POLST program;
- Prescribe a standardized POLST form;
- Provide the POLST form in an electronic format on the DOH's website and prominently state the requirements for a POLST form;
- Consult with health care professional licensing groups, provider advocacy groups, medical ethicists, and other appropriate stakeholders on the development of rules and forms;
- Collaborate with the AHCA to develop and maintain the clearinghouse;
- Ensure that the DOH staff receive ongoing training on the POLST program and the availability of POLST forms;
- Recommend a statewide, uniform process through which a patient that has, or whose legal representative has, executed a POLST form is identified and the health care providers currently treating the patient are provided with contact information for the examining physician who signed the POLST form;
- Adopt POLST-related continuing education requirements for health care providers licensed by the DOH; and
- Develop a process for collecting provider feedback to facilitate the periodic re-design of the POLST form consistent with current health care best practices.

POLST Form (Section 1)

The form must be voluntarily executed by the patient, or if the patient is incapacitated or a minor, by the patient's legal representative. All directives included in the form must be made by the patient, or if the patient is a minor, the patient's legal representative.

To be valid and to be included in a patient's medical records, the POLST form must meet all of the following requirements:
- Be printed on one or both sides of a single piece of paper as determined by the DOH rule;
- Include the signatures of the patient and the patient's examining physician or, if the patient is incapacitated or a minor, the patient's legal representative and the patient's examining physician, executed after consultation with the patient or the patient's legal representative as appropriate;
- Indicate prominently that completion of the form is voluntary, the use of the form is not a condition of any treatment, and the form cannot be given any affect if the patient is conscious and competent to make health care decisions;
- Prominently provide in a conspicuous location on the form a space for the examining physician to attest and affirm that, in his or her good faith clinical judgment, at the time the POLST form is completed and signed, the patient has the ability to make and communicate

health care decisions or, if the patient is incapacitated or a minor, that the patient's legal representative has such an ability;
- Provide an expiration date, provided by the patient's examining physician, that is within one year after the patient or the patient's legal representative signs the form or that is contingent on the completion of the course of treatment addressed in the POLST form, whichever occurs first;
- Identify the medical condition or conditions, provided by the patient's examining physician, that necessitate the POLST form; and
- Not include a directive regarding hydration or the preselection of any decisions or directives.

The POLST form may only be used by a patient whose examining physician has determined that the patient has an end-stage condition or who, in the good faith clinical judgment of the examining physician, is suffering from at least one life-limiting medical condition that will likely result in the death of the patient within one year.

At a minimum, the patient's physician must review the POLST form with the patient or the patient's representative, when the patient:
- Is transferred from one health care setting or level of care to another;
- Is discharged from a health care setting to return home before the expiration of the POLST form;
- Experiences a substantial change in his or her condition as determined by the patient's examining physician, in which case the review must occur within 24 hours of the substantial change; or
- Expresses an intent to change his or her treatment preferences.

A POLST form may be revoked at any time by a patient, or the patient's legal representative if the patient is a minor or the patient is incapacitated or and the authority to revoke a POLST form has been granted by the patient to his or her legal representative. The execution of a subsequent POLST form by a patient and his or her examining physician under this section automatically revokes any prior POLST form previously executed by the patient.

In addition, if any directive on a patient's POLST form conflicts with another advance directive of the patient which addresses a substantially similar health care condition or treatment, the document most recently signed by the patient takes precedence. Such directives may include, but are not limited to:
- Living wills;
- Health care powers of attorney;
- POLST forms for the specific medical condition of treatment; or
- An order not-to-resuscitate.

If a family member of the patient, the health care facility providing services to the patient, or the patient's physician who may reasonably be expected to be affected by the patient's POLST form directives believes the directives executed by the patient's legal representative are in conflict with the patient's prior expressed desires regarding end-of-life care, he or she or the facility may seek expedited judicial intervention pursuant to the Florida Probate Rules.

The bill establishes immunity from criminal prosecution, civil liability, or professional discipline for a licensee, physician, medical director, emergency medical technician, or paramedic who in good faith complies with or carries out the directives of a POLST form. Also, any person, acting in good faith as a legal representative, is not subject to civil liability or criminal prosecution for executing a POLST form pursuant to this law.

If medical orders on a POLST form are carried out to withhold life-sustaining treatment for a minor, the order must include certification by a health care provider in addition to the physician executing the POLST form that, in their clinical judgement, the order is in the best interest of the minor patient. A POLST form for a minor patient must also be signed by the minor patient's legal representative. The minor patient's physician must certify the basis for the authority of the minor patient's legal representative to execute the POLST form, including his or her compliance with the relevant statutory provisions of ch. 765, F.S., relating to health care advance directives and ch. 744, F.S., relating to guardianship.

The bill further requires that when a patient who has executed a valid POLST form is transferred from one health care facility to another, the health care facility initiating the transfer must communicate the existence of the POLST form to the receiving facility before the transfer. Upon the patient's transfer, the receiving facility's treating physician must review the POLST form with the patient or if the patient is incapacitated or a minor, the patient's legal representative.

Facilities and providers may not require a person to complete, revise, or revoke a POLST as a prerequisite or condition of receiving services or treatment or as a condition of admission. The execution, revision, or revocation of a POLST form must be a voluntary decision of the patient, or if incapacitated or a minor, the patient's legal representative.

The presence or absence of a POLST form does not affect, impair, or modify a contract of life or health insurance or annuity to which an individual is a party and may not serve as the basis for any delay in issuing or refusing to issue an annuity or policy of life or health insurance or for an increase or decrease in premiums charged to an individual.

A POLST form is invalid if payment or other remuneration was offered or made in exchange for its execution.

The bill specifies that the act may not be construed to condone, authorize, or approve mercy killing or euthanasia. A statement of legislative intent provides that this act is not to be construed as permitting any affirmative or deliberate act to end a person's life, except to permit the natural process of dying.

Clearinghouse for Compassionate and Palliative Care Plans (Section 2)

Section 2 creates s. 408.064, F.S., which establishes the Clearinghouse for Compassionate and Palliative Care Plans (clearinghouse) within the AHCA. The AHCA is responsible for establishing and maintaining the clearinghouse directly or through a designee. The clearinghouse must be a reliable and secure database that will allow Florida residents to electronically submit their individual plans for compassionate and palliative care. The database may only be accessed by a health care provider who is treating the patient-resident.

As used in this section, the bill provides definitions for these terms:

- "Advance directive" means the same as in s. 765.101, F.S.;[34]
- "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to this section;
- "Compassionate and palliative care plan" or "plan" means any end-of-life document or medical directive document recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, an order to do-not-resuscitate, a physician order for life-sustaining treatment, or a health care surrogate designation;
- "Department" means the Department of Health;
- "End-stage condition" means the same as in s. 765.101, F.S.;[35]
- "Order not to resuscitate" means an order issued pursuant to s. 401.45(3), F.S.; and
- "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to s. 401.451, F.S., which specifies the care and medical treatment under certain medical conditions for a patient with an end stage conditions.

The AHCA is required to establish and maintain the clearinghouse by January 1, 2019. The database must allow for electronic submission, storage, indexing, and retrieval of compassionate and palliative care plans. The AHCA must also develop and maintain an identity validation system that confirms the identity of the facility, health care provider, or other authorized individual seeking retrieval of plans while protecting the privacy of patient's personal and medical information. The system must meet all applicable state and federal privacy and security standards.

The AHCA is directed to seek input on the clearinghouse from state residents, compassionate and palliative care providers, and health care facilities for its development and implementation. The AHCA may subscribe to or participate in a national or private clearinghouse that will accomplish the same goals in lieu of establishing an independent clearinghouse. Once clearinghouse information is available, the AHCA is required to publish and disseminate information regarding the availability of the clearinghouse to Floridians. The AHCA must also provide training to health care providers and health care facilities on how to access plans.

Statutory Revisions to Include POLST (Sections 3-10 and 12)

Provisions in statute requiring health professional staff to honor "do not resuscitate" orders (DNROs) are revised to include recognition of a POLST document in the same manner.

The table below reflects the statutes impacted by these revisions.

[34] "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care or health information, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part V of ch. 765, F.S.

[35] "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

Statutory Revisions - Addition of POLST Language		
Bill Section	**F.S. Citation**	**Description**
3	§400.142	Nursing Homes; Emergency medication kits; DNROs
4	§400.487	Home Health Service Agreements; DNROs
5	§400.605	Hospices; Administration; forms; fees
6	§400.6095	Hospice; patient admission; assessment; plan of care; discharge; death
7	§401.35	Medical Transportation Services: Rules
8	§401.45	Denial of emergency treatment; civil liability
9	§429.255	Assisted Living Facilities; Use of personnel; emergency care
10	§429.73	Rules and standards relating to adult family-care homes
11	§456.072	Grounds for discipline; penalties; enforcement
12	§765.205	Responsibility of the surrogate

Section 11 - amends s. 456.072, F.S., relating to discipline for health care practitioners generally, to allow a licensee to withhold or withdraw cardiopulmonary resuscitation (CPR) or the use of an automated external defibrillator if presented with an order not to resuscitate or a POLST which includes a DNRO. The DOH is directed to adopt rules for the implementation of such orders. Additionally, the bill provides that licensees who withhold CPR or the use of an automated external defibrillator may not be subject to criminal prosecution and may not be considered to have acted in a negligent or unprofessional manner for carrying out DNRO or POLST orders.

The bill further provides that the absence of an order [not] to resuscitate pursuant to s. 408.064, F.S., or a POLST form executed pursuant to s. 408.064, F.S., does not preclude a licensee from withholding or withdrawing CPR or the use of an external automated defibrillator or otherwise carrying out medical orders allowed by law.

The effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

A separate public records exemption bill for the Clearinghouse for Compassionate and Palliative Care Plans (SB 476) is linked to this bill to ensure that the personally identifying information contained on the POLST forms is kept confidential and exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. The POLST forms contain sensitive medical information and personal identifying information.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The AHCA anticipates that a private sector vendor would be selected to operate the clearinghouse. The estimated fiscal impact for implementation would be $661,101 for the first year and $618,434 for the second year.[36] Based on initial research conducted by the AHCA, there are no currently existing national databases that exist or regional databases that cover all of Florida that meet the requirements outlined in the bill, although it is possible that there might be one that could be customized to meet the requirements.[37]

Patients might request their providers complete and submit POLST forms on their behalf to the clearinghouse which could increase a provider's administrative costs.

C. Government Sector Impact:

The AHCA estimates the overall costs for SB 474 to be $1,084,143 for the first year of implementation and $1,041,476 for the second year of operations as detailed in the chart below.[38] Cost estimates for the clearinghouse were based on experiences of Washington State and adjusted for Florida's population size and inflation, according to the AHCA.[39]

The AHCA requested 3.00 FTEs for the implementation and administration of the clearinghouse under the alternative option as a contracted service. The 3.00 FTEs would also be responsible for educating and conducting outreach activities for residents and providers about the availability of the POLST and the clearinghouse statewide.

The AHCA has also noted that it does not believe that the clearinghouse can be implemented in the 6 month timeframe outlined in the bill and recommends a one year timeframe.

The DOH estimated its fiscal impact based on significant personnel time relating to developing rules and procedures for the POLST form and orders not to resuscitate pursuant to a POLST form and to create and maintain the clearinghouse in coordination

[36] Agency for Health Care Administration, *Senate Bill 474 Analysis*, p. 7-9, (Oct. 13, 2017) (on file with the Senate Committee on Health Policy).
[37] Id at 5.
[38] Id.
[39] Id at 2.

with the AHCA and DOEA.[40] The DOH indicated these costs are estimated at $232,230 for the first year and $218,808 for the second year.[41] To conduct these activities, the DOH requested 3 FTEs and their associated expenses as shown in the chart below.

FISCAL IMPACT – SB 474		
Expenditure	**Year One**	**Year Two**
Department of Health[42]		
Professional Positions		
Program Administrator	$64,598	$64,598
Program Manager	$64,598	$64,598
Administrative Assistant II	41,962	41,962
Total Salary & Fringe:	**$171,159**	**$171,159**
Non-Recurring Expense Std.		
Professional:	$13,422	-
Total Non-Recurring Expense:	**$13,422**	-
Recurring Expense Std.		
Professional:	$17,844	$17,844
Total Recurring Expense Standard:	**$17,844**	**$17,844**
Recurring Professional Travel Std.		
Medium Travel	$28,818	$28,818
Total Recurring Expense – Travel:	**$28,818**	**$28,818**
HR Outsourcing		
FTE	$987	$987
CHD	$-	$-
OPS	$-	$-
Total HR Outsourcing:	**$987**	**$987**
Total Recurring Costs – DOH	$218,808	$218,808
Total Non-Recurring & Recurring Costs – DOH	**$232,230**	**$232,808**
Agency for Health Care Administration[43]		
Expenditure	**Year One**	**Year Two**
Professional Staff		
3 FTEs Professional Staff	$13,422	$-
Total Non-Recurring Expense – 3 FTEs	**$13,422**	$-
Salaries		
Government Ops Consultant II (1 FTE)	$62,128	$62,128
Health Services & Facility Consultant (2 FTEs)	116,948	116,948
Total Salary and Benefits (3 FTEs):	**$179,076**	**$179,076**
Expenses		
Professional Staff (3 FTEs @ $5,993)	$17,979	$17,979
Educational Materials (facilities and providers)	75,000	75,000
Educational Materials (consumers)	150,000	150,000
Total Expenses:	**$242,979**	**$242,979**
Human Resources Services		
FTE Positions (3 FTEs @ $329):	$987	$987

[40] Department of Health, *Senate Bill 474 Analysis*, pp. 4-5 (Oct. 10, 2017) (on file with the Senate Committee on Health Policy).
[41] Id. at 5.
[42] *Supra* note 40.
[43] Agency for Health Care Administration, *Senate Bill 474 Analysis*, pp. 7-9, (Oct. 13, 2017) (on file with the Senate Committee of Health Policy).

FISCAL IMPACT – SB 474		
Expenditure	**Year One**	**Year Two**
Total Human Resources Services:	**$987**	**$987**
Special Categories/Contracted Services		
Contracted Services	$611,101	$618,434
Contracted Services (Customized Services)	50,000	$-
Total Special Categories/Contracted Services:	**$661,101**	**$618,434**
Total Recurring Costs – AHCA:	$1,084,143	1,041,476
Total Non-Recurring Costs – AHCA:	$13,422	$-
Total Net Impact – AHCA:	**$1,097,565**	**$1,041,476**

In 2016 under an identical bill, the Department of Elderly Affairs (DOEA) estimated a minimal fiscal impact related to rulemaking for implementation of the POLST forms at hospices, assisted living facilities, and adult family day cares.[44] The DOEA indicated these costs could be absorbed within existing resources.[45] No fiscal impact has been received from DOEA for SB 474.

VI. Technical Deficiencies:

SB 474 does not amend s. 395.1041(3)(l), F.S., to protect hospital personnel for honoring a POLST form.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.142, 400.487, 400.605, 400.6095, 401.35, 401.45, 429.255, 429.73, 456.072, and 765.205.

This bill creates the following sections of the Florida Statutes: 401.451 and 408.064.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[44] Department of Elderly Affairs, *Senate Bill 664 Analysis*, p. 2 (Dec. 15, 2015) (on file with the Senate Committee on Health Policy).
[45] Id at 4.

By Senator Brandes

24-00549-18 2018474__

A bill to be entitled

An act relating to physician orders for life-sustaining treatment; creating s. 401.451, F.S.; establishing the Physician Orders for Life-Sustaining Treatment (POLST) Program within the Department of Health; defining terms; providing duties of the department; providing requirements for POLST forms; providing a restriction on the use of POLST forms; requiring periodic review of POLST forms; providing for the revocation of POLST forms under certain circumstances; authorizing expedited judicial intervention under certain circumstances; specifying which document takes precedence when directives in POLST forms conflict with other advance directives; providing limited immunity for legal representatives and specified health care providers acting in good faith in reliance on POLST forms; specifying additional requirements for POLST forms executed on behalf of minor patients under certain circumstances; requiring the review of a POLST form upon the transfer of a patient; prohibiting POLST forms from being required as a condition for treatment or admission to health care facilities; providing that the presence or absence of POLST forms does not affect, impair, or modify certain insurance contracts; declaring a POLST form invalid if it is executed in exchange for payment or other remuneration; providing construction; creating s. 408.064, F.S.; defining terms; requiring the Agency for Health Care Administration to establish

and maintain a database of compassionate and palliative care plans by a specified date; providing duties of the agency; authorizing the agency to subscribe to or participate in a public or private clearinghouse in lieu of establishing and maintaining an independent database; amending ss. 400.142 and 400.487, F.S.; authorizing specified personnel to withhold or withdraw cardiopulmonary resuscitation if presented with a POLST form that contains an order not to resuscitate the patient; providing immunity from criminal prosecution or civil liability to such personnel for such actions; providing that the absence of a POLST form does not preclude physicians or home health agency personnel from withholding or withdrawing cardiopulmonary resuscitation under certain conditions; amending s. 400.605, F.S.; requiring the Department of Elderly Affairs, in consultation with the agency, to adopt by rule procedures for the implementation of POLST forms in hospice care; amending s. 400.6095, F.S.; authorizing hospice care teams to withhold or withdraw cardiopulmonary resuscitation if presented with POLST forms that contain an order not to resuscitate; providing immunity from criminal prosecution or civil liability to hospice staff for such actions; providing that the absence of a POLST form does not preclude physicians from withholding or withdrawing cardiopulmonary resuscitation; amending s. 401.35, F.S.; requiring the Department of Health to establish

circumstances and procedures for honoring certain POLST forms; amending s. 401.45, F.S.; authorizing emergency medical personnel to withhold or withdraw cardiopulmonary resuscitation or other medical interventions if presented with POLST forms that contain an order not to resuscitate; amending s. 429.255, F.S.; authorizing assisted living facility personnel to withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with POLST forms that contain an order not to resuscitate; providing immunity from criminal prosecution or civil liability to facility staff and facilities for such actions; providing that the absence of a POLST form does not preclude physicians from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator; amending s. 429.73, F.S.; requiring the Department of Elderly Affairs to adopt rules for the implementation of POLST forms in adult family-care homes; authorizing providers of such homes to withhold or withdraw cardiopulmonary resuscitation if presented with POLST forms that contain an order not to resuscitate; providing immunity from criminal prosecution or civil liability to providers for such actions; amending s. 456.072, F.S.; authorizing certain licensees to withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with orders not to resuscitate or POLST forms that contain

an order not to resuscitate; requiring the Department of Health to adopt rules providing for the implementation of such orders; providing immunity from criminal prosecution or civil liability to licensees for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or for carrying out specified orders under certain circumstances; providing that the absence of a POLST form does not preclude a licensee from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator under certain conditions; amending s. 765.205, F.S.; requiring health care surrogates to provide written consent for POLST forms under certain circumstances; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 401.451, Florida Statutes, is created to read:

401.451 Physician Orders for Life-Sustaining Treatment Program.—The Physician Orders for Life-Sustaining Treatment Program is established within the Department of Health to implement and administer the development and use of physician orders for life-sustaining treatment consistent with this section and to collaborate with the Agency for Health Care Administration in the implementation and operation of the Clearinghouse for Compassionate and Palliative Care Plans created under s. 408.064.

