HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HHSC 11-04 Office of Drug Control
SPONSOR(S): Health & Human Services Committee; Schenck
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	12 Y, 5 N	Poche	Gormley

SUMMARY ANALYSIS

PCB HHSC 11-04 repeals s. 397.332, F.S., establishing the Office of Drug Control (ODC) within the Executive Office of the Governor (EOG). The PCB also repeals s. 893.055, F.S., establishing the prescription drug monitoring program (PDMP), repeals s. 893.0551, F.S., providing a public records exemption for information gathered by and maintained by the PDMP.

Lastly, the PCB makes several conforming changes to reflect the elimination of the ODC, the PDMP, and the public records exemption provided to the PDMP.

The PCB has a positive fiscal impact on the Executive Office of the Governor in the amount of $1,020,805. (See Fiscal Notes.)

The PCB provides an effective date of July 1, 2011.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Office of Drug Control

Section 397.332, F.S., created the Office of Drug Control within the Executive Office of the Governor (EOG) in 1999.[1] The Governor is required to appoint a director of the Office of Drug Control (ODC), who is subject to confirmation by the Florida Senate. The purpose of the Office of Drug Control is to work, in collaboration with the Office of Planning and Budgeting (OPB), to:

- Coordinate drug control efforts and enlist the assistance of the public and private sectors in those efforts, including, but not limited to, federal, state, and local agencies.
- Provide information to the public about the problem of substance abuse and the substance abuse programs and services that are available.
- Act as the Governor's liaison with state agencies, other state governments, the federal Office of National Drug Control Policy, federal agencies, and with the public and private sectors on matters that relate to substance abuse.
- Work to secure funding and other support for the state's drug control efforts, including, but not limited to, establishing cooperative relationships among state and private agencies.
- Develop a strategic program and funding initiative that links the separate jurisdictional activities of state agencies with respect to drug control. The office may designate lead and contributing agencies to develop such initiatives.
- Advise the Governor and the Legislature on substance abuse trends in this state, the status of current substance abuse programs and services, the funding of those programs and services, and the status of the Office of Drug Control in developing and implementing the state drug control strategy.
- Make recommendations to the Governor on measures that the director considers advisable for the effective implementation of the state drug control strategy.

The ODC has 7 full-time employees (FTE) of which 5 FTEs comprise the ODC and 2 FTEs comprise the subordinate Office of Suicide Prevention. One FTE position is currently unfunded and is vacant. In addition, two full-time Florida National Guard Counterdrug officers are assigned to the office. The office also has two liaisons from other agencies – one from the Department of Children and Families (DCF) and one from the Department of Health.

The ODC participates in various statutory task forces, councils, and work groups:[2]

- Drug Policy Advisory Council (1999)
- Seaport Security Standards Advisory Council (2000)
- Violent Crime and Drug Control Council (2000)
- Drug Free Workplace Advisory Panel (2004)
- Florida Alliance for Drug Endangered Children (2005)
- Methamphetamine Work Group (2005)
- Governor's State Leadership Task Force on Reducing Underage Drinking (2005)
- State Epidemiology Work Group (2005)
- Gender-Specific Substance Abuse Services Workgroup (2006)
- Suicide Prevention Coordinating Council (2007)
- Drug Paraphernalia Abatement Task Force (2007)
- Remediation of Illicit Drug Labs Task Force (2007)

[1] Ch. 99-187, s. 2, Laws of Fla. (1999)

[2] The Director of the Office of Drug Control chairs the Drug Policy Advisory Council, Seaport Security Standards Advisory Council, the 28-member Suicide Prevention Coordinating Council and the Prescription Drug Monitoring Program Oversight and Implementation Task Force.

- Attorney General's Gang Reduction Executive Workgroup (2007)
- Prescription Drug Monitoring Program (PDMP) Implementation and Oversight Task Force (2009)

The Statewide Office for Suicide Prevention

Section 14.2019, F.S., creates the Statewide Office of Suicide Prevention (Office) as a unit of the ODC. Its statutory mission is to reduce the suicide rate in Florida. The Office produces a Suicide Prevention Strategy to provide a framework for activities to reduce Florida's suicide rate.[3] The goals of the Strategy are to:

- Promote awareness that suicide is a preventable public health problem.
- Reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
- Create collaborations and networks that support common goals in suicide prevention.
- Develop and implement evidence-based suicide prevention, intervention and 'postvention' programs.
- Develop and promote clinical and professional practices for delivery of effective treatment.
- Improve community access to mental health and substance abuse services.
- Reduce access to lethal means and methods of self-harm.
- Support suicide prevention research and improve surveillance systems.

