CHAPTER 98-191

Committee Substitute for
Committee Substitute for Senate Bill No. 484

An act relating to health care; providing an important state interest; amending ss. 154.301, 154.302, 154.304, 154.306, 154.308, 154.309, 154.31, 154.3105, 154.312, 154.314, and 154.316, F.S., relating to health care responsibility for indigents; revising short title; revising definitions; limiting the maximum amount a county may be required to pay an out-of-county hospital; providing hospitals additional time to notify counties of admission or treatment of out-of-county patients; revising language and conforming references; providing penalties; amending s. 154.504, F.S.; limiting applicability of copayments under the Primary Care for Children and Families Challenge Grant Program; amending s. 198.30, F.S.; requiring certain reports of estates of decedents to be provided to the Agency for Health Care Administration; amending ss. 240.4075 and 240.4076, F.S., relating the Nursing Student Loan Forgiveness Program, the Nursing Student Loan Forgiveness Trust Fund, and the nursing scholarship program; transferring powers, duties, and functions with respect thereto from the Department of Health to the Department of Education; creating ss. 381.0022 and 402.115, F.S.; authorizing the Department of Health and the Department of Children and Family Services to share confidential and exempt information; amending s. 381.004, F.S., relating to HIV testing; providing a penalty and increasing existing penalties; amending s. 384.34, F.S., relating to sexually transmissible diseases; providing a penalty and increasing existing penalties; amending s. 414.028, F.S.; providing for a representative of a county health department or Healthy Start Coalition to serve on the local WAGES coalition; amending s. 766.101, F.S.; redefining the term “medical review committee” to include a committee of the Department of Health; amending s. 383.011, F.S.; providing that the Department of Health is the designated state agency for receiving federal funds for the Child Care Food Program; requiring the department to adopt rules for administering the program; amending s. 383.04, F.S.; revising the requirements for the prophylactic to be used for the eyes of infants; repealing s. 383.05, F.S., relating to the free distribution of such prophylactic; amending s. 409.903, F.S.; providing Medicaid eligibility standards for certain persons; conforming references; amending s. 409.908, F.S.; requiring the agency to establish a reimbursement methodology for long-term-care services for Medicaid-eligible nursing home residents; specifying requirements for the methodology; providing legislative intent; prescribing guidelines for Medicaid payment of Medicare deductibles and coinsurance; eliminating a prohibition on specified contracts; repealing redundant provisions; amending s. 409.912, F.S.; authorizing the agency to include disease-management initiatives in providing and monitoring Medicaid services; authorizing the agency to competitively negotiate home health services; authorizing the

agency to seek necessary federal waivers that relate to the competitive negotiation of such services; directing the Agency for Health Care Administration to establish an outpatient specialty services pilot project; providing definitions; providing criteria for participation; requiring an evaluation and a report to the Governor and Legislature; modifying the licensure requirements for a provider of services under a pilot project; amending s. 409.9122, F.S.; requiring the Agency for Health Care Administration to reimburse county health departments for school-based services; requiring Medicaid managed–care contractors to attempt to enter agreements with school districts and county health departments for specified services; specifying the departments that are required to make certain information available to Medicaid recipients; extending the period during which a Medicaid recipient may disenroll from a managed care plan or MediPass provider; deleting authorization for the agency to request a federal waiver from the requirement that a Medicaid managed care plan include a specified ratio of enrollees; amending requirements for the mandatory assignment of Medicaid recipients; amending s. 409.910, F.S.; providing for the distribution of amounts recovered in certain tort suits involving intervention by the Agency for Health Care Administration; requiring that certain third-party benefits received by a Medicaid recipient be remitted within a specified period; amending s. 414.28, F.S.; revising the order under which a claim may be made against the estate of a recipient of public assistance; amending s. 627.912, F.S.; revising reporting requirements by certain insurers; requiring certain self-insurers to report certain information to the Department of Insurance; naming the Carl S. Lytle, M.D., Memorial Health Facility in Marion County; providing an appropriation to be matched by federal Medicaid funds; providing effective dates.

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

Section 1. The Legislature finds that the provisions of this act which amend sections 154.301 through 154.316, Florida Statutes, fulfill the important state interest of promoting the legislative intent of the Florida Health Care Responsibility Act, as that intent is expressed in section 154.302, Florida Statutes.

Section 2. Section 154.301, Florida Statutes, is amended to read:

154.301 Short title.—Sections 154.301-154.316 may be cited as "The Florida Health Care Responsibility Act ~~of 1988~~."

Section 3. Section 154.302, Florida Statutes, is amended to read:

154.302 Legislative intent.—The Legislature finds that certain hospitals provide a disproportionate share of charity care for persons who are indigent, ~~and~~ not able to pay their medical bills, and ~~who are~~ not eligible for government-funded programs. The burden of absorbing the cost of this uncompensated charity care is borne by the hospital, the private pay patients,

and, many times, by the taxpayers in the county when the hospital is subsidized by tax revenues. The Legislature further finds that it is inequitable for hospitals and taxpayers of one county to be expected to subsidize the care of out-of-county indigent persons. Finally, the Legislature declares that the state and the counties must share the responsibility of assuring that adequate and affordable health care is available to all Floridians. Therefore, it is the intent of the Legislature to place the ultimate financial obligation for the out-of-county hospital care of qualified indigent patients on the county in which the indigent patient resides.

Section 4. Section 154.304, Florida Statutes, is amended to read:

154.304 Definitions.—As used in this part, the term ~~For the purpose of this act~~:

(1) "Agency" means the Agency for Health Care Administration.

~~(1) "Board" means the Health Care Board as established in chapter 408.~~

(2) "Certification determination procedures" means the process used by the county of residence or the agency ~~department~~ to determine a person's county of residence.

(3) "Certified resident" means a United States citizen or lawfully admitted alien who has been certified as a resident of the county by a person designated by the county governing body to provide certification determination procedures for the county in which the patient resides; by the agency ~~department~~ if such county does not make a determination of residency within 60 days after ~~of~~ receiving a certified letter from the treating hospital; or by the agency ~~department~~ if the hospital appeals the decision of the county making such determination.

(4) "Charity care obligation" means the minimum amount of uncompensated charity care as reported to the agency ~~for Health Care Administration~~, based on the hospital's most recent audited actual experience, which must be provided by a participating hospital or a regional referral hospital before the hospital is eligible to be reimbursed by a county under ~~the provisions of~~ this part ~~act~~. That amount shall be the ratio of uncompensated charity care days compared to total acute care inpatient days, which shall be equal to or greater than 2 percent.

(5) "Department" means the Department of Health.

(6) "Eligibility determination procedures" means the process used by a county or the agency ~~department~~ to evaluate a person's financial eligibility, eligibility for state-funded or federally funded programs, and the availability of insurance, in order to document a person as a qualified indigent for the purpose of this part ~~act~~.

(7) "Hospital~~,~~" ~~for the purposes of this act,~~ means an establishment as defined in s. 395.002 and licensed by the agency ~~department~~ which qualifies as either a participating hospital or as a regional referral hospital pursuant to this section; except that, hospitals operated by the department shall not be considered participating hospitals for purposes of this part ~~act~~.

(8) "Participating hospital" means a hospital which is eligible to receive reimbursement under the provisions of this part ~~act~~ because it has been certified by the agency ~~board~~ as having met its charity care obligation and has either:

(a) A formal signed agreement with a county or counties to treat such county's indigent patients; or

(b) Demonstrated to the agency ~~board~~ that at least 2.5 percent of its uncompensated charity care, as reported to the agency ~~board~~, is generated by out-of-county residents.

