

Health and Human Services Bill 28-01190A-11

Section 1: Authorized Dept. of Health Positions

Amends s. 216.262, F.S.

Exempts FTEs in the Dept. of Health that are funded by the County Health Dept. Trust Fund from the requirement that the total number of authorized positions at a state agency may not exceed the total provided in the GAA and allows CHDs the flexibility to establish and delete positions without legislative approval.

Section 2: Down Syndrome

Amends s. 393.063, F.S.

Amends definition of “developmental disability” to specifically include “Down syndrome.” Provides definition of “Down syndrome.”

- Intended effect is to provide services to any person who presents with a diagnosis of Down, i.e., presence of an extra chromosome 21, prior to age 18 without requiring an IQ test.
- Expected to expand Medicaid eligibility, but by what amount is unknown at this time.

Section 3: Home and Community-based Services Delivery System

Amends s. 393.0661, F.S.

Directs the Agency for Persons with Disabilities to impose and collect a fee upon approval from the federal CMS. The fee in question is created later in the bill (Section 25) and is a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL

Section 4: Claim Dispute Resolution Program

Amends s. 408.7057, F.S.

Amends the existing statewide provider and health plan claim dispute resolution program. Establishes that this section creates a procedure for dispute resolution and not an independent right of recovery. The conclusions of law contained in the written recommendation of the resolution organization must identify the provisions of law or contract which, under the peculiar facts and circumstances of the case, entitle the provider or health plan to the amount awarded, if any.

Section 5: Part I of Chapter 409

Requests the Division of Statutory Revision to designate ss. 409.016 through 409.803, F.S., as part I of chapter 409, F.S., entitled “SOCIAL AND ECONOMIC ASSISTANCE.”

Section 6: Definitions in Current Law (technical)

Amends s. 409.016, F.S., to make some minor clarifications to definitions.

Section 7: Medical Care for Foster Kids

Creates s. 409.16713, F.S., relating to medical services for children in out-of-home care and adopted children.

Provides that those children and youth currently eligible for Medicaid remain so. Provides that if the federal government does not provide Florida with funds to support its Medicaid program, then those children and youth are eligible for medical services under the Managed Care Program and that medical coverage is to be procured by the CBC with funds appropriated for that purpose. Provides legislative intent.

Intended to ensure that Florida provides those children and youth with medical services necessary to comply with TANF and IV-E requirements, in order to continue receiving TANF and IV-E foster care and adoptions funding.

Section 8: Part II of Chapter 409

Requests the Division of Statutory Revision to designate ss. 409.810 through 409.821, Florida Statutes, as part II of chapter 409, Florida Statutes, and entitled "KIDCARE."

Section 9: Kidcare

Transfers s. 624.91, F.S., relating to the Fla Healthy Kids Corporation, to s. 409.8115, F.S., and makes technical changes and the following substantive changes:

- Changes the minimum MLR for health plans in the Healthy Kids program from 85 percent to 90 percent.
- Requires the Florida Healthy Kids Corporation, in the development and implementation of a plan for publicizing the Florida Kidcare program, to include the use of application forms for school lunch and breakfast programs (Senator Sobel language).

Section 10: FHKC (technical)

Amends s. 409.813, F.S., to make some technical changes to Kidcare statutes.

Section 11: Kidcare (technical)

Amends s. 409.8132, F.S., to make some technical changes to Kidcare statutes.

Section 12: Kidcare (technical)

Amends s. 409.815, F.S., to make some technical changes to Kidcare statutes.

Section 13: Kidcare (technical)

Amends s. 409.818, F.S., to make a technical change to Kidcare statutes.

Section 14: Kidcare (technical)

Amends s. 154.503, F.S., to make a technical change for Kidcare.

Section 15: Kidcare (technical)

Amends s. 408.915, F.S., to make a technical change for Kidcare.

Section 16: Kidcare and School Lunch/Breakfast Programs

Amends s. 1006.06, F.S.

Requires that school districts must provide application information about Kidcare or an application for Kidcare to students at the beginning of each school year, and modify the school district's application form for school breakfast and lunch programs to incorporate a provision that permits the school district to share data from the application form with the Florida Healthy Kids Corporation state agencies that administer Kidcare, unless the child's parent or guardian opts out of the provision. (Senator Sobel language)

Section 17: Part III of Chapter 409

Requests the Division of Statutory Revision to designate ss 409.901 through 409.9205, Florida Statutes, as part III of chapter 409, Florida Statutes, and entitled "MEDICAID."

Section 18: Medicaid Definitions in Current Law (technical)

Amends s. 409.901, F.S., to make some technical and clarifying changes to Medicaid definitions.

Section 19: Medicaid Eligibility and Loopholes

Amends s. 409.902, F.S., regarding Medicaid eligibility and rules.

