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CHAMBER ACTION

Senate	House
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The Conference Committee on CS for SB 1116, 1st Eng. recommended the following amendment:

Conference Committee Amendment (with title amendment)

Delete everything after the enacting clause

and insert:

Section 1. Subsections (6), (7), and (12) of section 381.0302, Florida Statutes, are amended to read:

381.0302 Florida Health Services Corps.--

(6) The department may provide loan repayment assistance and travel and relocation reimbursement to dentists, allopathic and osteopathic medical residents with primary care specialties during their last 2 years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of 2 years in the Florida Health Services Corps. During the period of service, the maximum amount of annual financial payments shall not be greater than the annual total of loan repayment assistance and tax subsidies authorized by

the National Health Services Corps loan repayment program.

(7) The financial penalty for noncompliance with participation requirements for persons who have received financial payments under subsection (5) or subsection (6) shall be determined in the same manner as in the National Health Services Corps scholarship program. In addition, noncompliance with participation requirements shall also result in ineligibility for professional licensure or renewal of licensure under chapter 458, chapter 459, chapter 460, part I of chapter 464, chapter 465, or chapter 466. For a participant who is unable to participate for reasons of disability, the penalty is the actual amount of financial assistance provided to the participant. Financial penalties shall be deposited in the Administrative ~~Florida Health Services Corps~~ Trust Fund and shall be used to provide additional scholarship and financial assistance.

(12) ~~Funds appropriated under this section shall be deposited in the Florida Health Services Corps Trust Fund, which shall be administered by the department.~~ The department may use funds appropriated for the Florida Health Services Corps as matching funds for federal service-obligation scholarship programs for health care practitioners, such as the Demonstration Grants to States for Community Scholarship Grants program. If funds appropriated under this section are used as matching funds, federal criteria shall be followed whenever there is a conflict between provisions in this section and federal requirements.

Section 2. Paragraph (a) of subsection (4) of section 394.9082, Florida Statutes, is amended to read:

394.9082 Behavioral health service delivery strategies.--

(4) CONTRACT FOR SERVICES.--

(a) The Department of Children and Family Services and the Agency for Health Care Administration may contract for the provision or management of behavioral health services with a managing entity in at least two geographic areas. Both the Department of Children and Family Services and the Agency for Health Care Administration must contract with the same managing entity in any distinct geographic area where the strategy operates. This managing entity shall be accountable at a minimum for the delivery of behavioral health services specified and funded by the department and the agency. The geographic area must be of sufficient size in population and have enough public funds for behavioral health services to allow for flexibility and maximum efficiency. ~~Notwithstanding the provisions of s. 409.912(4)(b)1.,~~ At least one service delivery strategy must be in one of the service districts in the catchment area of G. Pierce Wood Memorial Hospital.

Section 3. Paragraph (c) of subsection (5) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.--The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths 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 General Appropriations Act or chapter 216.

(5) HOSPITAL INPATIENT SERVICES.--The agency shall pay for all covered services provided for the medical care and treatment of a recipient who is admitted as an inpatient by a licensed physician or dentist to a hospital licensed under part I of chapter 395. However, the agency shall limit the payment for inpatient hospital services for a Medicaid recipient 21 years of age or older to 45 days or the number of days necessary to comply with the General Appropriations Act.

(c) The Agency for Health Care Administration shall adjust a hospital's current inpatient per diem rate to reflect the cost of serving the Medicaid population at that institution if:

1. The hospital experiences an increase in Medicaid caseload by more than 25 percent in any year, primarily resulting from the closure of a hospital in the same service area occurring after July 1, 1995, and~~;~~

~~2.~~ the hospital's Medicaid per diem rate is at least 25 percent below the Medicaid per patient cost for that year; or

2.~~3.~~ The hospital is located in a county that has five or fewer hospitals, began offering obstetrical services on or after September 1999, and has submitted a request in writing to the agency for a rate adjustment after July 1, 2000, but before September 30, 2000, in which case such hospital's Medicaid inpatient per diem rate shall be adjusted to cost, effective July 1, 2002.

No later than October 1 of each year, the agency must provide

estimated costs for any adjustment in a hospital inpatient per diem pursuant to this paragraph to the Executive Office of the Governor, the House of Representatives General Appropriations Committee, and the Senate Appropriations Committee. Before the agency implements a change in a hospital's inpatient per diem rate pursuant to this paragraph, the Legislature must have specifically appropriated sufficient funds in the General Appropriations Act to support the increase in cost as estimated by the agency.

Section 4. Subsection (22) of section 409.906, Florida Statutes, is amended, and subsection (26) is added to that section, to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may

direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(22) PSYCHIATRIC ~~STATE~~ HOSPITAL SERVICES.--The agency may pay for all-inclusive psychiatric inpatient hospital care provided to a recipient age 65 or older in a state treatment facility or in a qualified private free-standing specialty ~~mental~~ hospital.

(26) ANESTHESIOLOGIST ASSISTANT SERVICES.--The agency may pay for all services provided to a recipient by an anesthesiologist assistant licensed under s. 458.3475 or s. 459.023. Reimbursement for such services must be not less than 80 percent of the reimbursement that would be paid to a physician who provided the same services.