(9) "Qualified indigent person" or "qualified indigent patient" means a person who has been determined pursuant to s. 154.308 to have an average family income, for the 12 months preceding the determination, which is below 100 percent of the federal nonfarm poverty level; who is not eligible to participate in any other government program that ~~which~~ provides hospital care; who has no private insurance or has inadequate private insurance; and who does not reside in a public institution as defined under the medical assistance program for the needy under Title XIX of the Social Security Act, as amended.

(10) "Regional referral hospital" means any hospital that ~~which~~ is eligible to receive reimbursement under the provision of this part ~~act~~ because it has met its charity care obligation and it meets the definition of teaching hospital as defined in s. 408.07.

Section 5. Section 154.306, Florida Statutes, is amended to read:

154.306 Financial responsibility for certified residents who are qualified indigent patients treated at an out-of-county participating hospital or regional referral hospital.—Ultimate financial responsibility for treatment received at a participating hospital or a regional referral hospital by a qualified indigent patient who is a certified resident of a county in the State of Florida, but is not a resident of the county in which the participating hospital or regional referral hospital is located, is ~~shall be~~ the obligation of the county of which the qualified indigent patient is a resident. Each county shall ~~is directed to~~ reimburse participating hospitals or regional referral hospitals as provided for in this part ~~act~~, and shall provide or arrange for indigent eligibility determination procedures and resident certification determination procedures as provided for in rules developed to implement this part ~~act~~. The agency ~~department~~, or any county determining eligibility of a qualified indigent, shall provide to the county of residence, upon request, a copy of any documents, forms, or other information, as determined by rule, which may be used in making an eligibility determination.

(1) A county's financial obligation for each certified resident who qualifies as an indigent patient under this part ~~act~~, and who has received treatment at an out-of-county hospital, shall not exceed 45 days per county fiscal year at a rate of payment equivalent to 100 percent of the per diem reimbursement rate currently in effect for the out-of-county hospital under the medical assistance program for the needy under Title XIX of the Social

Security Act, as amended, except that those counties that are at their 10-mill cap on October 1, 1991, shall reimburse hospitals for such services at not less than 80 percent of the hospital Medicaid per diem. However, nothing in this section shall preclude a hospital that ~~which~~ has a formal signed agreement with a county to treat such county's indigents from negotiating a higher or lower per diem rate with the county. ~~In addition,~~ No county shall be required ~~by this act~~ to pay more than the equivalent of $4 per capita in the county's fiscal year. The agency ~~department~~ shall calculate and certify to each county by March 1 of each year, the maximum amount the county may be required to pay ~~under this act~~ by multiplying the most recent official state population estimate for the total population of the county by $4 per capita. Each county shall certify to the agency ~~department~~ within 60 days after ~~of~~ the end of the county's fiscal year, or upon reaching the $4 per capita threshold, should that occur before the end of the fiscal year, the amount of reimbursement it paid to all out- of-county hospitals under this part ~~act~~. The maximum amount a county may be required to pay to out-of-county hospitals for care provided to qualified indigent residents may be reduced by up to one-half, provided that the amount not paid has or is being spent for in-county hospital care provided to qualified indigent residents.

(2) No county shall be required to pay for any elective or nonemergency admissions or services at an out-of-county hospital for a qualified indigent who is a certified resident of the county if ~~when~~ the county provides funding for such services and the services are available at a local hospital in the county where the indigent resides; or the out-of-county hospital has not obtained prior written authorization and approval for such hospital admission or service, provided that the resident county has established a procedure to authorize and approve such admissions.

(3) The county where the indigent resides shall, in all instances, be liable for the cost of treatment provided to a qualified indigent patient at an out-of-county hospital for any emergency medical condition which will deteriorate from failure to provide such treatment if ~~and when~~ such condition is determined and documented by the attending physician to be of an emergency nature; provided that the patient has been certified to be a resident of such county pursuant to s. 154.309.

(4) No county shall be liable for payment for treatment of a qualified indigent who is a certified resident and has received services at an out-of-county participating hospital or regional referral hospital, until such time as that hospital has documented to the agency ~~board~~ and the agency ~~board~~ has determined that it has met its charity care obligation based on the most recent audited actual experience.

Section 6. Section 154.308, Florida Statutes, is amended to read:

154.308 Determination of patient's eligibility; spend-down program.—

(1) The agency ~~department~~, pursuant to s. 154.3105, shall adopt rules which provide statewide eligibility determination procedures, forms, and criteria which shall be used by all counties for determining whether a person financially qualifies as indigent for the purposes of this part ~~act~~.

(a) The criteria used to determine eligibility must ~~shall~~ be uniform statewide and ~~shall~~ include, at a minimum, which assets, if any, may be included in the determination, which verification of income shall be required, which categories of persons shall be eligible, and any other criteria which may be determined as necessary.

(b) The methodology for determining ~~by which to determine~~ financial eligibility must ~~shall also~~ be uniform statewide such that any county or the state could determine whether a person is ~~would be~~ a qualified indigent ~~under this act~~.

(2) Determination of financial eligibility as a qualified indigent may occur either prior to a person's admission to a participating ~~hospital~~ or a regional referral hospital or subsequent to such admission.

(3) Determination of whether a hospital patient not already determined eligible meets or does not meet eligibility standards to financially qualify as indigent ~~for the purpose of this act~~ shall be made within 60 days following notification by the hospital requesting a determination of indigency, by certified letter, to the county known or believed to be the county of residence or to the agency ~~department~~. If, for any reason, the county or agency ~~department~~ is unable to determine a patient's eligibility within the allotted timeframe, the hospital shall be notified in writing of the reason or reasons.

(4) A patient determined eligible as a qualified indigent ~~for the purpose of this act~~ subsequent to his or her admission to a participating hospital or a regional referral hospital shall be considered to have been qualified upon admission. Such determination shall be made by a person designated by the governing board of the county to make such a determination or by the agency ~~department~~.

(5) Notwithstanding any other provision of this part ~~within this act~~, any county may establish thresholds of financial eligibility ~~to qualify indigents under this act~~ which are less restrictive than 100 percent of the federal poverty line. However, a ~~no~~ county may not establish eligibility thresholds which are more restrictive than 100 percent of the federal poverty line.

(6) Notwithstanding any other provision of this part ~~act~~, there is hereby established a spend-down program for persons who would otherwise qualify as qualified indigent persons, but whose average family income, for the 12 months preceding the determination, is between 100 percent and 150 percent of the federal poverty level. The agency ~~department~~ shall adopt, by rule, procedures for the spend-down program. The rule shall require that in order to qualify ~~for the spend-down program~~, a person must have incurred bills for hospital care which would otherwise have qualified for payment under this part. This subsection does not apply to persons who are residents of counties that are at their 10-mill cap on October 1, 1991.

Section 7. Section 154.309, Florida Statutes, is amended to read:

154.309 Certification of county of residence.—

(1) The agency ~~department~~, pursuant to s. 154.3105, shall adopt rules for certification determination procedures which provide criteria to be used for

determining a qualified indigent's county of residence. Such criteria must ~~shall~~ include, at a minimum, how and to what extent residency shall be verified and how a hospital shall be notified of a patient's certification or the inability to certify a patient.