- Medicaid eligibility is restricted to U.S. citizens and lawfully admitted non-citizens. Citizenship or immigration status must be verified. State funds may not be used for individuals who do not qualify under these standards unless the services are necessary for treating an emergency medical condition or for pregnant women.
- Includes new language to provide criteria for DCF to use when evaluating personal care contracts. Intended to address concerns about Medicaid estate planning techniques. Provides DCF rulemaking authority.

Section 20: Eligibility and Requirement for Medicaid Premiums

Amends s. 409.9021, F.S., relating to conditions for Medicaid eligibility.

Additional conditions for Medicaid eligibility are created, subject to federal regulation and approval:

- An applicant must consent to forfeit all entitlement to Medicaid goods or services for 10 years if found to have committed Medicaid fraud.
- An applicant must consent to the release of her or his medical records to the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs.
- A recipient may be required to pay a \$10 monthly premium for Medicaid coverage subject to the approval of a federal waiver, except for SSI recipients in institutional care.
- An applicant must consent to participate, in good faith, in a medically-approved smoking cessation program if the applicant smokes, a medically-

directed weight loss program if the applicant is or becomes morbidly obese, and a medically-approved alcohol or substance abuse recovery program if the applicant is or becomes diagnosed as a substance abuser.

The language authorizes the agency to adopt rules providing for premium collection, advance notice of cancellation, and waiting periods for reinstatement of coverage upon cancellation for nonpayment of premiums. The agency is also directed to seek federal waiver authority to implement the provisions designed to assist recipients mitigate lifestyle choices and avoid behaviors associated with high-cost medical services.

Requires that a person eligible for Medicaid and who has access to coverage through an employer-sponsored health plan may not receive Medicaid services reimbursed under Medicaid but may use Medicaid financial assistance to pay the cost of premiums for the employer-sponsored coverage for himself/herself and his/her Medicaid-eligible family members. Also, a Medicaid recipient who has access to other insurance coverage created by state or federal law may opt-out of Medicaid-provided services and use Medicaid financial assistance to pay the cost of premiums for the recipient and his/her Medicaid-eligible family members.

Allows for Medicaid financial assistance to pay premiums in either of the above cases, not to exceed the capitation that would have been paid to a qualified Medicaid health plan for such coverage under the new managed care system created later in the bill.

Section 21: Limitations on Medicaid Expenditures

Creates s. 409.9022, F.S., relating to limitations on Medicaid expenditures.

Prohibits any state agency that administers a Medicaid program or waiver from expending funds during any fiscal year in excess of the amount appropriated in the GAA. If an agency determines that it will spend more than appropriated, it is required to notify the Social Services Estimating Conference and the conference is required to meet to determine if a Medicaid deficit will occur. Upon a determination by the conference that a Medicaid deficit will occur, an agency is required to take action during the fiscal year to remedy the deficit, including submitting a budget amendment to the LBC to reduce Medicaid spending in that fiscal year, or submitting any other type of budget amendment authorized in Chapter 216, F.S.

Section 22: Medicaid (technical)

Amends s. 409.903, F.S., to make some technical and clarifying changes.

Section 23: Medicaid Nonpoverty Medical Subsidy Program

Amends s. 409.904, F.S.

Renames the Medically Needy program as the Medicaid Nonpoverty Medical Subsidy, or MNMS, program, and limits coverage to physician services only. Also makes some technical changes.

Section 24: Mandatory Medicaid Services

Amends s. 409.905, F.S.

- Requires the agency to prior-authorize home health services (by changing “may” to “shall”).
- Requires an assessment of need for private-duty nursing services to specifically include medical necessity for such services instead of other more cost-effective services.
- Makes some technical and clarifying changes.

Section 25: Medicaid Optional Services

Amends s. 409.906, F.S., relating to optional Medicaid services.

- Creates a sliding-scale parental fee to be assessed on all parents of children under age 18 being served by a HCB waiver with an adjusted household income over 100 percent of FPL.
- Prohibits AHCA from paying for psychotropic medications prescribed for a child younger than the age approved by the FDA.
- Makes some technical and clarifying changes.

Section 26: Medicaid Lung Transplants (technical)

Amends s. 409.9062, F.S., relating to lung transplant services, to make some technical and clarifying changes.

Section 27: Medicaid Provider Agreements (conforming)

Amends s. 409.907, F.S., relating to Medicaid provider agreements, to conform to legal liability provisions created in s. 766.1183 later in the bill.

Section 28: Medicaid Provider Reimbursements

Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.

