

1                                   A bill to be entitled  
2           An act relating to health care; providing an  
3           important state interest; amending ss. 154.301,  
4           154.302, 154.304, 154.306, 154.308, 154.309,  
5           154.31, 154.3105, 154.312, 154.314, and  
6           154.316, F.S., relating to health care  
7           responsibility for indigents; revising short  
8           title; revising definitions; limiting the  
9           maximum amount a county may be required to pay  
10          an out-of-county hospital; providing hospitals  
11          additional time to notify counties of admission  
12          or treatment of out-of-county patients;  
13          revising language and conforming references;  
14          providing penalties; amending s. 154.504, F.S.;  
15          limiting applicability of copayments under the  
16          Primary Care for Children and Families  
17          Challenge Grant Program; amending s. 198.30,  
18          F.S.; requiring certain reports of estates of  
19          decedents to be provided to the Agency for  
20          Health Care Administration; amending ss.  
21          240.4075 and 240.4076, F.S., relating the  
22          Nursing Student Loan Forgiveness Program, the  
23          Nursing Student Loan Forgiveness Trust Fund,  
24          and the nursing scholarship program;  
25          transferring powers, duties, and functions with  
26          respect thereto from the Department of Health  
27          to the Department of Education; creating ss.  
28          381.0022 and 402.115, F.S.; authorizing the  
29          Department of Health and the Department of  
30          Children and Family Services to share  
31          confidential and exempt information; amending

1 s. 381.004, F.S., relating to HIV testing;  
2 providing a penalty and increasing existing  
3 penalties; amending s. 384.34, F.S., relating  
4 to sexually transmissible diseases; providing a  
5 penalty and increasing existing penalties;  
6 amending s. 414.028, F.S.; providing for a  
7 representative of a county health department or  
8 Healthy Start Coalition to serve on the local  
9 WAGES coalition; amending s. 766.101, F.S.;  
10 redefining the term "medical review committee"  
11 to include a committee of the Department of  
12 Health; amending s. 383.011, F.S.; providing  
13 that the Department of Health is the designated  
14 state agency for receiving federal funds for  
15 the Child Care Food Program; requiring the  
16 department to adopt rules for administering the  
17 program; amending s. 383.04, F.S.; revising the  
18 requirements for the prophylactic to be used  
19 for the eyes of infants; repealing s. 383.05,  
20 F.S., relating to the free distribution of such  
21 prophylactic; amending s. 409.903, F.S.;  
22 providing Medicaid eligibility standards for  
23 certain persons; conforming references;  
24 amending s. 409.908, F.S.; requiring the agency  
25 to establish a reimbursement methodology for  
26 long-term-care services for Medicaid-eligible  
27 nursing home residents; specifying requirements  
28 for the methodology; providing legislative  
29 intent; prescribing guidelines for Medicaid  
30 payment of Medicare deductibles and  
31 coinsurance; eliminating a prohibition on

1 specified contracts; repealing redundant  
2 provisions; amending s. 409.912, F.S.;  
3 authorizing the agency to include  
4 disease-management initiatives in providing and  
5 monitoring Medicaid services; authorizing the  
6 agency to competitively negotiate home health  
7 services; authorizing the agency to seek  
8 necessary federal waivers that relate to the  
9 competitive negotiation of such services;  
10 directing the Agency for Health Care  
11 Administration to establish an outpatient  
12 specialty services pilot project; providing  
13 definitions; providing criteria for  
14 participation; requiring an evaluation and a  
15 report to the Governor and Legislature;  
16 modifying the licensure requirements for a  
17 provider of services under a pilot project;  
18 amending s. 409.9122, F.S.; requiring the  
19 Agency for Health Care Administration to  
20 reimburse county health departments for  
21 school-based services; requiring Medicaid  
22 managed-care contractors to attempt to enter  
23 agreements with school districts and county  
24 health departments for specified services;  
25 specifying the departments that are required to  
26 make certain information available to Medicaid  
27 recipients; extending the period during which a  
28 Medicaid recipient may disenroll from a managed  
29 care plan or MediPass provider; deleting  
30 authorization for the agency to request a  
31 federal waiver from the requirement that a

1 Medicaid managed care plan include a specified  
2 ratio of enrollees; amending requirements for  
3 the mandatory assignment of Medicaid  
4 recipients; amending s. 409.910, F.S.;  
5 providing for the distribution of amounts  
6 recovered in certain tort suits involving  
7 intervention by the Agency for Health Care  
8 Administration; requiring that certain  
9 third-party benefits received by a Medicaid  
10 recipient be remitted within a specified  
11 period; amending s. 414.28, F.S.; revising the  
12 order under which a claim may be made against  
13 the estate of a recipient of public assistance;  
14 amending s. 627.912, F.S.; revising reporting  
15 requirements by certain insurers; requiring  
16 certain self-insurers to report certain  
17 information to the Department of Insurance;  
18 naming the Carl S. Lytle, M.D., Memorial Health  
19 Facility in Marion County; providing an  
20 appropriation to be matched by federal Medicaid  
21 funds; providing effective dates.

22  
23 Be It Enacted by the Legislature of the State of Florida:

24  
25 Section 1. The Legislature finds that the provisions  
26 of this act which amend sections 154.301 through 154.316,  
27 Florida Statutes, fulfill the important state interest of  
28 promoting the legislative intent of the Florida Health Care  
29 Responsibility Act, as that intent is expressed in section  
30 154.302, Florida Statutes.

