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 (l) 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 (l) 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) ~~(c)~~ "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

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

224 Internal Revenue Code, including designation of the employer's
225 plan as a premium payment plan, a salary reduction plan that has
226 flexible spending arrangements, or a salary reduction plan that
227 has a premium payment and flexible spending arrangements.
228 3. Determination of the employer's contribution, if any,
229 per employee, provided that such contribution is equal for each
230 eligible employee.
231 4. Establishment of payroll deduction procedures, subject
232 to the agreement of each individual employee who voluntarily
233 participates in the program.
234 5. Designation of the corporation as the third-party
235 administrator for the employer's health benefit plan.
236 6. Identification of eligible employees.
237 7. Arrangement for periodic payments.
238 8. Employer notification to employees of the intent to
239 transfer from an existing employee health plan to the program at
240 least 90 days before the transition.
241 (d) All eligible vendors who choose to participate and the
242 products and services that the vendors are permitted to sell are
243 as follows:
244 1. Insurers licensed under chapter 624 may sell health
245 insurance policies, limited benefit policies, other risk-bearing
246 coverage, and other products or services.
247 2. Health maintenance organizations licensed under part I
248 of chapter 641 may sell health maintenance contracts ~~insurance~~
249 ~~policies~~, limited benefit policies, other risk-bearing products,
250 and other products or services.
251 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

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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

420 any risk-bearing product that promises future payment or
421 coverage for a variable amount of benefits or services. The
422 limits do not apply to initiation of flexible spending plans if
423 those plans are not associated with specific high-deductible
424 insurance policies or the use of spending accounts for any
425 products offering individual participants specific amounts and
426 types of health services and treatments at a contracted price.
427 (8) CONSUMER INFORMATION.—The corporation shall:
428 (a) Establish a secure website to facilitate the purchase
429 of products and services by participating individuals. The
430 website must provide information about each product or service
431 available through the program.
432 (b) Inform individuals about other public health care
433 programs.
434 ~~(a) Prior to making a risk-bearing product available~~
435 ~~through the program, the corporation shall provide information~~
436 ~~regarding the product to the Office of Insurance Regulation. The~~
437 ~~office shall review the product information and provide consumer~~
438 ~~information and a recommendation on the risk-bearing product to~~
439 ~~the corporation within 30 days after receiving the product~~
440 ~~information.~~
441 ~~1. Upon receiving a recommendation that a risk-bearing~~
442 ~~product should be made available in the marketplace, the~~
443 ~~corporation may include the product on its website. If the~~
444 ~~consumer information and recommendation is not received within~~
445 ~~30 days, the corporation may make the risk-bearing product~~
446 ~~available on the website without consumer information from the~~
447 ~~office.~~

448 ~~2. Upon receiving a recommendation that a risk-bearing~~
449 ~~product should not be made available in the marketplace, the~~
450 ~~risk-bearing product may be included as an eligible product in~~
451 ~~the marketplace and on its website only if a majority of the~~
452 ~~board of directors vote to include the product.~~
453 ~~(b) If a risk-bearing product is made available on the~~
454 ~~website, the corporation shall make the consumer information and~~
455 ~~office recommendation available on the website and in print~~
456 ~~format. The corporation shall make late-submitted and ongoing~~
457 ~~updates to consumer information available on the website and in~~
458 ~~print format.~~
459 (9) RISK POOLING.—The program may use ~~shall utilize~~
460 methods for pooling the risk of individual participants and
461 preventing selection bias. These methods may ~~shall~~ include, but
462 are not limited to, a postenrollment risk adjustment of the
463 premium payments to the vendors. The corporation may ~~shall~~
464 establish a methodology for assessing the risk of enrolled
465 individual participants based on data reported annually by the
466 vendors about their enrollees. Distribution ~~Monthly~~
467 ~~distributions~~ of payments to the vendors may ~~shall~~ be adjusted
468 based on the assessed relative risk profile of the enrollees in
469 each risk-bearing product for the most recent period for which
470 data is available.
471 (10) EXEMPTIONS.—
472 (a) Products, other than the products set forth in
473 subparagraph (4)(d)1.-4., ~~Policies~~ sold as part of the program
474 are not subject to the licensing requirements of the Florida
475 Insurance Code, as defined in s. 624.01 ~~chapter 641,~~ or the

