By the Committee on Health Policy; and Senator Bean

588-02389-13 2013966c1

A bill to be entitled

An act relating to health care; amending s. 112.0455, F.S.; deleting a monthly reporting requirement for laboratories; amending s. 154.11, F.S.; revising references to certain accrediting organizations to conform to changes made by the act; creating s. 385.2035, F.S.; designating the Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes as a resource for diabetes research in this state; amending s. 394.741, F.S.; revising references to certain accrediting organizations to conform to changes made by the act; amending s. 395.0161, F.S.; deleting a requirement that hospitals pay certain inspection fees at the time of the inspection; repealing s. 395.1046, F.S., relating to the investigation by the Agency for Health Care Administration of certain complaints against hospitals; amending s. 395.3038, F.S.; deleting an obsolete provision relating to stroke centers; revising references to certain accrediting organizations to conform; amending s. 395.701, F.S.; revising the definition of the term "hospital" for purposes of annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; repealing s. 395.7015, F.S., relating to annual assessments on health care entities; amending s. 395.7016, F.S.; revising a cross-reference to conform to changes made by the act; amending ss. 397.403, 400.925, 400.9935, and 402.7306,

F.S.; revising references to certain accrediting organizations to conform to changes made by the act; amending s. 408.061, F.S.; exempting hospitals operated by state agencies from certain annual fiscal experience reporting requirements; amending s. 408.20, F.S.; exempting hospitals operated by state agencies from certain assessments; amending ss. 409.966, 409.967, and 430.80, F.S.; revising references to certain accrediting organizations to conform to changes made by the act; amending s. 440.102, F.S.; revising certain drug-testing standards for laboratories; deleting a requirement that a laboratory must comply with certain criteria to conduct an initial analysis of test specimens; deleting a monthly reporting requirement for laboratories; amending s. 440.13, F.S.; revising references to certain accrediting organizations to conform to changes made by the act; creating s. 456.0125, F.S.; providing legislative intent; providing definitions; creating the Standardized Credentials Collection and Verification Program for physicians; providing procedures and requirements with respect to the program; authorizing the Department of Health to adopt rules to develop and implement the program; amending s. 499.003, F.S.; exempting prescription drugs transferred either directly or through a hospital's or health care entity's supplier for the purpose of repackaging from the definition of "wholesale distribution"; amending s. 499.01, F.S.; requiring a

permit for prescription drug repackagers located in other states that repackage and distribute drugs for limited purposes into this state; amending s. 499.01212, F.S.; requiring pedigree papers for transfers pursuant to s. 499.003(54)(b)7., F.S., to include specified information; amending ss. 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015, F.S.; revising references to certain accrediting organizations to conform to changes made by the act; providing an effective date.

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

Section 1. Paragraphs (d) and (e) of subsection (12) of section 112.0455, Florida Statutes, are amended to read:

112.0455 Drug-Free Workplace Act.—

(12) DRUG-TESTING STANDARDS; LABORATORIES.—

~~(d) The laboratory shall submit to the Agency for Health Care Administration a monthly report with statistical information regarding the testing of employees and job applicants. The reports shall include information on the methods of analyses conducted, the drugs tested for, the number of positive and negative results for both initial and confirmation tests, and any other information deemed appropriate by the Agency for Health Care Administration. No monthly report shall identify specific employees or job applicants.~~

(d) ~~(e)~~ Laboratories shall provide technical assistance to the employer, employee, or job applicant for the purpose of interpreting any positive confirmed test results which could

have been caused by prescription or nonprescription medication taken by the employee or job applicant.

Section 2. Paragraph (n) of subsection (1) of section 154.11, Florida Statutes, is amended to read:

154.11 Powers of board of trustees.—

(1) The board of trustees of each public health trust shall be deemed to exercise a public and essential governmental function of both the state and the county and in furtherance thereof it shall, subject to limitation by the governing body of the county in which such board is located, have all of the powers necessary or convenient to carry out the operation and governance of designated health care facilities, including, but without limiting the generality of, the foregoing:

(n) To appoint originally the staff of physicians to practice in a ~~any~~ designated facility owned or operated by the board and to approve the bylaws and rules to be adopted by the medical staff of a ~~any~~ designated facility owned and operated by the board, such governing regulations to be in accordance with the standards of the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on the Accreditation of Hospitals~~ which provide, among other things, for the method of appointing additional staff members and for the removal of staff members.