- Requires that Medicaid fee-for-services payments to primary care physicians for primary care services may not be less than 100 percent of the Medicare payment rate for such services, effective January 1, 2013.
- Removes the requirement in existing law that AHCA must purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged. Further requires AHCA to either competitively procure transportation services or secure federal waiver authority necessary to draw down the highest federal match available for transportation services.
- Requires Medicaid qualified plans to provide access to covered Medical services and states that plans are not required to purchase transportation services via the community coordinated transportation system under the umbrella of the Commission for the Transportation Disadvantaged.
- Makes some technical and clarifying changes.

Section 29: Medicaid Copayments

Amends s. 409.9081, F.S., relating to copayments.

Requires that Medicaid recipients must pay copayments at the time of service, subject to federal waiver authority. Creates a \$3 copayment for visiting a specialty physician. Directs AHCA to seek a waiver of the federal requirement that cost sharing amounts for non-emergency services and care furnished in a hospital emergency department be nominal. Upon waiver approval, each Medicaid recipient must pay a \$100 copayment for non-emergency services and care provided in a hospital emergency department (instead of \$15 under current law).

Section 30: Amend Certain Provisions of Current Medicaid Law

Amends s. 409.912, F.S., relating to cost-effective purchasing of health care. Most notably:

- Paragraph (b) of subsection (4) relating to managed behavioral health care is amended to require that 90 percent (as opposed to 80 percent in current law) of the capitation paid to behavioral managed care plans must be spent on behavioral health services and that if a plan spends less, it must return the difference to AHCA.
- Paragraph (b) of subsection (4) is also amended to enroll foster children who reside in Highlands, Hardee, and Polk counties into the statewide behavioral managed care system for such children. Foster kids in those counties are currently excluded, as are foster kids in Escambia, Okaloosa, Santa Rosa, Walton, and Manatee counties. Foster kids in the latter counties would remain excluded.

Section 31: County Contributions (technical)

Amends s. 409.915, F.S., relating to county contributions to Medicaid, to make a technical change.

Section 32: Technical

Transfers and renumbers s. 409.9301, F.S. as section 409.9067 and amends subsections (1) and (2) to make some technical changes.

Section 33: Technical

Amends s. 409.9126, F.S., relating to children with special health care needs, to make a technical change.

Section 34: Part IV of Chapter 409

Requests the Division of Statutory Revision to create part IV of chapter 409, F.S., consisting of sections 409.961 through 409.978, entitled "MEDICAID MANAGED CARE."

Section 35: Statutory Conflicts

Creates s. 409.961, F.S.

Expresses legislative intent that if any conflict exists between ss. 409.961-409.978 and other parts or sections of ch. 409, the provisions of ss. 409.961-409.978 control, and those sections apply only to the Medicaid managed care program.

Section 36: Definitions

Creates s. 409.962, F.S., relating to definitions for pt. IV of ch. 409.

Section 37:

New Managed Care Program; Superwaiver Authority vs. State-only Program

Creates s. 409.963, F.S.

Establishes the new Medicaid managed care program. Directs AHCA to submit waiver and state plan amendment requests by August 1, 2011, as needed to implement the program. At a minimum, the requests must include a waiver to permit home and community-based services to be preferred before nursing home services and a waiver to require dual-eligibles to participate in the program. Also, the waiver is supposed to allow Florida to limit enrollment in managed LTC (in order to combat the “woodwork” effect).

Requires AHCA to initiate procurement processes as soon as practicable and no later than July 1, 2011, in anticipation of federal waiver authority. Requires AHCA to seek waiver approval by December 1, 2011, in order to begin implementation on December 31, 2011. Requires public notice and opportunity for public comment.

Requires AHCA to begin implementing on December 31, 2011. If necessary waivers are not timely received, directs AHCA to notify CMS of the state’s implementation of the program and request the federal agency to continue providing federal funds, as provided under the current Medicaid program, to be used for Florida’s new program.

- If CMS refuses to continue providing federal funds, the managed care program will be implemented to the extent state funds are available.
- If implemented as a state-only-funded program, priority will be given to providing
 - Nursing home services to persons eligible for nursing home care
 - Medical services for persons served by APD
 - Medical services to pregnant women
 - Physician and hospital services to persons who are eligible for Medicaid
 - Healthy Start waiver services
 - Medical services provided to persons in nursing home diversion

- Medical services provided to persons in ICF/DDs
- Medical care for children in the child welfare system, whose medical care shall be provided in accordance with s. 409.16713 as authorized by the GAA.
- If implemented as a state-only-funded program, all provisions related to eligibility standards of the state and federal Medicaid program remain in effect except as specifically provided under the managed care program.
- If implemented as a state-only-funded program, provider agreements and contracts necessary to provide for the preferred services listed above will remain in effect.

Section 38: Mandatory, Excluded and Voluntary Populations; Opt-out
Creates s. 409.964, F.S.