Section 5. Section 409.9061, Florida Statutes, is repealed.

Section 6. Paragraph (b) of subsection (2) and subsection (13) of section 409.908, Florida Statutes, are amended to read:

409.908 Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost

reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(2)

(b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

~~1. Changes of ownership or of licensed operator may or may not qualify for increases in reimbursement rates associated with the change of ownership or of licensed~~

~~operator. The agency may amend the Title XIX Long Term Care Reimbursement Plan to provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous owner's reimbursement rate.~~

1.~~2.~~ The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate cost-based ceilings shall be calculated for each patient care subcomponent. The direct care subcomponent of the per diem rate shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target.

2.~~3.~~ The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility. This excludes nursing administration, minimum data set, and care plan coordinators, staff development, and staffing coordinator.

3.~~4.~~ All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate. There shall be no costs directly or indirectly allocated to the direct care subcomponent from a home office

or management company.

4.~~5.~~ On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5.~~6.~~ In order to offset the cost of general and professional liability insurance, the agency shall amend the plan to allow for interim rate adjustments to reflect increases in the cost of general or professional liability insurance for nursing homes. This provision shall be implemented to the extent existing appropriations are available.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment.

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

follows:

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

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

(b)~~(c)~~ Medicaid will pay no portion of Medicare deductibles and coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payor. The combined payment of Medicare and Medicaid shall not exceed the amount Medicaid would have paid had it been the sole payor. The Legislature finds that there has been confusion regarding the reimbursement for services rendered to dually eligible Medicare beneficiaries. Accordingly, the Legislature clarifies that it has always been the intent of the Legislature before and after 1991 that, in reimbursing in accordance with fees established by Title XVIII for premiums, deductibles, and coinsurance for Medicare services rendered by physicians to Medicaid eligible persons, physicians be reimbursed at the lesser of the amount billed by the physician or the Medicaid maximum allowable fee established by the Agency for Health Care Administration, as is permitted by federal law. It has never been the intent of the Legislature with regard to such services rendered by physicians that Medicaid be required to provide any payment for deductibles, coinsurance, or copayments for Medicare cost sharing, or any expenses incurred relating thereto, in excess of the payment amount provided for under the State Medicaid plan for such service. This payment methodology is applicable even in those situations in which

the payment for Medicare cost sharing for a qualified Medicare beneficiary with respect to an item or service is reduced or eliminated. This expression of the Legislature is in clarification of existing law and shall apply to payment for, and with respect to provider agreements with respect to, items or services furnished on or after the effective date of this act. This paragraph applies to payment by Medicaid for items and services furnished before the effective date of this act if such payment is the subject of a lawsuit that is based on the provisions of this section, and that is pending as of, or is initiated after, the effective date of this act.

(c)~~(d)~~ Notwithstanding paragraphs(a)-(b) ~~(a)-(c)~~:

1. Medicaid payments for Nursing Home Medicare part A coinsurance shall be limited to ~~the lesser of the Medicare coinsurance amount or~~ the Medicaid nursing home per diem rate less any amount paid by Medicare, but only up to the Medicare coinsurance. The Medicaid per diem rate shall be the rate in effect for the dates of service of the crossover claims and may not be subsequently adjusted due to subsequent per diem rate adjustments.

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

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

4. Medicaid shall pay all deductibles and coinsurance for Medicare emergency transportation services provided by ambulances licensed pursuant to chapter 401.

Section 7. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.--Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2001, 2002, and 2003 ~~2000, 2001, and 2002~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2007-2008 ~~2006-2007~~ state fiscal year.

Section 8. Section 409.9112, Florida Statutes, is amended to read:

409.9112 Disproportionate share program for regional perinatal intensive care centers.--In addition to the payments made under s. 409.911, the Agency for Health Care Administration shall design and implement a system of making disproportionate share payments to those hospitals that participate in the regional perinatal intensive care center program established pursuant to chapter 383. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an

appropriation is made by making quarterly Medicaid payments. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2007-2008 ~~2005-2006~~, the agency shall not distribute moneys under the regional perinatal intensive care centers disproportionate share program.

(1) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the regional perinatal intensive care center program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a regional perinatal intensive care center.

HDSP = the prior state fiscal year regional perinatal intensive care center disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total regional perinatal intensive care center disproportionate share payments to all hospitals.

(2) The total additional payment for hospitals that participate in the regional perinatal intensive care center program shall be calculated by the agency as follows:

TAP = TAE x TA

Where:

TAP = total additional payment for a regional perinatal intensive care center.

TAE = total amount earned by a regional perinatal intensive care center.

TA = total appropriation for the regional perinatal intensive care center disproportionate share program.

(3) In order to receive payments under this section, a hospital must be participating in the regional perinatal intensive care center program pursuant to chapter 383 and must meet the following additional requirements:

(a) Agree to conform to all departmental and agency requirements to ensure high quality in the provision of services, including criteria adopted by departmental and agency rule concerning staffing ratios, medical records, standards of care, equipment, space, and such other standards and criteria as the department and agency deem appropriate as specified by rule.