Section 3. Section 385.2035, Florida Statutes, is created to read:

385.2035 Resource for research in the prevention and

treatment of diabetes.—The Florida Hospital Sanford-Burnham Translational Research Institute for Metabolism and Diabetes is designated as a resource in this state for research in the prevention and treatment of diabetes.

Section 4. Subsection (2) of section 394.741, Florida Statutes, is amended to read:

394.741 Accreditation requirements for providers of behavioral health care services.—

(2) Notwithstanding any provision of law to the contrary, accreditation shall be accepted by the agency and department in lieu of the agency's and department's facility licensure onsite review requirements and shall be accepted as a substitute for the department's administrative and program monitoring requirements, except as required by subsections (3) and (4), for:

(a) An ~~Any~~ organization from which the department purchases behavioral health care services which ~~that~~ is accredited by the Joint Commission, American Osteopathic Association/the Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Healthcare Organizations or~~ the Council on Accreditation ~~for Children and Family Services~~, or CARF International for the ~~has those~~ services that are being purchased by the department ~~accredited by CARF-the Rehabilitation Accreditation Commission~~.

(b) A ~~Any~~ mental health facility licensed by the agency or a ~~any~~ substance abuse component licensed by the department which

~~that~~ is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~on Accreditation of Healthcare Organizations, CARF-the Rehabilitation Accreditation Commission~~, or the Council on Accreditation ~~of Children and Family Services~~.

(c) A ~~Any~~ network of providers from which the department or the agency purchases behavioral health care services accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~on Accreditation of Healthcare Organizations, CARF-the Rehabilitation Accreditation Commission~~, the Council on Accreditation ~~of Children and Family Services~~, or the National Committee for Quality Assurance. A provider organization that~~, which~~ is part of an accredited network~~,~~ is afforded the same rights under this part.

Section 5. Subsection (3) of section 395.0161, Florida Statutes, is amended to read:

395.0161 Licensure inspection.—

(3) In accordance with s. 408.805, an applicant or licensee shall pay a fee for each license application submitted under this part, part II of chapter 408, and applicable rules. With the exception of state-operated licensed facilities, each facility licensed under this part shall pay to the agency~~, at~~

~~the time of inspection,~~ the following fees:

(a) *Inspection for licensure.*—A fee shall be paid which is not less than $8 per hospital bed, nor more than $12 per hospital bed, except that the minimum fee shall be $400 per facility.

(b) *Inspection for lifesafety only.*—A fee shall be paid which is not less than 75 cents per hospital bed, nor more than $1.50 per hospital bed, except that the minimum fee shall be $40 per facility.

Section 6. Section 395.1046, Florida Statutes, is repealed.

Section 7. Section 395.3038, Florida Statutes, is amended to read:

395.3038 State-listed primary stroke centers and comprehensive stroke centers; notification of hospitals.—

(1) The agency shall make available on its website and to the department a list of the name and address of each hospital that meets the criteria for a primary stroke center and the name and address of each hospital that meets the criteria for a comprehensive stroke center. The list of primary and comprehensive stroke centers must ~~shall~~ include only those hospitals that attest in an affidavit submitted to the agency that the hospital meets the named criteria, or those hospitals that attest in an affidavit submitted to the agency that the hospital is certified as a primary or a comprehensive stroke center by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the

state ~~on Accreditation of Healthcare Organizations~~.

(2)(a) If a hospital no longer chooses to meet the criteria for a primary or comprehensive stroke center, the hospital shall notify the agency and the agency shall immediately remove the hospital from the list.

(b)1. This subsection does not apply if the hospital is unable to provide stroke treatment services for a period of time not to exceed 2 months. The hospital shall immediately notify all local emergency medical services providers when the temporary unavailability of stroke treatment services begins and when the services resume.

2. If stroke treatment services are unavailable for more than 2 months, the agency shall remove the hospital from the list of primary or comprehensive stroke centers until the hospital notifies the agency that stroke treatment services have been resumed.

~~(3) The agency shall notify all hospitals in this state by February 15, 2005, that the agency is compiling a list of primary stroke centers and comprehensive stroke centers in this state. The notice shall include an explanation of the criteria necessary for designation as a primary stroke center and the criteria necessary for designation as a comprehensive stroke center. The notice shall also advise hospitals of the process by which a hospital might be added to the list of primary or comprehensive stroke centers.~~

(3) ~~(4)~~ The agency shall adopt by rule criteria for a primary stroke center which are substantially similar to the certification standards for primary stroke centers of the Joint Commission, the American Osteopathic Association/Healthcare

Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on Accreditation of Healthcare Organizations~~.