The Office of Suicide Prevention also oversees the Suicide Prevention Coordinating Council, a 28-member council appointed by the Executive Office of the Governor.

Prescription Drug Monitoring Program (PDMP)

Section 893.055, F.S.,[4] requires the Department of Health (DOH), by December 1, 2010, to design and establish a comprehensive electronic system for tracking Schedule II, III, IV and V controlled substance dispensing in Florida. All pharmacists and dispensing practitioners are required to report dispensing information to DOH for inclusion in a statewide database. Failure to report is a first degree misdemeanor. The report must include:

- The patient's name, address and date of birth
- Information about the prescribing physician
- Information about the pharmacy or dispensing physician
- The name, quantity and strength of the drug dispensed

The report must be made within 15 days of dispensing. The statute provides reporting exemptions for dispensing in the following contexts:

- By hospitals and other institutions;
- In the Department of Corrections health system;
- For a declared disaster;
- To children under the age of 16.

Section 893.055, F.S., requires that the PDMP be designed to provide information regarding dispensed prescriptions of controlled substances in order to prevent the inadvertent, improper, or illegal use of controlled substances and may not infringe upon the legitimate prescribing of a controlled substance by a prescribing practitioner, dispensing pharmacist, or dispensing practitioner acting in good faith and in the course of professional practice. The system must be consistent with standards of the American Society for Automation in Pharmacy for the validation of prescribing and dispensing controlled substances to an individual. The electronic system must also comply with the HIPAA and all other relevant state and federal privacy and security laws and regulations.

[3] Statewide Office of Suicide Prevention, Suicide Prevention Strategy 2011-2015, *available at* http://www.helppromotehope.com/strategy/index.php (last viewed March 12, 2011).
[4] Ch. 2009-198, s.1. Laws of Fla. (2009)

In addition, s. 893.0551, F.S., provides a public records exemption for information contained in the database. Information identifying patients, patients' agents, health care practitioners, pharmacists, pharmacists' agents and pharmacies are confidential and exempt from public access. However, DOH is required to disclose this confidential information to certain entities:

- The Agency for Health Care Administration when it has initiated a review of specific identifiers of Medicaid fraud and abuse.
- A criminal justice agency as defined in s. 119.011, F.S., which enforces the laws of this state or the United States relating to controlled substances and which has initiated an active investigation involving a specific violation of law.
- A practitioner as defined in s. 893.02, F.S., and an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, who requests such information and certifies that the information is necessary to provide medical treatment to a current patient in accordance with s. 893.05, F.S.
- A pharmacist as defined in s. 465.003, F.S., or a pharmacy intern or pharmacy technician who is acting on behalf of and at the direction of the pharmacist, who requests such information and certifies that the requested information is to be used to dispense controlled substances to a current patient in accordance with s. 893.04, F.S.
- A patient who is identified in the record upon a written request, for the purpose of verifying that information.
- A judge or probation or parole officer administering a drug or the probation program of a criminal defendant arising out of a violation of Ch. 893, F.S., or of a criminal defendant who is documented by the court as a substance abuser and who is eligible to participate in a court-ordered drug diversion, treatment, or probation program. A duly appointed medical examiner or agent who requests such information and certifies that the information is necessary in an active death investigation as provided in s. 406.11, F.S., which involves a suspected drug-related death.

A person who willfully and knowingly violates the restrictions on the use of personal identifying information about a patient, practitioner, or pharmacist commits a felony of the third-degree, punishable as provided in s. 775.082 or s. 775.083, F.S.

The PDMP must provide, as determined by the DOH rule, advisory reports to authorized pharmacies, prescribing practitioners, and dispensing health care practitioners. The advisory reports are not subject to discovery or introduction into evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient arising out of matters that are the subject of the report. A person who participates in the preparation of an advisory report is not permitted or may not be required to testify in any civil action regarding any findings, recommendations, evaluations, opinions, or other actions taken in connection with preparing the report.

DOH is required to adopt rules to implement the prescription drug validation program by October 1, 2010 concerning the reporting, evaluation, management, and storage of information within the PDMP, including rules for when information is provided to pharmacies, prescribers, health care practitioners, health care regulatory boards, and law enforcement agencies. DOH must work with professional licensure boards and other appropriate organizations, including the Attorney General, the Florida Department of Law Enforcement, and the Agency for Health Care Administration, to develop the rules.

