1 A bill to be entitled
2 An act relating to health care; amending s.
3 381.0302, F.S.; authorizing the Department of
4 Health to provide loan repayment assistance and
5 travel and relocation reimbursement to dentists
6 who agree to serve 2 years in the Florida
7 Health Services Corps; requiring that financial
8 penalties for noncompliance with requirements
9 for participating in the corps be deposited
10 into the Administrative Trust Fund; deleting
11 provisions requiring the deposit of moneys into
12 the Florida Health Services Corps Trust Fund;
13 amending s. 394.9082, F.S.; conforming a
14 cross-reference; amending s. 409.905, F.S.;
15 revising circumstances under which the Agency
16 for Health Care Administration adjusts a
17 hospital's inpatient per diem rate under the
18 Medicaid program; amending s. 409.906, F.S.;
19 authorizing the Agency for Health Care
20 Administration to pay for psychiatric inpatient
21 hospital care to certain persons in certain
22 treatment facilities or specialty hospitals;
23 authorizing the agency to pay for services
24 provided by an anesthesiologist assistant;
25 providing for reimbursement; repealing s.
26 409.9061, F.S., relating to the agency
27 contracting with statewide laboratory services;
28 amending s. 409.908, F.S.; deleting the
29 provision that authorizes the agency to amend
30 the Medicaid plan with regard to change of
31 ownership or of the licensed operator of a

1 nursing home; deleting the provision that
2 prohibits Medicaid from making payment toward
3 deductibles and coinsurance for services not
4 covered by Medicaid; revising the calculation
5 for Medicaid payments for Nursing Home Medicare
6 part A coinsurance; limiting Medicaid payments
7 for general hospital inpatient services to the
8 Medicare deductible per spell of illness and
9 coinsurance; amending s. 409.911, F.S.;
10 revising the share data used to calculate the
11 disproportionate share payments to hospitals;
12 amending s. 409.9112, F.S.; revising the time
13 period during which the agency is prohibited
14 from distributing disproportionate share
15 payments to regional perinatal intensive care
16 centers; amending s. 409.9113, F.S.; requiring
17 the agency to distribute moneys provided in the
18 General Appropriations Act to statutorily
19 defined teaching hospitals and family practice
20 teaching hospitals under the teaching hospital
21 disproportionate share program for the
22 2007-2008 fiscal year; amending s. 409.9117,
23 F.S.; prohibiting the agency from distributing
24 moneys under the primary care disproportionate
25 share program for the 2007-2008 fiscal year;
26 amending s. 409.912, F.S.; revising contract
27 requirements for behavioral health care
28 services for Medicaid recipients; exempting
29 certain Medicaid-eligible children from the
30 specialty prepaid plan upon the development of
31 a service delivery system for such children;

1 authorizing the agency to implement a
2 methodology to develop capitation rates for
3 prepaid health plans contracted to provide
4 behavioral health services; prohibiting a
5 pharmacist from dispensing a drug for
6 immunosuppressive therapy; providing an
7 exception; authorizing a pharmacist to
8 substitute certain drugs for immunosuppressive
9 therapy under certain conditions; requiring
10 that the agency notify the Legislature before
11 seeking an amendment to the state plan in order
12 to implement programs authorized by the Deficit
13 Reduction Act of 2005; amending s. 409.91211,
14 F.S.; requiring the agency to implement
15 delivery mechanisms to provide Medicaid
16 services to Medicaid-eligible children who are
17 open for child welfare services in the
18 HomeSafeNet system; requiring that the services
19 be sufficient to meet the medical,
20 developmental, behavioral, and emotional needs
21 of the children; directing the agency to
22 implement the service delivery by a specified
23 date; amending s. 409.9122, F.S.; requiring
24 that the agency give priority to certain
25 prepaid health plans when assigning enrollees
26 under the Medicaid program; limiting the
27 eligibility of certain providers to contract
28 with the agency; amending s. 409.9124, F.S.;
29 revising the methodology used by the agency in
30 reimbursing managed care plans; specifying
31 certain percentage increases in payment limits;