Requires all Medicaid recipients to receive covered services through the Medicaid managed care program unless excluded. Exclusions include:

- a. Women eligible only for family planning services
- b. Women eligible only for breast and cervical cancer services
- c. Persons with a developmental disability
- d. Persons eligible for the Medicaid Nonpoverty Medical Subsidy program
- e. Persons receiving emergency Medicaid services for aliens
- f. Persons residing in a nursing home facility or are considered a resident under the nursing home's bed-hold policy on or before July 1, 2011.
- g. Persons who are eligible for and receiving prescribed pediatric extended care.
- h. Persons eligible for Medicaid who have access to employer-sponsored health coverage. Medicaid financial assistance is available to pay premiums for such coverage for the eligible and his/her eligible family members. The amount of financial assistance may not exceed the capitations that would be paid to a qualified plan for the recipient and his/her eligible family members. A person is deemed to have access to employer-sponsored coverage only if the financial assistance available is sufficient to pay premiums. Also allows persons with access to other coverage created by state or federal law to opt-out of Medicaid coverage under the same premium-assistance conditions as for employer-sponsored coverage.

Provides for voluntary enrollment for those who are exempt from mandatory enrollment, including:

- a. Recipients residing in residential commitment facilities operated through DJJ, group care facilities operated by DCF, and treatment facilities funded through the Substance Abuse and Mental Health program of DCF

b. Persons eligible for refugee assistance

Provides that Medicaid recipients who are exempt from mandatory participation under this section and who do not choose to enroll in the Medicaid managed care program shall be served through Medicaid fee-for-service.

Section 39: Regions and Procurement

Creates s. 409.965, F.S.

- Establishes 19 regions in which qualified plans will provide Medicaid services.
- Provides that AHCA will conduct a competitive bid process and that separate ITNs will be issued for the managed medical assistance program and the managed long-term care program. Establishes selection criteria and process.
- Establishes the CMS network as a qualified plan under statewide contract that is not subject to the procurement requirements.
- Prohibits AHCA from selecting more than one plan per 20,000 Medicaid recipients residing in each region who are subject to mandatory enrollment, with a maximum of 10 plans per region.
- Requires AHCA to publish a databook containing information plans will need to formulate an ITN response.
- Provides for negotiation with qualified plans based on the adequacy of GAA funding.

Section 40: Contract Standards

Creates s. 409.966, F.S.

Establishes standards for managed care contracts, including 5-year durations, non-renewal of contracts, a primary care physician for each member, prompt pay, required rate of pay for non-contracted providers of emergency services, plan network adequacy, encounter data reporting, quality and performance standards, fraud prevention, grievance resolution, penalties, performance bonds, solvency standards, guaranteed savings, and penalties.

Section 41: Medical Loss Ratios and Plan Accountability

Creates s. 409.967, F.S.

- Establishes minimum medical loss ratios for plans similar to the MLR standards of the Healthy Kids program. Requires AHCA to adopt rules for calculating and reporting MLRs. Applies the minimum MLR requirement only to the medical assistance component, not the LTC component.
- Establishes requirements for plans to include providers in their networks. During first year after the initial procurement in a region, plans must offer contracts to FQHCs and (for LTC plans) nursing homes and certain aging network service providers in the region.

- Requires plans and providers to negotiate in good faith. Establishes a procedure for dealing with provider contracting impasses in areas containing no capitated plans prior to July 1, 2011. Requires AHCA to examine the negotiation process to determine good faith, under certain parameters, and based on the findings, a provider may be deemed part of a plan's network for the purpose of network adequacy and the plan must pay the provider rates determined by AHCA to be the average of rates for corresponding services paid in the region and similar counties under similar circumstances.
- Allows AHCA to continue calculating fee-for-service rates for Medicaid hospital inpatient and outpatient services, but specifies that these rates may not be the basis for contract negotiations between plans and hospitals.
- Requires plans to monitor the quality and performance of network providers based on metrics established by AHCA.
- Requires qualified plans to compensate primary care physicians with payments equivalent to or greater than the Medicare rate for primary care services no later than January 1, 2013.
- Requires non-LTC plans to establish specific programs and procedures to improve pregnancy outcomes and infant health.
- Requires non-LTC plans to achieve an 80% EPSDT rate for recipients continuously enrolled for at least 8 months.
- Requires that unresolved disputes between a qualified plan and a provider shall proceed in accordance with s. 408.7057, which is the existing statewide provider and health plan claim dispute resolution program.

Section 42: Plan Payment and IGTs

Creates s. 409.968, F.S.

Provides that plans will be paid per-member, per-month payments based on an assessment of each member's acuity level and that payment for LTC plans will be combined with rates for medical assistance plans. Requires AHCA to develop a methodology that ensures the availability of IGTs.