476 mandated offerings or coverages established in part VI of
477 chapter 627 and chapter 641.
478 (b) The corporation may act as an administrator as defined
479 in s. 626.88 but is not required to be certified pursuant to
480 part VII of chapter 626. However, a third party administrator
481 used by the corporation must be certified under part VII of
482 chapter 626.
483 (11) CORPORATION.—There is created the Florida Health
484 Choices, Inc., which shall be registered, incorporated,
485 organized, and operated in compliance with part III of chapter
486 112 and chapters 119, 286, and 617. The purpose of the
487 corporation is to administer the program created in this section
488 and to conduct such other business as may further the
489 administration of the program.
490 (a) The corporation shall be governed by a 15-member board
491 of directors consisting of:
492 1. Three ex officio, nonvoting members to include:
493 a. The Secretary of Health Care Administration or a
494 designee with expertise in health care services.
495 b. The Secretary of Management Services or a designee with
496 expertise in state employee benefits.
497 c. The commissioner of the Office of Insurance Regulation
498 or a designee with expertise in insurance regulation.
499 2. Four members appointed by and serving at the pleasure
500 of the Governor.
501 3. Four members appointed by and serving at the pleasure
502 of the President of the Senate.
503 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~~

588 ~~Speaker of the House of Representatives by January 1, 2009.~~
589 (12) REPORT.—Beginning in the 2009-2010 fiscal year,
590 submit by February 1 an annual report to the Governor, the
591 President of the Senate, and the Speaker of the House of
592 Representatives documenting the corporation's activities in
593 compliance with the duties delineated in this section.
594 (13) PROGRAM INTEGRITY.—To ensure program integrity and to
595 safeguard the financial transactions made under the auspices of
596 the program, the corporation is authorized to establish
597 qualifying criteria and certification procedures for vendors,
598 require performance bonds or other guarantees of ability to
599 complete contractual obligations, monitor the performance of
600 vendors, and enforce the agreements of the program through
601 financial penalty or disqualification from the program.
602 Section 5. Section 409.821, Florida Statutes, is amended
603 to read:
604 409.821 Florida Kidcare program public records exemption.—
605 (1) Personal identifying information of a Florida Kidcare
606 program applicant or enrollee, as defined in s. 409.811, held by
607 the Agency for Health Care Administration, the Department of
608 Children and Family Services, the Department of Health, or the
609 Florida Healthy Kids Corporation is confidential and exempt from
610 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.
611 (2)(a) Upon request, such information shall be disclosed
612 to:
613 1. Another governmental entity in the performance of its
614 official duties and responsibilities;
615 2. The Department of Revenue for purposes of administering

616 the state Title IV-D program; ~~or~~
617 3. The Florida Health Choices, Inc., for the purpose of
618 administering the program authorized pursuant to s. 408.910; or
619 4.~~3.~~ Any person who has the written consent of the program
620 applicant.
621 (b) This section does not prohibit an enrollee's legal
622 guardian from obtaining confirmation of coverage, dates of
623 coverage, the name of the enrollee's health plan, and the amount
624 of premium being paid.
625 (3) This exemption applies to any information identifying
626 a Florida Kidcare program applicant or enrollee held by the
627 Agency for Health Care Administration, the Department of
628 Children and Family Services, the Department of Health, or the
629 Florida Healthy Kids Corporation before, on, or after the
630 effective date of this exemption.
631 (4) A knowing and willful violation of this section is a
632 misdemeanor of the second degree, punishable as provided in s.
633 775.082 or s. 775.083.
634 Section 6. Subsection (41) of section 409.912, Florida
635 Statutes, is amended to read:
636 409.912 Cost-effective purchasing of health care.—The
637 agency shall purchase goods and services for Medicaid recipients
638 in the most cost-effective manner consistent with the delivery
639 of quality medical care. To ensure that medical services are
640 effectively utilized, the agency may, in any case, require a
641 confirmation or second physician's opinion of the correct
642 diagnosis for purposes of authorizing future services under the
643 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

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 colocated 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.