(2) In all instances, the county known or thought to be the county of residence shall be given first opportunity to certify a resident. If the county known or thought to be the county of residence fails to, or is unable to, make such determination within 60 days following written notification by a hospital, the agency ~~department~~ shall determine residency utilizing the same criteria required by rule as the county, and the agency's ~~department's~~ determination of residency shall be binding on the county of residence. The county determined as the residence of any qualified indigent ~~under this act~~ shall be liable to reimburse the treating hospital pursuant to s. 154.306. If, for any reason, a county or the agency ~~department~~ is unable to determine an indigent's residency, the hospital shall be notified in writing of such reason or reasons.

Section 8. Section 154.31, Florida Statutes, is amended to read:

154.31 Obligation of participating hospital or regional referral hospital.—As a condition of participation ~~accepting the procedures of this act~~, each participating hospital or regional referral hospital in Florida shall be obligated to admit for emergency treatment all Florida residents, without regard to county of residence, who meet the eligibility standards established pursuant to s. 154.308 and who meet the medical standards for admission to such institutions. If the agency ~~department~~ determines that a participating hospital or a regional referral hospital has failed to meet the requirements of this section, the agency ~~department~~ may impose an administrative fine, not to exceed $5,000 per incident, and suspend the hospital from eligibility for reimbursement under ~~the provisions of~~ this part ~~act~~.

Section 9. Section 154.3105, Florida Statutes, is amended to read:

154.3105 Rules.—Rules governing the Health Care Responsibility Act ~~of 1988~~ shall be developed by the agency ~~department~~ based on recommendations of a work group consisting of equal representation by the agency ~~department~~, the hospital industry, and the counties. County representatives to this work group shall be appointed by the Florida Association of Counties. Hospital representatives to this work group shall be appointed by the associations representing those hospitals which best represent the positions of the hospitals most likely to be eligible for reimbursement. Rules governing ~~the various aspects of~~ this part ~~act~~ shall be adopted by the agency. ~~department. Such rules shall address, at a minimum:~~

~~(1) Eligibility determination procedures and criteria.~~

~~(2) Certification determination procedures and methods of notification to hospitals.~~

Section 10. Section 154.312, Florida Statutes, is amended to read:

154.312 Procedure for settlement of disputes.—All disputes among counties, ~~the board,~~ the agency ~~department~~, a participating hospital, or a re-

gional referral hospital shall be resolved ~~by order as provided in chapter 120. Hearings held under this provision shall be conducted in the same manner~~ as provided in ss. 120.569 and 120.57, except that the presiding officer's order shall be final agency action. Cases filed under chapter 120 may combine all disputes between parties. Notwithstanding any other provisions of this part, if ~~when~~ a county alleges that a residency determination or eligibility determination made by the agency ~~department~~ is incorrect, the burden of proof shall be on the county to demonstrate that such determination is, in light of the total record, not supported by the evidence.

Section 11. Section 154.314, Florida Statutes, is amended to read:

154.314 Certification of the State of Florida.—

(1) In the event payment for the costs of services rendered by a participating hospital or a regional referral hospital is not received from the responsible county within 90 days of receipt of a statement for services rendered to a qualified indigent who is a certified resident of the county, or if the payment is disputed and said payment is not received from the county determined to be responsible within 60 days of the date of exhaustion of all administrative and legal remedies ~~as provided in chapter 120~~, the hospital shall certify to the Comptroller the amount owed by the county.

(2) The Comptroller shall have no ~~not~~ longer than 45 days from the date of receiving the hospital's certified notice to forward the amount delinquent to the appropriate hospital from any funds due to the county under any revenue-sharing or tax-sharing fund established by the state, except as otherwise provided by the State Constitution. The Comptroller shall provide the Governor and the fiscal ~~appropriations and finance and tax~~ committees in the House of Representatives and the Senate with a quarterly accounting of the amounts certified by hospitals as owed by counties and the amount paid to hospitals out of any revenue or tax sharing funds due to the county.

Section 12. Section 154.316, Florida Statutes, is amended to read:

154.316 Hospital's responsibility to notify of admission of indigent patients.—

(1) Any hospital admitting or treating any out-of-county patient who may qualify as indigent under this part ~~act~~ shall, within 30 ~~10~~ days after admitting or treating such patient, notify the county known~~,~~ or thought to be~~,~~ the county of residency of such admission, or such hospital forfeits its right to reimbursement.

(2) It shall be the responsibility of any participating hospital or regional referral hospital to initiate any eligibility or certification determination procedures with any appropriate state or county agency which can determine financial eligibility or certify an indigent as a resident under this part ~~act~~.

Section 13. Subsection (1) of section 154.504, Florida Statutes, is amended to read:

154.504 Eligibility and benefits.—

(1) Any county or counties may apply for a primary care for children and families challenge grant to provide primary health care services to children and families with incomes of up to 150 percent of the federal poverty level. Participants shall pay no monthly premium for participation, but shall be required to pay a copayment at the time a service is provided. Copayments may be paid from sources other than the participant, including, but not limited to, the child's or parent's employer, or other private sources. As used in s. 766.1115, the term "copayment" may not be considered and may not be used as compensation for services to health care providers, and all funds generated from copayments shall be used by the governmental contractor.

Section 14. Section 198.30, Florida Statutes, is amended to read:

198.30 Circuit judge to furnish department with names of decedents, etc.—Each circuit judge of this state shall, on or before the 10th day of every month, notify the department of the names of all decedents; the names and addresses of the respective personal representatives, administrators, or curators appointed; the amount of the bonds, if any, required by the court; and the probable value of the estates, in all estates of decedents whose wills have been probated or propounded for probate before the circuit judge or upon which letters testamentary or upon whose estates letters of administration or curatorship have been sought or granted, during the preceding month; and such report shall contain any other information which the circuit judge may have concerning the estates of such decedents. In addition, a copy of this report shall be provided to the Agency for Health Care Administration. A circuit judge shall also furnish forthwith such further information, from the records and files of the circuit court in regard to such estates, as the department may from time to time require.

Section 15. Section 240.4075, Florida Statutes, is amended to read:

240.4075 Nursing Student Loan Forgiveness Program.—

(1) To encourage qualified personnel to seek employment in areas of this state in which critical nursing shortages exist, there is established the Nursing Student Loan Forgiveness Program. The primary function of the program is to increase employment and retention of registered nurses and licensed practical nurses in nursing homes and hospitals in the state and in state-operated medical and health care facilities, birth centers, federally sponsored community health centers and teaching hospitals by making repayments toward loans received by students from federal or state programs or commercial lending institutions for the support of postsecondary study in accredited or approved nursing programs.

(2) To be eligible, a candidate must have graduated from an accredited or approved nursing program and have received a Florida license as a licensed practical nurse or a registered nurse or a Florida certificate as an advanced registered nurse practitioner.

(3) Only loans to pay the costs of tuition, books, and living expenses shall be covered, at an amount not to exceed $4,000 for each year of education towards the degree obtained.

(4) Receipt of funds pursuant to this program shall be contingent upon continued proof of employment in the designated facilities in this state. Loan principal payments shall be made by the Department of Education ~~Health~~ directly to the federal or state programs or commercial lending institutions holding the loan as follows:

(a) Twenty-five percent of the loan principal and accrued interest shall be retired after the first year of nursing;

(b) Fifty percent of the loan principal and accrued interest shall be retired after the second year of nursing;

(c) Seventy-five percent of the loan principal and accrued interest shall be retired after the third year of nursing; and

(d) The remaining loan principal and accrued interest shall be retired after the fourth year of nursing.

In no case may payment for any nurse exceed $4,000 in any 12-month period.