(1) DEFINITIONS.—As used in this section, the term:

(a) "Advance directive" has the same meaning as provided in s. 765.101.

(b) "Agency" means the Agency for Health Care Administration.

(c) "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" has the same meaning as provided in s. 408.064.

(d) "End-stage condition" has the same meaning as provided in s. 765.101.

(e) "Examining physician" means a physician who examines a patient who wishes, or whose legal representative wishes, to execute a POLST form; who attests to the ability of the patient or the patient's legal representative to make and communicate health care decisions; who signs the POLST form; and who attests to the execution of the POLST form by the patient or by the patient's legal representative.

(f) "Health care provider" has the same meaning as provided in s. 408.07.

(g) "Legal representative" means a patient's legally authorized health care surrogate or proxy as provided in chapter 765, a patient's court-appointed guardian as provided in chapter 744 who has been delegated authority to make health care decisions on behalf of the patient, an attorney in fact under a durable power of attorney as provided in chapter 709 who has been delegated authority to make health care decisions on behalf of the patient, or a patient's parent if the patient is under 18 years of age.

(h) "Order not to resuscitate" means an order issued under

s. 401.45(3).

(i) "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to this section which specifies a patient with an end-stage condition and provides directives for that patient's medical treatment and care under certain conditions.

(2) DUTIES OF THE DEPARTMENT.—The department shall:

(a) Adopt rules to implement and administer the POLST program.

(b) Prescribe a standardized POLST form.

(c) Provide the POLST form in an electronic format on the department's website and prominently state on the website the requirements for a POLST form as specified under paragraph (3)(a).

(d) Consult with health care professional licensing groups, provider advocacy groups, medical ethicists, and other appropriate stakeholders on the development of rules and forms to implement and administer the POLST program.

(e) Collaborate with the agency to develop and maintain the clearinghouse.

(f) Ensure that department staff receive ongoing training on the POLST program and are aware of the availability of POLST forms.

(g) Recommend a statewide, uniform process for identifying a patient who has, or whose legal representative has, executed a POLST form and for providing the contact information for the examining physician to the health care providers currently treating the patient.

(h) Adopt POLST-related continuing education requirements

for health care providers licensed by the department.

(i) Develop a process for collecting feedback from health care providers to facilitate the periodic redesign of the POLST form in accordance with current health care best practices.

(3) POLST FORM.—

(a) *Requirements*.—A POLST form may not include a directive regarding hydration or the preselection of any decision or directive. A POLST form must be voluntarily executed by the patient or, if the patient is incapacitated or a minor, the patient's legal representative, and all directives included in the form must be made by the patient or, if the patient is incapacitated or a minor, the patient's legal representative at the time of signing the form. A POLST form is not valid and may not be included in a patient's medical records or submitted to the clearinghouse unless the form:

1. Is clearly printed on one or both sides of a single piece of paper as determined by department rule;

2. Includes the signatures of the patient and the patient's examining physician or, if the patient is incapacitated or a minor, the patient's legal representative and the patient's examining physician. The POLST form may be executed only after the examining physician consults with the patient or the patient's legal representative, as appropriate;

3. Prominently states that completion of a POLST form is voluntary, that the execution or use of a POLST form may not be required as a condition for medical treatment, and that a POLST form may not be given effect if the patient is conscious and competent to make health care decisions;

4. Prominently provides in a conspicuous location on the

form a space for the patient's examining physician to attest that, in his or her clinical judgment and with good faith, at the time the POLST form is completed and signed, the patient has the ability to make and communicate health care decisions or, if the patient is incapacitated or a minor, that the patient's legal representative has such ability;

5. Includes an expiration date, provided by the patient's examining physician, that is within 1 year after the patient or the patient's legal representative signs the form or that is contingent on completion of the course of treatment addressed in the POLST form, whichever occurs first; and

6. Identifies the medical condition or conditions, provided by the patient's examining physician, that necessitate the POLST form.

(b) *Restriction on the use of a POLST form.*—A POLST form may be completed only by or for a patient determined by the patient's examining physician to have an end-stage condition or a patient who, in the good faith clinical judgment of the examining physician, is suffering from a life-limiting medical condition that will likely result in the death of the patient within 1 year after the execution of the form.

(c) *Periodic review of a POLST form.*—At a minimum, the patient's examining physician must review the patient's POLST form with the patient or the patient's legal representative, as appropriate, when the patient:

1. Is transferred from one health care facility or level of care to another in accordance with subsection (6);

2. Is discharged from a health care facility to return home before the expiration of the POLST form;

3. Experiences a substantial change in his or her condition as determined by the patient's examining physician, in which case the review must occur within 24 hours after the substantial change; or

4. Expresses an intent to change his or her medical treatment preferences.

(d) *Revocation of a POLST form.*—

1. A POLST form may be revoked at any time by the patient or the patient's legal representative if the patient is a minor or if the patient is incapacitated and has granted the authority to revoke a POLST form to his or her legal representative.

2. The execution of a POLST form by a patient and the patient's examining physician or, if the patient is incapacitated or a minor, by the patient's legal representative and the patient's examining physician under this section automatically revokes all POLST forms previously executed by the patient.

(e) *Review of a legal representative's decision on a POLST form.*—If a family member of the patient, the health care facility providing services to the patient, or the patient's physician who may reasonably be expected to be affected by the patient's POLST form directives believes that directives executed by the patient's legal representative are in conflict with the patient's prior expressed desires regarding end-of-life care, the family member, facility, or physician may seek expedited judicial intervention pursuant to the Florida Probate Rules.

(f) *Conflicting advance directives.*—To the extent that a directive made on a patient's POLST form conflicts with another

advance directive of the patient which addresses a substantially similar health care condition or treatment, the document most recently signed by the patient takes precedence. Such directives may include, but are not limited to:

1. A living will.

2. A health care power of attorney.

3. A POLST form for the specific medical condition or treatment.

4. An order not to resuscitate.

(4) ACTING IN GOOD FAITH; LIMITED IMMUNITY.—

(a) An individual acting in good faith as a legal representative who executes a POLST form on behalf of an incapacitated patient or a minor patient in accordance with this section and rules adopted by the department is not subject to criminal prosecution or civil liability for executing the POLST form.

(b) A licensee, physician, medical director, emergency medical technician, paramedic, or registered nurse who in good faith complies with a POLST form is not subject to criminal prosecution or civil liability for complying with the POLST form, and has not engaged in negligent or unprofessional conduct as a result of carrying out the directives of a POLST form executed in accordance with this section and rules adopted by the department.

(5) POLST FORM FOR A MINOR PATIENT.—If a medical order on a POLST form executed for a minor patient directs that life-sustaining treatment may be withheld from the minor patient, the order must include certifications by the patient's examining physician and a health care provider other than the examining

physician stating that, in their clinical judgment, an order to withhold medical treatment is in the best interest of the minor patient. A POLST form for a minor patient must be signed by the minor patient's legal representative. The minor patient's examining physician must certify the basis for the authority of the minor patient's legal representative to execute the POLST form on behalf of the minor patient, including the legal representative's compliance with the relevant provisions of chapter 744 or chapter 765.

(6) PATIENT TRANSFER; POLST FORM REVIEW REQUIRED.—If a patient whose goals and preferences for care have been entered in a valid POLST form is transferred from one health care facility or level of care to another, the health care facility or level of care initiating the transfer must communicate the existence of the POLST form to the receiving facility or level of care before the transfer. Upon the patient's transfer, the treating health care provider at the receiving facility or level of care must review the POLST form with the patient or, if the patient is incapacitated or a minor, the patient's legal representative.

(7) POLST FORM NOT A PREREQUISITE.—A POLST form may not be a prerequisite for receiving medical services or for admission to a health care facility. A health care facility or health care provider may not require a person to complete, revise, or revoke a POLST form as a condition of receiving medical services or treatment or as a condition of admission. The execution, revision, or revocation of a POLST form must be a voluntary decision of the patient or, if the patient is incapacitated or a minor, the patient's legal representative.

(8) INSURANCE NOT AFFECTED.—The presence or absence of a POLST form does not affect, impair, or modify a contract of life or health insurance or annuity to which an individual is a party and may not serve as the basis for a delay in issuing or refusing to issue a policy of life or health insurance or an annuity or for an increase or decrease in premiums charged to the individual.

(9) INVALIDITY.—A POLST form is invalid if payment or other remuneration was offered or made in exchange for execution of the form.

(10) CONSTRUCTION.—This section may not be construed to condone, authorize, or approve mercy killing or euthanasia. The Legislature does not intend that this act be construed as authorizing an affirmative or deliberate act to end a person's life, except to allow the natural process of dying.

Section 2. Section 408.064, Florida Statutes, is created to read:

408.064 Clearinghouse for Compassionate and Palliative Care Plans.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Advance directive" has the same meaning as provided in s. 765.101.

(b) "Clearinghouse for Compassionate and Palliative Care Plans" or "clearinghouse" means the state's electronic database of compassionate and palliative care plans submitted by residents of this state and managed by the agency pursuant to this section.

(c) "Compassionate and palliative care plan" or "plan" means an end-of-life document or medical directive document

recognized by this state and executed by a resident of this state, including, but not limited to, an advance directive, an order not to resuscitate, a physician order for life-sustaining treatment, or a health care surrogate designation.

(d) "Department" means the Department of Health.

(e) "End-stage condition" has the same meaning as provided in s. 765.101.

(f) "Order not to resuscitate" means an order issued pursuant to s. 401.45(3).

(g) "Physician order for life-sustaining treatment" or "POLST" means an order issued pursuant to s. 401.451 which specifies a patient with an end-stage condition and provides directions for that patient's medical treatment and care under certain conditions.

(2) ELECTRONIC DATABASE.—The Agency for Health Care Administration shall:

(a) By January 1, 2019, establish and maintain the Clearinghouse for Compassionate and Palliative Care Plans, a reliable and secure database consisting of compassionate and palliative care plans submitted by residents of this state which is accessible to health care providers, health care facilities, and other authorized individuals through a secure electronic portal. The clearinghouse must allow the electronic submission, storage, indexing, and retrieval of such plans and allow access to them by the treating health care providers of the patients.

(b) Develop and maintain a validation system that confirms the identity of the health care facility, health care provider, or other authorized individual seeking the retrieval of a plan and provides privacy protections that meet all state and federal

privacy and security standards for the release of a patient's personal and medical information to a third party.

(c) Consult with compassionate and palliative care providers, health care facilities, and residents of this state as necessary and appropriate to facilitate the development and implementation of the clearinghouse.

(d) Publish and disseminate to residents of this state information regarding the clearinghouse.

(e) In collaboration with the department, develop and maintain a process for the submission of compassionate and palliative care plans by residents of this state or by health care providers on behalf of, and at the direction of, their patients, or the patients' legal representatives as defined in s. 401.451, for inclusion in the clearinghouse.

(f) Provide training to health care providers and health care facilities in this state on how to access plans in the clearinghouse.

(3) ALTERNATIVE IMPLEMENTATION.—In lieu of establishing and maintaining the clearinghouse, the agency may subscribe to or otherwise participate in a database operated by a public or private entity if that database meets the requirements of this section. The alternative database must operate on a statewide basis in this state, and may operate on a nationwide or regionwide basis.

Section 3. Subsection (3) of section 400.142, Florida Statutes, is amended to read:

400.142 Emergency medication kits; orders not to resuscitate.—

(3) Facility staff may withhold or withdraw cardiopulmonary

resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. Facility staff and facilities are not subject to criminal prosecution or civil liability, or considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such an order or a POLST form. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise authorized ~~permitted~~ by law.

Section 4. Section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate; physician orders for life-sustaining treatment.—

(1) Services provided by a home health agency must be covered by an agreement between the home health agency and the patient or the patient's legal representative specifying the home health services to be provided, the rates or charges for services paid with private funds, and the sources of payment, which may include Medicare, Medicaid, private insurance, personal funds, or a combination thereof. A home health agency providing skilled care must make an assessment of the patient's

needs within 48 hours after the start of services.

(2) If ~~When~~ required by ~~the provisions of~~ chapter 464; part I, part III, or part V of chapter 468; or chapter 486, the attending physician, physician assistant, or advanced registered nurse practitioner, acting within his or her respective scope of practice, shall establish treatment orders for a patient who is to receive skilled care. The treatment orders must be signed by the physician, physician assistant, or advanced registered nurse practitioner before a claim for payment for the skilled services is submitted by the home health agency. If the claim is submitted to a managed care organization, the treatment orders must be signed within the time allowed under the provider agreement. The treatment orders shall be reviewed, as frequently as the patient's illness requires, by the physician, physician assistant, or advanced registered nurse practitioner in consultation with the home health agency.

(3) A home health agency shall arrange for supervisory visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction, approval, and agreement to pay the charge for the visits.

(4) Each patient has the right to be informed of and to participate in the planning of his or her care. Each patient must be provided, upon request, a copy of the plan of care established and maintained for that patient by the home health agency.

(5) If ~~When~~ nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation

visits, and the discharge visit by a direct employee. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

(6) The skilled care services provided by a home health agency, directly or under contract, must be supervised and coordinated in accordance with the plan of care.

(7) Home health agency personnel may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The agency shall adopt rules providing for the implementation of such orders. Home health personnel and agencies are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and are not ~~nor be~~ considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such orders ~~an order~~ and rules adopted by the agency.

Section 5. Paragraph (e) of subsection (1) of section 400.605, Florida Statutes, is amended to read:

400.605 Administration; forms; fees; rules; inspections; fines.—

(1) The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. The department, in consultation with the agency, shall by

rule establish minimum standards and procedures for a hospice pursuant to this part. The rules must include:

(e) Procedures relating to the implementation of advance ~~advanced~~ directives; physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 401.451; and orders not to resuscitate ~~do-not-resuscitate orders~~.

Section 6. Subsection (8) of section 400.6095, Florida Statutes, is amended to read:

400.6095 Patient admission; assessment; plan of care; discharge; death.—

(8) The hospice care team may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Hospice staff are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and are not ~~nor be~~ considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such orders ~~an order~~ and applicable rules. The absence of an order to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation as otherwise authorized ~~permitted~~ by law.

Section 7. Subsection (4) of section 401.35, Florida Statutes, is amended to read:

401.35 Rules.—The department shall adopt rules, including

definitions of terms, necessary to carry out the purposes of this part.

(4) The rules must establish circumstances and procedures under which emergency medical technicians and paramedics may honor orders by the patient's physician not to resuscitate executed pursuant to s. 401.45, or under a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate, or honor orders to withhold or withdraw other forms of medical intervention, and the documentation and reporting requirements for handling such requests.

Section 8. Paragraph (a) of subsection (3) of section 401.45, Florida Statutes, is amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation or other forms of medical intervention may be withheld or withdrawn from a patient by an emergency medical technician, ~~or~~ paramedic, or other health care professional if the technician, paramedic, or professional is presented with evidence of an order not to resuscitate by the patient's physician or evidence of a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate or an order not to perform other medical intervention, as applicable ~~is presented to the emergency medical technician or paramedic~~. To be valid, an order not to resuscitate or not to perform other medical intervention~~, to be valid,~~ must be on the form adopted by rule of the department. The form must be signed by the patient's physician and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as

provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709 or, if the patient is a minor, the patient's parent or legal guardian. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

Section 9. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. Facility staff and facilities are ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and are not ~~nor be~~ considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator pursuant to such an order or a POLST form which contains an order not to resuscitate and rules adopted by the department. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator as otherwise authorized ~~permitted~~ by law.

Section 10. Subsection (3) of section 429.73, Florida Statutes, is amended to read:

429.73 Rules and standards relating to adult family-care homes.—

(3) The department shall adopt rules providing for the implementation of orders not to resuscitate and physician orders for life-sustaining treatment (POLST) forms executed pursuant to s. 401.451. The provider may withhold or withdraw cardiopulmonary resuscitation if presented with an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 which contains an order not to resuscitate. The provider is ~~shall~~ not ~~be~~ subject to criminal prosecution or civil liability, and is not ~~nor be~~ considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation pursuant to such orders ~~an order~~ and applicable rules.

Section 11. Present subsections (7) and (8) of section 456.072, Florida Statutes, are redesignated as subsections (8) and (9), respectively, and a new subsection (7) is added to that section, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) A licensee may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45 or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451 which contains an order not to resuscitate. The department shall adopt rules providing for the implementation of such orders. A licensee is not subject to criminal prosecution or civil liability, and is

not considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator, or otherwise carrying out an order in an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451, pursuant to the order not to resuscitate or the POLST form and pursuant to rules adopted by the department. The absence of an order not to resuscitate executed pursuant to s. 401.45 or a POLST form executed pursuant to s. 401.451 does not preclude a licensee from withholding or withdrawing cardiopulmonary resuscitation or the use of an automated external defibrillator or otherwise carrying out a medical order authorized by law.

Section 12. Paragraph (c) of subsection (1) of section 765.205, Florida Statutes, is amended to read:

765.205 Responsibility of the surrogate.—

(1) The surrogate, in accordance with the principal's instructions, unless such authority has been expressly limited by the principal, shall:

(c) Provide written consent using an appropriate form whenever consent is required, including a physician's order not to resuscitate or a physician order for life-sustaining treatment (POLST) form executed pursuant to s. 401.451.

Section 13. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Dana D. Young
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 26, 2017

I respectfully request that **Senate Bill #474**, relating to **Physician Orders for Life-sustaining Treatment**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

SB 474
Bill Number (if applicable)

Topic POLST (SB 474)

Amendment Barcode (if applicable)

Name Dr. Diane Gowski (MD)

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Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing State director for Florida guilds of the Catholic Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

474
Bill Number (if applicable)

Topic POLST

Amendment Barcode (if applicable)

Name MARTHA DeCASTRO

Job Title VP for Nursing + Clinical Care Policy

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Tallahassee FL 32301
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Email martha@fha.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

474
Bill Number (if applicable)

Topic POLST

Amendment Barcode (if applicable)

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Email kenbrummelsmith@gmail.com

Speaking: [x] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FL Medical Directors Assoc

Appearing at request of Chair: [ ] Yes [x] No

Lobbyist registered with Legislature: [ ] Yes [x] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

01162016
Meeting Date

SB 474
Bill Number (if applicable)

Topic Physician Orders for Life Sustaining Treatment

Amendment Barcode (if applicable)

Name Teresa Ward

Job Title Attorney at Law

Address 1591 Summit Lake Drive
Street

Phone 850-544-5171

Tallahassee FL 32317
City *State* *Zip*

Email teresacooperward@gmail.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Right to Life

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

Reset Form

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/16/2018
Meeting Date

SB-474
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic P.O.L.S.T.

Name Lynda Bell

Job Title President, Florida Right to Life

Address 507 S. Prospect Ave.
Street

Clearwater, FL. 33756
City *State* *Zip*

Phone 850-999-8821

Email Lyndaforlife@bellsouth.net.

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Right to Life

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4774

Meeting Date

Bill Number (if applicable)

Topic ROLL

Amendment Barcode (if applicable)

Name AARON WORTHMS.

Job Title 1625 SE 13 ST

Address CAPE CORAL FL 33990 Phone 2399385869

Street

FL -

City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against

(The Chair will read this information into the record.)