1 amending s. 409.913, F.S.; prohibiting the
2 explanation of certain Medicaid benefits from
3 being mailed; amending s. 430.705, F.S.;
4 including hospice care within the long-term
5 care community diversion pilot projects;
6 amending ss. 458.319 and 459.0092, F.S.;
7 requiring the Department of Health to waive the
8 biennial license renewal fee for up to a
9 specified number of allopathic or osteopathic
10 physicians; providing conditions for such
11 waiver; authorizing the department to adopt
12 rules; providing for future expiration;
13 providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Subsections (6), (7), and (12) of section
18 381.0302, Florida Statutes, are amended to read:
19 381.0302 Florida Health Services Corps.--
20 (6) The department may provide loan repayment
21 assistance and travel and relocation reimbursement to
22 dentists, allopathic and osteopathic medical residents with
23 primary care specialties during their last 2 years of
24 residency training or upon completion of residency training,
25 and to physician assistants and nurse practitioners with
26 primary care specialties, in return for an agreement to serve
27 a minimum of 2 years in the Florida Health Services Corps.
28 During the period of service, the maximum amount of annual
29 financial payments shall not be greater than the annual total
30 of loan repayment assistance and tax subsidies authorized by
31 the National Health Services Corps loan repayment program.

1 (7) The financial penalty for noncompliance with
2 participation requirements for persons who have received
3 financial payments under subsection (5) or subsection (6)
4 shall be determined in the same manner as in the National
5 Health Services Corps scholarship program. In addition,
6 noncompliance with participation requirements shall also
7 result in ineligibility for professional licensure or renewal
8 of licensure under chapter 458, chapter 459, chapter 460, part
9 I of chapter 464, chapter 465, or chapter 466. For a
10 participant who is unable to participate for reasons of
11 disability, the penalty is the actual amount of financial
12 assistance provided to the participant. Financial penalties
13 shall be deposited in the Administrative ~~Florida Health~~
14 ~~Services Corps~~ Trust Fund and shall be used to provide
15 additional scholarship and financial assistance.
16 (12) ~~Funds appropriated under this section shall be~~
17 ~~deposited in the Florida Health Services Corps Trust Fund,~~
18 ~~which shall be administered by the department.~~ The department
19 may use funds appropriated for the Florida Health Services
20 Corps as matching funds for federal service-obligation
21 scholarship programs for health care practitioners, such as
22 the Demonstration Grants to States for Community Scholarship
23 Grants program. If funds appropriated under this section are
24 used as matching funds, federal criteria shall be followed
25 whenever there is a conflict between provisions in this
26 section and federal requirements.
27 Section 2. Paragraph (a) of subsection (4) of section
28 394.9082, Florida Statutes, is amended to read:
29 394.9082 Behavioral health service delivery
30 strategies.--
31 (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

1 the availability of moneys and any limitations or directions
2 provided for in the General Appropriations Act or chapter 216.
3 (5) HOSPITAL INPATIENT SERVICES.--The agency shall pay
4 for all covered services provided for the medical care and
5 treatment of a recipient who is admitted as an inpatient by a
6 licensed physician or dentist to a hospital licensed under
7 part I of chapter 395. However, the agency shall limit the
8 payment for inpatient hospital services for a Medicaid
9 recipient 21 years of age or older to 45 days or the number of
10 days necessary to comply with the General Appropriations Act.
11 (c) The Agency for Health Care Administration shall
12 adjust a hospital's current inpatient per diem rate to reflect
13 the cost of serving the Medicaid population at that
14 institution if:
15 1. The hospital experiences an increase in Medicaid
16 caseload by more than 25 percent in any year, primarily
17 resulting from the closure of a hospital in the same service
18 area occurring after July 1, 1995, and~~;~~
19 ~~2.~~ the hospital's Medicaid per diem rate is at least
20 25 percent below the Medicaid per patient cost for that year;
21 or
22 2.~~3.~~ The hospital is located in a county that has five
23 or fewer hospitals, began offering obstetrical services on or
24 after September 1999, and has submitted a request in writing
25 to the agency for a rate adjustment after July 1, 2000, but
26 before September 30, 2000, in which case such hospital's
27 Medicaid inpatient per diem rate shall be adjusted to cost,
28 effective July 1, 2002.
29
30 No later than October 1 of each year, the agency must provide
31 estimated costs for any adjustment in a hospital inpatient per

