A bill to be entitled

An act relating to health and human services contracts; establishing the Health and Human Services Contract Resource Center to be administratively housed in the Department of Management Services; providing the center's duties; establishing a board of trustees composed of certain agency heads; providing for an executive director appointed by the Governor; providing for implementation by a certain date; amending s. 287.057, F.S.; exempting services provided by an eligible lead community-based provider from being subject to the state competitive bidding process; amending ss. 402.7305 and 427.0135, F.S.; conforming cross-references; reenacting s. 287.058(5), F.S., relating to contract documents for the procurement of specified contractual services, to incorporate the amendment made to s. 287.057, F.S., in a reference thereto; reenacting s. 627.311(5)(c), F.S., relating to joint underwriters and joint reinsurers, to incorporate the amendment made to s. 287.057, F.S., in a reference thereto; reenacting s. 627.351(6)(e), F.S., relating to the Citizens Property Insurance Corporation, to incorporate the amendment made to s. 287.057, F.S., in a reference thereto; providing an effective date.

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

Section 1. Health and Human Services Contract Resource Center.—The Health and Human Services Contract Resource Center

is created and housed for administrative purposes only in the Department of Management Services. The Legislature intends that the center serve as a single, consolidated unit for the administrative and fiscal contract management of health and human services outsourced by the Department of Children and Family Services, the Department of Elderly Affairs, the Department of Health, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and the Agency for Health Care Administration.

(1) CENTER DUTIES.—The center shall:

(a) Serve as the lead state agency for all administrative and fiscal matters related to health and human services contracts.

(b) Provide administrative and fiscal monitoring activities in coordination with the agency responsible for the program components related to the services provided by the health and human services contract.

(c) Establish administrative and fiscal performance standards for vendors providing health and human services. The standards shall be used in contract monitoring and as part of each agency's evaluation of competitive bids for health and human services.

(d) Develop uniform policies, contract administrative requirements, and monitoring protocols related to the administrative and fiscal requirements of vendors providing health and human services.

(e) Establish or arrange for the establishment of a consolidated data warehouse and archive to maintain the

corporate, fiscal, and administrative records of health and human services vendors. The center shall ensure that this data is up to date and accessible to other agencies, participating vendors, and the general public through web-based technology. The records may include, but need not be limited to:

1. Articles of incorporation.

2. Bylaws.

3. Governing board and committee meeting minutes.

4. Financial audits.

5. Organizational charts.

(f) Manage the administrative and fiscal data in a manner that allows contract information to be aggregated and assessed to determine the amount, value, and achievement of administrative standards by vendor, by agency, and by type of service.

(g) Establish a consolidated schedule for site visits to monitor and evaluate the administrative and fiscal compliance of vendors providing health and human services. The center shall facilitate joint site visits with agency program staff whenever possible.

(h) Create an enterprise that allows nonstate agencies to purchase center services. Eligible buyers include, but are not limited to, local governments, nongovernmental organizations, and vendors that have contracts for health and human services with other local service agencies or organizations.

(2) BOARD OF TRUSTEES.—

(a) The center shall be governed by a board of trustees consisting of the agency heads, or designees, of the Department

of Children and Family Services, the Department of Health, the Department of Elderly Affairs, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and the Agency for Health Care Administration. The chair of the board shall be appointed by the Governor from the participating agency heads.

(b) The board shall approve an annual work program and business plan, review and approve center policies, and establish a mechanism for receiving and evaluating feedback from health and human services vendors.

(3) EXECUTIVE DIRECTOR.—The Governor shall appoint an executive director of the center. The executive director must have a graduate degree from an accredited institution and at least 7 years of executive-level experience.

(4) IMPLEMENTATION.—The activities of the center shall be phased in beginning with children's services contracts of the Department of Children and Family Services and the Department of Health. Other agency contracts shall be incorporated into the center's management protocols in accordance with a schedule developed by the board of trustees and approved by the Legislative Budget Commission. However, the phasing in of all agency contracts must be completed by June 30, 2011.

Section 2. Paragraph (f) of subsection (3) of section 287.057, Florida Statutes, is amended to read:

287.057 Procurement of commodities or contractual services.—

(3) When the purchase price of commodities or contractual services exceeds the threshold amount provided in s. 287.017 for CATEGORY TWO, no purchase of commodities or contractual services

may be made without receiving competitive sealed bids, competitive sealed proposals, or competitive sealed replies unless:

(f) The purchase is for any of the following contractual services and commodities ~~are not subject to the competitive solicitation requirements of this section~~:

1. Artistic services. For the purposes of this subsection, the term "artistic services" does not include advertising or typesetting. As used in this subparagraph, the term "advertising" means the making of a representation in any form in connection with a trade, business, craft, or profession in order to promote the supply of commodities or services by the person promoting the commodities or contractual services.

2. Academic program reviews if the fee for such services does not exceed $50,000.

3. Lectures by individuals.

4. Legal services, including attorney, paralegal, expert witness, appraisal, or mediator services.

5.~~a.~~ Health services involving examination, diagnosis, treatment, prevention, medical consultation, or administration.

~~b.~~ Beginning January 1, 2011, health services~~,~~ include ~~including~~, but are not limited to, substance abuse and mental health services~~,~~ involving examination, diagnosis, treatment, prevention, or medical consultation, if ~~when~~ such services are offered to eligible individuals participating in a specific program that qualifies multiple providers and uses a standard payment methodology. Reimbursement for the ~~of~~ administrative costs of ~~for~~ providers of services purchased in this manner are

~~shall~~ also ~~be~~ exempt. For purposes of this subparagraph ~~sub-subparagraph~~, the term "providers" means health professionals, health facilities, or organizations that deliver or arrange for the delivery of health services.

6. Services provided to persons with mental or physical disabilities by not-for-profit corporations which have obtained exemptions under ~~the provisions of~~ s. 501(c)(3) of the United States Internal Revenue Code or ~~when~~ such services ~~are~~ governed by ~~the provisions of~~ Office of Management and Budget Circular A-122. However, in acquiring such services, the agency shall consider the ability of the vendor, past performance, willingness to meet time requirements, and price.

7. Medicaid services delivered to an eligible Medicaid recipient unless the agency is directed otherwise by ~~in~~ law.

8. Family placement services.

9. Services provided by an eligible lead community-based provider as described in s. 409.1671(1)(e) currently under contract with the Department of Children and Family Services and in compliance with the department's performance, fiscal, and administrative standards.

10.~~9.~~ Prevention services related to mental health, including drug abuse prevention programs, child abuse prevention programs, and shelters for runaways, operated by not-for-profit corporations. However, in acquiring such services, the agency must ~~shall~~ consider the ability of the vendor, past performance, willingness to meet time requirements, and price.

11.~~10.~~ Training and education services provided to injured employees pursuant to s. 440.491(6).

12.~~11.~~ Contracts entered into pursuant to s. 337.11.

13.~~12.~~ Services or commodities provided by governmental agencies.

Section 3. Paragraph (a) of subsection (2) of section 402.7305, Florida Statutes, is amended to read:

402.7305 Department of Children and Family Services; procurement of contractual services; contract management.—

(2) PROCUREMENT OF COMMODITIES AND CONTRACTUAL SERVICES.—

(a) Notwithstanding s. 287.057(3)(f)13.~~12.~~, whenever the department intends to contract with a public postsecondary institution to provide a service, the department must allow all public postsecondary institutions in this state that are accredited by the Southern Association of Colleges and Schools to bid on the contract. Thereafter, notwithstanding any other provision to the contrary, if a public postsecondary institution intends to subcontract for any service awarded in the contract, the subcontracted service must be procured by competitive procedures.

Section 4. Subsection (3) of section 427.0135, Florida Statutes, is amended to read:

427.0135 Purchasing agencies; duties and responsibilities.—Each purchasing agency, in carrying out the policies and procedures of the commission, shall:

(3) Not procure transportation disadvantaged services without initially negotiating with the commission, as provided in s. 287.057(3)(f)13.~~12.~~, or unless otherwise authorized by statute. If the purchasing agency, after consultation with the commission, determines that it cannot reach mutually acceptable

contract terms with the commission, the purchasing agency may contract for the same transportation services provided in a more cost-effective manner and of comparable or higher quality and standards. The Medicaid agency shall implement this subsection in a manner consistent with s. 409.908(18) and as otherwise limited or directed by the General Appropriations Act.

Section 5. For the purpose of incorporating the amendment made by this act to section 287.057, Florida Statutes, in a reference thereto, subsection (5) of section 287.058, Florida Statutes, is reenacted to read:

287.058 Contract document.—

(5) Unless otherwise provided in the General Appropriations Act or the substantive bill implementing the General Appropriations Act, the Chief Financial Officer may waive the requirements of this section for services which are included in s. 287.057(3)(f).

Section 6. For the purpose of incorporating the amendment made by this act to section 287.057, Florida Statutes, in a reference thereto, paragraph (c) of subsection (5) of section 627.311, Florida Statutes, is reenacted to read:

627.311 Joint underwriters and joint reinsurers; public records and public meetings exemptions.—

(5)

(c) The operation of the plan shall be governed by a plan of operation that is prepared at the direction of the board of governors and approved by order of the office. The plan is subject to continuous review by the office. The office may, by order, withdraw approval of all or part of a plan if the office

determines that conditions have changed since approval was granted and that the purposes of the plan require changes in the plan. The plan of operation shall:

1. Authorize the board to engage in the activities necessary to implement this subsection, including, but not limited to, borrowing money.

2. Develop criteria for eligibility for coverage by the plan, including, but not limited to, documented rejection by at least two insurers which reasonably assures that insureds covered under the plan are unable to acquire coverage in the voluntary market.

3. Require notice from the agent to the insured at the time of the application for coverage that the application is for coverage with the plan and that coverage may be available through an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer through another agent at a lower cost.

4. Establish programs to encourage insurers to provide coverage to applicants of the plan in the voluntary market and to insureds of the plan, including, but not limited to:

a. Establishing procedures for an insurer to use in notifying the plan of the insurer's desire to provide coverage to applicants to the plan or existing insureds of the plan and in describing the types of risks in which the insurer is interested. The description of the desired risks must be on a form developed by the plan.

b. Developing forms and procedures that provide an insurer with the information necessary to determine whether the insurer

wants to write particular applicants to the plan or insureds of the plan.

c. Developing procedures for notice to the plan and the applicant to the plan or insured of the plan that an insurer will insure the applicant or the insured of the plan, and notice of the cost of the coverage offered; and developing procedures for the selection of an insuring entity by the applicant or insured of the plan.

d. Provide for a market-assistance plan to assist in the placement of employers. All applications for coverage in the plan received 45 days before the effective date for coverage shall be processed through the market-assistance plan. A market-assistance plan specifically designed to serve the needs of small, good policyholders as defined by the board must be reviewed and updated periodically.

5. Provide for policy and claims services to the insureds of the plan of the nature and quality provided for insureds in the voluntary market.

6. Provide for the review of applications for coverage with the plan for reasonableness and accuracy, using any available historic information regarding the insured.

7. Provide for procedures for auditing insureds of the plan which are based on reasonable business judgment and are designed to maximize the likelihood that the plan will collect the appropriate premiums.

8. Authorize the plan to terminate the coverage of and refuse future coverage for any insured that submits a fraudulent application to the plan or provides fraudulent or grossly

erroneous records to the plan or to any service provider of the plan in conjunction with the activities of the plan.

9. Establish service standards for agents who submit business to the plan.

10. Establish criteria and procedures to prohibit any agent who does not adhere to the established service standards from placing business with the plan or receiving, directly or indirectly, any commissions for business placed with the plan.

11. Provide for the establishment of reasonable safety programs for all insureds in the plan. All insureds of the plan must participate in the safety program.

12. Authorize the plan to terminate the coverage of and refuse future coverage to any insured who fails to pay premiums or surcharges when due; who, at the time of application, is delinquent in payments of workers' compensation or employer's liability insurance premiums or surcharges owed to an insurer, group self-insurers' fund, commercial self-insurance fund, or assessable mutual insurer licensed to write such coverage in this state; or who refuses to substantially comply with any safety programs recommended by the plan.

13. Authorize the board of governors to provide the goods and services required by the plan through staff employed by the plan, through reasonably compensated service providers who contract with the plan to provide services as specified by the board of governors, or through a combination of employees and service providers.

a. Purchases that equal or exceed $2,500 but are less than or equal to $25,000, shall be made by receipt of written quotes,

telephone quotes, or informal bids, whenever practical. The procurement of goods or services valued over $25,000 is subject to competitive solicitation, except in situations in which the goods or services are provided by a sole source or are deemed an emergency purchase, or the services are exempted from competitive-solicitation requirements under s. 287.057(3)(f). Justification for the sole-sourcing or emergency procurement must be documented. Contracts for goods or services valued at or over $100,000 are subject to board approval.

b. The board shall determine whether it is more cost-effective and in the best interests of the plan to use legal services provided by in-house attorneys employed by the plan rather than contracting with outside counsel. In making such determination, the board shall document its findings and shall consider the expertise needed; whether time commitments exceed in-house staff resources; whether local representation is needed; the travel, lodging, and other costs associated with in-house representation; and such other factors that the board determines are relevant.

14. Provide for service standards for service providers, methods of determining adherence to those service standards, incentives and disincentives for service, and procedures for terminating contracts for service providers that fail to adhere to service standards.

15. Provide procedures for selecting service providers and standards for qualification as a service provider that reasonably assure that any service provider selected will continue to operate as an ongoing concern and is capable of

providing the specified services in the manner required.

16. Provide for reasonable accounting and data-reporting practices.

17. Provide for annual review of costs associated with the administration and servicing of the policies issued by the plan to determine alternatives by which costs can be reduced.

18. Authorize the acquisition of such excess insurance or reinsurance as is consistent with the purposes of the plan.

19. Provide for an annual report to the office on a date specified by the office and containing such information as the office reasonably requires.

20. Establish multiple rating plans for various classifications of risk which reflect risk of loss, hazard grade, actual losses, size of premium, and compliance with loss control. At least one of such plans must be a preferred-rating plan to accommodate small-premium policyholders with good experience as defined in sub-subparagraph 22.a.

21. Establish agent commission schedules.

22. For employers otherwise eligible for coverage under the plan, establish three tiers of employers meeting the criteria and subject to the rate limitations specified in this subparagraph.

a. Tier One.—

(I) Criteria; rated employers.—An employer that has an experience modification rating shall be included in Tier One if the employer meets all of the following:

(A) The experience modification is below 1.00.

(B) The employer had no lost-time claims subsequent to the

applicable experience modification rating period.

(C) The total of the employer's medical-only claims subsequent to the applicable experience modification rating period did not exceed 20 percent of premium.

(II) Criteria; non-rated employers.—An employer that does not have an experience modification rating shall be included in Tier One if the employer meets all of the following:

(A) The employer had no lost-time claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(B) The total of the employer's medical-only claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan did not exceed 20 percent of premium.

(C) The employer has secured workers' compensation coverage for the entire 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(D) The employer is able to provide the plan with a loss history generated by the employer's prior workers' compensation insurer, except if the employer is not able to produce a loss history due to the insolvency of an insurer, the receiver shall provide to the plan, upon the request of the employer or the employer's agent, a copy of the employer's loss history from the records of the insolvent insurer if the loss history is contained in records of the insurer which are in the possession of the receiver. If the receiver is unable to produce the loss history, the employer may, in lieu of the loss history, submit

an affidavit from the employer and the employer's insurance agent setting forth the loss history.

(E) The employer is not a new business.

(III) Premiums.—The premiums for Tier One insureds shall be set at a premium level 25 percent above the comparable voluntary market premiums until the plan has sufficient experience as determined by the board to establish an actuarially sound rate for Tier One, at which point the board shall, subject to paragraph (e), adjust the rates, if necessary, to produce actuarially sound rates, provided such rate adjustment shall not take effect prior to January 1, 2007.

b. Tier Two.—

(I) Criteria; rated employers.—An employer that has an experience modification rating shall be included in Tier Two if the employer meets all of the following:

(A) The experience modification is equal to or greater than 1.00 but not greater than 1.10.

(B) The employer had no lost-time claims subsequent to the applicable experience modification rating period.

(C) The total of the employer's medical-only claims subsequent to the applicable experience modification rating period did not exceed 20 percent of premium.

(II) Criteria; non-rated employers.—An employer that does not have any experience modification rating shall be included in Tier Two if the employer is a new business. An employer shall be included in Tier Two if the employer has less than 3 years of loss experience in the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under

the plan and the employer meets all of the following:

(A) The employer had no lost-time claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan.

(B) The total of the employer's medical-only claims for the 3-year period immediately preceding the inception date or renewal date of the employer's coverage under the plan did not exceed 20 percent of premium.