Representing FLORIDA COLLEGE OF EMERGENCY PHYSICIANS

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 476
INTRODUCER:	Health Policy Committee and Senator Brandes
SUBJECT:	Public Records/Compassionate and Palliative Care Plans/Agency for Health Care Administration
DATE:	January 16, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 476 creates a public records exemption for personal identifying information in the Compassionate and Palliative Care Plans Clearinghouse (clearinghouse) managed by the Agency for Health Care Administration (AHCA) or its designee under s. 408.604, F.S. Specifically, the bill makes the information confidential and exempt from the public records law.

The bill also provides a process by which, upon request and after verification of the legitimacy of the request, the AHCA may disclose such confidential and exempt information to:

- A health care provider as defined in s. 408.07, F.S., to provide medical treatment to a patient with a terminal illness;
- A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness; or
- A health care facility to treat a patient with a terminal illness.

The bill provides an open government sunset review date of October 2, 2023, and includes the constitutionally required public necessity statement.

The bill requires a two-thirds vote from each chamber for passage.

The bill has no impact on state revenues or expenditures.

This bill is effective on the same date that SB 474 (2018), or similar legislation, takes effect.

II. Present Situation:

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] This applies to the official business of any public body, officer or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

In addition to the Florida Constitution, the Florida Statutes provide that the public may access legislative and executive branch records.[3] Chapter 119, F.S., constitutes the main body of public records laws, and is known as the Public Records Act.[4] The Public Records Act states that:

> It is the policy of this state that all state, county and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] The Florida Supreme Court has interpreted public records as being "any material prepared in connection with official agency business which is intended to perpetuate, communicate or formalize knowledge of some type."[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

The Legislature may create an exemption to public records requirements.[9] An exemption must pass by a two-thirds vote of the House and the Senate.[10] In addition, an exemption must explicitly lay out the public necessity justifying the exemption, and the exemption must be no broader than necessary to accomplish the stated purpose of the exemption.[11] A statutory

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[1] FLA. CONST., art. I, s. 24(a).
[2] *Id*.
[3] The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). Also see *Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995). The Legislature's records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislatures are primarily located in s. 11.0431(2)-(3), F.S.
[4] Public records laws are found throughout the Florida Statutes.
[5] Section 119.01(1), F.S.
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST., art. I, s. 24(c).
[10] *Id.*
[11] *Id.*

exemption that does not meet these criteria may be unconstitutional and may not be judicially saved.[12]

When creating a public records exemption, the Legislature may provide that a record is "confidential and exempt" or "exempt."[13] Records designated as "confidential and exempt" may be released by the records custodian only under the circumstances defined by the Legislature. Records designated as "exempt" are not required to be made available for public inspection, but may be released at the discretion of the records custodian under certain circumstances.[14]

Open Government Sunset Review Act

The Open Government Sunset Review Act (referred to hereafter as the "OGSR") prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.[15] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[16]

The OGSR provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[17] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[18]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[19] or
- It protects trade or business secrets.[20]

The OGSR also requires specified questions to be considered during the review process.[21] In examining an exemption, the OGSR asks the Legislature to carefully question the purpose and necessity of reenacting the exemption.

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[12] *Halifax Hosp. Medical Center v. New-Journal Corp.*, 724 So. 2d 567 (Fla. 1999). See also *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004).

[13] If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So. 2d 48 (Fla. 5th DCA 2004).

[14] *Williams v. City of Minneola*, 575 So. 2d 687 (Fla. 5th DCA 1991).

[15] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to section 119.15(2), F.S.

[16] Section 119.15(3), F.S.

[17] Section 119.15(6)(b), F.S.

[18] Section 119.15(6)(b)1., F.S.

[19] Section 119.15(6)(b)2., F.S.

[20] Section 119.15(6)(b)3., F.S.

[21] Section 119.15(6)(a), F.S. The specified questions are:

1. What specific records or meetings are affected by the exemption?
2. Whom does the exemption uniquely affect, as opposed to the general public?

If enacting a new exemption then a public necessity statement written with specificity justifying the exemption and a two-thirds vote of each chamber are required for passage.[22] If an existing exemption is reenacted without substantive changes or if an existing exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, the previously exempt records remain exempt unless provided for by law.[23]

End of Life Decision-Making Options in Florida

Individuals may express their end of life health care decisions through one or more different mechanisms such as formal or informal discussions with a health care provider or a loved one or through one of several recognized legal documents. Sometimes, the conversation may be the result of a recent hospitalization and the health care provider seeks guidance from the patient or the patient's caregiver about how to treat the individual's condition next, such as when and if to change to comfort (palliative or hospice) care rather than care that is aimed at a cure for the patient's illness.[24] Florida law defines an advance directive as any witnessed, oral statements or written instructions that express a person's desires about any aspect of his or her future health care, including the designation of a health care surrogate, a living will, or an anatomical gift.[25] Designation of a health care surrogate, a living will, or an anatomical gift each serve different purposes and have their own unique requirements and specifications under the law.

One type of advance directive not currently available in Florida, a Physician Order for Life-Sustaining Treatment (POLST), documents a patient's health care wishes in the form of a physician order for a variety of end of life measures, including cardiopulmonary resuscitation (CPR).[26] The POLST form can only be completed by a physician and is then provided to the patient to be kept secured in a visible location for emergency personnel.[27] It is suggested that the form be completed when an individual has a serious illness or frailty, regardless of age, as the POLST serves as a medical order for a current, life-threatening illness where the patient has a life expectancy of a year or less.[28] The POLST is intended to express the patient's treatment wishes when the patient is unable to speak for himself or herself during a medical crises.

3. What is the identifiable public purpose or goal of the exemption?
4. Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
5. Is the record or meeting protected by another exemption?
6. Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

[22] FLA. CONST. art. I, s. 24(c).
[23] Section 119.15(7), F.S.
[24] American Family Physician, *Information from Your Family Doctor: End of Life Choices for Families* (August 14, 2004); 70(4): 725-726, https://www.aafp.org/afp/2004/0815/p725.html (last visited: Jan. 9, 2018).
[25] *See* s. 765.101, F.S.
[26] POLST.ORG, *About the National POLST Paradigm*, http://www.polst.org/about-the-national-polst-paradigm/ (last visited Jan. 9, 2018).
[27] POLST.ORG, *FAQ*, http://www.polst.org/advance-care-planning/faq/ (last visited Jan. 8, 2018).
[28] POLST.ORG, *POLST v. Advance Directives*, http://www.polst.org/advance-care-planning/polst-and-advance-directives/ (last visited Jan. 8, 2018).

Physician Orders for Life-Sustaining Treatment (POLST) Program

SB 474 creates s. 401.451, F.S., the Physician Order for Life-Sustaining Treatment (POLST) program, within the DOH. The bill requires the DOH to implement and administer the POLST program (program) and to collaborate with the AHCA on the implementation and operation of the Clearinghouse for Compassionate and Palliative Care plans (clearinghouse) which would electronically store the forms.

A POLST provides directives for the patient's medical care and treatment under certain conditions. The contents of the POLST form is also prescribed by SB 474. It must be voluntarily executed by the patient, or if the patient is incapacitated or the patient is a minor, by the patient's legal representative with all directives included in the form at the time of the signing.

Any licensee, physician, medical director, emergency medical technician, or paramedic who in good faith complies with a POLST form is not subject to criminal prosecution or civil liability, and has not engaged in negligent or unprofessional conduct as a result of carrying out the directives of a POLST form. A person, acting in good faith as a legal representative, is not subject to civil liability or criminal prosecution for executing a POLST form pursuant to this law.

SB 474 further requires that when a patient who has executed a valid POLST form is transferred from one health care facility to another, the health care facility initiating the transfer must communicate the existence of the POLST form to the receiving facility before the transfer. Upon the patient's transfer, the receiving facility's treating physician must review the POLST form with the patient or if the patient is incapacitated or a minor, the patient's legal representative.

Clearinghouse for Compassionate and Palliative Care Plans

SB 474 also creates s. 408.064, F.S., which establishes the Clearinghouse for Compassionate and Palliative Care Plans (clearinghouse) within the AHCA. The clearinghouse serves as a warehouse for POLST plans and other advance directives. Under SB 474, the AHCA is responsible for establishing and maintaining the clearinghouse directly or through a designee. The clearinghouse is required to be a reliable and secure database that will allow Florida residents to electronically submit their individual plans for compassionate and palliative care. The deadline for completion of the clearinghouse is January 1, 2019.

The secure database shall consist of compassionate and palliative care plans submitted by state residents and must be accessible to health care providers, facilities, and other authorized individuals through a secure portal. The database must allow for electronic submission, storage, indexing, and retrieval of plans. The AHCA must also develop and maintain an identity validation system that confirms the identity of the facility, health care provider, or other authorized individual seeking retrieval of plans while protecting the privacy of patient's personal and medical information. The system must meet all applicable state and federal privacy and security standards.

The AHCA may subscribe to or participate in a national or private clearinghouse that will accomplish the same goals in lieu of establishing an independent clearinghouse. Once clearinghouse information is available, the AHCA is required to publish and disseminate

information regarding the availability of the clearinghouse to Floridians. The AHCA must also provide training to health care providers and health care facilities on how to access plans.

Health Insurance Portability and Accountability Act (HIPAA)

Federal law provides a right to privacy for health and medical records under the Health Insurance Portability and Accountability Act (HIPAA) of 1996,[29] the law required the federal Health and Human Services Secretary to develop privacy regulations by 1999 if Congress did not enact federal legislation on the same subject matter. The final regulation, the Privacy Rule, was published December 28, 2000.[30] The main goal of the federal Privacy Rule is the protection of individual health information while allowing for the flow of necessary health data for the promotion and provision of quality health care. The other objective was to inform individuals about how their health information was to be used and to allow individuals more control over the use of their health information.[31]

The Privacy Rule covers health plans, health care providers, and health care clearinghouses[32] which are collectively known as "covered entities." The rule protects all individually identifiable health information[33] or protects health information held or transmitted by a covered entity or its business associates.[34] A covered entity is permitted, but not required, to use and disclose protected information, without an individual's authorization for the following purposes or situations:

- To the individual;
- For treatment, payment, and health care operations;
- In an opportunity to agree or object (example: patient listings in hospital directory);
- For public interest and benefit activities (example: when required by law); and
- In a limited data set for purposes of research, public health, or health care operations.[35]

A HIPAA-covered health care provider or health care plan may share a patient's protected health information if it has a court order. A subpoena issued by someone other than a judge, such as a court clerk or an attorney in a case is different from a court order. However, a HIPAA-covered provider may disclose HIPAA-covered provider or plan information to a party issuing a

[29] Health Insurance Portability and Accountability, Act, Pub. L. 104-191, (Aug. 21, 1996).
[30] Standards for Privacy of Individually Identifiable Health Information, 65 Fed. Reg. 82,462 (Dec. 29, 2000) (codified at 45 CFR 160 and 45 CFR 164; effective Feb. 26, 2001).
[31] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, p 1, https://www.hhs.gov/sites/default/files/privacysummary.pdf (last visited Jan. 9, 2018).
[32] A health care clearinghouse is an entity that processes nonstandard information that they receive from another entity into a standard (i.e.: standard format or data content) or vice versa.
[33] Individually identifiable health information is information that relates to the individuals past, present or future physical or mental health condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual.
[34] A business associate is defined as a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individual identifiable health information. Functions include claims processing, data analysis, utilization, and billing. *See also* 45 CFR 160.103.
[35] *Supra* note 31, at 4-9.

subpoena only if the notification requirements of the Privacy Rule are met. Those notification requirements require the provider or plan to:

- Notify the person who is the subject of the information about the request, so the person has the opportunity to object to the disclosure; or
- Seek a qualified protective order for the information from the court.[36]

In general, the HIPAA privacy provisions shall preempt any state law that is contrary to its provisions.[37] However, if a state law with regard to its privacy provisions is more stringent, the state can apply to the Secretary of HHS for an exception under certain circumstances.[38]

III. Effect of Proposed Changes:

Section 1 of the bill:

- Creates s. 408.0641, F.S., establishing an exemption from public records for personal identifying information filed under and held in the Clearinghouse for Compassionate and Palliative Care Plans. Such information held and managed by the AHCA or its designee in the clearinghouse is confidential and exempt from s. 119.07(1) and s. 24(a), Art. 1 of the State Constitution.
- The AHCA or its designee may disclose confidential and exempt information to the following persons or entities upon request using a verification process to ensure legitimacy of the request and the requestor's identity for patients with a terminal illness and a plan in the clearinghouse:
  - A health care provider as defined in s. 408.07, F.S., who certifies that the information is necessary to provide medical treatment;
  - A patient or legal guardian or designated health care surrogate of a patient; or
  - A health care facility that certifies that the information is necessary to provide medical treatment.

This section of the bill is subject to the Open Government Sunset Review Act and shall stand repealed on October 2, 2023, unless reviewed and saved from repeal through reenactment by the Legislature.

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[36] U.S. Department of Health and Human Services, *HIPAA for Individuals*, Court Orders and Subpoenas, https://www.hhs.gov/hipaa/for-individuals/court-orders-subpoenas/index.html (last visited Jan. 9, 2018).

[37] *Supra* note 29, at §1178. *See also* 45 CFR §§160.201-205 (January 2018).

[38] *See* 45 CFR §160.202- A standard, or implementation specification adopted under this subchapter that is contrary to a provision of State law preempts the provision of State law. This general rule applies, except if one or more of the following conditions is met. (a) A determination is made by the Secretary under §160.204 that the provision of State law: (1) Is necessary: (i) To prevent fraud and abuse related to the provision of or payment of health care; (ii) To ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation; (iii) To ensure appropriate State reporting on health care delivery or costs; or (iv) For purposes of serving a compelling need related to public health, safety, or welfare, and, if a standard, requirement, or implementation specification under part 164 of this subchapter is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served, or (2) Has as its principal purpose the regulation or manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law. (b) The provision of state law, including any state procedures established under that state law, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention. (d) The provision of State law requires a health plan to report, or to provide access to, information for the purpose of management audits, financial audits, program monitoring and evaluation, or the licensure or certification of facilities or individuals.

Section 2 of the bill provides legislative findings. The bill finds that it is a public necessity to make confidential and exempt from disclosure information held in the clearinghouse which would identify a patient, his or her terminal illness, or the patient's family members. If made publicly available, such personal information would invade the personal privacy of the patient and his or her family. Family medical decisions are a private matter. The Legislature also finds that public disclosure of such information could hinder the efficient administration of the clearinghouse and could reduce participation. Finally, information could be used to solicit, harass, stalk, or intimidate terminally ill patients or their families.

Section 3 of the bill provides that the bill takes effect on the same date that SB 474, or a similar bill, takes effect.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Voting Requirement

Article I, s. 24(c) of the Florida Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public records or public meetings exemption. The bill creates a new public record exemption; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement

Article I, s. 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public records or public meetings exemption. The bill creates a new public records exemption and includes a public necessity statement.

Breadth of Exemption

Article I, s. 24(c) of the Florida Constitution requires a newly created public records exemption to be no broader than necessary to accomplish the stated purpose of the law. The bill exempts certain identifying information of patients, the patient's terminal illness, and the patient's family members that is held by the AHCA within the clearinghouse. The public necessity for the exemption provides that it is necessary to protect patient and caregiver information from disclosure to protect their privacy and to protect them from potential harassment and for the efficient and effective administration of the clearinghouse. This bill appears to be no broader than necessary to accomplish the public necessity for this public records exemption.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

In general, the federal HIPAA privacy provisions shall preempt any state law that is contrary to its provisions. However, if a state law with regard to its privacy provisions is more stringent, the state can apply to the Secretary of HHS for an exception under certain circumstances.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The private sector already has a duty under federal law and regulation to maintain personal identifiable information that would be contained in this clearinghouse as private; however, individuals and entities are permitted to release that information under certain circumstances to specified individuals.

If the AHCA decides to contract for the clearinghouse, there may be ongoing costs responding to requests from third parties for data.

C. Government Sector Impact:

The AHCA reports that CS/SB 476 has no fiscal impact.[39]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 408.0641 of the Florida Statutes.

[39] E-Mail from Tony Guzzo, Legislative Affairs, Agency for Health Care Administration (Jan. 9, 2018) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 16, 2018:
The CS aligns the public records language with the substantive bill as to who may request information from the clearinghouse for medical treatment to reflect health care providers and adds the substantive bill number.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
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	.	
	.	

The Committee on Health Policy (Brandes) recommended the following:

Senate Amendment

Delete lines 31 - 69
and insert:
(a) A health care provider as defined in s. 408.07 who certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse. ~~A physician who certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the~~

~~clearinghouse.~~

(b) A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness who has a plan in the clearinghouse.

(c) A health care facility that certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2023, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity to make confidential and exempt from disclosure information held in the Clearinghouse for Compassionate and Palliative Care Plans which would identify a patient, his or her terminal illness, or the patient's family members. Such personal identifying information, if publicly available, could be used to invade the personal privacy of the patient or his or her family. The decisions made under a compassionate and palliative care plan for a terminal condition are a private matter. Furthermore, the public disclosure of such information could hinder the effective and efficient administration of the clearinghouse. Public access to such information could reduce participation in and minimize the effectiveness of compassionate and palliative care plans to meet the needs of individuals. Finally, access to such information could be used to solicit, harass, stalk, or intimidate terminally ill patients or their families. Therefore, the Legislature finds that information held in the clearinghouse

854172

which would identify a patient who has a plan on file with the clearinghouse or which contains or reflects the patient's medical information should be confidential and exempt from public records requirements.

Section 3. This act shall take effect on the same date that SB 474 or similar legislation takes effect if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

By Senator Brandes

24-00550-18 2018476__

A bill to be entitled

An act relating to public records; creating s. 408.0641, F.S.; creating an exemption from public records for personal identifying information in compassionate and palliative care plans filed with the Clearinghouse for Compassionate and Palliative Care Plans managed by the Agency for Health Care Administration or its designee; authorizing the disclosure of such information to certain entities and individuals; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing a contingent effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 408.0641, Florida Statutes, is created to read:

408.0641 Clearinghouse for Compassionate and Palliative Care Plans; public records exemption.—

(1) Personal identifying information held in the Clearinghouse for Compassionate and Palliative Care Plans managed by the Agency for Health Care Administration or its designee under s. 408.064 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) The agency or its designee may disclose such confidential and exempt information to the following persons or entities upon request after using a verification process to ensure the legitimacy of the request and the requestor's

identity:

(a) A physician who certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

(b) A patient or the legal guardian or designated health care surrogate of a patient with a terminal illness who has a plan in the clearinghouse.

(c) A health care facility that certifies that the information is necessary to provide medical treatment to a patient with a terminal illness who has a plan in the clearinghouse.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2023, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity to make confidential and exempt from disclosure information held in the Clearinghouse for Compassionate and Palliative Care Plans which would identify a patient, his or her terminal illness, or the patient's family members. Such personal identifying information, if publicly available, could be used to invade the personal privacy of the patient or his or her family. The decisions made under a compassionate and palliative care plan for a terminal condition are a private matter. Furthermore, the public disclosure of such information could hinder the effective and efficient administration of the clearinghouse. Public access to such information could reduce participation in and minimize the effectiveness of compassionate and palliative care plans to meet the needs of individuals. Finally, access to

such information could be used to solicit, harass, stalk, or intimidate terminally ill patients or their families. Therefore, the Legislature finds that information held in the clearinghouse which would identify a patient who has a plan on file with the clearinghouse or which contains or reflects the patient's medical information should be confidential and exempt from public records requirements.