(b) Agree to provide information to the department and agency, in a form and manner to be prescribed by rule of the department and agency, concerning the care provided to all patients in neonatal intensive care centers and high-risk maternity care.

(c) Agree to accept all patients for neonatal intensive care and high-risk maternity care, regardless of ability to pay, on a functional space-available basis.

(d) Agree to develop arrangements with other maternity and neonatal care providers in the hospital's region for the appropriate receipt and transfer of patients in need of specialized maternity and neonatal intensive care services.

(e) Agree to establish and provide a developmental evaluation and services program for certain high-risk neonates, as prescribed and defined by rule of the department.

(f) Agree to sponsor a program of continuing education in perinatal care for health care professionals within the region of the hospital, as specified by rule.

(g) Agree to provide backup and referral services to the department's county health departments and other low-income perinatal providers within the hospital's region, including the development of written agreements between these organizations and the hospital.

(h) Agree to arrange for transportation for high-risk obstetrical patients and neonates in need of transfer from the community to the hospital or from the hospital to another more appropriate facility.

(4) Hospitals which fail to comply with any of the conditions in subsection (3) or the applicable rules of the department and agency shall not receive any payments under this section until full compliance is achieved. A hospital which is not in compliance in two or more consecutive quarters shall not receive its share of the funds. Any forfeited funds shall be distributed by the remaining participating regional perinatal intensive care center program hospitals.

Section 9. Section 409.9113, Florida Statutes, is amended to read:

409.9113 Disproportionate share program for teaching hospitals.--In addition to the payments made under ss. 409.911 and 409.9112, the Agency for Health Care Administration shall make disproportionate share payments to statutorily defined teaching hospitals for their increased costs associated with medical education programs and for tertiary health care

services provided to the indigent. This system of payments shall conform with federal requirements and shall distribute funds in each fiscal year for which an appropriation is made by making quarterly Medicaid payments. Notwithstanding s. 409.915, counties are exempt from contributing toward the cost of this special reimbursement for hospitals serving a disproportionate share of low-income patients. For the state fiscal year 2007-2008 ~~2006-2007~~, the agency shall distribute the moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program. The funds provided for statutorily defined teaching hospitals shall be distributed in the same proportion as the state fiscal year 2003-2004 teaching hospital disproportionate share funds were distributed. The funds provided for family practice teaching hospitals shall be distributed equally among family practice teaching hospitals.

(1) On or before September 15 of each year, the Agency for Health Care Administration shall calculate an allocation fraction to be used for distributing funds to state statutory teaching hospitals. Subsequent to the end of each quarter of the state fiscal year, the agency shall distribute to each statutory teaching hospital, as defined in s. 408.07, an amount determined by multiplying one-fourth of the funds appropriated for this purpose by the Legislature times such hospital's allocation fraction. The allocation fraction for each such hospital shall be determined by the sum of three primary factors, divided by three. The primary factors are:

(a) The number of nationally accredited graduate medical education programs offered by the hospital, including

programs accredited by the Accreditation Council for Graduate Medical Education and the combined Internal Medicine and Pediatrics programs acceptable to both the American Board of Internal Medicine and the American Board of Pediatrics at the beginning of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of programs, where the total is computed for all state statutory teaching hospitals.

(b) The number of full-time equivalent trainees in the hospital, which comprises two components:

1. The number of trainees enrolled in nationally accredited graduate medical education programs, as defined in paragraph (a). Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the hospital represents of the total number of full-time equivalent trainees enrolled in accredited graduate programs, where the total is computed for all state statutory teaching hospitals.

2. The number of medical students enrolled in accredited colleges of medicine and engaged in clinical activities, including required clinical clerkships and clinical electives. Full-time equivalents are computed using the fraction of the year during which each trainee is primarily assigned to the given institution, over the course of the state fiscal year preceding the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of

the total number of full-time equivalent students enrolled in accredited colleges of medicine, where the total is computed for all state statutory teaching hospitals.

The primary factor for full-time equivalent trainees is computed as the sum of these two components, divided by two.

(c) A service index that comprises three components:

1. The Agency for Health Care Administration Service Index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to services offered by the given hospital, as reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation fraction is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total Agency for Health Care Administration Service Index values, where the total is computed for all state statutory teaching hospitals.

2. A volume-weighted service index, computed by applying the standard Service Inventory Scores established by the Agency for Health Care Administration to the volume of each service, expressed in terms of the standard units of measure reported on Worksheet A-2 for the last fiscal year reported to the agency before the date on which the allocation factor is calculated. The numerical value of this factor is the fraction that the given hospital represents of the total volume-weighted service index values, where the total is computed for all state statutory teaching hospitals.

3. Total Medicaid payments to each hospital for direct inpatient and outpatient services during the fiscal year preceding the date on which the allocation factor is

calculated. This includes payments made to each hospital for such services by Medicaid prepaid health plans, whether the plan was administered by the hospital or not. The numerical value of this factor is the fraction that each hospital represents of the total of such Medicaid payments, where the total is computed for all state statutory teaching hospitals.

The primary factor for the service index is computed as the sum of these three components, divided by three.

