A bill to be entitled

An act relating to health care; amending s. 395.0191, F.S.; defining terms; requiring a certain percent of surgical assistants or surgical technologists employed or contracting with a hospital to be certified; providing exceptions; amending s. 395.003, F.S.; revising provisions relating to the provision of cardiovascular services by a hospital; amending s. 400.235, F.S.; revising the criteria for recognition as a Gold Seal Program nursing home facility; amending s. 394.9082, F.S.; requiring the Department of Children and Families to develop standards and protocols for the collection, storage, transmittal, and analysis of utilization data from public receiving facilities; defining the term "public receiving facility"; requiring the department to require compliance by managing entities by a specified date; requiring a managing entity to require public receiving facilities in its provider network to submit certain data within specified timeframes; requiring managing entities to reconcile data to ensure accuracy; requiring managing entities to submit certain data to the department within specified timeframes; requiring the department to create a statewide database; requiring the department to adopt rules; requiring the department to submit an annual report to the Governor and the Legislature; providing that implementation is subject to specific appropriations; amending s. 409.967, F.S.; revising

contract requirements for Medicaid managed care programs; providing requirements for plans establishing a drug formulary or preferred drug list; requiring the use of a standardized prior authorization form; providing requirements for the form and for the availability and submission of the form; requiring a pharmacy benefits manager to use and accept the form under certain circumstances; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; amending s. 465.189, F.S.; authorizing a pharmacist to administer meningococcal and shingles vaccines; creating s. 627.42392, F.S.; requiring health insurers to use a standardized prior authorization form; providing requirements for the form and for the availability and submission of the form; requiring a pharmacy benefits manager to use and accept the form under certain circumstances; providing an exemption; creating s. 627.42393, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; providing an exemption; amending s. 627.6131, F.S.; prohibiting an insurer from retroactively denying a claim in certain circumstances; amending s. 627.6471, F.S.; requiring insurers to post preferred provider information on a

website; specifying that changes to such a website must be made within a certain time; amending s. 627.6515, F.S.; applying provisions relating to prior authorization and override protocols to out-of-state groups; amending s. 641.3155, F.S.; prohibiting a health maintenance organization from retroactively denying a claim in certain circumstances; creating s. 641.393, F.S.; requiring the use of a standardized prior authorization form by a health maintenance organization; providing requirements for the availability and submission of the form; requiring a pharmacy benefits manager to use and accept the form under certain circumstances; providing an exemption; creating s. 641.394, F.S.; establishing a process for providers to override certain treatment restrictions; providing requirements for approval of such overrides; providing an exception to the override protocol in certain circumstances; providing an exemption; amending s. 395.4001, F.S.; conforming cross-references; amending s. 395.401, F.S.; limiting trauma service fees to a certain amount; providing for future expiration; conforming a cross-reference; amending s. 395.402, F.S.; requiring the Department of Health to convene the Florida Trauma System Plan Advisory Council by a specified date; requiring the advisory council to review the Trauma System Consultation Report and make recommendations to the Legislature by a specified date; authorizing the advisory council to make recommendations to the State Surgeon General;

designating the membership of the advisory council; amending s. 395.4025, F.S.; deleting a provision relating to the procedure for protesting an application decision by the department; conforming cross-references; authorizing certain provisional and verified trauma centers to continue operating and to apply for renewal; restricting the department from verifying, designating, or provisionally approving hospitals as trauma centers; providing for future expiration; providing effective dates.

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

Section 1. Present subsections (1) through (10) of section 395.0191, Florida Statutes, are redesignated as subsections (2) through (11), respectively, present subsection (6) is amended, and a new subsection (1) and subsection (12) are added to that section, to read:

395.0191 Staff membership and clinical privileges.—

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

(a) "Certified surgical assistant" means a surgical assistant who maintains a valid and active certification under one of the following designations:

1. Certified surgical first assistant, from the National Board of Surgical Technology and Surgical Assisting.

2. Certified surgical assistant, from the National Surgical Assistant Association.

3. Surgical assistant-certified, from the American Board of Surgical Assistants.

(b) "Certified surgical technologist" means a surgical technologist who maintains a valid and active certification as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting.

(c) "Surgeon" means a health care practitioner as defined in s. 456.001 whose scope of practice includes performing surgery and who is listed as the primary surgeon in the operative record.

(d) "Surgical assistant" means a person who provides aid in exposure, hemostasis, closures, and other intraoperative technical functions and who assists the surgeon in performing a safe operation with optimal results for the patient.