Section 3. This act shall take effect on the same date that SB ___ or similar legislation takes effect if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

The Florida Senate

Committee Agenda Request

To: Senator Dana D. Young
Committee on Health Policy

Subject: Committee Agenda Request

Date: October 26, 2017

I respectfully request that **Senate Bill #476**, relating to **Public Records/Compassionate and Palliative Care Plans/Agency for Health Care Administration**, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jeff Brandes
Florida Senate, District 24

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 764
INTRODUCER:	Senators Bean and Mayfield
SUBJECT:	Dental Student Loan Repayment Program
DATE:	January 12, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			AHE	
3.			AP	

I. Summary:

SB 764 creates the Dental Student Loan Repayment Program (program) for Florida-licensed dentists who practice in specific public health programs located in designated dental health professional shortage areas (HPSAs) or medically underserved areas. Subject to the availability of funds, the Department of Health (DOH) will award funds from the program in an amount not to exceed $50,000 per eligible dentist per year. A participant is eligible to receive funds for a minimum of one year and a maximum of five years.

The bill defines eligibility for the program and conditions for termination from the program. The Department of Health (DOH) is directed to adopt rules to administer the program.

The DOH has reported a fiscal impact of $570,941 for Fiscal Year 2018-2019 and $566,467 for Fiscal Year 2019-2020.

The bill is effective July 1, 2018.

II. Present Situation:

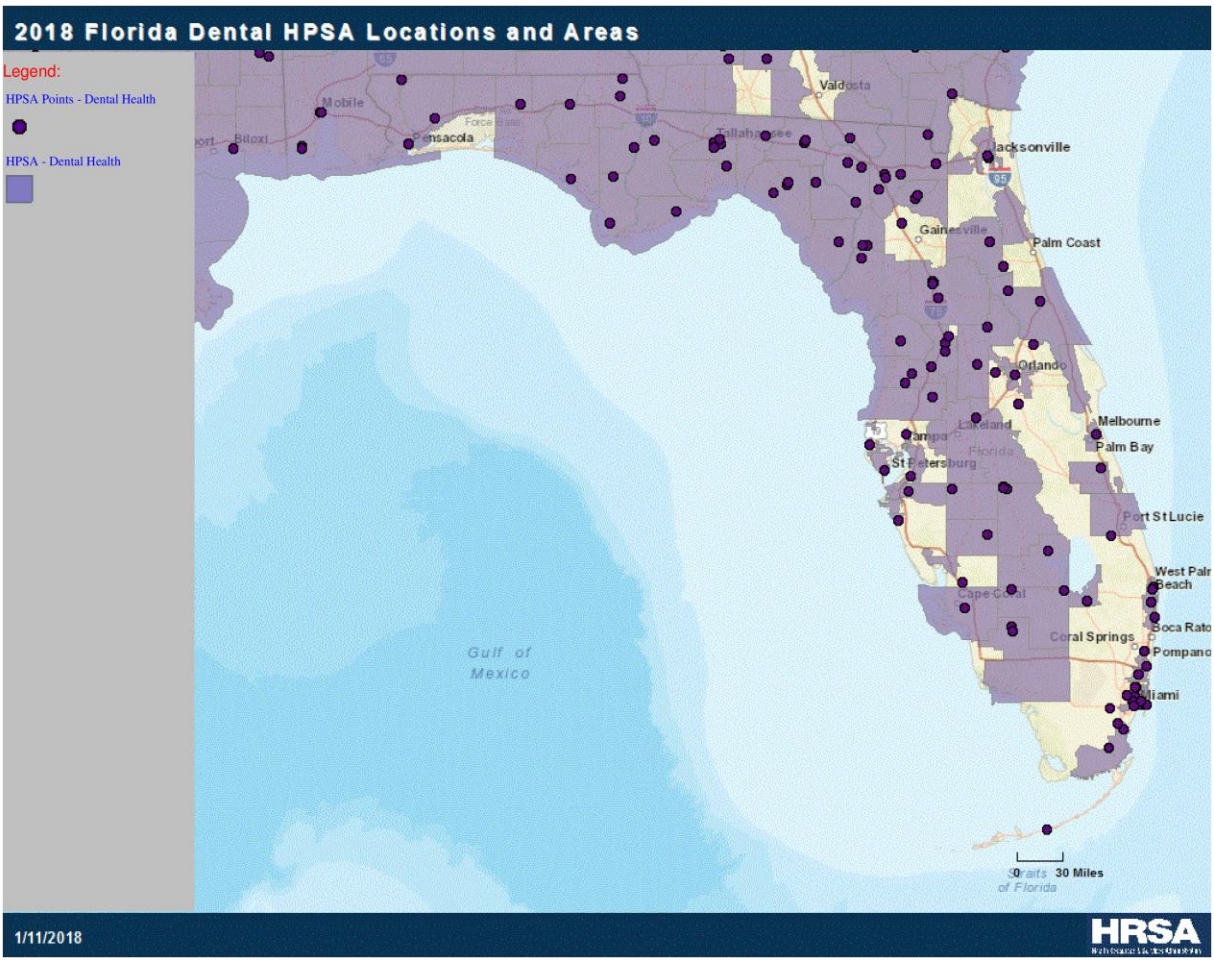
The Health Resources and Services Administration or HRSA, a federal agency within the United States Department of Health and Human Services (HHS), is charged with, among other responsibilities, improving health care for individuals who are geographically isolated, or economically or medically vulnerable.[1] Four of the five agency goals focus on access to care

[1] U.S. Department of Health and Human Services, HRSA, *About HRSA*, https://www.hrsa.gov/about/index.html (last visited Jan. 4, 2018).

through either building a healthy workforce or improvements in accessing quality care and services.[2]

Health Professional Shortage Areas (HPSAs)

Health Professional Shortage Areas (HPSAs) are designated by the HRSA according to criteria developed in accordance with section 332 of the Public Health Services Act. HPSA designations are used to identify areas and groups within the United States that are experiencing a shortage of health professionals. An HPSA can be a geographic area, a population group, or a health care facility. These areas have a shortage of health care professionals or have population groups who face specific barriers to health care. The map *(Picture 1)* below shows the locations of the state's current dental HPSAs as of January 1, 2018.[3]



There are three categories for HPSA designation: (1) primary medical care; (2) dental; and (3) mental health.

[2] *Id.*
[3] Map generated based on information held in the U.S. Dep't of Health and Human Services, HRSA Data Warehouse, *Dental Health Professional Shortage Areas (HPSAs) Primary Dataset*, https://datawarehouse.hrsa.gov/Tools/DataPortalResults.aspx (results last generated on Jan. 11, 2018).

The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. State Primary Care Offices apply to HRSA for most designations of HPSAs in their states. HRSA will review provider-level data, whether providers are actively engaged in clinical practice, if a provider has any additional practice locations, the number of hours served at each location, the populations served, and the amount of time that a provider spends with specific populations.[4] Primary care and mental health HPSAs can score between 0-25 and dental health can score between 0-26.[5] Three scoring criteria are common across all disciplines HPSA (primary care medical, dental, and mental health):

- The population to provider ratio;
- The percentage of the population below 100 percent of the federal poverty level; and
- The travel time to the nearest source of care outside of the HPSA designation.[6]

The dental scoring system also reviews the water fluoridation status of the areas.

The following chart indicates the percentage of current need that is being met for Florida's dental HPSA compared to data nationwide.

Health Professional Shortage Areas as of January 1, 2018[7]						
HPSA Types	**Number of Designations** *(geographic area, population group, or facility)*		**Population Covered by Designation**		**Percent of Need Met**	
	National	*FL*	*National*	*FL*	*National*	*FL*
Dental	5,866	223	62,916,553	5,185,561	35.28%	13.28%

Medically Underserved Area

Medically Underserved Areas (MUA) are also designated by the HRSA. These areas are designated using one of three methods and can consist of a whole county, a group of contiguous counties, or census tracts having too few health care providers, high infant mortality, high poverty rates, or a high elderly population.[8] Nationally, there are 4,235 such designated areas, with 128 designated in Florida.[9]

[4] U.S. Dep't of Health and Human Services, HRSA Health Workforce, *Shortage Designation Application and Scoring Process*, https://bhw.hrsa.gov/shortage-designation/application-scoring-process (last visited Jan. 3, 2018).
[5] *Id.*
[6] *Id.*
[7] U.S. Dep't of Health and Human Services, HRSA, *Designated Health Professional Shortage Areas Statistics – Generated by HRSA Data Warehouse* (as of January 1, 2018) https://datawarehouse.hrsa.gov/tools/quickReports.aspx (last visited Jan. 4, 2018).
[8] HHS, *supra* note 4.
[9] U.S. Dep't of Health and Human Services, HRSA, *Medically Underserved Areas/Populations (MUA/P) – State Summary of Designated MUA/P* (January 5, 2018), pg. 1, https://datawarehouse.hrsa.gov/topics/shortageareas.aspx (last visited Jan. 5, 2018).

The first method, the Index of Medical Underservice (IMU), calculates a score based on the ratio of primary medical care physicians per 1,000 in population, percentage of the population with incomes below the federal poverty level, infant mortality rate, and percentage of population aged 65 or older.[10]

The second method, Medically Underserved Populations (MUP), is based on data collected under the MUA process and reviews the ratio of primary care physicians serving the population seeking the designation. A MUP is a group of people who encounter economic or cultural barriers to primary health care services.[11]

The third process, Exceptional MUP Designations, includes those population groups which do not meet the criteria of an IMU but may be considered for designation because of unusual conditions with a request by the governor or another senior executive level official and a local state health official.[12]

The Dental Workforce

The Health Policy Institute (HPI) for the American Dental Association recently updated its estimates on the future supply of dentists and concluded the nation's per capita supply of dentists is projected to increase through 2035.[13] The unadjusted number of dentists per 100,000 population increases from 60.9 in 2015 to 65.7 in 2035.[14] The per capita calculation takes into account only the calculation of total number of dentist available and total population and, as the report cautions, does not consider the location of the providers and access to care issues in particular regions or needs of special populations. This distinction may make a difference between whether there is an adequate supply of dentists on a per capita basis nationally and whether there is a provider shortage in a particular area, region, or to address a specific need. For example, a shortage could be only for participation by dental health providers in public programs such as Medicaid and the Children's Health Insurance Program (CHIP), two programs that serve high numbers of children and families from low and moderate income families. In the same HPI report, dental providers were reviewed in 2016 for their participation in Medicaid and CHIP and the rates ranged from a high of 77.2 percent in Montana to a low of three states in the 15 percent range (California, Maine and New Hampshire).[15] Florida's participation rate is 30 percent; the national average is 38.6 percent.[16] This national average also matches the percentage of dentists who report any patients covered by public assistance:

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[10] U.S. Department of Health and Human Services, HRSA, *Shortage Designation,* https://bhw.hrsa.gov/shortage-designation/muap-process (last visited Jan. 11, 2018).
[11] *Id.*
[12] *Id.*
[13] Muson, B. and Vujicic, M., *Number of Practicing Dentists per Capita in the United States Will Grow Steadily*, Health Policy Institute, American Dental Association (June 2016), http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0616_1.pdf?la=en (last visited Jan. 4, 2018).
[14] *Id* at 2.
[15] , Health Policy Institute, American Dental Association, *Supply and Profile of Dentists – Dentist Profile Snapshot by State 2016- Table 4: Dentist Participation in Medicaid or CHIP* (January 2016), http://www.ada.org/en/science-research/health-policy-institute/data-center/supply-and-profile-of-dentists (last visited Jan. 4, 2018).
[16] *Id.*

Percentage of Dentists' Practices that Had Any Patients Covered by Public Assistance[17]		
Type of Provider	**2015**	**2016**
National %	*% Public Assistance*	*% Public Assistance*
General Practitioner	36.4%	37.3%
Specialists	35.5%	41.4%
All Dentists	36.2%	38.2%

A more recent national study which included Florida dentists looked further out and found a more positive result. Using 2016 population data as a baseline, there were 10,781 listed dentists for a state population of 20.6 million resulting in a per capita calculation of 52.3.[18] The HPI report found Florida's overall dental supply would be expected to increase by the year 2035 to a per capita of 56.9.[19] The calculation assumes that in 2030-2035, 414 dentists would be leaving the workforce, but 598 would be entering during this same time period. The supply number does not review where those dental providers would practice, which lines of business they would participate under, or any special demographic groups they might cover, such as Medicaid.

Most dentists – 77.8 percent – practice in general dentistry.[20] In many rural communities, the county health department may be the primary provider of health care services, including dental care. According to the DOH, Florida's current designated dental HPSAs have only enough dentists to serve 13.28 percent of the population living within them.[21] As of January 1, 2018, HRSA estimated that 1,169 additional dentists were required to meet the state's total need and eliminate the state's shortage.[22]

The American Dental Association (ADA) has also studied this issue and found that while there may be a sufficient number of dentists overall for the state's population or the national population, there may be an inadequate number available for certain populations or geographic areas.[23] Children are acutely affected by the shortage of dentists to serve low income patients.

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[17] Health Policy Institute, American Dental Association, *Dental Practice – 2016 Characteristics of Private Dental Practice – Table 4 – Percentage of Dentists' Practices That Had Any Patients Covered by Public Assistance, 1990-2016* (January 2016), http://www.ada.org/en/science-research/health-policy-institute/data-center/dental-practice (last visited Jan. 4, 2018).
[18] Health Policy Institute, American Dental Association, *Supply and Profile of Dentists – Dentist Profile Snapshot by State 2016*, http://www.ada.org/en/science-research/health-policy-institute/data-center/supply-and-profile-of-dentists (last visited Jan. 4, 2018).
[19] Health Policy Institute, American Dental Association, *Projected Supply of Dentists: Florida*, http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/ProjectedSupplyofDentists/Florida-Projected-Supply-of-Dentists.pdf?la=en (last visited Jan. 4, 2018).
[20] *Id.*
[21] U.S. Dep't of Health and Human Services, Bureau of Health Workforce – HRSA, *Designated Health Professional Shortage Areas Statistics* (as of December 31, 2017), https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Qtr_Smry_HTML&rc:Toolbar=false (last visited Jan. 11, 2017).
[22] U.S. Dep't of Health and Human Services, *supra* note 7, at 8.
[23] Bradley Munson, B.A., and Marko Vujicic, Ph.D.: Health Policy Institute Research Brief, American Dental Association, *Supply of Dentists in the United States Likely to Grow*, p.2. (October 2014) http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.ashx (last visited Jan. 11, 2018).

For example in Florida for FFY 2016, 37.6 percent of all Medicaid-enrolled children and 42.8 percent of all CHIP-enrolled children received preventive dental services.[24] For Medicaid, this was an increase from 2012 when only 26 percent of Medicaid-enrolled children received one or more dental care services.[25]

In 2011, the Legislature passed HB 7107[26] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The program has two primary components: Managed Medical Assistance program (MMA) and Long Term Care program. To implement MMA, the law required the AHCA to create an integrated managed care program for the delivery of Medicaid primary and acute care services, including dental. Medicaid recipients who are enrolled in MMA receive their dental services through managed care plans. Although most dental services are designated as a required benefit only for Medicaid recipients under age 21, many of the managed care plans also provide dental services for adults as an enhanced benefit. As the managed care contracts are rebid this Spring, this benefit will be carved out of the MMA managed care contracts and contracted for as a separate benefit by the AHCA.[27]

The Cost of Dental Education

According to a survey of dental school students, the average debt for graduates in 2017 was $287,337,[28] a 72 percent increase in the last decade.[29] Over 30 percent of the Class of 2016 reported student loan debt in excess of $300,000.[30] The amount of a graduate's average debt differed based on whether the student attended a public or private school by a significant amount. The average reported by a public school attendee in 2016 was $238,582 and for a private school attendee the average was $291,668.[31]

For in-state tuition at a state university, such as the University of Florida, one year's tuition is $41,720, non-residents pay $68,202. When housing, books and other costs are added, three or four years of dental school for a DMD degree can result in a total dental school bill ranging from $148,275 to $215,835.[32] In comparison, a northern private school's tuition is listed at $73,364

[24] Brishke, J., Gaskins, J., and Shenkman, B., *Florida KidCare: The Florida KidCare Program Evaluation Calendar Year 2016* (Dec. 1 2017), p. 141, http://ahca.myflorida.com/medicaid/Policy_and_Quality/Quality/performance_evaluation/MER/contracts/med147/FL_KidCare_MED147_Deliverable_66_12-2017_Final.pdf (last visited Jan. 4, 2018).
[25] U.S. Dep't of Health and Human Services, *supra* note 7, at 8.
[26] *See* chapter 2011-134, Laws of Fla.
[27] AHCA, Invitation to Negotiate 012-17/18 (Oct. 16, 2017). A copy of the ITN can be downloaded from http://www.myflorida.com/apps/vbs/vbs_www.ad_r2.view_ad?advertisement_key_num=137442 (last visited Jan. 10, 2018). See also Chapter 2016-109, Laws of Fla.
[28] American Student Dental Education Association, *Dental Student Debt*, https://www.asdanet.org/index/get-involved/advocate/issues-and-legislative-priorities/Dental-Student-Debt (last visited Jan. 8, 2018).
[29] American Student Dental Education Association, *Paying for Dental School*, https://www.asdanet.org/index/get-into-dental-school/before-you-apply/paying-for-dental-school, (last visited Jan. 8, 2018).
[30] American Dental Education Association, *Education Debt*, http://www.adea.org/GoDental/Money_Matters/Educational_Debt.aspx#sthash.rYlqVawm.dpbs (last visited Jan. 8, 2018).
[31] *Id.*
[32] University of Florida, Office of Admissions – College of Dentistry, *Budgets & Costs of Attendance: DMD*, http://admissions.dental.ufl.edu/financial-aid-2/d-m-d/budgets-cost-of-attendance-d-m-d/ (last visited Jan. 8, 2018).

per year and with other supplies, housing and fees, the total estimated costs over four years for 2017-2018 would be $450,412.[33]

In 2013, Congress enacted the Bipartisan Student Loan Certainty Act of 2013 (Public Law 113-28) that tied certain student loan interest rates to the 10-year Treasury Note plus 2.05 percent for undergraduates. For graduate and professional student loans, the interest rate is tied to 10-year Treasury Note plus 3.6 percent, but may not exceed 9.5 percent in any given year.[34]

In June 2014, through a Presidential Memorandum, President Barack Obama directed the Secretary of Education to propose final regulations to allow additional students with student loan debt to cap their payments at 10 percent of their income, by December 31, 2015.[35] The Presidential Memorandum called the plan, "*Pay as You Earn Plan."*[36] President Obama's memorandum also called for the Secretary to improve communication with vulnerable borrowers to help with loan rehabilitation, to encourage support and awareness of repayment options during tax filing season, and to promote collaboration between students and their families to ensure better borrowing decisions.[37] In 2016, Florida had over 826,000 federal student loan borrowers with 188,613 borrowers enrolled in a *Pay as You Earn* or other income driven payment plans. The state has a total student federal loan debt outstanding of $23.9 billion.[38]