(4) ~~(5)~~ The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on Accreditation of Healthcare Organizations~~ establishes criteria for a comprehensive stroke center, the agency shall establish criteria for a comprehensive stroke center which are substantially similar to those criteria established by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or such national accrediting organization ~~on Accreditation of Healthcare Organizations~~.

(5) ~~(6)~~ This act is not a medical practice guideline and may not be used to restrict the authority of a hospital to provide services for which it is licensed ~~has received a license~~ under chapter 395. The Legislature intends that all patients be treated individually based on each patient’s needs and circumstances.

Section 8. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical

assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(12), but does not include any hospital operated by a state ~~the~~ agency ~~or the Department of Corrections~~.

Section 9. Section 395.7015, Florida Statutes, is repealed.

Section 10. Section 395.7016, Florida Statutes, is amended to read:

395.7016 Annual appropriation.—The Legislature shall appropriate each fiscal year from either the General Revenue Fund or the Agency for Health Care Administration Tobacco Settlement Trust Fund an amount sufficient to replace the funds lost due to ~~reduction by chapter 2000-256, Laws of Florida, of the assessment on other health care entities under s. 395.7015,~~ ~~and~~ the reduction by chapter 2000-256 in the assessment on hospitals under s. 395.701, and to maintain federal approval of the reduced amount of funds deposited into the Public Medical Assistance Trust Fund under s. 395.701, as state match for the state's Medicaid program.

Section 11. Subsection (3) of section 397.403, Florida Statutes, is amended to read:

397.403 License application.—

(3) The department shall accept proof of accreditation by CARF International, ~~the Commission on Accreditation of Rehabilitation Facilities(CARF) or~~ the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid

Services and whose standards incorporate comparable licensure regulations required by the state; or through another ~~any other~~ nationally recognized certification process that is acceptable to the department and meets the minimum licensure requirements under this chapter, in lieu of requiring the applicant to submit the information required by paragraphs (1)(a)-(c).

Section 12. Subsection (1) of section 400.925, Florida Statutes, is amended to read:

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

(1) "Accrediting organizations" means the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on Accreditation of Healthcare Organizations~~ or other national accrediting ~~accreditation~~ agencies whose standards for accreditation are comparable to those required by this part for licensure.

Section 13. Paragraph (g) of subsection (1) and subsection (7) of section 400.9935, Florida Statutes, are amended to read:

400.9935 Clinic responsibilities.—

(1) Each clinic shall appoint a medical director or clinic director who shall agree in writing to accept legal responsibility for the following activities on behalf of the clinic. The medical director or the clinic director shall:

(g) Conduct systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful. Upon discovery of an unlawful charge, the medical director or clinic director shall take immediate corrective action. If the clinic performs

only the technical component of magnetic resonance imaging, static radiographs, computed tomography, or positron emission tomography, and provides the professional interpretation of such services, in a fixed facility that is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, ~~on Accreditation of Healthcare Organizations or~~ the Accreditation Association for Ambulatory Health Care, Inc., or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state; and the American College of Radiology; and if, in the preceding quarter, the percentage of scans performed by that clinic which was billed to all personal injury protection insurance carriers was less than 15 percent, the chief financial officer of the clinic may, in a written acknowledgment provided to the agency, assume the responsibility for the conduct of the systematic reviews of clinic billings to ensure that the billings are not fraudulent or unlawful.

(7)(a) Each clinic engaged in magnetic resonance imaging services must be accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on Accreditation of Healthcare Organizations~~, the American College of Radiology, or the Accreditation Association for Ambulatory Health Care, Inc., within 1 year after licensure. A clinic that is accredited by the American College of Radiology or that is within the original

1-year period after licensure and replaces its core magnetic resonance imaging equipment shall be given 1 year after the date on which the equipment is replaced to attain accreditation. However, a clinic may request a single, 6-month extension if it provides evidence to the agency establishing that, for good cause shown, such clinic cannot be accredited within 1 year after licensure, and that such accreditation will be completed within the 6-month extension. After obtaining accreditation as required by this subsection, each such clinic must maintain accreditation as a condition of renewal of its license. A clinic that files a change of ownership application must comply with the original accreditation timeframe requirements of the transferor. The agency shall deny a change of ownership application if the clinic is not in compliance with the accreditation requirements. When a clinic adds, replaces, or modifies magnetic resonance imaging equipment and the accrediting ~~accreditation~~ agency requires new accreditation, the clinic must be accredited within 1 year after the date of the addition, replacement, or modification but may request a single, 6-month extension if the clinic provides evidence of good cause to the agency.