(2) By October 1 of each year, the agency shall use the following formula to calculate the maximum additional disproportionate share payment for statutorily defined teaching hospitals:

TAP = THAF x A

Where:

TAP = total additional payment.

THAF = teaching hospital allocation factor.

A = amount appropriated for a teaching hospital disproportionate share program.

Section 10. Section 409.9117, Florida Statutes, is amended to read:

409.9117 Primary care disproportionate share program.--For the state fiscal year 2007-2008 ~~2006-2007~~, the agency shall not distribute moneys under the primary care disproportionate share program.

(1) If federal funds are available for disproportionate share programs in addition to those otherwise provided by law, there shall be created a primary care disproportionate share program.

(2) The following formula shall be used by the agency to calculate the total amount earned for hospitals that participate in the primary care disproportionate share program:

TAE = HDSP/THDSP

Where:

TAE = total amount earned by a hospital participating in the primary care disproportionate share program.

HDSP = the prior state fiscal year primary care disproportionate share payment to the individual hospital.

THDSP = the prior state fiscal year total primary care disproportionate share payments to all hospitals.

(3) The total additional payment for hospitals that participate in the primary care disproportionate share program shall be calculated by the agency as follows:

TAP = TAE x TA

Where:

TAP = total additional payment for a primary care hospital.

TAE = total amount earned by a primary care hospital.

TA = total appropriation for the primary care disproportionate share program.

(4) In the establishment and funding of this program, the agency shall use the following criteria in addition to those specified in s. 409.911, payments may not be made to a

hospital unless the hospital agrees to:

(a) Cooperate with a Medicaid prepaid health plan, if one exists in the community.

(b) Ensure the availability of primary and specialty care physicians to Medicaid recipients who are not enrolled in a prepaid capitated arrangement and who are in need of access to such physicians.

(c) Coordinate and provide primary care services free of charge, except copayments, to all persons with incomes up to 100 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, and to provide such services based on a sliding fee scale to all persons with incomes up to 200 percent of the federal poverty level who are not otherwise covered by Medicaid or another program administered by a governmental entity, except that eligibility may be limited to persons who reside within a more limited area, as agreed to by the agency and the hospital.

(d) Contract with any federally qualified health center, if one exists within the agreed geopolitical boundaries, concerning the provision of primary care services, in order to guarantee delivery of services in a nonduplicative fashion, and to provide for referral arrangements, privileges, and admissions, as appropriate. The hospital shall agree to provide at an onsite or offsite facility primary care services within 24 hours to which all Medicaid recipients and persons eligible under this paragraph who do not require emergency room services are referred during normal daylight hours.

(e) Cooperate with the agency, the county, and other entities to ensure the provision of certain public health services, case management, referral and acceptance of

patients, and sharing of epidemiological data, as the agency and the hospital find mutually necessary and desirable to promote and protect the public health within the agreed geopolitical boundaries.

(f) In cooperation with the county in which the hospital resides, develop a low-cost, outpatient, prepaid health care program to persons who are not eligible for the Medicaid program, and who reside within the area.

(g) Provide inpatient services to residents within the area who are not eligible for Medicaid or Medicare, and who do not have private health insurance, regardless of ability to pay, on the basis of available space, except that nothing shall prevent the hospital from establishing bill collection programs based on ability to pay.

(h) Work with the Florida Healthy Kids Corporation, the Florida Health Care Purchasing Cooperative, and business health coalitions, as appropriate, to develop a feasibility study and plan to provide a low-cost comprehensive health insurance plan to persons who reside within the area and who do not have access to such a plan.

(i) Work with public health officials and other experts to provide community health education and prevention activities designed to promote healthy lifestyles and appropriate use of health services.

(j) Work with the local health council to develop a plan for promoting access to affordable health care services for all persons who reside within the area, including, but not limited to, public health services, primary care services, inpatient services, and affordable health insurance generally.

Any hospital that fails to comply with any of the provisions

of this subsection, or any other contractual condition, may not receive payments under this section until full compliance is achieved.

Section 11. Paragraph (b) of subsection (4) of section 409.912, Florida Statutes, is amended, and subsections (53) and (54) are added to that section, to read:

409.912 Cost-effective purchasing of health care.--The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines

of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers shall not be entitled to enrollment in the

Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(4) The agency may contract with:

(b) An entity that is providing comprehensive behavioral health care services to certain Medicaid recipients through a capitated, prepaid arrangement pursuant to the federal waiver provided for by s. 409.905(5). Such an entity must be licensed under chapter 624, chapter 636, or chapter 641 and must possess the clinical systems and operational competence to manage risk and provide comprehensive behavioral health care to Medicaid recipients. As used in this paragraph, the term "comprehensive behavioral health care services" means covered mental health and substance abuse treatment services that are available to Medicaid recipients. The secretary of the Department of Children and Family Services shall approve provisions of procurements related to children in the department's care or custody prior to enrolling such children in a prepaid behavioral health plan. Any contract awarded under this paragraph must be competitively procured. In developing the behavioral health care prepaid plan procurement document, the agency shall ensure that the procurement document requires the contractor to develop and implement a plan to ensure compliance with s. 394.4574 related to services provided to residents of licensed assisted living facilities

