The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Wednesday, January 23, 2013
TIME: 4:00 —6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Brandes, Braynon, Flores, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 56** Hays (Similar H 83)	Infant Death; Revising legislative findings and intent with respect to the sudden unexpected death of an infant under a specified age; defining the term "sudden unexpected infant death"; revising provisions relating to training requirements for first responders; revising requirements relating to autopsies performed by medical examiners; requiring the Medical Examiners Commission to provide for the development and implementation of a protocol for the medicolegal investigation of sudden unexpected infant deaths; deleting references to the SIDS hotline and local SIDS alliances, etc. HP 01/23/2013 Favorable CF	Favorable Yeas 8 Nays 0
	Consideration of proposed committee bill:		
2	**SPB 7004**	OGSR/Joshua Abbott Organ and Tissue Registry/Donor Information; Amending a provision which provides an exemption from public records requirements for personal identifying information of a donor held in the Joshua Abbott Organ and Tissue Registry; saving the exemption from repeal under the Open Government Sunset Review Act; removing the scheduled repeal of the exemption, etc.	Submitted as Committee Bill
3	Presentation on the implementation status of Statewide Medicaid Managed Care by Justin Senior, Deputy Secretary, Division of Medicaid, Agency for Health Care Administration		Presented
4	Presentation on the Prescription Drug Monitoring Program by Lucy Gee, M.S., Director, Division of Medical Quality Assurance, Department of Health		Presented
	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: SB 56

INTRODUCER: Senator Hays

SUBJECT: Infant Death

DATE: January 21, 2013 REVISED: 1/23/13

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Favorable**
2.			CF	
3.				
4.				
5.				
6.				

I. Summary:

This bill replaces the concept of Sudden Infant Death Syndrome (SIDS) with Sudden Unexplained Infant Death (SUID). Accordingly, requirements for training first responders and protocols for medical examiners are revised to reflect this change in emphasis. The changes reflect the current practices of medical examiners and coroners in the identification of the SUID classification for infant deaths.

References to the SIDS hotline and local SIDS alliances are deleted.

This bill substantially amends Section 383.3362, Florida Statutes.

II. Present Situation:

Sudden Infant Death Syndrome (SIDS)

Subsection 383.3362(2), F.S., defines SIDS as the "sudden unexpected death of an infant under 1 year of age which remains unexplained after a complete autopsy, death-scene investigation, and review of case history. The term includes only those deaths for which, currently, there is no known cause or cure."

Subsection 383.3362(3), F.S., acknowledges that first responders such as emergency medical technicians, paramedics, firefighters and law enforcement officers, should be trained in how to respond to sudden infant death as the likely first responders to a request for assistance. Basic training programs for certification for certain first responders include instruction on SIDS. The Department of Health (DOH) is responsible for the training curriculum in consultation with the

Emergency Medical Services Advisory Council, the Firefighters Employment Standards, and Training Council and the Criminal Justice Standards and Training Commission. This curriculum is adopted by rule[1].

A medical examiner is required to perform an autopsy on any infant under age 1 who is suspected to have died of Sudden Infant Death Syndrome.[2] Furthermore, the autopsy must be performed within 24 hours after the death or as soon thereafter as is feasible. If the medical examiner's findings are consistent with SIDS, this condition must be listed as the cause of death on the death certificate.

The Medical Examiners Commission is required to develop a protocol for dealing with suspected SIDS.[3] The law requires that all medical examiners follow the protocol and provides the contents and requirements for the protocol.

A medical examiner is not liable for damages done in compliance with s. 383.3362, F.S.

The DOH is responsible for:

- Developing and presenting SIDS training programs for first responders;
- Maintaining a database of statistics on reported SIDS deaths;
- Serving as a liaison and coordinating activities with the Florida SIDS Alliance, including the SIDS hotline;
- Maintaining a library reference list and materials for public disseminations about SIDS;
- Providing professional support to field staff; and,
- Coordinating the activities of and promoting a link between the fetal and infant mortality review committees of the local healthy start coalitions, the local SIDS alliance and other related support groups.

Infant Death Statistics

The DOH reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.[4] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race and compares that data to national figures. Additionally, specific information on infant mortality rates, including data on SIDS and SUID deaths by county, is compiled by the DOH and available on-line at FloridaCHARTS.com.[5]

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[1] *See* Department of Health Rule 64F-5.002, Florida Administrative Code. Found at: https://www.flrules.org/gateway/ruleNo.asp?id=64F-5.002, (last visited Jan. 21, 2013).
[2] *See* s. 383.3362(4), F.S.
[3] *Id. But see* Florida Administrative Code Rule 11G-2.0031at: https://www.flrules.org/gateway/ruleNo.asp?id=11G-2.0031, (last visited Jan. 21, 2013). Administrative rule repealed effective 5-21-2012 and SIDS autopsy protocol moved to Practice Guidelines.
[4] *See* Florida Vital Statistics Annual Report 2011, http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx, (last visited Jan. 21, 2013).
[5] *See* Florida Department of Health, Division of Public Health Statistics & Performance Management, Infant Death Indicators. http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer.aspx?indNumber=0053, (last visited Jan. 21, 2013).

Over the last three years, (2009-2011), 2,839 resident neonatal deaths in Florida were recorded. A neonatal death is defined as an infant death occurring with the first 27 days of birth. The overall number of resident neonatal infant deaths for 2011 was 915 which reflect a reduction from the prior year of 14.[6] The resident neonatal death rate per 1,000 live births for 2011 translates to 4.3 for all births in the state.

The resident infant (less than one year old) death rate for the same rolling three year period (2009-2011) in Florida was 4,297. The overall number of resident infant deaths for the most recent single year, 2011, was 1,372 which was a reduction from the prior year of 28. Florida's rate of all infant death's for 2001 was 6.4 per 1,000 live births.[7]

Infant Mortality Rates – All Causes		
Time Period	**Resident Neo-Natal Deaths** (Within First 27 Days)	**Resident Infant Deaths** (Within First Year)
2010	929	1,400
2011	915	1,372

Infant deaths are also reported by specific categories by year and in the same rolling 3 year periods for many categories in FloridaCHARTS.com. For the period of 2009- 2011, there were 179 SIDS reported deaths in Florida. These deaths were defined as occurring during the infant's first year of life. [8] In 2011, there were 46 reported SIDS deaths in the neonatal period with 4 occurring in the first 27 days of life and the remainder after day 28.[9]

Infant Mortality Rates – from SIDS			
Time Period	**Total Infant Deaths**	**Resident Neo-Natal Deaths** (Within First 27 Days)	**Resident Infant Deaths** (Within First Year)
2010	63	6	57
2011	46	4	42

Role of Medical Examiners

Medical Examiners are required to perform an autopsy in accordance with the authority granted under Section 406.11, F.S. Part I of Chapter 406 specifically governs the medical examiners who are practicing physicians in pathology appointed by the Governor in each medical examiner district of the state.

Section 406.02, F.S., creates the Medical Examiner Commission within the Florida Department of Law Enforcement. The Commission is comprised of nine appointed persons who are charged with adopting rules to implement Chapter 406 that ensure minimum and uniform standards of excellence, performance of duties, and maintenance of records so as to provide useful and adequate information to the state in death investigations.

[6] *Id.*
[7] *Id.*
[8] *Supra, n. 5.*
[9] *Id.*

Section 406.11, F.S., mandates the circumstances under which a medical examiner shall determine the cause of death and shall perform an examination, investigation and autopsy. Those instances include when any person dies in the state:

- Of criminal violence.
- By accident.
- By suicide.
- *Suddenly, when in apparent good health. (emphasis added)*
- Unattended by a practicing physician or other recognized practitioner.
- In any prison or penal institution.
- In police custody.
- In any suspicious or unusual circumstances.
- By criminal abortion.
- By poison.
- By disease constituting a threat to public health.
- By disease, injury, or toxic agent result from employment.

Sudden Unexpected Infant Death (SUID) Initiative

The Centers for Disease Control and Prevention (CDC) defines SIDS as the sudden death of an infant less than 1 year of age that cannot be explained *after* a thorough investigation is conducted, including a completed autopsy, examination of the death scene, and review of the clinical history.[10] Beginning in 1998, records showed that medical examiners and coroners began to move away from classifying infant deaths as SIDS and identifying more deaths as accidental suffocations or unknown cause. This movement suggested that the medical examiners and coroners had adopted different reporting and diagnostic procedures. As a result of these changes, the CDC began the Sudden Unexpected Infant Death (SUID) Initiative in order to improve investigation and reporting practices for SIDS and other SUID.[11]

In contrast to SIDS, SUID is defined as deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death is not immediately obvious *prior* to investigation. According to the CDC, more than 4,500 infants die each year suddenly of no immediately obvious cause. Half of these SUIDs are due to SIDS.

The SUID Initiative's goals include the standardization and improvement of data collection at the death scene, promotion of the consistent classification and reporting of the cause of death, improving the national reporting of SUID and reducing SUID by using improved data to identify those at risk. To accomplish these goals, the collaborative has revised reporting forms, developed training materials, trained medicolegal professional and child advocates on how to complete

[10] Centers for Disease Control and Prevention, *Sudden Infant Death Syndrome*, http://www.cdc.gov/sids/index.htm, (last visited Dec. 19, 2012).
[11] Centers for Disease Control and Prevention, *CDC's Sudden Unexpected Infant Death Initiative,* http://www.cdc.gov/sids/suidabout.htm, (last visited Jan. 21, 2013).

death investigations and implemented a state-based SUID case registry in initially 5 pilot states and later expanded through grants to cover 10 states.[12]

According to the CDC, SIDS is one of several causes of SUID, however, SIDS, unlike SUID causes, is a diagnosis of exclusion. SIDS is a diagnosis that should be given only after all other possible causes of sudden, unexplained death have been ruled out through a careful case investigation, which includes a thorough examination of the death scene, a complete autopsy, and a review of the infant's medical history. The most common causes of SUID are: SIDS, suffocation, metabolic errors, injury or trauma and unclassified causes (if the death scene investigation and/or autopsy were incomplete or not done and the death certifier has insufficient evidence to record a more specific cause of death).[13]

Healthy Start Programs

Florida's Healthy Start initiative was signed into law on June 4, 1991. The Healthy Start law provides for universal risk screening of all of Florida's pregnant women and newborn infants to identify those at risk of poor birth, health and development outcomes. The Florida Department of Health administers the program and services are provided through local coalitions.[14]

The state's 33 Healthy Start Coalitions are non-profit organizations that provide services statewide to pregnant women and their babies up to age 3. By providing these services, the Coalitions seek to reduce infant mortality, reduce the number of low birth weight babies, and improve health and developmental outcomes.[15] The program identifies women and infants at an increased risk for poor outcomes, provides a professional assessment of their needs, and identifies resources to address those needs. The program provides timely and important linkages, referrals, or services.

Fetal and Infant Mortality Review

Fetal and Infant Mortality Review (FIMR) began nationally in 1990 as a collaborative process between health departments, providers and maternal and child health coalitions to address factors that impact fetal and infant mortality and to develop strategies to address those factors.

FIMR projects were adopted in Florida in 1992 and currently 29 counties participate in this project.[16] A Local Infant Mortality Committee of the Healthy Start Coalition provides an analysis of the basic statistical and epidemiological aspects of the fetal and infant mortality, and then selects objectives, plans, and manages the review process.

[12] Centers for Disease Control and Prevention, *Sudden Unexpected Infant Death Case Registry*, *http://www.cdc.gov/sids/suidabout.htm*, (last visited Jan. 21, 2013).
[13] Carrie Shapiro-Mendoza, Ph.D., M.P.H., CDC, *Sudden, Unexplained Death Investigation, Chapter 1, Types of Sudden, Unexplained Infant Death*, http://www.cdc.gov/sids/PDF/SUIDManual/Chapter1_tag508.pdf , (last visited Jan. 21, 2013).
[14] *See* ss. 383.011(1)(e) and 383.216, F.S.
[15] Florida Department of Health, *Healthy Start Annual Report 2011*, http://www.doh.state.fl.us/family/mch/hs/HealthyStartReport2011.pdf, (last visited: Jan. 21, 2013)
[16] Florida Department of Health. *FIMR*, http://www.doh.state.fl.us/family/mch/FIMR/fimr_facts.html, (last visited Jan. 21, 2013).