PDMP Funding

The Legislature made no appropriations to fund the PDMP. Under s. 893.055(10), F.S., implementation is contingent on the receipt of non-state funds. Section 893.055(11), F.S., authorizes the ODC to create a direct-support organization (DSO) to solicit grants and donations for the support of the PDMP.

The DSO's board of directors is appointed by the director of ODC, and serves at his pleasure. The DSO operates under a contract with ODC, and its activities must be consistent with the goals and mission of the ODC. The DSO is authorized to:

- Collect and expend funds to be used for the functions of the organization's board of directors;

- Establish and administer the PDMP's electronic database;
- Conduct studies on the efficiency and effectiveness of the program;
- Provide funds for future enhancements of the program;
- Provide health care practitioner education;
- Pay for travel expenses, administrative costs and all other requirements needed to establish the program.

Section 893.055(d), F.S., provides that, if the DSO ceases to exist or its contract is terminated all moneys and property held in trust by the DSO for the benefit of the PDMP revert to the ODC without penalty. If the ODC ceases to exist, such moneys and property revert to the state. Since 2009, the DSO has generated funds through grants and donations as follows:

Federal Grants	Funding	Expenditures per Funding Source FY09/10	Expenditures per Funding Source FY10/11	Total Funds Remaining as of 1/31/11
Harold Rogers Implementation Grant	$400,000	($3,628)	($36,854)	$359,518
Harold Rogers Enhancement Grant	$400,000			$400,000
Federal Grants Sub-Total	**$800,000**	**($3,628)**	**($36,854)**	**$759,518**
Private Grants				
National Association of States Controlled Substance Authorities (NASCSA)Grant 1	$20,000	($2,595)	($9,369)	$8,036
NASCSA Grant 2	$6,271		($945)	$5,326
NASCSA Grant 3	$19,681			$19,681
Private Grants Sub-Total	**$45,952**	**($2,595)**	**($10,314)**	**$33,043**
Direct Support Organization				
Florida PDMP Foundation, Inc.	$240,660	($193)	($86,979)	$153,488
DSO Sub-Total	**$240,660**	**($193)**	**($86,979)**	**$153,488**
FUNDING TOTAL	**$1,086,612**	**($6,416)**	**($134,147)**	**$946,049**

Procurement of the PDMP Database

Section 893.055 requires DOH to procure a vendor to create the PDMP through a competitive bid process, and DOH made two efforts to do so. In August 2010 and, again, in January 2011, DOH procurements were challenged by a losing company, delaying implementation of the PDMP. In the second procurement, DOH awarded the contract to Health Information Designs. Optimum Technology, a losing bidder, filed a bid challenge alleging that the contract was awarded unfairly and that Optimum Technology should have received the contract. On March 8, 2011, a hearing officer with the Department of Administrative Hearings rejected the bid challenge and directed DOH to enter a final order dismissing the Formal Written Protest.[5] Optimum Technology may appeal the DOH final order to the First District Court of Appeal in Tallahassee, further delaying implementation of the PDMP database.

[5] *See* Recommended Order dated March 8, 2011, Optimum Technology, Inc. v. Dept. of Health, Case No. 11-0257BID, Div. of Admin. Hrgs.

Studies of the Effectiveness of PDMPs

U.S. General Accounting Office

The U.S. General Accounting Office (U.S. GAO) was the first entity to conduct an in-depth examination of state monitoring programs as a tool to reduce the diversion of prescription drugs.[6] At the time of completion of the report, only 15 states had PDMPs.[7] The report found that the most frequently diverted prescription drugs during the time period of the study, October 2001 through April 2001, were those that are prone to abuse, addiction, and dependence, including, but not limited to, hydrocodone (the active ingredient in Lortab and many other drugs), diazepam (Valium), methylphenidate (Ritalin), and oxycodone (the active ingredient in OxyContin and many other drugs).[8]

The report addressed four aspects of PDMPs. First, the report found that there was considerable variation in the actual operation of the PDMP across the 15 states. Second, the report found benefits in using a PDMP, including timeliness of law enforcement investigations of diversion or abuse and a chilling effect on doctor shopping. Third, the report identified certain challenges to the successful implementation and use of a PDMP. These challenges included concerns with individual privacy, educating people about the program to encourage its use, and long-term costs. Lastly, the report pointed out that the federal government could provide guidance in setting up and operating a PDMP and provide technical assistance with the database itself.

