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 directing the Agency for Health Care
21 Administration to establish an outpatient
22 specialty services pilot project; providing
23 definitions; providing criteria for
24 participation; requiring an evaluation and a
25 report to the Governor and Legislature;
26 modifying the licensure requirements for a
27 provider of services under a pilot project;
28 amending s. 409.9122, F.S.; requiring the
29 Agency for Health Care Administration to
30 reimburse county health departments for
31 school-based services; requiring Medicaid

1 managed-care contractors to attempt to enter
2 agreements with school districts and county
3 health departments for specified services;
4 specifying the departments that are required to
5 make certain information available to Medicaid
6 recipients; extending the period during which a
7 Medicaid recipient may disenroll from a managed
8 care plan or MediPass provider; deleting
9 authorization for the agency to request a
10 federal waiver from the requirement that a
11 Medicaid managed care plan include a specified
12 ratio of enrollees; amending requirements for
13 the mandatory assignment of Medicaid
14 recipients; amending s. 409.910, F.S.;
15 providing for the distribution of amounts
16 recovered in certain tort suits involving
17 intervention by the Agency for Health Care
18 Administration; requiring that certain
19 third-party benefits received by a Medicaid
20 recipient be remitted within a specified
21 period; amending s. 414.28, F.S.; revising the
22 order under which a claim may be made against
23 the estate of a recipient of public assistance;
24 amending s. 198.30, F.S.; requiring that each
25 circuit judge provide a report of decedents to
26 the Agency for Health Care Administration;
27 amending s. 154.504, F.S.; providing certain
28 restrictions on the use of copayments by public
29 health facilities; creating ss. 381.0022,
30 402.115, F.S.; authorizing the Department of
31 Health and the Department of Children and

1 Family Services to share certain confidential
2 information; amending s. 414.028, F.S.;
3 providing for a representative of a county
4 health department or Healthy Start Coalition to
5 serve on the local WAGES coalition; amending s.
6 766.101, F.S.; redefining the term "medical
7 review committee" to include a committee of the
8 Department of Health; amending s. 383.011,
9 F.S.; providing that the Department of Health
10 is the designated state agency for receiving
11 federal funds for the Child Care Food Program;
12 requiring the department to adopt rules for
13 administering the program; amending s. 383.04,
14 F.S.; revising the requirements for the
15 prophylactic to be used for the eyes of
16 infants; repealing s. 383.05, F.S., relating to
17 the free distribution of such prophylactic;
18 amending s. 409.903, F.S.; providing Medicaid
19 eligibility standards for certain persons;
20 conforming references; providing an
21 appropriation to be matched by federal Medicaid
22 funds; providing an effective date.
23
24 Be It Enacted by the Legislature of the State of Florida:
25
26 Section 1. Subsections (2) and (13) of section
27 409.908, Florida Statutes, are amended to read:
28 409.908 Reimbursement of Medicaid providers.--Subject
29 to specific appropriations, the agency shall reimburse
30 Medicaid providers, in accordance with state and federal law,
31 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

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1 community nursing homes, reimbursement must be determined by
2 averaging the nursing home payments, in counties that surround
3 the county in which the hospital is located. Reimbursement to
4 hospitals, including Medicaid payment of Medicare copayments,
5 for skilled nursing services shall be limited to 30 days,
6 unless a prior authorization has been obtained from the
7 agency. Medicaid reimbursement may be extended by the agency
8 beyond 30 days, and approval must be based upon verification
9 by the patient's physician that the patient requires
10 short-term rehabilitative and recuperative services only, in
11 which case an extension of no more than 15 days may be
12 approved. Reimbursement to a hospital licensed under part I of
13 chapter 395 for the temporary provision of skilled nursing
14 services to nursing home residents who have been displaced as
15 the result of a natural disaster or other emergency may not
16 exceed the average county nursing home payment for those
17 services in the county in which the hospital is located and is
18 limited to the period of time which the agency considers
19 necessary for continued placement of the nursing home
20 residents in the hospital.
21 (b) Subject to any limitations or directions provided
22 for in the General Appropriations Act, the agency shall
23 establish and implement a Florida Title XIX Long-Term Care
24 Reimbursement Plan (Medicaid) for nursing home care in order
25 to provide care and services in conformance with the
26 applicable state and federal laws, rules, regulations, and
27 quality and safety standards and to ensure that individuals
28 eligible for medical assistance have reasonable geographic
29 access to such care. Effective no earlier than the
30 rate-setting period beginning April 1, 1999, the agency shall
31 establish a case-mix reimbursement methodology for the rate of