Loan forgiveness is also one of the top priorities of the American Student Dental Association (ASDA). Listed among the organization's priorities is for Congress and state legislatures to pass measures that include loan forgiveness, scholarship opportunities, and tax deductions or rebates for students that agree to practice in underserved areas after graduation.[39]

Florida does not have a current state program to address the dental health professional shortage areas or medically underserved areas. According to the DOH, there are 20 vacant positions for dentists in the DOH.[40]

Florida Health Services Corps

In 1992, the Legislature created the Florida Health Services Corps (FHSC), administered by the DOH, to encourage medical professionals to practice in locations that are underserved because of

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[33] Tufts School of Dental Medicine, *Financial Aid Application Forms and Costs of Attendance for D.M.D. and D.I.S. Programs*, https://dental.tufts.edu/academics/financial-aid/forms-and-costs-dmd-and-dis-programs (last visited Jan. 8, 2018).
[34] Bipartisan Student Loan Certainty Act of 2013, Pub. L. No. 113-28, §2, 127 Stat. 506, 506 (2013).
[35] *Id.*
[36] The White House, Office of the Press Secretary, *Presidential Memorandum - Federal Student Loan Repayments* (June 9, 2014) https://www.whitehouse.gov/the-press-office/2014/06/09/presidential-memorandum-federal-student-loan-repayments (last visited Jan. 8, 2018).
[37] The White House, Office of the Press Secretary, *Presidential Memorandum – Federal Student Loan Repayments* (June 9, 2014) https://obamawhitehouse.archives.gov/the-press-office/2014/06/09/presidential-memorandum-federal-student-loan-repayments (last visited Jan. 8, 2018).
[38] Jason Furman, Sandra Black, The White House, Office of Press Secretary, *Six Recent Trends in Student Debt* (April 28, 2016), https://obamawhitehouse.archives.gov/blog/2016/04/28/six-recent-trends-student-debt (last visited Jan. 8, 2018).
[39] American Student Dental Education Association, *supra* note 37.
[40] E-Mail from Dennis Ragosta, Office of Legislative Planning, Florida Dept. of Health, (Jan. 11, 2018) (on file with the Senate Committee on Health Policy).

a shortage of qualified professionals.[41] The FHSC was defined[42] as a program that offered scholarships to allopathic, osteopathic, chiropractic, podiatric, dental, physician assistant, and nursing students, and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractic physicians, podiatric physicians, nurse practitioners, dentists, and physician assistants, in return for service in a public health care program[43] or in a medically underserved area.[44] Membership in the FHSC could be extended to any health care practitioner who provided uncompensated care to medically indigent patients.[45] All FHSC members were required to enroll in Medicaid and to accept all patients referred by the DOH pursuant to the program agreement.[46] In exchange for this service, an FHSC member was made an agent of the state and granted sovereign immunity under s. 768.28(9), F.S., when providing uncompensated care to medically indigent patients referred for treatment by the DOH.[47]

The statute authorized the DOH to provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last two years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of two years in the FHSC. During the period of service, the maximum amount of annual financial payments was limited to no more than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps (NHSC) loan repayment program.[48]

During the 20 years the program was authorized by law, it was funded only three times. A total of $3,684,000 was appropriated in the 1994-1995 fiscal year, 1995-1996 fiscal year, and 1996-1997 fiscal year for loan assistance payments to all categories of eligible health care practitioners. Of that amount, $971,664 was directed to 18 dentists for an average award of $25,570 per year of service in the program.[49] The 2007 Legislature attempted to reinvigorate the program by appropriating $700,000 to fund loan repayment assistance for dentists only.[50]

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[41] Chapter 92-33, s. 111, Laws of Fla. (creating s. 381.0302, F.S., effective July 1, 1992).
[42] Section 381.0302(2)(b)1., F.S. (2011).
[43] "Public health program" was defined to include a county health department, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department. Section 381.0302(2)(e), F.S. (2011).
[44] "Medically underserved area" was defined to include: a geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations; a county health department, community health center, or migrant health center; or a geographic area or facility designated by rule of the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients. Section 381.0302(2)(c), F.S. (2011).
[45] "Medically indigent person" was defined as a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with income at or below 185 percent of the federal poverty level. Section 381.0302(2)(d), F.S. (2011).
[46] Section 381.0302(10), F.S. (2011).
[47] Section 381.0302(11), F.S. (2011).
[48] Section 381.0302(6), F.S. (2011).
[49] E-mail from Karen Lundberg, Florida Dept. of Health, to Joe Anne Hart, Florida Dental Association (Sept. 16, 2005) (on file with the Senate Committee on Health Policy).
[50] Chapter 2007-72, Laws of Fla. The funding was contained in Specific Appropriations 677A of the General Appropriation Act, but later vetoed pursuant to the Governor's line item veto authority.

However, the appropriation and a related substantive bill were vetoed.[51] The Legislature repealed the program in 2012.[52]

National Health Service Corps (NHSC)

The NHSC programs provide scholarships and educational loan repayment to primary care providers[53] who agree to practice in areas that are medically underserved and are located in selected HPSAs. The chart below shows the different loan programs that dental students may be eligible for based on where the participant is placed (HPSA score) and whether the participant provides full (40 hours per week) or part-time (20 hours per week) service.

The NHSC-approved sites are community-based health care facilities that provide comprehensive outpatient, ambulatory, and primary health care services. Eligible dental facilities must be located in a dental HPSA and offer comprehensive primary dental health services. NHSC-approved sites (with the exception of correctional facilities and free clinics) are required to provide services for free or on a sliding fee scale (SFS) or discounted fee schedule for low-income individuals.

Participants may be eligible to continue loan repayment beyond the initial term. If a participant breaches his or her LRP agreement, he or she will be subject to monetary damages, which are the sum of the amount of assistance received by the participant representing any period of obligated service not completed, a penalty, and interest. As of January 2018, there were 49, full-time-equivalent NHSC dentists in Florida in the loan repayment program, all of which are located at federally qualified health centers.[54]

Federal Loan Programs Applicable for Dental Students – National Health Services Corps (NHSC)				
Program Name	**Time Commitment**	**Maximum Amount**	**Service Commitment Locations**	**Additional Time**
Loan Repayment Program (LRP) [55,56]	2 years	Vary based on where placed Range: $30,000 - $50,000 (Full-time) $15,000- 25,000 – (Part-time)	NHSC approved sites in HPSAs	Option to annually renew after 2 years

[51] *Journal of the Florida Senate*, at 3 (June 12, 2007).
[52] Chapter 2012-184, s. 45, Laws of Fla.
[53] Primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and behavioral and mental health providers, including health service psychologists, licensed clinical social workers, marriage and family therapists, psychiatrist nurse specialists, and licensed professional counselors.
[54]. E-Mail from Dennis Ragosta, Office of Legislative Planning, Florida Dept. of Health, (Jan. 11, 2018) (on file with the Senate Committee on Health Policy).
[55] The definition of part-time and full-time vary by discipline. The guidelines for both can be found in the *Fiscal Year 2015 Application and Program Guidance* packet beginning on 19, http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Jan. 11, 2018).
[56] U.S. Dep't. of Health and Human Services, Loan Repayment Program - *Fiscal Year 2017 Application and Program Guidance*, pp. 4-5 (January 2017) http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Jan. 8, 2018).

Federal Loan Programs Applicable for Dental Students – National Health Services Corps (NHSC)				
Program Name	**Time Commitment**	**Maximum Amount**	**Service Commitment Locations**	**Additional Time**
Student to Service LRP[57]	Students in last year of school must commit to serve 3 years	Up to $120,000	At an HPSA of greatest need	Option to annually renew after 3 year commitment to pay off loan remainder
Public Service Loan Forgiveness[58]	120 qualifying on time loan payments	Forgiveness of remainder of qualified federal loan	Qualified public service employment while making 120 loan payments	Remainder of qualified federal loan amounts forgiven at end of 120 payments

All of the NHSC programs require an application process; some require a background checking depending on the setting; and all require that the applicant be:

- A U.S. Citizen or U.S. National;
- Eligible to participate in the Medicare, Medicaid, and the State Children's Health Insurance Program, as appropriate; and
- Fully trained and licensed to practice in the NHSC-eligible primary care medical, dental, mental/behavioral health discipline for which the applicant seeks approval.

Additionally, the applicant must:

- Have unpaid student loans, taken before application to the NHSC's Loan Repayment Program to support undergraduate or graduate education and
- Be working at or have an accepted an offer of employment at an NHSC-approved site by the designated date (date determined each year).[59]

The State Loan Repayment Program (SLRP) offers cost-sharing grants to states to operate their own state educational loan repayment programs for primary care providers, including dental professionals, working in HPSAs within the state. The SLRP varies from state to state and may differ in eligible categories of providers, practice sites, length of required service commitment, and the amount of loan repayment assistance offered. However, there are certain statutory requirements SLRP grantees must meet. There is a minimum two-year service commitment with an additional one-year commitment for each year of additional support requested. Any SLRP program participant must practice at an eligible site located in a federally-designated HPSA.

In addition, the SLRP requires a $1 state match for every $1 provided under the federal grant. While the SLRP does not limit award amounts, the maximum award amount per provider that the federal government will support through its grant is $50,000 per year, with a minimum service commitment of two years. Florida does not currently participate in SLRP.

[57] US Dep't of Health and Human Services, HRSA, *Loan Repayment – NHSC Loan Repayment Program*, https://www.nhsc.hrsa.gov/loanrepayment/index.html (last visited Jan. 8, 2018).
[58] *Id.* A qualifying public employer is a government organization at any level (federal, state, local, or tribal), not-for-profit organizations that are tax exempt under Section 501(c)(3) of the Internal Revenue Code, or other types of not-for-profit organizations that provide certain types of qualifying public services.
[59] National Health Services Corps, Loan Repayment Program, *Eligibility*, https://www.nhsc.hrsa.gov/loanrepayment/eligibility.html (last visited Jan. 8, 2018).

There are several other federal loan repayment programs that are open to most all borrowers, including dental, that have certain post-graduate working conditions such as a requirement to work as a faculty member at an approved health institution, as a biomedical researcher, as a provider at an Indian health program site, as a commissioned dental officer in the U.S. Public Health Service Commissioned Corps, or with the United States Army or Navy.[60]

III. Effect of Proposed Changes:

The bill creates the dental student loan repayment program at the DOH. The initiative is conditioned on the availability of funds and is intended to promote access to dental care, encourage dentists to practice in dental health professional shortage areas or medically underserved areas, or serve a medically underserved population. The bill defines several key terms:

- Dental health professional shortage area: A geographic area so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services;
- Loan program: The Dental Student Loan Repayment Program.
- Medically underserved area: A designated health professional shortage area that lacks an adequate number of dental health professionals to serve Medicaid and other low income patients; and
- Public health program: A county health department, the Children's Medical Services program, a federally qualified community health center, a federally-funded migrant health center, or other publicly-funded or not-for-profit health care program designated by the DOH.

The DOH is required to establish a dental student loan repayment program to benefit state-licensed dentists who demonstrate active employment in a public health program that serves Medicaid recipients and other low income patients. The employment must be located in a dental health professional shortage area (HPSA) or a medically underserved area (MUA). Compliance with these requirements will be established by rule as determined by the DOH.

The DOH shall award funds from the loan program to repay student dental loans of a dentist who meets these requirements; however, no award may exceed $50,000 per year, per dentist. A dentist may receive funds for at least one year and up to a maximum of five years. The dentist's period of obligated service begins when the dentist who receives the funds begins his employment.

A dentist is not eligible to receive funds under this bill if:

- The dentist's employment by a public health program is terminated;
- The dentist's practice in a designated health professional shortage area or medically underserved area is terminated;
- The dentist's participation in the Florida Medicaid program is terminated; or
- The dentist knowingly fails to disclose any participation in fraudulent activity.

[60] American Dental Education Association, *State and Federal Loan Forgiveness Programs* (November 1, 2017), www.adea.org/advocacy/state/loan-forgiveness-programs.aspx (last visited Jan. 8, 2018).

The DOH is required to adopt rules to administer the loan program.

The bill is effective July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Floridians living in those areas identified as medically underserved with little or no access to dental care could benefit from this initiative. The program could bring additional dental professionals to underserved communities, populations, and facilities. The program could also be a reason that a dental graduate elects to stay in Florida instead of practicing in another state after graduation.

Dentists who qualify for the loan program will benefit from another option to reduce in their student loan debt.

As dentists practice in their public service employment programs, the DOH will be making the dentist's already incurred student loan payments. The DOH notes that during the period that the state funded repayment assistance is in place, underwriters for the student loans will receive guaranteed repayments.[61] The DOH will need to have financial arrangements in place to ensure timely payments to the loan guarantors and arrangements with the dentists who participate in the program to ensure continued eligibility while payments are being made.

[61] Id at 5.

C. Government Sector Impact:

The DOH estimates the first year fiscal impact of the bill at $570,941 and the second year impact at $566,467. The impact includes the cost of 10 grants at $50,000 each annually, plus administrative costs to operate and conduct outreach related to the program.

Department of Health – Fiscal Impact – SB 764[62]		
Item	**Year One (2018-2019)**	**Year Two (2019-2020)**
Personnel		
OPS		
Program Analyst	$36,505	$36,505
OPS Benefit	$7,301	$7,301
Expense		
Standard Expense	$10,422	$10,422
Standard Medium Travel	$9,606	$9,606
Develop Materials for Student Recruitment	$3,000	$3,000
Develop Job Fair Materials for student recruitment	$1,500	$1,500
Contracted Services		
Printing education pamphlets for statewide student recruitment	$2,000	$2,000
Printing of materials for job fair display for use in student recruitment	$500	$500
Special Category/G&A Student Loan Repayment 10 students @$50,000 per student	$500,000	$500,000
Human Resources Services	$107	$107
Total Estimated Expenses	**$570,941**	**$566,467**

VI. Technical Deficiencies:

None.

VII. Related Issues:

The DOH counts 224 Health Profession Shortage Areas for dental in its bill analysis. Of these, 111 qualify for the maximum loan repayment of $50,000 per year for up to two years. These sites must meet National Health Services Corps requirements and follow the provisions of services that do not allow for any type of discrimination for patient selection such as age or the ability to pay.[63]

[62] Florida Department of Health, *Senate Bill 764 Analysis* (Dec. 6, 2017) (on file with the Senate Committee on Health Policy).
[63] Id at 2.

The DOH recommends clarifying lines 72 through 73 relating to the termination for failure to disclose participation in a fraudulent activity, as this language may allow a dentist who unknowingly fails to disclose participation in fraudulent activity or who in fact discloses participation in fraudulent activity to still be eligible to participate in the program. Also, the bill does not provide criteria for the selection of applicants if more dentists apply than available funding.[64]

VIII. Statutes Affected:

This bill creates section 381.4019 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[64] Id at 6.

By Senator Bean

4-00543C-18 2018764__

A bill to be entitled

An act relating to the Dental Student Loan Repayment Program; creating s. 381.4019, F.S.; establishing the Dental Student Loan Repayment Program to support dentists who practice in public health programs located in certain underserved areas; providing definitions; requiring the Department of Health to establish the loan program; providing for the award of funds; providing the maximum number of years funds may be awarded; providing eligibility requirements; requiring the department to adopt rules; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental Student Loan Repayment Program.—Subject to the availability of funds, the Legislature establishes the Dental Student Loan Repayment Program to promote access to dental care by supporting qualified dentists who treat medically underserved populations in dental health professional shortage areas or medically underserved areas. The Legislature recognizes that maintaining good oral health is integral to overall health status and that the good health of residents in this state is an important contributing factor in state economic development. Better health, including better oral health, increases workplace productivity, reduces the burden of health care costs, and improves the cognitive development of children.

(1) As used in this section, the term:

(a) "Dental health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Loan program" means the Dental Student Loan Repayment Program.

(d) "Medically underserved area" means a geographic area, an area having a special population, or a facility which is designated by department rule as a health professional shortage area as defined by federal regulation and which has a shortage of dental health professionals who serve Medicaid recipients and other low-income patients.

(e) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a dental student loan repayment program to benefit state-licensed dentists who demonstrate, as required by department rule, active employment in a public health program that serves Medicaid recipients and other low-income patients and is located in a dental health professional shortage area or a medically underserved area.

(3) The department shall award funds from the loan program to repay the student loans of a dentist who meets the requirements of subsection (2). An award may not exceed $50,000 per year per eligible dentist.

(4) A participant in the loan program is eligible to receive funds for at least 1 year, up to a maximum of 5 years. The period of obligated service begins when the dentist begins employment as provided in subsection (2).

(5) A dentist is not eligible to participate in the loan program if:

(a) The dentist's employment by a public health program is terminated;

(b) The dentist's practice in a designated health professional shortage area or medically underserved area is terminated;

(c) The dentist's participation in the Florida Medicaid program is terminated; or

(d) The dentist knowingly fails to disclose any participation in fraudulent activity.

(6) The department shall adopt rules to administer the loan program.