31

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

3           154.301 Short title.--Sections 154.301-154.316 may be  
4 cited as "The Florida Health Care Responsibility Act ~~of 1988.~~"

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

7           154.302 Legislative intent.--The Legislature finds  
8 that certain hospitals provide a disproportionate share of  
9 charity care for persons who are indigent, ~~and~~ not able to pay  
10 their medical bills, ~~and who are~~ not eligible for  
11 government-funded programs. The burden of absorbing the cost  
12 of this uncompensated charity care is borne by the hospital,  
13 the private pay patients, and, many times, by the taxpayers in  
14 the county when the hospital is subsidized by tax revenues.  
15 The Legislature further finds that it is inequitable for  
16 hospitals and taxpayers of one county to be expected to  
17 subsidize the care of out-of-county indigent persons. Finally,  
18 the Legislature declares that the state and the counties must  
19 share the responsibility of assuring that adequate and  
20 affordable health care is available to all Floridians.  
21 Therefore, it is the intent of the Legislature to place the  
22 ultimate financial obligation for the out-of-county hospital  
23 care of qualified indigent patients on the county in which the  
24 indigent patient resides.

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

27           154.304 Definitions.--As used in this part, the term  
28 ~~For the purpose of this act:~~

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

31

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

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

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

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

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

27           (6) "Eligibility determination procedures" means the  
28 process used by a county or the agency department to evaluate  
29 a person's financial eligibility, eligibility for state-funded  
30 or federally funded programs, and the availability of  
31

1 insurance, in order to document a person as a qualified  
2 indigent for the purpose of this part act.

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

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

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

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

19 (9) "Qualified indigent person" or "qualified indigent  
20 patient" means a person who has been determined pursuant to s.  
21 154.308 to have an average family income, for the 12 months  
22 preceding the determination, which is below 100 percent of the  
23 federal nonfarm poverty level; who is not eligible to  
24 participate in any other government program that ~~which~~  
25 provides hospital care; who has no private insurance or has  
26 inadequate private insurance; and who does not reside in a  
27 public institution as defined under the medical assistance  
28 program for the needy under Title XIX of the Social Security  
29 Act, as amended.

30 (10) "Regional referral hospital" means any hospital  
31 that ~~which~~ is eligible to receive reimbursement under the

1 provision of this part act because it has met its charity care  
2 obligation and it meets the definition of teaching hospital as  
3 defined in s. 408.07.

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

6 154.306 Financial responsibility for certified  
7 residents who are qualified indigent patients treated at an  
8 out-of-county participating hospital or regional referral  
9 hospital.--Ultimate financial responsibility for treatment  
10 received at a participating hospital or a regional referral  
11 hospital by a qualified indigent patient who is a certified  
12 resident of a county in the State of Florida, but is not a  
13 resident of the county in which the participating hospital or  
14 regional referral hospital is located, is ~~shall be~~ the  
15 obligation of the county of which the qualified indigent  
16 patient is a resident. Each county shall ~~is directed to~~  
17 reimburse participating hospitals or regional referral  
18 hospitals as provided for in this part act, and shall provide  
19 or arrange for indigent eligibility determination procedures  
20 and resident certification determination procedures as  
21 provided for in rules developed to implement this part act.  
22 The agency ~~department~~, or any county determining eligibility  
23 of a qualified indigent, shall provide to the county of  
24 residence, upon request, a copy of any documents, forms, or  
25 other information, as determined by rule, which may be used in  
26 making an eligibility determination.

27 (1) A county's financial obligation for each certified  
28 resident who qualifies as an indigent patient under this part  
29 act, and who has received treatment at an out-of-county  
30 hospital, shall not exceed 45 days per county fiscal year at a  
31 rate of payment equivalent to 100 percent of the per diem



1 reimbursement rate currently in effect for the out-of-county  
2 hospital under the medical assistance program for the needy  
3 under Title XIX of the Social Security Act, as amended, except  
4 that those counties that are at their 10-mill cap on October  
5 1, 1991, shall reimburse hospitals for such services at not  
6 less than 80 percent of the hospital Medicaid per diem.  
7 However, nothing in this section shall preclude a hospital  
8 that ~~which~~ has a formal signed agreement with a county to  
9 treat such county's indigents from negotiating a higher or  
10 lower per diem rate with the county. ~~In addition,~~No county  
11 shall be required ~~by this act~~ to pay more than the equivalent  
12 of \$4 per capita in the county's fiscal year. The agency  
13 ~~department~~ shall calculate and certify to each county by March  
14 1 of each year, the maximum amount the county may be required  
15 to pay ~~under this act~~ by multiplying the most recent official  
16 state population estimate for the total population of the  
17 county by \$4 per capita. Each county shall certify to the  
18 agency department within 60 days after ~~of~~ the end of the  
19 county's fiscal year, or upon reaching the \$4 per capita  
20 threshold, should that occur before the end of the fiscal  
21 year, the amount of reimbursement it paid to all out-  
22 of-county hospitals under this part act. The maximum amount a  
23 county may be required to pay to out-of-county hospitals for  
24 care provided to qualified indigent residents may be reduced  
25 by up to one-half, provided that the amount not paid has or is  
26 being spent for in-county hospital care provided to qualified  
27 indigent residents.

28 (2) No county shall be required to pay for any  
29 elective or nonemergency admissions or services at an  
30 out-of-county hospital for a qualified indigent who is a  
31 certified resident of the county if ~~when~~ the county provides

1 funding for such services and the services are available at a  
2 local hospital in the county where the indigent resides; or  
3 the out-of-county hospital has not obtained prior written  
4 authorization and approval for such hospital admission or  
5 service, provided that the resident county has established a  
6 procedure to authorize and approve such admissions.

7 (3) The county where the indigent resides shall, in  
8 all instances, be liable for the cost of treatment provided to  
9 a qualified indigent patient at an out-of-county hospital for  
10 any emergency medical condition which will deteriorate from  
11 failure to provide such treatment if ~~and when~~ such condition  
12 is determined and documented by the attending physician to be  
13 of an emergency nature; provided that the patient has been  
14 certified to be a resident of such county pursuant to s.  
15 154.309.

