

1                   A bill to be entitled  
2       An act relating to health and human services; amending s.  
3       408.036, F.S.; providing an exemption from review by the  
4       agency and the requirement to file an application for a  
5       certificate of need with the agency for certain Level III  
6       neonatal intensive care units under certain circumstances;  
7       amending s. 408.909, F.S.; removing a limitation on  
8       eligibility for enrollment in an approved health flex  
9       plan; amending s. 766.202, F.S.; revising the definition  
10      of the term "health care provider" to include orthotists,  
11      orthotic fitters, orthotic fitter assistants, pedorthists,  
12      and prosthetists; amending s. 408.910, F.S.; providing and  
13      revising definitions; revising eligibility requirements  
14      for participation in the Florida Health Choices Program;  
15      providing that statutory rural hospitals are eligible as  
16      employers rather than participants under the program;  
17      permitting specified eligible vendors to sell health  
18      maintenance contracts or products and services; requiring  
19      certain risk-bearing products offered by insurers to be  
20      approved by the Office of Insurance Regulation; providing  
21      requirements for product certification; providing duties  
22      of the Florida Health Choices, Inc., including maintenance  
23      of a toll-free telephone hotline to respond to requests  
24      for assistance; providing for enrollment periods;  
25      providing for certain risk pooling data used by the  
26      corporation to be reported annually; amending s. 409.821,  
27      F.S.; authorizing personal identifying information of a  
28      Florida Kidcare program applicant to be disclosed to the

29        Florida Health Choices, Inc., to administer the program;  
30        amending s. 409.912, F.S.; requiring the Agency for Health  
31        Care Administration to establish a demonstration project  
32        in Miami-Dade County of a long-term-care facility and a  
33        psychiatric facility to improve access to health care by  
34        medically underserved persons; providing an effective  
35        date.

36  
37        Be It Enacted by the Legislature of the State of Florida:

38  
39        Section 1. Paragraph (1) of subsection (3) of section  
40        408.036, Florida Statutes, is amended to read:

41        408.036 Projects subject to review; exemptions.—

42        (3) EXEMPTIONS.—Upon request, the following projects are  
43        subject to exemption from the provisions of subsection (1):

44        (1) For the establishment of:

45        1. A Level II neonatal intensive care unit with at least  
46        10 beds, upon documentation to the agency that the applicant  
47        hospital had a minimum of 1,500 births during the previous 12  
48        months; ~~or~~

49        2. A Level III neonatal intensive care unit with at least  
50        15 beds, upon documentation to the agency that the applicant  
51        hospital has a Level II neonatal intensive care unit of at least  
52        10 beds and had a minimum of 3,500 births during the previous 12  
53        months; or,

54        3. A Level III neonatal intensive care unit with at least  
55        5 beds, upon documentation to the agency that the applicant  
56        hospital is a verified trauma center pursuant to s.

57 395.4001(14), and has a Level II neonatal intensive care unit,  
58  
59 if the applicant demonstrates that it meets the requirements for  
60 quality of care, nurse staffing, physician staffing, physical  
61 plant, equipment, emergency transportation, and data reporting  
62 found in agency certificate-of-need rules for Level II and Level  
63 III neonatal intensive care units and if the applicant commits  
64 to the provision of services to Medicaid and charity patients at  
65 a level equal to or greater than the district average. Such a  
66 commitment is subject to s. 408.040.

67 Section 2. Paragraph (a) of subsection (5) of section  
68 408.909, Florida Statutes, is amended to read:

69 408.909 Health flex plans.—

70 (5) ELIGIBILITY.—Eligibility to enroll in an approved  
71 health flex plan is limited to residents of this state who:

72 (a)1. ~~Are 64 years of age or younger;~~

73 ~~2.~~ Have a family income equal to or less than 300 percent  
74 of the federal poverty level;

75 ~~2.3.~~ Are not covered by a private insurance policy and are  
76 not eligible for coverage through a public health insurance  
77 program, such as Medicare or Medicaid, or another public health  
78 care program, such as Kidcare, and have not been covered at any  
79 time during the past 6 months, except that:

80 a. A person who was covered under an individual health  
81 maintenance contract issued by a health maintenance organization  
82 licensed under part I of chapter 641 which was also an approved  
83 health flex plan on October 1, 2008, may apply for coverage in  
84 the same health maintenance organization's health flex plan

85 without a lapse in coverage if all other eligibility  
86 requirements are met; or

87       b. A person who was covered under Medicaid or Kidcare and  
88 lost eligibility for the Medicaid or Kidcare subsidy due to  
89 income restrictions within 90 days prior to applying for health  
90 care coverage through an approved health flex plan may apply for  
91 coverage in a health flex plan without a lapse in coverage if  
92 all other eligibility requirements are met; and

93       ~~3.4.~~ Have applied for health care coverage as an  
94 individual through an approved health flex plan and have agreed  
95 to make any payments required for participation, including  
96 periodic payments or payments due at the time health care  
97 services are provided; or

98       Section 3. Subsection (4) of section 766.202, Florida  
99 Statutes, is amended to read:

100       766.202 Definitions; ss. 766.201-766.212.—As used in ss.  
101 766.201-766.212, the term:

102       (4) "Health care provider" means any hospital, ambulatory  
103 surgical center, or mobile surgical facility as defined and  
104 licensed under chapter 395; a birth center licensed under  
105 chapter 383; any person licensed under chapter 458, chapter 459,  
106 chapter 460, chapter 461, chapter 462, chapter 463, part I of  
107 chapter 464, chapter 466, chapter 467, part XIV of chapter 468,  
108 or chapter 486; a clinical lab licensed under chapter 483; a  
109 health maintenance organization certificated under part I of  
110 chapter 641; a blood bank; a plasma center; an industrial  
111 clinic; a renal dialysis facility; or a professional association

112 partnership, corporation, joint venture, or other association  
113 for professional activity by health care providers.

114 Section 4. Section 408.910, Florida Statutes, is amended  
115 to read:

116 408.910 Florida Health Choices Program.—

117 (1) LEGISLATIVE INTENT.—The Legislature finds that a  
118 significant number of the residents of this state do not have  
119 adequate access to affordable, quality health care. The  
120 Legislature further finds that increasing access to affordable,  
121 quality health care can be best accomplished by establishing a  
122 competitive market for purchasing health insurance and health  
123 services. It is therefore the intent of the Legislature to  
124 create the Florida Health Choices Program to:

125 (a) Expand opportunities for Floridians to purchase  
126 affordable health insurance and health services.

127 (b) Preserve the benefits of employment-sponsored  
128 insurance while easing the administrative burden for employers  
129 who offer these benefits.

130 (c) Enable individual choice in both the manner and amount  
131 of health care purchased.

132 (d) Provide for the purchase of individual, portable  
133 health care coverage.

134 (e) Disseminate information to consumers on the price and  
135 quality of health services.

136 (f) Sponsor a competitive market that stimulates product  
137 innovation, quality improvement, and efficiency in the  
138 production and delivery of health services.

139 (2) DEFINITIONS.—As used in this section, the term:

140 (a) "Corporation" means the Florida Health Choices, Inc.,  
141 established under this section.

142 (b) "Corporation's marketplace" means the single,  
143 centralized market established by the program that facilitates  
144 the purchase of products made available in the marketplace.

145 (c)~~(b)~~ "Health insurance agent" means an agent licensed  
146 under part IV of chapter 626.

147 (d)~~(e)~~ "Insurer" means an entity licensed under chapter  
148 624 which offers an individual health insurance policy or a  
149 group health insurance policy, a preferred provider organization  
150 as defined in s. 627.6471, ~~or~~ an exclusive provider organization  
151 as defined in s. 627.6472, or a health maintenance organization  
152 licensed under part I of chapter 641, or a prepaid limited  
153 health service organization or discount medical plan  
154 organization licensed under chapter 636.

155 (e)~~(d)~~ "Program" means the Florida Health Choices Program  
156 established by this section.

157 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health  
158 Choices Program is created as a single, centralized market for  
159 the sale and purchase of various products that enable  
160 individuals to pay for health care. These products include, but  
161 are not limited to, health insurance plans, health maintenance  
162 organization plans, prepaid services, service contracts, and  
163 flexible spending accounts. The components of the program  
164 include:

165 (a) Enrollment of employers.