that hold a limited mental health license. Except as provided in subparagraph 8., and except in counties where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211, the agency shall seek federal approval to contract with a single entity meeting these requirements to provide comprehensive behavioral health care services to all Medicaid recipients not enrolled in a Medicaid managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in an AHCA area. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Each entity must offer sufficient choice of providers in its network to ensure recipient access to care and the opportunity to select a provider with whom they are satisfied. The network shall include all public mental health hospitals. To ensure unimpaired access to behavioral health care services by Medicaid recipients, all contracts issued pursuant to this paragraph shall require each managed care company to report to the agency on an annual basis the percentage of the capitation paid to the managed care company which is expended for the provision of behavioral health care services. ~~80 percent of the capitation paid to the managed care plan, including health maintenance organizations, to be expended for the provision of behavioral health care services. In the event the managed care plan expends less than 80 percent of the capitation paid pursuant to this paragraph for the provision of behavioral health care services, the difference shall be returned to the agency.~~ The agency shall provide the managed care plan with a

certification letter indicating the amount of capitation paid during each calendar year for the provision of behavioral health care services pursuant to this section. The agency may reimburse for substance abuse treatment services on a fee-for-service basis until the agency finds that adequate funds are available for capitated, prepaid arrangements.

~~1. By January 1, 2001, the agency shall modify the contracts with the entities providing comprehensive inpatient and outpatient mental health care services to Medicaid recipients in Hillsborough, Highlands, Hardee, Manatee, and Polk Counties, to include substance abuse treatment services.~~

1.~~2.~~ By July 1, 2003, the agency and the Department of Children and Family Services shall execute a written agreement that requires collaboration and joint development of all policy, budgets, procurement documents, contracts, and monitoring plans that have an impact on the state and Medicaid community mental health and targeted case management programs.

2.~~3.~~ Except as provided in subparagraph 7. ~~8.~~, by July 1, 2006, the agency and the Department of Children and Family Services shall contract with managed care entities in each AHCA area except area 6 or arrange to provide comprehensive inpatient and outpatient mental health and substance abuse services through capitated prepaid arrangements to all Medicaid recipients who are eligible to participate in such plans under federal law and regulation. In AHCA areas where eligible individuals number less than 150,000, the agency shall contract with a single managed care plan to provide comprehensive behavioral health services to all recipients who are not enrolled in a Medicaid health maintenance organization or a Medicaid capitated managed care plan authorized under s. 409.91211. The agency may contract with more than one

comprehensive behavioral health provider to provide care to recipients who are not enrolled in a Medicaid capitated managed care plan authorized under s. 409.91211 or a Medicaid health maintenance organization in AHCA areas where the eligible population exceeds 150,000. In an AHCA area where the Medicaid managed care pilot program is authorized pursuant to s. 409.91211 in one or more counties, the agency may procure a contract with a single entity to serve the remaining counties as an AHCA area or the remaining counties may be included with an adjacent AHCA area and shall be subject to this paragraph. Contracts for comprehensive behavioral health providers awarded pursuant to this section shall be competitively procured. Both for-profit and not-for-profit corporations shall be eligible to compete. Managed care plans contracting with the agency under subsection (3) shall provide and receive payment for the same comprehensive behavioral health benefits as provided in AHCA rules, including handbooks incorporated by reference. In AHCA area 11, the agency shall contract with at least two comprehensive behavioral health care providers to provide behavioral health care to recipients in that area who are enrolled in, or assigned to, the MediPass program. One of the behavioral health care contracts shall be with the existing provider service network pilot project, as described in paragraph (d), for the purpose of demonstrating the cost-effectiveness of the provision of quality mental health services through a public hospital-operated managed care model. Payment shall be at an agreed-upon capitated rate to ensure cost savings. Of the recipients in area 11 who are assigned to MediPass under the provisions of s. 409.9122(2)(k), a minimum of 50,000 of those MediPass-enrolled recipients shall be assigned to the existing provider service

network in area 11 for their behavioral care.

3.~~4.~~ By October 1, 2003, the agency and the department shall submit a plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives which provides for the full implementation of capitated prepaid behavioral health care in all areas of the state.

a. Implementation shall begin in 2003 in those AHCA areas of the state where the agency is able to establish sufficient capitation rates.

b. If the agency determines that the proposed capitation rate in any area is insufficient to provide appropriate services, the agency may adjust the capitation rate to ensure that care will be available. The agency and the department may use existing general revenue to address any additional required match but may not over-obligate existing funds on an annualized basis.

c. Subject to any limitations provided for in the General Appropriations Act, the agency, in compliance with appropriate federal authorization, shall develop policies and procedures that allow for certification of local and state funds.

4.~~5.~~ Children residing in a statewide inpatient psychiatric program, or in a Department of Juvenile Justice or a Department of Children and Family Services residential program approved as a Medicaid behavioral health overlay services provider shall not be included in a behavioral health care prepaid health plan or any other Medicaid managed care plan pursuant to this paragraph.