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

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

25 154.308 Determination of patient's eligibility;  
26 spend-down program.--

27 (1) The agency department, pursuant to s. 154.3105,  
28 shall adopt rules which provide statewide eligibility  
29 determination procedures, forms, and criteria which shall be  
30 used by all counties for determining whether a person  
31

1 financially qualifies as indigent for the purposes of this  
2 part act.

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

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

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

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

29 (4) A patient determined eligible as a qualified  
30 indigent ~~for the purpose of this act~~ subsequent to his or her  
31 admission to a participating hospital or a regional referral

1 hospital shall be considered to have been qualified upon  
2 admission. Such determination shall be made by a person  
3 designated by the governing board of the county to make such a  
4 determination or by the agency department.

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

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

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

27 154.309 Certification of county of residence.--

28 (1) The agency department, pursuant to s. 154.3105,  
29 shall adopt rules for certification determination procedures  
30 which provide criteria to be used for determining a qualified  
31 indigent's county of residence. Such criteria must ~~shall~~

1 include, at a minimum, how and to what extent residency shall  
2 be verified and how a hospital shall be notified of a  
3 patient's certification or the inability to certify a patient.

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

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

21 154.31 Obligation of participating hospital or  
22 regional referral hospital.--As a condition of participation  
23 ~~accepting the procedures of this act~~, each participating  
24 hospital or regional referral hospital in Florida shall be  
25 obligated to admit for emergency treatment all Florida  
26 residents, without regard to county of residence, who meet the  
27 eligibility standards established pursuant to s. 154.308 and  
28 who meet the medical standards for admission to such  
29 institutions. If the agency ~~department~~ determines that a  
30 participating hospital or a regional referral hospital has  
31 failed to meet the requirements of this section, the agency

1 ~~department~~ may impose an administrative fine, not to exceed  
2 \$5,000 per incident, and suspend the hospital from eligibility  
3 for reimbursement under ~~the provisions of this part act~~.

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

6 154.3105 Rules.--Rules governing the Health Care  
7 Responsibility Act ~~of 1988~~ shall be developed by the agency  
8 ~~department~~ based on recommendations of a work group consisting  
9 of equal representation by the agency department, the hospital  
10 industry, and the counties. County representatives to this  
11 work group shall be appointed by the Florida Association of  
12 Counties. Hospital representatives to this work group shall  
13 be appointed by the associations representing those hospitals  
14 which best represent the positions of the hospitals most  
15 likely to be eligible for reimbursement. Rules governing ~~the~~  
16 ~~various aspects of this part act~~ shall be adopted by the  
17 agency department. ~~Such rules shall address, at a minimum:~~

18 ~~(1) Eligibility determination procedures and criteria.~~  
19 ~~(2) Certification determination procedures and methods~~  
20 ~~of notification to hospitals.~~

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

23 154.312 Procedure for settlement of disputes.--All  
24 disputes among counties, ~~the board~~, the agency department, a  
25 participating hospital, or a regional referral hospital shall  
26 be resolved by order as provided in chapter 120. ~~Hearings held~~  
27 ~~under this provision shall be conducted in the same manner as~~  
28 provided in ss. 120.569 and 120.57, except that the presiding  
29 officer's order shall be final agency action. Cases filed  
30 under chapter 120 may combine all disputes between parties.  
31 Notwithstanding any other provisions of this part, if ~~when~~ a

1 county alleges that a residency determination or eligibility  
2 determination made by the agency ~~department~~ is incorrect, the  
3 burden of proof shall be on the county to demonstrate that  
4 such determination is, in light of the total record, not  
5 supported by the evidence.

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

8 154.314 Certification of the State of Florida.--

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

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

31

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

3           154.316 Hospital's responsibility to notify of  
4 admission of indigent patients.--

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

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

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

19           154.504 Eligibility and benefits.--

20           (1) Any county or counties may apply for a primary  
21 care for children and families challenge grant to provide  
22 primary health care services to children and families with  
23 incomes of up to 150 percent of the federal poverty level.  
24 Participants shall pay no monthly premium for participation,  
25 but shall be required to pay a copayment at the time a service  
26 is provided. Copayments may be paid from sources other than  
27 the participant, including, but not limited to, the child's or  
28 parent's employer, or other private sources. As used in s.  
29 766.1115, the term "copayment" may not be considered and may  
30 not be used as compensation for services to health care

31



1 providers, and all funds generated from copayments shall be  
2 used by the governmental contractor.

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

5 198.30 Circuit judge to furnish department with names  
6 of decedents, etc.--Each circuit judge of this state shall, on  
7 or before the 10th day of every month, notify the department  
8 of the names of all decedents; the names and addresses of the  
9 respective personal representatives, administrators, or  
10 curators appointed; the amount of the bonds, if any, required  
11 by the court; and the probable value of the estates, in all  
12 estates of decedents whose wills have been probated or  
13 propounded for probate before the circuit judge or upon which  
14 letters testamentary or upon whose estates letters of  
15 administration or curatorship have been sought or granted,  
16 during the preceding month; and such report shall contain any  
17 other information which the circuit judge may have concerning  
18 the estates of such decedents. In addition, a copy of this  
19 report shall be provided to the Agency for Health Care  
20 Administration.A circuit judge shall also furnish forthwith  
21 such further information, from the records and files of the  
22 circuit court in regard to such estates, as the department may  
23 from time to time require.