(e) "Surgical technologist" means a person whose duties include, but are not limited to, maintaining sterility during a surgical procedure, handling and ensuring the availability of necessary equipment and supplies, and maintaining visibility of the operative site to ensure that the operating room environment is safe, that proper equipment is available, and that the operative procedure is conducted efficiently.

(7) ~~(6)~~ Upon the written request of the applicant, a ~~any~~ licensed facility that has denied staff membership or clinical privileges to an ~~any~~ applicant specified in subsection (2) ~~(1)~~ or subsection (3) ~~(2)~~ shall, within 30 days of such request, provide the applicant with the reasons for such denial in writing. A denial of staff membership or clinical privileges to an ~~any~~ applicant shall be submitted, in writing, to the applicant's respective licensing board.

(12)(a) At least 50 percent of the surgical assistants that a facility employs or contracts must be certified surgical

assistants.

(b) At least 50 percent of the surgical technologists that a facility employs or contracts must be certified surgical technologists.

(c) Paragraphs (a) and (b) do not apply to:

1. A person who has completed an appropriate training program for surgical technology in any branch of the Armed Forces or reserve component of the Armed Forces.

2. A person who was employed or contracted to perform the duties of a surgical technologist or surgical assistant before July 1, 2014.

3. A health care practitioner as defined in s. 456.001 or a student if the duties performed by the practitioner or the student are within the scope of the practitioner's or the student's training and practice.

4. A person enrolled in a surgical technology or surgical assisting training program accredited by the Commission on Accreditation of Allied Health Education Programs, the Accrediting Bureau of Health Education Schools, or other accrediting body recognized by the United States Department of Education on July 1, 2014. A person may practice as a surgical technologist or a surgical assistant for 2 years after completing such training program before he or she is required to meet the criteria in paragraph (a).

Section 2. Paragraph (a) of subsection (6) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(6)(a) A specialty hospital may not provide any service or regularly serve any population group beyond those services or

groups specified in its license. A ~~specialty-licensed children's~~ hospital that is authorized to provide pediatric cardiac catheterization and pediatric open-heart surgery services may provide cardiovascular service to adults who, as children, were previously served by the hospital for congenital heart disease, or to ~~those~~ patients who are referred only for a specialized procedure ~~only~~ for congenital heart disease by an adult hospital, without obtaining additional licensure as a provider of adult cardiovascular services. The agency may request documentation as needed to support patient selection and treatment. This subsection does not apply to a specialty-licensed children's hospital that is already licensed to provide adult cardiovascular services.

Section 3. Paragraph (f) of subsection (5) of section 400.235, Florida Statutes, is amended to read:

400.235 Nursing home quality and licensure status; Gold Seal Program.—

(5) Facilities must meet the following additional criteria for recognition as a Gold Seal Program facility:

(f) Had no evidence of unresolved, verified complaints generated through ~~an outstanding record regarding the number and types of substantiated complaints reported to~~ the State Long-Term Care Ombudsman Program ~~Council~~ within the 30 months preceding application for the program.

A facility assigned a conditional licensure status may not qualify for consideration for the Gold Seal Program until after it has operated for 30 months with no class I or class II deficiencies and has completed a regularly scheduled relicensure

survey.

Section 4. Present subsections (10) and (11) of section 394.9082, Florida Statutes, are redesignated as subsections (11) and (12), respectively, and a new subsection (10) is added to that section, to read:

394.9082 Behavioral health managing entities.—

(10) CRISIS STABILIZATION SERVICES UTILIZATION DATABASE.— The department shall develop, implement, and maintain standards under which a managing entity shall collect utilization data from all public receiving facilities situated within its geographic service area. As used in this subsection, the term "public receiving facility" means an entity that meets the licensure requirements of and is designated by the department to operate as a public receiving facility under s. 394.875 and that is operating as a licensed crisis stabilization unit.

(a) The department shall develop standards and protocols for managing entities and public receiving facilities to be used for data collection, storage, transmittal, and analysis. The standards and protocols must allow for compatibility of data and data transmittal between public receiving facilities, managing entities, and the department for the implementation and requirements of this subsection. The department shall require managing entities contracted under this section to comply with this subsection by August 1, 2014.

(b) A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for:

1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as

defined in s. 394.4787; and

2. Current active census of total licensed beds, the number of beds purchased by the department, the number of clients qualifying as indigent occupying those beds, and the total number of unoccupied licensed beds regardless of funding.