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1 payment for long-term-care services for nursing home
2 residents. The agency shall compute a per diem rate for
3 Medicaid residents, adjusted for case mix, which is based on a
4 resident classification system that accounts for the relative
5 resource utilization by different types of residents and which
6 is based on level-of-care data and other appropriate data. The
7 case-mix methodology developed by the agency shall take into
8 account the medical, behavioral, and cognitive deficits of
9 residents. In developing the reimbursement methodology, the
10 agency shall evaluate and modify other aspects of the
11 reimbursement plan as necessary to improve the overall
12 effectiveness of the plan with respect to the costs of patient
13 care, operating costs, and property costs. In the event
14 adequate data are not available, the agency is authorized to
15 adjust the patient's care component or the per diem rate to
16 more adequately cover the cost of services provided in the
17 patient's care component. The agency shall work with the
18 Department of Elderly Affairs, the Florida Health Care
19 Association, and the Florida Association of Homes for the
20 Aging in developing the methodology. It is the intent of the
21 Legislature that the reimbursement plan achieve the goal of
22 providing access to health care for nursing home residents who
23 require large amounts of care while encouraging diversion
24 services as an alternative to nursing home care for residents
25 who can be served within the community.The agency shall base
26 the establishment of any maximum rate of payment, whether
27 overall or component, on the available moneys as provided for
28 in the General Appropriations Act. The agency may base the
29 maximum rate of payment on the results of scientifically valid
30 analysis and conclusions derived from objective statistical
31 data pertinent to the particular maximum rate of payment.

1 (13) Medicare premiums for persons eligible for both
2 Medicare and Medicaid coverage shall be paid at the rates
3 established by Title XVIII of the Social Security Act. For
4 Medicare services rendered to Medicaid-eligible persons,
5 Medicaid shall pay Medicare deductibles and coinsurance as
6 follows:
7 (a) Medicaid shall make no payment toward deductibles
8 and coinsurance for any service that is not covered by
9 Medicaid.
10 (b) Medicaid's financial obligation for deductibles
11 and coinsurance payments shall be based on Medicare allowable
12 fees, not on a provider's billed charges.
13 (c) Medicaid will pay no portion of Medicare
14 deductibles and coinsurance when payment that Medicare has
15 made for the service equals or exceeds what Medicaid would
16 have paid if it had been the sole payor. The combined payment
17 of Medicare and Medicaid shall not exceed the amount Medicaid
18 would have paid had it been the sole payor.
19 (d) The following provisions are exceptions to
20 paragraphs (a)-(c):
21 1. Medicaid payments for Nursing Home Medicare Part A
22 coinsurance shall be the lesser of the Medicare coinsurance
23 amount or the Medicaid nursing home per diem rate.
24 2. Medicaid shall pay all deductibles and coinsurance
25 for Nursing Home Medicare Part B services.
26 3. Medicaid shall pay all deductibles and coinsurance
27 for Medicare-eligible recipients receiving freestanding end
28 stage renal dialysis center services.
29 4. Medicaid shall pay all deductibles and coinsurance
30 for hospital outpatient Medicare Part B services.
31

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 2. Paragraph (c) of subsection (4) of section 409.912, Florida Statutes, is repealed, paragraphs (b) and (d) 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.

(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

1 waivers as necessary to implement the provisions of this
2 section. A demonstration project awarded pursuant to this
3 paragraph shall be for 2 years from the date of
4 implementation.
5 (13) The agency shall identify health care utilization
6 and price patterns within the Medicaid program which ~~that~~ are
7 not cost-effective or medically appropriate and assess the
8 effectiveness of new or alternate methods of providing and
9 monitoring service, and may implement such methods as it
10 considers appropriate. Such methods may include
11 disease-management initiatives, an integrated and systematic
12 approach for managing the health care needs of recipients who
13 are at risk of or diagnosed with a specific disease by using
14 best practices, prevention strategies, clinical-practice
15 improvement, clinical interventions and protocols, outcomes
16 research, information technology, and other tools and
17 resources to reduce overall costs and improve measurable
18 outcomes.
19 (34) The agency may provide for cost-effective
20 purchasing of home health services through competitive
21 negotiation pursuant to s. 287.057. The agency may request
22 appropriate waivers from the federal Health Care Financing
23 Administration in order to competitively bid home health
24 services.
25 (35) The Agency for Health Care Administration is
26 directed to issue a request for proposal or intent to
27 negotiate to implement on a demonstration basis an outpatient
28 specialty services pilot project in a rural and urban county
29 in the state. As used in this subsection, the term
30 "outpatient specialty services" means clinical laboratory,
31 diagnostic imaging, and specified home medical services to