1 diem pursuant to this paragraph to the Executive Office of the
2 Governor, the House of Representatives General Appropriations
3 Committee, and the Senate Appropriations Committee. Before the
4 agency implements a change in a hospital's inpatient per diem
5 rate pursuant to this paragraph, the Legislature must have
6 specifically appropriated sufficient funds in the General
7 Appropriations Act to support the increase in cost as
8 estimated by the agency.
9 Section 4. Subsection (22) of section 409.906, Florida
10 Statutes, is amended, and subsection (26) is added to that
11 section, to read:
12 409.906 Optional Medicaid services.--Subject to
13 specific appropriations, the agency may make payments for
14 services which are optional to the state under Title XIX of
15 the Social Security Act and are furnished by Medicaid
16 providers to recipients who are determined to be eligible on
17 the dates on which the services were provided. Any optional
18 service that is provided shall be provided only when medically
19 necessary and in accordance with state and federal law.
20 Optional services rendered by providers in mobile units to
21 Medicaid recipients may be restricted or prohibited by the
22 agency. Nothing in this section shall be construed to prevent
23 or limit the agency from adjusting fees, reimbursement rates,
24 lengths of stay, number of visits, or number of services, or
25 making any other adjustments necessary to comply with the
26 availability of moneys and any limitations or directions
27 provided for in the General Appropriations Act or chapter 216.
28 If necessary to safeguard the state's systems of providing
29 services to elderly and disabled persons and subject to the
30 notice and review provisions of s. 216.177, the Governor may
31 direct the Agency for Health Care Administration to amend the

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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

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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.

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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

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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:

$$TAP = TAE \times TA$$

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1 Where:
2 TAP = total additional payment for a regional perinatal
3 intensive care center.
4 TAE = total amount earned by a regional perinatal
5 intensive care center.
6 TA = total appropriation for the regional perinatal
7 intensive care center disproportionate share program.
8
9 (3) In order to receive payments under this section, a
10 hospital must be participating in the regional perinatal
11 intensive care center program pursuant to chapter 383 and must
12 meet the following additional requirements:
13 (a) Agree to conform to all departmental and agency
14 requirements to ensure high quality in the provision of
15 services, including criteria adopted by departmental and
16 agency rule concerning staffing ratios, medical records,
17 standards of care, equipment, space, and such other standards
18 and criteria as the department and agency deem appropriate as
19 specified by rule.
20 (b) Agree to provide information to the department and
21 agency, in a form and manner to be prescribed by rule of the
22 department and agency, concerning the care provided to all
23 patients in neonatal intensive care centers and high-risk
24 maternity care.
25 (c) Agree to accept all patients for neonatal
26 intensive care and high-risk maternity care, regardless of
27 ability to pay, on a functional space-available basis.
28 (d) Agree to develop arrangements with other maternity
29 and neonatal care providers in the hospital's region for the
30 appropriate receipt and transfer of patients in need of
31 specialized maternity and neonatal intensive care services.

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1 (e) Agree to establish and provide a developmental
2 evaluation and services program for certain high-risk
3 neonates, as prescribed and defined by rule of the department.
4 (f) Agree to sponsor a program of continuing education
5 in perinatal care for health care professionals within the
6 region of the hospital, as specified by rule.
7 (g) Agree to provide backup and referral services to
8 the department's county health departments and other
9 low-income perinatal providers within the hospital's region,
10 including the development of written agreements between these
11 organizations and the hospital.
12 (h) Agree to arrange for transportation for high-risk
13 obstetrical patients and neonates in need of transfer from the
14 community to the hospital or from the hospital to another more
15 appropriate facility.
16 (4) Hospitals which fail to comply with any of the
17 conditions in subsection (3) or the applicable rules of the
18 department and agency shall not receive any payments under
19 this section until full compliance is achieved. A hospital
20 which is not in compliance in two or more consecutive quarters
21 shall not receive its share of the funds. Any forfeited funds
22 shall be distributed by the remaining participating regional
23 perinatal intensive care center program hospitals.
24 Section 9. Section 409.9113, Florida Statutes, is
25 amended to read:
26 409.9113 Disproportionate share program for teaching
27 hospitals.--In addition to the payments made under ss. 409.911
28 and 409.9112, the Agency for Health Care Administration shall
29 make disproportionate share payments to statutorily defined
30 teaching hospitals for their increased costs associated with
31 medical education programs and for tertiary health care