(b) The agency may deny the application or revoke the license of an ~~any~~ entity formed for the purpose of avoiding compliance with the accreditation provisions of this subsection and whose principals were previously principals of an entity that was unable to meet the accreditation requirements within the specified timeframes. The agency may adopt rules as to the accreditation of magnetic resonance imaging clinics.

Section 14. Subsections (1) and (2) of section 402.7306,

Florida Statutes, are amended to read:

402.7306 Administrative monitoring of child welfare providers, and administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers.—The Department of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, community-based care lead agencies, managing entities as defined in s. 394.9082, and agencies who have contracted with monitoring agents shall identify and implement changes that improve the efficiency of administrative monitoring of child welfare services, and the administrative, licensure, and programmatic monitoring of mental health and substance abuse service providers. For the purpose of this section, the term "mental health and substance abuse service provider" means a provider who provides services to this state's priority population as defined in s. 394.674. To assist with that goal, each such agency shall adopt the following policies:

(1) Limit administrative monitoring to once every 3 years if the child welfare provider is accredited by the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~the Commission on Accreditation of Rehabilitation Facilities~~, or the Council on Accreditation. If the accrediting body does not require documentation that the state agency requires, that documentation shall be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the

survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints or suspected problems and monitoring the service provider's compliance with ~~any~~ resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Medicaid certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

(2) Limit administrative, licensure, and programmatic monitoring to once every 3 years if the mental health or substance abuse service provider is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~the Commission on Accreditation of Rehabilitation Facilities~~, or the Council on Accreditation. If the services being monitored are not the services for which the provider is accredited, the

limitations of this subsection do not apply. If the accrediting body does not require documentation that the state agency requires, that documentation, except documentation relating to licensure applications and fees, must be requested by the state agency and may be posted by the service provider on the data warehouse for the agency's review. Notwithstanding the survey or inspection of an accrediting organization specified in this subsection, an agency specified in and subject to this section may continue to monitor the service provider as necessary with respect to:

(a) Ensuring that services for which the agency is paying are being provided.

(b) Investigating complaints, identifying problems that would affect the safety or viability of the service provider, and monitoring the service provider's compliance with ~~any~~ resulting negotiated terms and conditions, including provisions relating to consent decrees that are unique to a specific service and are not statements of general applicability.

(c) Ensuring compliance with federal and state laws, federal regulations, or state rules if such monitoring does not duplicate the accrediting organization's review pursuant to accreditation standards.

Federal certification and precertification reviews are exempt from this subsection to ensure Medicaid compliance.

Section 15. Subsection (4) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges;

confidential information; immunity.—

(4) Within 120 days after the end of its fiscal year, each health care facility, excluding continuing care facilities, hospitals operated by state agencies, and nursing homes as defined in s. 408.07(14) and (37), shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports which are certified to be complete and accurate by the provider. However, hospitals' actual financial experience shall be their audited actual experience. Every nursing home shall submit to the agency, in a format designated by the agency, a statistical profile of the nursing home residents. The agency, in conjunction with the Department of Elderly Affairs and the Department of Health, shall review these statistical profiles and develop recommendations for the types of residents who might more appropriately be placed in their homes or other noninstitutional settings.

Section 16. Subsection (4) of section 408.20, Florida Statutes, is amended to read:

408.20 Assessments; Health Care Trust Fund.—

(4) Hospitals operated by state agencies ~~the Department of Children and Family Services, the Department of Health, or the Department of Corrections~~ are exempt from the assessments required under this section.

Section 17. Paragraph (a) of subsection (3) of section 409.966, Florida Statutes, is amended to read:

409.966 Eligible plans; selection.—

(3) QUALITY SELECTION CRITERIA.—

(a) The invitation to negotiate must specify the criteria and the relative weight of the criteria that will be used for determining the acceptability of the reply and guiding the selection of the organizations with which the agency negotiates. In addition to criteria established by the agency, the agency shall consider the following factors in the selection of eligible plans:

1. Accreditation by the National Committee for Quality Assurance, the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, or another nationally recognized accrediting body.