Simeone Associates (2006)

The seminal study addressing the effectiveness of PDMPs was conducted by Simeone Associates, Inc., in 2006.[9] At the time that the study was conducted, 20 states had PDMPs and 23 others were planning PDMPs. The study focused on Schedule II controlled substances because all 20 PDMPs monitored at least Schedule II controlled substances. The study used 2 measures to evaluate effectiveness: the supply of drugs and the admission rate to treatment programs.

Supply data was obtained through the Drug Enforcement Agency's Automation of Reports and Consolidated Orders System (ARCOS)[10], which provides data reflecting distributions of controlled substances from the manufacturer through commercial distribution channels to the point of sale or distribution at the dispensing/retail level. Drug treatment admissions data was obtained through the Treatment Episode Data Set (TEDS)[11], the federal surveillance system of all drug admissions to publicly funded rehabilitation facilities.

The ARCOS data was used to measure changes in drug supply—based on the reasonable assumption that fewer drugs leads to less abuse. The supply data was examined at a state level—thus it is considered an aggregate model and the analysis compares the supply in states with PDMPs versus states without PDMPs; in states with PDMPs, a further distinction is made between pro-active and re-active PDMPs. The TEDs data reports individual behavior by tracking admissions to treatment programs. Because individuals abuse drugs, not states, this type of modeling is considered a measurement of an indirect effect of the PDMP. The study assumed that changes in these admission rates was indicative of a PDMP's direct effect on prescribing and dispensing behavior.

The study found that the presence of a PDMP reduces per capita supply of prescription pain relievers and stimulants, and that this in turn reduces the probability of abuse for such drugs. The study pointed

[6] *See* Prescription Drugs- State Monitoring Programs Provide Useful Tool to Reduce Diversion, U.S. GAO Report #GAO-02-634, May 2002.
[7] *Id.* at pg. 3.
[8] *Id.* at pg. 1.
[9] Ronald Simeone and Lynn Holland, Simeone Associates, Inc., *An Evaluation of Prescription Drug Monitoring Program*, Sept. 1, 2006.
[10] Automation of Reports and Consolidated Orders System, maintained by the Drug Enforcement Administration Office of Drug Control, found at http://www.deadiversion.usdoj.gov/arcos/index.html
[11] Treatment Episode Data set, maintained by the Substance Abuse and Mental Health Services Administration, found at http://oas.samhsa.gov/dasis.htm

out that the probability of prescription pain reliever abuse is a function of the per capita supply of prescription pain relievers, and the probability of prescription stimulant abuse is a function of the per capita supply of prescription stimulants. The evidence also suggested that states which are proactive in their approach to regulation may be more effective in reducing the per capita supply of prescription pain relievers and stimulants than states which are reactive in their approach to regulation.

In summary, the results of the study indicate that PDMPs which monitor proactively have inhibited growth in prescription sales for both pain relievers and stimulants and in so doing exerted an indirect effect on the probability of abuse for these drugs. However, the authors of the study noted several limitations of the study and offered several notes of caution when interpreting the results of the study:

- Modeling of the study is based on numerous assumptions
- The study evaluated correlation, not causality.
- Selected data for measuring rates of abuse is significantly affected by numerous other factors, such as availability of treatment programs.
- The study did not fully deal with population risk factors
- The study did not fully deal with "simultaneity", or the impact of other factors not measured or contemplated by the study.
- The study did not test whether any other mechanism of reducing supply was similarly correlated
- These types of studies can only suggest causality
- The study was not able to account for duplicated patients
- The problem of "upward secular trends", meaning drug supply and use was increasing significantly throughout the period, hid any marginal changes.

Reisman

In 2009, another study similar to the 2006 Simeone Associates study examined ARCOS and TEDS data in conjunction with a greater number of operational PDMPs.[12] The Reisman study looked at a different aspect of the ARCOS data: opioids shipments in grams, specifically oxycodone and methadone in Schedule II and hydrocodone and codeine in Schedule III, per 100,000 population. The study also examined the TEDS data from 1997 to 2003. The authors of the study conducted a statistical analysis to assess the association of the following variables:

- Increased medication usage association with increased abuse
- PDMPs effect on opioid shipments
- PDMPs effect on substance abuse

During the study period, the shipments of opioids increased dramatically, nationwide: oxycodone shipments were up 479 percent, hydrocodone shipments were up 148 percent, and morphine shipments were up 100 percent. In the same period, rehabilitation admission rates for opioid addiction more than doubled. The increase in oxycodone shipments had the strongest positive correlation with abuse admission rate: "[t]he PDMP group demonstrated a 553% increase in oxycodone shipments and 158% increase in hydrocodone shipments from 1997 to 2003. The control group demonstrated a 456% increase in oxycodone shipments and a 138% increase in hydrocodone shipments."[13] Based on grams per population, hydrocodone shipments were higher in the PDMP group compared to the control group.