(5) There is created the Nursing Student Loan Forgiveness Trust Fund to be administered by the Department of Education ~~Health~~ pursuant to this section and s. 240.4076 and department rules. The Comptroller shall authorize expenditures from the trust fund upon receipt of vouchers approved by the Department of Education ~~Health~~. All moneys collected from the private health care industry and other private sources for the purposes of this section shall be deposited into the Nursing Student Loan Forgiveness Trust Fund. Any balance in the trust fund at the end of any fiscal year shall remain therein and shall be available for carrying out the purposes of this section and s. 240.4076.

(6) In addition to licensing fees imposed under chapter 464, there is hereby levied and imposed an additional fee of $5, which fee shall be paid upon licensure or renewal of nursing licensure. Revenues collected from the fee imposed in this subsection shall be deposited in the Nursing Student Loan Forgiveness Trust Fund of the Department of Education ~~Health~~ and will be used solely for the purpose of carrying out the provisions of this section and s. 240.4076. Up to 50 percent of the revenues appropriated to implement this subsection may be used for the nursing scholarship program established pursuant to s. 240.4076.

(7)(a) Funds contained in the Nursing Student Loan Forgiveness Trust Fund which are to be used for loan forgiveness for those nurses employed by hospitals, birth centers, and nursing homes must be matched on a dollar-for-dollar basis by contributions from the employing institutions, except that this provision shall not apply to state-operated medical and health care facilities, county health departments, federally sponsored community health centers, or teaching hospitals as defined in s. 408.07.

(b) All Nursing Student Loan Forgiveness Trust Fund moneys shall be invested pursuant to s. 18.125. Interest income accruing to that portion of the trust fund not matched shall increase the total funds available for loan

forgiveness and scholarships. Pledged contributions shall not be eligible for matching prior to the actual collection of the total private contribution for the year.

(8) The Department of Education ~~Health~~ may solicit technical assistance relating to the conduct of this program from the Department of Health ~~Education~~.

(9) The Department of Education ~~Health~~ is authorized to recover from the Nursing Student Loan Forgiveness Trust Fund its costs for administering the Nursing Student Loan Forgiveness Program.

(10) The Department of Education ~~Health~~ may adopt rules necessary to administer this program.

(11) This section shall be implemented only as specifically funded.

Section 16. Section 240.4076, Florida Statutes, is amended to read:

240.4076 Nursing scholarship program.—

(1) There is established within the Department of Education ~~Health~~ a scholarship program for the purpose of attracting capable and promising students to the nursing profession.

(2) A scholarship applicant shall be enrolled as a full-time or part-time student in the upper division of an approved nursing program leading to the award of a baccalaureate or any advanced registered nurse practitioner degree or be enrolled as a full-time or part-time student in an approved program leading to the award of an associate degree in nursing or a diploma in nursing.

(3) A scholarship may be awarded for no more than 2 years, in an amount not to exceed $8,000 per year. However, registered nurses pursuing an advanced registered nurse practitioner degree may receive up to $12,000 per year. Beginning July 1, 1998, these amounts shall be adjusted by the amount of increase or decrease in the consumer price index for urban consumers published by the United States Department of Commerce.

(4) Credit for repayment of a scholarship shall be as follows:

(a) For each full year of scholarship assistance, the recipient agrees to work for 12 months at a health care facility in a medically underserved area as approved by the Department of Education ~~Health~~. Scholarship recipients who attend school on a part-time basis shall have their employment service obligation prorated in proportion to the amount of scholarship payments received.

(b) Eligible health care facilities include state-operated medical or health care facilities, county health departments, federally sponsored community health centers, or teaching hospitals as defined in s. 408.07. The recipient shall be encouraged to complete the service obligation at a single employment site. If continuous employment at the same site is not feasible, the

recipient may apply to the department for a transfer to another approved health care facility.

(c) Any recipient who does not complete an appropriate program of studies or who does not become licensed shall repay to the Department of Education ~~Health~~, on a schedule to be determined by the department, the entire amount of the scholarship plus 18 percent interest accruing from the date of the scholarship payment. Moneys repaid shall be deposited into the Nursing Student Loan Forgiveness Trust Fund established in s. 240.4075. However, the department may provide additional time for repayment if the department finds that circumstances beyond the control of the recipient caused or contributed to the default.

(d) Any recipient who does not accept employment as a nurse at an approved health care facility or who does not complete 12 months of approved employment for each year of scholarship assistance received shall repay to the Department of Education ~~Health~~ an amount equal to two times the entire amount of the scholarship plus interest accruing from the date of the scholarship payment at the maximum allowable interest rate permitted by law. Repayment shall be made within 1 year of notice that the recipient is considered to be in default. However, the department may provide additional time for repayment if the department finds that circumstances beyond the control of the recipient caused or contributed to the default.

(5) Scholarship payments shall be transmitted to the recipient upon receipt of documentation that the recipient is enrolled in an approved nursing program. The Department of Education ~~Health~~ shall develop a formula to prorate payments to scholarship recipients so as not to exceed the maximum amount per academic year.

(6) The Department of Education ~~Health~~ shall adopt rules, including rules to address extraordinary circumstances that may cause a recipient to default on either the school enrollment or employment contractual agreement, to implement this section and may solicit technical assistance relating to the conduct of this program from the Department of Health ~~Education~~.

(7) The Department of Education ~~Health~~ is authorized to recover from the Nursing Student Loan Forgiveness Trust Fund its costs for administering the nursing scholarship program.

Section 17. All statutory powers, duties and functions, records, rules, personnel, property, and unexpended balances of appropriations, allocations, or other funds, of the Department of Health relating to the Nursing Student Loan Forgiveness Program and the Nursing Student Loan Forgiveness Trust Fund, as created in section 240.4075, Florida Statutes, and the nursing scholarship program, as created in section 240.4076, Florida Statutes, are transferred by a type two transfer, as provided for in section 20.06(2), Florida Statutes, from the Department of Health to the Department of Education. Such transfer shall take effect July 1, 1998. Any rules adopted by or for the Department of Health for the administration and operation of the Nursing Student Loan Forgiveness Program, the Nursing Student Loan Forgiveness Trust Fund, and the nursing scholarship program are included in such transfer.

Section 18. Section 381.0022, Florida Statutes, is created to read:

381.0022 Sharing confidential or exempt information.—Notwithstanding any other provision of law to the contrary, the Department of Health and the Department of Children and Family Services may share confidential information or information exempt from disclosure under chapter 119 on any individual who is or has been the subject of a program within the jurisdiction of each agency. Information so exchanged remains confidential or exempt as provided by law.

Section 19. Section 402.115, Florida Statutes, is created to read:

402.115 Sharing confidential or exempt information.—Notwithstanding any other provision of law to the contrary, the Department of Health and the Department of Children and Family Services may share confidential information or information exempt from disclosure under chapter 119 on any individual who is or has been the subject of a program within the jurisdiction of each agency. Information so exchanged remains confidential or exempt as provided by law.

Section 20. Subsection (6) of section 381.004, Florida Statutes, is amended to read:

381.004 Testing for human immunodeficiency virus.—

(6) PENALTIES.—

(a) Any violation of this section by a facility or licensed health care provider shall be a ground for disciplinary action contained in the facility's or professional's respective licensing chapter.

