By the Committees on Ways and Means and Health Care

301-1983-98

1 A bill to be entitled
2 An act relating to public assistance; amending
3 s. 409.908, F.S.; requiring the agency to
4 establish a reimbursement methodology for
5 long-term-care services for Medicaid-eligible
6 nursing home residents; specifying requirements
7 for the methodology; providing legislative
8 intent; prescribing guidelines for Medicaid
9 payment of Medicare deductibles and
10 coinsurance; eliminating a prohibition on
11 specified contracts; repealing redundant
12 provisions; amending s. 409.912, F.S.;
13 authorizing the agency to include
14 disease-management initiatives in providing and
15 monitoring Medicaid services; authorizing the
16 agency to competitively negotiate home health
17 services; authorizing the agency to seek
18 necessary federal waivers that relate to the
19 competitive negotiation of such services;
20 amending s. 409.9122, F.S.; specifying the
21 departments that are required to make certain
22 information available to Medicaid recipients;
23 extending the period during which a Medicaid
24 recipient may disenroll from a managed care
25 plan or MediPass provider; deleting
26 authorization for the agency to request a
27 federal waiver from the requirement that a
28 Medicaid managed care plan include a specified
29 ratio of enrollees; amending s. 409.910, F.S.;
30 providing for the distribution of amounts
31 recovered in certain tort suits involving

1 intervention by the Agency for Health Care
2 Administration; requiring that certain
3 third-party benefits received by a Medicaid
4 recipient be remitted within a specified
5 period; amending s. 414.28, F.S.; revising the
6 order under which a claim may be made against
7 the estate of a recipient of public assistance;
8 amending s. 198.30, F.S.; requiring that each
9 circuit judge provide a report of decedents to
10 the Agency for Health Care Administration;
11 amending s. 154.504, F.S.; providing certain
12 restrictions on the use of copayments by public
13 health facilities; creating ss. 381.0022,
14 402.115, F.S.; authorizing the Department of
15 Health and the Department of Children and
16 Family Services to share certain confidential
17 information; amending s. 414.028, F.S.;
18 providing for a representative of a county
19 health department or Healthy Start Coalition to
20 serve on the local WAGES coalition; amending s.
21 766.101, F.S.; redefining the term "medical
22 review committee" to include a committee of the
23 Department of Health; amending s. 383.04, F.S.;
24 revising the requirements for the prophylactic
25 to be used for the eyes of infants; repealing
26 s. 383.05, F.S., relating to the free
27 distribution of such prophylactic; providing an
28 effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
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1 Section 1. Subsections (2) and (13) of section
2 409.908, Florida Statutes, are amended to read:
3 409.908 Reimbursement of Medicaid providers.--Subject
4 to specific appropriations, the agency shall reimburse
5 Medicaid providers, in accordance with state and federal law,
6 according to methodologies set forth in the rules of the
7 agency and in policy manuals and handbooks incorporated by
8 reference therein. These methodologies may include fee
9 schedules, reimbursement methods based on cost reporting,
10 negotiated fees, competitive bidding pursuant to s. 287.057,
11 and other mechanisms the agency considers efficient and
12 effective for purchasing services or goods on behalf of
13 recipients. Payment for Medicaid compensable services made on
14 behalf of Medicaid eligible persons is subject to the
15 availability of moneys and any limitations or directions
16 provided for in the General Appropriations Act or chapter 216.
17 Further, nothing in this section shall be construed to prevent
18 or limit the agency from adjusting fees, reimbursement rates,
19 lengths of stay, number of visits, or number of services, or
20 making any other adjustments necessary to comply with the
21 availability of moneys and any limitations or directions
22 provided for in the General Appropriations Act, provided the
23 adjustment is consistent with legislative intent.
24 (2)(a)1. Reimbursement to nursing homes licensed under
25 part II of chapter 400 and state-owned-and-operated
26 intermediate care facilities for the developmentally disabled
27 licensed under chapter 393 must be made prospectively.
28 2. Unless otherwise limited or directed in the General
29 Appropriations Act, reimbursement to hospitals licensed under
30 part I of chapter 395 for the provision of swing-bed nursing
31 home services must be made on the basis of the average

