By the Committee on Banking and Insurance; and Senator Garcia

597-04914-11 20111922c1

A bill to be entitled

An act relating to health and human services; amending s. 408.910, F.S.; providing and revising definitions; revising eligibility requirements for participation in the Florida Health Choices Program; providing that statutory rural hospitals are eligible as employers rather than participants under the program; permitting specified eligible vendors to sell health maintenance contracts or products and services; requiring certain risk-bearing products offered by insurers to be approved by the Office of Insurance Regulation; providing requirements for product certification; providing duties of the Florida Health Choices, Inc., including maintenance of a toll-free telephone hotline to respond to requests for assistance; providing for enrollment periods; providing for certain risk pooling data used by the corporation to be reported annually; amending s. 409.821, F.S.; authorizing personal identifying information of a Florida Kidcare program applicant to be disclosed to the Florida Health Choices, Inc., to administer the program; amending s. 409.912, F.S.; requiring the Agency for Health Care Administration to establish a demonstration project in Miami-Dade County of a long-term-care facility and a psychiatric facility to improve access to health care by medically underserved persons; providing an effective date.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

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

3. Management of individual benefit accounts.

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

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

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

4. Services that promote healthy behaviors.

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

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

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

(g) Information services for individuals and employers.

(h) Program evaluation.

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

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

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

2. Fiscally constrained counties described in s. 218.67.

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

4. School districts in fiscally constrained counties.

5. Statutory rural hospitals.

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

1. Individual employees of enrolled employers.

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

3. State retirees.

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

~~5. Statutory rural hospitals.~~

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

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

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

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

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

6. Identification of eligible employees.

7. Arrangement for periodic payments.

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

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

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

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

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount medical plan organizations may sell products and services as authorized under part II of chapter 636.

4.~~3.~~ Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and

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

other arrangements for a specified amount and type of health services or treatments.

5.~~4.~~ Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6.~~5.~~ Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

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

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

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

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

Any non-risk-bearing product must be approved by the corporation.

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

1. Submission of required information.

2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

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

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

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

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

4. Establishment of product prices based on age, gender,

family composition, and location of the individual participant, which may include medical underwriting.

5. Arrangements for receiving payment for enrolled participants.

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

7. Compliance with grievance procedures established by the corporation.

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

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

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

4. Arrangements to receive payment from the corporation for

services as a buyer's representative.

(5) PRODUCTS.—

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

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types of health services and treatments.

6. Flexible spending accounts.

7. Health maintenance contracts.

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

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

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

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

(6) PRICING.—Prices for the products sold through the program must be transparent to participants and established by

the vendors. Risk-bearing products approved by the Office of Insurance Regulation must be priced pursuant to state law governing the rates of insurance product ~~based on age, gender, and location of participants~~. ~~The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period.~~ The corporation shall annually assess a surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) MARKETPLACE ~~EXCHANGE~~ PROCESS.—The program shall provide a single, centralized market for purchase of health insurance, health maintenance contracts, and other health products and services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and

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

services shall be referred to a participating agent in his or her area.

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

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

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

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

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

types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.—The corporation shall:

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

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

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

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

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

~~(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and~~

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

~~office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.~~

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

(10) EXEMPTIONS.—

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

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

(11) CORPORATION.—There is created the Florida Health

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

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

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

1. Three ex officio, nonvoting members to include:

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

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

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

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

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

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

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

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

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

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

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

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

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

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

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

(g) The corporation may exercise all powers granted to it

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

under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

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

(i) The corporation shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

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

409.821 Florida Kidcare program public records exemption.—

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

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

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

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

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

4.~~3.~~ Any person who has the written consent of the program applicant.

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

(3) This exemption applies to any information identifying a Florida Kidcare program applicant or enrollee held by the Agency for Health Care Administration, the Department of Children and Family Services, the Department of Health, or the Florida

Healthy Kids Corporation before, on, or after the effective date of this exemption.

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

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

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician’s opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify

trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer

review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

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

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

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