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LEGISLATIVE ACTION

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| Senate | . | House |
| Comm: RCS | . | |
| 04/25/2011 | . | |
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The Committee on Banking and Insurance (Oelrich) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause
and insert:

Section 1. Section 408.910, Florida Statutes, is amended to
read:

408.910 Florida Health Choices Program.—

(1) LEGISLATIVE INTENT.—The Legislature finds that a
significant number of the residents of this state do not have
adequate access to affordable, quality health care. The
Legislature further finds that increasing access to affordable,
quality health care can be best accomplished by establishing a



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13 competitive market for purchasing health insurance and health
14 services. It is therefore the intent of the Legislature to
15 create the Florida Health Choices Program to:

16 (a) Expand opportunities for Floridians to purchase
17 affordable health insurance and health services.

18 (b) Preserve the benefits of employment-sponsored insurance
19 while easing the administrative burden for employers who offer
20 these benefits.

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

23 (d) Provide for the purchase of individual, portable health
24 care coverage.

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

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

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

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

33 (b) "Corporation's marketplace" means the single,
34 centralized market established by the program which facilitates
35 the purchase of products made available in the marketplace.

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

38 (d) ~~(e)~~ "Insurer" means an entity licensed under chapter 624
39 which offers an individual health insurance policy or a group
40 health insurance policy, a preferred provider organization as
41 defined in s. 627.6471, ~~or~~ an exclusive provider organization as



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42 defined in s. 627.6472, a health maintenance organization
43 licensed under part I of chapter 641, or a prepaid limited
44 health service organization or discount medical plan
45 organization licensed under chapter 636.

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

48 (3) PROGRAM PURPOSE AND COMPONENTS.—The Florida Health
49 Choices Program is created as a single, centralized market for
50 the sale and purchase of various products that enable
51 individuals to pay for health care. These products include, but
52 are not limited to, health insurance plans, health maintenance
53 organization plans, prepaid services, service contracts, and
54 flexible spending accounts. The components of the program
55 include:

56 (a) Enrollment of employers.

57 (b) Administrative services for participating employers,
58 including:

59 1. Assistance in seeking federal approval of cafeteria
60 plans.

61 2. Collection of premiums and other payments.

62 3. Management of individual benefit accounts.

63 4. Distribution of premiums to insurers and payments to
64 other eligible vendors.

65 5. Assistance for participants in complying with reporting
66 requirements.

67 (c) Services to individual participants, including:

68 1. Information about available products and participating
69 vendors.

70 2. Assistance with assessing the benefits and limits of



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71 each product, including information necessary to distinguish
72 between policies offering creditable coverage and other products
73 available through the program.

74 3. Account information to assist individual participants
75 with managing available resources.

76 4. Services that promote healthy behaviors.

77 (d) Recruitment of vendors, including insurers, health
78 maintenance organizations, prepaid clinic service providers,
79 provider service networks, and other providers.

80 (e) Certification of vendors to ensure capability,
81 reliability, and validity of offerings.

82 (f) Collection of data, monitoring, assessment, and
83 reporting of vendor performance.

84 (g) Information services for individuals and employers.

85 (h) Program evaluation.

86 (4) ELIGIBILITY AND PARTICIPATION.—Participation in the
87 program is voluntary and is ~~shall be~~ available to employers,
88 individuals, vendors, and health insurance agents as specified
89 in this subsection.

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

91 1. Employers that meet criteria established by the
92 corporation and elect to make their employees eligible for one
93 or more health products offered through the program ~~have 1 to 50~~
94 ~~employees.~~

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

96 3. Municipalities having populations of fewer than 50,000
97 residents.

98 4. School districts in fiscally constrained counties.

99 5. Statutory rural hospitals.



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- 100 (b) Individuals eligible to participate in the program
101 include:
- 102 1. Individual employees of enrolled employers.
 - 103 2. State employees not eligible for state employee health
104 benefits.
 - 105 3. State retirees.
 - 106 4. Medicaid ~~reform~~ participants who opt out ~~select the opt-~~
107 ~~out provision of reform.~~
 - 108 ~~5. Statutory rural hospitals.~~
- 109 (c) Employers who choose to participate in the program may
110 enroll by complying with the procedures established by the
111 corporation. The procedures must include, but are not limited
112 to:
- 113 1. Submission of required information.
 - 114 2. Compliance with federal tax requirements for the
115 establishment of a cafeteria plan, pursuant to s. 125 of the
116 Internal Revenue Code, including designation of the employer's
117 plan as a premium payment plan, a salary reduction plan that has
118 flexible spending arrangements, or a salary reduction plan that
119 has a premium payment and flexible spending arrangements.
 - 120 3. Determination of the employer's contribution, if any,
121 per employee, provided that such contribution is equal for each
122 eligible employee.
 - 123 4. Establishment of payroll deduction procedures, subject
124 to the agreement of each individual employee who voluntarily
125 participates in the program.
 - 126 5. Designation of the corporation as the third-party
127 administrator for the employer's health benefit plan.
 - 128 6. Identification of eligible employees.



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- 129 7. Arrangement for periodic payments.
- 130 8. Employer notification to employees of the intent to
131 transfer from an existing employee health plan to the program at
132 least 90 days before the transition.
- 133 (d) All eligible vendors who choose to participate and the
134 products and services that the vendors are permitted to sell are
135 as follows:
- 136 1. Insurers licensed under chapter 624 may sell health
137 insurance policies, limited benefit policies, other risk-bearing
138 coverage, and other products or services.
- 139 2. Health maintenance organizations licensed under part I
140 of chapter 641 may sell health maintenance contracts ~~insurance~~
141 ~~policies~~, limited benefit policies, other risk-bearing products,
142 and other products or services.
- 143 3. Prepaid limited health service organizations may sell
144 products and services as authorized under part I of chapter 636,
145 and discount medical plan organizations may sell products and
146 services as authorized under part II of chapter 636.
- 147 ~~4.3.~~ Prepaid health clinic service providers licensed under
148 part II of chapter 641 may sell prepaid service contracts and
149 other arrangements for a specified amount and type of health
150 services or treatments.
- 151 ~~5.4.~~ Health care providers, including hospitals and other
152 licensed health facilities, health care clinics, licensed health
153 professionals, pharmacies, and other licensed health care
154 providers, may sell service contracts and arrangements for a
155 specified amount and type of health services or treatments.
- 156 ~~6.5.~~ Provider organizations, including service networks,
157 group practices, professional associations, and other



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158 incorporated organizations of providers, may sell service
159 contracts and arrangements for a specified amount and type of
160 health services or treatments.

161 ~~7.6.~~ Corporate entities providing specific health services
162 in accordance with applicable state law may sell service
163 contracts and arrangements for a specified amount and type of
164 health services or treatments.

165
166 A vendor described in subparagraphs ~~4.-7.~~ ~~3.-6.~~ may not
167 sell products that provide risk-bearing coverage unless that
168 vendor is authorized under a certificate of authority issued by
169 the Office of Insurance Regulation and is authorized to provide
170 coverage in the relevant geographic area under the provisions of
171 the Florida Insurance Code. Otherwise eligible vendors may be
172 excluded from participating in the program for deceptive or
173 predatory practices, financial insolvency, or failure to comply
174 with the terms of the participation agreement or other standards
175 set by the corporation.

176 (e) Any risk-bearing product available under subparagraphs
177 (d)1.-4. must be approved by the Office of Insurance Regulation.
178 Any non-risk-bearing product must be approved by the
179 corporation.

180 ~~(f)(e)~~ Eligible individuals may voluntarily continue
181 participation in the program regardless of subsequent changes in
182 job status or Medicaid eligibility. Individuals who join the
183 program may participate by complying with the procedures
184 established by the corporation. These procedures must include,
185 but are not limited to:

186 1. Submission of required information.



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- 187 2. Authorization for payroll deduction.
- 188 3. Compliance with federal tax requirements.
- 189 4. Arrangements for payment in the event of job changes.
- 190 5. Selection of products and services.

191 (g) ~~(f)~~ Vendors who choose to participate in the program may
192 enroll by complying with the procedures established by the
193 corporation. These procedures may ~~must~~ include, but are not
194 limited to:

195 1. Submission of required information, including a complete
196 description of the coverage, services, provider network, payment
197 restrictions, and other requirements of each product offered
198 through the program.

199 2. Execution of an agreement that ~~to make~~ all risk-bearing
200 products offered through the program are in compliance with the
201 insurance code and are guaranteed-issue policies, subject to
202 preexisting condition exclusions established by the corporation.

203 3. Execution of an agreement that prohibits refusal to sell
204 any offered non-risk-bearing product to a participant who elects
205 to buy it.

206 4. Establishment of product prices based on age, gender,
207 family composition, and location of the individual participant,
208 which may include medical underwriting.

209 5. Arrangements for receiving payment for enrolled
210 participants.

211 6. Participation in ongoing reporting processes established
212 by the corporation.

213 7. Compliance with grievance procedures established by the
214 corporation.

215 (h) ~~(g)~~ Health insurance agents licensed under part IV of



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216 chapter 626 are eligible to voluntarily participate as buyers'
217 representatives. A buyer's representative acts on behalf of an
218 individual purchasing health insurance and health services
219 through the program by providing information about products and
220 services available through the program and assisting the
221 individual with both the decision and the procedure of selecting
222 specific products. Serving as a buyer's representative does not
223 constitute a conflict of interest with continuing
224 responsibilities as a health insurance agent if the relationship
225 between each agent and any participating vendor is disclosed
226 before advising an individual participant about the products and
227 services available through the program. In order to participate,
228 a health insurance agent shall comply with the procedures
229 established by the corporation, including:

- 230 1. Completion of training requirements.
231 2. Execution of a participation agreement specifying the
232 terms and conditions of participation.
233 3. Disclosure of any appointments to solicit insurance or
234 procure applications for vendors participating in the program.
235 4. Arrangements to receive payment from the corporation for
236 services as a buyer's representative.

237 (5) PRODUCTS.—

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

- 240 1. Health insurance policies.
241 2. Limited benefit plans.
242 3. Prepaid clinic services.
243 4. Service contracts.
244 5. Arrangements for purchase of specific amounts and types



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245 of health services and treatments.

246 6. Flexible spending accounts.

247 7. Health maintenance contracts.

248 (b) Health insurance policies, health maintenance
249 contracts, limited benefit plans, prepaid service contracts, and
250 other contracts for services must ensure the availability of
251 covered services ~~and benefits to participating individuals for~~
252 ~~at least 1 full enrollment year.~~

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

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

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

263 (6) PRICING.—Prices for the products sold through the
264 program must be transparent to participants and established by
265 the vendors. Risk-bearing products approved by the Office of
266 Insurance Regulation must be priced pursuant to state law
267 governing the rates of insurance product based on age, gender,
268 ~~and location of participants. The corporation shall develop a~~
269 ~~methodology for evaluating the actuarial soundness of products~~
270 ~~offered through the program. The methodology shall be reviewed~~
271 ~~by the Office of Insurance Regulation prior to use by the~~
272 ~~corporation. Before making the product available to individual~~
273 ~~participants, the corporation shall use the methodology to~~



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274 ~~compare the expected health care costs for the covered services~~
275 ~~and benefits to the vendor's price for that coverage. The~~
276 ~~results shall be reported to individuals participating in the~~
277 ~~program. Once established, the price set by the vendor must~~
278 ~~remain in force for at least 1 year and may only be redetermined~~
279 ~~by the vendor at the next annual enrollment period. The~~
280 corporation shall annually assess a surcharge for each premium
281 or price set by a participating vendor. The surcharge may not be
282 more than 2.5 percent of the price and shall be used to generate
283 funding for administrative services provided by the corporation
284 and payments to buyers' representatives.

285 (7) MARKETPLACE EXCHANGE PROCESS.—The program shall provide
286 a single, centralized market for purchase of health insurance,
287 health maintenance contracts, and other health products and
288 services. Purchases may be made by participating individuals
289 over the Internet or through the services of a participating
290 health insurance agent. Information about each product and
291 service available through the program shall be made available
292 through printed material and an interactive Internet website. A
293 participant needing personal assistance to select products and
294 services shall be referred to a participating agent in his or
295 her area.

296 (a) Participation in the program may begin at any time
297 during a year after the employer completes enrollment and meets
298 the requirements specified by the corporation pursuant to
299 paragraph (4) (c).

300 (b) Initial selection of products and services must be made
301 by an individual participant within 60 days after the date the
302 individual's employer qualified for participation. An individual



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303 who fails to enroll in products and services by the end of this
304 period is limited to participation in flexible spending account
305 services until the next annual enrollment period.

306 (c) Initial enrollment periods for each product selected by
307 an individual participant must last at least 12 months, unless
308 the individual participant specifically agrees to a different
309 enrollment period.

310 (d) If an individual has selected one or more products and
311 enrolled in those products for at least 12 months or any other
312 period specifically agreed to by the individual participant,
313 changes in selected products and services may only be made
314 during the annual enrollment period established by the
315 corporation.

316 (e) The limits established in paragraphs (b)-(d) apply to
317 any risk-bearing product that promises future payment or
318 coverage for a variable amount of benefits or services. The
319 limits do not apply to initiation of flexible spending plans if
320 those plans are not associated with specific high-deductible
321 insurance policies or the use of spending accounts for any
322 products offering individual participants specific amounts and
323 types of health services and treatments at a contracted price.

324 (8) CONSUMER INFORMATION.—The corporation shall:

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

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

331 ~~(a) Prior to making a risk-bearing product available~~



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332 ~~through the program, the corporation shall provide information~~
333 ~~regarding the product to the Office of Insurance Regulation. The~~
334 ~~office shall review the product information and provide consumer~~
335 ~~information and a recommendation on the risk-bearing product to~~
336 ~~the corporation within 30 days after receiving the product~~
337 ~~information.~~

338 ~~1. Upon receiving a recommendation that a risk-bearing~~
339 ~~product should be made available in the marketplace, the~~
340 ~~corporation may include the product on its website. If the~~
341 ~~consumer information and recommendation is not received within~~
342 ~~30 days, the corporation may make the risk-bearing product~~
343 ~~available on the website without consumer information from the~~
344 ~~office.~~

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

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

356 (9) RISK POOLING.—The program may use ~~shall utilize~~ methods
357 for pooling the risk of individual participants and preventing
358 selection bias. These methods may ~~shall~~ include, but are not
359 limited to, a postenrollment risk adjustment of the premium
360 payments to the vendors. The corporation may ~~shall~~ establish a



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361 methodology for assessing the risk of enrolled individual
362 participants based on data reported annually by the vendors
363 about their enrollees. Distribution ~~Monthly distributions~~ of
364 payments to the vendors may ~~shall~~ be adjusted based on the
365 assessed relative risk profile of the enrollees in each risk-
366 bearing product for the most recent period for which data is
367 available.

368 (10) EXEMPTIONS.—

369 (a) Products, other than the risk-bearing products set
370 forth in subparagraph (4) (d) 1.-4., ~~Policies~~ sold as part of the
371 program are not subject to the licensing requirements of the
372 Florida Insurance Code, as defined in s. 624.01 ~~chapter 641~~, or
373 the mandated offerings or coverages established in part VI of
374 chapter 627 and chapter 641.

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

380 (11) CORPORATION.—There is created the Florida Health
381 Choices, Inc., which shall be registered, incorporated,
382 organized, and operated in compliance with part III of chapter
383 112 and chapters 119, 286, and 617. The purpose of the
384 corporation is to administer the program created in this section
385 and to conduct such other business as may further the
386 administration of the program.

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

389 1. Three ex officio, nonvoting members to include:



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- 390 a. The Secretary of Health Care Administration or a
391 designee with expertise in health care services.
- 392 b. The Secretary of Management Services or a designee with
393 expertise in state employee benefits.
- 394 c. The commissioner of the Office of Insurance Regulation
395 or a designee with expertise in insurance regulation.
- 396 2. Four members appointed by and serving at the pleasure of
397 the Governor.
- 398 3. Four members appointed by and serving at the pleasure of
399 the President of the Senate.
- 400 4. Four members appointed by and serving at the pleasure of
401 the Speaker of the House of Representatives.
- 402 5. Board members may not include insurers, health insurance
403 agents or brokers, health care providers, health maintenance
404 organizations, prepaid service providers, or any other entity,
405 affiliate or subsidiary of eligible vendors.
- 406 (b) Members shall be appointed for terms of up to 3 years.
407 Any member is eligible for reappointment. A vacancy on the board
408 shall be filled for the unexpired portion of the term in the
409 same manner as the original appointment.
- 410 (c) The board shall select a chief executive officer for
411 the corporation who shall be responsible for the selection of
412 such other staff as may be authorized by the corporation's
413 operating budget as adopted by the board.
- 414 (d) Board members are entitled to receive, from funds of
415 the corporation, reimbursement for per diem and travel expenses
416 as provided by s. 112.061. No other compensation is authorized.
- 417 (e) There is no liability on the part of, and no cause of
418 action shall arise against, any member of the board or its



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419 employees or agents for any action taken by them in the
420 performance of their powers and duties under this section.

421 (f) The board shall develop and adopt bylaws and other
422 corporate procedures as necessary for the operation of the
423 corporation and carrying out the purposes of this section. The
424 bylaws shall:

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

428 2. Require an annual membership meeting that provides an
429 opportunity for input and interaction with individual
430 participants in the program.

431 3. Specify policies and procedures regarding conflicts of
432 interest, including the provisions of part III of chapter 112,
433 which prohibit a member from participating in any decision that
434 would inure to the benefit of the member or the organization
435 that employs the member. The policies and procedures shall also
436 require public disclosure of the interest that prevents the
437 member from participating in a decision on a particular matter.

438 (g) The corporation may exercise all powers granted to it
439 under chapter 617 necessary to carry out the purposes of this
440 section, including, but not limited to, the power to receive and
441 accept grants, loans, or advances of funds from any public or
442 private agency and to receive and accept from any source
443 contributions of money, property, labor, or any other thing of
444 value to be held, used, and applied for the purposes of this
445 section.

446 (h) The corporation may establish technical advisory panels
447 consisting of interested parties, including consumers, health



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448 care providers, individuals with expertise in insurance
449 regulation, and insurers.

450 (i) The corporation shall:

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

453 2. Establish procedures necessary for the operation of the
454 program, including, but not limited to, procedures for
455 application, enrollment, risk assessment, risk adjustment, plan
456 administration, performance monitoring, and consumer education.

457 3. Arrange for collection of contributions from
458 participating employers and individuals.

459 4. Arrange for payment of premiums and other appropriate
460 disbursements based on the selections of products and services
461 by the individual participants.

462 5. Establish criteria for disenrollment of participating
463 individuals based on failure to pay the individual's share of
464 any contribution required to maintain enrollment in selected
465 products.

466 6. Establish criteria for exclusion of vendors pursuant to
467 paragraph (4) (d).

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

470 8. Secure staff and consultant services necessary to the
471 operation of the program.

472 9. Establish policies and procedures regarding
473 participation in the program for individuals, vendors, health
474 insurance agents, and employers.

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



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477 11. Provide for initial, open, and special enrollment
478 periods not to exceed 60 days.

479 12. Establish options for employer participation which may
480 conform with common insurance practices.

481 ~~10. Develop a plan, in coordination with the Department of~~
482 ~~Revenue, to establish tax credits or refunds for employers that~~
483 ~~participate in the program. The corporation shall submit the~~
484 ~~plan to the Governor, the President of the Senate, and the~~
485 ~~Speaker of the House of Representatives by January 1, 2009.~~

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

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

499 Section 2. Section 409.821, Florida Statutes, is amended to
500 read:

501 409.821 Florida Kidcare program public records exemption.—

502 (1) Personal identifying information of a Florida Kidcare
503 program applicant or enrollee, as defined in s. 409.811, held by
504 the Agency for Health Care Administration, the Department of
505 Children and Family Services, the Department of Health, or the



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506 Florida Healthy Kids Corporation is confidential and exempt from
507 s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

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

512 2. The Department of Revenue for purposes of administering
513 the state Title IV-D program; ~~or~~

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

516 4.3. Any person who has the written consent of the program
517 applicant.

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

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

528 (4) A knowing and willful violation of this section is a
529 misdemeanor of the second degree, punishable as provided in s.
530 775.082 or s. 775.083.

531 Section 3. Subsection (41) of section 409.912, Florida
532 Statutes, is amended to read:

533 409.912 Cost-effective purchasing of health care.—The
534 agency shall purchase goods and services for Medicaid recipients



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535 in the most cost-effective manner consistent with the delivery
536 of quality medical care. To ensure that medical services are
537 effectively utilized, the agency may, in any case, require a
538 confirmation or second physician's opinion of the correct
539 diagnosis for purposes of authorizing future services under the
540 Medicaid program. This section does not restrict access to
541 emergency services or poststabilization care services as defined
542 in 42 C.F.R. part 438.114. Such confirmation or second opinion
543 shall be rendered in a manner approved by the agency. The agency
544 shall maximize the use of prepaid per capita and prepaid
545 aggregate fixed-sum basis services when appropriate and other
546 alternative service delivery and reimbursement methodologies,
547 including competitive bidding pursuant to s. 287.057, designed
548 to facilitate the cost-effective purchase of a case-managed
549 continuum of care. The agency shall also require providers to
550 minimize the exposure of recipients to the need for acute
551 inpatient, custodial, and other institutional care and the
552 inappropriate or unnecessary use of high-cost services. The
553 agency shall contract with a vendor to monitor and evaluate the
554 clinical practice patterns of providers in order to identify
555 trends that are outside the normal practice patterns of a
556 provider's professional peers or the national guidelines of a
557 provider's professional association. The vendor must be able to
558 provide information and counseling to a provider whose practice
559 patterns are outside the norms, in consultation with the agency,
560 to improve patient care and reduce inappropriate utilization.
561 The agency may mandate prior authorization, drug therapy
562 management, or disease management participation for certain
563 populations of Medicaid beneficiaries, certain drug classes, or



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564 particular drugs to prevent fraud, abuse, overuse, and possible
565 dangerous drug interactions. The Pharmaceutical and Therapeutics
566 Committee shall make recommendations to the agency on drugs for
567 which prior authorization is required. The agency shall inform
568 the Pharmaceutical and Therapeutics Committee of its decisions
569 regarding drugs subject to prior authorization. The agency is
570 authorized to limit the entities it contracts with or enrolls as
571 Medicaid providers by developing a provider network through
572 provider credentialing. The agency may competitively bid single-
573 source-provider contracts if procurement of goods or services
574 results in demonstrated cost savings to the state without
575 limiting access to care. The agency may limit its network based
576 on the assessment of beneficiary access to care, provider
577 availability, provider quality standards, time and distance
578 standards for access to care, the cultural competence of the
579 provider network, demographic characteristics of Medicaid
580 beneficiaries, practice and provider-to-beneficiary standards,
581 appointment wait times, beneficiary use of services, provider
582 turnover, provider profiling, provider licensure history,
583 previous program integrity investigations and findings, peer
584 review, provider Medicaid policy and billing compliance records,
585 clinical and medical record audits, and other factors. Providers
586 shall not be entitled to enrollment in the Medicaid provider
587 network. The agency shall determine instances in which allowing
588 Medicaid beneficiaries to purchase durable medical equipment and
589 other goods is less expensive to the Medicaid program than long-
590 term rental of the equipment or goods. The agency may establish
591 rules to facilitate purchases in lieu of long-term rentals in
592 order to protect against fraud and abuse in the Medicaid program



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593 as defined in s. 409.913. The agency may seek federal waivers
594 necessary to administer these policies.

595 (41) The agency shall establish ~~provide for the development~~
596 ~~of~~ a demonstration project ~~by establishment~~ in Miami-Dade County
597 of a long-term-care facility and a psychiatric facility licensed
598 pursuant to chapter 395 to improve access to health care for a
599 predominantly minority, medically underserved, and medically
600 complex population and to evaluate alternatives to nursing home
601 care and general acute care for such population. Such project is
602 to be located in a health care condominium and collocated
603 ~~collocated~~ with licensed facilities providing a continuum of
604 care. These projects are ~~The establishment of this project is~~
605 not subject to the provisions of s. 408.036 or s. 408.039.

606 Section 4. This act shall take effect July 1, 2011.

607
608 ===== T I T L E A M E N D M E N T =====

609 And the title is amended as follows:

610
611 Delete everything before the enacting clause
612 and insert:

613 A bill to be entitled

614 An act relating to health and human services; amending
615 s. 408.910, F.S.; providing and revising definitions;
616 revising eligibility requirements for participation in
617 the Florida Health Choices Program; providing that
618 statutory rural hospitals are eligible as employers
619 rather than participants under the program; permitting
620 specified eligible vendors to sell health maintenance
621 contracts or products and services; requiring certain



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622 risk-bearing products offered by insurers to be
623 approved by the Office of Insurance Regulation;
624 providing requirements for product certification;
625 providing duties of the Florida Health Choices, Inc.,
626 including maintenance of a toll-free telephone hotline
627 to respond to requests for assistance; providing for
628 enrollment periods; providing for certain risk pooling
629 data used by the corporation to be reported annually;
630 amending s. 409.821, F.S.; authorizing personal
631 identifying information of a Florida Kidcare program
632 applicant to be disclosed to the Florida Health
633 Choices, Inc., to administer the program; amending s.
634 409.912, F.S.; requiring the Agency for Health Care
635 Administration to establish a demonstration project in
636 Miami-Dade County of a long-term-care facility and a
637 psychiatric facility to improve access to health care
638 by medically underserved persons; providing an
639 effective date.