(b) Any person who violates the confidentiality provisions of this section and s. 951.27 commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Any person who obtains information that identifies an individual who has a sexually transmissible disease including human immunodeficiency virus or acquired immunodeficiency syndrome, who knew or should have known the nature of the information and maliciously, or for monetary gain, disseminates this information or otherwise makes this information known to any other person, except by providing it either to a physician or nurse employed by the department or to a law enforcement agency, commits a felony of the third degree, punishable as provided in ss. 775.082 or 775.083.

Section 21. Section 384.34, Florida Statutes, is amended to read:

384.34 Penalties.—

(1) Any person who violates the provisions of s. 384.24(1) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(2) Any person who violates the provisions of s. 384.26 or s. 384.29 commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) Any person who maliciously disseminates any false information or report concerning the existence of any sexually transmissible disease commits a felony of the third ~~is guilty of a misdemeanor of the second~~ degree, punishable as provided in ss. ~~s.~~ 775.082, ~~or s.~~ 775.083, and 775.084.

(4) Any person who violates the provisions of the department's rules pertaining to sexually transmissible diseases may be punished by a fine not to exceed $500 for each violation. Any penalties enforced under this subsection shall be in addition to other penalties provided by this act.

(5) Any person who violates the provisions of s. 384.24(2) commits a felony of the third degree, punishable as provided in ss. 775.082, 775.083, 775.084, and 775.0877(7). Any person who commits multiple violations of the provisions of s. 384.24(2) commits a felony of the first degree, punishable as provided in ss. 775.082, 775.083, 775.084, and 775.0877(7).

(6) Any person who obtains information that identifies an individual who has a sexually transmissible disease, who knew or should have known the nature of the information and maliciously, or for monetary gain, disseminates this information or otherwise makes this information known to any other person, except by providing it either to a physician or nurse employed by the Department of Health or to a law enforcement agency, commits a felony of the third degree, punishable as provided in ss. 775.082, 775.083, or 775.084.

Section 22. Paragraph (e) is added to subsection (1) of section 414.028, Florida Statutes, to read:

414.028 Local WAGES coalitions.—The WAGES Program State Board of Directors shall create and charter local WAGES coalitions to plan and coordinate the delivery of services under the WAGES Program at the local level. The boundaries of the service area for a local WAGES coalition shall conform to the boundaries of the service area for the regional workforce development board established under the Enterprise Florida workforce development board. The local delivery of services under the WAGES Program shall be coordinated, to the maximum extent possible, with the local services and activities of the local service providers designated by the regional workforce development boards.

(1)

(e) A representative of a county health department or a representative of a Healthy Start Coalition shall serve as an ex officio, nonvoting member of the coalition.

Section 23. Paragraph (a) of subsection (1) of section 766.101, Florida Statutes, is amended to read:

766.101 Medical review committee, immunity from liability.—

(1) As used in this section:

(a) The term "medical review committee" or "committee" means:

1.a. A committee of a hospital or ambulatory surgical center licensed under chapter 395 or a health maintenance organization certificated under part I of chapter 641,

b. A committee of a state or local professional society of health care providers,

c. A committee of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home,

d. A committee of the Department of Corrections or the Correctional Medical Authority as created under s. 945.602, or employees, agents, or consultants of either the department or the authority or both,

e. A committee of a professional service corporation formed under chapter 621 or a corporation organized under chapter 607 or chapter 617, which is formed and operated for the practice of medicine as defined in s. 458.305(3), and which has at least 25 health care providers who routinely provide health care services directly to patients,

f. A committee of a mental health treatment facility licensed under chapter 394 or a community mental health center as defined in s. 394.907, provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

g. A committee of a substance abuse treatment and education prevention program licensed under chapter 397 provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

h. A peer review or utilization review committee organized under chapter 440, or

i. A committee of the Department of Health, a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service or to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

Section 24. Paragraph (i) is added to subsection (1) of section 383.011, Florida Statutes, and subsection (2) of that section is amended, to read:

383.011 Administration of maternal and child health programs.—

(1) The Department of Health is designated as the state agency for:

(i) Receiving federal funds for children eligible for assistance through the child portion of the federal Child and Adult Care Food Program, which is referred to as the Child Care Food Program, and for establishing and administering this program. The purpose of the Child Care Food Program is to provide nutritious meals and snacks for children in nonresidential day care. To ensure the quality and integrity of the program, the department shall develop standards and procedures that govern sponsoring organizations, day care homes, child care centers, and centers that operate outside school hours. Standards and procedures must address the following: participation criteria for sponsoring organizations, which may include administrative budgets, staffing requirements, requirements for experience in operating similar programs, operating hours and availability, bonding requirements, geographic coverage, and a required minimum number of homes or centers; procedures for investigating complaints and allegations of noncompliance; application and renewal requirements; audit requirements; meal pattern requirements; requirements for managing funds; participant eligibility for free and reduced-price meals; food storage and preparation; food service companies; reimbursements; use of commodities; administrative reviews and monitoring; training requirements; recordkeeping requirements; and criteria pertaining to imposing sanctions and penalties, including the denial, termination, and appeal of program eligibility.

(2) The Department of Health shall follow federal requirements and may adopt any rules necessary for the implementation of the maternal and child health care program, ~~or~~ the WIC program, and the Child Care Food Program. With respect to the Child Care Food Program, the department shall adopt rules that interpret and implement relevant federal regulations, including 7 C.F.R., part 226. The rules must address at least those program requirements and procedures identified in paragraph (1)(i).

Section 25. Section 383.04, Florida Statutes, is amended to read:

383.04 Prophylactic required for eyes of infants.—Every physician, midwife, or other person in attendance at the birth of a child in the state is required to instill or have instilled into the eyes of the baby within 1 hour after birth an effective prophylactic recommended by the Committee on Infectious Diseases of the American Academy of Pediatrics ~~a 1-percent fresh solution of silver nitrate (with date of manufacture marked on container), two drops of the solution to be dropped into each eye after the eyelids have been opened, or some equally effective prophylactic approved by the Department of Health,~~ for the prevention of neonatal ~~blindness from~~ ophthalmia ~~neonatorum~~. This section does ~~shall~~ not apply to cases where the parents ~~shall~~ file with the physician, midwife, or other person in attendance at the birth of a child written objections on account of religious beliefs contrary to the use of drugs. In such case the physician, midwife, or other person in attendance shall maintain a record that such measures were or were not employed and attach thereto any written objection.

Section 26. Section 383.05, Florida Statutes, is repealed.

Section 27. Section 409.903, Florida Statutes, is amended to read:

409.903 Mandatory payments for eligible persons.—The agency ~~department~~ shall make payments for medical assistance and related services on behalf of the following persons who the agency ~~department~~ determines to be eligible, subject to the income, assets, and categorical eligibility tests set forth in federal and state law. Payment on behalf of these Medicaid eligible persons is subject to the availability of moneys and any limitations established by the General Appropriations Act or chapter 216.

(1) Low-income families with children are eligible for Medicaid provided they meet the following requirements: ~~Persons who receive payments from or are determined eligible to participate in the WAGES Program, and certain persons who would be eligible but do not meet certain technical requirements. This group includes, but is not limited to:~~

(a) The family includes a dependent child who is living with a caretaker relative. ~~Low-income, single-parent families and their children.~~

(b) The family's income does not exceed the gross income test limit. ~~Low-income, two-parent families in which at least one parent is disabled or otherwise incapacitated.~~

(c) The family's countable income and resources do not exceed the applicable aid-to-families-with-dependent-children (AFDC) income and resource standards under the AFDC state plan in effect in July 1996, except as amended in the Medicaid state plan to conform as closely as possible to the requirements of the WAGES Program as created in s. 414.015, to the extent permitted by federal law. ~~Certain unemployed two-parent families and their children.~~

(2) A person who receives payments from, who is determined eligible for, or who was eligible for but lost cash benefits from the federal program known as the Supplemental Security Income program (SSI). This category includes a low-income person age 65 or over and a low-income person under age 65 considered to be permanently and totally disabled.