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

26 240.4075 Nursing Student Loan Forgiveness Program.--

27 (1) To encourage qualified personnel to seek  
28 employment in areas of this state in which critical nursing  
29 shortages exist, there is established the Nursing Student Loan  
30 Forgiveness Program. The primary function of the program is  
31 to increase employment and retention of registered nurses and

1 licensed practical nurses in nursing homes and hospitals in  
2 the state and in state-operated medical and health care  
3 facilities, birth centers, federally sponsored community  
4 health centers and teaching hospitals by making repayments  
5 toward loans received by students from federal or state  
6 programs or commercial lending institutions for the support of  
7 postsecondary study in accredited or approved nursing  
8 programs.

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

14 (3) Only loans to pay the costs of tuition, books, and  
15 living expenses shall be covered, at an amount not to exceed  
16 \$4,000 for each year of education towards the degree obtained.

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

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

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

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

31

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

3  
4 In no case may payment for any nurse exceed \$4,000 in any  
5 12-month period.

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

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

29 (7)(a) Funds contained in the Nursing Student Loan  
30 Forgiveness Trust Fund which are to be used for loan  
31 forgiveness for those nurses employed by hospitals, birth

1 centers, and nursing homes must be matched on a  
2 dollar-for-dollar basis by contributions from the employing  
3 institutions, except that this provision shall not apply to  
4 state-operated medical and health care facilities, county  
5 health departments, federally sponsored community health  
6 centers, or teaching hospitals as defined in s. 408.07.

7 (b) All Nursing Student Loan Forgiveness Trust Fund  
8 moneys shall be invested pursuant to s. 18.125. Interest  
9 income accruing to that portion of the trust fund not matched  
10 shall increase the total funds available for loan forgiveness  
11 and scholarships. Pledged contributions shall not be eligible  
12 for matching prior to the actual collection of the total  
13 private contribution for the year.

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

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

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

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

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

27 240.4076 Nursing scholarship program.--

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

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

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

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

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

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

1 apply to the department for a transfer to another approved  
2 health care facility.

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

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

27 (5) Scholarship payments shall be transmitted to the  
28 recipient upon receipt of documentation that the recipient is  
29 enrolled in an approved nursing program. The Department of  
30 Education ~~Health~~ shall develop a formula to prorate payments  
31

1 to scholarship recipients so as not to exceed the maximum  
2 amount per academic year.

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

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

14 Section 17. All statutory powers, duties and  
15 functions, records, rules, personnel, property, and unexpended  
16 balances of appropriations, allocations, or other funds, of  
17 the Department of Health relating to the Nursing Student Loan  
18 Forgiveness Program and the Nursing Student Loan Forgiveness  
19 Trust Fund, as created in section 240.4075, Florida Statutes,  
20 and the nursing scholarship program, as created in section  
21 240.4076, Florida Statutes, are transferred by a type two  
22 transfer, as provided for in section 20.06(2), Florida  
23 Statutes, from the Department of Health to the Department of  
24 Education. Such transfer shall take effect July 1, 1998. Any  
25 rules adopted by or for the Department of Health for the  
26 administration and operation of the Nursing Student Loan  
27 Forgiveness Program, the Nursing Student Loan Forgiveness  
28 Trust Fund, and the nursing scholarship program are included  
29 in such transfer.

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

1           381.0022 Sharing confidential or exempt  
2 information.--Notwithstanding any other provision of law to  
3 the contrary, the Department of Health and the Department of  
4 Children and Family Services may share confidential  
5 information or information exempt from disclosure under  
6 chapter 119 on any individual who is or has been the subject  
7 of a program within the jurisdiction of each agency.  
8 Information so exchanged remains confidential or exempt as  
9 provided by law.

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

12           402.115 Sharing confidential or exempt  
13 information.--Notwithstanding any other provision of law to  
14 the contrary, the Department of Health and the Department of  
15 Children and Family Services may share confidential  
16 information or information exempt from disclosure under  
17 chapter 119 on any individual who is or has been the subject  
18 of a program within the jurisdiction of each agency.  
19 Information so exchanged remains confidential or exempt as  
20 provided by law.

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

23           381.004 Testing for human immunodeficiency virus.--

24           (6) PENALTIES.--

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

29           (b) Any person who violates the confidentiality  
30 provisions of this section and s. 951.27 commits a misdemeanor  
31



1 of the first degree, punishable as provided in s. 775.082 or  
2 s. 775.083.

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

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

15 384.34 Penalties.--

16 (1) Any person who violates the provisions of s.  
17 384.24(1) commits a misdemeanor of the first degree,  
18 punishable as provided in s. 775.082 or s. 775.083.

19 (2) Any person who violates the provisions of s.  
20 384.26 or s. 384.29 commits a misdemeanor of the first degree,  
21 punishable as provided in s. 775.082 or s. 775.083.

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

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

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

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

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

19           414.028 Local WAGES coalitions.--The WAGES Program  
20 State Board of Directors shall create and charter local WAGES  
21 coalitions to plan and coordinate the delivery of services  
22 under the WAGES Program at the local level. The boundaries of  
23 the service area for a local WAGES coalition shall conform to  
24 the boundaries of the service area for the regional workforce  
25 development board established under the Enterprise Florida  
26 workforce development board. The local delivery of services  
27 under the WAGES Program shall be coordinated, to the maximum  
28 extent possible, with the local services and activities of the  
29 local service providers designated by the regional workforce  
30 development boards.