Florida SIDS Alliance

Concerned SIDS parents and professional formed the Florida SIDS Alliance in 1985. The Florida SIDS Alliance operates a hotline (1-800-SIDS-FLA) and a website. Their mission is to provide a reliable and continuous source of assistance to parents who have lost a child suddenly and unexpectedly, provide information and referral networking, sponsor educational campaigns, and promote and support research into the cause and possible prevention of SIDS through fundraising and public education.[17]

III. Effect of Proposed Changes:

The bill modifies the provisions of s. 383.3362, F.S., relating to "sudden infant death syndrome" (SIDS) and replaces those references with the term and corresponding activities for "sudden unexpected infant death" (SUID). SIDS and SUID are two distinct classifications. The SUID classification occurs prior to an investigation of an infant death and includes numerous common causes, while SIDS is designated only after a full investigation (SIDS). SIDS is still a classification utilized in state reporting.

Legislative findings and intent are amended to reflect current infant death mortality rates and the revised terminology. The bill recognizes that first responders need special training to better recognize that infant deaths may be caused by natural or accidental causes as well as by criminal acts and to act appropriately with the deceased infant's parents or caretakers. The bill also recognizes the importance of multi-disciplinary investigations and the need for standardized investigative protocols in the cases of sudden unexpected infant deaths. Language concerning a standard protocol for the review of SIDS deaths by medical examiners and the importance of follow-up in such deaths is deleted.

The bill further modifies legislative intent by replacing references to SIDS with SUID in order to expand analysis and research on possible causes of sudden unexpected infant death and on how to reduce its incidence.

SUID is defined as the sudden unexpected death of an infant under 1 year of age while in apparent good health whose death may have been a result of natural or unnatural causes, replacing the definition of SIDS. The SUID definition matches the definition utilized by the Centers for Disease Control and Prevention.

The bill changes the basic training program for emergency medical technicians, paramedics, firefighters, and certain law enforcement officers to address SUID rather than SIDS and deletes an obsolete date.

The bill requires the DOH, in consultation with the Emergency Medical Services Advisory Council; the Firefighters Employment, Standards, and Training Council; and the Criminal Justice Standard and Training Commission to develop and adopt, by rule, curriculum that includes training on SUID, instead of SIDS.

[17] Florida SIDS Alliance, *About Us*, http://flasids.com/blog/florida-sids-alliance/ (last visited Jan. 21, 2013).

The bill provides for an autopsy for the death of any infant younger than 1 year of age who dies suddenly and unexpectedly while in apparent good health to the medical examiner under s. 406.11, F.S. To conform to the responsibility for the regulation of medical examiners under ch. 406, F.S., a medical examiner is no longer required under this section of law to: perform an autopsy, within 24 hours, on any infant that the medical examiner suspected to have died of SIDS, state on the death certificate that SIDS was the cause of death, or follow the SIDS protocol when conducting autopsies. The bill deletes a redundant statutory cross reference to the authority of the medical examiner.

The bill directs the Medical Examiners Commission to develop and implement a protocol for the medicolegal investigation of SUID and deletes a reference to a protocol for SIDS.

The bill amends the duties of the DOH to replace SIDS references to SUID in the training programs of the department, the database of statistics, and the library of reference materials.

The bill deletes the DOH's liaison responsibility with the Florida SIDS Alliance with regard specifically to the SIDS hotline. The bill also deletes the DOH's responsibilities to coordinate activities with the local SIDS alliance and the promotion of their link with other groups including the fetal and infant mortality review committee of the local healthy start coalitions. Coordination with other related support groups remains a function under this provision.

The effective date of the bill is July 1, 2013.

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:

The Department of Health is no longer required to specifically include the local SIDS alliances in certain coordination and promotion activities. This may result in reduced participation by the community-based alliances.

C. Government Sector Impact:

Rules, training curriculum and guidelines will need to be amended to reflect the changes in terminology and standards from SIDS to SUID. The Department of Health reports no fiscal impact to implement the modifications included in this bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

By Senator Hays

11-00035A-13 201356__

A bill to be entitled

An act relating to infant death; amending s. 383.3362, F.S.; revising legislative findings and intent with respect to the sudden unexpected death of an infant under a specified age; defining the term "sudden unexpected infant death"; revising provisions relating to training requirements for first responders; revising requirements relating to autopsies performed by medical examiners; requiring the Medical Examiners Commission to provide for the development and implementation of a protocol for the medicolegal investigation of sudden unexpected infant deaths; deleting references to the SIDS hotline and local SIDS alliances; providing an effective date.

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

Section 1. Section 383.3362, Florida Statutes, is amended to read:

383.3362 Sudden unexpected infant death ~~Syndrome~~.—

(1) FINDINGS AND INTENT.—The Legislature recognizes that more than 4,500 infants in the United States die suddenly and unexpectedly of no immediate or obvious cause. According to statistics from the Department of Health, more than 200 infants in this state experienced sudden unexpected infant death in 2010 ~~sudden Infant death Syndrome, or SIDS, is a leading cause of death among children under the age of 1 year, both nationally and in this state~~. The Legislature further recognizes that first responders to emergency calls relating to such a death need

11-00035A-13 201356__

access to special training to better enable them to recognize that such deaths may result from natural and accidental causes or may be caused ~~distinguish SIDS from death caused~~ by criminal acts and to appropriately interact with the deceased infant's parents or caretakers. At the same time, the Legislature, recognizing that the primary focus of first responders is to carry out their assigned duties, intends to increase ~~the~~ awareness of the possible causes of sudden unexpected infant deaths ~~SIDS by first responders~~, but in no way expand or take away from their duties. Further, the Legislature recognizes the importance of a multidisciplinary investigation and standardized investigative protocols in cases of sudden unexpected infant ~~standard protocol for review of SIDS deaths by medical examiners and the importance of appropriate followup in cases of certified or suspected SIDS~~ deaths. Finally, the Legislature finds that it is desirable to analyze existing data~~,~~ and ~~to~~ conduct further research on~~,~~ the possible causes of sudden unexpected infant death ~~SIDS~~ and on how to reduce its incidence ~~lower the number of sudden infant deaths~~.

(2) DEFINITION.—As used in this section, the term "sudden unexpected infant death ~~Syndrome~~," or "SUID," ~~"SIDS,"~~ means the sudden unexpected death of an infant under 1 year of age while in apparent good health whose death may have been a result of natural or unnatural causes ~~which remains unexplained after a complete autopsy, death scene investigation, and review of the case history~~. ~~The term includes only those deaths for which, currently, there is no known cause or cure.~~

(3) TRAINING.—

(a) The Legislature finds that an emergency medical

technician, a paramedic, a firefighter, or a law enforcement officer is likely to be the first responder to a request for assistance which is made immediately after the sudden unexpected death of an infant. The Legislature further finds that these first responders should be trained in appropriate responses to sudden infant death.

(b) ~~After January 1, 1995,~~ The basic training programs required for certification as an emergency medical technician, a paramedic, a firefighter, or a law enforcement officer as defined in s. 943.10, other than a correctional officer or a correctional probation officer, must include curriculum that contains instruction on SUID ~~Sudden Infant Death Syndrome~~.

(c) The Department of Health, in consultation with the Emergency Medical Services Advisory Council, the Firefighters Employment, Standards, and Training Council, and the Criminal Justice Standards and Training Commission, shall develop and adopt, by rule, curriculum that, at a minimum, includes training in the nature of SUID ~~SIDS~~, standard procedures to be followed by law enforcement agencies in investigating cases involving sudden deaths of infants, and training in responding appropriately to the parents or caretakers who have requested assistance.

(4) AUTOPSIES.—

(a) The death of any infant younger than 1 year of age who dies suddenly and unexpectedly while in apparent good health falls under the jurisdiction of the medical examiner as provided in s. 406.11. ~~The medical examiner must perform an autopsy upon any infant under the age of 1 year who is suspected to have died of Sudden Infant Death Syndrome. The autopsy must be performed~~

~~within 24 hours after the death, or as soon thereafter as is feasible. When the medical examiner's findings are consistent with the definition of sudden infant death syndrome in subsection (2), the medical examiner must state on the death certificate that sudden infant death syndrome was the cause of death.~~

(b) The Medical Examiners Commission shall provide for the development and implementation of ~~develop and implement~~ a protocol for the medicolegal investigation of SUID ~~dealing with suspected sudden infant death syndrome~~. ~~The protocol must be followed by all medical examiners when conducting the autopsies required under this subsection.~~ The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for any specific tissue sampling, and any other requirements that are deemed ~~ascertaining cause of death based on the autopsy, criteria for any specific tissue sampling, and any other requirements that the commission considers~~ necessary.

(c) A medical examiner is not liable for damages in a civil action for any act or omission done in compliance with this subsection.

~~(d) An autopsy must be performed under the authority of a medical examiner under s. 406.11.~~

(5) DEPARTMENT DUTIES RELATING TO SUDDEN UNEXPECTED INFANT DEATH (SUID) ~~SYNDROME (SIDS)~~.—The Department of Health shall:

(a) Collaborate with other agencies in the development and presentation of the SUID ~~Sudden Infant Death Syndrome (SIDS)~~ training programs for first responders, including those for emergency medical technicians and paramedics, firefighters, and

law enforcement officers.

(b) Maintain a database of statistics on reported SUID ~~SIDS~~ deaths~~,~~ and analyze the data as funds allow.

(c) Serve as liaison and closely coordinate activities with the Florida SIDS Alliance~~, including the services related to the SIDS hotline~~.

(d) Maintain a library reference list and materials about SUID ~~SIDS~~ for public dissemination.

(e) Provide professional support to field staff.

(f) Coordinate the activities of and promote a link between the fetal and infant mortality review committees of the local healthy start coalitions~~, the local SIDS alliance,~~ and other related support groups.

Section 2. This act shall take effect July 1, 2013.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1/23/13
Meeting Date

Topic SUID

Bill Number SB56 *(if applicable)*

Name SAM BELL

Amendment Barcode *(if applicable)*

Job Title

Address 1298 MILLSTREAM ROAD *Street*

Phone 850-222-3533

TALLAHASSEE, FL 32312 *City State Zip*

E-mail sbell@penningtonlaw.com

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Pediatric Society

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 (10/20/11)

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: SPB 7004

INTRODUCER: For consideration by Health Policy Committee

SUBJECT: OGSR/Joshua Abbott Organ and Tissue Registry/Donor Information

DATE: January 16, 2013 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall		**Submitted as Committee Bill**
2.				
3.				
4.				
5.				
6.				

I. Summary:

This proposed committee bill reenacts the public records exemption for personal identifying information held in the Joshua Abbott Organ and Tissue Donor Registry. This exemption will sunset on October 2, 2013, unless saved from repeal by reenactment by the Legislature. This proposed committee bill is the result of a review under the Open Government Sunset Review Act.

This proposed committee bill amends section 765.51551 of the Florida Statutes.

II. Present Situation:

Public Records

The State of Florida has a long history of providing public access to governmental records. The Florida Legislature enacted the first public records law in 1892.[1] One hundred years later, Floridians adopted an amendment to the State Constitution that raised the statutory right of access to public records to a constitutional level.[2] Article I, s. 24 of the State Constitution, provides that:

> Every person has the right to inspect or copy any public record made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

In addition to the State Constitution, the Public Records Act,[3] which pre-dates the current State Constitution, specifies conditions under which public access must be provided to records of the executive branch and other agencies. Section 119.07(1)(a), F.S., states:

> Every person who has custody of a public record shall permit the record to be inspected and copied by any person desiring to do so, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public records.

Unless specifically exempted, all agency[4] records are available for public inspection. The term "public record" is broadly defined 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.[5]

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business, which are used to perpetuate, communicate, or formalize knowledge.[6] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[7]

Only the Legislature is authorized to create exemptions to open government requirements.[8] An exemption must be created in general law, must state the public necessity justifying it, and must not be broader than necessary to meet that public necessity.[9] A bill enacting an exemption[10] may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[11]

[1] Section 1390, 1391 Florida Statutes. (Rev. 1892).
[2] Article I, s. 24 of the State Constitution.

[3] Chapter 119, F.S.
[4] The word "agency" is defined in s. 119.011(2), F.S., to mean ". . . 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."
[5] Section 119.011(12), F.S.
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Associates, Inc.*, 379 So.2d 633, 640 (Fla. 1980).
[7] *Wait v. Florida Power & Light Company*, 372 So.2d 420 (Fla. 1979).
[8] Article I, s. 24(c) of the State Constitution.
[9] *Memorial Hospital-West Volusia v. News-Journal Corporation*, 729 So. 2d 373, 380 (Fla. 1999); *Halifax Hospital Medical Center v. News-Journal Corporation*, 724 So.2d 567 (Fla. 1999).
[10] Under s. 119.15, F.S., an existing exemption may be considered a new exemption if the exemption is expanded to cover additional records.
[11] Article I, s. 24(c) of the State Constitution.