(3) A child under age 21 living in a low-income, two-parent family, and a child under age 7 living with a nonrelative, if the income and assets of the family or child, as applicable, do not exceed the resource limits under the WAGES Program.

(4) A child who is eligible under Title IV-E of the Social Security Act for subsidized board payments, foster care, or adoption subsidies, and a child for whom the state has assumed temporary or permanent responsibility and who does not qualify for Title IV-E assistance but is in foster care, shelter or emergency shelter care, or subsidized adoption.

(5) A pregnant woman for the duration of her pregnancy and for the post partum period as defined in federal law and rule, or a child under age 1, if either is living in a family that has an income which is at or below 150

percent of the most current federal poverty level, or, effective January 1, 1992, that has an income which is at or below 185 percent of the most current federal poverty level. Such a person is not subject to an assets test. Further, a pregnant woman who applies for eligibility for the Medicaid program through a qualified Medicaid provider must be offered the opportunity, subject to federal rules, to be made presumptively eligible for the Medicaid program.

(6) A child born after September 30, 1983, living in a family that has an income which is at or below 100 percent of the current federal poverty level, who has attained the age of 6, but has not attained the age of 19. In determining the eligibility of such a child, an assets test is not required.

(7) A child living in a family that has an income which is at or below 133 percent of the current federal poverty level, who has attained the age of 1, but has not attained the age of 6. In determining the eligibility of such a child, an assets test is not required.

(8) A person who is age 65 or over or is determined by the agency ~~department~~ to be disabled, whose income is at or below 100 percent of the most current federal poverty level and whose assets do not exceed limitations established by the agency ~~department~~. However, the agency ~~department~~ may only pay for premiums, coinsurance, and deductibles, as required by federal law, unless additional coverage is provided for any or all members of this group by s. 409.904(1).

Section 28. Subsections (2) and (13) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under chapter 393 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement must be determined by averaging the nursing home payments, in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. Effective no earlier than the rate-setting period beginning April 1, 1999, the agency shall establish a case-mix reimbursement methodology for the rate of payment for long-term-care services for nursing home residents. The agency shall compute a per diem rate for Medicaid residents, adjusted for case mix, which is based on a resident classification system that accounts for the relative resource utilization by different types of residents and which is based on level-of-care data and other appropriate data. The case-mix methodology developed by the agency shall take into account the medical, behavioral, and cognitive deficits of residents. In developing the reimbursement methodology, the agency shall evaluate and modify other aspects of the reimbursement plan as necessary to improve the overall effectiveness of the plan with respect to the costs of patient care, operating costs, and property costs. In the event adequate data are not available, the agency is authorized to adjust the patient's care component or the per diem rate to more adequately cover the cost of services provided in the patient's care component. The agency shall work with the Department of Elderly Affairs, the Florida Health Care Association, and the Florida Association of Homes for the Aging in developing the methodology. It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an

alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

(13) Medicare premiums for persons eligible for both Medicare and Medicaid coverage shall be paid at the rates established by Title XVIII of the Social Security Act. For Medicare services rendered to Medicaid-eligible persons, Medicaid shall pay Medicare deductibles and coinsurance as follows:

(a) Medicaid shall make no payment toward deductibles and coinsurance for any service that is not covered by Medicaid.

(b) Medicaid's financial obligation for deductibles and coinsurance payments shall be based on Medicare allowable fees, not on a provider's billed charges.

(c) Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor.

(d) The following provisions are exceptions to paragraphs (a)-(c):

1. Medicaid payments for Nursing Home Medicare Part A coinsurance shall be the lesser of the Medicare coinsurance amount or the Medicaid nursing home per diem rate.

2. Medicaid shall pay all deductibles and coinsurance for Nursing Home Medicare Part B services.

3. Medicaid shall pay all deductibles and coinsurance for Medicare-eligible recipients receiving freestanding end stage renal dialysis center services.

4. Medicaid shall pay all deductibles and coinsurance for hospital outpatient Medicare Part B services.

5. Medicaid payments for general hospital inpatient services shall be limited to the Medicare deductible per spell of illness. Medicaid shall make no payment toward coinsurance for Medicare general hospital inpatient services.

6. Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401. ~~Premiums, deductibles, and coinsurance for Medicare services rendered to Medicaid eligible persons shall be reimbursed in accordance with fees established by Title XVIII of the Social Security Act.~~

Section 29. Paragraph (c) of subsection (4) of section 409.912, Florida Statutes, is repealed, paragraph (b) of subsection (3) and subsection (13) of that section are amended, and subsections (34) and (35) are added to that section, 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. 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.

(3) The agency may contract with:

(b) An entity that is providing comprehensive inpatient and outpatient mental health care services to certain Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must become licensed under chapter 624, chapter 636, or chapter 641 by December 31, 1998, and is exempt from the provisions of part I of chapter 641 until then. However, if the entity assumes risk, the Department of Insurance shall develop appropriate regulatory requirements by rule under the insurance code before the entity becomes operational.

(13) The agency shall identify health care utilization and price patterns within the Medicaid program which ~~that~~ are not cost-effective or medically appropriate and assess the effectiveness of new or alternate methods of providing and monitoring service, and may implement such methods as it considers appropriate. Such methods may include disease-management initiatives, an integrated and systematic approach for managing the health care needs of recipients who are at risk of or diagnosed with a specific disease by using best practices, prevention strategies, clinical-practice improvement, clinical interventions and protocols, outcomes research, information technology, and other tools and resources to reduce overall costs and improve measurable outcomes.

(34) The agency may provide for cost-effective purchasing of home health services through competitive negotiation pursuant to s. 287.057. The agency may request appropriate waivers from the federal Health Care Financing Administration in order to competitively bid home health services.

(35) The Agency for Health Care Administration is directed to issue a request for proposal or intent to negotiate to implement on a demonstration basis an outpatient specialty services pilot project in a rural and urban county in the state. As used in this subsection, the term "outpatient specialty services" means clinical laboratory, diagnostic imaging, and specified home

medical services to include durable medical equipment, prosthetics and orthotics, and infusion therapy.

(a) The entity that is awarded the contract to provide Medicaid managed care outpatient specialty services must, at a minimum, meet the following criteria:

1. The entity must be licensed by the Department of Insurance under part II of chapter 641.

2. The entity must be experienced in providing outpatient specialty services.

3. The entity must demonstrate to the satisfaction of the agency that it provides high-quality services to its patients.

4. The entity must demonstrate that it has in place a complaints and grievance process to assist Medicaid recipients enrolled in the pilot managed care program to resolve complaints and grievances.

(b) The pilot managed care program shall operate for a period of 3 years. The objective of the pilot program shall be to determine the cost-effectiveness and effects on utilization, access, and quality of providing outpatient specialty services to Medicaid recipients on a prepaid, capitated basis.

(c) The agency shall conduct a quality-assurance review of the prepaid health clinic each year that the demonstration program is in effect. The prepaid health clinic is responsible for all expenses incurred by the agency in conducting a quality assurance review.

(d) The entity that is awarded the contract to provide outpatient specialty services to Medicaid recipients shall report data required by the agency in a format specified by the agency, for the purpose of conducting the evaluation required in paragraph (e).