31           (1)

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

4           Section 23. Paragraph (a) of subsection (1) of section  
5 766.101, Florida Statutes, is amended to read:

6           766.101 Medical review committee, immunity from  
7 liability.--

8           (1) As used in this section:

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

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

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

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

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

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

30           f. A committee of a mental health treatment facility  
31 licensed under chapter 394 or a community mental health center

1 as defined in s. 394.907, provided the quality assurance  
2 program operates pursuant to the guidelines which have been  
3 approved by the governing board of the agency,

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

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

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

15  
16 which committee is formed to evaluate and improve the quality  
17 of health care rendered by providers of health service or to  
18 determine that health services rendered were professionally  
19 indicated or were performed in compliance with the applicable  
20 standard of care or that the cost of health care rendered was  
21 considered reasonable by the providers of professional health  
22 services in the area; or

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

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

29 383.011 Administration of maternal and child health  
30 programs.--

31

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

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

30 (2) The Department of Health shall follow federal  
31 requirements and may adopt any rules necessary for the

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

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

10 383.04 Prophylactic required for eyes of  
11 infants.--Every physician, midwife, or other person in  
12 attendance at the birth of a child in the state is required to  
13 instill or have instilled into the eyes of the baby within 1  
14 hour after birth an effective prophylactic recommended by the  
15 Committee on Infectious Diseases of the American Academy of  
16 Pediatrics ~~a 1-percent fresh solution of silver nitrate (with~~  
17 ~~date of manufacture marked on container), two drops of the~~  
18 ~~solution to be dropped into each eye after the eyelids have~~  
19 ~~been opened, or some equally effective prophylactic approved~~  
20 ~~by the Department of Health,~~for the prevention of neonatal  
21 ~~blindness from ophthalmia neonatorum.~~ This section does ~~shall~~  
22 not apply to cases where the parents ~~shall~~ file with the  
23 physician, midwife, or other person in attendance at the birth  
24 of a child written objections on account of religious beliefs  
25 contrary to the use of drugs. In such case the physician,  
26 midwife, or other person in attendance shall maintain a record  
27 that such measures were or were not employed and attach  
28 thereto any written objection.

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

31

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

3 409.903 Mandatory payments for eligible persons.--The  
4 ~~agency department~~ shall make payments for medical assistance  
5 and related services on behalf of the following persons who  
6 the ~~agency department~~ determines to be eligible, subject to  
7 the income, assets, and categorical eligibility tests set  
8 forth in federal and state law. Payment on behalf of these  
9 Medicaid eligible persons is subject to the availability of  
10 moneys and any limitations established by the General  
11 Appropriations Act or chapter 216.

12 (1) Low-income families with children are eligible for  
13 Medicaid provided they meet the following requirements:

14 ~~Persons who receive payments from or are determined eligible~~  
15 ~~to participate in the WAGES Program, and certain persons who~~  
16 ~~would be eligible but do not meet certain technical~~  
17 ~~requirements. This group includes, but is not limited to:~~

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

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

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

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

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

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

18           (5) A pregnant woman for the duration of her pregnancy  
19 and for the post partum period as defined in federal law and  
20 rule, or a child under age 1, if either is living in a family  
21 that has an income which is at or below 150 percent of the  
22 most current federal poverty level, or, effective January 1,  
23 1992, that has an income which is at or below 185 percent of  
24 the most current federal poverty level. Such a person is not  
25 subject to an assets test. Further, a pregnant woman who  
26 applies for eligibility for the Medicaid program through a  
27 qualified Medicaid provider must be offered the opportunity,  
28 subject to federal rules, to be made presumptively eligible  
29 for the Medicaid program.

30           (6) A child born after September 30, 1983, living in a  
31 family that has an income which is at or below 100 percent of



1 the current federal poverty level, who has attained the age of  
2 6, but has not attained the age of 19. In determining the  
3 eligibility of such a child, an assets test is not required.

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

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

17 Section 28. Subsections (2) and (13) of section  
18 409.908, Florida Statutes, are amended to read:

19 409.908 Reimbursement of Medicaid providers.--Subject  
20 to specific appropriations, the agency shall reimburse  
21 Medicaid providers, in accordance with state and federal law,  
22 according to methodologies set forth in the rules of the  
23 agency and in policy manuals and handbooks incorporated by  
24 reference therein. These methodologies may include fee  
25 schedules, reimbursement methods based on cost reporting,  
26 negotiated fees, competitive bidding pursuant to s. 287.057,  
27 and other mechanisms the agency considers efficient and  
28 effective for purchasing services or goods on behalf of  
29 recipients. Payment for Medicaid compensable services made on  
30 behalf of Medicaid eligible persons is subject to the  
31 availability of moneys and any limitations or directions

1 provided for in the General Appropriations Act or chapter 216.  
2 Further, nothing in this section shall be construed to prevent  
3 or limit the agency from adjusting fees, reimbursement rates,  
4 lengths of stay, number of visits, or number of services, or  
5 making any other adjustments necessary to comply with the  
6 availability of moneys and any limitations or directions  
7 provided for in the General Appropriations Act, provided the  
8 adjustment is consistent with legislative intent.

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

13           2. Unless otherwise limited or directed in the General  
14 Appropriations Act, reimbursement to hospitals licensed under  
15 part I of chapter 395 for the provision of swing-bed nursing  
16 home services must be made on the basis of the average  
17 statewide nursing home payment, and reimbursement to a  
18 hospital licensed under part I of chapter 395 for the  
19 provision of skilled nursing services must be made on the  
20 basis of the average nursing home payment for those services  
21 in the county in which the hospital is located. When a  
22 hospital is located in a county that does not have any  
23 community nursing homes, reimbursement must be determined by  
24 averaging the nursing home payments, in counties that surround  
25 the county in which the hospital is located. Reimbursement to  
26 hospitals, including Medicaid payment of Medicare copayments,  
27 for skilled nursing services shall be limited to 30 days,  
28 unless a prior authorization has been obtained from the  
29 agency. Medicaid reimbursement may be extended by the agency  
30 beyond 30 days, and approval must be based upon verification  
31 by the patient's physician that the patient requires

1 short-term rehabilitative and recuperative services only, in  
2 which case an extension of no more than 15 days may be  
3 approved. Reimbursement to a hospital licensed under part I of  
4 chapter 395 for the temporary provision of skilled nursing  
5 services to nursing home residents who have been displaced as  
6 the result of a natural disaster or other emergency may not  
7 exceed the average county nursing home payment for those  
8 services in the county in which the hospital is located and is  
9 limited to the period of time which the agency considers  
10 necessary for continued placement of the nursing home  
11 residents in the hospital.