5.~~6.~~ In converting to a prepaid system of delivery, the agency shall in its procurement document require an entity providing only comprehensive behavioral health care services

to prevent the displacement of indigent care patients by enrollees in the Medicaid prepaid health plan providing behavioral health care services from facilities receiving state funding to provide indigent behavioral health care, to facilities licensed under chapter 395 which do not receive state funding for indigent behavioral health care, or reimburse the unsubsidized facility for the cost of behavioral health care provided to the displaced indigent care patient.

6.~~7.~~ Traditional community mental health providers under contract with the Department of Children and Family Services pursuant to part IV of chapter 394, child welfare providers under contract with the Department of Children and Family Services in areas 1 and 6, and inpatient mental health providers licensed pursuant to chapter 395 must be offered an opportunity to accept or decline a contract to participate in any provider network for prepaid behavioral health services.

7.~~8.~~ For fiscal year 2004-2005, all Medicaid eligible children, except children in areas 1 and 6, whose cases are open for child welfare services in the HomeSafeNet system, shall be enrolled in MediPass or in Medicaid fee-for-service and all their behavioral health care services including inpatient, outpatient psychiatric, community mental health, and case management shall be reimbursed on a fee-for-service basis. Beginning July 1, 2005, such children, who are open for child welfare services in the HomeSafeNet system, shall receive their behavioral health care services through a specialty prepaid plan operated by community-based lead agencies either through a single agency or formal agreements among several agencies. The specialty prepaid plan must result in savings to the state comparable to savings achieved in other Medicaid managed care and prepaid programs. Such plan

must provide mechanisms to maximize state and local revenues. The specialty prepaid plan shall be developed by the agency and the Department of Children and Family Services. The agency is authorized to seek any federal waivers to implement this initiative. Medicaid-eligible children whose cases are open for child welfare services in the HomeSafeNet system and who reside in AHCA area 10 shall be exempt from the specialty prepaid plan upon the development of a service delivery mechanism for area 10 children as specified in s. 409.91211(3)(dd).

8. The agency may implement a methodology based on encounter data to develop capitation rates for prepaid health plans contracted to provide behavioral health services pursuant to this paragraph and for health maintenance organizations contracted to provide behavioral health services pursuant to subsection (3). For contracts beginning in the first state fiscal year in which an encounter-based system is used in any agency service area, 90 percent of the capitation rate shall be based on the agency's fee-for-service methodology and 10 percent shall be based on the behavioral health encounter data system methodology. For contracts beginning in the second and third state fiscal years in which an encounter-based system is used in any agency service area, no less than 75 percent of the capitation rate shall be based on the agency's fee-for-service methodology and not more than 25 percent shall be based on the behavioral health encounter data system methodology. If the agency applies an encounter data system methodology in agency service areas 1 and 6 in state fiscal year 2007-2008, the 2007-2008 state fiscal year shall be considered the first year of the implementation.

(53)(a) A pharmacist may not dispense a drug for

immunosuppressive therapy following transplant unless the drug is the specific formulation and manufactured by the specific manufacturer as prescribed by the patient's physician.

(b) A pharmacist may substitute a drug product that is generically equivalent for immunosuppressive therapy following transplant only if, before making the substitution, the pharmacist obtains a signed authorization from the prescribing physician.

(54) Before seeking an amendment to the state plan for purposes of implementing programs authorized by the Deficit Reduction Act of 2005, the agency shall notify the Legislature.

Section 12. Paragraph (dd) of subsection (3) of section 409.91211, Florida Statutes, is amended to read:

409.91211 Medicaid managed care pilot program.--

(3) The agency shall have the following powers, duties, and responsibilities with respect to the pilot program:

(dd) To implement ~~develop and recommend~~ service delivery mechanisms within capitated managed care plans to provide Medicaid services as specified in ss. 409.905 and 409.906 to Medicaid-eligible children who are open for child welfare services in the HomeSafeNet system ~~in foster care~~. These services must be coordinated with community-based care providers as specified in s. 409.1671 ~~s. 409.1675~~, where available, and be sufficient to meet the medical, developmental, behavioral, and emotional needs of these children. These service-delivery mechanisms must be implemented no later than July 1, 2008, in AHCA area 10 in order for the children in AHCA area 10 to remain exempt from the statewide plan under s. 409.912(4)(b)7.

Section 13. Subsection (13) of section 409.9122, Florida Statutes, is amended to read:

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

(13) Effective July 1, 2003, the agency shall adjust the enrollee assignment process of Medicaid managed prepaid health plans for those Medicaid managed prepaid plans operating in Miami-Dade County which have executed a contract with the agency for a minimum of 8 consecutive years in order for the Medicaid managed prepaid plan to maintain a minimum enrollment level of 15,000 members per month. When assigning enrollees pursuant to this subsection, the agency shall give priority to providers that initially qualified under this subsection until such providers reach and maintain an enrollment level of 15,000 members per month. A prepaid health plan that has a statewide Medicaid enrollment of 25,000 or more members is not eligible for enrollee assignments under this subsection.

Section 14. Subsection (2) of section 409.9124, Florida Statutes, is amended, and subsections (7) and (8) are added to that section, to read:

409.9124 Managed care reimbursement.--The agency shall develop and adopt by rule a methodology for reimbursing managed care plans.