However, PDMP states experienced a statistically significant reduction in the rise of oxycodone shipments. In fact, oxycodone was the only opioid demonstrating a statistically significant, strong positive association with the changes in admission rates. The authors of the study concluded that increasing oxycodone medical usage contributes to increasing prescription opioid diversion and abuse. The PDMP group demonstrated a clear trend of decreasing oxycodone shipments and decreasing abuse compared to the control group.

As was the case in previous studies, the authors named several limiting factors that impacted the efficacy of the study results, including:

[12] Richard M. Reisman, et al., *Prescription Opioid Usage and Abuse Relationships: An Evaluation of State Prescription Drug Monitoring Program Efficacy,* Substance Abuse: Research and Treatment 2009:3 41-51.
[13] *Id.* at pg. 46.

- Confounding variables;
- Assumption that dramatic increases in supply demonstrate that PDMPs have no chilling effect on medical usage. Given this assumption, the authors also assumed that decreases in oxycodone shipments are secondary to decreased diversion;
- Impact of PDMP was measured based on treatment utilization rates which vary based on availability and other factors;
- No distinction between pro-active and re-active PDMPs; and
- No identification of other important factors, including pharmacy and practitioner regulations.

Simeone Associates (2009)

Simeone Associates completed another study, in 2009, to study the effect of PDMPs on "doctor shopping".[14] The authors of the study expected that a PDMP would reduce doctor shopping; therefore, it was important to measure the possible effect. The study examined 2008 data from PDMPs about prescribers and dispensers and established three thresholds addressing doctor shopping, based on monthly prescriptions received from and filled at the following combinations of prescribers and dispensers: 5 prescribers and 5 dispensers; 10 prescribers and 10 dispensers; and 15 prescribers and 15 dispensers.
The study next evaluated the amount of drugs provided to individuals in each of these categories. The study found that doctor shopping is relatively uncommon. The amount of doctor shopping depends on the definition and each larger threshold decreases the number of individuals involved.

Again, limitations were identified by the authors of the study, including:
- The threshold definitions are vague; and
- Variability in data sources prevents data from being compared across states

Paulozzi and Steir

A study completed in 2010 made an effort to identify successful prescription overdose prevention strategies in states with PDMPs.[15] The study compared the New York and Pennsylvania PDMPs, which differ in several ways, including levels of funding, proactive investigation of irregularities, and the use of other strategies to reduce or eliminate diversion. The study found per capita opioid usage in New York was 2/3 of the usage rate in Pennsylvania. Also, overdose drug mortality was 1.6 times higher in Pennsylvania compared to New York. The study concluded that "[t]he current situation, a patchwork quilt of rapidly changing state legislation whose evaluation lags behind its implementation, is a prescription for continued overdose morbidity and mortality."[16]

Paulozzi

Another study examined prescription drug overdose mortality in all fifty states and the District of Columbia between 1999 and 2005.[17] Using ARCOS data for the supply of controlled substances listed in Schedule II and III, specifically including hydrocodone, the study adjusted supply data to calculate morphine milligram equivalents (MME) to allow for direct comparison of drugs across states and across the schedules. The study distinguished between those states with an operational PDMP and states with proactive PDMP, which generate non-solicited reports for prescribers, dispensers, or law enforcement, and measured the results against states without an operational PDMP. The study sought to analyze the association of PDMPs with drug overdose mortality, opioid overdose-relate mortality and MME.

[14] Simeone Associates, Inc. and Carnevale Associates, LLC, *Performance Indicators for Prescription Drug Monitoring Programs: Doctor Shopping*, presented at the Fifth National Meeting of the Harold Rogers Prescription Drug Monitoring Program, Sept. 24, 2009.
[15] Leonard Paulozzi, MD and Daniel D. Stier, *Prescription drug laws, drug overdoses, and drug sales in New York and Pennsylvania,* 31 Journal of Public Health Policy 4, pgs. 422-32 (2010).
[16] *Id.* at pg. 429.
[17] Leonard Paulozzi, MD, et al, *Prescription Drug Monitoring Programs and Death Rates from Drug Overdose*, -- Pain Medicine --, 2011 (not yet published, copy on file with Health and Human Services Committee)