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency to anyone other than to the persons or entities designated in the statute.[12] If a record is simply made exempt from disclosure requirements, an agency is not prohibited from disclosing the record in all circumstances.[13]

Open Government Sunset Review Act

The Open Government Sunset Review Act (the Act)[14] provides for the systematic review, through a 5-year cycle ending October 2 of the 5th year following enactment, of an exemption from the Public Records Act or the Sunshine Law. Each year, by June 1, the Division of Statutory Revision of the Office of Legislative Services is required to certify to the President of the Senate and the Speaker of the House of Representatives the language and statutory citation of each exemption scheduled for repeal the following year.

The Act states that an exemption may be created, revised, or maintained only if it serves an identifiable public purpose and if the exemption is no broader than is necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. The three statutory criteria are that the exemption:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;
- Protects information of a sensitive personal nature concerning individuals, the release of which would be defamatory or cause unwarranted damage to the good name or reputation of such individuals, or would jeopardize their safety; or
- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information that is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[15]

The Act also requires the Legislature to consider the following:

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?

[12] Attorney General Opinion 85-62.
[13] *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d 289 (Fla. 1991).
[14] Section 119.15, F.S.
[15] Section 119.15(6)(b), F.S.

- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

While the standards in the Act may appear to limit the Legislature in the exemption review process, those aspects of the Act that are only statutory, as opposed to constitutional, do not limit the Legislature because one session of the Legislature cannot bind another.[16] The Legislature is only limited in its review process by constitutional requirements.

Further, s. 119.15(8), F.S., makes explicit that:

> … notwithstanding s. 778.28 or any other law, neither the state or its political subdivisions nor any other public body shall be made party to any suit in any court or incur any liability for the repeal or revival and reenactment of any exemption under this section. The failure of the Legislature to comply strictly with this section does not invalidate an otherwise valid reenactment.

Organ Donations in Florida

Over 3,500 people in Florida are registered and waiting for organ transplants and thousands more wait for tissue donations.[17] The most common types of organ transplants include the kidneys, liver, heart, lungs and pancreas, but many other organs and tissues can be transplanted or used for various other medical procedures.[18] Nationwide, nearly 6,000 people die each year waiting for an organ donation.[19]

Four major organ and tissue procurement agencies operate in Florida to facilitate the process of organ donation. These agencies are certified by the U.S. Centers for Medicare and Medicaid Services (CMS) and operate in Florida to increase the number of registered donors and coordinate the donation process when organs become available. [20] Each agency serves a different region of the state. [21] In addition to federal certification of organ procurement organizations, the Agency for Healthcare Administration (AHCA) also certifies these organ procurement organizations and other eye and tissue organizations.[22]

[16] *Straughn v. Camp*, 293 So.2d 689, 694 (Fla. 1974).
[17] *FAQs About Donation*, Donate Life Florida, 2009, available at: http://www.donatelifeflorida.org/content/about/facts/faq/#faq_22, (last visited Jan. 16, 2013).
[18] Id.
[19] Id.
[20] Organ Procurement Organizations, Organdonor.gov, available at http://organdonor.gov/materialsresources/materialsopolist.html, (last visited Jan. 16, 2013).
[21] Id.; LifeLink of Florida serves west Florida, LifeQuest Organ Recovery Services serves north Florida, TransLife Organ and Tissue Donation Services serves east Florida, and LifeAlliance Organ Recovery Services serves south Florida.
[22] AHCA's authority for certifying organ, eye, and tissue banks can be found in s. 765.542, F.S., and a list of organ, eye and tissue banks is available on FloridaHealthFinder at www.floridahealthfinder.gov, (last visited on Jan. 16, 2013.)

The Joshua Abbott Organ and Tissue Donor Registry[23] (Donor Registry)

In 2008,[24] Florida's Legislature found a shortage of organ and tissue donors in Florida and there was a need for a statewide donor registry with online donor registration capability and enhanced donor education to increase the number of organ and tissue donors. This online registry would afford more persons who are awaiting organ or tissue transplants the opportunity for a full and productive life.[25] As directed by the legislature, the AHCA and the Department of Highway Safety and Motor Vehicles (DHSMV) jointly contracted for the operation of Florida's interactive web-based donor registry that, through electronic means, allows for online donor registration and the recording of organ and tissue donation records submitted through the driver's license identification program or through other sources. The AHCA and the DHSMV selected Donate Life Florida, which is a coalition of Florida's organ, tissue and eye donor programs, to run the donor registry and maintain donor records.

Floridians who are age 18 or older can join the donor registry either online,[26] at the DHSMV (or their local drivers license office), or by contacting Donate Life Florida for a paper application. Children ages 13 to 17 may join the registry, but the final decision on any organ donation of a minor rests with the parent or guardian. The registry collects personal information from each donor including, but not limited to, their name, address, date and place of birth, race, ethnicity, and driver's license number.

Since 2007, the number of donors registered in the donor registry has increased by over 1,500,000.[27] As of January 16, 2013, there were 6,938,301 people registered in the donor registry.[28] Its large number of registered donors ranks the Joshua Abbott Organ and Tissue Donor Registry as the second largest donor registry in the United States in terms of enrollment. [29]

Organ Donor Registration at the DHSMV

Section 765.521, F.S., which predates the establishment of the donor registry, requires that the AHCA and the DHSMV implement a system to encourage potential donors to make anatomical gifts through the process of issuing and renewing driver's licenses. Though the DHSMV no longer maintains an organ donor database, it still gives out organ donor cards in its offices around the state. The DHSMV will collect those cards if they are returned to their offices, but donors are encouraged to register with the donor registry electronically or to mail their organ donation cards directly to Donate Life Florida. Any donor cards collected by the DHSMV are mailed directly to Donate Life Florida for entry into the donor registry without copies of the

[23] Section 765.5155(5), F.S., designates the donor registry as the Joshua Abbott Organ and Tissue Registry, however it is currently referred to as the Joshua Abbott Organ and Tissue Donor Registry.
[24] Chapter 2008-223, L.O.F.
[25] Section 765.5155(1), F.S.
[26] At https://www.donatelifeflorida.org/ (last visited on Jan. 16, 2013)
[27] There were 5,215,437 registered donors reported in the DHSMV's annual report for 2007-2008, which is available at: http://www.flhsmv.gov/html/AgencyAnnualReport2008.pdf, (last visited Sept. 27, 2012).
[28] http://www.donatelifeflorida.org/content/about/facts/faq/#faq_22, (last visited Jan. 16, 2013).
[29] From Donate Life Florida's annual report to AHCA for 2011. This report is on file with the Senate Health Policy Committee.

information being made. The DHSMV maintains in its driver's license database a flag marking the person as a donor.[30]

Donor Registry Public Records Law Exemption

Section 765.51551, F.S., enacted in 2008,[31] makes all personal identifying information in the donor registry confidential and exempt from s. 119.07(1), F.S., and Article I, s. 24 of the State Constitution.

However, the statute authorizes exempt information to be made available to:

- Organ, tissue and eye procurement organizations that have been certified by the AHCA for purposes of ascertaining or effectuating the existence of a gift; and
- Persons engaged in bona fide research who agree to:
- Submit a research plan to the AHCA that specifies the exact nature of the requested information and the intended use of such information;
- Maintain the confidentiality of the records or information made available;
- Destroy any confidential records or information once the research is concluded; and
- Not directly or indirectly contact, for any purpose, any donor or donee.[32]

In enacting the public records exemption for the donor registry, the Florida Legislature found that it was a public necessity to make confidential and exempt from disclosure all information held in the donor registry which would identify a donor because:

- Making such information publicly available could open up donors in the registry to invasion of their personal privacy;
- The disclosure of such information could hinder the effective and efficient administration of the organ and tissue donor program;
- Opening such information up to the public could reduce donations and the availability of potentially life-saving organs and tissues; and,
- Access to such information could be used to stalk, harass, solicit or intimidate organ and tissue donors.[33]

Section 765.51551, F.S., does not exempt any information which is collected by the DHSMV before it is sent to Donate Life Florida for entry into the donor registry. However, personally identifying information[34] pertaining to a motor vehicle record collected by the DHSMV is protected from disclosure by the federal Driver Privacy Protection Act[35] and other Florida Statutes.[36]

[30] Email memo from Deborah Todd, program manager for Division of Motorist Services at the DHSMV, on file with the Senate Health Regulation Committee.
[31] Chapter 2008-222, L.O.F.
[32] Section 765.51551(2), F.S.
[33] Chapter 2008-222, L.O.F.
[34] Including a driver's social security number, driver's license number, name, address, telephone number, and medical and disability information.
[35] 18 U.S.C. 2721-2725
[36] Section 322.142(4), F.S., protects the driver's photograph; s. 322.126, F.S., protects the driver's medical and disability

Open Government Sunset Review for Section 765.51551, F.S.

Senate professional staff of the Health Policy Committee conducted a review of the public records exemption in s. 765.51551, F.S., as required by the Open Government Sunset Review Act.[37] This review included gathering information on the past and current status of the Joshua Abbott Organ and Tissue Donor Registry and the public records exemption in s. 765.51551, F.S. Senate professional staff distributed a questionnaire to various interested parties, including the AHCA, the DHSMV, Donate Life Florida, and multiple organ and tissue procurement agencies, in order to determine the necessity of maintaining the public records exemption.[38] All organizations responding to the questionnaire supported the reenactment of this public records exemption.

III. Effect of Proposed Changes:

Personal identifying information contained in the Joshua Abbott Organ and Tissue Donor Registry will remain confidential and exempt from the public records laws.

Section 1 amends s. 765.51551, F.S., to remove its scheduled repeal on October 2, 2013, thereby reenacting the exemption for personal identifying information in the Joshua Abbott Organ and Tissue Donor Registry.

Section 2 provides an effective date of October 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

This bill reenacts and amends an existing public records exemption specified in s. 765.51551, F.S. The bill does not expand the scope of the exemption and therefore does not require a two-thirds vote of each house of the Legislature for passage.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

information; and see generally s. 119.0712(2), F.S.
[37] Section 119.15, F.S.
[38] These completed questionnaires are on file with the Senate Health Policy Committee.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

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

None.

B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

588-00423-13 20137004__

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 765.51551, F.S., which provides an exemption from public records requirements for personal identifying information of a donor held in the Joshua Abbott Organ and Tissue Registry; saving the exemption from repeal under the Open Government Sunset Review Act; removing the scheduled repeal of the exemption; providing an effective date.

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

Section 1. Section 765.51551, Florida Statutes, is amended to read:

765.51551 Donor registry; public records exemption.—

(1) Information held in the donor registry which identifies a donor is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2) Such information may be disclosed to the following:

(a) Procurement organizations that have been certified by the agency for the purpose of ascertaining or effectuating the existence of a gift under s. 765.522.

(b) Persons engaged in bona fide research if the person agrees to:

1. Submit a research plan to the agency <u>which</u> ~~that~~ specifies the exact nature of the information requested and the intended use of the information;

2. Maintain the confidentiality of the records or information if personal identifying information is made

588-00423-13 20137004__

available to the researcher;

3. Destroy any confidential records or information obtained after the research is concluded; and

4. Not directly or indirectly contact, for any purpose, any donor or donee.

~~(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, 2013, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 2. This act shall take effect October 1, 2013.

Florida Medicaid: An Overview

Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration

Senate Health Policy
January 23, 2013

Statewide Medicaid Managed Care
(Beginning 2013/2014)

During the 2011 Florida Legislative Session, the House and Senate passed House Bill 7107 and HB 7109, which require the state Medicaid program to implement a Statewide Medicaid Managed Care Program.

- *~ 1915 (b)(c) Waiver*
- *~ 1115 Demonstration Waiver*
- *~ State Plan Amendment*

Statewide Medicaid Managed Care: Legislation and Key Components

- In 2011, the Florida Legislature created a new program: Statewide Medicaid Managed Care (SMMC) Chapter 409, Part IV, Florida Statutes
- The SMMC program has two key program components:
  - Long-term Care Managed Care Program
    - Will begin in the fall of 2013
    - Only provides long-term care services
  - Managed Medical Assistance Program
    - Will begin in mid - 2014
    - Provides all health care services other than long-term care services to eligible recipients

Statewide Medicaid Managed Care (2013/2014): Status of Federal Approval

- **Long-term Care Managed Care Program:**
  - The Agency submitted the 1915b/c application for the Long-term Care Managed Care waiver program on August 1, 2011.
  - The LTC SMMC waiver went “back on the clock” for the final 90 day review period on November 9, 2012.
  - After much negotiation/ conversation/ provision of additional information, we anticipate approval by early February, 2013.