Section 43: Enrollment, Disenrollment, and Grievances

Creates s. 409.969, F.S.

Provides that recipients may choose from plans available in their region of residence. Recipients who have not chosen within 30 days of becoming eligible will be automatically assigned to a plan. Provides guidelines for auto-assignment based on certain criteria, including family continuity, adherence to quality standards, network capacity, prior enrollment, and geographic accessibility of providers. Requires enrollment for 12-month period, except for a 90-day window at the outset of enrollment and "good cause" as determined by AHCA.

Section 44: Encounter Data

Creates s. 409.970, F.S.

Requires AHCA to maintain and operate the Medicaid Encounter Data System. Provides guidelines for data reporting, validation, and analysis. Requires qualified plans to submit encounter data according to deadlines established by AHCA.

Section 45: Managed Care Medical Assistance

Creates s. 409.971, F.S.

Requires AHCA to begin implementing the new managed care medical assistance component as of December 31, 2011 and finish implementing the component in all regions no later than December 31, 2012. Applies ss. 409.961-409.970 to the medical assistance component.

Section 46: Medical Assistance Services

Creates s. 409.972, F.S.

Establishes minimum services that plans must provide in the medical assistance component. Allows for additional services as specified in the GAA. Allows plans to customize benefit packages for nonpregnant adults, vary cost-sharing provisions, and provide coverage for additional services, subject to standards of sufficiency and actuarial equivalence. Requires services provided to be medically necessary. Authorizes the agency to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA or s. 409.9022, F.S.

Section 47: Managed Long-term Care

Creates s. 409.973, F.S.

Establishes the managed long-term care program. Requires the agency to begin implementing the managed long-term care program by March 31, 2012, with full implementation in all regions by March 31, 2013. Applies the provisions of ss. 409.961-409.970 to the managed long-term care program. Requires AHCA to make payments for long-term care, including home and community-based services, using a capitated managed care model. Requires DOEA to assist the agency develop specifications for ITNs and the model contract, determine clinical eligibility for enrollment in managed long-term care plans, monitor plan performance and measure quality of service delivery, assist clients and families to address complaints with the plans, facilitate working relationships between plans and providers serving elders and disabled adults, and perform other functions specified in a memorandum of agreement.

Section 48: LTC Eligibility

Creates s. 409.974, F.S.

Requires Medicaid recipients to receive covered long-term care services through the managed long-term care program unless excluded pursuant to s. 409.964.

Recipients who meet all of the following criteria may participate in the managed long-term care program. Recipients must be:

- Sixty-five years of age or older or eligible for Medicaid by reason of a disability
- Determined by the CARES Program to meet the requirements for nursing facility care

Allows recipients already residing in a nursing home or enrolled in certain LTC waiver programs to remain eligible for those programs. Specifies that this part does not create an entitlement for any home and community based services provided under the program.

Section 49: LTC Services

Creates s. 409.975, F.S.

Establishes minimum benefits that managed LTC plans must provide, including all services provided by medical assistance plans, plus nursing facility services and home and community-based services, including but not limited to ALF services. Requires services provided to be medically necessary. Authorizes the agency to adjust fees, reimbursement rates, length of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the GAA, ch. 216, or s. 409.9022, F.S

Section 50: LTC Qualified Plans

Creates s. 409.976, F.S.

Adds the following plans to the list of qualified plans for LTC coverage: Medicare Advantage PPOs, Medicare Advantage PSOs, and Medicare Advantage special needs plans. Specifies that the PACE program is a qualified plan and is not subject to procurement requirements. Requires AHCA to issue an ITN by November 14, 2011. Establishes selection criteria and process.

Section 51: LTC Provider Networks

Creates s. 409.977, F.S.

Establishes requirements for LTC plans for including providers in their networks, in addition to the requirements for non-LTC plans.

Section 52: LTC Level of Care

Creates s. 409.978, F.S.

Provides for an assessment of an enrollee's level of care by the CARES program.

Section 53: Medical Home Pilot (technical)

Transfers and renumbers s. 409.91207, F.S., relating to medical home pilot program, as s. 409.985.

Section 54: Medicaid Reform Pilot (technical)

Transfers and renumbers s. 409.91211, F.S., relating to the existing Medicaid Reform pilot program, as s. 409.986, F.S.

Section 55: Technical

Transfers and renumbers s. 409.9122, F.S., relating to managed care mandatory enrollment, to s. 409.987. Performs clean-up duty on the language within the statute.

Section 56: Technical

Transfers and renumbers s. 409.9123, F.S., relating to quality of care reporting, to s. 409.988.

Section 57: Technical

Transfers and renumbers s. 409.9124, F.S., relating to manage care reimbursement, to s. 409.989.