The study found that, in all states, mortality rates rose substantially and consistently during 1999-2005. Proactive PDMP states did not have lower mortality rates than other states, although three states stood out for distinctly lower mortality rates: California, New York and Texas. Analysis of supply using MME showed the mean rates tripling during the study period- from 175 MME/person to about 525 MME/person. PDMP and non-PDMP states had almost identical mean MME rates during this period. The study concluded, unequivocally, that PDMP states did not fare any better than non-PDMP states in controlling the rise in drug overdose mortality during the time period examined by the study.[18]

Effect of Proposed Changes

The PCB repeals s. 397.332, F.S., eliminating the ODC. The PCB makes necessary conforming changes to Florida Statutes to implement the repeal of the ODC and the PDMP. The Statewide Office of Suicide Prevention is moved to Department of Children and Family Services, and receives ODC's suicide-related functions. ODC roles on various task forces, work groups, and councils are eliminated or assigned to other entities.

The PCB repeals ss. s. 893.055 and 893.0551, F.S., eliminating the PDMP, its public records exemption, and the DSO.

Section 893.055(d), F.S., provides that, if the DSO ceases to exist or its contract is terminated all moneys and property held in trust by the DSO for the benefit of the PDMP revert to the ODC without penalty. If the ODC ceases to exist, such moneys and property revert to the state. However, the PCB repeals this provision concurrently with the provisions establishing the ODC and the DSO, making the effect on the DSO-held funds unclear.

B. SECTION DIRECTORY:

Section 1: Amends s. 14.2019, F.S., relating to the Statewide Office for Suicide Prevention
Section 2: Amends s. 14.20195, F.S., relating to the Suicide Prevention Coordinating Council; creation; membership; duties
Section 3: Amends s. 311.115, F.S., relating to the Seaport Security Standards Advisory Council
Section 4: Amends s. 311.12, F.S., relating to seaport security
Section 5: Amends s. 311.123, F.S., relating to the maritime domain security awareness training program
Section 6: Amends s. 397.331, F.S., relating to definitions; legislative intent
Section 7: Repeals s. 397.332, F.S, relating to the Office of Drug Control
Section 8: Amends s. 397.333, F.S., relating to the Statewide Drug Policy Advisory Council
Section 9: Repeals s. 893.055, F.S., relating to the prescription drug monitoring program
Section 10: Repeals s. 893.0551, F.S., relating to the public records exemption for the prescription drug monitoring program
Section 11: Amends s. 943.031, F.S., relating to the Florida Violent Crime and Drug Control Council
Section 12: Amends s. 943.042, F.S., relating to the Violent Crime Investigative Emergency and Drug Control Strategy Implementation Account
Section 13: Provides an effective date of July 1, 2011

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See fiscal comments.

[18] *Id.* at pg. 6.

2. Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

DOH will not award a contract to create and maintain the PDMP database. The company to whom the last contract was awarded, Health Information Systems, will lose the contract.

Pharmacies and dispensing physicians will not be required to expend personnel hours uploading prescriptions for controlled substances to the PDMP database, thereby saving money in the form of labor costs.

D. FISCAL COMMENTS:

The elimination of the ODC will result in savings to the state in the form of salaries and operating and administrative costs previously appropriated for 7 full-time employees (FTEs) working in the ODC.

Salary and Benefits	$492,207	GR
Lump Sum	$ 82,050	GR (transferred annually by budget amendment, as needed)
Risk Management	$ 5,220	GR
HR Mgt – To DMS	$ 2,266	GR
Total	**$581,743**	**GR**
EUDL Block Grant	$439,062	Federal Grant
Total Funds	**$1,020,805**	

The DSO holds $153,488 in donations for the PDMP. Section 893.055(d), F.S., provides that, if the DSO ceases to exist or its contract is terminated all moneys and property held in trust by the DSO for the benefit of the PDMP revert to the ODC without penalty. If the ODC ceases to exist, such moneys and property revert to the state. However, the PCB repeals this provision concurrently with the provisions establishing the ODC and the DSO, making the effect on the DSO-held funds unclear.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Section 893.055(d), F.S., provides that, if the DSO ceases to exist or its contract is terminated all moneys and property held in trust by the DSO for the benefit of the PDMP revert to the ODC without penalty. If the ODC ceases to exist, such moneys and property revert to the state. However, the PCB repeals this provision concurrently with the provisions establishing the ODC and the DSO, making the effect on the DSO-held funds unclear. The PCB should be amended to resolve this issue.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES