1 A bill to be entitled
2 An act relating to health and human services; amending s.
3 408.910, F.S.; providing and revising definitions;
4 revising eligibility requirements for participation in the
5 Florida Health Choices Program; providing that statutory
6 rural hospitals are eligible as employers rather than
7 participants under the program; permitting specified
8 eligible vendors to sell health maintenance contracts or
9 products and services; requiring certain risk-bearing
10 products offered by insurers to be approved by the Office
11 of Insurance Regulation; providing requirements for
12 product certification; providing duties of the Florida
13 Health Choices, Inc., including maintenance of a toll-free
14 telephone hotline to respond to requests for assistance;
15 providing for enrollment periods; providing for certain
16 risk pooling data used by the corporation to be reported
17 annually; amending s. 409.821, F.S.; authorizing personal
18 identifying information of a Florida Kidcare program
19 applicant to be disclosed to the Florida Health Choices,
20 Inc., to administer the program; amending s. 409.912,
21 F.S.; requiring the Agency for Health Care Administration
22 to establish a demonstration project in Miami-Dade County
23 of a long-term-care facility and a psychiatric facility to
24 improve access to health care by medically underserved
25 persons; providing an effective date.
26
27 Be It Enacted by the Legislature of the State of Florida:
28

29 Section 1. Section 408.910, Florida Statutes, is amended
30 to read:
31 408.910 Florida Health Choices Program.—
32 (1) LEGISLATIVE INTENT.—The Legislature finds that a
33 significant number of the residents of this state do not have
34 adequate access to affordable, quality health care. The
35 Legislature further finds that increasing access to affordable,
36 quality health care can be best accomplished by establishing a
37 competitive market for purchasing health insurance and health
38 services. It is therefore the intent of the Legislature to
39 create the Florida Health Choices Program to:
40 (a) Expand opportunities for Floridians to purchase
41 affordable health insurance and health services.
42 (b) Preserve the benefits of employment-sponsored
43 insurance while easing the administrative burden for employers
44 who offer these benefits.
45 (c) Enable individual choice in both the manner and amount
46 of health care purchased.
47 (d) Provide for the purchase of individual, portable
48 health care coverage.
49 (e) Disseminate information to consumers on the price and
50 quality of health services.
51 (f) Sponsor a competitive market that stimulates product
52 innovation, quality improvement, and efficiency in the
53 production and delivery of health services.
54 (2) DEFINITIONS.—As used in this section, the term:
55 (a) "Corporation" means the Florida Health Choices, Inc.,
56 established under this section.

57 <u>(b) "Corporation's marketplace" means the single,</u>
58 <u>centralized market established by the program that facilitates</u>
59 <u>the purchase of products made available in the marketplace.</u>
60 <u>(c)</u> ~~(b)~~ "Health insurance agent" means an agent licensed
61 under part IV of chapter 626.
62 <u>(d)</u> ~~(c)~~ "Insurer" means an entity licensed under chapter
63 624 which offers an individual health insurance policy or a
64 group health insurance policy, a preferred provider organization
65 as defined in s. 627.6471, ~~or~~ an exclusive provider organization
66 as defined in s. 627.6472<u>, or a health maintenance organization</u>
67 <u>licensed under part I of chapter 641, or a prepaid limited</u>
68 <u>health service organization or discount medical plan</u>
69 <u>organization licensed under chapter 636</u>.
70 <u>(e)</u> ~~(d)~~ "Program" means the Florida Health Choices Program
71 established by this section.
72 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health
73 Choices Program is created as a single, centralized market for
74 the sale and purchase of various products that enable
75 individuals to pay for health care. These products include, but
76 are not limited to, health insurance plans, health maintenance
77 organization plans, prepaid services, service contracts, and
78 flexible spending accounts. The components of the program
79 include:
80 (a) Enrollment of employers.
81 (b) Administrative services for participating employers,
82 including:
83 1. Assistance in seeking federal approval of cafeteria
84 plans.

85 2. Collection of premiums and other payments.
86 3. Management of individual benefit accounts.
87 4. Distribution of premiums to insurers and payments to
88 other eligible vendors.
89 5. Assistance for participants in complying with reporting
90 requirements.
91 (c) Services to individual participants, including:
92 1. Information about available products and participating
93 vendors.
94 2. Assistance with assessing the benefits and limits of
95 each product, including information necessary to distinguish
96 between policies offering creditable coverage and other products
97 available through the program.
98 3. Account information to assist individual participants
99 with managing available resources.
100 4. Services that promote healthy behaviors.
101 (d) Recruitment of vendors, including insurers, health
102 maintenance organizations, prepaid clinic service providers,
103 provider service networks, and other providers.
104 (e) Certification of vendors to ensure capability,
105 reliability, and validity of offerings.
106 (f) Collection of data, monitoring, assessment, and
107 reporting of vendor performance.
108 (g) Information services for individuals and employers.
109 (h) Program evaluation.
110 (4) ELIGIBILITY AND PARTICIPATION.—Participation in the
111 program is voluntary and shall be available to employers,
112 individuals, vendors, and health insurance agents as specified

113 in this subsection.
114 (a) Employers eligible to enroll in the program include:
115 1. Employers that meet criteria established by the
116 corporation and elect to make their employees eligible through
117 the program ~~have 1 to 50 employees~~.
118 2. Fiscally constrained counties described in s. 218.67.
119 3. Municipalities having populations of fewer than 50,000
120 residents.
121 4. School districts in fiscally constrained counties.
122 5. Statutory rural hospitals.
123 (b) Individuals eligible to participate in the program
124 include:
125 1. Individual employees of enrolled employers.
126 2. State employees not eligible for state employee health
127 benefits.
128 3. State retirees.
129 4. Medicaid ~~reform~~ participants who opt out ~~select the~~
130 ~~opt-out provision of reform~~.
131 ~~5. Statutory rural hospitals.~~
132 (c) Employers who choose to participate in the program may
133 enroll by complying with the procedures established by the
134 corporation. The procedures must include, but are not limited
135 to:
136 1. Submission of required information.
137 2. Compliance with federal tax requirements for the
138 establishment of a cafeteria plan, pursuant to s. 125 of the
139 Internal Revenue Code, including designation of the employer's
140 plan as a premium payment plan, a salary reduction plan that has

141 flexible spending arrangements, or a salary reduction plan that
142 has a premium payment and flexible spending arrangements.
143 3. Determination of the employer's contribution, if any,
144 per employee, provided that such contribution is equal for each
145 eligible employee.
146 4. Establishment of payroll deduction procedures, subject
147 to the agreement of each individual employee who voluntarily
148 participates in the program.
149 5. Designation of the corporation as the third-party
150 administrator for the employer's health benefit plan.
151 6. Identification of eligible employees.
152 7. Arrangement for periodic payments.
153 8. Employer notification to employees of the intent to
154 transfer from an existing employee health plan to the program at
155 least 90 days before the transition.
156 (d) All eligible vendors who choose to participate and the
157 products and services that the vendors are permitted to sell are
158 as follows:
159 1. Insurers licensed under chapter 624 may sell health
160 insurance policies, limited benefit policies, other risk-bearing
161 coverage, and other products or services.
162 2. Health maintenance organizations licensed under part I
163 of chapter 641 may sell health maintenance contracts ~~insurance~~
164 ~~policies~~, limited benefit policies, other risk-bearing products,
165 and other products or services.
166 3. Prepaid limited health service organizations may sell
167 products and services as authorized under part I of chapter 636,
168 and discount medical plan organizations may sell products and

169 services as authorized under part II of chapter 636.
170 4.~~3.~~ Prepaid health clinic service providers licensed
171 under part II of chapter 641 may sell prepaid service contracts
172 and other arrangements for a specified amount and type of health
173 services or treatments.
174 5.~~4.~~ Health care providers, including hospitals and other
175 licensed health facilities, health care clinics, licensed health
176 professionals, pharmacies, and other licensed health care
177 providers, may sell service contracts and arrangements for a
178 specified amount and type of health services or treatments.
179 6.~~5.~~ Provider organizations, including service networks,
180 group practices, professional associations, and other
181 incorporated organizations of providers, may sell service
182 contracts and arrangements for a specified amount and type of
183 health services or treatments.
184 7.~~6.~~ Corporate entities providing specific health services
185 in accordance with applicable state law may sell service
186 contracts and arrangements for a specified amount and type of
187 health services or treatments.
188
189 A vendor described in subparagraphs 3.-7. ~~3.-6.~~ may not sell
190 products that provide risk-bearing coverage unless that vendor
191 is authorized under a certificate of authority issued by the
192 Office of Insurance Regulation and is authorized to provide
193 coverage in the relevant geographic area ~~under the provisions of~~
194 ~~the Florida Insurance Code~~. Otherwise eligible vendors may be
195 excluded from participating in the program for deceptive or
196 predatory practices, financial insolvency, or failure to comply