LTC Timelines: Invitation to Negotiate

Long-term Care Managed Care Program: Invitation To Negotiate	
Activity	**Date**
Release of Invitation to Negotiate	June 29, 2012
Deadline for Receipt of Written Inquiries	July 6, 2012
Vendor Conference for Regions 1-11	July 19, 2012
Deadline for receipt of responses	August 28, 2012
Published List of Respondents for Provider Comments	August 31, 2012
Anticipated Dates for Negotiation	November 13, 2012 – January 4, 2013
Posting of Notice of Intent to Award	January 15, 2013

LTC Intent to Award Per Region

Region	Plans
1	American Eldercare, Inc.; Sunshine State Health Plan
2	American Eldercare, Inc.; United Healthcare of Florida, Inc.
3	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc.
4	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc.
5	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc.
6	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Health Plan
7	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Health Plan
8	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc.
9	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Health Plan
10	American Eldercare, Inc.; Sunshine State Health Plan, Amerigroup Florida, Inc.
11	American Eldercare, Inc.; Sunshine State Health Plan, United Healthcare of Florida, Inc., Coventry Health Plan, Amerigroup Florida Inc.

LTC Timelines: Recipient Enrollment Schedule

Region	Counties	Plan Readiness Deadline	Enrollment Effective Date	Total Eligible Population
7	Brevard, Orange, Osceola and Seminole	1-May-13	1-Aug-13	Region 1: 9,338
8 & 9	Charlotte, Collier, DeSoto, Glades, Hendry, Lee and Sarasota, Indian River, Martin, Okeechobee, Palm Beach and St. Lucie	1-Jun-13	1-Sep-13	Region 8: 5,596; Region 9: 7,854: Total = 13,450
1, 2 & 10	Escambia, Okaloosa, Santa Rosa and Walton, Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington, Broward	1-Aug-13	1-Nov-13	Region 1: 2,973; Region 2, 4058; Region 10, 7,877; Total = 14,853
11	Miami-Dade and Monroe	1-Sep-13	1-Dec-13	Region 11: 17,257
5 & 6	Pasco, Pinellas, Hardee, Highlands, Hillsborough, Manatee and Polk	1-Nov-13	1-Feb-14	Region 5, 9.963; Region 6, 9.575: Total = 19.538
3 & 4	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee Union, Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia	1-Dec-13	1-Mar-14	Region 3: 6,911; Region 4: 9.087: Total = 15,990

LTC Timelines: Recipient Notification & Choice Counseling

Recipient Notification & Choice Counseling (Region Enrolling August 2013)	
Activity	**Date**
Mail pre-go-live informational letter to recipients	March 2, 2013
Mail welcome letter to recipients to choose a plan	May 20, 2013
Mail plan choice reminder notice to recipients	July 1, 2013
Plans go live/ first date of service	August 1, 2013

Statewide Medicaid Managed Care (2013/2014): Status of Federal Approval

- **NOTE: Due to the competitive procurement, we are in a statutorily imposed "Blackout Period" until 72 hours after the award and cannot provide interpretation or additional information not included in the or MMA ITN documents.**
- **Managed Medical Assistance Program:**
  - The Agency submitted a request to amend the 1115 Medicaid Reform Demonstration Waiver for implementation of the Managed Medical Assistance Managed Care waiver program on August 1, 2011.
- **Medically Needy Program: Seeking Section 1115 Research and Demonstration Waiver**
  - The Agency submitted a concept paper to federal CMS on August 1, 2011, and submitted the final waiver application on November 21, 2012.
- **State Plan Amendment**
  - To authorize the Health Insurance Premium Payment Program
  - Approved by federal CMS September 2011
  - Rulemaking is in process

MMA Timelines: Invitation to Negotiate

Long-term Care Managed Care Program: Invitation To Negotiate	
Activity	**Date**
Release of Invitation to Negotiate	December 28, 2012
Deadline for Receipt of Written Inquiries	January 22, 2013
Vendor Conference for Regions 1-11	February 12, 2013
Anticipated Deadline for Agency Responses to Written Inquiries	February 26, 2012
Deadline for Receipt of Responses	March 15, 2013
Published List of Respondents for Provider Comments	March 20, 2013
Anticipated Dates for Negotiation	July 1, 2013 – August 20, 2013
Anticipated Posting of Notice of Intent to Award	September 16, 2013

Request for Letters of Intent: MMA Program

- To assist with planning, on August 7, 2012, the Agency requested non-binding letters of intent to bid on the MMA program from interested parties.
- Interested parties were asked to send a letter of intent to the Agency by August 17, 2012.

Request for Letters of Intent: MMA Program (part 1)

	1	2	3	4	5	6	7	8	9	10	11
Amerigroup	X	X	X	X	X	X	X	X	X	X	X
Care Access											
Community Health Solutions of America	X	X	X	X	X	X	X	X	X	X	X
Confident Care Health Plan	X	X	X	X	X	X	X	X	X	X	X
Shands Jacksonville Medical Center d/b/a First Coast Advantage				X							
First Coast Advantage Central, LLC			X								
Freedom health	X	X	X	X	X	X	X	X	X	X	X
Florida True Health	X			X			X		X		
Healthy Palm Beaches, Inc.									X		
Humana, Inc.	X	X	X	X	X	X	X	X	X	X	X
Integral Quality Care	X		X			X	X	X			
Jackson Health System											X
Magellan Complete Care		X		X	X				X	X	X
Max Care	X	X	X	X	X	X	X	X	X	X	X
Molina	X			X	X	X	X		X	X	X

Request for Letters of Intent: MMA Program (continued)

	1	2	3	4	5	6	7	8	9	10	11
PPSC USA LLC	X	X	X	X	X	X	X	X	X	X	X
Preferred Medical Plan, Inc.										X	X
Prestige Health Choice	X	X	X		X	X	X	X	X		X
Salubris									X	X	X
Sunshine State Health Plan	X	X	X	X	X	X	X	X	X	X	X
United HealthCare Community plan	X	X	X	X	X	X	X	X	X	X	X
Universal				X	X	X	X	X	X	X	X
WeCare Health Plans	X	X	X		X	X	X	X	X		
WellCare of Florida, Inc.	X	X	X	X	X	X	X	X	X	X	X
TOTAL RESPONDENTS	15	13	14	15	15	15	16	14	18	15	17

Statewide Medicaid Managed Care (2013/2014): Program Improvements

- Integrates long-term care for a more comprehensive and coordinated delivery system
- Comprehensive Plans
  - Ensure comprehensive care for recipients receiving both long-term care and managed medical assistance services

Statewide Medicaid Managed Care (2013/2014): Program Improvements

- Achieved Savings Rebate
  - Ensures appropriate medical services expenditures
- Access to Care Partnership
  - Ensures appropriate distribution of local funds (intergovernmental transfers) and Low Income Pool funds
- Florida Medical Schools Quality Network
  - Ensures continued involvement of medical schools and graduate medical education programs to improve clinical outcomes of managed care plans

Statewide Medicaid Managed Care Program: Program Improvements

- Increased access to quality providers:
  - Plan selection based on the Agency's 11 regions in the state
  - Expanding services available in rural areas.

Statewide Medicaid Managed Care Program: Program Improvements

- Increased predictability for recipients and providers:
  - Five year contracting period - less confusion for providers and recipients
  - Penalties for plan withdrawals
  - Maintenance of role of critical community-based providers
  - Parameters for payments to certain providers (nursing facilities, hospice)

Statewide Medicaid Managed Care Program: Program Improvements

- Increased accountability:
  - Enhanced quality measures
  - Enhanced access to encounter data for long-term care services and other services
  - Enhanced contract compliance tools, including liquidated damages, sanctions, and statutory penalties and terminations
  - Additional integrity functions and activities to reduce the incidence of fraud and abuse

Questions?

Presenter

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11/23/13
Meeting Date

Topic SMMC update

Bill Number _____ *(if applicable)*

Name Justin Senior

Amendment Barcode _____ *(if applicable)*

Job Title Deputy Secretary of Medicaid

Address 2727 Mahan Drive
Street

Phone 850-412-3626

Tallahassee FL 32308
City *State* *Zip*

E-mail justin.senior@ahca.myflorida.com

Speaking: ☐ For ☐ Against ☑ Information

Representing AHCA

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 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Medicaid Managed Care — Bill Number _____ *(if applicable)*

Name Stan Whittaker — Amendment Barcode _____ *(if applicable)*

Job Title Chairman FL Association of Nurse Practitioners

Address 6294 NW Torrenzo Ct — Phone _____

Street

Bristol FL 32321 — E-mail stanwh.hc@aol.com

City State Zip

Speaking: ☐ For ☐ Against ☒ Information

Representing FL Association of Nurse Practitioners

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 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Medicaid Managed Care — Bill Number _____ *(if applicable)*

Name Marifrances Gullo ARNP — Amendment Barcode _____ *(if applicable)*

Job Title Nurse Practitioner

Address 2089 S. Ridgewood Ave. — Phone 386-310-5766

Street

S. Daytona, FL. 32129 — E-mail mgullo@cfl.rr.com

City State Zip

Speaking: ☐ For ☐ Against ☒ Information

Representing Advanced Practice Nursing Services LLC

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 (10/20/11)

Florida's Prescription Drug Monitoring Program

January 23, 2012

Lucy C. Gee, M.S.
Director, Division of Medical Quality Assurance

Purpose

To prevent the abuse of prescription narcotics by providing health care professionals with protected patient information.

Protect, promote and improve the health of all people in Florida.

Health Care Use

- Prescribers & dispensers have accessed PDMP 2.6 million times to guide their clinical decisions
- Deaths from Oxycodone use fell in 2011 by 17.7% from 1,516 to 1,247
- Individuals visiting 5 or more physicians & 5 or more pharmacies in a 90-day period fell by 35% from 2,864 to 1,861

Law Enforcement Use

- E-FORCSE staff has approved 216 Agency Administrators
- E-FORCSE staff has approved >20,000 queries from credentialed law enforcement personnel
- There are currently 409 pain management clinics registered in Florida, a 56 % reduction from 921 on June 30, 2010

Protect, promote and improve the health of all people in Florida.

FUNDING

- No state funds or funds received directly or indirectly from prescription drug manufacturers may be used to support the PDMP
- The PDMP Foundation is responsible for sustaining the continuing operation of the PDMP
- Annual operating budget is <$500,000
- PDMP is funded through FY 12/13

Questions?

Protect, promote and improve the health of all people in Florida.

2011-2012
Prescription Drug Monitoring Program Annual Report

December 1, 2012

RICK SCOTT
Governor

JOHN H. ARMSTRONG, MD, FACS
Surgeon General & Secretary
Florida Department of Health

REBECCA POSTON, RPh
Program Manager

FLORIDA DEPARTMENT OF HEALTH

Prescription Drug Monitoring Program
E-FORCSE®
4052 Bald Cypress Way, Bin C-16
Tallahassee, FL 32399
(850) 245-4444 X 3700

Prescription Drug Monitoring Program
2011-2012 Annual Report

Table of Contents

Message from the State Surgeon General

As State Surgeon General of the Florida Department of Health (DOH), I am pleased to join the Prescription Drug Monitoring Program (PDMP) staff and Foundation Board of Directors in presenting the 2011-2012 Annual Report. This report reflects the hard work and dedication of the program staff in the program's first full year of implementation.

The PDMP's goals are integrally aligned with the Department's mission to protect, promote, and improve the health of all people in Florida through integrated state, county and community efforts. Last year E-FORCSE®, Florida's PDMP, supported the Department's mission by improving clinical decision-making, reducing diversion of controlled substances, and assisting in inter-agency efforts to curb the prescription drug abuse epidemic in our State. The evidence of its value in just one year is apparent.

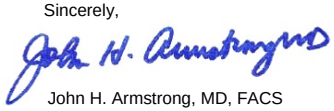
The PDMP was used by physicians and pharmacists 2.6 million times to guide their prescribing and dispensing decisions for patients. It was queried by law enforcement more than 20,000 times to assist in active criminal investigations involving controlled substances. 56 million controlled substance prescriptions were entered into the database, by nearly 5,000 pharmacies.

These numbers are remarkable; yet, the real story is that lives are being saved. The 2011 Medical Examiner's *Drugs Identified in Deceased Persons Report* shows that deaths caused by oxycodone plunged by almost 18% in 2011, and overall drug deaths fell by 6.3%.