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1 statewide nursing home payment, and reimbursement to a
2 hospital licensed under part I of chapter 395 for the
3 provision of skilled nursing services must be made on the
4 basis of the average nursing home payment for those services
5 in the county in which the hospital is located. When a
6 hospital is located in a county that does not have any
7 community nursing homes, reimbursement must be determined by
8 averaging the nursing home payments, in counties that surround
9 the county in which the hospital is located. Reimbursement to
10 hospitals, including Medicaid payment of Medicare copayments,
11 for skilled nursing services shall be limited to 30 days,
12 unless a prior authorization has been obtained from the
13 agency. Medicaid reimbursement may be extended by the agency
14 beyond 30 days, and approval must be based upon verification
15 by the patient's physician that the patient requires
16 short-term rehabilitative and recuperative services only, in
17 which case an extension of no more than 15 days may be
18 approved. Reimbursement to a hospital licensed under part I of
19 chapter 395 for the temporary provision of skilled nursing
20 services to nursing home residents who have been displaced as
21 the result of a natural disaster or other emergency may not
22 exceed the average county nursing home payment for those
23 services in the county in which the hospital is located and is
24 limited to the period of time which the agency considers
25 necessary for continued placement of the nursing home
26 residents in the hospital.
27 (b) Subject to any limitations or directions provided
28 for in the General Appropriations Act, the agency shall
29 establish and implement a Florida Title XIX Long-Term Care
30 Reimbursement Plan (Medicaid) for nursing home care in order
31 to provide care and services in conformance with the

1 applicable state and federal laws, rules, regulations, and
2 quality and safety standards and to ensure that individuals
3 eligible for medical assistance have reasonable geographic
4 access to such care. Effective not later than the rate-setting
5 period beginning July 1, 1999, the agency shall establish a
6 case-mix reimbursement methodology for the rate of payment for
7 long-term-care services for nursing home residents. The agency
8 shall compute a per diem rate for Medicaid residents, adjusted
9 for case mix, which is based on a resident classification
10 system that accounts for the relative resource utilization by
11 different types of residents and which is based on
12 level-of-care data and other appropriate data. The case-mix
13 methodology developed by the agency shall take into account
14 the medical, behavioral, and cognitive deficits of residents.
15 In developing the reimbursement methodology, the agency shall
16 evaluate and modify other aspects of the reimbursement plan as
17 necessary to improve the overall effectiveness of the plan
18 with respect to the costs of patient care, operating costs,
19 and property costs. The agency shall work with the Department
20 of Elderly Affairs, the Florida Health Care Association, and
21 the Florida Association of Homes for the Aging in developing
22 the methodology. It is the intent of the Legislature that the
23 reimbursement plan achieve the goal of providing access to
24 health care for nursing home residents who require large
25 amounts of care while encouraging diversion services as an
26 alternative to nursing home care for residents who can be
27 served within the community. The agency shall base the
28 establishment of any maximum rate of payment, whether overall
29 or component, on the available moneys as provided for in the
30 General Appropriations Act. The agency may base the maximum
31 rate of payment on the results of scientifically valid

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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.~~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 2. Paragraph (c) of subsection (4) of section 409.912, Florida Statutes, is repealed, paragraph (d) of subsection (3) and subsection (13) of that section are amended, and subsection (34) is 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:

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(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.

(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.