166 (b) Administrative services for participating employers,  
167 including:

- 168           1. Assistance in seeking federal approval of cafeteria  
169 plans.
- 170           2. Collection of premiums and other payments.
- 171           3. Management of individual benefit accounts.
- 172           4. Distribution of premiums to insurers and payments to  
173 other eligible vendors.
- 174           5. Assistance for participants in complying with reporting  
175 requirements.
- 176           (c) Services to individual participants, including:
  - 177               1. Information about available products and participating  
178 vendors.
  - 179               2. Assistance with assessing the benefits and limits of  
180 each product, including information necessary to distinguish  
181 between policies offering creditable coverage and other products  
182 available through the program.
  - 183               3. Account information to assist individual participants  
184 with managing available resources.
  - 185               4. Services that promote healthy behaviors.
- 186           (d) Recruitment of vendors, including insurers, health  
187 maintenance organizations, prepaid clinic service providers,  
188 provider service networks, and other providers.
- 189           (e) Certification of vendors to ensure capability,  
190 reliability, and validity of offerings.
- 191           (f) Collection of data, monitoring, assessment, and  
192 reporting of vendor performance.
- 193           (g) Information services for individuals and employers.
- 194           (h) Program evaluation.
- 195           (4) ELIGIBILITY AND PARTICIPATION.—Participation in the

196 program is voluntary and shall be available to employers,  
197 individuals, vendors, and health insurance agents as specified  
198 in this subsection.

199 (a) Employers eligible to enroll in the program include:

200 1. Employers that meet criteria established by the  
201 corporation and elect to make their employees eligible through  
202 the program ~~have 1 to 50 employees.~~

203 2. Fiscally constrained counties described in s. 218.67.

204 3. Municipalities having populations of fewer than 50,000  
205 residents.

206 4. School districts in fiscally constrained counties.

207 5. Statutory rural hospitals.

208 (b) Individuals eligible to participate in the program  
209 include:

210 1. Individual employees of enrolled employers.

211 2. State employees not eligible for state employee health  
212 benefits.

213 3. State retirees.

214 4. Medicaid ~~reform~~ participants who opt out ~~select the~~  
215 ~~opt-out provision of reform.~~

216 ~~5. Statutory rural hospitals.~~

217 (c) Employers who choose to participate in the program may  
218 enroll by complying with the procedures established by the  
219 corporation. The procedures must include, but are not limited  
220 to:

221 1. Submission of required information.

222 2. Compliance with federal tax requirements for the  
223 establishment of a cafeteria plan, pursuant to s. 125 of the



Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts ~~insurance policies~~, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell

252 products and services as authorized under part I of chapter 636,  
253 and discount medical plan organizations may sell products and  
254 services as authorized under part II of chapter 636.

255 ~~4.3.~~ Prepaid health clinic service providers licensed  
256 under part II of chapter 641 may sell prepaid service contracts  
257 and other arrangements for a specified amount and type of health  
258 services or treatments.

259 ~~5.4.~~ Health care providers, including hospitals and other  
260 licensed health facilities, health care clinics, licensed health  
261 professionals, pharmacies, and other licensed health care  
262 providers, may sell service contracts and arrangements for a  
263 specified amount and type of health services or treatments.

264 ~~6.5.~~ Provider organizations, including service networks,  
265 group practices, professional associations, and other  
266 incorporated organizations of providers, may sell service  
267 contracts and arrangements for a specified amount and type of  
268 health services or treatments.

269 ~~7.6.~~ Corporate entities providing specific health services  
270 in accordance with applicable state law may sell service  
271 contracts and arrangements for a specified amount and type of  
272 health services or treatments.

273  
274 A vendor described in subparagraphs 3.-7. ~~3.-6.~~ may not sell  
275 products that provide risk-bearing coverage unless that vendor  
276 is authorized under a certificate of authority issued by the  
277 Office of Insurance Regulation and is authorized to provide  
278 coverage in the relevant geographic area ~~under the provisions of~~  
279 ~~the Florida Insurance Code.~~ Otherwise eligible vendors may be

280 excluded from participating in the program for deceptive or  
281 predatory practices, financial insolvency, or failure to comply  
282 with the terms of the participation agreement or other standards  
283 set by the corporation.

284 (e) Eligible individuals may voluntarily continue  
285 participation in the program regardless of subsequent changes in  
286 job status or Medicaid eligibility. Individuals who join the  
287 program may participate by complying with the procedures  
288 established by the corporation. These procedures must include,  
289 but are not limited to:

- 290 1. Submission of required information.
- 291 2. Authorization for payroll deduction.
- 292 3. Compliance with federal tax requirements.
- 293 4. Arrangements for payment in the event of job changes.
- 294 5. Selection of products and services.

295 (f) Vendors who choose to participate in the program may  
296 enroll by complying with the procedures established by the  
297 corporation. These procedures may ~~must~~ include, but are not  
298 limited to:

- 299 1. Submission of required information, including a  
300 complete description of the coverage, services, provider  
301 network, payment restrictions, and other requirements of each  
302 product offered through the program.
- 303 2. Execution of an agreement to ~~make all risk-bearing~~  
304 ~~products offered through the program guaranteed-issue policies,~~  
305 ~~subject to preexisting condition exclusions established~~ comply  
306 with requirements established by the corporation.
- 307 3. Execution of an agreement that prohibits refusal to

308 sell any offered non-risk-bearing product to a participant who  
309 elects to buy it.

310 4. Establishment of product prices based on age, gender,  
311 and location of the individual participant, which may include  
312 medical underwriting.

313 5. Arrangements for receiving payment for enrolled  
314 participants.

315 6. Participation in ongoing reporting processes  
316 established by the corporation.

317 7. Compliance with grievance procedures established by the  
318 corporation.

319 (g) Health insurance agents licensed under part IV of  
320 chapter 626 are eligible to voluntarily participate as buyers'  
321 representatives. A buyer's representative acts on behalf of an  
322 individual purchasing health insurance and health services  
323 through the program by providing information about products and  
324 services available through the program and assisting the  
325 individual with both the decision and the procedure of selecting  
326 specific products. Serving as a buyer's representative does not  
327 constitute a conflict of interest with continuing  
328 responsibilities as a health insurance agent if the relationship  
329 between each agent and any participating vendor is disclosed  
330 before advising an individual participant about the products and  
331 services available through the program. In order to participate,  
332 a health insurance agent shall comply with the procedures  
333 established by the corporation, including:

334 1. Completion of training requirements.

335 2. Execution of a participation agreement specifying the

336 terms and conditions of participation.

337 3. Disclosure of any appointments to solicit insurance or  
338 procure applications for vendors participating in the program.

339 4. Arrangements to receive payment from the corporation  
340 for services as a buyer's representative.

341 (5) PRODUCTS.—

342 (a) The products that may be made available for purchase  
343 through the program include, but are not limited to:

344 1. Health insurance policies.

345 2. Health maintenance contracts.

346 ~~3.2.~~ Limited benefit plans.

347 ~~4.3.~~ Prepaid clinic services.

348 ~~5.4.~~ Service contracts.

349 ~~6.5.~~ Arrangements for purchase of specific amounts and  
350 types of health services and treatments.

351 ~~7.6.~~ Flexible spending accounts.

352 (b) Health insurance policies, health maintenance  
353 contracts, limited benefit plans, prepaid service contracts, and  
354 other contracts for services must ensure the availability of  
355 covered services ~~and benefits to participating individuals for~~  
356 ~~at least 1 full enrollment year.~~

357 (c) Products may be offered for multiyear periods provided  
358 the price of the product is specified for the entire period or  
359 for each separately priced segment of the policy or contract.

360 (d) The corporation shall provide a disclosure form for  
361 consumers to acknowledge their understanding of the nature of,  
362 and any limitations to, the benefits provided by the products  
363 and services being purchased by the consumer.

364        (e) The corporation must determine that making the plan  
365 available through the program is in the interest of eligible  
366 individuals and eligible employers in the state.