(c) A managing entity shall require a public receiving facility within its provider network to submit data, on a monthly basis, to the managing entity that aggregates the daily data submitted under paragraph (b). The managing entity shall reconcile the data in the monthly submission to the data received by the managing entity under paragraph (b) to check for consistency. If the monthly aggregate data submitted by a public receiving facility under this paragraph is inconsistent with the daily data submitted under paragraph (b), the managing entity shall consult with the public receiving facility to make corrections as necessary to ensure accurate data.

(d) A managing entity shall require a public receiving facility within its provider network to submit data, on an annual basis, to the managing entity that aggregates the data submitted and reconciled under paragraph (c). The managing entity shall reconcile the data in the annual submission to the data received and reconciled by the managing entity under paragraph (c) to check for consistency. If the annual aggregate data submitted by a public receiving facility under this paragraph is inconsistent with the data received and reconciled under paragraph (c), the managing entity shall consult with the public receiving facility to make corrections as necessary to ensure accurate data.

(e) After ensuring accurate data under paragraphs (c) and

(d), the managing entity shall submit the data to the department on a monthly and annual basis. The department shall create a statewide database for the data described under paragraph (b) and submitted under this paragraph for the purpose of analyzing the payments for and the use of crisis stabilization services funded by the Baker Act on a statewide basis and on an individual public receiving facility basis.

(f) The department shall adopt rules to administer this subsection.

(g) The department shall submit a report by January 31, 2015, and annually thereafter, to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides details on the implementation of this subsection, including the status of the data collection process and a detailed analysis of the data collected under this subsection.

(h) The implementation of this subsection is subject to specific appropriations provided to the department in the General Appropriations Act.

Section 5. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

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

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and

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

2. If establishing a prescribed drug formulary or preferred drug list, a managed care plan shall:

a. Provide a broad range of therapeutic options for the treatment of disease states which are consistent with the general needs of an outpatient population. If feasible, the

formulary or preferred drug list must include at least two products in a therapeutic class.

b. ~~Each managed care plan must~~ Publish the ~~any~~ prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan shall ~~must~~ update the list within 24 hours after making a change. ~~Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers.~~

3. For enrollees ~~Medicaid recipients~~ diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

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

4. Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a managed care plan shall use a single standardized form for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefit. The form may not exceed two pages in length, excluding any instructions or guiding documentation.

a. The managed care plan shall make the form available electronically and online to practitioners. The prescribing provider may electronically submit the completed prior

authorization form to the managed care plan.

b. If the managed care plan contracts with a pharmacy benefits manager to perform prior authorization services for a medical procedure, course of treatment, or prescription drug benefit, the pharmacy benefits manager must use and accept the standardized prior authorization form.

c. A completed prior authorization request submitted by a health care provider using the standardized prior authorization form is deemed approved upon receipt by the managed care plan unless the managed care plan responds otherwise within 3 business days.

5. If medications for the treatment of a medical condition are restricted for use by a managed care plan by a step-therapy or fail-first protocol, the prescribing provider must have access to a clear and convenient process to request an override of the protocol from the managed care plan.

a. The managed care plan shall grant an override within 72 hours if the prescribing provider documents that:

(I) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the enrollee’s disease or medical condition; or

(II) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

(A) Is expected or is likely to be ineffective based on known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or

(B) Will cause or will likely cause an adverse reaction or

other physical harm to the enrollee.

b. If the prescribing provider allows the enrollee to enter the step-therapy or fail-first protocol recommended by the managed care plan, the duration of the step-therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the managed care plan can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period to provide any relief or amelioration to the enrollee, the step-therapy or fail-first protocol may be extended for an additional period, but no longer than the original customary period for use of the medication. Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the enrollee is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

Section 6. Subsections (1) and (2) of section 465.189, Florida Statutes, are amended to read:

465.189 Administration of vaccines and epinephrine autoinjection.—

(1) In accordance with guidelines of the Centers for Disease Control and Prevention for each recommended immunization or vaccine, a pharmacist may administer the following vaccines to an adult within the framework of an established protocol under a supervising physician licensed under chapter 458 or chapter 459:

(a) Influenza vaccine.

(b) Pneumococcal vaccine.

(c) Meningococcal vaccine.

(d) Shingles vaccine.