Section 3. Subsection (2) of section 409.9122, Florida Statutes, is 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

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1 3. The agency receives any necessary waivers from the
2 federal Health Care Financing Administration.
3
4 The agency shall develop rules to establish policies by which
5 exceptions to the mandatory managed care enrollment
6 requirement may be made on a case-by-case basis. The rules
7 shall include the specific criteria to be applied when making
8 a determination as to whether to exempt a recipient from
9 mandatory enrollment in a managed care plan or MediPass.
10 School districts participating in the certified school match
11 program pursuant to ss. 236.0812 and 409.908(21) shall be
12 reimbursed by Medicaid, subject to the limitations of s.
13 236.0812(1) and (2), for a Medicaid-eligible child
14 participating in the services as authorized in s. 236.0812, as
15 provided for in s. 409.9071, regardless of whether the child
16 is enrolled in MediPass or a managed care plan. Managed care
17 plans shall make a good faith effort to execute agreements
18 with school districts and county health departments regarding
19 the coordinated provision of services authorized under s.
20 236.0812. To ensure continuity of care for Medicaid patients,
21 the agency and the Department of Education shall develop
22 procedures for ensuring that a student's managed care plan or
23 MediPass provider receives information relating to services
24 provided in accordance with ss. 236.0812 and 409.9071.
25 (b) A Medicaid recipient shall not be enrolled in or
26 assigned to a managed care plan or MediPass unless the managed
27 care plan or MediPass has complied with the quality-of-care
28 standards specified in paragraphs (3)(a) and (b),
29 respectively.
30 (c) Medicaid recipients shall have a choice of managed
31 care plans or MediPass. The Agency for Health Care

1 Administration, the Department of Health ~~and Rehabilitative~~
2 ~~Services~~, <u>the Department of Children and Family Services,</u>and
3 the Department of Elderly Affairs shall cooperate to ensure
4 that each Medicaid recipient receives clear and easily
5 understandable information that meets the following
6 requirements:
7 1. Explains the concept of managed care, including
8 MediPass.
9 2. Provides information on the comparative performance
10 of managed care plans and MediPass in the areas of quality,
11 credentialing, preventive health programs, network size and
12 availability, and patient satisfaction.
13 3. Explains where additional information on each
14 managed care plan and MediPass in the recipient's area can be
15 obtained.
16 4. Explains that recipients have the right to choose
17 their own managed care plans or MediPass. However, if a
18 recipient does not choose a managed care plan or MediPass, the
19 agency will assign the recipient to a managed care plan or
20 MediPass according to the criteria specified in this section.
21 5. Explains the recipient's right to complain, file a
22 grievance, or change managed care plans or MediPass providers
23 if the recipient is not satisfied with the managed care plan
24 or MediPass.
25 (d) The agency shall develop a mechanism for providing
26 information to Medicaid recipients for the purpose of making a
27 managed care plan or MediPass selection. Examples of such
28 mechanisms may include, but not be limited to, interactive
29 information systems, mailings, and mass marketing materials.
30 Managed care plans and MediPass providers are prohibited from
31 providing inducements to Medicaid recipients to select their

1 plans or from prejudicing Medicaid recipients against other
2 managed care plans or MediPass providers.
3 (e) Prior to requesting a Medicaid recipient who is
4 subject to mandatory managed care enrollment to make a choice
5 between a managed care plan or MediPass, the agency shall
6 contact and provide choice counseling to the recipient.
7 Medicaid recipients who are already enrolled in a managed care
8 plan or MediPass shall be offered the opportunity to change
9 managed care plans or MediPass providers on a staggered basis,
10 as defined by the agency. All Medicaid recipients shall have
11 90 days in which to make a choice of managed care plans or
12 MediPass providers. Those Medicaid recipients who do not make
13 a choice shall be assigned to a managed care plan or MediPass
14 in accordance with paragraph (f). To facilitate continuity of
15 care, for a Medicaid recipient who is also a recipient of
16 Supplemental Security Income (SSI), prior to assigning the SSI
17 recipient to a managed care plan or MediPass, the agency shall
18 determine whether the SSI recipient has an ongoing
19 relationship with a MediPass provider or managed care plan,
20 and if so, the agency shall assign the SSI recipient to that
21 MediPass provider or managed care plan. Those SSI recipients
22 who do not have such a provider relationship shall be assigned
23 to a managed care plan or MediPass provider in accordance with
24 paragraph (f).
25 (f) When a Medicaid recipient does not choose a
26 managed care plan or MediPass provider, the agency shall
27 assign the Medicaid recipient to a managed care plan or
28 MediPass provider. In the first period that assignment
29 begins, the assignments shall be divided equally between the
30 MediPass program and managed care plans. Thereafter,
31 assignment of Medicaid recipients who fail to make a choice