197 with the terms of the participation agreement or other standards
198 set by the corporation.
199 (e) Eligible individuals may voluntarily continue
200 participation in the program regardless of subsequent changes in
201 job status or Medicaid eligibility. Individuals who join the
202 program may participate by complying with the procedures
203 established by the corporation. These procedures must include,
204 but are not limited to:
205 1. Submission of required information.
206 2. Authorization for payroll deduction.
207 3. Compliance with federal tax requirements.
208 4. Arrangements for payment in the event of job changes.
209 5. Selection of products and services.
210 (f) Vendors who choose to participate in the program may
211 enroll by complying with the procedures established by the
212 corporation. These procedures may ~~must~~ include, but are not
213 limited to:
214 1. Submission of required information, including a
215 complete description of the coverage, services, provider
216 network, payment restrictions, and other requirements of each
217 product offered through the program.
218 2. Execution of an agreement to ~~make all risk-bearing~~
219 ~~products offered through the program guaranteed-issue policies,~~
220 ~~subject to preexisting condition exclusions established~~ comply
221 with requirements established by the corporation.
222 3. Execution of an agreement that prohibits refusal to
223 sell any offered non-risk-bearing product to a participant who
224 elects to buy it.

225 4. Establishment of product prices based on age, gender,
226 and location of the individual participant, which may include
227 medical underwriting.
228 5. Arrangements for receiving payment for enrolled
229 participants.
230 6. Participation in ongoing reporting processes
231 established by the corporation.
232 7. Compliance with grievance procedures established by the
233 corporation.
234 (g) Health insurance agents licensed under part IV of
235 chapter 626 are eligible to voluntarily participate as buyers'
236 representatives. A buyer's representative acts on behalf of an
237 individual purchasing health insurance and health services
238 through the program by providing information about products and
239 services available through the program and assisting the
240 individual with both the decision and the procedure of selecting
241 specific products. Serving as a buyer's representative does not
242 constitute a conflict of interest with continuing
243 responsibilities as a health insurance agent if the relationship
244 between each agent and any participating vendor is disclosed
245 before advising an individual participant about the products and
246 services available through the program. In order to participate,
247 a health insurance agent shall comply with the procedures
248 established by the corporation, including:
249 1. Completion of training requirements.
250 2. Execution of a participation agreement specifying the
251 terms and conditions of participation.
252 3. Disclosure of any appointments to solicit insurance or

253 procure applications for vendors participating in the program.
254 4. Arrangements to receive payment from the corporation
255 for services as a buyer's representative.
256 (5) PRODUCTS.—
257 (a) The products that may be made available for purchase
258 through the program include, but are not limited to:
259 1. Health insurance policies.
260 <u>2. Health maintenance contracts.</u>
261 <u>3.</u>~~2.~~ Limited benefit plans.
262 <u>4.</u>~~3.~~ Prepaid clinic services.
263 <u>5.</u>~~4.~~ Service contracts.
264 <u>6.</u>~~5.~~ Arrangements for purchase of specific amounts and
265 types of health services and treatments.
266 <u>7.</u>~~6.~~ Flexible spending accounts.
267 (b) Health insurance policies, <u>health maintenance</u>
268 <u>contracts,</u> limited benefit plans, prepaid service contracts, and
269 other contracts for services must ensure the availability of
270 covered services ~~and benefits to participating individuals for~~
271 ~~at least 1 full enrollment year~~.
272 (c) Products may be offered for multiyear periods provided
273 the price of the product is specified for the entire period or
274 for each separately priced segment of the policy or contract.
275 (d) The corporation shall provide a disclosure form for
276 consumers to acknowledge their understanding of the nature of,
277 and any limitations to, the benefits provided by the products
278 and services being purchased by the consumer.
279 <u>(e) The corporation must determine that making the plan</u>
280 <u>available through the program is in the interest of eligible</u>