The PDMP is becoming a routine part of everyday clinical practice not because it is mandated, but because it makes good clinical sense. We will continue to market, train, and educate professionals about the value of the program. We will continue to develop performance measures and targets to see where we need to focus our resources. We will continue to monitor results to identify best practices.

The strategic plan for the future of the PDMP includes building integration into existing clinical practice workflow and technology; establishing inter-operability of data between states; strengthening partnerships with third party payers to reduce fraud and abuse; and identifying sustainable funding. This is just the beginning; there is no finish line until prescription drug abuse is eliminated in Florida.

Sincerely,



John H. Armstrong, MD, FACS
Surgeon General & Secretary
Florida Department of Health

Prescription Drug Monitoring Program
2011-2012 Annual Report

Executive Summary

As required by section 893.055(8), *Florida Statutes* (F.S.), the 2011-2012 PDMP Annual Report highlights the accomplishments of the PDMP in its efforts to achieve the following outcomes: reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts; reduction of the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit; increased coordination among interested parties participating in the PDMP; and involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug diversion.

The Florida PDMP was created by the 2009 Florida Legislature as an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the State of Florida. Section 893.055, F.S., created the PDMP within DOH to provide information that can help guide a health care practitioner's prescribing and dispensing decisions regarding highly abused controlled substance prescription drugs.

Section 893.055, F.S., requires DOH to establish a comprehensive database system that collects controlled substance prescription information from health care practitioners within seven (7) days of dispensing controlled substances to an individual. The information collected in the database is available to registered health care practitioners to help guide their prescribing and dispensing decisions. It may also assist health care practitioners in identifying patients who are "doctor shopping" or trying to obtain multiple prescriptions for the same controlled substance from multiple health care practitioners, which is a felony in the State of Florida.

DOH contracted with Health Information Designs, Inc. (HID) to develop a Prescription Drug Monitoring System (PDMS) to collect and store prescribing and dispensing data for controlled substances in Schedules II, III, and IV, as defined in section 893.03, F.S. The PDMS is a web-based program that facilitates the collection and analysis of prescription data to enable state regulators and practitioners to detect and prevent the diversion, abuse, and misuse of controlled substance prescription drugs.

The PDMP became operational on September 1, 2011, when it began receiving controlled substance dispensing data from pharmacies and dispensing practitioners. Health care practitioners began accessing the data reported to the PDMP on October 17, 2011, and law enforcement agencies began requesting PDMP investigative reports during the course of active investigations on November 14, 2011.

Since implementation of Florida's Prescription Drug Monitoring Program, dispensers have reported over 53 million controlled substance prescriptions to the E-FORCSE® database. Physicians and pharmacists queried these records more than 2.3 million times to improve their clinical decision-making, help reduce diversion and abuse of controlled substances, and to assist in curbing the prescription drug abuse epidemic in Florida. Evidence of its effectiveness is documented in the 2011 Medical Examiner's *Drugs Identified in Deceased Persons Report* which shows that deaths caused by oxycodone plunged by almost 18% in 2011, and overall drug deaths fell by 6.3%.

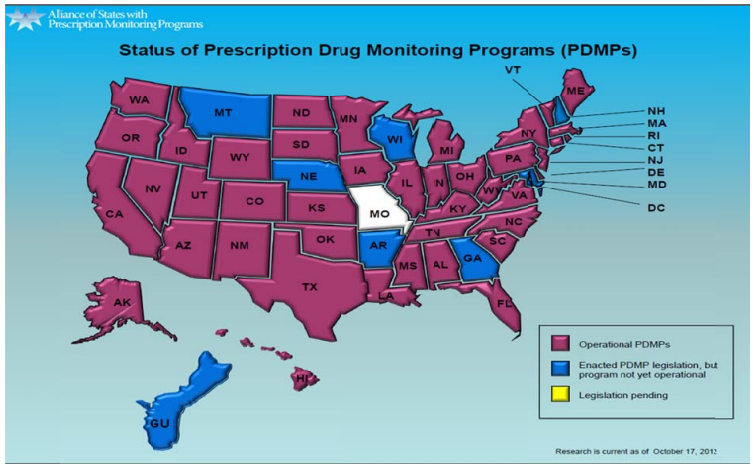
Introduction

BACKGROUND

A PDMP is an electronic database that collects designated data on controlled substances dispensed or prescribed within a given state. The data collected usually includes the names and demographic information for the patient, prescriber, and dispenser; the name and dosage of the drug; the quantity supplied, the number of authorized refills; and the method of payment.

As of October 2012, 49 states, one US Territory, and the District of Columbia have enacted legislation that establishes a PDMP; 41 states have operational PDMPs; 8 other states and the District of Columbia enacted legislation to create them. Illustration 1 below displays the status of the PDMPs across the United States.[1]

Illustration 1
Status of Prescription Drug Monitoring Programs



PDMPs are established and managed at the state level and can vary considerably from state-to-state. Some areas of variation include:

- **Substances monitored**. Some PDMPs monitor only Schedule II drugs (i.e. those with a high potential for abuse), while others monitor Schedules III through V (i.e., those with a lower potential for abuse) in addition to Schedule II drugs.

[1] Alliance of State Prescription Monitoring Programs, http://www.pmpalliance.org/pdf/pmp_status_map_2012.pdf

- **Level of access**. Some PDMPs allow law enforcement to access the database directly; others require law enforcement to obtain a court order or subpoena to access data; and some, like Florida, allow indirect access via a report in response to a request from law enforcement as a part of an active investigation.

- **Proactive versus reactive**. A proactive PDMP gives access to state regulatory or law enforcement agencies to monitor program data to detect patterns that might indicate prescription drug abuse or fraud. Reactive programs prohibit regulatory agencies or law enforcement from accessing data unless a person is already under investigation for a drug-related offense. Florida's program has both proactive and reactive components. The PDMP is proactive in that program staff may provide information to law enforcement if a pattern consistent with indicators of controlled substance abuse is identified, and the program manager believes that the patient has doctor shopped, or received multiple controlled substance prescription drugs of like therapeutic use from more than one practitioner in less than 30 days. The PDMP is reactive in that law enforcement does not have direct access to the information in the database; instead law enforcement officers may request information from the program during an active investigation regarding a crime involving prescribed controlled substance prescription drugs.

- **Timeliness of data.** Most PDMPs require monthly or bi-weekly reporting, however, a few states including Florida require weekly reporting. One state, Oklahoma, requires reporting at the time of sale.

Florida's Prescription Drug Monitoring Program

The 2009 Florida Legislature created the PDMP as an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the State of Florida. Section 893.055, F.S., created the PDMP within DOH for the purpose of providing information that can help guide a health care practitioner's prescribing and dispensing decisions regarding highly abused controlled substance prescription drugs.

The authorizing legislation called for the PDMP to be implemented by December 1, 2010, and prohibited use of state funds for program administration. The implementation of the PDMP was postponed due to funding delays and bid protests filed during the procurement of the PDMS. A hearing held February 7, 2011, before an Administrative Law Judge at the Florida Division of Administrative Hearings, resulted in entry of a Recommended Order upholding DOH's contract award to HID. On April 8, DOH entered its Final Order allowing DOH to enter into a contract with HID.

The contract between DOH and HID was executed on May 26, 2011, and implementation of the PDMS began with a kick-off meeting on June 15, 2011. The PDMS is a web-based program that facilitates the collection and analysis of pharmacy data to enable state regulators and practitioners to detect and prevent the diversion, abuse, and misuse of controlled substance prescription drugs. HID currently provides PDMS services in 17 states, including neighboring southern states, Alabama, Louisiana, and South Carolina.

The PDMP became operational on September 1, 2011, when it began receiving controlled substance dispensing data from pharmacies and dispensing practitioners. Health care practitioners began accessing the data reported to the PDMP on October 17, 2011, and law enforcement agencies began requesting PDMP investigative reports during the course of active investigations on November 14, 2011.

Funding

The PDMP is currently operating through the use of three funding sources: direct support organization private fund raising (PDMP Foundation); federal grants; and private grants. Since its inception in 2010, the PDMP has spent $983,320 for database infrastructure and enhancements, personnel and facility expenses.

- The PDMP Foundation is the primary source of revenue to cover database operation and infrastructure, personnel and facility expenses. The spending plan for FY 12/13 identifies $238,531 in planned expenditures for the PDMP. The Foundation's fundraising efforts are on-going.

- Federal grants are another source of funds to operate the PDMP. Awards are based on specific projects outlined in the grant application and only a limited portion (if any) may be used to offset personnel and facility expenses. DOH applied for and was approved for three Harold Rogers PDMP grants totaling $1,199,300, and DOH has expended $566,460 of those funds.

- The final source of funding is private grants. DOH has received three grant awards from the National Association of State Controlled Substance Authorities (NASCSA) totaling $49,952. The grant period ended June 30, 2011, and $44,886 was drawn down.

DOH supports the PDMP as a valuable tool that has helped to save lives and reduce prescription drug abuse in Florida. DOH is committed to ensuring that PDMP funding is sustained. Through the innovation of DOH in leveraging federal grant money and also funds raised by the PDMP Foundation, funding is available through June 30, 2013. DOH will continue to work closely with the PDMP Foundation and all stakeholders to increase fundraising efforts moving forward for both the intermediate and long-term sustainability of this critical program. DOH is asking law enforcement partners and each Foundation Director to make a pledge to meet the fundraising goal for the next fiscal year and DOH will work with them to secure program funding.

Prescription Drug Monitoring System Enhancements

The PDMP implemented three major enhancements to its PDMS during the last year: 1) automated licensure verification for health care practitioners; 2) automated credentialing of law enforcement and regulatory board users; and 3) Prescription Monitoring Information Exchange (PMIX). These enhancements were funded through the 2010 Harold Rogers Prescription Drug Monitoring Program Enhancement Grant (2010-PM-BX-0010).

Automated Licensure Verification

In April 2012, the PDMS was enhanced to automate the licensure verification process. Each time a health care practitioner registers for access to the PDMS, licensure with the applicable health care regulatory board must be verified. The E-FORCSE® PDMS established an XML web service with DOH to automate licensure verification. Once the registrant clicks "Accept & Submit" on the registration screen, the PDMS calls the web service and securely passes identifying criteria for the practitioner.

If the identifying criterion provided by the PDMS matches the DOH licensure database, a match is indicated, and emails containing the user name and password are automatically sent to the registrant. If the identifying criterion does not match, the reason is provided, and the registration is queued for PDMP staff review. If upon review of the registration, PDMP staff determines that

licensure verification cannot be completed, the request is denied, and an email is sent to the registrant indicating the reason for denial.

This enhancement has reduced the amount of time a health care practitioner user must wait to receive their user name and password from several days to just a few minutes. Prior to this enhancement, PDMP staff manually performed licensure verification and registration approval. The automation has saved approximately five minutes of staff time per registration.

Automated Credentialing

Section 893.055, F.S., does not authorize law enforcement, Attorney General's Medicaid Fraud Control Unit, or DOH health care regulatory boards to have direct access to PDMP information; however, they are required to register with E-FORCSE® before they are able to request information during an active investigation involving prescribed controlled substance prescription drugs, known as an investigative report.

In April 2012, the PDMS was enhanced to automate the process of credentialing law enforcement and regulatory board users. Each agency that is authorized to access the Florida PDMP must appoint an "Agency E-FORCSE® Administrator" to serve as the liaison and gatekeeper between their agency and E-FORCSE®. The Administrator identifies the individuals authorized within the agency to have indirect access. Once program staff has reviewed and approved the credentials submitted by the Agency E-FORCSE® Administrator, the program staff provides the individual with a link to the E-FORCSE® registration website. The information provided on the registration website is automatically verified against the personal information provided by the E-FORCSE® Administrator. Upon authentication, the individual will receive an email confirmation, including a link to a password set-up page on the website.

This enhancement has reduced the amount of time a law enforcement user must wait to receive their user name and password from several days to just a few minutes. Prior to this enhancement, PDMP staff manually performed law enforcement credentialing and registration approval. The automation has saved approximately five minutes of staff time per registration.

Prescription Monitoring Information Exchange (PMIX)

In June 2012, the PDMS was enhanced to connect to the Prescription Monitoring Information Exchange (PMIX) hub, known as the RxCheck hub, to allow prescribers and dispensers access to other states' PDMP information. The PMIX project is a national initiative funded by the Bureau of Justice Assistance (BJA) and the Office of National Drug Control Policy (ONDCP) and led by the IJIS Institute.