1 services provided to the indigent. This system of payments
2 shall conform with federal requirements and shall distribute
3 funds in each fiscal year for which an appropriation is made
4 by making quarterly Medicaid payments. Notwithstanding s.
5 409.915, counties are exempt from contributing toward the cost
6 of this special reimbursement for hospitals serving a
7 disproportionate share of low-income patients. For the state
8 fiscal year 2007-2008 ~~2006-2007~~, the agency shall distribute
9 the moneys provided in the General Appropriations Act to
10 statutorily defined teaching hospitals and family practice
11 teaching hospitals under the teaching hospital
12 disproportionate share program. The funds provided for
13 statutorily defined teaching hospitals shall be distributed in
14 the same proportion as the state fiscal year 2003-2004
15 teaching hospital disproportionate share funds were
16 distributed. The funds provided for family practice teaching
17 hospitals shall be distributed equally among family practice
18 teaching hospitals.
19 (1) On or before September 15 of each year, the Agency
20 for Health Care Administration shall calculate an allocation
21 fraction to be used for distributing funds to state statutory
22 teaching hospitals. Subsequent to the end of each quarter of
23 the state fiscal year, the agency shall distribute to each
24 statutory teaching hospital, as defined in s. 408.07, an
25 amount determined by multiplying one-fourth of the funds
26 appropriated for this purpose by the Legislature times such
27 hospital's allocation fraction. The allocation fraction for
28 each such hospital shall be determined by the sum of three
29 primary factors, divided by three. The primary factors are:
30 (a) The number of nationally accredited graduate
31 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

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1 the total number of full-time equivalent students enrolled in
2 accredited colleges of medicine, where the total is computed
3 for all state statutory teaching hospitals.
4
5 The primary factor for full-time equivalent trainees is
6 computed as the sum of these two components, divided by two.
7 (c) A service index that comprises three components:
8 1. The Agency for Health Care Administration Service
9 Index, computed by applying the standard Service Inventory
10 Scores established by the Agency for Health Care
11 Administration to services offered by the given hospital, as
12 reported on Worksheet A-2 for the last fiscal year reported to
13 the agency before the date on which the allocation fraction is
14 calculated. The numerical value of this factor is the
15 fraction that the given hospital represents of the total
16 Agency for Health Care Administration Service Index values,
17 where the total is computed for all state statutory teaching
18 hospitals.
19 2. A volume-weighted service index, computed by
20 applying the standard Service Inventory Scores established by
21 the Agency for Health Care Administration to the volume of
22 each service, expressed in terms of the standard units of
23 measure reported on Worksheet A-2 for the last fiscal year
24 reported to the agency before the date on which the allocation
25 factor is calculated. The numerical value of this factor is
26 the fraction that the given hospital represents of the total
27 volume-weighted service index values, where the total is
28 computed for all state statutory teaching hospitals.
29 3. Total Medicaid payments to each hospital for direct
30 inpatient and outpatient services during the fiscal year
31 preceding the date on which the allocation factor is

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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:

$$TAP = THAF \times A$$

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.

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(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

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1 those specified in s. 409.911, payments may not be made to a
2 hospital unless the hospital agrees to:
3 (a) Cooperate with a Medicaid prepaid health plan, if
4 one exists in the community.
5 (b) Ensure the availability of primary and specialty
6 care physicians to Medicaid recipients who are not enrolled in
7 a prepaid capitated arrangement and who are in need of access
8 to such physicians.
9 (c) Coordinate and provide primary care services free
10 of charge, except copayments, to all persons with incomes up
11 to 100 percent of the federal poverty level who are not
12 otherwise covered by Medicaid or another program administered
13 by a governmental entity, and to provide such services based
14 on a sliding fee scale to all persons with incomes up to 200
15 percent of the federal poverty level who are not otherwise
16 covered by Medicaid or another program administered by a
17 governmental entity, except that eligibility may be limited to
18 persons who reside within a more limited area, as agreed to by
19 the agency and the hospital.
20 (d) Contract with any federally qualified health
21 center, if one exists within the agreed geopolitical
22 boundaries, concerning the provision of primary care services,
23 in order to guarantee delivery of services in a nonduplicative
24 fashion, and to provide for referral arrangements, privileges,
25 and admissions, as appropriate. The hospital shall agree to
26 provide at an onsite or offsite facility primary care services
27 within 24 hours to which all Medicaid recipients and persons
28 eligible under this paragraph who do not require emergency
29 room services are referred during normal daylight hours.
30 (e) Cooperate with the agency, the county, and other
31 entities to ensure the provision of certain public health