(2) Each year prior to establishing new managed care rates, the agency shall review all prior year adjustments for changes in trend, and shall reduce or eliminate those adjustments which are not reasonable and which reflect policies or programs which are not in effect. In addition, the agency shall apply only those policy reductions applicable to the fiscal year for which the rates are being set, which can

be accurately estimated and verified by an independent actuary, and which have been implemented prior to or will be implemented during the fiscal year. ~~The agency shall pay rates at per-member, per-month averages that do not exceed the amounts allowed for in the General Appropriations Act applicable to the fiscal year for which the rates will be in effect.~~

(7) Effective January 1, 2008, the agency shall amend its rule pertaining to the methodology for reimbursing managed care plans created pursuant to this section, and for each agency area and eligibility category, the percentage of the payment limit shall be increased by 0.5 percentage point from the percentage of the payment limit specified in the 2006-2007 rule. The percentage of the payment limit may not exceed 100 percent for any agency area or eligibility category.

(8) Effective January 1, 2009, the agency shall amend its rule pertaining to the methodology for reimbursing managed care plans created pursuant to this section, and for each agency area and eligibility category, the percentage of the payment limit shall be increased by 1.5 percentage points from the percentage of the payment limit specified in the 2007-2008 rule. The percentage of the payment limit may not exceed 100 percent for any agency area or eligibility category.

Section 15. Subsection (36) of section 409.913, Florida Statutes, is amended to read:

409.913 Oversight of the integrity of the Medicaid program.--The agency shall operate a program to oversee the activities of Florida Medicaid recipients, and providers and their representatives, to ensure that fraudulent and abusive behavior and neglect of recipients occur to the minimum extent possible, and to recover overpayments and impose sanctions as

appropriate. Beginning January 1, 2003, and each year thereafter, the agency and the Medicaid Fraud Control Unit of the Department of Legal Affairs shall submit a joint report to the Legislature documenting the effectiveness of the state's efforts to control Medicaid fraud and abuse and to recover Medicaid overpayments during the previous fiscal year. The report must describe the number of cases opened and investigated each year; the sources of the cases opened; the disposition of the cases closed each year; the amount of overpayments alleged in preliminary and final audit letters; the number and amount of fines or penalties imposed; any reductions in overpayment amounts negotiated in settlement agreements or by other means; the amount of final agency determinations of overpayments; the amount deducted from federal claiming as a result of overpayments; the amount of overpayments recovered each year; the amount of cost of investigation recovered each year; the average length of time to collect from the time the case was opened until the overpayment is paid in full; the amount determined as uncollectible and the portion of the uncollectible amount subsequently reclaimed from the Federal Government; the number of providers, by type, that are terminated from participation in the Medicaid program as a result of fraud and abuse; and all costs associated with discovering and prosecuting cases of Medicaid overpayments and making recoveries in such cases. The report must also document actions taken to prevent overpayments and the number of providers prevented from enrolling in or reenrolling in the Medicaid program as a result of documented Medicaid fraud and abuse and must recommend changes necessary to prevent or recover overpayments.

(36) The agency shall provide to each Medicaid recipient or his or her representative an explanation of benefits in the form of a letter that is mailed to the most recent address of the recipient on the record with the Department of Children and Family Services. The explanation of benefits must include the patient's name, the name of the health care provider and the address of the location where the service was provided, a description of all services billed to Medicaid in terminology that should be understood by a reasonable person, and information on how to report inappropriate or incorrect billing to the agency or other law enforcement entities for review or investigation. The explanation of benefits may not be mailed for Medicaid independent laboratory services as described in s. 409.905(7) or for the Medicaid certified match services as described in ss. 409.9071 and 1011.70.

Section 16. Paragraph (a) of subsection (9) of section 430.705, Florida Statutes, is amended to read:

430.705 Implementation of the long-term care community diversion pilot projects.--

(9) Community diversion pilot projects must:

(a) Provide services for participants that are of sufficient quality, quantity, type, and duration to prevent or delay nursing facility placement. Services shall include hospice care by a licensed hospice.

Section 17. Present subsections (3) and (4) of section 458.319, Florida Statutes, are redesignated as subsections (4) and (5), respectively, and a new subsection (3) is added to that section, to read:

458.319 Renewal of license.--

(3) The Department of Health shall waive the biennial

license renewal fee for up to 10,000 allopathic or osteopathic physicians, in the aggregate, who have a valid, active license to practice under this chapter or chapter 459; whose primary practice address, as reported under s. 456.041, is located within the state; and who submit to the department, prior to the applicable license renewal date, a sworn affidavit that the physician is prescribing medications exclusively through the use of electronic prescribing software at the physician's primary practice address. For purposes of this subsection, the term "electronic prescribing software" means, at a minimum, software that electronically generates and securely transmits, in real time, a patient prescription to a pharmacy. The department may adopt rules necessary to implement this subsection. This subsection expires July 1, 2008.