1 include durable medical equipment, prosthetics and orthotics,
2 and infusion therapy.
3 (a) The entity that is awarded the contract to provide
4 Medicaid managed care outpatient specialty services must, at a
5 minimum, meet the following criteria:
6 1. The entity must be licensed by the Department of
7 Insurance under part II of chapter 641.
8 2. The entity must be experienced in providing
9 outpatient specialty services.
10 3. The entity must demonstrate to the satisfaction of
11 the agency that it provides high-quality services to its
12 patients.
13 4. The entity must demonstrate that it has in place a
14 complaints and grievance process to assist Medicaid recipients
15 enrolled in the pilot managed care program to resolve
16 complaints and grievances.
17 (b) The pilot managed care program shall operate for a
18 period of 3 years. The objective of the pilot program shall
19 be to determine the cost-effectiveness and effects on
20 utilization, access, and quality of providing outpatient
21 specialty services to Medicaid recipients on a prepaid,
22 capitated basis.
23 (c) The agency shall conduct a quality-assurance
24 review of the prepaid health clinic each year that the
25 demonstration program is in effect. The prepaid health clinic
26 is responsible for all expenses incurred by the agency in
27 conducting a quality assurance review.
28 (d) The entity that is awarded the contract to provide
29 outpatient specialty services to Medicaid recipients shall
30 report data required by the agency in a format specified by
31

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 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

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, subject to s. 409.908(19), for a Medicaid-eligible child participating in the services as authorized in s. 381.0056 and 381.0057, 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 authorized under ss. 381.0056 and 381.0057.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.

(b) A Medicaid recipient shall not be enrolled in or assigned to a managed care plan or MediPass unless the managed care plan or MediPass has complied with the quality-of-care standards specified in paragraphs (3)(a) and (b), respectively.

(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

1 if the recipient is not satisfied with the managed care plan
2 or MediPass.
3 (d) The agency shall develop a mechanism for providing
4 information to Medicaid recipients for the purpose of making a
5 managed care plan or MediPass selection. Examples of such
6 mechanisms may include, but not be limited to, interactive
7 information systems, mailings, and mass marketing materials.
8 Managed care plans and MediPass providers are prohibited from
9 providing inducements to Medicaid recipients to select their
10 plans or from prejudicing Medicaid recipients against other
11 managed care plans or MediPass providers.
12 (e) Prior to requesting a Medicaid recipient who is
13 subject to mandatory managed care enrollment to make a choice
14 between a managed care plan or MediPass, the agency shall
15 contact and provide choice counseling to the recipient.
16 Medicaid recipients who are already enrolled in a managed care
17 plan or MediPass shall be offered the opportunity to change
18 managed care plans or MediPass providers on a staggered basis,
19 as defined by the agency. All Medicaid recipients shall have
20 90 days in which to make a choice of managed care plans or
21 MediPass providers. Those Medicaid recipients who do not make
22 a choice shall be assigned to a managed care plan or MediPass
23 in accordance with paragraph (f). To facilitate continuity of
24 care, for a Medicaid recipient who is also a recipient of
25 Supplemental Security Income (SSI), prior to assigning the SSI
26 recipient to a managed care plan or MediPass, the agency shall
27 determine whether the SSI recipient has an ongoing
28 relationship with a MediPass provider or managed care plan,
29 and if so, the agency shall assign the SSI recipient to that
30 MediPass provider or managed care plan. Those SSI recipients
31 who do not have such a provider relationship shall be assigned