281 individuals and eligible employers in the state.
282 (6) PRICING.—Prices for the products and services sold
283 through the program must be transparent to participants and
284 established by the vendors. ~~based on age, gender, and location~~
285 ~~of participants. The corporation shall develop a methodology for~~
286 ~~evaluating the actuarial soundness of products offered through~~
287 ~~the program. The methodology shall be reviewed by the Office of~~
288 ~~Insurance Regulation prior to use by the corporation. Before~~
289 ~~making the product available to individual participants, the~~
290 ~~corporation shall use the methodology to compare the expected~~
291 ~~health care costs for the covered services and benefits to the~~
292 ~~vendor's price for that coverage. The results shall be reported~~
293 ~~to individuals participating in the program. Once established,~~
294 ~~the price set by the vendor must remain in force for at least 1~~
295 ~~year and may only be redetermined by the vendor at the next~~
296 ~~annual enrollment period.~~ The corporation shall annually assess
297 a surcharge for each premium or price set by a participating
298 vendor. The surcharge may not be more than 2.5 percent of the
299 price and shall be used to generate funding for administrative
300 services provided by the corporation and payments to buyers'
301 representatives.
302 (7) THE MARKETPLACE ~~EXCHANGE~~ PROCESS.—The program shall
303 provide a single, centralized market for purchase of health
304 insurance, health maintenance contracts, and other health
305 products and services. Purchases may be made by participating
306 individuals over the Internet or through the services of a
307 participating health insurance agent. Information about each
308 product and service available through the program shall be made

309 available through printed material and an interactive Internet
310 website. A participant needing personal assistance to select
311 products and services shall be referred to a participating agent
312 in his or her area.
313 (a) Participation in the program may begin at any time
314 during a year after the employer completes enrollment and meets
315 the requirements specified by the corporation pursuant to
316 paragraph (4)(c).
317 (b) Initial selection of products and services must be
318 made by an individual participant within 60 days after the date
319 the individual's employer qualified for participation. An
320 individual who fails to enroll in products and services by the
321 end of this period is limited to participation in flexible
322 spending account services until the next annual enrollment
323 period.
324 (c) Initial enrollment periods for each product selected
325 by an individual participant must last at least 12 months,
326 unless the individual participant specifically agrees to a
327 different enrollment period.
328 (d) If an individual has selected one or more products and
329 enrolled in those products for at least 12 months or any other
330 period specifically agreed to by the individual participant,
331 changes in selected products and services may only be made
332 during the annual enrollment period established by the
333 corporation.
334 (e) The limits established in paragraphs (b)-(d) apply to
335 any risk-bearing product that promises future payment or
336 coverage for a variable amount of benefits or services. The

337 limits do not apply to initiation of flexible spending plans if
338 those plans are not associated with specific high-deductible
339 insurance policies or the use of spending accounts for any
340 products offering individual participants specific amounts and
341 types of health services and treatments at a contracted price.
342 (8) CONSUMER INFORMATION.—The corporation shall:
343 (a) Establish a secure website to facilitate the purchase
344 of products and services by participating individuals. The
345 website must provide information about each product or service
346 available through the program.
347 (b) Inform individuals about other public health care
348 programs.
349 ~~(a) Prior to making a risk-bearing product available~~
350 ~~through the program, the corporation shall provide information~~
351 ~~regarding the product to the Office of Insurance Regulation. The~~
352 ~~office shall review the product information and provide consumer~~
353 ~~information and a recommendation on the risk-bearing product to~~
354 ~~the corporation within 30 days after receiving the product~~
355 ~~information.~~
356 ~~1. Upon receiving a recommendation that a risk-bearing~~
357 ~~product should be made available in the marketplace, the~~
358 ~~corporation may include the product on its website. If the~~
359 ~~consumer information and recommendation is not received within~~
360 ~~30 days, the corporation may make the risk-bearing product~~
361 ~~available on the website without consumer information from the~~
362 ~~office.~~
363 ~~2. Upon receiving a recommendation that a risk-bearing~~
364 ~~product should not be made available in the marketplace, the~~