Section 2. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Dana D. Young, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: December 2, 2017

I respectfully request that **Senate Bill # 764**, relating to Dental Student Loan Repayment Program, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

764
Bill Number (if applicable)

Topic Dental Student Loans

Amendment Barcode (if applicable)

Name Doug Bell

Job Title

Address 119 S. Monroe
Street

Phone 205-9000

TLH FL
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

764
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Dental Student Loan Repayment Program

Name Edward Briggs

Job Title Consultant

Address 113 E. College Ave.
Street

Phone 850-933-5994

Tallahassee FL 32301
City *State* *Zip*

Email edward@rsaconsultllc.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Suncoast Community Health Centers

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 764
Bill Number (if applicable)

Topic Dental Student Loan Repayment Program *Amendment Barcode (if applicable)*

Name Joe Anne Hart

Job Title Chief Legislative Officer

Address 118 N. Jefferson Street *Street*
Tall, FL 32301 *City* *State* *Zip*

Phone (850) 224-1089

Email jahart@floridadentalorg

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Dental Association

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 764
Bill Number (if applicable)

Topic Rental Student Loan Repayment

Amendment Barcode (if applicable)

Name Anne Swerlick

Job Title health policy analyst

Address 255 Primera Blvd.
Street

Phone 850-524-0602

Lake Mary Fl. 32746
City *State* *Zip*

Email swerlick@fpi.institute

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Policy Institute

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 800
INTRODUCER:	Senator Braynon
SUBJECT:	Infectious Disease Elimination Pilot Programs
DATE:	January 12, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

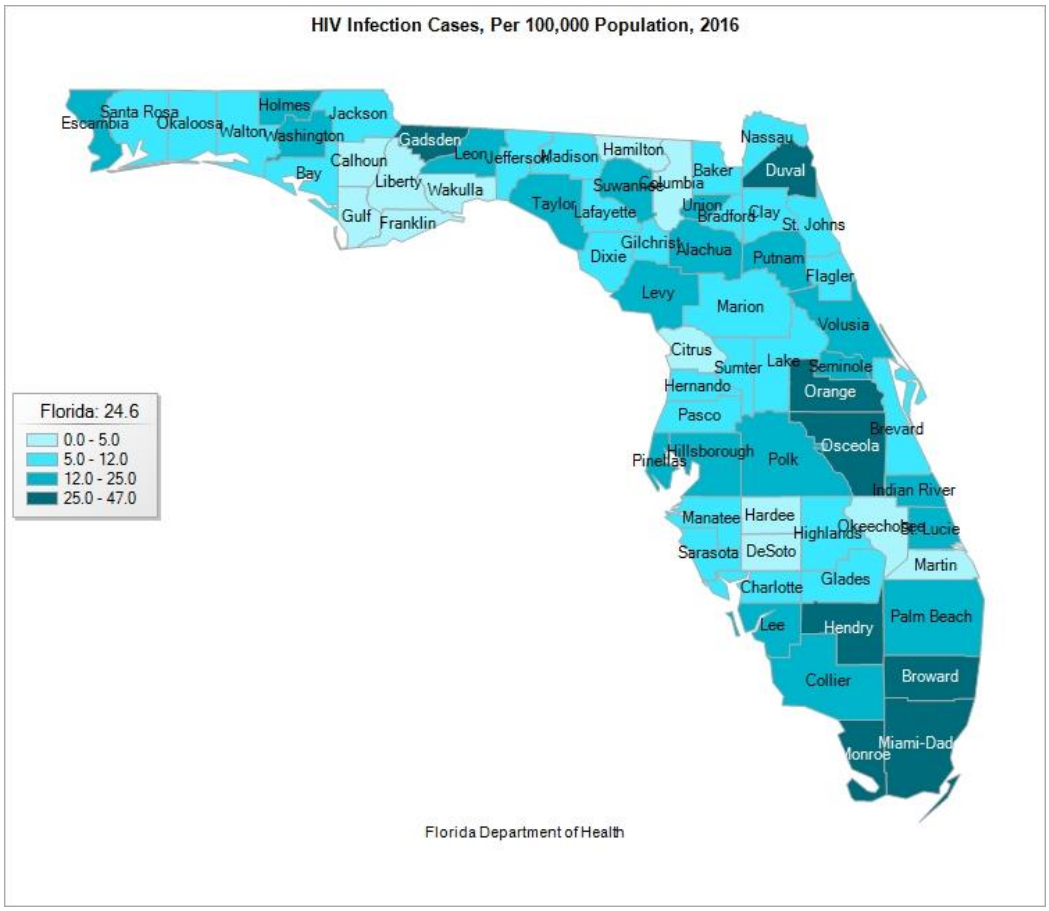
SB 800 expands the existing Miami-Dade sterile needle and syringe exchange pilot program, creating a state pilot program, and renames the section as the "Florida Statewide Infectious Disease Elimination Act." The bill authorizes the Department of the Health (DOH) to establish additional pilot sites upon request from eligible entities, provides program requirements, modifies what types of entities are eligible to operate a program, and extends the program termination date to July 1, 2023.

The effective date of the bill is July 1, 2018.

II. Present Situation:

Needle and syringe exchange programs (NSEPs) provide sterile needles and syringes in exchange for used needles and syringes to reduce the transmission of human immunodeficiency virus (HIV) and other blood-borne infections associated with the reuse of contaminated needles and syringes by injection-drug-users (IDUs). The map below shows the number of HIV infection cases, per 100,000 population for 2016.[1]

[1] Florida Department of Health, HIV Section, FLCharts.com, *Division of Public Health Statistics and Performance Management*, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalHIVAIDSViewer.aspx?cid=0471 (last viewed Jan. 11, 2018).



Intravenous Drug Use in Florida

Of the total individuals living with an HIV infection in Florida, 4,972 individuals were newly diagnosed during 2016.[2] Florida is second in the nation, behind only California, with both the percentage of the national total (12 percent) and the number of newly diagnosed HIV infections in 2016.[3] The vast majority of those infected are exposed through male to male sexual contact (60 percent) while 4 percent are infected through intravenous drug use (IDU).[4] Statistics show Florida's HIV-infected population is 78 percent male.[5]

The DOH reports that 60 to 90 percent of HIV-infected IDUs are also co-infected with Hepatitis C Virus.[6] Hepatitis C is a liver disease caused by a virus that spreads through contact with

[2] Centers for Disease Control and Prevention, *HIV Surveillance Report, 2015 (most recent available),* vol. 27, Table 18a,. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2015-vol-27.pdf (November 2016) (last visited Jan. 11, 2018).
[3] Kaiser Family Foundation, *The HIV/AIDS Epidemic in the United States: The Basics* (December 2017), http://files.kff.org/attachment/Fact-Sheet-HIV-AIDS-in-the-United-States-The-Basics, (last visited Jan. 11, 2018).
[4] Florida Department of Health, *HIV Cases Diagnosed in 2016 by Selected Demographics and Risk Factors in the U.S. and Florida*, http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_images/County_HIV_Trends_2007-2016pdf.pdf (last visited Jan. 11, 2018).
[5] *Id.*
[6] Florida Department of Health, *Hepatitis, Hepatitis C and HIV Co*-Infection, http://www.floridahealth.gov/diseases-and-conditions/hepatitis/co-infection.html (last visited: Jan. 11, 2018.

infected blood and can cause cirrhosis of the liver, liver cancer, and death.[7] The Hepatitis C virus can be acquired through:

- Injection of shared drug equipment;
- A blood transfusion before 1992;
- An occupational needle stick,
- A long-term hemodialysis,
- An infected mother to her infant, and
- Sexual transmission.[8]

In 2016, the majority of Florida counties with high rates of persons living with HIV/AIDS (PLWHA), and with a high IDU-associated risk, were in the southeast or central parts of the state.[9] The chart below displays data from 2016 of the 11 Florida counties with the highest incidence of PLWHA with an IDU-associated risk.[10]

County	Total PLWHA Cases	Total IDU	Percent IDU
Miami-Dade	26,946	2,873	11%
Broward	20,020	2,188	11%
Orange	8,663	1,389	16%
Palm Beach	8,198	1,323	16%
Hillsborough	6,691	1,229	18%
Duval	6,199	981	16%
Pinellas	4,589	830	18%
Lee	2,238	333	15%
Volusia	1,698	410	24%
St. Lucie	1,610	284	18%
Brevard	1,566	307	20%
State Totals	**114,608**	**17,886**	**16%**

Needle and Syringe Exchange Programs

In the mid-1980s, the National Institute on Drug Abuse (NIDA) undertook a research program to develop, implement, and evaluate the effectiveness of intervention strategies to reduce risk behaviors and prevent the spread of HIV/AIDS, particularly among IDUs, their sexual partners, and offspring. The studies found that comprehensive strategies—in the absence of a vaccine or cure for AIDS—are the most cost effective and reliable approaches to prevent new blood-borne infections. The strategies NIDA recommends are community-based outreach, drug abuse

[7] Florida Dep't of Health, *Hepatitis C Palm Card*, http://www.floridahealth.gov/diseases-and-conditions/hepatitis/_documents/educational-materials/_documents/hcv-palmcard.pdf
[8] *Id*.
[9] Florida Dep't of Health, *HIV Infection Among Those with an Injection Drug Use-Associated Risk, Florida, 2014* (power point slide 18) (revised Jan. 29, 2015), *available at* http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/hiv-aids-slide-sets/2014/idu-2014.pdf (last visited Jan. 11, 2018).
[10] Florida Department of Health, Senate Bill 800 *2017 Bill Analysis – SB 800 (Nov. 13, 2017) p. 2*, (on file with the Senate Committee on Health Policy).

treatment, and sterile syringe access programs, including needle and syringe exchange programs (NSEPs). In general, these strategies are referred to as harm reduction.[11]

Needle and syringe exchange programs provide free sterile needles and syringe units and collect used needles and syringes from IDUs to reduce transmission of blood-borne pathogens, including HIV, hepatitis B virus, and HCV. In addition, the programs help to:

- Increase the number of drug users who enter and remain in available treatment programs;
- Disseminate HIV risk reduction information and referrals for HIV testing and counseling and drug treatment;
- Reduce injection frequency and needle-sharing behaviors;
- Reduce the number of contaminated syringes in circulation in a community; and
- Increase the availability of sterile needles, thereby reducing the risk that new infections will spread.[12]

The first sanctioned NSEP in the world began in Amsterdam, the Netherlands, in 1984. The first sanctioned program to operate in North America originated in Tacoma, Washington, in 1988. As of May 2015, there were 228 NSEPs in 35 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Indian Nations.[13]

Miami's Needle and Syringe Exchange Program

Florida's first legal needle exchange program was approved by the legislature in 2016.[14] The pilot program is limited to Miami-Dade County and must be funded with private funds, grants, and donations. No state, county, or municipal funds may be used to operate the pilot program. The pilot is limited to a single sterile needle and syringe exchange program in the county and must operate from a mobile unit. The legislation requires the University of Miami to offer the exchange of free, clean, unused needles and hypodermic syringes for used needles and hypodermic syringes.[15] The pilot program must provide educational materials, secure the used needles, and collect required data.[16] The pilot program is scheduled to expire on July 1, 2021.

The Miami NSEP costs more than $500,000 annually and receives funding from private organizations such as the MAC AIDS Fund, Gilead Pharmaceuticals, the Elton John AIDS

[11] National Institute of Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, *Principles of HIV Prevention in Drug-Using Populations: A Research-Based Guide* (March 2002), *available at* http://www.nhts.net/media/Principles%20of%20HIV%20Prevention%20(17).pdf (last visited Jan. 11, 2018).
[12] *Id*, at 18. *See also* World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users* (2004) pp. 28–29, *available at* http://www.who.int/hiv/pub/idu/pubidu/en/ (last visited Jan. 11, 2018).
[13] North American Syringe Exchange Network, *Directory* (Updated May 2015), *available at* https://nasen.org/ (last visited Jan. 11, 2018).
[14] Chapter 2016-68, Laws of Fla. (creating the Miami-Dade Infectious Disease Elimination Act, amending s. 381.0038, F.S., effective July 1, 2016).
[15] Section 381.0038(4), F.S.
[16] Section 381.0038(4)(a), F.S.

Foundation, and the AIDS Healthcare Foundation as well as support from the University of Miami.[17]

Program officials indicate that in the first year, the Miami NSEP has reached more than 500 injection drug users, collected more than 85,000 used needles and reversed at least 235 overdoses.[18] A total of 232 participants have tested HCV positive.[19]

Safe Sharps Disposal

Improperly discarded sharps pose a serious risk for injury and infection to sanitation workers and the community. "Sharps" is a medical term for devices with sharp points or edges that can puncture or cut skin.[20]

Examples of sharps include:

- Needles - hollow needles used to inject drugs (medication) under the skin;
- Syringes - devices used to inject medication into or withdraw fluid from the body;
- Lancets - also called "finger stick" devices - instruments with a short, two-edged blade used to get drops of blood for testing;
- Auto injectors - including epinephrine and insulin pens - syringes pre-filled with fluid medication designed to be self-injected into the body;
- Infusion sets - tubing systems with a needle used to deliver drugs to the body; and
- Connection needles/sets - needles that connect to a tub to transfer fluids in and out of the body.[21]

Used needles and other sharps pose a dangerous risk to people and animals if not properly disposed as they can spread disease and cause injury. The most common infections from such injuries are Hepatitis B (HBV), HCV, and HIV.[22] The FDA's guidelines for disposal are to never place loose needles or other sharps into household or public trash cans or recycling bins, and to never flush them down toilets.[23] Many Florida counties have their own sharps disposal programs through the county health department.[24]

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[17] Sammy Mack, *"The Most Pro-Life Thing:" HIV Activists Push to Expand Miami's Needle Exchange Statewide,* HEALTH NEWS FLORIDA, (Jan. 8, 2018) http://health.wusf.usf.edu/post/most-pro-life-thing-hiv-activists-push-expand-miamis-needle-exchange-statewide.
[18] *Id.*
[19] *Supra,* note 10, at 3.
[20] U.S. Food and Drug Administration, *Needles and Other Sharps (Safe Disposal Outside of Health Care Settings),* (Jan. 27, 2014) *available at:* http://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/HomeHealthandConsumer/ConsumerProducts/Sharps/ (last visited Jan. 11. 2018).
[21] *Id.*
[22] *Supra,* note 10.
[23] *Id.*
[24] Florida Department of Health, *Environmental Health –Needle Collection Programs,* http://www.floridahealth.gov/environmental-health/biomedical-waste/needle-collection-programs.html (last visited Jan. 11, 2018).

Federal Funding for Needle and Syringe Exchange Programs

On December 23, 2011, President Barack Obama signed the 2012 omnibus spending bill that reinstated a 1988 ban on the use of federal funds for NSEPs, which reversed the 111th Congress's 2009 decision to allow federal funds to be used for NSEPs.[25] However, on December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016 (Pub. L. 114-113), which modified the restriction on the use of federal funds for syringe services programs (SSPs) for persons who inject drugs to allow the use of federal funds for certain services.[26]

The Department of Health and Human Services defines SSPs as the provision of sterile needles and syringes and other drug preparation equipment and disposal services as well as some or all of the following services:

- Comprehensive sexual and injection risk reduction counselling;
- HIV, viral hepatitis, other sexually transmitted diseases (STDs) and tuberculosis (TB) screening, other STDs and TB prevention care and treatment services, referral and linkage to HIV, viral hepatitis A virus (HAV) and HPV vaccinations; and
- Referral to integrated and coordinated substance abuse disorder, mental health services, physical health care, social services, and recovery support services.[27]

While the federal law continues to prohibit the use of federal funds to purchase sterile needles and syringes, it does allow the use of federal funds by the state or local health department for other needs of the SSPs.[28] In order to receive funds from the DHHS, a state must first consult with the Centers for Disease Control and provide evidence that their jurisdiction is experiencing or at risk for significant increases in hepatitis infections or an HIV outreach due to injection drug use.[29] As of December 2017, 30 states and seven counties have been determined of such a status by the CDC. Florida is not included in that list.[30] Examples of what federal funds may be used for under this determination include:

- Personnel;
- Testing kids for HCV and HIV;
- Syringe disposal services;
- Provision of naloxone;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs,
- Communication and outreach activities and
- Educational materials.[31]

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[25] *Id*.
[26] U.S. Department of Health and Human Services, *Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016,* https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf (last visited Jan. 11, 2018).
[27] *Id*.
[28] *Id*.
[29] Centers for Disease Control and Prevention, *CDC Consultation on Determination of Need Requests,* https://www.cdc.gov/hiv/risk/ssps-jurisdictions.html (last visited Jan. 11, 2018).
[30] *Id*.
[31] Supra, note 25.

Florida Comprehensive Drug Abuse Prevention and Control Act

In Florida, the term "drug paraphernalia" is defined as all equipment, products, and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body, a controlled substance in violation of ch. 893, F.S., or s. 877.111, F.S.[32]

Section 893.147, F.S., regulates the use or possession of drug paraphernalia. Currently, it is unlawful for any person to use, or to possess with intent to use, drug paraphernalia:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this chapter; or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of ch. 893, F.S.

Any person who violates this provision commits a first degree misdemeanor.[33]

It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this act, or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this act.

Any person who violates this provision commits a third degree felony.[34]

A court, jury, or other authority, when determining in a criminal case whether an object constitutes drug paraphernalia, must consider specified facts surrounding the connection between the item and the individual arrested for possessing drug paraphernalia. A court or jury is required to consider a number of factors in determining whether an object is drug paraphernalia, such as proximity of the object in time and space to a controlled substance, the existence of residue of controlled substances on the object, and expert testimony concerning its use.[35]

Federal Law Exemption

Any person authorized by local, state, or federal law to manufacture, possess, or distribute drug paraphernalia is exempt from the federal drug paraphernalia statute.[36]

[32] Section 893.145, F.S.
[33] A first degree misdemeanor is punishable by up to 1-year imprisonment in a county jail, a fine of up to $1,000, or both. *See* ss. 775.082 and 775.083, F.S.
[34] A third degree felony is punishable by up to 5 years in state prison, a fine not to exceed $5,000, or both. *See* ss. 775.082 and 775.083, F.S.
[35] Section 893.146, F.S.
[36] 21 U.S.C. § 863(f)(1).

III. Effect of Proposed Changes:

Section 1 names the act the "Florida Infectious Disease Elimination Act (IDEA)."

Section 2 amends s. 381.0038, F.S., which modifies the existing single-county, Miami-Dade sterile needle and syringe exchange pilot program to establish a statewide program through the DOH, rather than the University of Miami. The bill allows the program to be administered either by the DOH or one of the participating, eligible entities. No state, county, or municipal funds may be used to operate the program.

The bill permits a pilot program to continue to be established at a mobile health unit or at one of several new location types:

- A hospital licensed under chapter 395;
- A health care clinic licensed under chapter 400;
- A substance abuse treatment program;
- An HIV or AIDS service organization; or
- Another nonprofit entity designated by the DOH.

Quarterly and annual reports must be submitted to the DOH under the revised pilot program, rather than to the local DOH office in Miami-Dade County. A final report will be due from all programs by August 1, 2023.

The expiration date for all pilot programs is extended to July 1, 2023.

Section 3 includes a severability clause which provides that if any provision of this act or its application to any person or its circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 800 continues the requirement that all pilot program sites must raise funds from private donations, grants, and other non-government sources. The University of Miami was also required to obtain a Biomedical Waste Operating permit as a sharps collection program in accordance with Chapter 64E-16, Florida Administrative Code, through the DOH's Miami-Dade's Environmental Health office.[37] This expense would be required for any entity that elects to participate in this program.

Private sector health care providers may also see an impact in emergency rooms through a reduction in the treatment of individuals related to drug-related overdoses, earlier linkage to substance abuse and mental health treatment programs, and prevention of mother to child HIV transmissions.[38]

C. Government Sector Impact:

The pilot programs may reduce state and local government expenses for the treatment of blood-borne diseases associated with intravenous drug use on those counties or areas that elect to participate in the program. For example, state and local governments currently pay for medical expenditures for some patients with AIDS, such as Medicaid, the AIDS Drug Assistance Program, and the AIDS Insurance Continuation Program. The lifetime cost of HIV treatment is estimated to be $379,668 in 2010 dollars.[39] The initial market prices of HCV ranged from $84,000 to $96,000 in 2014, but had fallen to $40,000 for Medicaid programs.[40]

The DOH did not provide a specific fiscal impact for the bill, but indicated it was uncertain how the DOH could provide administrative support to receive reports, summarize, and provide state level program update without state funding.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

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[37] Department of Health, *Senate Bill 1040 Analysis* (Jan. 29, 2015) (on file with Senate Committee on Fiscal Policy).
[38] Centers for Disease Control and Prevention, *Syringe Services Programs*, https://www.cdc.gov/hiv/risk/ssps.html (last visited Jan. 11, 2018).
[39] Centers for Disease Control and Prevention, *HIV Cost-effectiveness*, https://www.cdc.gov/policy/hst/hi5/cleansyringes/index.html (last visited Jan. 11, 2018).
[40] *Id*.