~~(2) In accordance with guidelines of the Centers for Disease Control and Prevention, a pharmacist may administer the shingles vaccine within the framework of an established protocol and pursuant to a written or electronic prescription issued to the patient by a physician licensed under chapter 458 or chapter 459.~~

Section 7. Section 627.42392, Florida Statutes, is created to read:

627.42392 Prior authorization.—

(1) Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a health insurer that delivers, issues for delivery, renews, amends, or continues an individual or group health insurance policy in this state, including a policy issued to a small employer as defined in s. 627.6699, shall use a single standardized form for obtaining prior authorization for a medical procedure, course of treatment, or prescription drug benefit. The form may not exceed two pages in length, excluding any instructions or guiding documentation.

(a) The health insurer shall make the form available electronically and online to practitioners. The prescribing provider may submit the completed prior authorization form electronically to the health insurer.

(b) If the health insurer contracts with a pharmacy benefits manager to perform prior authorization services for a medical procedure, course of treatment, or prescription drug

benefit, the pharmacy benefits manager must use and accept the standardized prior authorization form.

(c) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form is deemed approved upon receipt by the health insurer unless the health insurer responds otherwise within 3 business days.

(2) This section does not apply to a grandfathered health plan as defined in s. 627.402.

Section 8. Section 627.42393, Florida Statutes, is created to read:

627.42393 Medication protocol override.—If an individual or group health insurance policy, including a policy issued by a small employer as defined in s. 627.6699, restricts medications for the treatment of a medical condition by a step-therapy or fail-first protocol, the prescribing provider must have access to a clear and convenient process to request an override of the protocol from the health insurer.

(1) The health insurer shall authorize an override of the protocol within 72 hours if the prescribing provider documents that:

(a) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

1. Is expected or is likely to be ineffective based on

known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

2. Will cause or is likely to cause an adverse reaction or other physical harm to the insured.

(2) If the prescribing provider allows the insured to enter the step-therapy or fail-first protocol recommended by the health insurer, the duration of the step-therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the health insurer can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period for such medication to provide any relief or amelioration to the insured, the step-therapy or fail-first protocol may be extended for an additional period of time, but no longer than the original customary period for the medication. Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the insured is having an adverse reaction or is suffering from other physical harm resulting from the use of the medication.

(3) This section does not apply to grandfathered health plans, as defined in s. 627.402.

Section 9. Subsection (11) of section 627.6131, Florida Statutes, is amended to read:

627.6131 Payment of claims.—

(11) A health insurer may not retroactively deny a claim because of insured ineligibility:

(a) More than 1 year after the date of payment of the

claim; or

(b) If, under a policy compliant with the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations adopted pursuant to those acts, the health insurer verified the eligibility of the insured at the time of treatment and provided an authorization number, unless, at the time eligibility was verified, the provider was notified that the insured was delinquent in paying the premium.

Section 10. Subsection (2) of section 627.6471, Florida Statutes, is amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(2) An ~~Any~~ insurer issuing a policy of health insurance in this state~~,~~ which ~~insurance~~ includes coverage for the services of a preferred provider shall~~, must~~ provide each policyholder and certificateholder with a current list of preferred providers, shall ~~and must~~ make the list available for public inspection during regular business hours at the principal office of the insurer within the state, and shall post a link to the list of preferred providers on the home page of the insurer's website. Changes to the list of preferred providers must be reflected on the insurer's website within 24 hours.

Section 11. Paragraph (c) of subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this

state is provided coverage if:

(c) The policy provides the benefits specified in ss. 627.419, 627.42392, 627.42393, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, 627.6691, and 627.66911, and complies with the requirements of s. 627.66996.

Section 12. Subsection (10) of section 641.3155, Florida Statutes, is amended to read:

641.3155 Prompt payment of claims.—

(10) A health maintenance organization may not retroactively deny a claim because of subscriber ineligibility:

(a) More than 1 year after the date of payment of the claim; or

(b) If, under a policy in compliance with the federal Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and the regulations adopted pursuant to those acts, the health maintenance organization verified the eligibility of the subscriber at the time of treatment and provided an authorization number, unless, at the time eligibility was verified, the provider was notified that the subscriber was delinquent in paying the premium.

Section 13. Section 641.393, Florida Statutes, is created to read:

641.393 Prior authorization.—Notwithstanding any other law, in order to establish uniformity in the submission of prior authorization forms, effective January 1, 2015, a health maintenance organization shall use a single standardized form for obtaining prior authorization for prescription drug

benefits. The form may not exceed two pages in length, excluding any instructions or guiding documentation.