365 ~~risk-bearing product may be included as an eligible product in~~
366 ~~the marketplace and on its website only if a majority of the~~
367 ~~board of directors vote to include the product.~~
368 ~~(b) If a risk-bearing product is made available on the~~
369 ~~website, the corporation shall make the consumer information and~~
370 ~~office recommendation available on the website and in print~~
371 ~~format. The corporation shall make late-submitted and ongoing~~
372 ~~updates to consumer information available on the website and in~~
373 ~~print format.~~
374 (9) RISK POOLING.—The program may use ~~shall utilize~~
375 methods for pooling the risk of individual participants and
376 preventing selection bias. These methods may ~~shall~~ include, but
377 are not limited to, a postenrollment risk adjustment of the
378 premium payments to the vendors. The corporation may ~~shall~~
379 establish a methodology for assessing the risk of enrolled
380 individual participants based on data reported annually by the
381 vendors about their enrollees. Distribution ~~Monthly~~
382 ~~distributions~~ of payments to the vendors may ~~shall~~ be adjusted
383 based on the assessed relative risk profile of the enrollees in
384 each risk-bearing product for the most recent period for which
385 data is available.
386 (10) EXEMPTIONS.—
387 (a) Products, other than the products set forth in
388 subparagraph (4)(d)1.-4., ~~Policies~~ sold as part of the program
389 are not subject to the licensing requirements of the Florida
390 Insurance Code, as defined in s. 624.01 ~~chapter 641,~~ or the
391 mandated offerings or coverages established in part VI of
392 chapter 627 and chapter 641.

393 (b) The corporation may act as an administrator as defined
394 in s. 626.88 but is not required to be certified pursuant to
395 part VII of chapter 626. However, a third party administrator
396 used by the corporation must be certified under part VII of
397 chapter 626.
398 (11) CORPORATION.—There is created the Florida Health
399 Choices, Inc., which shall be registered, incorporated,
400 organized, and operated in compliance with part III of chapter
401 112 and chapters 119, 286, and 617. The purpose of the
402 corporation is to administer the program created in this section
403 and to conduct such other business as may further the
404 administration of the program.
405 (a) The corporation shall be governed by a 15-member board
406 of directors consisting of:
407 1. Three ex officio, nonvoting members to include:
408 a. The Secretary of Health Care Administration or a
409 designee with expertise in health care services.
410 b. The Secretary of Management Services or a designee with
411 expertise in state employee benefits.
412 c. The commissioner of the Office of Insurance Regulation
413 or a designee with expertise in insurance regulation.
414 2. Four members appointed by and serving at the pleasure
415 of the Governor.
416 3. Four members appointed by and serving at the pleasure
417 of the President of the Senate.
418 4. Four members appointed by and serving at the pleasure
419 of the Speaker of the House of Representatives.
420 5. Board members may not include insurers, health

421 insurance agents or brokers, health care providers, health
422 maintenance organizations, prepaid service providers, or any
423 other entity, affiliate or subsidiary of eligible vendors.
424 (b) Members shall be appointed for terms of up to 3 years.
425 Any member is eligible for reappointment. A vacancy on the board
426 shall be filled for the unexpired portion of the term in the
427 same manner as the original appointment.
428 (c) The board shall select a chief executive officer for
429 the corporation who shall be responsible for the selection of
430 such other staff as may be authorized by the corporation's
431 operating budget as adopted by the board.
432 (d) Board members are entitled to receive, from funds of
433 the corporation, reimbursement for per diem and travel expenses
434 as provided by s. 112.061. No other compensation is authorized.
435 (e) There is no liability on the part of, and no cause of
436 action shall arise against, any member of the board or its
437 employees or agents for any action taken by them in the
438 performance of their powers and duties under this section.
439 (f) The board shall develop and adopt bylaws and other
440 corporate procedures as necessary for the operation of the
441 corporation and carrying out the purposes of this section. The
442 bylaws shall:
443 1. Specify procedures for selection of officers and
444 qualifications for reappointment, provided that no board member
445 shall serve more than 9 consecutive years.
446 2. Require an annual membership meeting that provides an
447 opportunity for input and interaction with individual
448 participants in the program.