2. Experience serving similar populations, including the organization's record in achieving specific quality standards with similar populations.

3. Availability and accessibility of primary care and specialty physicians in the provider network.

4. Establishment of community partnerships with providers that create opportunities for reinvestment in community-based services.

5. Organization commitment to quality improvement and documentation of achievements in specific quality improvement projects, including active involvement by organization leadership.

6. Provision of additional benefits, particularly dental care and disease management, and other initiatives that improve

health outcomes.

7. Evidence that an eligible plan has written agreements or signed contracts or has made substantial progress in establishing relationships with providers before the plan submitting a response.

8. Comments submitted in writing by an ~~any~~ enrolled Medicaid provider relating to a specifically identified plan participating in the procurement in the same region as the submitting provider.

9. Documentation of policies and procedures for preventing fraud and abuse.

10. The business relationship an eligible plan has with another ~~any other~~ eligible plan that responds to the invitation to negotiate.

Section 18. Paragraph (e) 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:

(e) *Continuous improvement.*—The agency shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

1. Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network

providers.

2. Each plan must collect and report the Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the agency. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The agency shall use the HEDIS measures as a tool to monitor plan performance.

3. Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed. The agency shall suspend automatic assignment under ss. 409.977 and 409.984 for a ~~any~~ plan not accredited within 18 months after executing the contract~~, the agency shall suspend automatic assignment under s. 409.977 and 409.984~~.

4. By the end of the fourth year of the first contract term, the agency shall issue a request for information to determine whether cost savings could be achieved by contracting for plan oversight and monitoring, including analysis of encounter data, assessment of performance measures, and compliance with other contractual requirements.

Section 19. Paragraph (b) of subsection (3) of section 430.80, Florida Statutes, is amended to read:

430.80 Implementation of a teaching nursing home pilot project.—

(3) To be designated as a teaching nursing home, a nursing home licensee must, at a minimum:

(b) Participate in a nationally recognized accrediting ~~accreditation~~ program and hold a valid accreditation, such as the accreditation awarded by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, or, at the time of initial designation, possess a Gold Seal Award as conferred by the state on its licensed nursing home;

Section 20. Paragraphs (b) and (d) of subsection (9) of section 440.102, Florida Statutes, are amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(9) DRUG-TESTING STANDARDS FOR LABORATORIES.—

(b) A laboratory may analyze ~~initial or~~ confirmation test specimens only if:

1. The laboratory obtains a license under part II of chapter 408 and s. 112.0455(17). Each applicant for licensure and each licensee must comply with all requirements of this section, part II of chapter 408, and applicable rules.

2. The laboratory has written procedures to ensure the chain of custody.

3. The laboratory follows proper quality control procedures, including, but not limited to:

a. The use of internal quality controls, including the use

of samples of known concentrations which are used to check the performance and calibration of testing equipment, and periodic use of blind samples for overall accuracy.

b. An internal review and certification process for drug test results, conducted by a person qualified to perform that function in the testing laboratory.

c. Security measures implemented by the testing laboratory to preclude adulteration of specimens and drug test results.

d. Other necessary and proper actions taken to ensure reliable and accurate drug test results.

~~(d) The laboratory shall submit to the Agency for Health Care Administration a monthly report with statistical information regarding the testing of employees and job applicants. The report must include information on the methods of analysis conducted, the drugs tested for, the number of positive and negative results for both initial tests and confirmation tests, and any other information deemed appropriate by the Agency for Health Care Administration. A monthly report must not identify specific employees or job applicants.~~

Section 21. Paragraph (a) of subsection (2) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(2) MEDICAL TREATMENT; DUTY OF EMPLOYER TO FURNISH.—

(a) Subject to the limitations specified elsewhere in this chapter, the employer shall furnish to the employee such medically necessary remedial treatment, care, and attendance for such period as the nature of the injury or the process of recovery may require, which is in accordance with established

practice parameters and protocols of treatment as provided for in this chapter, including medicines, medical supplies, durable medical equipment, orthoses, prostheses, and other medically necessary apparatus. Remedial treatment, care, and attendance, including work-hardening programs or pain-management programs accredited by CARF International, the ~~Commission on Accreditation of Rehabilitation Facilities or~~ Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, ~~on the Accreditation of Health Organizations~~ or pain-management programs affiliated with medical schools, shall be considered ~~as~~ covered treatment only when such care is given based on a referral by a physician as defined in this chapter. Medically necessary treatment, care, and attendance does not include chiropractic services in excess of 24 treatments or rendered 12 weeks beyond the date of the initial chiropractic treatment, whichever comes first, unless the carrier authorizes additional treatment or the employee is catastrophically injured.