(e) The agency shall conduct an evaluation of the pilot managed care program and report its findings to the Governor and the Legislature by no later than January 1, 2001.

(f) Nothing in this subsection is intended to conflict with the provision of the 1997-1998 General Appropriations Act which authorizes competitive bidding for Medicaid home health, clinical laboratory, or x-ray services.

Section 30. Effective January 1, 1999, paragraph (d) of subsection (3) 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. 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.

(3) The agency may contract with:

(d) No more than four provider service networks for demonstration projects to test Medicaid direct contracting. ~~However, no such demonstration project shall be established with a federally qualified health center nor shall any provider service network under contract with the agency pursuant to this paragraph include a federally qualified health center in its provider network.~~ One demonstration project must be located in Orange County. The demonstration projects may be reimbursed on a fee-for-service or prepaid basis. A provider service network which is reimbursed by the agency on a prepaid basis shall be exempt from parts I and III of chapter 641, but must meet appropriate financial reserve, quality assurance, and patient rights requirements as established by the agency. The agency shall award contracts on a competitive bid basis and shall select bidders based upon price and quality of care. Medicaid recipients assigned to a demonstration project shall be chosen equally from those who would otherwise have been assigned to prepaid plans and MediPass. The agency is authorized to seek federal Medicaid waivers as necessary to implement the provisions of this section. A demonstration project awarded pursuant to this paragraph shall be for 2 years from the date of implementation.

Section 31. Paragraphs (a), (c), (f), (i), and (k) of subsection (2) of section 409.9122, Florida Statutes, are amended to read:

409.9122 Mandatory Medicaid managed care enrollment; programs and procedures.—

(2)(a) The agency shall enroll in a managed care plan or MediPass all Medicaid recipients, except those Medicaid recipients who are: in an institution; enrolled in the Medicaid medically needy program; or eligible for both Medicaid and Medicare. However, to the extent permitted by federal law, the agency may enroll in a managed care plan or MediPass a Medicaid recipient who is exempt from mandatory managed care enrollment, provided that:

1. The recipient's decision to enroll in a managed care plan or MediPass is voluntary;

2. If the recipient chooses to enroll in a managed care plan, the agency has determined that the managed care plan provides specific programs and services which address the special health needs of the recipient; and

3. The agency receives any necessary waivers from the federal Health Care Financing Administration.

The agency shall develop rules to establish policies by which exceptions to the mandatory managed care enrollment requirement may be made on a

case-by-case basis. The rules shall include the specific criteria to be applied when making a determination as to whether to exempt a recipient from mandatory enrollment in a managed care plan or MediPass. School districts participating in the certified school match program pursuant to ss. 236.0812 and 409.908(21) shall be reimbursed by Medicaid, subject to the limitations of s. 236.0812(1) and (2), for a Medicaid-eligible child participating in the services as authorized in s. 236.0812, as provided for in s. 409.9071, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with school districts ~~and county health departments~~ regarding the coordinated provision of services authorized under s. 236.0812. County health departments delivering school–based services pursuant to ss. 381.0056 and 381.0057 shall be reimbursed by Medicaid for the federal share for a Medicaid–eligible child who receives Medicaid-covered services in a school setting, regardless of whether the child is enrolled in MediPass or a managed care plan. Managed care plans shall make a good faith effort to execute agreements with county health departments regarding the coordinated provision of services to a Medicaid-eligible child. To ensure continuity of care for Medicaid patients, the agency, the Department of Health, and the Department of Education shall develop procedures for ensuring that a student's managed care plan or MediPass provider receives information relating to services provided in accordance with ss. 236.0812, 381.0056, 381.0057, and 409.9071.

(c) Medicaid recipients shall have a choice of managed care plans or MediPass. The Agency for Health Care Administration, the Department of Health ~~and Rehabilitative Services~~, the Department of Children and Family Services, and the Department of Elderly Affairs shall cooperate to ensure that each Medicaid recipient receives clear and easily understandable information that meets the following requirements:

1. Explains the concept of managed care, including MediPass.

2. Provides information on the comparative performance of managed care plans and MediPass in the areas of quality, credentialing, preventive health programs, network size and availability, and patient satisfaction.

3. Explains where additional information on each managed care plan and MediPass in the recipient's area can be obtained.

4. Explains that recipients have the right to choose their own managed care plans or MediPass. However, if a recipient does not choose a managed care plan or MediPass, the agency will assign the recipient to a managed care plan or MediPass according to the criteria specified in this section.

5. Explains the recipient's right to complain, file a grievance, or change managed care plans or MediPass providers if the recipient is not satisfied with the managed care plan or MediPass.

(f) When a Medicaid recipient does not choose a managed care plan or MediPass provider, the agency shall assign the Medicaid recipient to a managed care plan or MediPass provider. Medicaid recipients who are subject to mandatory assignment but who fail to make a choice shall be assigned

to managed care plans or provider service networks until an equal enrollment of 50 percent in MediPass and provider service networks and 50 percent in managed care plans is achieved. Once equal enrollment is achieved, the assignments shall be divided in order to maintain an equal enrollment in MediPass and managed care plans for the 1998-99 fiscal year. ~~In the first period that assignment begins, the assignments shall be divided equally between the MediPass program and managed care plans.~~ Thereafter, assignment of Medicaid recipients who fail to make a choice shall be based proportionally on the preferences of recipients who have made a choice in the previous period. Such proportions shall be revised at least quarterly to reflect an update of the preferences of Medicaid recipients. When making assignments, the agency shall take into account the following criteria:

1. A managed care plan has sufficient network capacity to meet the need of members.

2. The managed care plan or MediPass has previously enrolled the recipient as a member, or one of the managed care plan's primary care providers or MediPass providers has previously provided health care to the recipient.

3. The agency has knowledge that the member has previously expressed a preference for a particular managed care plan or MediPass provider as indicated by Medicaid fee-for-service claims data, but has failed to make a choice.

4. The managed care plan's or MediPass primary care providers are geographically accessible to the recipient's residence.

(i) After a recipient has made a selection or has been enrolled in a managed care plan or MediPass, the recipient shall have 90 ~~60~~ days in which to voluntarily disenroll and select another managed care plan or MediPass provider. After 90 ~~60~~ days, no further changes may be made except for cause. Cause shall include, but not be limited to, poor quality of care, lack of access to necessary specialty services, an unreasonable delay or denial of service, or fraudulent enrollment. The agency shall develop criteria for good cause disenrollment for chronically ill and disabled populations who are assigned to managed care plans if more appropriate care is available through the MediPass program. The agency must make a determination as to whether cause exists. However, the agency may require a recipient to use the managed care plan's or MediPass grievance process prior to the agency's determination of cause, except in cases in which immediate risk of permanent damage to the recipient's health is alleged. The grievance process, when utilized, must be completed in time to permit the recipient to disenroll no later than the first day of the second month after the month the disenrollment request was made. If the managed care plan or MediPass, as a result of the grievance process, approves an enrollee's request to disenroll, the agency is not required to make a determination in the case. The agency must make a determination and take final action on a recipient's request so that disenrollment occurs no later than the first day of the second month after the month the request was made. If the agency fails to act within the specified timeframe, the recipient's request to disenroll is deemed to be approved as of the date agency action was required. Recipients who disagree

with the agency's finding that cause does not exist for disenrollment shall be advised of their right to pursue a Medicaid fair hearing to dispute the agency's finding.