12 (b) Subject to any limitations or directions provided  
13 for in the General Appropriations Act, the agency shall  
14 establish and implement a Florida Title XIX Long-Term Care  
15 Reimbursement Plan (Medicaid) for nursing home care in order  
16 to provide care and services in conformance with the  
17 applicable state and federal laws, rules, regulations, and  
18 quality and safety standards and to ensure that individuals  
19 eligible for medical assistance have reasonable geographic  
20 access to such care. Effective no earlier than the  
21 rate-setting period beginning April 1, 1999, the agency shall  
22 establish a case-mix reimbursement methodology for the rate of  
23 payment for long-term-care services for nursing home  
24 residents. The agency shall compute a per diem rate for  
25 Medicaid residents, adjusted for case mix, which is based on a  
26 resident classification system that accounts for the relative  
27 resource utilization by different types of residents and which  
28 is based on level-of-care data and other appropriate data. The  
29 case-mix methodology developed by the agency shall take into  
30 account the medical, behavioral, and cognitive deficits of  
31 residents. In developing the reimbursement methodology, the

1 agency shall evaluate and modify other aspects of the  
2 reimbursement plan as necessary to improve the overall  
3 effectiveness of the plan with respect to the costs of patient  
4 care, operating costs, and property costs. In the event  
5 adequate data are not available, the agency is authorized to  
6 adjust the patient's care component or the per diem rate to  
7 more adequately cover the cost of services provided in the  
8 patient's care component. The agency shall work with the  
9 Department of Elderly Affairs, the Florida Health Care  
10 Association, and the Florida Association of Homes for the  
11 Aging in developing the methodology. It is the intent of the  
12 Legislature that the reimbursement plan achieve the goal of  
13 providing access to health care for nursing home residents who  
14 require large amounts of care while encouraging diversion  
15 services as an alternative to nursing home care for residents  
16 who can be served within the community.The agency shall base  
17 the establishment of any maximum rate of payment, whether  
18 overall or component, on the available moneys as provided for  
19 in the General Appropriations Act. The agency may base the  
20 maximum rate of payment on the results of scientifically valid  
21 analysis and conclusions derived from objective statistical  
22 data pertinent to the particular maximum rate of payment.

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

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

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

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

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

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

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

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

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

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

26           6. Medicaid shall pay all deductibles and coinsurance  
27 for Medicare emergency transportation services provided by  
28 ambulances licensed pursuant to chapter 401. Premiums,  
29 ~~deductibles, and coinsurance for Medicare services rendered to~~  
30 ~~Medicaid eligible persons shall be reimbursed in accordance~~  
31

1 ~~with fees established by Title XVIII of the Social Security~~  
2 ~~Act.~~

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

8 409.912 Cost-effective purchasing of health care.--The  
9 agency shall purchase goods and services for Medicaid  
10 recipients in the most cost-effective manner consistent with  
11 the delivery of quality medical care. The agency shall  
12 maximize the use of prepaid per capita and prepaid aggregate  
13 fixed-sum basis services when appropriate and other  
14 alternative service delivery and reimbursement methodologies,  
15 including competitive bidding pursuant to s. 287.057, designed  
16 to facilitate the cost-effective purchase of a case-managed  
17 continuum of care. The agency shall also require providers to  
18 minimize the exposure of recipients to the need for acute  
19 inpatient, custodial, and other institutional care and the  
20 inappropriate or unnecessary use of high-cost services.

21 (3) The agency may contract with:

22 (b) An entity that is providing comprehensive  
23 inpatient and outpatient mental health care services to  
24 certain Medicaid recipients in Hillsborough, Highlands,  
25 Hardee, Manatee, and Polk Counties, through a capitated,  
26 prepaid arrangement pursuant to the federal waiver provided  
27 for by s. 409.905(5). Such an entity must become licensed  
28 under chapter 624, chapter 636, or chapter 641 by December 31,  
29 1998, and is exempt from the provisions of part I of chapter  
30 641 until then. However, if the entity assumes risk, the  
31 Department of Insurance shall develop appropriate regulatory

1 requirements by rule under the insurance code before the  
2 entity becomes operational.

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

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

23 (35) The Agency for Health Care Administration is  
24 directed to issue a request for proposal or intent to  
25 negotiate to implement on a demonstration basis an outpatient  
26 specialty services pilot project in a rural and urban county  
27 in the state. As used in this subsection, the term  
28 "outpatient specialty services" means clinical laboratory,  
29 diagnostic imaging, and specified home medical services to  
30 include durable medical equipment, prosthetics and orthotics,  
31 and infusion therapy.

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

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

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

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

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

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

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

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

31



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

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

8           Section 30. Effective January 1, 1999, paragraph (d)  
9 of subsection (3) of section 409.912, Florida Statutes, is  
10 amended to read:

11           409.912 Cost-effective purchasing of health care.--The  
12 agency shall purchase goods and services for Medicaid  
13 recipients in the most cost-effective manner consistent with  
14 the delivery of quality medical care. The agency shall  
15 maximize the use of prepaid per capita and prepaid aggregate  
16 fixed-sum basis services when appropriate and other  
17 alternative service delivery and reimbursement methodologies,  
18 including competitive bidding pursuant to s. 287.057, designed  
19 to facilitate the cost-effective purchase of a case-managed  
20 continuum of care. The agency shall also require providers to  
21 minimize the exposure of recipients to the need for acute  
22 inpatient, custodial, and other institutional care and the  
23 inappropriate or unnecessary use of high-cost services.