VIII. Statutes Affected:

This bill substantially amends section 381.0038 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Braynon

35-00461-18 2018800__

A bill to be entitled

An act relating to infectious disease elimination pilot programs; providing a short title; amending s. 381.0038, F.S.; authorizing the Department of Health to establish sterile needle and syringe exchange pilot programs upon request from eligible entities, rather than a single program established in Miami-Dade County; specifying who may be designated to operate a program; providing for the expiration of all pilot programs; providing for severability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. This act may be cited as the "Florida Infectious Disease Elimination Act (IDEA)."

Section 2. Subsection (4) of section 381.0038, Florida Statutes, is amended to read:

381.0038 Education; sterile needle and syringe exchange pilot program.—The Department of Health shall establish a program to educate the public about the threat of acquired immune deficiency syndrome.

(4) The department ~~University of Miami and its affiliates~~ may establish a ~~single~~ sterile needle and syringe exchange pilot program upon request from an eligible entity ~~in Miami-Dade County~~. Each pilot program must be administered by the department, or the department may designate one of the following eligible entities to operate the pilot program ~~may operate~~ at a fixed location or through a mobile health unit: a hospital

licensed under chapter 395, a health care clinic licensed under part X of chapter 400, a substance abuse treatment program, an HIV or AIDS service organization, or another nonprofit entity designated by the department. Each ~~The~~ pilot program shall offer the free exchange of clean, unused needles and hypodermic syringes for used needles and hypodermic syringes as a means to prevent the transmission of HIV, AIDS, viral hepatitis, or other blood-borne diseases among intravenous drug users and their sexual partners and offspring.

(a) Each ~~The~~ pilot program must:

1. Provide for maximum security of exchange sites and equipment, including an accounting of the number of needles and syringes in use, the number of needles and syringes in storage, safe disposal of returned needles, and any other measure that may be required to control the use and dispersal of sterile needles and syringes.

2. Operate a one-to-one exchange, whereby the participant shall receive one sterile needle and syringe unit in exchange for each used one.

3. Make available educational materials and referrals to education regarding the transmission of HIV, viral hepatitis, and other blood-borne diseases; provide referrals for drug abuse prevention and treatment; and provide or refer for HIV and viral hepatitis screening.

(b) The possession, distribution, or exchange of needles or syringes as part of each ~~the~~ pilot program established under this subsection is not a violation of any part of chapter 893 or any other law.

(c) A pilot program staff member, volunteer, or participant

is not immune from criminal prosecution for:

1. The possession of needles or syringes that are not a part of the pilot program; or

2. The redistribution of needles or syringes in any form, if acting outside the pilot program.

(d) Each ~~The~~ pilot program must collect data for quarterly, annual, and final reporting purposes. The annual report must include information on the number of participants served, the number of needles and syringes exchanged and distributed, the demographic profiles of the participants served, the number of participants entering drug counseling and treatment; the number of participants receiving testing for HIV, AIDS, viral hepatitis, or other blood-borne diseases; and other data necessary for the pilot program. However, personal identifying information may not be collected from a participant for any purpose. Quarterly reports must be submitted to the department ~~of Health in Miami-Dade County~~ by October 15, January 15, April 15, and July 15 of each year. An annual report must be submitted to the department ~~of Health~~ by August 1 every year until the program expires. A final report is due on August 1, 2023 ~~2021~~, to the department ~~of Health~~ and must describe the performance and outcomes of the pilot program and include a summary of the information in the annual reports for all pilot program years.

(e) State, county, or municipal funds may not be used to operate a ~~the~~ pilot program. A ~~The~~ pilot program must ~~shall~~ be funded through grants and donations from private resources and funds.

(f) All ~~The~~ pilot programs ~~program~~ shall expire July 1, 2023 ~~2021~~.

Section 3. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 4. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Dana D. Young, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 8, 2018

I respectfully request that **Senate Bill # 800, Infectious Disease Elimination Pilot Programs**, relating to Citing this act as the "Florida Infectious Disease Elimination Act (IDEA)", authorizing the Department of Health to establish sterile needle and syringe exchange pilot programs upon request from eligible entities, rather than single program established in Miami Dade County, etc, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Oscar Braynon II
Florida Senate, District 35

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB800

Meeting Date | *Bill Number (if applicable)*

Topic SB800 IDEA

Amendment Barcode (if applicable)

Name Dr. Scott Kjelson

Job Title Director / Professor NSU / Florida Society of Health System Pharmacy

Address 200 S. Birch Rd *Street*

Phone 786-3011483

Fort Lauderdale *City* *State* *Zip*

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Health System Pharmacy.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 800
Bill Number (if applicable)

Topic Infectious Disease Elimination Pilot Program

Amendment Barcode (if applicable)

Name Aimee Diaz Lyon

Job Title

Address 119 South Monroe Street Suite 200 *Street*

Phone 850-205-9000

Tallahassee FL 32301 *City* *State* *Zip*

Email aimee.diaz lyon@mhdfirm.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing the AIDS Institute

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

January 16th 2018
Meeting Date

800
Bill Number (if applicable)

Topic IDEA

Amendment Barcode (if applicable)

Name Corinne Bullock

Job Title 2nd yr medical student at the University of Miami

Address 1430 Piedmont Dr E
Street

Phone 850-224-6496

Tallahassee FL 32308
City *State* *Zip*

Email Cmb292@med.miami.edu

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing University of Miami

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/16/18
Meeting Date

800
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic I.D.E.A

Name Mary Thomas

Job Title Assistant General Cansel

Address 1430 Piedmont Dr E
Street

Tlh FL 32308
City *State* *Zip*

Phone 8502246496

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

800
Bill Number (if applicable)

Topic IDEA

Amendment Barcode (if applicable)

Name Tyler Bartholomew

Job Title 1st year PhD student in Prevention Science at UM

Address 1430 Piedmont Dr East
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-274-6496

Email tsb61@miami.edu

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing University of Miami

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

01/16/2018
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

800
Bill Number (if applicable)

Topic IDEA

Amendment Barcode (if applicable)

Name Jason Onugha

Job Title MD-MPH Student

Address 1430 Piedmont Dr. E.
Street
Tallahassee FL 32308
City *State* *Zip*

Phone 850-224-6496

Email JKO17@miami.edu

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing University of Miami & FMA

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

SB 800
Bill Number (if applicable)

Topic Infectious Disease Elimination Pilot Programs

Amendment Barcode (if applicable)

Name Devon West

Job Title Policy Advisor

Address 115 S. Andrews Ave.
Street

Phone 954-789-9293

Ft. Lauderdale FL 33301
City *State* *Zip*

Email dewest@broward.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Broward County

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

808
Bill Number (if applicable)

Topic IDEA

Amendment Barcode (if applicable)

Name MARTHA DeCASTRO

Job Title VP for Nursing & Clinical Care Policy

Address 306 E. College
Street

Phone 850 222 9800

Tallahassee FL 32301
City *State* *Zip*

Email martha@fha.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

412-K
4:00 pm

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-2018
Meeting Date

SB 800
Bill Number (if applicable)

Topic INFECTIOUS DISEASE ELIMINATION PILOT PROGRAMS

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

January 16, 2018
Meeting Date

SB 800
Bill Number (if applicable)

Topic Infectious Disease Elimination Pilot Programs

Amendment Barcode (if applicable)

Name Jessica Love

Job Title Government Consultant

Address P.O. Box 11189
Street
Tallahassee, FL 32302
City *State* *Zip*

Phone 850-577-9090

Email jessica.love@gray-robinson.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1-16-18
Meeting Date

SB 800
Bill Number (if applicable)

Topic Infectious Disease Elimination

Amendment Barcode (if applicable)

Name MARK FONTAINE

Job Title CEO

Address 2868 Mahan Drive
Street

Phone 878-2196

Tallahassee FL 32308
City *State* *Zip*

Email mfontaine@fadaa.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Behavioral Health Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 906
INTRODUCER:	Health Policy Committee and Senator Young
SUBJECT:	Public Records/Health Care Facilities
DATE:	January 16, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 906 exempts building plans, blueprints, and other such drawings and diagrams that depict the internal structural layout or structural elements of a hospital, ambulatory surgical center, nursing home, hospice, or intermediate care facility for the developmentally disabled from the public records law.

The bill provides a statement of public necessity supporting the exemption and establishes an Open Government Sunset Review Act automatic repeal date of October 2, 2023, unless reviewed and saved from repeal by the Legislature.

This bill requires a two-thirds vote if each chamber for passage because it creates a public records exemption.

The provisions of the bill take effect upon becoming law.

II. Present Situation:

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] This applies to the official business

[1] FLA. CONST., art. I, s. 24(a).

of any public body, officer or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

In addition to the Florida Constitution, the Florida Statutes provides that the public may access legislative and executive branch records.[3] Chapter 119, F.S., constitutes the main body of public records laws, and is known as the Public Records Act.[4] The Public Records Act states that:

> …it is the policy of this state that all state, county and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] The Florida Supreme Court has interpreted public records as being "any material prepared in connection with official agency business which is intended to perpetuate, communicate or formalize knowledge of some type."[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

The Legislature may create an exemption to public records requirements.[9] An exemption must pass by a two-thirds vote of the House and the Senate.[10] In addition, an exemption must explicitly lay out the public necessity justifying the exemption, and the exemption must be no broader than necessary to accomplish the stated purpose of the exemption.[11] A statutory exemption which does not meet these criteria may be unconstitutional and may not be judicially saved.[12]

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[2] *Id*.
[3] The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). Also see *Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995). The Legislature's records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislatures are primarily located in s. 11.0431(2)-(3), F.S.
[4] Public records laws are found throughout the Florida Statutes.
[5] Section 119.01(1), F.S.
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[7] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST., art. I, s. 24(c).
[10] *Id.*
[11] *Id.*
[12] *Halifax Hosp. Medical Center v. New-Journal Corp.*, 724 So. 2d 567 (Fla. 1999). See also *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004).

When creating a public records exemption, the Legislature may provide that a record is "confidential and exempt" or "exempt."[13] Records designated as "confidential and exempt" may be released by the records custodian only under the circumstances defined by the Legislature. Records designated as "exempt" are not required to be made available for public inspection, but may be released at the discretion of the records custodian under certain circumstances.[14]

Open Government Sunset Review Act

The Open Government Sunset Review Act (referred to hereafter as the "OGSR") prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.[15] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[16]

The OGSR provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[17] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[18]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[19] or
- It protects trade or business secrets.[20]

The OGSR also requires specified questions to be considered during the review process.[21] In examining an exemption, the OGSR asks the Legislature to carefully question the purpose and necessity of reenacting the exemption.

---

[13] If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So. 2d 48 (Fla. 5th DCA 2004).

[14] *Williams v. City of Minneola*, 575 So. 2d 687 (Fla. 5th DCA 1991).

[15] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S.

[16] Section 119.15(3), F.S.

[17] Section 119.15(6)(b), F.S.

[18] Section 119.15(6)(b)1., F.S.

[19] Section 119.15(6)(b)2., F.S.

[20] Section 119.15(6)(b)3., F.S.

[21] Section 119.15(6)(a), F.S. The specified questions are:

1. What specific records or meetings are affected by the exemption?
2. Whom does the exemption uniquely affect, as opposed to the general public?
3. What is the identifiable public purpose or goal of the exemption?
4. Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
5. Is the record or meeting protected by another exemption?
6. Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

If, in reenacting an exemption, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[22] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[23]

Agency for Health Care Administration (AHCA) Review of Health Care Facility Building Plans

The Office of Plans and Construction (Office) within the AHCA is primarily responsible for ensuring that hospitals, nursing homes, ambulatory surgical centers, and Intermediate Care Facilities for the Developmentally Disabled are safe, functional, and provide safety-to-life for the patients and residents. The Office reviews and approves facilities' plans and specifications and surveys their construction. These licensed health care facilities must notify the Office in writing before any equipment replacements, renovations, additions, or new facilities are created. Plans and specifications for such activities must be approved before any construction begins. Architects, engineers and other specially trained plans and construction personnel survey facilities under construction and, when necessary, write reports for required corrections to the construction before approval of the project is given.[24]

Schematics, preliminary plans and construction documents received by the Agency and other government agencies for hospitals, ambulatory surgical centers, nursing homes and intermediate care facilities for the developmentally disabled are currently subject to release as public record. These plans include building floor plans, communication systems, medical gas systems, electrical systems, and other physical plant and security details. Recent security threats have been shared by state and federal security and emergency preparedness officials that describe the targeting of health care facilities by terrorists. Because architectural and engineering plans reviewed and held by government agencies include information regarding emergency egress, locking arrangements, critical life safety systems and restricted areas these plans could be used by criminals or terrorists to examine the physical plant for vulnerabilities.[25]

III. Effect of Proposed Changes:

Section 1 amends s. 119.071, F.S., to exempt the building plans, blueprints, schematic drawings, and diagrams, including draft, preliminary, and final formats, which depict the internal layout or structural elements of a health care facility. The bill defines "health care facility" as a hospital, ambulatory surgical center, nursing home, hospice, or intermediate care facility for the developmentally disabled. This exemption currently exists for an attraction and recreation facility, entertainment or resort complex, industrial complex, retail and services development, office development, and hotel and motel development.

[22] FLA. CONST. art. I, s. 24(c).
[23] Section 119.15(7), F.S.
[24] AHCA, Office of Plans and Construction http://ahca.myflorida.com/MCHQ/Plans/, (last visited Jan. 10, 2018).
[25] AHCA, *HB 551 Analysis* (Nov. 28, 2017) (on file with the Senate Committee on Health Policy).

The bill also states that s. 119.071(3)(c), F.S., is subject to the Open Government Sunset Review Act and establishes an automatic repeal date of October 2, 2023, unless saved from repeal by the Legislature.

Section 2 of the bill provides the public necessity statement that is required for all new public records exemptions by art. I, s. 24(c) of the State Constitution. The bill provides that, because the plans and blueprints of health care facilities are held by the AHCA, they are subject to public records laws and may be obtained by criminals and terrorists that wish to exploit any vulnerabilities in the health care facilities' physical plants. These documents should be made exempt from the requirements of s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitutions to ensure the safety of the health care facility's staff, patients, and visitors. The bill states that it is a public necessity to exempt these records from public records laws in order to prevent possible terrorist or criminal actions and to reduce these facilities' exposure to security threats.

Section 3 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Voting Requirement
Article I, Section 24(c) of the Florida Constitution requires a two-thirds vote of each chamber for public records exemptions to pass.

Public Necessity Statement
Article I, Section 24(c) of the Florida Constitution requires a public necessity statement for a newly created or expanded public-records exemption. The Florida Constitution provides that an exemption must state with specificity the public necessity of the exemption. The public necessity statement provides that the exemption is needed to protect the safety of the health care facility's staff, patients, and visitors, to prevent possible terrorist or criminal actions, and to reduce these facilities' exposure to security threats against health care facilities.

Breadth of Exemption
Article I, Section 24(c) of the Florida Constitution requires a newly created public records exemption to be no broader than necessary to accomplish the stated purpose of the law. The bill exempts only building plans, blueprints, schematic drawings, and diagrams, including draft, preliminary, and final formats, which depict the internal layout or structural elements of a health care facility. This bill appears to be no broader than necessary to accomplish the public necessity for this public records exemption.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 119.071 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 16, 2018:
The CS rewords the public necessity statement to make grammatical changes and to eliminate a reference to information on emergency generators being made exempt from public records laws.

B. Amendments:

None.

293126

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
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The Committee on Health Policy (Young) recommended the following:

Senate Amendment

Delete lines 101 - 115
and insert:
drawings, and diagrams of a health care facility should be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution to ensure the safety of the health care facility's staff, patients, and visitors. Building plans, blueprints, schematic drawings, diagrams, preliminary plans, and construction documents the Agency for Health Care

293126

Administration and other governmental agencies receive which depict the internal layout or structural elements of hospitals, ambulatory surgical centers, nursing homes, hospices, and intermediate care facilities for the developmentally disabled are currently public records and are subject to release upon request. The Agency for Health Care Administration reviews the building plans for proposed health care facility construction to ensure compliance with building codes and agency rules and standards in order to protect the public health and safety. These building plans include diagrams and schematics of building floor plans, communication systems, medical gas systems, electrical systems, and other physical plant and security details depicting the internal layout and structural elements of the health care facilities.

By Senator Young

18-01051-18 2018906__

A bill to be entitled

An act relating to public records; amending s. 119.071, F.S.; providing an exemption from public records requirements for building plans, blueprints, schematic drawings, and diagrams held by an agency which depict the internal layout or structural elements of certain health care facilities; providing for future legislative review and repeal of the exemption; providing a statement of public necessity; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) of subsection (3) of section 119.071, Florida Statutes, is amended to read:

119.071 General exemptions from inspection or copying of public records.—

(3) SECURITY.—

(c)1. Building plans, blueprints, schematic drawings, and diagrams, including draft, preliminary, and final formats, which depict the internal layout or structural elements of an attractions and recreation facility, entertainment or resort complex, industrial complex, retail and service development, office development, <u>health care facility,</u> or hotel or motel development, which records are held by an agency are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2. This exemption applies to any such records held by an agency before, on, or after the effective date of this act.

3. Information made exempt by this paragraph may be

disclosed to another governmental entity if disclosure is necessary for the receiving entity to perform its duties and responsibilities; to the owner or owners of the structure in question or the owner's legal representative; or upon a showing of good cause before a court of competent jurisdiction.

4. This paragraph does not apply to comprehensive plans or site plans, or amendments thereto, which are submitted for approval or which have been approved under local land development regulations, local zoning regulations, or development-of-regional-impact review.

5. As used in this paragraph, the term:

a. "Attractions and recreation facility" means any sports, entertainment, amusement, or recreation facility, including, but not limited to, a sports arena, stadium, racetrack, tourist attraction, amusement park, or pari-mutuel facility that:

(I) For single-performance facilities:

(A) Provides single-performance facilities; or

(B) Provides more than 10,000 permanent seats for spectators.

(II) For serial-performance facilities:

(A) Provides parking spaces for more than 1,000 motor vehicles; or

(B) Provides more than 4,000 permanent seats for spectators.

b. "Entertainment or resort complex" means a theme park comprised of at least 25 acres of land with permanent exhibitions and a variety of recreational activities, which has at least 1 million visitors annually who pay admission fees thereto, together with any lodging, dining, and recreational

facilities located adjacent to, contiguous to, or in close proximity to the theme park, as long as the owners or operators of the theme park, or a parent or related company or subsidiary thereof, has an equity interest in the lodging, dining, or recreational facilities or is in privity therewith. Close proximity includes an area within a 5-mile radius of the theme park complex.

c. "Industrial complex" means any industrial, manufacturing, processing, distribution, warehousing, or wholesale facility or plant, as well as accessory uses and structures, under common ownership that:

(I) Provides onsite parking for more than 250 motor vehicles;

(II) Encompasses 500,000 square feet or more of gross floor area; or

(III) Occupies a site of 100 acres or more, but excluding wholesale facilities or plants that primarily serve or deal onsite with the general public.

d. "Retail and service development" means any retail, service, or wholesale business establishment or group of establishments which deals primarily with the general public onsite and is operated under one common property ownership, development plan, or management that:

(I) Encompasses more than 400,000 square feet of gross floor area; or

(II) Provides parking spaces for more than 2,500 motor vehicles.

e. "Office development" means any office building or park operated under common ownership, development plan, or management

that encompasses 300,000 or more square feet of gross floor area.

f. "Health care facility" means a hospital, ambulatory surgical center, nursing home, hospice, or intermediate care facility for the developmentally disabled.

g.~~f.~~ "Hotel or motel development" means any hotel or motel development that accommodates 350 or more units.