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1 shall be based proportionally on the preferences of recipients
2 who have made a choice in the previous period. Such
3 proportions shall be revised at least quarterly to reflect an
4 update of the preferences of Medicaid recipients. When making
5 assignments, the agency shall take into account the following
6 criteria:
7 1. A managed care plan has sufficient network capacity
8 to meet the need of members.
9 2. The managed care plan or MediPass has previously
10 enrolled the recipient as a member, or one of the managed care
11 plan's primary care providers or MediPass providers has
12 previously provided health care to the recipient.
13 3. The agency has knowledge that the member has
14 previously expressed a preference for a particular managed
15 care plan or MediPass provider as indicated by Medicaid
16 fee-for-service claims data, but has failed to make a choice.
17 4. The managed care plan's or MediPass primary care
18 providers are geographically accessible to the recipient's
19 residence.
20 (g) When more than one managed care plan or MediPass
21 provider meets the criteria specified in paragraph (f), the
22 agency shall make recipient assignments consecutively by
23 family unit.
24 (h) The agency may not engage in practices that are
25 designed to favor one managed care plan over another or that
26 are designed to influence Medicaid recipients to enroll in
27 MediPass rather than in a managed care plan or to enroll in a
28 managed care plan rather than in MediPass. This subsection
29 does not prohibit the agency from reporting on the performance
30 of MediPass or any managed care plan, as measured by
31 performance criteria developed by the agency.

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(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.

(j) The agency shall apply for a federal waiver from the Health Care Financing Administration to lock eligible Medicaid recipients into a managed care plan or MediPass for 12 months after an open enrollment period. After 12 months' enrollment, a recipient may select another managed care plan or MediPass provider. However, nothing shall prevent a Medicaid recipient from changing primary care providers within the managed care plan or MediPass program during the 12-month period.

~~(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 4. 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, the department shall reduce its recovery to take account of the cost of procuring the judgment, award, or settlement amount as provided in this section.

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1. 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 and in which the amount of any judgment, award, or settlement from third-party benefits, excluding medical coverage as defined in sub-subparagraph d. ~~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 as follows:

a.~~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.

b.~~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.

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

d. As used in ~~4. For purposes of~~ this paragraph, the term "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.

2. 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 and in which the amount of any

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1 judgment, award, or settlement from the third-party benefits,
2 excluding medical coverage as defined in sub-subparagraph
3 1.d., after reasonable costs and expenses of litigation, is an
4 amount more than 200 percent of the amount of medical
5 assistance provided by Medicaid, less any medical coverage
6 paid or payable to the department, then distribution of the
7 amount of recovery must be computed as follows:
8 a. Determine the ratio of the procurement costs to the
9 total judgment or settlement payment. Procurement costs must
10 include reasonable costs and expenses of litigation and
11 attorney's fees. The total amount of attorney's fees used to
12 determine the procurement costs attributable to Medicaid must
13 not exceed 25 percent of the award, judgment, or settlement
14 from third-party benefits, excluding medical coverage as
15 defined in sub-subparagraph 1.d., and after reasonable costs
16 and expenses of litigation.
17 b. Apply the ratio to the Medicaid payment. The
18 product is the Medicaid share of procurement costs.
19 c. Subtract the Medicaid share of procurement costs
20 from the Medicaid payments. The remainder is the department's
21 recovery amount.
22 (18) A recipient or his or her legal representative or
23 any person representing, or acting as agent for, a recipient
24 or the recipient's legal representative, who has notice,
25 excluding notice charged solely by reason of the recording of
26 the lien pursuant to paragraph (6)(d), or who has actual
27 knowledge of the department's rights to third-party benefits
28 under this section, who receives any third-party benefit or
29 proceeds therefrom for a covered illness or injury, is
30 required either to pay the department, within 60 days after
31 receipt of settlement proceeds, the full amount of the