24           (3) The agency may contract with:

25           (d) No more than four provider service networks for  
26 demonstration projects to test Medicaid direct contracting.  
27 ~~However, no such demonstration project shall be established~~  
28 ~~with a federally qualified health center nor shall any~~  
29 ~~provider service network under contract with the agency~~  
30 ~~pursuant to this paragraph include a federally qualified~~  
31 ~~health center in its provider network.~~ One demonstration

1 project must be located in Orange County. The demonstration  
2 projects may be reimbursed on a fee-for-service or prepaid  
3 basis. A provider service network which is reimbursed by the  
4 agency on a prepaid basis shall be exempt from parts I and III  
5 of chapter 641, but must meet appropriate financial reserve,  
6 quality assurance, and patient rights requirements as  
7 established by the agency. The agency shall award contracts  
8 on a competitive bid basis and shall select bidders based upon  
9 price and quality of care. Medicaid recipients assigned to a  
10 demonstration project shall be chosen equally from those who  
11 would otherwise have been assigned to prepaid plans and  
12 MediPass. The agency is authorized to seek federal Medicaid  
13 waivers as necessary to implement the provisions of this  
14 section. A demonstration project awarded pursuant to this  
15 paragraph shall be for 2 years from the date of  
16 implementation.

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

20 409.9122 Mandatory Medicaid managed care enrollment;  
21 programs and procedures.--

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

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

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

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

7  
8 The agency shall develop rules to establish policies by which  
9 exceptions to the mandatory managed care enrollment  
10 requirement may be made on a case-by-case basis. The rules  
11 shall include the specific criteria to be applied when making  
12 a determination as to whether to exempt a recipient from  
13 mandatory enrollment in a managed care plan or MediPass.  
14 School districts participating in the certified school match  
15 program pursuant to ss. 236.0812 and 409.908(21) shall be  
16 reimbursed by Medicaid, subject to the limitations of s.  
17 236.0812(1) and (2), for a Medicaid-eligible child  
18 participating in the services as authorized in s. 236.0812, as  
19 provided for in s. 409.9071, regardless of whether the child  
20 is enrolled in MediPass or a managed care plan. Managed care  
21 plans shall make a good faith effort to execute agreements  
22 with school districts ~~and county health departments~~ regarding  
23 the coordinated provision of services authorized under s.  
24 236.0812. County health departments delivering school-based  
25 services pursuant to ss. 381.0056 and 381.0057 shall be  
26 reimbursed by Medicaid for the federal share for a  
27 Medicaid-eligible child who receives Medicaid-covered services  
28 in a school setting, regardless of whether the child is  
29 enrolled in MediPass or a managed care plan. Managed care  
30 plans shall make a good faith effort to execute agreements  
31 with county health departments regarding the coordinated

1 provision of services to a Medicaid-eligible child.To ensure  
2 continuity of care for Medicaid patients, the agency, the  
3 Department of Health,and the Department of Education shall  
4 develop procedures for ensuring that a student's managed care  
5 plan or MediPass provider receives information relating to  
6 services provided in accordance with ss. 236.0812, 381.0056,  
7 381.0057,and 409.9071.

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

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

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

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

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

30 5. Explains the recipient's right to complain, file a  
31 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 (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

1 care plan or MediPass provider as indicated by Medicaid  
2 fee-for-service claims data, but has failed to make a choice.

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

6 (i) After a recipient has made a selection or has been  
7 enrolled in a managed care plan or MediPass, the recipient  
8 shall have 90 ~~60~~ days in which to voluntarily disenroll and  
9 select another managed care plan or MediPass provider. After  
10 90 ~~60~~ days, no further changes may be made except for cause.  
11 Cause shall include, but not be limited to, poor quality of  
12 care, lack of access to necessary specialty services, an  
13 unreasonable delay or denial of service, or fraudulent  
14 enrollment. The agency shall develop criteria for good cause  
15 disenrollment for chronically ill and disabled populations who  
16 are assigned to managed care plans if more appropriate care is  
17 available through the MediPass program. The agency must make  
18 a determination as to whether cause exists. However, the  
19 agency may require a recipient to use the managed care plan's  
20 or MediPass grievance process prior to the agency's  
21 determination of cause, except in cases in which immediate  
22 risk of permanent damage to the recipient's health is alleged.  
23 The grievance process, when utilized, must be completed in  
24 time to permit the recipient to disenroll no later than the  
25 first day of the second month after the month the  
26 disenrollment request was made. If the managed care plan or  
27 MediPass, as a result of the grievance process, approves an  
28 enrollee's request to disenroll, the agency is not required to  
29 make a determination in the case. The agency must make a  
30 determination and take final action on a recipient's request  
31 so that disenrollment occurs no later than the first day of

1 the second month after the month the request was made. If the  
2 agency fails to act within the specified timeframe, the  
3 recipient's request to disenroll is deemed to be approved as  
4 of the date agency action was required. Recipients who  
5 disagree with the agency's finding that cause does not exist  
6 for disenrollment shall be advised of their right to pursue a  
7 Medicaid fair hearing to dispute the agency's finding.