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1 services, case management, referral and acceptance of
2 patients, and sharing of epidemiological data, as the agency
3 and the hospital find mutually necessary and desirable to
4 promote and protect the public health within the agreed
5 geopolitical boundaries.
6 (f) In cooperation with the county in which the
7 hospital resides, develop a low-cost, outpatient, prepaid
8 health care program to persons who are not eligible for the
9 Medicaid program, and who reside within the area.
10 (g) Provide inpatient services to residents within the
11 area who are not eligible for Medicaid or Medicare, and who do
12 not have private health insurance, regardless of ability to
13 pay, on the basis of available space, except that nothing
14 shall prevent the hospital from establishing bill collection
15 programs based on ability to pay.
16 (h) Work with the Florida Healthy Kids Corporation,
17 the Florida Health Care Purchasing Cooperative, and business
18 health coalitions, as appropriate, to develop a feasibility
19 study and plan to provide a low-cost comprehensive health
20 insurance plan to persons who reside within the area and who
21 do not have access to such a plan.
22 (i) Work with public health officials and other
23 experts to provide community health education and prevention
24 activities designed to promote healthy lifestyles and
25 appropriate use of health services.
26 (j) Work with the local health council to develop a
27 plan for promoting access to affordable health care services
28 for all persons who reside within the area, including, but not
29 limited to, public health services, primary care services,
30 inpatient services, and affordable health insurance generally.
31

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1 Any hospital that fails to comply with any of the provisions
2 of this subsection, or any other contractual condition, may
3 not receive payments under this section until full compliance
4 is achieved.
5 Section 11. Paragraph (b) of subsection (4) of section
6 409.912, Florida Statutes, is amended, and subsections (53)
7 and (54) are added to that section, to read:
8 409.912 Cost-effective purchasing of health care.--The
9 agency shall purchase goods and services for Medicaid
10 recipients in the most cost-effective manner consistent with
11 the delivery of quality medical care. To ensure that medical
12 services are effectively utilized, the agency may, in any
13 case, require a confirmation or second physician's opinion of
14 the correct diagnosis for purposes of authorizing future
15 services under the Medicaid program. This section does not
16 restrict access to emergency services or poststabilization
17 care services as defined in 42 C.F.R. part 438.114. Such
18 confirmation or second opinion shall be rendered in a manner
19 approved by the agency. The agency shall maximize the use of
20 prepaid per capita and prepaid aggregate fixed-sum basis
21 services when appropriate and other alternative service
22 delivery and reimbursement methodologies, including
23 competitive bidding pursuant to s. 287.057, designed to
24 facilitate the cost-effective purchase of a case-managed
25 continuum of care. The agency shall also require providers to
26 minimize the exposure of recipients to the need for acute
27 inpatient, custodial, and other institutional care and the
28 inappropriate or unnecessary use of high-cost services. The
29 agency shall contract with a vendor to monitor and evaluate
30 the clinical practice patterns of providers in order to
31 identify trends that are outside the normal practice patterns

1 of a provider's professional peers or the national guidelines
2 of a provider's professional association. The vendor must be
3 able to provide information and counseling to a provider whose
4 practice patterns are outside the norms, in consultation with
5 the agency, to improve patient care and reduce inappropriate
6 utilization. The agency may mandate prior authorization, drug
7 therapy management, or disease management participation for
8 certain populations of Medicaid beneficiaries, certain drug
9 classes, or particular drugs to prevent fraud, abuse, overuse,
10 and possible dangerous drug interactions. The Pharmaceutical
11 and Therapeutics Committee shall make recommendations to the
12 agency on drugs for which prior authorization is required. The
13 agency shall inform the Pharmaceutical and Therapeutics
14 Committee of its decisions regarding drugs subject to prior
15 authorization. The agency is authorized to limit the entities
16 it contracts with or enrolls as Medicaid providers by
17 developing a provider network through provider credentialing.
18 The agency may competitively bid single-source-provider
19 contracts if procurement of goods or services results in
20 demonstrated cost savings to the state without limiting access
21 to care. The agency may limit its network based on the
22 assessment of beneficiary access to care, provider
23 availability, provider quality standards, time and distance
24 standards for access to care, the cultural competence of the
25 provider network, demographic characteristics of Medicaid
26 beneficiaries, practice and provider-to-beneficiary standards,
27 appointment wait times, beneficiary use of services, provider
28 turnover, provider profiling, provider licensure history,
29 previous program integrity investigations and findings, peer
30 review, provider Medicaid policy and billing compliance
31 records, clinical and medical record audits, and other