The primary goal of the project is to establish a national interoperability architecture, created by PDMP stakeholders based on certain specifications. The PMIX Architecture utilizes "end-to-end encryption" so that no protected health information can be stored at the hub. The encrypted data leaves the sending state PDMP system and cannot be decrypted until it reaches the receiving state PDMP system.

Section 893.055, F.S., prohibits the PDMP from sharing its data with other states; however it does not prohibit the PDMP from receiving data from other states. DOH successfully exchanged test data with the Alabama PDMP on June 1, 2012, through a Memorandum of Understanding (MOU). DOH is currently negotiating MOUs with the Alabama and Kentucky PDMPs to allow one way data exchange to Florida. Through these MOUs, users of the Florida PDMP will be able to review prescriptions dispensed to their patients by out-of-state health care practitioners.

Moving forward, the PDMP plans to utilize this connection to the RxCheck hub to incorporate PDMP data into existing clinical workflows by integrating the PDMP data into existing health technologies.

Legal Framework

History of Legislation

The PDMP was created by the 2009 Florida Legislature, with the passage of SB 462, which created section 893.055, F.S. A companion bill, SB 440, created section 893.0551, F.S., which sets forth the exemption from public records requirements for information contained in the PDMP.

The 2010 Florida Legislature amended sections 893.055 and 893.0551, F.S., with the passage of SB 2272, which established a definition for "program manager," and requires the program manager to work with certain stakeholders to promulgate rules setting forth indicators of controlled substance abuse. It also authorized the program manager to provide relevant information to law enforcement under certain circumstances.

The 2011 Florida Legislature amended section 893.055, F.S., to reassign the duties of the Governor's Office of Drug Control to DOH, to require reports be made to the PDMP within 7 days of dispensing rather than 15 days; to prohibit the use of certain funds to implement the PDMP; and to require criminal background screening for all PDMP staff who have direct access to the PDMP.

Summary of Statute

Section 893.055, F.S., creates the PDMP within DOH and requires the DOH to design and establish a comprehensive electronic database system to collect controlled substance prescription information, while not infringing upon the legitimate prescribing or dispensing of controlled substances by a prescriber or dispenser acting in good faith and in the course of professional practice.

It provides definitions for the following terms:

- "Patient advisory report" means information provided by DOH in writing, or as determined by DOH, to a prescriber, dispenser, pharmacy, or patient concerning the dispensing of controlled substances. All advisory reports are informational and impose no obligations of any nature or any legal duty on the aforementioned report recipients. Advisory reports are not discoverable in civil or administrative actions against a prescriber, dispenser, pharmacy, or patient arising out of the matters that are the subject of the report. No person who participates in preparing the report is permitted or required to testify in such a proceeding.
- "Controlled substance" means a controlled substance listed in Schedule II, Schedule III, or Schedule IV in section 893.03, F.S.
- "Dispenser" means a dispensing pharmacist or dispensing health care practitioner.
- "Health care practitioner" or "practitioner" means any practitioner subject to licensure or regulation by DOH under chapters 458, 459, 461, 462, 464, 465, or 466, F.S. These chapters govern allopathic physicians, osteopathic physicians, podiatric physicians, naturopaths, nurses, pharmacists, and dentists, respectively.
- "Health care regulatory board" means a board for a practitioner licensed or regulated by DOH.

- "Pharmacy" means any pharmacy subject to licensure and regulation by DOH under chapter 465, F.S., that dispenses or delivers a controlled substance to a patient in this state.
- "Prescriber" means any prescribing physician or other prescribing health care practitioner.
- "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 for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.
- "Law enforcement agency" means the Department of Law Enforcement, a Florida sheriff's department, a Florida police department, 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.
- "Program manager" means an employee of or a person contracted by DOH who is designated to ensure the integrity of the PDMP.

The system must be consistent with standards of the American Society for Automation in Pharmacy (ASAP) for the validation of prescribing and dispensing controlled substances to an individual. The system must also comply with the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to protected health information (PHI) and electronic protected health information (EPHI).

DOH must adopt rules concerning the reporting, evaluation, management, and storage of information within the system, including rules for when patient advisory reports are provided to pharmacists and practitioners and rules for when information is provided to health care regulatory boards, law enforcement, and others. All dispensers and prescribers subject to the reporting requirements must be notified by DOH of the implementation date for such reporting requirements. DOH must work with the professional healthcare licensure boards and other specified stakeholders to develop indicators for controlled substance abuse.

The following information must be reported by a pharmacy or dispenser that dispenses a controlled substance, within seven (7) days of dispensing:

- Name of the prescribing practitioner and 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.
- Date the prescription was filled and the method of payment (not to include individual credit card or other account numbers).
- Full name, address, and date of birth of the person for whom the prescription was written.
- Name, national drug code, quantity, and strength of the controlled substance dispensed.
- Full name and address of the pharmacy or other location from which the controlled substance was dispensed.
- Name of the pharmacist or practitioner dispensing the controlled substance, the practitioner's NPI and other appropriate identifying information as determined by DOH rule.
- Other identifying information as determined by DOH rule.

The following activities are exempt from reporting to the PDMP:

- A health care practitioner 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 administering a controlled substance to a patient or resident receiving care as an admitted patient at a hospital, nursing home, hospice, ambulatory surgery center, or intermediate care facility for the developmentally disabled that is licensed in this state.
- A practitioner administering a controlled substance in the health care system of the Department of Corrections.
- A practitioner administering a controlled substance in the emergency room of a licensed hospital.
- A practitioner administering or dispensing a controlled substance to a person under the age of 16.
- A pharmacist or a dispensing practitioner dispensing a one-time, 72 hour emergency re-supply of a controlled substance to a patient.

A pharmacy, prescriber, or dispenser may access information in the PDMP that relates to a patient of that pharmacy, prescriber, or dispenser for the purpose of reviewing their specific patient's controlled drug prescription history. Prescribers and dispensers acting in good faith for receiving or using information from the program are immune from any civil, criminal, or administrative liability.

Other access is limited to the program's manager and designated program staff. Confidential and exempt information in the database shall only be released as provided in section 893.0551, F.S. Indirect access may be requested by the following organizations, upon being verified and authenticated by program staff:

- DOH or appropriate health care regulatory boards who are involved in a specific investigation involving a specific individual for one or more prescribed controlled substances;
- The Attorney General for Medicaid fraud cases involving prescribed controlled substances;
- A law enforcement agency during active investigations regarding potential criminal activity, fraud or theft relating to prescribed controlled substances; or
- A patient, legal guardian or designated health care surrogate who submits a notarized written request, for the purpose of verifying the information collected.

Performance measures must be reported annually by DOH each December 1, beginning in 2011. Data that does not contain patient, physician, health care practitioner, or dispenser identifying information may be requested during the year by DOH employees so that DOH may undertake public health care and safety initiatives by taking advantage of observed trends. Performance measures may include, but are not limited to, efforts to achieve the following outcomes:

- Reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts.
- Reduction of the quantity of controlled substances obtained by individuals attempting to engage in fraud and deceit.
- Increased coordination among prescription drug validation program partners.
- Involvement of stakeholders in achieving improved patient healthcare and reduction of prescription drug abuse and diversion.

A practitioner who willfully and knowingly fails to report the dispensing of controlled substances commits a misdemeanor of the first degree, punishable as provided in sections 775.082 or 775.083, F.S.

All costs incurred by DOH to administer the PDMP must be funded through federal or private grant funding applied for or received by the state.

DOH may establish a direct-support organization with a 5 or greater member board to provide assistance, funding, and promotional support for the activities authorized for the PDMP. It defines "direct support organization" as a Florida not for profit incorporated under chapter 617, F.S., organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts and bequests of money; acquire, receive, hold and invest securities, funds, objects of value or other property either real or personal; and make expenditures in the furtherance of the program. It is not a registered lobbyist. The State Surgeon General shall appoint a board of directors for the direct-support organization.

Summary of Administrative Rules

Section 893.055, F.S., directs DOH to adopt rules as necessary concerning reporting, accessing, evaluation, management, development, implementation, operation, and storage of information within the PDMS. DOH collaborated with stakeholders, including licensure boards, professional membership organizations, and other state agencies to develop rules appropriate for implementation of the PDMP. The PDMP promulgated rules in chapter 64K, Florida Administrative Code, (F.A.C.) to provide a framework for the administration of the program. The promulgated rules set forth what constitutes advisory alerts and reports, access to and operation of the database, security of information, and program evaluation.

The 2010 Florida Legislature amended section 893.055, F.S., to require the program manager to work with certain stakeholders to promulgate rules setting forth indicators of controlled substance abuse. DOH met with stakeholders on December 1, 2011 and created proposed language for the development of Rule 64K-1.007, Indicators for Controlled Substance Abuse. This rule sets forth the criteria under which an individual may be identified as abusing controlled substance prescription drugs. It authorizes the Program Manager to provide relevant information to the health care practitioners who have prescribed or dispensed controlled substances to that individual.

Program Description

DOH has regulatory authority over the PDMP. DOH contracts with HID to administer the PDMP database and to manage the collection of the data. Program staff, consisting of a manager and administrator, oversee the day-to-day operation of the PDMP, act as liaisons with the software vendor, seek grant funding to support the PDMP, and provide administrative support to the PDMP Foundation.

Reporting

Beginning on September 1, 2011, each time a controlled substance is dispensed to an individual; it must be reported to the PDMP by the pharmacy or dispensing practitioner as soon as possible, within 7 days. The PDMP offers several methods for reporting dispensing data, including: secure file transfer protocol (FTP) over Secure Shell Hub (SSH), encrypted file with open Pretty Good Privacy (PGP) via FTP Secure Socket Layer (SSL) web site, physical media (tape, diskette, compact disc (CD), Digital Versatile Disc (DVD)), or Universal Claim Form (UCF) submission.

Within 7 days, a health care practitioner must report the following information each time a controlled substance prescription is dispensed:

- Name of the prescribing practitioner and the prescribing practitioner's federal Drug Enforcement Administration (DEA) number;
- Prescribing practitioner's National Provider Identification (NPI) number (or other appropriate identification number);
- Date of the prescription;
- Date the prescription was filled/dispensed;
- Refill number;
- Patient's method of payment (private pay, Medicaid, Medicare, commercial insurance, military installations and Veterans Administration, workers compensation, Indian nation or other);
- Patient's full name, address, date of birth and gender;
- Name, National Drug Control (NDC) number, quantity and strength of the controlled substance dispensed;
- Full name, DEA number and address of the pharmacy or other location from which a controlled substance was dispensed (if the controlled substance was dispensed by a practitioner other than a pharmacist, the practitioner's full name, DEA number, and address);
- Name of the pharmacy or practitioner, other than a pharmacist, dispensing the controlled substance and the practitioner's NPI; and
- Other appropriate identifying information as determined by DOH rule.

A health care practitioner is not required to report to E-FORCSE® when he/she:

- Administers a controlled substance directly to a patient if the amount is adequate to treat the patient during that particular treatment session;
- Administers 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;
- Administers or dispenses a controlled substance in the health care system of the Florida Department of Corrections;
- Administers a controlled substance in the Emergency Room of a licensed hospital;
- Administers or dispenses a controlled substance to a patient under the age of 16; or
- Dispenses a one-time, 72-hour re-supply of controlled substances.

For the purposes of this report, the quarters are broken down as follows: Q1 is October 1, 2011 to December 31, 2011; Q2 is January 1, 2012 to March 31, 2012; Q3 is April 1, 2012 to June 30, 2012; and Q4 is July 1, 2012 to September 30, 2012.

Table 1 displays the number of pharmacies and dispensers who have reported controlled substance prescription data to the PDMP, and the total number of prescriptions reported to the PDMP quarterly between October 1, 2011 and September 30, 2012.

Table 1
Number of Pharmacies/Dispensers and Prescriptions Reported

MEASURE	Q1	Q2	Q3	Q4
Number of Pharmacies/Dispensers who have reported to the PDMP	5,309	5,511	5,596	5,488
Number of prescription records reported to the PDMP	17,077,605	9,942,655	8,760,190	8,715,602

The information collected in the database is available to registered health care practitioners to help guide their decisions in prescribing and dispensing certain highly-abused prescription drugs. It may also assist health care practitioners in identifying patients who are "doctor shopping" or trying to obtain multiple prescriptions for the same controlled substance from multiple health care practitioners, which is a felony in the State of Florida.

Access

Direct Access

A prescriber or dispenser who is subject to licensure or regulation by DOH under chapter 458, chapter 459, chapter 461, chapter 462, chapter 464, chapter 465 or chapter 466, F.S., will have direct access to their specific patient's information. Other direct access to information will be limited to the Program Manager and designated staff for the purpose of program management.