Failure of the carrier to timely comply with this subsection shall be a violation of this chapter and the carrier shall be subject to penalties as provided for in s. 440.525.

Section 22. Section 456.0125, Florida Statutes, is created to read:

456.0125 Standardized Credentials Collection and Verification Program for physicians.—

(1) It is the intent of the Legislature to establish the Standardized Credentials Collection and Verification Program to designate an entity to act as a repository for the core credentials data of physicians and to ensure that this information is collected only once unless a correction, update, or modification is required. The Legislature further intends that the credentials collection and verification entity, the department, health care entities, and physicians work cooperatively to ensure the integrity and accuracy of the program. A physician, an insurance company operating in accordance with chapter 624 which offers health insurance coverage under part VI of chapter 627, a health maintenance organization as defined in s. 641.19, or an entity licensed under chapter 395 must participate in the program.

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

(a) "Accredited" or "certified" means approved by a national accrediting organization as defined in this subsection, another nationally recognized and accepted organization authorized by the department to assess and certify a credentials collection and verification program, or another entity or organization that verifies the credentials of a physician.

(b) "Core credentials data" means data that are verified by a primary source as defined in this subsection and that include professional education, professional training, licensure, current Drug Enforcement Administration certification, specialty board certification, Educational Commission for Foreign Medical Graduates certification, and final disciplinary action reported pursuant to s. 456.039(1)(a)8.

(c) "Credential" or "credentialing" means the process by

which the qualifications of a licensed physician or an applicant for licensure as a physician are assessed and verified.

(d) "Credentials collection and verification entity" or "CCVE" means an organization controlled by a statewide association of physicians of all specialties licensed pursuant to chapter 458 or chapter 459 which has been in existence since July 1, 2003, and was selected by the department to collect and store credentialing data, documents, and information.

(e) "Drug Enforcement Administration certification" means certification issued by the Drug Enforcement Administration for purposes of administration or prescription of controlled substances. Submission of such certification under this section must include evidence that the certification is current and must also include all current addresses to which the certification is issued.

(f) "Health care entity" means:

1. A health care facility licensed pursuant to chapter 395;

2. An entity licensed by the Department of Insurance as a prepaid health care plan, a health maintenance organization, or an insurer that provides coverage for health care services through a network of health care providers or similar organizations licensed under chapter 627, chapter 636, chapter 641, or chapter 651; or

3. An accredited medical school in the state.

(g) "National accrediting organization" means an organization that awards accreditation or certification to hospitals, managed care organizations, CCVEs, or other health care entities, including, but not limited to, the Joint Commission, the American Osteopathic Association/Healthcare

Facilities Accreditation Program, URAC, and the National Committee for Quality Assurance (NCQA).

(h) "Physician" means a person licensed or, for credentialing purposes only, a person applying for licensure pursuant to chapter 458 or chapter 459.

(i) "Primary source verification" means verification of professional qualifications based on evidence obtained directly from the issuing source of the applicable qualification, any other source deemed as a primary source for verification by the department, or an accrediting organization as defined in this subsection approved by the department.

(j) "Professional training" means an internship, residency, or fellowship related to the profession for which the physician is licensed or seeking licensure.

(k) "Specialty board certification" means certification in a specialty issued by a specialty board that is recognized by a board as defined in s. 456.001 and that regulates the profession for which the physician is licensed or seeking licensure.

(3) The Standardized Credentials Collection and Verification Program is established and shall be administered by the department, as follows:

(a) Each physician shall report all core credentials data to the CCVE and notify the CCVE within 45 days after any corrections, updates, or modifications are made to the core credentials data. Failure to report and update information as required under this paragraph constitutes a ground for disciplinary action under the respective licensing chapter and s. 456.072(1)(k). If a licensee or person applying for initial licensure fails to report and update information as required

under this paragraph, the department or board, as appropriate, may:

1. For a person applying for initial licensure, refuse to issue a license.

2. For a licensee, issue a citation pursuant to s. 456.077 and assess a fine, as determined by rule by the board or the department.