367        (6) PRICING.—Prices for the products and services sold  
368 through the program must be transparent to participants and  
369 established by the vendors. ~~based on age, gender, and location~~  
370 ~~of participants. The corporation shall develop a methodology for~~  
371 ~~evaluating the actuarial soundness of products offered through~~  
372 ~~the program. The methodology shall be reviewed by the Office of~~  
373 ~~Insurance Regulation prior to use by the corporation. Before~~  
374 ~~making the product available to individual participants, the~~  
375 ~~corporation shall use the methodology to compare the expected~~  
376 ~~health care costs for the covered services and benefits to the~~  
377 ~~vendor's price for that coverage. The results shall be reported~~  
378 ~~to individuals participating in the program. Once established,~~  
379 ~~the price set by the vendor must remain in force for at least 1~~  
380 ~~year and may only be redetermined by the vendor at the next~~  
381 ~~annual enrollment period.~~ The corporation shall annually assess  
382 a surcharge for each premium or price set by a participating  
383 vendor. The surcharge may not be more than 2.5 percent of the  
384 price and shall be used to generate funding for administrative  
385 services provided by the corporation and payments to buyers'  
386 representatives.

387        (7) THE MARKETPLACE EXCHANGE PROCESS.—The program shall  
388 provide a single, centralized market for purchase of health  
389 insurance, health maintenance contracts, and other health  
390 products and services. Purchases may be made by participating  
391 individuals over the Internet or through the services of a

392 participating health insurance agent. Information about each  
393 product and service available through the program shall be made  
394 available through printed material and an interactive Internet  
395 website. A participant needing personal assistance to select  
396 products and services shall be referred to a participating agent  
397 in his or her area.

398       (a) Participation in the program may begin at any time  
399 during a year after the employer completes enrollment and meets  
400 the requirements specified by the corporation pursuant to  
401 paragraph (4)(c).

402       (b) Initial selection of products and services must be  
403 made by an individual participant within 60 days after the date  
404 the individual's employer qualified for participation. An  
405 individual who fails to enroll in products and services by the  
406 end of this period is limited to participation in flexible  
407 spending account services until the next annual enrollment  
408 period.

409       (c) Initial enrollment periods for each product selected  
410 by an individual participant must last at least 12 months,  
411 unless the individual participant specifically agrees to a  
412 different enrollment period.

413       (d) If an individual has selected one or more products and  
414 enrolled in those products for at least 12 months or any other  
415 period specifically agreed to by the individual participant,  
416 changes in selected products and services may only be made  
417 during the annual enrollment period established by the  
418 corporation.

419       (e) The limits established in paragraphs (b)-(d) apply to

any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.—The corporation shall:

(a) Establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the program.

(b) Inform individuals about other public health care programs.

~~(a) Prior to making a risk-bearing product available through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.~~

~~1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.~~



2. ~~Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.~~

~~(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.~~

(9) RISK POOLING.—The program may use ~~shall utilize~~ methods for pooling the risk of individual participants and preventing selection bias. These methods may ~~shall~~ include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation may ~~shall~~ establish a methodology for assessing the risk of enrolled individual participants based on data reported annually by the vendors about their enrollees. Distribution ~~Monthly~~ ~~distributions~~ of payments to the vendors may ~~shall~~ be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.—

(a) Products, other than the products set forth in subparagraph (4)(d)1.-4., ~~Policies~~ sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, as defined in s. 624.01 ~~chapter 641,~~ or the

mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.—There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure

504 of the Speaker of the House of Representatives.

505 5. Board members may not include insurers, health  
506 insurance agents or brokers, health care providers, health  
507 maintenance organizations, prepaid service providers, or any  
508 other entity, affiliate or subsidiary of eligible vendors.

509 (b) Members shall be appointed for terms of up to 3 years.  
510 Any member is eligible for reappointment. A vacancy on the board  
511 shall be filled for the unexpired portion of the term in the  
512 same manner as the original appointment.

513 (c) The board shall select a chief executive officer for  
514 the corporation who shall be responsible for the selection of  
515 such other staff as may be authorized by the corporation's  
516 operating budget as adopted by the board.