1 third-party benefits, but not in excess of the total medical
2 assistance provided by Medicaid, or to place the full amount
3 of the third-party benefits in a trust account for the benefit
4 of the department pending judicial or administrative
5 determination of the department's right thereto. Proof that
6 any such person had notice or knowledge that the recipient had
7 received medical assistance from Medicaid, and that
8 third-party benefits or proceeds therefrom were in any way
9 related to a covered illness or injury for which Medicaid had
10 provided medical assistance, and that any such person
11 knowingly obtained possession or control of, or used,
12 third-party benefits or proceeds and failed either to pay the
13 department the full amount required by this section or to hold
14 the full amount of third-party benefits or proceeds in trust
15 pending judicial or administrative determination, unless
16 adequately explained, gives rise to an inference that such
17 person knowingly failed to credit the state or its agent for
18 payments received from social security, insurance, or other
19 sources, pursuant to s. 414.39(4)(b), and acted with the
20 intent set forth in s. 812.014(1).
21 (a) The department is authorized to investigate and to
22 request appropriate officers or agencies of the state to
23 investigate suspected criminal violations or fraudulent
24 activity related to third-party benefits, including, without
25 limitation, ss. 409.325 and 812.014. Such requests may be
26 directed, without limitation, to the Medicaid Fraud Control
27 Unit of the Office of the Attorney General, or to any state
28 attorney. Pursuant to s. 409.913, the Attorney General has
29 primary responsibility to investigate and control Medicaid
30 fraud.
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1 (b) In carrying out duties and responsibilities
2 related to Medicaid fraud control, the department may subpoena
3 witnesses or materials within or outside the state and,
4 through any duly designated employee, administer oaths and
5 affirmations and collect evidence for possible use in either
6 civil or criminal judicial proceedings.
7 (c) All information obtained and documents prepared
8 pursuant to an investigation of a Medicaid recipient, the
9 recipient's legal representative, or any other person relating
10 to an allegation of recipient fraud or theft is confidential
11 and exempt from s. 119.07(1):
12 1. Until such time as the department takes final
13 agency action;
14 2. Until such time as the Attorney General refers the
15 case for criminal prosecution;
16 3. Until such time as an indictment or criminal
17 information is filed by a state attorney in a criminal case;
18 or
19 4. At all times if otherwise protected by law.
20 Section 5. Subsection (1) of section 414.28, Florida
21 Statutes, is amended to read:
22 414.28 Public assistance payments to constitute debt
23 of recipient.--
24 (1) CLAIMS.--The acceptance of public assistance
25 creates a debt of the person accepting assistance, which debt
26 is enforceable only after the death of the recipient. The
27 debt thereby created is enforceable only by claim filed
28 against the estate of the recipient after his or her death or
29 by suit to set aside a fraudulent conveyance, as defined in
30 subsection (3). After the death of the recipient and within
31 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 6. 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 7. 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

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1 primary health care services to children and families with
2 incomes of up to 150 percent of the federal poverty level.
3 Participants shall pay no monthly premium for participation,
4 but shall be required to pay a copayment at the time a service
5 is provided. Copayments may be paid from sources other than
6 the participant, including, but not limited to, the child's or
7 parent's employer, or other private sources. As used in s.
8 766.1115, the term "copayment" may not be considered and may
9 not be used as compensation for services to health care
10 providers, and all funds generated from copayments shall be
11 used by the governmental contractor.
12 Section 8. Section 381.0022, Florida Statutes, is
13 created to read:
14 381.0022 Sharing confidential
15 information.--Notwithstanding any other law to the contrary,
16 the Department of Health and the Department of Children and
17 Family Services may share confidential or exempt information
18 that concerns clients served by both agencies. Confidential
19 information exchanged as provided in this section remains
20 confidential and exempt for disclosure as otherwise provided
21 by law.
22 Section 9. Section 402.115, Florida Statutes, is
23 created to read:
24 402.115 Sharing confidential
25 information.--Notwithstanding any other law to the contrary,
26 the Department of Health and the Department of Children and
27 Family Services may share confidential or exempt information
28 that concerns clients served by both agencies. Confidential
29 information exchanged as provided in this section remains
30 confidential and exempt for disclosure as otherwise provided
31 by law.