(b) The department:

1. By January 1, 2014, shall contract with one CCVE to collect and store credentialing data, documents, and information. The CCVE must be fully accredited or certified by a national accrediting organization. If a CCVE fails to maintain full accreditation or certification or to provide data authorized by a physician, the department may terminate the contract with the CCVE.

2. Shall require the CCVE to maintain liability insurance sufficient to meet the certification or accreditation requirements established under this section.

3. May designate by rule additional elements of the core credentials data required under this section.

(c) The CCVE shall:

1. Maintain a complete current file of applicable core credentials data on each physician.

2. If authorized by the physician, release the core credentials data and any corrections, updates, and modifications to the data that are otherwise confidential or exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution to a health care entity.

3. Develop standardized forms on which a physician may

initially report and authorize the release of core credentials data and subsequently report corrections, updates, and modifications to that data.

(d) A health care entity:

1. Shall use the CCVE to obtain core credentials data, including corrections, updates, and modifications, on any physician being considered for or renewing membership in, privileges with, or participation in any plan or program with the health care entity.

2. May not request core credentials data from the physician.

(4) This section does not restrict the authority of a health care entity to credential, approve, or deny an application for hospital staff membership, clinical privileges, or participation in a managed care network.

(5) A health care entity may rely upon any data that has been verified by the CCVE to meet the primary source verification requirements of a national accrediting organization.

(6) The department shall adopt rules necessary to develop and implement the program established under this section.

Section 23. Paragraph (b) of subsection (54) of section 499.003, Florida Statutes, is amended to read:

499.003 Definitions of terms used in this part.—As used in this part, the term:

(54) "Wholesale distribution" means distribution of prescription drugs to persons other than a consumer or patient, but does not include:

(b) Any of the following activities, which is not a

violation of s. 499.005(21) if such activity is conducted in accordance with rules established by the department:

1. The sale, purchase, or trade of a prescription drug among federal, state, or local government health care entities that are under common control and are authorized to purchase such prescription drug.

2. The sale, purchase, or trade of a prescription drug or an offer to sell, purchase, or trade a prescription drug for emergency medical reasons. For purposes of this subparagraph, the term "emergency medical reasons" includes transfers of prescription drugs by a retail pharmacy to another retail pharmacy to alleviate a temporary shortage.

3. The transfer of a prescription drug acquired by a medical director on behalf of a licensed emergency medical services provider to that emergency medical services provider and its transport vehicles for use in accordance with the provider's license under chapter 401.

4. The revocation of a sale or the return of a prescription drug to the person's prescription drug wholesale supplier.

5. The donation of a prescription drug by a health care entity to a charitable organization that has been granted an exemption under s. 501(c)(3) of the Internal Revenue Code of 1986, as amended, and that is authorized to possess prescription drugs.

6. The transfer of a prescription drug by a person authorized to purchase or receive prescription drugs to a person licensed or permitted to handle reverse distributions or destruction under the laws of the jurisdiction in which the person handling the reverse distribution or destruction receives

the drug.

7. The transfer of a prescription drug by a hospital or other health care entity, either directly or through the hospital's or health care entity's supplier, to a person licensed under this part to repackage prescription drugs for the purpose of repackaging the prescription drug for use by that hospital, or other health care entity and other health care entities that are under common control, if ownership of the prescription drugs remains with the hospital or other health care entity at all times. In addition to the recordkeeping requirements of s. 499.0121(6) and the requirements for repackagers in s. 499.01212(2), the hospital or health care entity that transfers prescription drugs pursuant to this subparagraph must reconcile all drugs transferred and returned and resolve any discrepancies in a timely manner.

Section 24. Paragraph (b) of subsection (2) of section 499.01, Florida Statutes, is amended to read

499.01 Permits.—

(2) The following permits are established:

(b) *Prescription drug repackager permit.*—A prescription drug repackager permit is required for any person that repackages a prescription drug in this state or any person located in another state that repackages and distributes prescription drugs in or into this state that are received in a transfer pursuant to s. 499.003(54)(b)7.

1. A person that operates an establishment permitted as a prescription drug repackager may engage in wholesale distribution of prescription drugs repackaged at that establishment and must comply with all the provisions of this

part and the rules adopted under this part that apply to a wholesale distributor.