6. This paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2023, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that the building plans, blueprints, schematic drawings, and diagrams of a health care facility should remain confidential to ensure the safety of the health care facility's staff, patients, and visitors. The Agency for Health Care Administration reviews the building plans of proposed health care facility construction to ensure compliance with health care rules, codes, and standards in order to protect the public health and safety. Schematics, preliminary plans, and construction documents received by the agency and other governmental agencies for hospitals, ambulatory surgical centers, nursing homes, hospices, and intermediate care facilities for the developmentally disabled are currently subject to release as public records and subject to release upon request. These plans include building floor plans, communication systems, medical gas systems, electrical systems, emergency generators, and other physical plant and security details. Recent security threats have been shared by state and federal

security and emergency preparedness officials which describe the targeting of health care facilities by terrorists. Because architectural and engineering plans reviewed and held by governmental agencies include information regarding emergency egress, locking arrangements, critical life safety systems, and restricted areas, these plans could be used by criminals or terrorists to examine the physical plant for vulnerabilities. Information contained in these documents could aid in the planning of, training for, and execution of criminal actions including infant abduction, cybercrime, arson, and terrorism. Consequently, the Legislature finds that the public records exemption created by this act is a public necessity to reduce exposure to security threats and protect the public.

Section 3. This act shall take effect upon becoming a law.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 1134
INTRODUCER:	Health Policy Committee; Senator Rouson and others
SUBJECT:	Department of Health Responsibilities Related to the Medical Use of Marijuana
DATE:	January 17, 2018
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.			AP	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1334 amends Department of Health (DOH) responsibilities under s. 381.986, F.S., relating to the medical use of marijuana. The bill:

- Requires the DOH to adopt rules that allow qualified patients to change qualified physicians while remaining registered with the Medical Marijuana Use Registry.
- Eliminates the requirement that the applicant for the one Medical Marijuana Treatment Center (MMTC) license designated to be issued to a recognized class member of Pigford v. Glickman[1] or In Re Black Farmers Litig.,[2] and that is a member of the Black Farmers and Agriculturalists Association-Florida Chapter (BFAA-FC) be a member of the BFAA-FC.
- Requires that all applicants for the one Recognized Class Member License be registered to do business in Florida for five consecutive years before applying for the license.
- Strikes an obsolete date by which such license was to be issued.

The effective date of the bill is July 1, 2018.

[1] 185 F.R.D. 82 (D.D.C. 1999).
[2] 856 F. Supp. 2d 1 (D.D.C. 2011).

II. Present Situation:

On November 4, 2016, Amendment 2 was voted into law and established article X, section 29 of the State Constitution. This section of the constitution became effective on January 3, 2017, and created several exemptions from criminal and civil liability for:

- Qualifying patients medically using marijuana in compliance with the amendment;
- Physicians, solely for issuing physician certifications with reasonable care and in compliance with the amendment; and
- MMTCs, their agents, and employees for actions or conduct under the amendment and in compliance with DOH rules.

Physician Certifications

The Legislature passed Chapter 2017-232, L.O.F., during the 2017 Special Session A to implement Amendment 2. Included in the many provisions of the law, the law established a system allowing qualified physicians who have successfully completed the required training and examination to issue physician certifications to qualified patients. Prior to issuing a physician certification the bill requires that each qualified physician check the Medical Marijuana Use Registry to ensure that the patient does not have an active physician certification from another physician.[3] The law also requires that a physician deactivate his or her patient's registration on the Medical Marijuana Use Registry when the physician no longer recommends the medical use of marijuana for the patient.[4] However, the law does not include any provisions that allow a qualified patient to deactivate his or her own registration or remove a physician relationship from the registry. As established, a qualified physician may prevent a qualified patient from switching to a different qualified physician for treatment with medical marijuana by refusing to deactivate the physician certification for that qualified patient.

Medical Marijuana Treatment Centers

The law also requires the DOH to license a number of MMTCs including:

- All previously licensed Dispensing Organizations that were licensed under the Compassionate Medical Cannabis Act.[5]
- Ten additional MMTCs, as follows:
  - By August 1, 2017, any denied dispensing organization applicant whose application was scored by DOH and had one or more administrative or legal challenges pending as of January 1, 2017, or had a final ranking within one point of the highest final ranking applicant in its region, and proves to the DOH that it has the infrastructure and ability to begin cultivating marijuana within 30 days after registration as an MMTC;

[3] Section 381.986(4)(a)6., F.S.
[4] Section 381.986(4)(a)7.c., F.S.
[5] The Compassionate Medical Cannabis Act (Act) was the precursor to the full-strength medical marijuana program established by Amendment 2 and ch. 2017-232, L.O.F. The Act allowed the use of low-THC cannabis to treat cancer and epilepsy disorders and the use of full-strength medical cannabis for the treatment of terminal patients. The Act required the DOH to license five dispensing organizations to grow, process, and dispense low-THC and medical cannabis and three additional dispensing organizations upon the registration of 250,000 active qualified patients in the compassionate use registry. The Act required one of the three additional dispensing organizations to be owned and operated by a recognized class member of Pigford v. Glickman, 185 F.R.D. 82 (D.D.C. 1999), or In Re Black Farmers Litig., 856 F. Supp. 2d 1 (D.D.C. 2011), and a member of the Black Farmers and Agriculturalists Association. See s. 381.986(5)(c), F.S. (2016).

  - By October 3, 2017, one license to an applicant that is a recognized class member of Pigford v. Glickman or In Re Black Farmers Litig., and that is a member of the BFAA-FC. These applicants are exempt from the requirement to be a registered business in Florida for five consecutive years prior to applying and the requirement to possess a valid certificate of registration as a nursery issued by the Department of Agriculture and Consumer Services; and
  - By October 3, 2017, all remaining of the ten licenses.
- Four additional licenses each time the medical marijuana use registry reaches 100,000 patients.[6]

On September 22, 2017, Columbus Smith (Smith) filed a lawsuit challenging the requirement that a Recognized Class Member License applicant be a member of the BFAA-FC. Smith is a recognized class member of Pigford v. Glickman, or In Re Black Farmers Litig., but is not a member of the Florida Black Farmers and Agriculturalists Association. According to Smith he was denied membership in the BFAA-FC. Smith also sought an injunction to enjoin DOH from awarding a Recognized Class Member License which the court granted on January 9, 2018, preventing the DOH from issuing the Recognized Class Member License. The DOH has delayed issuing any of the additional MMTC licenses that it was required to grant by October 3, 2017, due to this lawsuit.[7, 8]

III. Effect of Proposed Changes:

CS/SB 1334 amends the DOH responsibilities under s. 381.986, F.S. The bill:

- Requires the DOH to adopt rules to establish a process for qualified patients to change qualified physicians while remaining registered with the Medical Marijuana Use Registry. The system may not allow a qualified patient to exceed statutory limits on the supply of marijuana.[9]
- Eliminates the requirement that the applicant for the one MMTC license designated to be issued to a recognized class member of Pigford v. Glickman[10] or In Re Black Farmers Litig.,[11] and that is a member of the BFAA-FC be a member of the BFAA-FC.
- Requires that all applicants for the Recognized Class Member License be registered to do business in Florida for five consecutive years before applying for the license by eliminating the exemption from this requirement. This change will ensure that any applicant for this license will be a Florida based applicant despite the elimination of the requirement that the applicant be a member of the BFAA-FC.
- Strikes an obsolete date by which such license was to be issued.

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[6] Section 381.986(8)(a), F.S.
[7] Smith v. Florida Department of Health, case number 17-CA-1972, in the Circuit Court for the Second Judicial Circuit of Florida.
[8] Letter from Christian Bax to Chair Dana Young, (September 29, 2017) (on file with the Senate Committee on Health Policy).
[9] Section 381.986(4)(c), F.S., restricts a qualified physician from certifying a patient for more than three 70-day supplies of marijuana and 381.986(8)(e)13.b., F.S., restricts an MMTC from dispensing more than a 70-day supply to a qualified patient or caregiver. The effects of these provisions require that the patient or caregiver must return to an MMTC for a refill at least every 70 days and return to the physician for recertification at a minimum every 210 days.
[10] 185 F.R.D. 82 (D.D.C. 1999).
[11] 856 F. Supp. 2d 1 (D.D.C. 2011).

The effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 1134 may have an indeterminate positive fiscal impact on an applicant for licensure as an MMTC that is a recognized class member of Pigford v. Glickman or In Re Black Farmers Litig., but that is not a member of the BFAA-FC if the applicant is chosen to receive a license to operate as an MMTC.

The bill may have an indeterminate negative fiscal impact on an applicant for licensure as an MMTC that is a recognized class member of Pigford v. Glickman or In Re Black Farmers Litig., and that is a member of the BFAA-FC if such applicant would have been chosen to receive the Recognized Class Member License to operate as an MMTC under current law but is not chosen to receive such license due to changes made by the bill.

The bill may have an indeterminate negative fiscal impact on Recognized Class Member License applicants that have not been registered businesses in Florida for the past five consecutive years and that, consequently, no longer qualify as an MMTC applicant due to changes made by the bill.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 381.986 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on January 16, 2018:
The CS:

- Requires the DOH to adopt rules that allow qualified patients to change qualified physicians while remaining registered with the Medical Marijuana Use Registry. The process may not allow a qualified patient to exceed statutory limits on the supply of marijuana.
- Requires all applicants for the Recognized Class Member License to be registered to do business in Florida for five consecutive years before applying for the license.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
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The Committee on Health Policy (Young) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 15 and 16
insert:

(4) PHYSICIAN CERTIFICATION.—

(h) The department, the Board of Medicine, and the Board of Osteopathic Medicine may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection. Rules adopted pursuant to this subsection must include a process by which a patient may change qualified physicians while retaining an active

606862

registration on the medical marijuana use registry. This process must include safeguards to ensure that any new physician certification issued to the patient after changing physicians does not combine with any existing patient certification to allow the patient to possess more than the 70-day supply limits.

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:

Delete lines 13 - 14

and insert:

Section 1. Paragraph (h) of subsection (4) and paragraph (a) of subsection (8) of section 381.986, Florida Statutes, are amended to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete lines 1 - 2

and insert:

An act relating to Department of Health responsibilities related to medical marijuana; amending s. 381.986, F.S.; requiring the Department of Health to adopt rules to allow qualified patients to change qualified physicians; deleting an

459848

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
01/16/2018	.	
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The Committee on Health Policy (Rouson) recommended the following:

Senate Amendment

Delete line 62
and insert:
requirement of subparagraph (b)2 ~~requirements of subparagraphs (b)1. and 2~~.

By Senator Rouson

19-01232-18 20181134__

A bill to be entitled

An act relating to medical marijuana treatment center licensure; amending s. 381.986, F.S.; deleting an obsolete date; revising a requirement that the Department of Health license one applicant who is a member of a certain class to exclude a requirement that the applicant also be a member of the Black Farmers and Agriculturalist Association-Florida Chapter; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (8) of section 381.986, Florida Statutes, is amended to read:

381.986 Medical use of marijuana.—

(8) MEDICAL MARIJUANA TREATMENT CENTERS.—

(a) The department shall license medical marijuana treatment centers to ensure reasonable statewide accessibility and availability as necessary for qualified patients registered in the medical marijuana use registry and who are issued a physician certification under this section.

1. As soon as practicable, but no later than July 3, 2017, the department shall license as a medical marijuana treatment center any entity that holds an active, unrestricted license to cultivate, process, transport, and dispense low-THC cannabis, medical cannabis, and cannabis delivery devices, under former s. 381.986, Florida Statutes 2016, before July 1, 2017, and which meets the requirements of this section. In addition to the authority granted under this section, these entities are

authorized to dispense low-THC cannabis, medical cannabis, and cannabis delivery devices ordered pursuant to former s. 381.986, Florida Statutes 2016, which were entered into the compassionate use registry before July 1, 2017, and are authorized to begin dispensing marijuana under this section on July 3, 2017. The department may grant variances from the representations made in such an entity's original application for approval under former s. 381.986, Florida Statutes 2014, pursuant to paragraph (e).

2. The department shall license as medical marijuana treatment centers 10 applicants that meet the requirements of this section, under the following parameters:

a. As soon as practicable, but no later than August 1, 2017, the department shall license any applicant whose application was reviewed, evaluated, and scored by the department and which was denied a dispensing organization license by the department under former s. 381.986, Florida Statutes 2014; which had one or more administrative or judicial challenges pending as of January 1, 2017, or had a final ranking within one point of the highest final ranking in its region under former s. 381.986, Florida Statutes 2014; which meets the requirements of this section; and which provides documentation to the department that it has the existing infrastructure and technical and technological ability to begin cultivating marijuana within 30 days after registration as a medical marijuana treatment center.

b. As soon as practicable, ~~but no later than October 3, 2017,~~ the department shall license one applicant that is a recognized class member of *Pigford v. Glickman*, 185 F.R.D. 82 (D.D.C. 1999), or *In Re Black Farmers Litig.*, 856 F. Supp. 2d 1

(D.D.C. 2011) ~~and is a member of the Black Farmers and Agriculturalists Association-Florida Chapter~~. An applicant licensed under this sub-subparagraph is exempt from the requirements of subparagraphs (b)1. and 2.

c. As soon as practicable, but no later than October 3, 2017, the department shall license applicants that meet the requirements of this section in sufficient numbers to result in 10 total licenses issued under this subparagraph, while accounting for the number of licenses issued under sub-subparagraphs a. and b.

3. For up to two of the licenses issued under subparagraph 2., the department shall give preference to applicants that demonstrate in their applications that they own one or more facilities that are, or were, used for the canning, concentrating, or otherwise processing of citrus fruit or citrus molasses and will use or convert the facility or facilities for the processing of marijuana.

4. Within 6 months after the registration of 100,000 active qualified patients in the medical marijuana use registry, the department shall license four additional medical marijuana treatment centers that meet the requirements of this section. Thereafter, the department shall license four medical marijuana treatment centers within 6 months after the registration of each additional 100,000 active qualified patients in the medical marijuana use registry that meet the requirements of this section.

5. Dispensing facilities are subject to the following requirements:

a. A medical marijuana treatment center may not establish

or operate more than a statewide maximum of 25 dispensing facilities, unless the medical marijuana use registry reaches a total of 100,000 active registered qualified patients. When the medical marijuana use registry reaches 100,000 active registered qualified patients, and then upon each further instance of the total active registered qualified patients increasing by 100,000, the statewide maximum number of dispensing facilities that each licensed medical marijuana treatment center may establish and operate increases by five.

b. A medical marijuana treatment center may not establish more than the maximum number of dispensing facilities allowed in each of the Northwest, Northeast, Central, Southwest, and Southeast Regions. The department shall determine a medical marijuana treatment center's maximum number of dispensing facilities allowed in each region by calculating the percentage of the total statewide population contained within that region and multiplying that percentage by the medical marijuana treatment center's statewide maximum number of dispensing facilities established under sub-subparagraph a., rounded to the nearest whole number. The department shall ensure that such rounding does not cause a medical marijuana treatment center's total number of statewide dispensing facilities to exceed its statewide maximum. The department shall initially calculate the maximum number of dispensing facilities allowed in each region for each medical marijuana treatment center using county population estimates from the Florida Estimates of Population 2016, as published by the Office of Economic and Demographic Research, and shall perform recalculations following the official release of county population data resulting from each

United States Decennial Census. For the purposes of this subparagraph:

(I) The Northwest Region consists of Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, and Washington Counties.

(II) The Northeast Region consists of Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Marion, Nassau, Putnam, St. Johns, Suwannee, and Union Counties.

(III) The Central Region consists of Brevard, Citrus, Hardee, Hernando, Indian River, Lake, Orange, Osceola, Pasco, Pinellas, Polk, Seminole, St. Lucie, Sumter, and Volusia Counties.

(IV) The Southwest Region consists of Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, Hillsborough, Lee, Manatee, Okeechobee, and Sarasota Counties.

(V) The Southeast Region consists of Broward, Miami-Dade, Martin, Monroe, and Palm Beach Counties.

c. If a medical marijuana treatment center establishes a number of dispensing facilities within a region that is less than the number allowed for that region under sub-subparagraph b., the medical marijuana treatment center may sell one or more of its unused dispensing facility slots to other licensed medical marijuana treatment centers. For each dispensing facility slot that a medical marijuana treatment center sells, that medical marijuana treatment center’s statewide maximum number of dispensing facilities, as determined under sub-subparagraph a., is reduced by one. The statewide maximum number

of dispensing facilities for a medical marijuana treatment center that purchases an unused dispensing facility slot is increased by one per slot purchased. Additionally, the sale of a dispensing facility slot shall reduce the seller's regional maximum and increase the purchaser's regional maximum number of dispensing facilities, as determined in sub-subparagraph b., by one for that region. For any slot purchased under this sub-subparagraph, the regional restriction applied to that slot's location under sub-subparagraph b. before the purchase shall remain in effect following the purchase. A medical marijuana treatment center that sells or purchases a dispensing facility slot must notify the department within 3 days of sale.

d. This subparagraph shall expire on April 1, 2020.

If this subparagraph or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this subparagraph are severable.

Section 2. This act shall take effect July 1, 2018.

The Florida Senate

Committee Agenda Request

To: Senator Dana Young, Chair
Health Policy

Subject: Committee Agenda Request

Date: November 9, 2017

I respectfully request that **Senate Bill # 1134**, relating to Medical Marijuana Treatment Center Licensure, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Darryl S Rouson

Senator Darryl Rouson
Florida Senate, District 19

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/16/18
Meeting Date

1134
Bill Number (if applicable)

606862
Amendment Barcode (if applicable)

by Chair Young

Topic Medical Cannabis

Name Ron Watson

Job Title Lobbyist

Address 3738 Mardon Way
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Cannabis Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/16/2017
Meeting Date

SB 1134
Bill Number (if applicable)

606862
Amendment Barcode (if applicable)

Topic MEDICAL CANNABIS LICENSING

Name GARY STEIN

Job Title POLITICAL DIRECTOR

Address 7035 BOCA LINDA LOOP
Street

WESLEY CHAPEL, FL 33545
City *State* *Zip*

Phone (513) 305-8280

Email GSTEINMAN@ME.COM

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing CENTRAL FLORIDA NORML

Appearing at request of Chair: [ ] Yes [✓] No

Lobbyist registered with Legislature: [ ] Yes [✓] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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1/16/2017
Meeting Date

SB 1134
Bill Number (if applicable)

Topic MEDICAL CANNABIS PHYSICIAN SWITCHING

Amendment Barcode (if applicable)

Name GARY STEIN

Job Title POLITICAL DOCTOR

Address 7035 BELT LINE LOOP
Street

Phone (561) 305-8280

WESTON FL 33195
City *State* *Zip*

Email GSTEINMPN@ME.COM

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing CENTRAL FL. NORML

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

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Topic Medical Cannabis

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

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Street

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City *State* *Zip*

Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing AH/Med Florida

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

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