449 3. Specify policies and procedures regarding conflicts of
450 interest, including the provisions of part III of chapter 112,
451 which prohibit a member from participating in any decision that
452 would inure to the benefit of the member or the organization
453 that employs the member. The policies and procedures shall also
454 require public disclosure of the interest that prevents the
455 member from participating in a decision on a particular matter.
456 (g) The corporation may exercise all powers granted to it
457 under chapter 617 necessary to carry out the purposes of this
458 section, including, but not limited to, the power to receive and
459 accept grants, loans, or advances of funds from any public or
460 private agency and to receive and accept from any source
461 contributions of money, property, labor, or any other thing of
462 value to be held, used, and applied for the purposes of this
463 section.
464 (h) The corporation may establish technical advisory
465 panels consisting of interested parties, including consumers,
466 health care providers, individuals with expertise in insurance
467 regulation, and insurers.
468 (i) The corporation shall:
469 1. Determine eligibility of employers, vendors,
470 individuals, and agents in accordance with subsection (4).
471 2. Establish procedures necessary for the operation of the
472 program, including, but not limited to, procedures for
473 application, enrollment, risk assessment, risk adjustment, plan
474 administration, performance monitoring, and consumer education.
475 3. Arrange for collection of contributions from
476 participating employers and individuals.

477 4. Arrange for payment of premiums and other appropriate
478 disbursements based on the selections of products and services
479 by the individual participants.
480 5. Establish criteria for disenrollment of participating
481 individuals based on failure to pay the individual's share of
482 any contribution required to maintain enrollment in selected
483 products.
484 6. Establish criteria for exclusion of vendors pursuant to
485 paragraph (4)(d).
486 7. Develop and implement a plan for promoting public
487 awareness of and participation in the program.
488 8. Secure staff and consultant services necessary to the
489 operation of the program.
490 9. Establish policies and procedures regarding
491 participation in the program for individuals, vendors, health
492 insurance agents, and employers.
493 <u>10. Provide for the operation of a toll-free hotline to</u>
494 <u>respond to requests for assistance.</u>
495 <u>11. Provide for initial, open, and special enrollment</u>
496 <u>periods.</u>
497 <u>12. Evaluate options for employer participation which may</u>
498 <u>conform with common insurance practices.</u>
499 ~~10. Develop a plan, in coordination with the Department of~~
500 ~~Revenue, to establish tax credits or refunds for employers that~~
501 ~~participate in the program. The corporation shall submit the~~
502 ~~plan to the Governor, the President of the Senate, and the~~
503 ~~Speaker of the House of Representatives by January 1, 2009.~~
504 (12) REPORT.—Beginning in the 2009-2010 fiscal year,

505 submit by February 1 an annual report to the Governor, the
506 President of the Senate, and the Speaker of the House of
507 Representatives documenting the corporation's activities in
508 compliance with the duties delineated in this section.
509 (13) PROGRAM INTEGRITY.—To ensure program integrity and to
510 safeguard the financial transactions made under the auspices of
511 the program, the corporation is authorized to establish
512 qualifying criteria and certification procedures for vendors,
513 require performance bonds or other guarantees of ability to
514 complete contractual obligations, monitor the performance of
515 vendors, and enforce the agreements of the program through
516 financial penalty or disqualification from the program.
517 Section 2. Section 409.821, Florida Statutes, is amended
518 to read:
519 409.821 Florida Kidcare program public records exemption.—
520 (1) Personal identifying information of a Florida Kidcare
521 program applicant or enrollee, as defined in s. 409.811, held by
522 the Agency for Health Care Administration, the Department of
523 Children and Family Services, the Department of Health, or the
524 Florida Healthy Kids Corporation is confidential and exempt from
525 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
526 (2)(a) Upon request, such information shall be disclosed
527 to:
528 1. Another governmental entity in the performance of its
529 official duties and responsibilities;
530 2. The Department of Revenue for purposes of administering
531 the state Title IV-D program; ~~or~~
532 <u>3. The Florida Health Choices, Inc., for the purpose of</u>