Section 18. Section 459.0092, Florida Statutes, is amended to read:

459.0092 Fees.--

(1) The board shall set fees according to the following schedule:

(a)~~(1)~~ The fee for application or certification pursuant to ss. 459.007, 459.0075, and 459.0077 shall not exceed $500.

(b)~~(2)~~ The fee for application and examination pursuant to s. 459.006 shall not exceed $175 plus the actual per applicant cost to the department for purchase of the examination from the National Board of Osteopathic Medical Examiners or a similar national organization.

(c)~~(3)~~ The fee for biennial renewal of licensure or certification shall not exceed $500.

(2) The Department of Health shall waive the biennial license renewal fee for up to 10,000 allopathic or osteopathic

physicians, in the aggregate, who have a valid, active license to practice under chapter 458 or this chapter; whose primary practice address, as reported under s. 456.041, is located within the state; and who submit to the department, prior to the applicable license renewal date, a sworn affidavit that the physician is prescribing medications exclusively through the use of electronic prescribing software at the physician's primary practice address. For purposes of this subsection, the term "electronic prescribing software" means, at a minimum, software that electronically generates and securely transmits, in real time, a patient prescription to a pharmacy. The department may adopt rules necessary to implement this subsection. This subsection expires July 1, 2008.

Section 19. This act shall take effect July 1, 2007.

========== T I T L E A M E N D M E N T ==========

And the title is amended as follows:

Delete everything before the enacting clause

and insert:

A bill to be entitled

An act relating to health care; amending s. 381.0302, F.S.; authorizing the Department of Health to provide loan repayment assistance and travel and relocation reimbursement to dentists who agree to serve 2 years in the Florida Health Services Corps; requiring that financial penalties for noncompliance with requirements for participating in the corps be deposited into the Administrative Trust Fund; deleting

provisions requiring the deposit of moneys into the Florida Health Services Corps Trust Fund; amending s. 394.9082, F.S.; conforming a cross-reference; amending s. 409.905, F.S.; revising circumstances under which the Agency for Health Care Administration adjusts a hospital's inpatient per diem rate under the Medicaid program; amending s. 409.906, F.S.; authorizing the Agency for Health Care Administration to pay for psychiatric inpatient hospital care to certain persons in certain treatment facilities or specialty hospitals; authorizing the agency to pay for services provided by an anesthesiologist assistant; providing for reimbursement; repealing s. 409.9061, F.S., relating to the agency contracting with statewide laboratory services; amending s. 409.908, F.S.; deleting the provision that authorizes the agency to amend the Medicaid plan with regard to change of ownership or of the licensed operator of a nursing home; deleting the provision that prohibits Medicaid from making payment toward deductibles and coinsurance for services not covered by Medicaid; revising the calculation for Medicaid payments for Nursing Home Medicare part A coinsurance; limiting Medicaid payments for general hospital inpatient services to the Medicare deductible per spell of illness and coinsurance; amending s. 409.911, F.S.; revising the share data used to calculate the

disproportionate share payments to hospitals; amending s. 409.9112, F.S.; revising the time period during which the agency is prohibited from distributing disproportionate share payments to regional perinatal intensive care centers; amending s. 409.9113, F.S.; requiring the agency to distribute moneys provided in the General Appropriations Act to statutorily defined teaching hospitals and family practice teaching hospitals under the teaching hospital disproportionate share program for the 2007-2008 fiscal year; amending s. 409.9117, F.S.; prohibiting the agency from distributing moneys under the primary care disproportionate share program for the 2007-2008 fiscal year; amending s. 409.912, F.S.; revising contract requirements for behavioral health care services for Medicaid recipients; exempting certain Medicaid-eligible children from the specialty prepaid plan upon the development of a service delivery system for such children; authorizing the agency to implement a methodology to develop capitation rates for prepaid health plans contracted to provide behavioral health services; prohibiting a pharmacist from dispensing a drug for immunosuppressive therapy; providing an exception; authorizing a pharmacist to substitute certain drugs for immunosuppressive therapy under certain conditions; requiring that the agency notify the Legislature before

seeking an amendment to the state plan in order to implement programs authorized by the Deficit Reduction Act of 2005; amending s. 409.91211, F.S.; requiring the agency to implement delivery mechanisms to provide Medicaid services to Medicaid-eligible children who are open for child welfare services in the HomeSafeNet system; requiring that the services be sufficient to meet the medical, developmental, behavioral, and emotional needs of the children; directing the agency to implement the service delivery by a specified date; amending s. 409.9122, F.S.; requiring that the agency give priority to certain prepaid health plans when assigning enrollees under the Medicaid program; limiting the eligibility of certain providers to contract with the agency; amending s. 409.9124, F.S.; revising the methodology used by the agency in reimbursing managed care plans; specifying certain percentage increases in payment limits; amending s. 409.913, F.S.; prohibiting the explanation of certain Medicaid benefits from being mailed; amending s. 430.705, F.S.; including hospice care within the long-term care community diversion pilot projects; amending ss. 458.319 and 459.0092, F.S.; requiring the Department of Health to waive the biennial license renewal fee for up to a specified number of allopathic or osteopathic physicians; providing conditions for such

waiver; authorizing the department to adopt rules; providing for future expiration; providing an effective date.