Section 58: LTC Waiver Transition

Amends s. 430.04, F.S.

Requires DOEA to transition persons from existing waivers to qualified managed care plans as they become available.

Section 59: Aging Resource Centers

Amends s. 430.2053, F.S.

Deletes obsolete language. Provides additional duties of Aging Resource Centers (ARCs):

- Assist clients who request long-term care services in being evaluated for eligibility for enrollment in the Medicaid long-term care managed care program as qualified plans become available.
- Provide enrollment and coverage information for the Medicaid long-term care managed care program as qualified plans become available.
- Assist Medicaid recipients enrolled in the Medicaid long-term care managed care program with informally resolving grievances with a managed care network and in accessing the managed care network's formal grievance process as qualified plans become available.

Section 60: Psychotropic Drugs for Children in Foster Care

Amends s. 39.407, F.S.

- Provides that for any child under the age of 11 in an out-of-home placement, any administration of a psychotropic medication must be reviewed by a child psychiatrist;
- Specifies criteria to be included in the review and requires that the results of the review be provided to the child and a parent or legal guardian before consent is given; and

- Provides that absent a compelling governmental interest, psychotropic medication may not be court-authorized for any child under the age of 11 in an out-of-home placement.

Sections 61 and 62: Nursing Home Civil Liability

Amend ss. 400.023 and 400.0237, F.S., respectively.

Revises the requirements for suing an officer or director of a nursing home or its management company for alleged negligence or a violation of rights enumerated in regulatory provisions applicable to nursing homes. The requirements for suing an officer, director, or owner of a nursing home for negligence or a violation of rights are modified to require an evidentiary hearing. The claimant must provide sufficient evidence for a court to determine that a reasonable basis exists for a finding that the nursing home's officer or other principal has breached, failed to perform, or acted outside the scope of the principal's duties. Such breach or failure must be the legal cause of actual loss, injury, death, or damage to the nursing home resident.

In wrongful death actions brought against a nursing home, the noneconomic damages may not exceed \$250,000, regardless of the number of claimants.

A hearing is required for the evaluation of evidence proffered by all parties for a judge's consideration of a punitive damages claim against a nursing home. In the hearing, the plaintiff must demonstrate that a reasonable basis exists for the recovery of punitive damages prior to any discovery of the nursing home's financial worth. The circumstances for which a nursing home is liable for punitive damages are modified to require the trier of fact as a prerequisite to find that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or conduct amounting to gross negligence that contributed to the loss, damages, or injury suffered by the claimant.

The requirements for the recovery of punitive damages from a nursing home are revised. The defendant may proffer admissible evidence to refute the claimant's proffer of evidence to recover punitive damages. The trial judge must conduct an evidentiary hearing and weigh the admissible evidence proffered by the parties to ensure that a reasonable basis exists for the punitive damages claim by clear and convincing evidence.

In a situation where a nursing home employer is vicariously liable for the conduct of employees, officers, directors, managers or others, additional requirements are imposed on punitive damage claims. A defendant may be liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence. Punitive damages may not be imposed on the employer for the conduct of an identified employee unless the principal condoned, ratified, or consented to the alleged conduct.

Section 63: Limits of Liability Foster Care Outsourcing

Amends s. 409.1671, F.S., relating to limits of liability for child welfare lead CBC providers and subcontractors.

- Deletes legislative findings that minimum levels of insurance were to be in excess of the rights of recovery under s. 768.28 (sovereign immunity amounts).
- Reduces amounts of general liability coverage required by CBC contractors and their subcontractors to \$200,00 per claim or \$300,000 per incident from \$1 million per claim/\$3 million per incident
- In tort actions against CBC contractors and their subcontractors:
 - Reduces existing limitations on net economic damages to \$200,000 per liability claim, \$300,000 per liability incident from \$1 million per liability claim
 - Limits total economic damages recoverable by all claimants to \$500,000 in the aggregate
 - Limits noneconomic damages to \$300,000 per incident
 - Limits total economic damages recoverable by all claimants to \$500,000 in the aggregate
- Removes requirement that the limitations on damages increase 5 percent annually
- Requires that DCF use diligent efforts to ensure delivery of contracted services
 - DCF is not liable in tort for acts or omissions of CBC providers or their subcontractors
 - DCF may not require CBC providers or their subcontractors to indemnify the department or to add the department as an additional named insured on their insurance policies.

Section 64: Medical Physician Expert Witness Certificate

Creates s. 458.3167, F.S.

Specifies requirements for a medical physician licensed in another state or Canada to obtain a certificate from the Board of Medicine to provide expert medical opinions in Florida in a medical malpractice action. The board is granted rulemaking authority to implement the requirements to issue the certificate.