517 (d) Board members are entitled to receive, from funds of  
518 the corporation, reimbursement for per diem and travel expenses  
519 as provided by s. 112.061. No other compensation is authorized.

520 (e) There is no liability on the part of, and no cause of  
521 action shall arise against, any member of the board or its  
522 employees or agents for any action taken by them in the  
523 performance of their powers and duties under this section.

524 (f) The board shall develop and adopt bylaws and other  
525 corporate procedures as necessary for the operation of the  
526 corporation and carrying out the purposes of this section. The  
527 bylaws shall:

528 1. Specify procedures for selection of officers and  
529 qualifications for reappointment, provided that no board member  
530 shall serve more than 9 consecutive years.

531 2. Require an annual membership meeting that provides an

532 opportunity for input and interaction with individual  
533 participants in the program.

534 3. Specify policies and procedures regarding conflicts of  
535 interest, including the provisions of part III of chapter 112,  
536 which prohibit a member from participating in any decision that  
537 would inure to the benefit of the member or the organization  
538 that employs the member. The policies and procedures shall also  
539 require public disclosure of the interest that prevents the  
540 member from participating in a decision on a particular matter.

541 (g) The corporation may exercise all powers granted to it  
542 under chapter 617 necessary to carry out the purposes of this  
543 section, including, but not limited to, the power to receive and  
544 accept grants, loans, or advances of funds from any public or  
545 private agency and to receive and accept from any source  
546 contributions of money, property, labor, or any other thing of  
547 value to be held, used, and applied for the purposes of this  
548 section.

549 (h) The corporation may establish technical advisory  
550 panels consisting of interested parties, including consumers,  
551 health care providers, individuals with expertise in insurance  
552 regulation, and insurers.

553 (i) The corporation shall:

554 1. Determine eligibility of employers, vendors,  
555 individuals, and agents in accordance with subsection (4).

556 2. Establish procedures necessary for the operation of the  
557 program, including, but not limited to, procedures for  
558 application, enrollment, risk assessment, risk adjustment, plan  
559 administration, performance monitoring, and consumer education.

560           3. Arrange for collection of contributions from  
561 participating employers and individuals.

562           4. Arrange for payment of premiums and other appropriate  
563 disbursements based on the selections of products and services  
564 by the individual participants.

565           5. Establish criteria for disenrollment of participating  
566 individuals based on failure to pay the individual's share of  
567 any contribution required to maintain enrollment in selected  
568 products.

569           6. Establish criteria for exclusion of vendors pursuant to  
570 paragraph (4) (d).

571           7. Develop and implement a plan for promoting public  
572 awareness of and participation in the program.

573           8. Secure staff and consultant services necessary to the  
574 operation of the program.

575           9. Establish policies and procedures regarding  
576 participation in the program for individuals, vendors, health  
577 insurance agents, and employers.

578           10. Provide for the operation of a toll-free hotline to  
579 respond to requests for assistance.

580           11. Provide for initial, open, and special enrollment  
581 periods.

582           12. Evaluate options for employer participation which may  
583 conform with common insurance practices.

584           ~~10. Develop a plan, in coordination with the Department of~~  
585 ~~Revenue, to establish tax credits or refunds for employers that~~  
586 ~~participate in the program. The corporation shall submit the~~  
587 ~~plan to the Governor, the President of the Senate, and the~~

~~Speaker of the House of Representatives by January 1, 2009.~~

(12) REPORT.—Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.—To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

Section 5. Section 409.821, Florida Statutes, is amended to read:

409.821 Florida Kidcare program public records exemption.—

(1) Personal identifying information of a Florida Kidcare program applicant or enrollee, as defined in s. 409.811, held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(2)(a) Upon request, such information shall be disclosed to:

1. Another governmental entity in the performance of its official duties and responsibilities;

2. The Department of Revenue for purposes of administering

the state Title IV-D program; ~~or~~

3. The Florida Health Choices, Inc., for the purpose of administering the program authorized pursuant to s. 408.910; or

4.3. Any person who has the written consent of the program applicant.

(b) This section does not prohibit an enrollee's legal guardian from obtaining confirmation of coverage, dates of coverage, the name of the enrollee's health plan, and the amount of premium being paid.