1 to a managed care plan or MediPass provider in accordance with
2 paragraph (f).
3 (f) When a Medicaid recipient does not choose a
4 managed care plan or MediPass provider, the agency shall
5 assign the Medicaid recipient to a managed care plan or
6 MediPass provider. Medicaid recipients who are subject to
7 mandatory assignment but who fail to make a choice shall be
8 assigned to managed care plans or provider service networks
9 until an equal enrollment of 50 percent in MediPass and
10 provider service networks and 50 percent in managed care plans
11 is achieved. Once equal enrollment is achieved, the
12 assignments shall be divided in order to maintain an equal
13 enrollment in MediPass and managed care plans for the 1998-99
14 fiscal year.~~In the first period that assignment begins, the~~
15 ~~assignments shall be divided equally between the MediPass~~
16 ~~program and managed care plans.~~Thereafter, assignment of
17 Medicaid recipients who fail to make a choice shall be based
18 proportionally on the preferences of recipients who have made
19 a choice in the previous period. Such proportions shall be
20 revised at least quarterly to reflect an update of the
21 preferences of Medicaid recipients. When making assignments,
22 the agency shall take into account the following criteria:
23 1. A managed care plan has sufficient network capacity
24 to meet the need of members.
25 2. The managed care plan or MediPass has previously
26 enrolled the recipient as a member, or one of the managed care
27 plan's primary care providers or MediPass providers has
28 previously provided health care to the recipient.
29 3. The agency has knowledge that the member has
30 previously expressed a preference for a particular managed
31

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.

(g) When more than one managed care plan or MediPass provider meets the criteria specified in paragraph (f), the agency shall make recipient assignments consecutively by family unit.

(h) The agency may not engage in practices that are designed to favor one managed care plan over another or that are designed to influence Medicaid recipients to enroll in MediPass rather than in a managed care plan or to enroll in a managed care plan rather than in MediPass. This subsection does not prohibit the agency from reporting on the performance of MediPass or any managed care plan, as measured by performance criteria developed by the agency.

(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, 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

1 attorney. Pursuant to s. 409.913, the Attorney General has
2 primary responsibility to investigate and control Medicaid
3 fraud.
4 (b) In carrying out duties and responsibilities
5 related to Medicaid fraud control, the department may subpoena
6 witnesses or materials within or outside the state and,
7 through any duly designated employee, administer oaths and
8 affirmations and collect evidence for possible use in either
9 civil or criminal judicial proceedings.
10 (c) All information obtained and documents prepared
11 pursuant to an investigation of a Medicaid recipient, the
12 recipient's legal representative, or any other person relating
13 to an allegation of recipient fraud or theft is confidential
14 and exempt from s. 119.07(1):
15 1. Until such time as the department takes final
16 agency action;
17 2. Until such time as the Attorney General refers the
18 case for criminal prosecution;
19 3. Until such time as an indictment or criminal
20 information is filed by a state attorney in a criminal case;
21 or
22 4. At all times if otherwise protected by law.
23 Section 5. Subsection (1) of section 414.28, Florida
24 Statutes, is amended to read:
25 414.28 Public assistance payments to constitute debt
26 of recipient.--
27 (1) CLAIMS.--The acceptance of public assistance
28 creates a debt of the person accepting assistance, which debt
29 is enforceable only after the death of the recipient. The
30 debt thereby created is enforceable only by claim filed
31 against the estate of the recipient after his or her death or

1 by suit to set aside a fraudulent conveyance, as defined in
2 subsection (3). After the death of the recipient and within
3 the time prescribed by law, the department may file a claim
4 against the estate of the recipient for the total amount of
5 public assistance paid to or for the benefit of such
6 recipient, reimbursement for which has not been made. Claims
7 so filed shall take priority as class 3 ~~class 7~~ claims as
8 provided by s. 733.707(1)(g).
9 Section 6. Section 198.30, Florida Statutes, is
10 amended to read:
11 198.30 Circuit judge to furnish department with names
12 of decedents, etc.--Each circuit judge of this state shall, on
13 or before the 10th day of every month, notify the department
14 of the names of all decedents; the names and addresses of the
15 respective personal representatives, administrators, or
16 curators appointed; the amount of the bonds, if any, required
17 by the court; and the probable value of the estates, in all
18 estates of decedents whose wills have been probated or
19 propounded for probate before the circuit judge or upon which
20 letters testamentary or upon whose estates letters of
21 administration or curatorship have been sought or granted,
22 during the preceding month; and such report shall contain any
23 other information which the circuit judge may have concerning
24 the estates of such decedents. In addition, a copy of this
25 report shall be provided to the Agency for Health Care
26 Administration.A circuit judge shall also furnish forthwith
27 such further information, from the records and files of the
28 circuit court in regard to such estates, as the department may
29 from time to time require.
30 Section 7. Subsection (1) of section 154.504, Florida
31 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 8. 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 9. 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