533 administering the program authorized pursuant to s. 408.910; or
534 4.~~3.~~ Any person who has the written consent of the program
535 applicant.
536 (b) This section does not prohibit an enrollee's legal
537 guardian from obtaining confirmation of coverage, dates of
538 coverage, the name of the enrollee's health plan, and the amount
539 of premium being paid.
540 (3) This exemption applies to any information identifying
541 a Florida Kidcare program applicant or enrollee held by the
542 Agency for Health Care Administration, the Department of
543 Children and Family Services, the Department of Health, or the
544 Florida Healthy Kids Corporation before, on, or after the
545 effective date of this exemption.
546 (4) A knowing and willful violation of this section is a
547 misdemeanor of the second degree, punishable as provided in s.
548 775.082 or s. 775.083.
549 Section 3. Subsection (41) of section 409.912, Florida
550 Statutes, is amended to read:
551 409.912 Cost-effective purchasing of health care.—The
552 agency shall purchase goods and services for Medicaid recipients
553 in the most cost-effective manner consistent with the delivery
554 of quality medical care. To ensure that medical services are
555 effectively utilized, the agency may, in any case, require a
556 confirmation or second physician's opinion of the correct
557 diagnosis for purposes of authorizing future services under the
558 Medicaid program. This section does not restrict access to
559 emergency services or poststabilization care services as defined
560 in 42 C.F.R. part 438.114. Such confirmation or second opinion

561 shall be rendered in a manner approved by the agency. The agency
562 shall maximize the use of prepaid per capita and prepaid
563 aggregate fixed-sum basis services when appropriate and other
564 alternative service delivery and reimbursement methodologies,
565 including competitive bidding pursuant to s. 287.057, designed
566 to facilitate the cost-effective purchase of a case-managed
567 continuum of care. The agency shall also require providers to
568 minimize the exposure of recipients to the need for acute
569 inpatient, custodial, and other institutional care and the
570 inappropriate or unnecessary use of high-cost services. The
571 agency shall contract with a vendor to monitor and evaluate the
572 clinical practice patterns of providers in order to identify
573 trends that are outside the normal practice patterns of a
574 provider's professional peers or the national guidelines of a
575 provider's professional association. The vendor must be able to
576 provide information and counseling to a provider whose practice
577 patterns are outside the norms, in consultation with the agency,
578 to improve patient care and reduce inappropriate utilization.
579 The agency may mandate prior authorization, drug therapy
580 management, or disease management participation for certain
581 populations of Medicaid beneficiaries, certain drug classes, or
582 particular drugs to prevent fraud, abuse, overuse, and possible
583 dangerous drug interactions. The Pharmaceutical and Therapeutics
584 Committee shall make recommendations to the agency on drugs for
585 which prior authorization is required. The agency shall inform
586 the Pharmaceutical and Therapeutics Committee of its decisions
587 regarding drugs subject to prior authorization. The agency is
588 authorized to limit the entities it contracts with or enrolls as

589 Medicaid providers by developing a provider network through
590 provider credentialing. The agency may competitively bid single-
591 source-provider contracts if procurement of goods or services
592 results in demonstrated cost savings to the state without
593 limiting access to care. The agency may limit its network based
594 on the assessment of beneficiary access to care, provider
595 availability, provider quality standards, time and distance
596 standards for access to care, the cultural competence of the
597 provider network, demographic characteristics of Medicaid
598 beneficiaries, practice and provider-to-beneficiary standards,
599 appointment wait times, beneficiary use of services, provider
600 turnover, provider profiling, provider licensure history,
601 previous program integrity investigations and findings, peer
602 review, provider Medicaid policy and billing compliance records,
603 clinical and medical record audits, and other factors. Providers
604 shall not be entitled to enrollment in the Medicaid provider
605 network. The agency shall determine instances in which allowing
606 Medicaid beneficiaries to purchase durable medical equipment and
607 other goods is less expensive to the Medicaid program than long-
608 term rental of the equipment or goods. The agency may establish
609 rules to facilitate purchases in lieu of long-term rentals in
610 order to protect against fraud and abuse in the Medicaid program
611 as defined in s. 409.913. The agency may seek federal waivers
612 necessary to administer these policies.
613 (41) The agency shall establish ~~provide for the~~
614 ~~development of~~ a demonstration project ~~by establishment~~ in
615 Miami-Dade County of a long-term-care facility and a psychiatric
616 facility licensed pursuant to chapter 395 to improve access to

617 health care for a predominantly minority, medically underserved,
618 and medically complex population and to evaluate alternatives to
619 nursing home care and general acute care for such population.
620 Such project is to be located in a health care condominium and
621 collocated ~~colocated~~ with licensed facilities providing a
622 continuum of care. These projects are ~~The establishment of this~~
623 ~~project is~~ not subject to the provisions of s. 408.036 or s.
624 408.039.
625 Section 4. This act shall take effect July 1, 2011.