~~(k) In order to provide increased access to managed care, the agency may request from the Health Care Financing Administration a waiver of the regulation requiring health maintenance organizations to have one commercial enrollee for each three Medicaid enrollees.~~

Section 32. Paragraph (f) of subsection (12) and subsection (18) of section 409.910, Florida Statutes, are amended to read:

409.910 Responsibility for payments on behalf of Medicaid-eligible persons when other parties are liable.—

(12) The department may, as a matter of right, in order to enforce its rights under this section, institute, intervene in, or join any legal or administrative proceeding in its own name in one or more of the following capacities: individually, as subrogee of the recipient, as assignee of the recipient, or as lienholder of the collateral.

(f) Notwithstanding any provision in this section to the contrary, in the event of an action in tort against a third party in which the recipient or his or her legal representative is a party which results in a ~~and in which the amount of any~~ judgment, award, or settlement from a third party, ~~third-party benefits, excluding medical coverage as defined in subparagraph 4., after reasonable costs and expenses of litigation, is an amount equal to or less than 200 percent of the amount of medical assistance provided by Medicaid less any medical coverage paid or payable to the department, then distribution of~~ the amount recovered shall be distributed as follows:

1. After attorney's fees and taxable costs as defined by the Florida Rules of Civil Procedure, one-half of the remaining recovery shall be paid to the department up to the total amount of medical assistance provided by Medicaid.

2. The remaining amount of the recovery shall be paid to the recipient.

3. For purposes of calculating the department's recovery of medical assistance benefits paid, the fee for services of an attorney retained by the recipient or his or her legal representative shall be calculated at 25 percent of the judgment, award, or settlement.

4. Notwithstanding any provision of this section to the contrary, the department shall be entitled to all medical coverage benefits up to the total amount of medical assistance provided by Medicaid.

~~1. Any fee for services of an attorney retained by the recipient or his or her legal representative shall not exceed an amount equal to 25 percent of the recovery, after reasonable costs and expenses of litigation, from the judgment, award, or settlement.~~

~~2. After attorney's fees, two-thirds of the remaining recovery shall be designated for past medical care and paid to the department for medical assistance provided by Medicaid.~~

~~3. The remaining amount from the recovery shall be paid to the recipient.~~

~~4.~~ For purposes of this paragraph, "medical coverage" means any benefits under health insurance, a health maintenance organization, a preferred provider arrangement, or a prepaid health clinic, and the portion of benefits designated for medical payments under coverage for workers' compensation, personal injury protection, and casualty.

(18) A recipient or his or her legal representative or any person representing, or acting as agent for, a recipient or the recipient's legal representative, who has notice, excluding notice charged solely by reason of the recording of the lien pursuant to paragraph (6)(d), or who has actual knowledge of the department's rights to third-party benefits under this section, who receives any third-party benefit or proceeds therefrom for a covered illness or injury, is required either to pay the department, within 60 days after receipt of settlement proceeds, the full amount of the third-party benefits, but not in excess of the total medical assistance provided by Medicaid, or to place the full amount of the third-party benefits in a trust account for the benefit of the department pending judicial or administrative determination of the department's right thereto. Proof that any such person had notice or knowledge that the recipient had received medical assistance from Medicaid, and that third-party benefits or proceeds therefrom were in any way related to a covered illness or injury for which Medicaid had provided medical assistance, and that any such person knowingly obtained possession or control of, or used, third-party benefits or proceeds and failed either to pay the department the full amount required by this section or to hold the full amount of third-party benefits or proceeds in trust pending judicial or administrative determination, unless adequately explained, gives rise to an inference that such person knowingly failed to credit the state or its agent for payments received from social security, insurance, or other sources, pursuant to s. 414.39(4)(b), and acted with the intent set forth in s. 812.014(1).

(a) The department is authorized to investigate and to request appropriate officers or agencies of the state to investigate suspected criminal violations or fraudulent activity related to third-party benefits, including, without limitation, ss. 409.325 and 812.014. Such requests may be directed, without limitation, to the Medicaid Fraud Control Unit of the Office of the Attorney General, or to any state attorney. Pursuant to s. 409.913, the Attorney General has primary responsibility to investigate and control Medicaid fraud.

(b) In carrying out duties and responsibilities related to Medicaid fraud control, the department may subpoena witnesses or materials within or outside the state and, through any duly designated employee, administer oaths and affirmations and collect evidence for possible use in either civil or criminal judicial proceedings.

(c) All information obtained and documents prepared pursuant to an investigation of a Medicaid recipient, the recipient's legal representative, or any other person relating to an allegation of recipient fraud or theft is confidential and exempt from s. 119.07(1):

1. Until such time as the department takes final agency action;

2. Until such time as the Attorney General refers the case for criminal prosecution;

3. Until such time as an indictment or criminal information is filed by a state attorney in a criminal case; or

4. At all times if otherwise protected by law.

Section 33. Subsection (1) of section 414.28, Florida Statutes, is amended to read:

414.28 Public assistance payments to constitute debt of recipient.—

(1) CLAIMS.—The acceptance of public assistance creates a debt of the person accepting assistance, which debt is enforceable only after the death of the recipient. The debt thereby created is enforceable only by claim filed against the estate of the recipient after his or her death or by suit to set aside a fraudulent conveyance, as defined in subsection (3). After the death of the recipient and within the time prescribed by law, the department may file a claim against the estate of the recipient for the total amount of public assistance paid to or for the benefit of such recipient, reimbursement for which has not been made. Claims so filed shall take priority as class 3 ~~class 7~~ claims as provided by s. 733.707(1)(g).

Section 34. Subsection (1) of section 627.912, Florida Statutes, is amended, and subsection (5) is added to said section, to read:

627.912 Professional liability claims and actions; reports by insurers.—

(1) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatrist licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

~~(c) A final disposition not resulting in payment on behalf of the insured.~~

Reports shall be filed with the department and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with

the Agency for Health Care Administration, no later than 30 days following the occurrence of any event listed in paragraph (a) or, paragraph (b), or paragraph (c). The Agency for Health Care Administration shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. The Agency for Health Care Administration, as part of the annual report required by s. 455.2285, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the agency or the appropriate regulatory board.

(5) Any self-insurance program established under s. 240.213 shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of professional services provided by the Board of Regents through an employee or agent of the Board of Regents, including practitioners of medicine licensed under chapter 458, practitioners of osteopathic medicine licensed under chapter 459, podiatrists licensed under chapter 461, and dentists licensed under chapter 466, or based on a claimed performance of professional services without consent if the claim resulted in a final judgment in any amount, or a settlement in any amount. The reports required by this subsection shall contain the information required by subsection (3) and the name, address, and specialty of the employee or agent of the Board of Regents whose performance or professional services is alleged in the claim or action to have caused personal injury.

Section 35. Upon completion, the Marion County Health Department building to be constructed in Belleview, Florida, shall be known as the "Carl S. Lytle, M.D., Memorial Health Facility."

Section 36. The amount of $2 million is appropriated from tobacco settlement revenues to the Grants and Donations Trust Fund of the Agency for Health Care Administration to be matched at an appropriate level with federal Medicaid funds available under Title XIX of the Social Security Act to provide prosthetic and orthotic devices for Medicaid recipients when such devices are prescribed by licensed practitioners participating in the Medicaid program.

Section 37. Except as otherwise provided herein, this act shall take effect July 1 of the year in which enacted.

Became a law without the Governor's approval May 24, 1998.

Filed in Office Secretary of State May 22, 1998.