2. A prescription drug repackager must comply with all appropriate state and federal good manufacturing practices.

Section 25. Paragraph (a) of subsection (2) of section 499.01212, Florida Statutes, is amended to read:

499.01212 Pedigree paper.—

(2) FORMAT.—A pedigree paper must contain the following information:

(a) For the wholesale distribution of a prescription drug within the normal distribution chain or pursuant to a transfer described in s. 499.003(54)(b)7.:

1. The following statement: "This wholesale distributor purchased the specific unit of the prescription drug directly from the manufacturer."

2. The manufacturer's national drug code identifier and the name and address of the wholesale distributor and the purchaser of the prescription drug.

3. The name of the prescription drug as it appears on the label.

4. The quantity, dosage form, and strength of the prescription drug.

The wholesale distributor must also maintain and make available to the department, upon request, the point of origin of the prescription drugs, including intracompany transfers, the date of the shipment from the manufacturer to the wholesale distributor, the lot numbers of such drugs, and the invoice numbers from the manufacturer. When a repackager further

distributes prescription drugs to a hospital or other health care entity pursuant to s. 499.003(54)(b)7., the pedigree paper must contain the statement from the wholesale distributor in this subsection, along with the lot numbers of the prescription drugs, the name and address of the repackager and his or her signature, the date of receipt, and the name and address of the person authorized by law to purchase prescription drugs for the purpose of administering or dispensing the drug, as defined in s. 465.003.

Section 26. Subsection (1) of section 627.645, Florida Statutes, is amended to read:

627.645 Denial of health insurance claims restricted.—

(1) A ~~No~~ claim for payment under a health insurance policy or self-insured program of health benefits for treatment, care, or services in a licensed hospital that ~~which~~ is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on the Accreditation of Hospitals~~, the American Osteopathic Association, or CARF International may not ~~the Commission on the Accreditation of Rehabilitative Facilities shall~~ be denied because such hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for treatment of physical disability.

Section 27. Paragraph (c) of subsection (2) of section 627.668, Florida Statutes, is amended to read:

627.668 Optional coverage for mental and nervous disorders required; exception.—

(2) Under group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors shall not be less favorable than for physical illness generally, except that:

(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program that is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state; ~~on Accreditation of Hospitals (JCAH)~~ or that is in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission ~~on Accreditation of Hospitals~~ or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given ~~any~~ benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used ~~utilized~~, the total benefits paid for all such services may ~~shall~~ not exceed the cost of 30 days after ~~of~~ inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits

set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

Section 28. Subsection (3) of section 627.669, Florida Statutes, is amended to read:

627.669 Optional coverage required for substance abuse impaired persons; exception.—

(3) The benefits provided under this section are ~~shall be~~ applicable only if treatment is provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if services are provided in a program that is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on Accreditation of Hospitals~~ or that is approved by the state.

Section 29. Paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and

paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided, supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, or a chiropractic physician licensed under chapter 460 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or, to the extent permitted by applicable law and under the supervision of such physician,

osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner licensed under chapter 464. Followup services and care may also be provided by ~~any of~~ the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, CARF International ~~on Accreditation of Healthcare Organizations, the~~ ~~American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities~~, or the Accreditation Association for Ambulatory Health Care, Inc., or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years

or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner licensed under chapter 464 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a ~~any~~ provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of

the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such~~, which~~ rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 30. Subsection (12) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(12) The provisions of part I of chapter 395 do not apply to a health maintenance organization that, on or before January 1, 1991, provides not more than 10 outpatient holding beds for short-term and hospice-type patients in an ambulatory care facility for its members, provided that such health maintenance organization maintains current accreditation by the Joint Commission ~~on Accreditation of Health Care Organizations~~, a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state, the Accreditation Association for Ambulatory Health Care, Inc., or the National Committee for Quality Assurance.

Section 31. Subsection (2) of section 766.1015, Florida Statutes, is amended to read:

766.1015 Civil immunity for members of or consultants to certain boards, committees, or other entities.—

(2) Such committee, board, group, commission, or other entity must be established in accordance with state law, ~~or~~ in accordance with requirements of the Joint Commission, the American Osteopathic Association/Healthcare Facilities Accreditation Program, or a national accrediting organization that is approved by the Centers for Medicare and Medicaid Services and whose standards incorporate comparable licensure regulations required by the state ~~on Accreditation of Healthcare Organizations~~, established and duly constituted by one or more

public or licensed private hospitals or behavioral health agencies, or established by a governmental agency. To be protected by this section, the act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent.

Section 32. This act shall take effect July 1, 2013.