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

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

16 409.910 Responsibility for payments on behalf of  
17 Medicaid-eligible persons when other parties are liable.--

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

24 (f) Notwithstanding any provision in this section to  
25 the contrary, in the event of an action in tort against a  
26 third party in which the recipient or his or her legal  
27 representative is a party which results in a ~~and in which the~~  
28 ~~amount of any~~ judgment, award, or settlement from a third  
29 party, ~~third-party benefits, excluding medical coverage as~~  
30 ~~defined in subparagraph 4., after reasonable costs and~~  
31 ~~expenses of litigation, is an amount equal to or less than 200~~

1 ~~percent of the amount of medical assistance provided by~~  
2 ~~Medicaid less any medical coverage paid or payable to the~~  
3 ~~department, then distribution of the amount recovered shall be~~  
4 distributed as follows:

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

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

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

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

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

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

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

30 ~~4.~~ For purposes of this paragraph, "medical coverage"  
31 means any benefits under health insurance, a health



1 maintenance organization, a preferred provider arrangement, or  
2 a prepaid health clinic, and the portion of benefits  
3 designated for medical payments under coverage for workers'  
4 compensation, personal injury protection, and casualty.

5 (18) A recipient or his or her legal representative or  
6 any person representing, or acting as agent for, a recipient  
7 or the recipient's legal representative, who has notice,  
8 excluding notice charged solely by reason of the recording of  
9 the lien pursuant to paragraph (6)(d), or who has actual  
10 knowledge of the department's rights to third-party benefits  
11 under this section, who receives any third-party benefit or  
12 proceeds therefrom for a covered illness or injury, is  
13 required either to pay the department, within 60 days after  
14 receipt of settlement proceeds, the full amount of the  
15 third-party benefits, but not in excess of the total medical  
16 assistance provided by Medicaid, or to place the full amount  
17 of the third-party benefits in a trust account for the benefit  
18 of the department pending judicial or administrative  
19 determination of the department's right thereto. Proof that  
20 any such person had notice or knowledge that the recipient had  
21 received medical assistance from Medicaid, and that  
22 third-party benefits or proceeds therefrom were in any way  
23 related to a covered illness or injury for which Medicaid had  
24 provided medical assistance, and that any such person  
25 knowingly obtained possession or control of, or used,  
26 third-party benefits or proceeds and failed either to pay the  
27 department the full amount required by this section or to hold  
28 the full amount of third-party benefits or proceeds in trust  
29 pending judicial or administrative determination, unless  
30 adequately explained, gives rise to an inference that such  
31 person knowingly failed to credit the state or its agent for

1 payments received from social security, insurance, or other  
2 sources, pursuant to s. 414.39(4)(b), and acted with the  
3 intent set forth in s. 812.014(1).

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

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

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

- 25 1. Until such time as the department takes final  
26 agency action;
- 27 2. Until such time as the Attorney General refers the  
28 case for criminal prosecution;
- 29 3. Until such time as an indictment or criminal  
30 information is filed by a state attorney in a criminal case;
- 31 or

1 4. At all times if otherwise protected by law.

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

4 414.28 Public assistance payments to constitute debt  
5 of recipient.--

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

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

22 627.912 Professional liability claims and actions;  
23 reports by insurers.--

24 (1) Each self-insurer authorized under s. 627.357 and  
25 each insurer or joint underwriting association providing  
26 professional liability insurance to a practitioner of medicine  
27 licensed under chapter 458, to a practitioner of osteopathic  
28 medicine licensed under chapter 459, to a podiatrist licensed  
29 under chapter 461, to a dentist licensed under chapter 466, to  
30 a hospital licensed under chapter 395, to a crisis  
31 stabilization unit licensed under part IV of chapter 394, to a

1 health maintenance organization certificated under part I of  
2 chapter 641, to clinics included in chapter 390, to an  
3 ambulatory surgical center as defined in s. 395.002, or to a  
4 member of The Florida Bar shall report in duplicate to the  
5 Department of Insurance any claim or action for damages for  
6 personal injuries claimed to have been caused by error,  
7 omission, or negligence in the performance of such insured's  
8 professional services or based on a claimed performance of  
9 professional services without consent, if the claim resulted  
10 in:

11 (a) A final judgment in any amount.

12 (b) A settlement in any amount.

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

15

16 Reports shall be filed with the department and, if the insured  
17 party is licensed under chapter 458, chapter 459, chapter 461,  
18 or chapter 466, with the Agency for Health Care  
19 Administration, no later than 30 days following the occurrence  
20 of any event listed in paragraph (a) or paragraph (b), ~~or~~  
21 ~~paragraph (c)~~. The Agency for Health Care Administration shall  
22 review each report and determine whether any of the incidents  
23 that resulted in the claim potentially involved conduct by the  
24 licensee that is subject to disciplinary action, in which case  
25 the provisions of s. 455.225 shall apply. The Agency for  
26 Health Care Administration, as part of the annual report  
27 required by s. 455.2285, shall publish annual statistics,  
28 without identifying licensees, on the reports it receives,  
29 including final action taken on such reports by the agency or  
30 the appropriate regulatory board.

31

1           (5) Any self-insurance program established under s.  
2 240.213 shall report in duplicate to the Department of  
3 Insurance any claim or action for damages for personal  
4 injuries claimed to have been caused by error, omission, or  
5 negligence in the performance of professional services  
6 provided by the Board of Regents through an employee or agent  
7 of the Board of Regents, including practitioners of medicine  
8 licensed under chapter 458, practitioners of osteopathic  
9 medicine licensed under chapter 459, podiatrists licensed  
10 under chapter 461, and dentists licensed under chapter 466, or  
11 based on a claimed performance of professional services  
12 without consent if the claim resulted in a final judgment in  
13 any amount, or a settlement in any amount. The reports  
14 required by this subsection shall contain the information  
15 required by subsection (3) and the name, address, and  
16 specialty of the employee or agent of the Board of Regents  
17 whose performance or professional services is alleged in the  
18 claim or action to have caused personal injury.

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

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

31

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