1 information or information exempt from disclosure under
2 chapter 119 on any individual who is or has been the subject
3 of a program within the jurisdiction of each agency.
4 Information so exchanged remains confidential or exempt as
5 provided by law.
6 Section 10. Paragraph (e) is added to subsection (1)
7 of section 414.028, Florida Statutes, to read:
8 414.028 Local WAGES coalitions.--The WAGES Program
9 State Board of Directors shall create and charter local WAGES
10 coalitions to plan and coordinate the delivery of services
11 under the WAGES Program at the local level. The boundaries of
12 the service area for a local WAGES coalition shall conform to
13 the boundaries of the service area for the regional workforce
14 development board established under the Enterprise Florida
15 workforce development board. The local delivery of services
16 under the WAGES Program shall be coordinated, to the maximum
17 extent possible, with the local services and activities of the
18 local service providers designated by the regional workforce
19 development boards.
20 (1)
21 (e) A representative of a county health department or
22 a representative of a Healthy Start Coalition shall serve as
23 an ex officio, nonvoting member of the coalition.
24 Section 11. Paragraph (a) of subsection (1) of section
25 766.101, Florida Statutes, is amended to read:
26 766.101 Medical review committee, immunity from
27 liability.--
28 (1) As used in this section:
29 (a) The term "medical review committee" or "committee"
30 means:
31

1 1.a. A committee of a hospital or ambulatory surgical
2 center licensed under chapter 395 or a health maintenance
3 organization certificated under part I of chapter 641,
4 b. A committee of a state or local professional
5 society of health care providers,
6 c. A committee of a medical staff of a licensed
7 hospital or nursing home, provided the medical staff operates
8 pursuant to written bylaws that have been approved by the
9 governing board of the hospital or nursing home,
10 d. A committee of the Department of Corrections or the
11 Correctional Medical Authority as created under s. 945.602, or
12 employees, agents, or consultants of either the department or
13 the authority or both,
14 e. A committee of a professional service corporation
15 formed under chapter 621 or a corporation organized under
16 chapter 607 or chapter 617, which is formed and operated for
17 the practice of medicine as defined in s. 458.305(3), and
18 which has at least 25 health care providers who routinely
19 provide health care services directly to patients,
20 f. A committee of a mental health treatment facility
21 licensed under chapter 394 or a community mental health center
22 as defined in s. 394.907, provided the quality assurance
23 program operates pursuant to the guidelines which have been
24 approved by the governing board of the agency,
25 g. A committee of a substance abuse treatment and
26 education prevention program licensed under chapter 397
27 provided the quality assurance program operates pursuant to
28 the guidelines which have been approved by the governing board
29 of the agency,
30 h. A peer review or utilization review committee
31 organized under chapter 440, or

1 i. A committee of the Department of Health, a county
2 health department, healthy start coalition, or certified rural
3 health network, when reviewing quality of care, or employees
4 of these entities when reviewing mortality records,
5
6 which committee is formed to evaluate and improve the quality
7 of health care rendered by providers of health service or to
8 determine that health services rendered were professionally
9 indicated or were performed in compliance with the applicable
10 standard of care or that the cost of health care rendered was
11 considered reasonable by the providers of professional health
12 services in the area; or
13 2. A committee of an insurer, self-insurer, or joint
14 underwriting association of medical malpractice insurance, or
15 other persons conducting review under s. 766.106.
16 Section 12. Paragraph (i) is added to subsection (1)
17 of section 383.011, Florida Statutes, and subsection (2) of
18 that section is amended, to read:
19 383.011 Administration of maternal and child health
20 programs.--
21 (1) The Department of Health is designated as the
22 state agency for:
23 (i) Receiving federal funds for children eligible for
24 assistance through the child portion of the federal Child and
25 Adult Care Food Program, which is referred to as the Child
26 Care Food Program, and for establishing and administering this
27 program. The purpose of the Child Care Food Program is to
28 provide nutritious meals and snacks for children in
29 nonresidential day care. To ensure the quality and integrity
30 of the program, the department shall develop standards and
31 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 13. Section 383.04, Florida Statutes, is amended to read:

383.04 Prophylactic required for eyes of infants.--Every physician, midwife, or other person in

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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 14. Section 383.05, Florida Statutes, is repealed.

Section 15. 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

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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 16. 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 17. This act shall take effect July 1, 1998.