1 factors. Providers shall not be entitled to enrollment in the
2 Medicaid provider network. The agency shall determine
3 instances in which allowing Medicaid beneficiaries to purchase
4 durable medical equipment and other goods is less expensive to
5 the Medicaid program than long-term rental of the equipment or
6 goods. The agency may establish rules to facilitate purchases
7 in lieu of long-term rentals in order to protect against fraud
8 and abuse in the Medicaid program as defined in s. 409.913.
9 The agency may seek federal waivers necessary to administer
10 these policies.
11 (4) The agency may contract with:
12 (b) An entity that is providing comprehensive
13 behavioral health care services to certain Medicaid recipients
14 through a capitated, prepaid arrangement pursuant to the
15 federal waiver provided for by s. 409.905(5). Such an entity
16 must be licensed under chapter 624, chapter 636, or chapter
17 641 and must possess the clinical systems and operational
18 competence to manage risk and provide comprehensive behavioral
19 health care to Medicaid recipients. As used in this paragraph,
20 the term "comprehensive behavioral health care services" means
21 covered mental health and substance abuse treatment services
22 that are available to Medicaid recipients. The secretary of
23 the Department of Children and Family Services shall approve
24 provisions of procurements related to children in the
25 department's care or custody prior to enrolling such children
26 in a prepaid behavioral health plan. Any contract awarded
27 under this paragraph must be competitively procured. In
28 developing the behavioral health care prepaid plan procurement
29 document, the agency shall ensure that the procurement
30 document requires the contractor to develop and implement a
31 plan to ensure compliance with s. 394.4574 related to services

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1 provided to residents of licensed assisted living facilities
2 that hold a limited mental health license. Except as provided
3 in subparagraph 8., and except in counties where the Medicaid
4 managed care pilot program is authorized pursuant to s.
5 409.91211, the agency shall seek federal approval to contract
6 with a single entity meeting these requirements to provide
7 comprehensive behavioral health care services to all Medicaid
8 recipients not enrolled in a Medicaid managed care plan
9 authorized under s. 409.91211 or a Medicaid health maintenance
10 organization in an AHCA area. In an AHCA area where the
11 Medicaid managed care pilot program is authorized pursuant to
12 s. 409.91211 in one or more counties, the agency may procure a
13 contract with a single entity to serve the remaining counties
14 as an AHCA area or the remaining counties may be included with
15 an adjacent AHCA area and shall be subject to this paragraph.
16 Each entity must offer sufficient choice of providers in its
17 network to ensure recipient access to care and the opportunity
18 to select a provider with whom they are satisfied. The network
19 shall include all public mental health hospitals. To ensure
20 unimpaired access to behavioral health care services by
21 Medicaid recipients, all contracts issued pursuant to this
22 paragraph shall require each managed care company to report to
23 the agency on an annual basis the percentage of the capitation
24 paid to the managed care company which is expended for the
25 provision of behavioral health care services. ~~80 percent of~~
26 ~~the capitation paid to the managed care plan, including health~~
27 ~~maintenance organizations, to be expended for the provision of~~
28 ~~behavioral health care services. In the event the managed care~~
29 ~~plan expends less than 80 percent of the capitation paid~~
30 ~~pursuant to this paragraph for the provision of behavioral~~
31 ~~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.

1 409.91211. The agency may contract with more than one
2 comprehensive behavioral health provider to provide care to
3 recipients who are not enrolled in a Medicaid capitated
4 managed care plan authorized under s. 409.91211 or a Medicaid
5 health maintenance organization in AHCA areas where the
6 eligible population exceeds 150,000. In an AHCA area where the
7 Medicaid managed care pilot program is authorized pursuant to
8 s. 409.91211 in one or more counties, the agency may procure a
9 contract with a single entity to serve the remaining counties
10 as an AHCA area or the remaining counties may be included with
11 an adjacent AHCA area and shall be subject to this paragraph.
12 Contracts for comprehensive behavioral health providers
13 awarded pursuant to this section shall be competitively
14 procured. Both for-profit and not-for-profit corporations
15 shall be eligible to compete. Managed care plans contracting
16 with the agency under subsection (3) shall provide and receive
17 payment for the same comprehensive behavioral health benefits
18 as provided in AHCA rules, including handbooks incorporated by
19 reference. In AHCA area 11, the agency shall contract with at
20 least two comprehensive behavioral health care providers to
21 provide behavioral health care to recipients in that area who
22 are enrolled in, or assigned to, the MediPass program. One of
23 the behavioral health care contracts shall be with the
24 existing provider service network pilot project, as described
25 in paragraph (d), for the purpose of demonstrating the
26 cost-effectiveness of the provision of quality mental health
27 services through a public hospital-operated managed care
28 model. Payment shall be at an agreed-upon capitated rate to
29 ensure cost savings. Of the recipients in area 11 who are
30 assigned to MediPass under the provisions of s.
31 409.9122(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