Table 2 displays the number of registered users of the PDMP by license type, by quarter between October 1, 2011 and September 30, 2012.

Table 2
Number of PDMP Registered Users

License Type	Q1	Q2	Q3	Q4	Total
Pharmacists	3,842	1,636	2,509	1,460	9,447
Medical Doctors	2,793	1,396	763	617	5,569
Osteopathic Physicians	500	299	151	149	1,099
Podiatric Physicians	38	10	16	7	71
Physician Assistants	334	161	105	105	705
Advanced Registered Nurse Practitioners	394	158	109	95	756
Dentists	284	61	35	32	412
TOTAL	8,185	3,721	3,688	2,465	18,059

Among the licensed professionals, pharmacists have the highest registration rate, with over 34.6% registering. Roughly 9.4% of all medical doctors and osteopathic physicians and 3.3% dentists have registered as of September 30, 2012.

Data collected from multiple states has demonstrated that the number of prescribers who actually issue one or more controlled substance prescriptions is significantly less than the number registered with the Drug Enforcement Administration (DEA). For example, several PMPs have found that only about two-thirds of DEA-registered prescribers issue controlled substance prescriptions in a year. Calculating the proportion of users based on the total number of all prescribers can result in the calculation underestimating the proportion of prescribers who actually have PMP accounts among those who *should* have accounts.[2]

In light of this information, The Brandeis University PMP Center of Excellence developed a PMP Management Tool to provide PDMP Administrators a more accurate method for calculating the

[2]Brandeis University PMP Center of Excellence, "Calculating the Level of Prescriber Enrollment in a Prescription Monitoring Program," *PMP Management Tool*, January 2011, <http://pdmpexcellence.org/sites/all/pdfs/PMP_management_tool_2_1_FINAL_2011_01_24.pdf> , accessed on November 7, 2012.

proportion of eligible prescribers who have established accounts with the PDMP to request prescription data. The calculation recommended by the PMP Management Tool is the number of in-state prescribers with PDMP accounts as a percentage of the number of in-state prescribers who issued controlled substance prescriptions during the prior year. Based on this calculation, 14% of the in-state prescribers who issued more than one controlled substance prescriptions have registered to use the database (8,612 in-state prescribers with PMP accounts to request patient prescription data / 61,284 in-state prescribers who issued controlled substance prescriptions during the prior year).

Indirect Access

Indirect access may be requested by the following organizations, upon being verified and authenticated by program staff:

- DOH or appropriate health care regulatory boards who are involved in a specific investigation involving a specific individual for one or more prescribed controlled substances;
- The Attorney General for Medicaid fraud cases involving prescribed controlled substances;
- A law enforcement agency during active investigations regarding potential criminal activity, fraud or theft relating to prescribed controlled substances; or
- A patient, legal guardian or designated health care surrogate who submits a notarized written request, for the purpose of verifying the information collected.

Additionally, the following entities may have indirect access to information that contains no identifying information, upon request:

- The Department of Health for the purpose of calculating performance measures; and
- The Program Implementation and Oversight Task Force for its report to the Governor, President of the Senate and Speaker of the House of Representatives.

Finally, if the Program Manager observes a pattern that indicates a patient may be "doctor shopping" or attempting to obtain multiple prescriptions for controlled substances from multiple health care practitioners, the information may be provided to law enforcement.

Patient Advisory Reports and Investigative Reports

A prescriber or dispenser who wishes to view their patient-specific information must submit a query in order to generate a patient advisory report. Similarly, a law enforcement agency that wishes to request information during the course of an active investigation must submit a query to request an investigative report. The law enforcement query must be reviewed and approved by PDMP staff prior to release of the report.

The PDMS became available for queries by prescribers and dispensers on October 17, 2011, and became available for queries by law enforcement on November 14, 2011.

Table 3 displays the number of queries for patient advisory reports submitted by prescribers and dispensers, and the number of queries for investigative reports submitted by law enforcement agencies, for each quarter between October 1, 2011 and September 30, 2012.

Table 3
Number of PDMP Queries by Registered User

User Type	Q1	Q2	Q3	Q4	Total by User Type
Prescribers	168,809	301,518	328,240	347,727	1,146,294
Dispensers	168,828	225,734	361,512	440,118	1,196,192
Law Enforcement	1,229	6,278	5,074	4,934	17,515
Regulatory Agency	0	96	171	0	267
Total Queries by Quarter	338,866	533,626	694,997	792,779	2,360,268

Performance Measures

Evidence suggests PDMPs are effective in improving the prescribing of controlled substances and addressing the prescription drug abuse epidemic.[3] The PDMP must become a routine part of every clinical practice not because it's mandated, but because it makes good clinical sense. The staff will continue to: market, train, and educate practitioners about the value of the program; develop performance measures and targets to identify where to focus resources; and monitor results to identify best practices.

Section 893.055(8), F.S., requires DOH to report its performance measures annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, beginning in 2011. Based on these measures, DOH has provided quarterly data as a basis of comparative review from October 1, 2011 through September 30, 2012.

To assist in fulfilling program responsibilities, DOH has identified performance measures and must report on its efforts to achieve the following outcomes:

- Reduction of the rate of inappropriate use of prescription drugs through education and safety efforts.
- Reduction of the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit.
- Increased coordination among partners participating in the prescription drug monitoring program.
- Involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug abuse and prescription drug diversion.

OUTCOME: Reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts.

PERFORMANCE MEASURE: The number of licensed prescribers, dispensers, and individuals authorized to conduct investigations that were trained in the use of the state's PDM system.

DEFINITIONS:

- The term "prescribers" refers to individual practitioners licensed to prescribe controlled substances.
- Formal training refers to training usually provided in-person and involves the use of some form of structured presentation. While formal training often occurs in a classroom setting it

[3] Thomas Clark et al, Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices, 6 (2012).

may also take place at a doctor's office, at a hospital, or at some other kind of facility. Formal training may also include web-based training if such training: requires enrollment, follows a well-defined curriculum, and provides some form of certification indicating that the training has been completed successfully.

- Informal training refers to training that ordinarily involves the provision of informational materials by mail (or by email). Informational materials may also be provided at professional conferences or trade shows. Each time an individual downloads materials on the operation of a PDMP system this constitutes an informal training "event" and may be counted as such.
- Prescribers (physicians, physician's assistants, and some nurses) and dispensers (typically pharmacists) are individuals licensed by the state to prescribe or dispense controlled substances. Individuals authorized to conduct investigations have case-specific (as is often true for law enforcement personnel) access to PDMP records.

DATA TO SUPPORT PERFORMANCE MEASURE

MEASURE FOR THIS REPORTING PERIOD	Q1	Q2	Q3	Q4
How many licensed PRESCRIBERS were trained formally (in a classroom setting) in the use of the PDM system?	158	60	85	300
How many licensed PRESCRIBERS were trained informally (e.g., via the Internet, mass mailings, and so on) in the use of the PDM system?	4,266	2,436	2,029	1,435
How many licensed PRESCRIBERS are there in your state?[4]	104,276	104,276	104,276	104,276
What is the number of licensed PRESCRIBERS in your state that issued one or more controlled substance prescriptions.	52,078	52,577	52,294	52,791
How many licensed DISPENSERS were trained formally (in a classroom setting) in the use of the PDM system?	1,025	350	150	0
How many licensed DISPENSERS were trained informally (e.g., via the Internet, mass mailings, and so on) in the use of the PDM system?[5]	3,724	2,000	1,844	1,235
How many licensed DISPENSERS are there in your state?	27,260	27,260	27,260	27,260
How many INDIVIDUALS AUTHORIZED TO CONDUCT INVESTIGATIONS were trained formally (in a classroom setting) in the use of the PDM system?	350	297	633	250
How many INDIVIDUALS AUTHORIZED TO CONDUCT INVESTIGATIONS were trained informally (e.g., via the Internet, mass mailings, and so on) in the use of the PDM system?	1,164	806	749	488
How many INDIVIDUALS AUTHORIZED TO CONDUCT INVESTIGATIONS are there in your state?[6]	49,909	50,062	50,142	49,439

[4] Division of Medical Quality Assurance Annual Report, 2010-2011
[5] Division of Medical Quality Assurance Annual Report, 2010-2011
[6] Florida Fusion Center, Florida Department of Law Enforcement, "# Individuals Authorized to Conduct Investigations," email messages, November 2011 to October 2012.

PERFORMANCE MEASURE: The number of coroner reports that indicate controlled prescription drug use as the primary or contributing cause of death.

DATA TO SUPPORT PERFORMANCE MEASURE

MEASURE FOR THIS REPORTING PERIOD	1/1/10 through 12/31/10	1/1/11 through 12/31/11
How many coroner reports indicated that controlled prescription drug use was the primary or contributing cause of death?[7]	2,710	2,539

OUTCOME: Reduction of the quantity of pharmaceutical controlled substances obtained by individuals attempting to engage in fraud and deceit.

PERFORMANCE MEASURE: Increase in solicited and unsolicited reports generated by prescribers, dispensers, and individuals authorized to conduct investigations.

DATA TO SUPPORT PERFORMANCE MEASURE

MEASURE FOR THIS REPORTING PERIOD	Q1	Q2	Q3	Q4
How many INDIVIDUALS filled prescriptions for Schedule II drugs?	568,330	574,341	555,221	549,180
How many INDIVIDUALS filled prescriptions for Schedule II drugs from 5 or more PRESCRIBERS at 5 or more pharmacies?	567	309	281	239
How many INDIVIDUALS filled prescriptions for Schedule II drugs from 10 or more PRESCRIBERS at 10 or more pharmacies?	19	10	2	7
How many INDIVIDUALS filled prescriptions for Schedule II drugs from 15 or more PRESCRIBERS at 15 or more pharmacies?	2	1	1	0
How many non-liquid doses of the following were associated with INDIVIDUALS that filled prescriptions for Schedule II drugs: a. Pain relievers. b. Tranquilizers. c. Stimulants. d. Sedatives.	 140,066,172 0 24,934,597 3,656	 140,525,636 0 27,459,991 3,003	 131,575,572 0 26,189,425 2,502	 125,614,373 0 25,813,743 2,726
How many INDIVIDUALS filled prescriptions for Schedule II, III drugs?	1,472,587	1,563,550	1,482,090	1,444,921
How many INDIVIDUALS filled prescriptions for Schedule II, III drugs from 5 or more PRESCRIBERS at 5 or more pharmacies?	1,513	1,222	1,075	931
How many INDIVIDUALS filled prescriptions for Schedule II, III	68	48	28	26

[7] Medical Examiner's Commission, "Drugs Identified in Deceased Persons by Florida Medical Examiners, 2010 Report, "Florida Department of Law Enforcement, Tallahassee, FL, August 2011

drugs from 10 or more PRESCRIBERS at 10 or more pharmacies?				
How many INDIVIDUALS filled prescriptions for Schedule II, III drugs from 15 or more PRESCRIBERS at 15 or more pharmacies?	8	13	5	5
How many non-liquid doses of the following were associated with INDIVIDUALS that filled prescriptions for Schedule II and III drugs:				
a. Pain relievers.	237,122,246	243,586,361	230,010,754	223,303,177
b. Tranquilizers.	0	0	0	0
c. Stimulants.	27,521,814	30,414,168	29,159,835	28,595,334
d. Sedatives.	705,608	772,535	706,957	659,324
How many INDIVIDUALS filled prescriptions for Schedule II, III, IV drugs?	3,156,182	3,396,372	3,226,855	3,160,011
How many INDIVIDUALS filled prescriptions for Schedule II, III, IV drugs from 5 or more PRESCRIBERS at 5 or more pharmacies?	2,381	2,064	1,870	1,799
How many INDIVIDUALS filled prescriptions for Schedule II, III, IV drugs from 10 or more PRESCRIBERS at 10 or more pharmacies?	90	63	42	41
How many INDIVIDUALS filled prescriptions for Schedule II, III, IV drugs from 15 or more PRESCRIBERS at 15 or more pharmacies?	13	17	7	7
How many non-liquid doses of the following were associated with INDIVIDUALS that filled prescriptions for Schedule II, III, IV drugs:				
a. Pain relievers.	237,364,530	243,838,311	230,251,697	223,527,706
b. Tranquilizers.	49,546,711	54,131,709	51,262,227	51,630,901
c. Stimulants.	33,604,740	37,458,419	36,200,276	35,482,760
d. Sedatives.	43,105,796	47,186,821	43,363,152	43,217,658

OUTCOME: Increased coordination among partners participating in the prescription drug monitoring program.