(1) A health maintenance organization shall make the form available electronically and online to practitioners. A health care provider may electronically submit the completed form to the health maintenance organization.

(2) If a health maintenance organization contracts with a pharmacy benefits manager to perform prior authorization services for prescription drug benefits, the pharmacy benefits manager must use and accept the standardized prior authorization form.

(3) A completed prior authorization request submitted by a health care provider using the standardized prior authorization form required under this section is deemed approved upon receipt by the health maintenance organization unless the health maintenance organization responds otherwise within 3 business days.

(4) This section does not apply to grandfathered health plans, as defined in s. 627.402.

Section 14. Section 641.394, Florida Statutes, is created to read:

641.394 Medication protocol override.—If a health maintenance organization contract restricts medications for the treatment of a medical condition by a step-therapy or fail-first protocol, the prescribing provider shall have access to a clear and convenient process to request an override of the protocol from the health maintenance organization.

(1) The health maintenance organization shall grant an override within 72 hours if the prescribing provider documents

that:

(a) Based on sound clinical evidence, the preferred treatment required under the step-therapy or fail-first protocol has been ineffective in the treatment of the subscriber's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence, the preferred treatment required under the step-therapy or fail-first protocol:

1. Is expected or is likely to be ineffective based on known relevant physical or mental characteristics of the subscriber and known characteristics of the drug regimen; or

2. Will cause or is likely to cause an adverse reaction or other physical harm to the subscriber.

(2) If the prescribing provider allows the subscriber to enter the step-therapy or fail-first protocol recommended by the health maintenance organization, the duration of the step-therapy or fail-first protocol may not exceed the customary period for use of the medication if the prescribing provider demonstrates such treatment to be clinically ineffective. If the health maintenance organization can, through sound clinical evidence, demonstrate that the originally prescribed medication is likely to require more than the customary period to provide any relief or amelioration to the subscriber, the step-therapy or fail-first protocol may be extended for an additional period, but no longer than the original customary period for use of the medication. Notwithstanding this provision, a step-therapy or fail-first protocol shall be terminated if the prescribing provider determines that the subscriber is having an adverse reaction or is suffering from other physical harm resulting from

the use of the medication.

(3) This section does not apply to grandfathered health plans, as defined in s. 627.402.

Section 15. Effective upon this act becoming a law, paragraph (a) of subsection (7) and subsection (14) of section 395.4001, Florida Statutes, are amended to read:

395.4001 Definitions.—As used in this part, the term:

(7) "Level II trauma center" means a trauma center that:

(a) Is verified by the department to be in substantial compliance with Level II trauma center standards and ~~has been~~ approved by the department to operate as a Level II trauma center or is designated pursuant to s. 395.4025(13) ~~s. 395.4025(14)~~.

(14) "Trauma center" means a hospital that has been verified by the department to be in substantial compliance with ~~the requirements in~~ s. 395.4025 and has been approved by the department to operate as a Level I trauma center, Level II trauma center, or pediatric trauma center, or is designated by the department as a Level II trauma center pursuant to s. 395.4025(13) ~~s. 395.4025(14)~~.

Section 16. Effective upon this act becoming a law, present paragraphs (k) through (o) of subsection (1) of section 395.401, Florida Statutes, are redesignated as paragraphs (l) through (p), respectively, a new paragraph (k) is added to that subsection, and present paragraph (k) of that subsection is amended, to read:

395.401 Trauma services system plans; approval of trauma centers and pediatric trauma centers; procedures; renewal.—

(1)

(k) A hospital operating a trauma center may not charge a trauma activation fee greater than $15,000. This paragraph expires on July 1, 2015.

(l) ~~(k)~~ A ~~It is unlawful for any~~ hospital or other facility may not ~~to~~ hold itself out as a trauma center unless it has been so verified or designated pursuant to s. 395.4025(13) ~~s. 395.4025(14)~~.