(C) The employer is able to provide the plan with a loss history generated by the workers' compensation insurer that provided coverage for the portion or portions of such period during which the employer had secured workers' compensation coverage, except if the employer is not able to produce a loss history due to the insolvency of an insurer, the receiver shall provide to the plan, upon the request of the employer or the employer's agent, a copy of the employer's loss history from the records of the insolvent insurer if the loss history is contained in records of the insurer which are in the possession of the receiver. If the receiver is unable to produce the loss history, the employer may, in lieu of the loss history, submit an affidavit from the employer and the employer's insurance agent setting forth the loss history.

(III) Premiums.—The premiums for Tier Two insureds shall be set at a rate level 50 percent above the comparable voluntary market premiums until the plan has sufficient experience as determined by the board to establish an actuarially sound rate for Tier Two, at which point the board shall, subject to paragraph (e), adjust the rates, if necessary, to produce

actuarially sound rates, provided such rate adjustment shall not take effect prior to January 1, 2007.

c. Tier Three.—

(I) Eligibility.—An employer shall be included in Tier Three if the employer does not meet the criteria for Tier One or Tier Two.

(II) Rates.—The board shall establish, subject to paragraph (e), and the plan shall charge, actuarially sound rates for Tier Three insureds.

23. For Tier One or Tier Two employers which employ no nonexempt employees or which report payroll which is less than the minimum wage hourly rate for one full-time employee for 1 year at 40 hours per week, the plan shall establish actuarially sound premiums, provided, however, that the premiums may not exceed $2,500. These premiums shall be in addition to the fee specified in subparagraph 26. When the plan establishes actuarially sound rates for all employers in Tier One and Tier Two, the premiums for employers referred to in this paragraph are no longer subject to the $2,500 cap.

24. Provide for a depopulation program to reduce the number of insureds in the plan. If an employer insured through the plan is offered coverage from a voluntary market carrier:

a. During the first 30 days of coverage under the plan;

b. Before a policy is issued under the plan;

c. By issuance of a policy upon expiration or cancellation of the policy under the plan; or

d. By assumption of the plan's obligation with respect to an in-force policy,

that employer is no longer eligible for coverage through the plan. The premium for risks assumed by the voluntary market carrier must be no greater than the premium the insured would have paid under the plan, and shall be adjusted upon renewal to reflect changes in the plan rates and the tier for which the insured would qualify as of the time of renewal. The insured may be charged such premiums only for the first 3 years of coverage in the voluntary market. A premium under this subparagraph is deemed approved and is not an excess premium for purposes of s. 627.171.

25. Require that policies issued and applications must include a notice that the policy could be replaced by a policy issued from a voluntary market carrier and that, if an offer of coverage is obtained from a voluntary market carrier, the policyholder is no longer eligible for coverage through the plan. The notice must also specify that acceptance of coverage under the plan creates a conclusive presumption that the applicant or policyholder is aware of this potential.

26. Require that each application for coverage and each renewal premium be accompanied by a nonrefundable fee of $475 to cover costs of administration and fraud prevention. The board may, with the prior approval of the office, increase the amount of the fee pursuant to a rate filing to reflect increased costs of administration and fraud prevention. The fee is not subject to commission and is fully earned upon commencement of coverage.

Section 7. For the purpose of incorporating the amendment made by this act to section 287.057, Florida Statutes, in a

reference thereto, paragraph (e) of subsection (6) of section 627.351, Florida Statutes, is reenacted to read:

627.351 Insurance risk apportionment plans.—

(6) CITIZENS PROPERTY INSURANCE CORPORATION.—

(e) Purchases that equal or exceed $2,500, but are less than $25,000, shall be made by receipt of written quotes, written record of telephone quotes, or informal bids, whenever practical. The procurement of goods or services valued at or over $25,000 shall be subject to competitive solicitation, except in situations where the goods or services are provided by a sole source or are deemed an emergency purchase; the services are exempted from competitive solicitation requirements under s. 287.057(3)(f); or the procurement of services is subject to s. 627.3513. Justification for the sole-sourcing or emergency procurement must be documented. Contracts for goods or services valued at or over $100,000 are subject to approval by the board.

Section 8. This act shall take effect July 1, 2011.