PERFORMANCE MEASURE: The number of licensed PRESCRIBERS and DISPENSERS trained formally in coordinating and sharing data.

DATA TO SUPPORT PERFORMANCE MEASURE

MEASURE FOR THIS REPORTING PERIOD	Q1	Q2	Q3	Q4
How many licensed PRESCRIBERS and DISPENSERS were trained formally in coordination and data sharing?	1,183	410	235	300
How many PDMP partners were trained in coordination of data sharing?	350	297	633	250

PDMP interorganizational best practices will permit data sharing and integrate PDMP data into the health care system, drug abuse prevention efforts, and the work of investigative agencies. They will enable efficient collaboration among PDMPs and outside organizations engaged in improving patient health and mitigating prescription drug abuse. They will also enable linking PDMP data with other prescription and health data to permit combined analyses and facilitate data access. Best practices include education initiatives targeted on the value and use of the PDMPs to help encourage increased utilization.

OUTCOME: Involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug abuse and prescription drug diversion.

PERFORMANCE MEASURE: Percentage of stakeholder (e.g., state, federal, and local agencies; professional associations, etc.) involvement.

DATA TO SUPPORT PERFORMANCE MEASURE

MEASURE FOR THIS REPORTING PERIOD	Q1	Q2	Q3	Q4
How many stakeholders engaged in the project through memorandums of understanding, meeting attendance, etc.?	13	13	14	11

PDMP effectiveness can also be understood in the context of how PDMPs work best and in concert with other agencies, organizations and health information technologies. Best practices include data standardization and sharing among agencies, integration with other systems, including public health, health information exchanges, electronic health records, electronic prescribing, public safety, drug abuse prevention and drug control. This will ensure data is seamlessly available to all those engaged in improving controlled substance prescribing and addressing the prescription drug abuse epidemic.

Results

The efforts of the PDMP are promoting the availability of prescription narcotics to patients truly in need, not to a system of addiction. According to Brandeis University, Prescription Drug Monitoring Program Center of Excellence in its assessment of the evidence for best practices: "The effectiveness of the PDMP in terms of impact is ensuring appropriate use of prescription controlled substances, reducing diversion and abuse, and improving health outcomes, both at the patient and community levels. Impact is maximized when the patient's prescription history is complete and accurate; analyzed appropriately and expeditiously; made available in a proactive and timely manner; disseminated in ways and formats that best serve the purposes of end users; and applied in all relevant domains by all appropriate users."

Doctor Shopping Trends

The 2009 Florida Legislature created the PDMP as an initiative to encourage safer prescribing of controlled substance, and to reduce abuse and diversion of controlled substances. One indicator of controlled substance abuse is visiting multiple prescribers and dispensers to obtain multiple prescriptions of the same therapeutic use; known as "doctor shopping."

Section 893.055, F.S., authorizes the PDMP program manager to provide information to the applicable law enforcement agency when the program manager determines a pattern consistent with the indicators of controlled substance abuse, outlined in rule 64K-1.007, F.A.C., *Indicators of*

Controlled Substance Abuse, and has cause to believe that one of the following violations has occurred:

- Section 893.13(7)(a)8., F.S.: A person may not withhold information from a practitioner from whom the person seeks to obtain a controlled substance or a prescription for a controlled substance that the person making the request has received a controlled substance or a prescription for a controlled substance of like therapeutic use from another practitioner within the previous 30 days.
- Section 893.13(8)(a), F.S.: Notwithstanding subsection (9), a prescribing practitioner may not:
  1. Knowingly assist a patient, other person, or the owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practice of the prescribing practitioner's professional practice;
  2. Employ a trick or scheme in the practice of the prescribing practitioner's professional practice to assist a patient, other person, or the owner of an animal in obtaining a controlled substance;
  3. Knowingly write a prescription for a controlled substance for a fictitious person; or
  4. Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing such prescription is to provide a monetary benefit to, or obtain a monetary benefit for, the prescribing practitioner.
- Section 893.13(8)(b),F.S.: If the prescribing practitioner wrote a prescription or multiple prescriptions for a controlled substance for the patient, other person, or animal for which there was no medical necessity, or which was in excess of what was medically necessary to treat the patient, other person, or animal, that fact does not give rise to any presumption that the prescribing practitioner violated subparagraph (a)1., but may be considered with other competent evidence in determining whether the prescribing practitioner knowingly assisted a patient, other person, or the owner of an animal to obtain a controlled substance in violation of subparagraph (a)1.

In addition, to the 2011 Medical Examiner's *Drugs Identified in Deceased Persons Report*[8] showing an overall drug death reduction of 6.3%, the number of doctor shoppers has significantly decreased since the implementation of the PDMP. There has been a 35% reduction in the number of individuals visiting five or more prescribers and five or more pharmacies in a 90-day period between October 1, 2011 and September 30, 2012.

Table 4 displays the numbers of individuals visiting X number of prescribers and X number of pharmacies each quarter between October 1, 2011 and September 30, 2012 and the percentage of change over the year.

[8] 2011 Medical Examiners Commission Drug Report- *Drugs Identified in Deceased Persons Report* available at http://www.fdle.state.fl.us/Content/getdoc/fa86790e-7b50-45f3-909d-c0a4759fefa8/2011-Drug-Report_Final.aspx

Table 4
Doctor Shopping Trends

Individuals Visiting X Number of Prescribers and X Number Dispensers	Q1	Q2	Q3	Q4	Percent Change
5 or more prescribers & 5 or more pharmacies	2,864	2,174	2,017	1,861	↓35.02%
6 or more prescribers & 6 or more pharmacies	1,097	797	711	607	↓44.67%
7 or more prescribers & 7 or more pharmacies	514	372	297	245	↓52.33%
8 or more prescribers & 8 or more pharmacies	295	185	153	117	↓60.34%
9 or more prescribers & 9 or more pharmacies	172	105	77	69	↓60.12%
10 or more prescribers & 10 or more pharmacies	105	68	45	43	↓59.05%
15 or more prescribers & 15 or more pharmacies	18	17	7	7	↓61.11%

As we move forward building integration into existing clinical practice workflow and technology, we will be strengthening partnerships to reduce fraud and abuse. Since implementation of Florida's Prescription Drug Monitoring Program, dispensers have reported over 53 million controlled substance prescriptions to the E-FORCSE® database. Physicians and pharmacists queried these records more than 2.3 million times to improve their clinical decision-making, help reduce diversion and abuse of controlled substances, and to assist in curbing the prescription drug abuse epidemic in Florida. Evidence of its effectiveness is documented in the 2011 Medical Examiner's *Drugs Identified in Deceased Persons Report* which shows that deaths caused by oxycodone plunged by almost 18% in 2011, and overall drug deaths fell 6.3% from 2,710 to 2,539.

Presenter

THE FLORIDA SENATE

APPEARANCE RECORD

4/23/13
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Topic PDMP update

Bill Number _____ *(if applicable)*

Name Lucy Gee

Amendment Barcode _____ *(if applicable)*

Job Title Div. Director

Address 4042 Bald Cypress Way *Street*

Phone 245-4224

Tallahassee FL 32399 *City* *State* *Zip*

E-mail lucy-gee@doh.state.fl.us

Speaking: ☐ For ☐ Against ☑ Information

Representing Dept. of Health

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 (10/20/11)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JEFF BRANDES
22nd District

COMMITTEES:
Transportation, *Chair*
Agriculture
Appropriations Subcommittee on Finance and Tax
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Education
Health Policy

SELECT COMMITTEE:
Select Committee on Patient Protection and Affordable Care Act

January 22, 2013

Senator Aaron Bean, Chair
302 Senate Office Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean:

Please accept this letter as my request for excused absence to the meeting of the Committee on Health Policy scheduled for 4:00PM on Wednesday, January 23rd. I will be presenting legislation before the Committees on Banking and Insurance and Military Affairs, Space, and Domestic Security. Please contact me with any questions or concerns.

Kind regards,

Jeff Brandes

CC: Sandra Stovall

REPLY TO:
❒ 3637 Fourth Street North, Suite 101, St. Petersburg, Florida 33704-1300 (727) 552-2745
❒ 318 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5022

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 1/23/2013 4:03:39 PM
Ends: 1/23/2013 4:52:48 PM **Length:** 00:49:10

4:03:44 PM Chair Bean's opening remarks
4:04:37 PM Roll call
4:05:11 PM (Tab 1) SB 56, Infant Death, by Senator Hays
4:06:30 PM SB 56 Public Testimony - Sam Bell, Florida Pediatrics Society, remarks
4:07:31 PM SB 56, Infant Death, vote
4:07:58 PM (Tab 2) SPB 7004, OGSR/Joshua Abbott Organ and Tissue Registry/Donor Information by Health Policy
4:08:59 PM Senator Galvano's question
4:09:15 PM Chair Bean's remarks
4:09:49 PM Sandra Stovall, Health Policy Staff Director, response
4:10:26 PM SPB 7004, OGSR/Joshua Abbott Organ and Tissue Registry/Donor Information vote
4:10:55 PM (Tab 3) Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, opening remarks
4:14:08 PM Chair Bean's question
4:14:14 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:14:32 PM Chair Bean's question
4:14:36 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:16:06 PM Senator Galvano question
4:16:22 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:16:27 PM Vice-Chair Sobel's question
4:17:01 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:18:14 PM Chair Bean's questions
4:18:31 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:18:53 PM Chair Bean's question
4:18:56 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:19:17 PM Chair Bean's question
4:19:19 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:20:34 PM Chair Bean's questions
4:20:44 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:20:47 PM Chair Bean's question
4:20:49 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:21:30 PM Vice-Chair Sobel's questions
4:21:47 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:22:38 PM Senator Garcia question
4:23:06 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:23:49 PM Senator Garcia's follow-up question and Chair Bean's question
4:24:07 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:24:24 PM Chair Bean's question
4:24:25 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:24:36 PM Chair Bean's question
4:24:46 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:24:55 PM Senator Garcia's remarks
4:25:06 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, continued remarks
4:25:40 PM Chair Bean's remarks
4:25:51 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, continued remarks
4:26:00 PM Chair Bean's question
4:26:03 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:26:28 PM Chair Bean's questions
4:26:36 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:27:10 PM Chair Bean's question
4:27:20 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response

4:27:24 PM Chair Bean's remarks
4:27:36 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, continued remarks
4:28:10 PM Chair Bean's question
4:28:20 PM Justin Senior, Deputy Secretary, Division on Medicaid, Agency for Health Care Administration, response
4:28:49 PM Chair Bean's remarks
4:29:33 PM Public Testimony -- Stan Whittaker, Florida Association of Nurse Practitioners, remarks
4:31:40 PM Chair Bean's remarks
4:31:52 PM Stan Whittaker, Florida Association of Nurse Practitioners, response
4:34:04 PM Public Testimony -- Marifrances Gullo, Advanced Practice Nursing Services LLC, remarks
4:38:42 PM Vice-Chair Sobel's question
4:39:01 PM Marifrances Gullo, Advanced Practice Nursing Services LLC, response
4:39:07 PM Vice-Chair Sobel's continued remarks
4:39:23 PM Marifrances Gullo, Advanced Practice Nursing Services LLC, response
4:39:52 PM Chair Bean's remarks
4:40:05 PM Vice-Chair Sobel's question
4:40:13 PM Chair Bean's remarks
4:40:52 PM (Tab 4) Lucy Gee, Division Director Medical Quality Assurance, Department of Health, prescription drug monitoring program update
4:42:25 PM Chair Bean's remarks
4:42:27 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, continued remarks
4:43:37 PM Chair Bean's remarks
4:44:19 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:44:42 PM Chair Bean's remarks
4:44:50 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, continued remarks
4:46:25 PM Chair Bean's question
4:46:34 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:46:46 PM Chair Bean's questions and Lucy Gee, Division Director Medical Quality Assurance, Department of Health, responses
4:47:12 PM Chair Bean's remarks
4:47:44 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, continued remarks
4:47:59 PM Chair Bean's question
4:48:08 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:48:59 PM Chair Bean's question
4:49:04 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response and continued remarks
4:50:12 PM Chair Bean's continued remarks
4:50:29 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, remarks
4:50:43 PM Chair Bean's question
4:50:52 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:51:27 PM Chair Bean's remarks
4:51:34 PM Senator Grimsley's question
4:51:53 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:52:23 PM Senator Grimsley's follow-up question
4:52:30 PM Lucy Gee, Division Director Medical Quality Assurance, Department of Health, response
4:52:33 PM Chair Bean's remarks
4:52:44 PM Meeting Adjourned