1 providing only comprehensive behavioral health care services
2 to prevent the displacement of indigent care patients by
3 enrollees in the Medicaid prepaid health plan providing
4 behavioral health care services from facilities receiving
5 state funding to provide indigent behavioral health care, to
6 facilities licensed under chapter 395 which do not receive
7 state funding for indigent behavioral health care, or
8 reimburse the unsubsidized facility for the cost of behavioral
9 health care provided to the displaced indigent care patient.
10 6.~~7.~~ Traditional community mental health providers
11 under contract with the Department of Children and Family
12 Services pursuant to part IV of chapter 394, child welfare
13 providers under contract with the Department of Children and
14 Family Services in areas 1 and 6, and inpatient mental health
15 providers licensed pursuant to chapter 395 must be offered an
16 opportunity to accept or decline a contract to participate in
17 any provider network for prepaid behavioral health services.
18 7.~~8.~~ For fiscal year 2004-2005, all Medicaid eligible
19 children, except children in areas 1 and 6, whose cases are
20 open for child welfare services in the HomeSafeNet system,
21 shall be enrolled in MediPass or in Medicaid fee-for-service
22 and all their behavioral health care services including
23 inpatient, outpatient psychiatric, community mental health,
24 and case management shall be reimbursed on a fee-for-service
25 basis. Beginning July 1, 2005, such children, who are open for
26 child welfare services in the HomeSafeNet system, shall
27 receive their behavioral health care services through a
28 specialty prepaid plan operated by community-based lead
29 agencies either through a single agency or formal agreements
30 among several agencies. The specialty prepaid plan must result
31 in savings to the state comparable to savings achieved in

1 other Medicaid managed care and prepaid programs. Such plan
2 must provide mechanisms to maximize state and local revenues.
3 The specialty prepaid plan shall be developed by the agency
4 and the Department of Children and Family Services. The agency
5 is authorized to seek any federal waivers to implement this
6 initiative. Medicaid-eligible children whose cases are open
7 for child welfare services in the HomeSafeNet system and who
8 reside in AHCA area 10 shall be exempt from the specialty
9 prepaid plan upon the development of a service delivery
10 mechanism for area 10 children as specified in s.
11 409.91211(3)(dd).
12 8. The agency may implement a methodology based on
13 encounter data to develop capitation rates for prepaid health
14 plans contracted to provide behavioral health services
15 pursuant to this paragraph and for health maintenance
16 organizations contracted to provide behavioral health services
17 pursuant to subsection (3). For contracts beginning in the
18 first state fiscal year in which an encounter-based system is
19 used in any agency service area, 90 percent of the capitation
20 rate shall be based on the agency's fee-for-service
21 methodology and 10 percent shall be based on the behavioral
22 health encounter data system methodology. For contracts
23 beginning in the second and third state fiscal years in which
24 an encounter-based system is used in any agency service area,
25 no less than 75 percent of the capitation rate shall be based
26 on the agency's fee-for-service methodology and not more than
27 25 percent shall be based on the behavioral health encounter
28 data system methodology. If the agency applies an encounter
29 data system methodology in agency service areas 1 and 6 in
30 state fiscal year 2007-2008, the 2007-2008 state fiscal year
31 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

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1 order for the children in AHCA area 10 to remain exempt from
2 the statewide plan under s. 409.912(4)(b)7.
3 Section 13. Subsection (13) of section 409.9122,
4 Florida Statutes, is amended to read:
5 409.9122 Mandatory Medicaid managed care enrollment;
6 programs and procedures.--
7 (13) Effective July 1, 2003, the agency shall adjust
8 the enrollee assignment process of Medicaid managed prepaid
9 health plans for those Medicaid managed prepaid plans
10 operating in Miami-Dade County which have executed a contract
11 with the agency for a minimum of 8 consecutive years in order
12 for the Medicaid managed prepaid plan to maintain a minimum
13 enrollment level of 15,000 members per month. When assigning
14 enrollees pursuant to this subsection, the agency shall give
15 priority to providers that initially qualified under this
16 subsection until such providers reach and maintain an
17 enrollment level of 15,000 members per month. A prepaid health
18 plan that has a statewide Medicaid enrollment of 25,000 or
19 more members is not eligible for enrollee assignments under
20 this subsection.
21 Section 14. Subsection (2) of section 409.9124,
22 Florida Statutes, is amended, and subsections (7) and (8) are
23 added to that section, to read:
24 409.9124 Managed care reimbursement.--The agency shall
25 develop and adopt by rule a methodology for reimbursing
26 managed care plans.
27 (2) Each year prior to establishing new managed care
28 rates, the agency shall review all prior year adjustments for
29 changes in trend, and shall reduce or eliminate those
30 adjustments which are not reasonable and which reflect
31 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