(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida Healthy Kids Corporation before, on, or after the effective date of this exemption.

(4) A knowing and willful violation of this section is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 6. Subsection (41) of section 409.912, Florida Statutes, is amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to

644 emergency services or poststabilization care services as defined  
645 in 42 C.F.R. part 438.114. Such confirmation or second opinion  
646 shall be rendered in a manner approved by the agency. The agency  
647 shall maximize the use of prepaid per capita and prepaid  
648 aggregate fixed-sum basis services when appropriate and other  
649 alternative service delivery and reimbursement methodologies,  
650 including competitive bidding pursuant to s. 287.057, designed  
651 to facilitate the cost-effective purchase of a case-managed  
652 continuum of care. The agency shall also require providers to  
653 minimize the exposure of recipients to the need for acute  
654 inpatient, custodial, and other institutional care and the  
655 inappropriate or unnecessary use of high-cost services. The  
656 agency shall contract with a vendor to monitor and evaluate the  
657 clinical practice patterns of providers in order to identify  
658 trends that are outside the normal practice patterns of a  
659 provider's professional peers or the national guidelines of a  
660 provider's professional association. The vendor must be able to  
661 provide information and counseling to a provider whose practice  
662 patterns are outside the norms, in consultation with the agency,  
663 to improve patient care and reduce inappropriate utilization.  
664 The agency may mandate prior authorization, drug therapy  
665 management, or disease management participation for certain  
666 populations of Medicaid beneficiaries, certain drug classes, or  
667 particular drugs to prevent fraud, abuse, overuse, and possible  
668 dangerous drug interactions. The Pharmaceutical and Therapeutics  
669 Committee shall make recommendations to the agency on drugs for  
670 which prior authorization is required. The agency shall inform  
671 the Pharmaceutical and Therapeutics Committee of its decisions



672 regarding drugs subject to prior authorization. The agency is  
673 authorized to limit the entities it contracts with or enrolls as  
674 Medicaid providers by developing a provider network through  
675 provider credentialing. The agency may competitively bid single-  
676 source-provider contracts if procurement of goods or services  
677 results in demonstrated cost savings to the state without  
678 limiting access to care. The agency may limit its network based  
679 on the assessment of beneficiary access to care, provider  
680 availability, provider quality standards, time and distance  
681 standards for access to care, the cultural competence of the  
682 provider network, demographic characteristics of Medicaid  
683 beneficiaries, practice and provider-to-beneficiary standards,  
684 appointment wait times, beneficiary use of services, provider  
685 turnover, provider profiling, provider licensure history,  
686 previous program integrity investigations and findings, peer  
687 review, provider Medicaid policy and billing compliance records,  
688 clinical and medical record audits, and other factors. Providers  
689 shall not be entitled to enrollment in the Medicaid provider  
690 network. The agency shall determine instances in which allowing  
691 Medicaid beneficiaries to purchase durable medical equipment and  
692 other goods is less expensive to the Medicaid program than long-  
693 term rental of the equipment or goods. The agency may establish  
694 rules to facilitate purchases in lieu of long-term rentals in  
695 order to protect against fraud and abuse in the Medicaid program  
696 as defined in s. 409.913. The agency may seek federal waivers  
697 necessary to administer these policies.

698 (41) The agency shall establish ~~provide for the~~  
699 ~~development of~~ a demonstration project ~~by establishment~~ in

CS/HB 1125, Engrossed 2

2011

700 Miami-Dade County of a long-term-care facility and a psychiatric  
701 facility licensed pursuant to chapter 395 to improve access to  
702 health care for a predominantly minority, medically underserved,  
703 and medically complex population and to evaluate alternatives to  
704 nursing home care and general acute care for such population.  
705 Such project is to be located in a health care condominium and  
706 collocated ~~collocated~~ with licensed facilities providing a  
707 continuum of care. These projects are ~~The establishment of this~~  
708 ~~project is~~ not subject to the provisions of s. 408.036 or s.  
709 408.039.

710       Section 7. This act shall take effect July 1, 2011.