Section 65: Expert Witness Disciplinary Action for Medical Physicians

Amends s. 458.331, F.S.

Establishes grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of medicine.

Section 66: Osteopath Expert Witness Certificate

Creates s. 459.0078, F.S.

Specifies requirements for an osteopath licensed in another state or Canada to obtain a certificate from the Board of Osteopathic Medicine to provide expert medical opinions in Florida in a medical malpractice action. The board is granted rulemaking authority to implement the requirements to issue the certificate.

Section 67: Expert Witness Disciplinary Action for Osteopaths

Amends s. 459.015, F.S.

Establishes grounds for physician disciplinary action for the act of providing misleading, deceptive, or fraudulent expert witness testimony relating to the practice of osteopathic medicine.

Section 68: Medical Negligence, Standards of Recovery, Expert Witness

Amends s. 766.102, F.S.

If a medical or osteopathic physician is a party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must otherwise meet the requirements of this section and be licensed as a medical or osteopathic physician, or must possess a valid expert witness certificate.

Section 69: Pleading in Medical Negligence Cases

Amends s. 766.104, F.S.

Provides that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure medical negligence damages, the presuit investigation and certification required by attorneys must demonstrate grounds for a good-faith belief that the requirement is met.

Section 70: Notice Before Filing Action for Medical Negligence

Amends s. 766.106, F.S.

Specifies that immunity from civil liability arising from participation in the presuit screening process does not prohibit expert witnesses from being subject to disciplinary action by the Board of Medicine or the Board of Osteopathic Medicine.

Section 71: Health Care Providers and Agency Relationship (conforming)

Amends s. 766.1115, F.S.

Conforms this section to sovereign immunity provisions for the state not-for-profit college or university owning or operating a medical school that appear in section 75 of the bill.

Section 72: Standard of Care for Medicaid Providers

Creates s. 766.1183, F.S., relating to standard of care for Medicaid providers.

- Modified Recovery of Civil Damages - Specifies that the liability of health care providers who provide covered medical services to Medicaid recipients is limited

to \$200,000 per claimant or \$300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, medical services to a Medicaid recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of \$200,000/\$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature.

- However, a provider may still be liable for amounts in excess of \$200,000 or \$300,000 if a claimant proves that the provider acted in a wrongful manner.
- Only the existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render medical services to a Medicaid recipient.
- Standard of care for imposing liability on provider greater than \$200,000 (\$300,000) is modified – Medical malpractice claimant who is a Medicaid recipient must prove that the provider acted in a wrongful manner. “Wrongful manner” is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of humans rights, safety, or property. The modified standard of care conforms to the standard of care used when the waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.
- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of \$200,000 per claimant (\$300,000 per occurrence). Plaintiffs can still recover damages from the provider up to \$200,000 (\$300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions.
- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are Medicaid recipients.

Section 73: Standard of Care for LIP Recipients / Primary Care Services

Creates s. 766.1184, F.S.

- “Low income pool recipient” is defined as a low income individual who is uninsured or underinsured and who receives primary care services from a provider which are delivered exclusively using funding received by that provider under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured.
- “Provider” is defined as a health care provider under the Medical Malpractice Act which received funding under proviso language (appropriation 191 in 2010-2011 fiscal year General Appropriations Act) to establish new or expand existing primary care clinics for low income persons who are uninsured or underinsured. The term includes persons or entities for whom the provider is vicariously liable;

and persons or entities whose liability is based solely on such persons or entities being vicariously liable for the actions of the provider.

- Modified Recovery of Civil Damages – Specifies that the liability of health care providers who provide covered medical services to low income recipients is limited to \$200,000 per claimant or \$300,000 per occurrence for any cause of action arising out of the rendering of, or the failure to render, primary care services to a low income pool recipient, unless the claimant proves that the provider acted in a wrongful manner. A claimant may still obtain a judgment in excess of \$200,000/\$300,000. The claimant may report the judgment to and seek the excess amount from the Legislature.
- However, a provider may still be liable for amounts in excess of \$200,000 or \$300,000 if a claimant proves that the provider acted in a wrongful manner.
- The existing limitations on damages in a medical malpractice action (limitation on damages passed during the 2003 Tort Reform) would apply if the claimant proved that the health care provider acted in a wrongful manner when rendering or failing to render primary care services to a low income recipient. .
- For the limitations on civil damages to apply, the provider must develop, implement, and maintain policies and procedures to: ensure that the appropriated funds (Specific appropriation 191) are used exclusively to serve low income persons who are uninsured or underinsured; determine whether funds (Specific appropriation 191) are being used to provide primary care services to a particular person; and identify whether an individual receiving primary care services is a low income recipient to whom the limitations apply. The provider also must provide notice of the statutory provisions prior to providing services to the recipient. Additionally, the provider must be in compliance with the agreement between the provider and the Agency for Health Care Administration governing the receipt of the funds.
- Standard of care for imposing liability on provider greater than \$200,000 (\$300,000) is modified – Medical malpractice claimant who is a low income pool recipient must prove that the provider acted in a wrongful manner. “Wrongful manner” is defined to mean an act or omission that was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of humans rights, safety, or property. The modified standard of care conforms to the standard of care used when the waiver of sovereign immunity is not extended to state officers, employees, or agents under s. 768.28(9)(a), F.S.
- Burden of Proof – Shifts from greater weight of the evidence to a more demanding standard of clear and convincing evidence for the claimant to prove that the provider acted in a wrongful manner in order to impose liability in excess of \$200,000 per claimant (\$300,000 per occurrence). Plaintiffs can still recover from the provider damages up to \$200,000 (\$300,000) if they can prove their case at the existing burden of proof (greater weight of evidence) which applies to all medical malpractice actions.