Section 17. Effective upon this act becoming a law, subsection (5) is added to section 395.402, Florida Statutes, to read:

395.402 Trauma service areas; number and location of trauma centers.—

(5) By October 1, 2014, the department must convene the Florida Trauma System Plan Advisory Council in order to review the Trauma System Consultation Report issued by the American College of Surgeons Committee on Trauma dated February 2-5, 2013. Based on this review, the advisory council must submit recommendations, including recommended statutory changes, to the President of the Senate and the Speaker of the House of Representatives by February 1, 2015. The advisory council may make recommendations to the State Surgeon General regarding the continuing development of the state trauma system. The advisory council shall consist of nine representatives of an inclusive trauma system appointed by the State Surgeon General as follows:

(a) A trauma patient, or a family member of a trauma patient, who has sustained and recovered from severe injuries;

(b) A member of the Florida Committee on Trauma;

(c) A member of the Association of Florida Trauma Coordinators;

(d) A chief executive officer of a nontrauma acute care hospital who is a member of the Florida Hospital Association;

(e) A member of the Florida Emergency Medical Services Advisory Council;

(f) A member of the Florida Injury Prevention Advisory Council;

(g) A member of the Brain and Spinal Cord Injury Program Advisory Council;

(h) A member of the Florida Chamber of Commerce; and

(i) A member of the Florida Health Insurance Advisory Board.

Section 18. Effective upon this act becoming a law, present subsections (8) through (12) of section 395.4025, Florida Statutes, are redesignated as subsections (7) through (11), respectively, paragraph (d) of subsection (2) and present subsection (7) of that section are amended, present subsections (13) and (14) of that section are redesignated as subsections (12) and (13), respectively, and amended, and a new subsection (14) and subsection (15) are added to that section, to read:

395.4025 Trauma centers; selection; quality assurance; records.—

(2)

(d)1. Notwithstanding other provisions in this section, the department may grant up to an additional 18 months to a hospital applicant that is unable to meet all requirements as provided in paragraph (c) at the time of application if the number of applicants in the service area in which the applicant is located is equal to or less than the service area allocation, as provided by rule of the department. An applicant that is granted

additional time under ~~pursuant to~~ this paragraph shall submit a plan for departmental approval which includes timelines and activities that the applicant proposes to complete in order to meet application requirements. An ~~Any~~ applicant that demonstrates an ongoing effort to complete the activities within the timelines outlined in the plan shall be included in the number of trauma centers at such time that the department has conducted a provisional review of the application and has determined that the application is complete and that the hospital has the critical elements required for a trauma center.

2. Timeframes provided in subsections (1)-(7) ~~(1)-(8)~~ shall be stayed until the department determines that the application is complete and that the hospital has the critical elements required for a trauma center.

~~(7) Any hospital that wishes to protest a decision made by the department based on the department's preliminary or in-depth review of applications or on the recommendations of the site visit review team pursuant to this section shall proceed as provided in chapter 120. Hearings held under this subsection shall be conducted in the same manner as provided in ss. 120.569 and 120.57. Cases filed under chapter 120 may combine all disputes between parties.~~

(12)~~(13)~~ The department may adopt, by rule, the procedures and process by which it will select trauma centers. Such procedures and process must be used in annually selecting trauma centers and must be consistent with subsections (1)-(7) ~~(1)-(8)~~ except in those situations in which it is in the best interest of, and mutually agreed to by, all applicants within a service area and the department to reduce the timeframes.

(13)~~(14)~~ Notwithstanding the procedures established pursuant to subsections (1)-(12) ~~(1) through (13)~~, hospitals located in areas with limited access to trauma center services shall be designated by the department as Level II trauma centers based on documentation of a valid certificate of trauma center verification from the American College of Surgeons. Areas with limited access to trauma center services are defined by the following criteria:

(a) The hospital is located in a trauma service area with a population greater than 600,000 persons but a population density of less than 225 persons per square mile;

(b) The hospital is located in a county with no verified trauma center; and

(c) The hospital is located at least 15 miles or 20 minutes travel time by ground transport from the nearest verified trauma center.

(14) Notwithstanding any other law, a hospital designated as a provisional or verified as a Level I, Level II, or pediatric trauma center after the enactment of chapter 2004-259, Laws of Florida, whose approval has not been revoked may continue to operate at the same trauma center level as a Level I, Level II, or pediatric trauma center until the approval period in subsection (6) expires, as long as the hospital continues to meet the other requirements of part II of this chapter related to trauma center standards and patient outcomes. Any hospital that meets the requirements of this section is eligible for renewal of its 7-year approval period pursuant to subsection (6).

(15) The department may not verify, designate, or

provisionally approve any hospital to operate as a trauma center through the procedures established in subsections (1)-(13). This subsection expires July 1, 2015.

Section 19. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon becoming a law, this act shall take effect July 1, 2014.