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

1 Section 10. Paragraph (e) is added to subsection (1)
2 of section 414.028, Florida Statutes, to read:
3 414.028 Local WAGES coalitions.--The WAGES Program
4 State Board of Directors shall create and charter local WAGES
5 coalitions to plan and coordinate the delivery of services
6 under the WAGES Program at the local level. The boundaries of
7 the service area for a local WAGES coalition shall conform to
8 the boundaries of the service area for the regional workforce
9 development board established under the Enterprise Florida
10 workforce development board. The local delivery of services
11 under the WAGES Program shall be coordinated, to the maximum
12 extent possible, with the local services and activities of the
13 local service providers designated by the regional workforce
14 development boards.
15 (1)
16 (e) A representative of a county health department or
17 a representative of a Healthy Start Coalition shall serve as
18 an ex officio, nonvoting member of the coalition.
19 Section 11. Paragraph (a) of subsection (1) of section
20 766.101, Florida Statutes, is amended to read:
21 766.101 Medical review committee, immunity from
22 liability.--
23 (1) As used in this section:
24 (a) The term "medical review committee" or "committee"
25 means:
26 1.a. A committee of a hospital or ambulatory surgical
27 center licensed under chapter 395 or a health maintenance
28 organization certificated under part I of chapter 641,
29 b. A committee of a state or local professional
30 society of health care providers,
31

1 c. A committee of a medical staff of a licensed
2 hospital or nursing home, provided the medical staff operates
3 pursuant to written bylaws that have been approved by the
4 governing board of the hospital or nursing home,
5 d. A committee of the Department of Corrections or the
6 Correctional Medical Authority as created under s. 945.602, or
7 employees, agents, or consultants of either the department or
8 the authority or both,
9 e. A committee of a professional service corporation
10 formed under chapter 621 or a corporation organized under
11 chapter 607 or chapter 617, which is formed and operated for
12 the practice of medicine as defined in s. 458.305(3), and
13 which has at least 25 health care providers who routinely
14 provide health care services directly to patients,
15 f. A committee of a mental health treatment facility
16 licensed under chapter 394 or a community mental health center
17 as defined in s. 394.907, provided the quality assurance
18 program operates pursuant to the guidelines which have been
19 approved by the governing board of the agency,
20 g. A committee of a substance abuse treatment and
21 education prevention program licensed under chapter 397
22 provided the quality assurance program operates pursuant to
23 the guidelines which have been approved by the governing board
24 of the agency,
25 h. A peer review or utilization review committee
26 organized under chapter 440, or
27 i. A committee of the Department of Health, a county
28 health department, healthy start coalition, or certified rural
29 health network, when reviewing quality of care, or employees
30 of these entities when reviewing mortality records,
31

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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 12. 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.

1 Section 13. Section 383.05, Florida Statutes, is
2 repealed.
3 Section 14. This act shall take effect July 1, 1998.
4
5 STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
6 CS/SB 484
7
8 Contains the following provisions:
9 Precribes guidelines for Medicaid payment of Medicare deductibles and coinsurance;
10
Repeals a prohibition on specified contracts and eliminates a
11 redundant provision;
12 Prohibits the use of copayments as compensation by health care providers;
13
Authorizes the Department of Health and the Department of
14 Children and Family Services to share confidential information on their mutual clients;
15
Provides for a representative of a county health department or
16 Healthy Start Coalition to serve as a nonvoting member of the local WAGES coalition;
17
Redefines the term "medical review committee" to include a
18 committee of the Department of Health;
19 Requires the prophylactic to be used for the eyes of newborn infants to be approved by the Committee on Infectious Diseases
20 of the American Academy of Pediatrics; and
21 Repeals provision requiring the Department of Health to prepare prophylactic solution, disallowed by s. 383.04, F.S.,
22 for free distribution.
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