- Existing damage caps from 2003 Tort Reform will continue to apply to medical malpractice plaintiffs who are low income pool recipients.

Section 74: Presuit Investigation for Medical Negligence Claims

Amends s. 766.203, F.S.

Provides that if the cause of action for medical malpractice requires the plaintiff to establish the breach of a standard of care other than negligence in order to impose liability or to secure medical negligence damages, then the presuit investigation and certification required for the claimant and the defendant must ascertain that reasonable grounds exist to believe that the requirement is met.

Section 75: Sovereign Immunity for State Not-for-Profit College or University Owning/Operating Medical School

Amends s. 768.28, F.S.

Extends the waiver of sovereign immunity to a state not-for-profit college or university that owns or operates an accredited medical school and its employees and agents when the employees or agents of the medical school are providing patient services at a teaching hospital that has an affiliation agreement with the medical school. The medical school and its employees when providing patient services to patients at the public teaching hospital would be considered an agent of the public teaching hospital for purposes of sovereign immunity.

Requires patients to be provided notice that employees of the medical school are considered agents of the public teaching hospital for purposes of the waiver of sovereign immunity. Additionally patients are provided notice that the exclusive remedy for any injury or damages suffered based on the acts of the employees of the medical school when providing patient services at the public teaching hospital is under the sovereign immunity provisions.

Section 76: Sovereign Immunity for Private Medical School Employees

Non-statutory provision of law.

Establishes a legislature declaration that there is an overpowering public necessity for extending the state's sovereign immunity to a college or university that owns and operates a medical school and the employees and agents of such private colleges or universities when providing medical services in public teaching hospitals and that there is no alternative method of meeting such public necessity.

Section 77: Sovereign Immunity for Shands

Amends s. 1004.41, F.S.

Extends the waiver of sovereign immunity to Shands Teaching Hospital and its subsidiaries. The bill provides that Shands Teaching Hospital and Clinics, Inc.; Shands Jacksonville Medical Center, Inc.; Shands Jacksonville Healthcare, Inc.; and any not-for-profit subsidiary of such entities are instrumentalities of the state for purposes of sovereign immunity. The University of Florida Board of Trustees

has the right to control Shands Teaching Hospital and Clinics, Inc. Shands Teaching Hospital and Clinics, Inc., and any not-for-profit subsidiaries are conclusively deemed corporations primarily acting as instrumentalities of the State of Florida.

Section 78: Repeal of Obsolete or Redundant Statutes (technical)

Effective October 1, 2013, repeals the following sections of Florida Statutes:

- 409.9121
- 409.919
- 624.915

Section 79: Technical

Transfers and renumbers section 409.942, F.S., relating to the electronic benefit transfer program, to s. 414.29, F.S.

Section 80: Technical

Amends s. 443.111, F.S., to make a technical statutory reference change.

Sections 81 and 82: Technical

Perform clean-up duty by transferring and renumbering several sections of Florida Statutes.

Section 83: AHCA Reorganization

Non-statutory provision of law.

Requires AHCA to submit a reorganizational plan to the Governor, the Speaker of the House of Representative, and the President of the Senate by January 1, 2012, which converts the agency from a check-writing and fraud-chasing agency into a contract compliance and monitoring agency.

Section 84: Medicaid Withdrawal

Non-statutory provision of law.

Effective December 1, 2011, if the Legislature has not received a letter from the Governor stating that the federal CMS has approved the waivers necessary to implement the Medicaid managed care reforms contained in this act, the State of Florida shall withdraw from the Medicaid program effective December 31, 2011.

Section 85: Severability

Non-statutory provision of law.

If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 86: Effective Date

This act shall take effect upon becoming a law.