A bill to be entitled

An act relating to health care; amending ss. 154.11, 394.741, 395.3038, 397.403, 400.925, 400.9935, 402.7306, 408.05, 409.966, 409.967, 430.80, 440.13, 627.645, 627.668, 627.669, 627.736, 641.495, and 766.1015, F.S.; conforming provisions to a redefinition of the term "accrediting organizations" in s. 395.002, F.S., relating to hospital licensing and regulation; 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; providing an effective date.

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

Section 1. 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 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 2. 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, 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 which obtains accreditation from 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, 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, 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 3. 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 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 must ~~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 must ~~shall~~ also advise hospitals of the process by which a hospital might be added to the list of primary or comprehensive stroke centers.

(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 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~~.

(5) The agency shall adopt by rule criteria for a comprehensive stroke center. However, if the Joint Commission 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 or such national accrediting organization ~~on Accreditation of Healthcare Organizations~~.

(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 4. 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, 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 5. 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, 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 6. 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 ~~on Accreditation of Healthcare Organizations or~~, the Accreditation Association for Ambulatory Health Care, Inc., 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, 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 7. 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, 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 8. Paragraph (k) of subsection (3) of section 408.05, Florida Statutes, is amended to read:

408.05 Florida Center for Health Information and Policy Analysis.—

(3) COMPREHENSIVE HEALTH INFORMATION SYSTEM.—In order to produce comparable and uniform health information and statistics for the development of policy recommendations, the agency shall perform the following functions:

(k) Develop, in conjunction with the State Consumer Health Information and Policy Advisory Council, and implement a long-range plan for making available health care quality measures and financial data that will allow consumers to compare health care services. The health care quality measures and financial data

the agency must make available includes ~~shall include~~, but is not limited to, pharmaceuticals, physicians, health care facilities, and health plans and managed care entities. The agency shall update the plan and report on the status of its implementation annually. The agency shall also make the plan and status report available to the public on its Internet website. As part of the plan, the agency shall identify the process and timeframes for implementation, ~~any~~ barriers to implementation, and recommendations of changes in the law that may be enacted by the Legislature to eliminate the barriers. As preliminary elements of the plan, the agency shall:

1. Make available patient-safety indicators, inpatient quality indicators, and performance outcome and patient charge data collected from health care facilities pursuant to s. 408.061(1)(a) and (2). The terms "patient-safety indicators" and "inpatient quality indicators" have the same meaning as that ascribed ~~shall be as defined~~ by the Centers for Medicare and Medicaid Services, the National Quality Forum, 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, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states. The agency shall determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon

input from the council. When determining which conditions and procedures are to be disclosed, the council and the agency shall consider variation in costs, variation in outcomes, and magnitude of variations and other relevant information. When determining which health care quality measures to disclose, the agency:

a. Shall consider such factors as volume of cases; average patient charges; average length of stay; complication rates; mortality rates; and infection rates, among others, which shall be adjusted for case mix and severity, if applicable.

b. May consider such additional measures that are adopted by the Centers for Medicare and Medicaid Studies, National Quality Forum, 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, the Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, or a similar national entity that establishes standards to measure the performance of health care providers, or by other states.

When determining which patient charge data to disclose, the agency shall include such measures as the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, the range of procedure charges from highest to lowest, average net revenue per adjusted patient day, average cost per adjusted patient day, and average cost per

admission, among others.

2. Make available performance measures, benefit design, and premium cost data from health plans licensed pursuant to chapter 627 or chapter 641. The agency shall determine which health care quality measures and member and subscriber cost data to disclose, based upon input from the council. When determining which data to disclose, the agency shall consider information that may be required by either individual or group purchasers to assess the value of the product, which may include membership satisfaction, quality of care, current enrollment or membership, coverage areas, accreditation status, premium costs, plan costs, premium increases, range of benefits, copayments and deductibles, accuracy and speed of claims payment, credentials of physicians, number of providers, names of network providers, and hospitals in the network. Health plans shall make available to the agency ~~any~~ such data or information that is not currently reported to the agency or the office.

3. Determine the method and format for public disclosure of data reported pursuant to this paragraph. The agency shall make its determination based upon input from the State Consumer Health Information and Policy Advisory Council. At a minimum, the data shall be made available on the agency's Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. The website must include such additional information as is determined necessary to ensure that the website enhances informed decisionmaking among consumers and health care purchasers, which shall include, at a

minimum, appropriate guidance on how to use the data and an explanation of why the data may vary from provider to provider.

4. Publish on its website undiscounted charges for no fewer than 150 of the most commonly performed adult and pediatric procedures, including outpatient, inpatient, diagnostic, and preventative procedures.

Section 9. 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, 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 10. 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 s. 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 11. 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 12. 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~~ the ~~or~~ 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, ~~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 13. 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, 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 ~~the Commission on the Accreditation of Rehabilitative Facilities~~ may not ~~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 14. 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 accredited by the Joint Commission 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 (JCAH)~~ or 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 15. 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 accredited by the Joint Commission 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 approved by the state.

Section 16. 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 ~~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, the American Osteopathic Association, CARF International ~~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 17. 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 18. 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 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 19. 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 20. This act shall take effect July 1, 2013.