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1 behavior and neglect of recipients occur to the minimum extent
2 possible, and to recover overpayments and impose sanctions as
3 appropriate. Beginning January 1, 2003, and each year
4 thereafter, the agency and the Medicaid Fraud Control Unit of
5 the Department of Legal Affairs shall submit a joint report to
6 the Legislature documenting the effectiveness of the state's
7 efforts to control Medicaid fraud and abuse and to recover
8 Medicaid overpayments during the previous fiscal year. The
9 report must describe the number of cases opened and
10 investigated each year; the sources of the cases opened; the
11 disposition of the cases closed each year; the amount of
12 overpayments alleged in preliminary and final audit letters;
13 the number and amount of fines or penalties imposed; any
14 reductions in overpayment amounts negotiated in settlement
15 agreements or by other means; the amount of final agency
16 determinations of overpayments; the amount deducted from
17 federal claiming as a result of overpayments; the amount of
18 overpayments recovered each year; the amount of cost of
19 investigation recovered each year; the average length of time
20 to collect from the time the case was opened until the
21 overpayment is paid in full; the amount determined as
22 uncollectible and the portion of the uncollectible amount
23 subsequently reclaimed from the Federal Government; the number
24 of providers, by type, that are terminated from participation
25 in the Medicaid program as a result of fraud and abuse; and
26 all costs associated with discovering and prosecuting cases of
27 Medicaid overpayments and making recoveries in such cases. The
28 report must also document actions taken to prevent
29 overpayments and the number of providers prevented from
30 enrolling in or reenrolling in the Medicaid program as a
31 result of documented Medicaid fraud and abuse and must

1 recommend changes necessary to prevent or recover
2 overpayments.
3 (36) The agency shall provide to each Medicaid
4 recipient or his or her representative an explanation of
5 benefits in the form of a letter that is mailed to the most
6 recent address of the recipient on the record with the
7 Department of Children and Family Services. The explanation of
8 benefits must include the patient's name, the name of the
9 health care provider and the address of the location where the
10 service was provided, a description of all services billed to
11 Medicaid in terminology that should be understood by a
12 reasonable person, and information on how to report
13 inappropriate or incorrect billing to the agency or other law
14 enforcement entities for review or investigation. The
15 explanation of benefits may not be mailed for Medicaid
16 independent laboratory services as described in s. 409.905(7)
17 or for the Medicaid certified match services as described in
18 ss. 409.9071 and 1011.70.
19 Section 16. Paragraph (a) of subsection (9) of section
20 430.705, Florida Statutes, is amended to read:
21 430.705 Implementation of the long-term care community
22 diversion pilot projects.--
23 (9) Community diversion pilot projects must:
24 (a) Provide services for participants that are of
25 sufficient quality, quantity, type, and duration to prevent or
26 delay nursing facility placement. Services shall include
27 hospice care by a licensed hospice.
28 Section 17. Present subsections (3) and (4) of section
29 458.319, Florida Statutes, are redesignated as subsections (4)
30 and (5), respectively, and a new subsection (3) is added to
31 that section, to read:

1 458.319 Renewal of license.--
2 (3) The Department of Health shall waive the biennial
3 license renewal fee for up to 10,000 allopathic or osteopathic
4 physicians, in the aggregate, who have a valid, active license
5 to practice under this chapter or chapter 459; whose primary
6 practice address, as reported under s. 456.041, is located
7 within the state; and who submit to the department, prior to
8 the applicable license renewal date, a sworn affidavit that
9 the physician is prescribing medications exclusively through
10 the use of electronic prescribing software at the physician's
11 primary practice address. For purposes of this subsection, the
12 term "electronic prescribing software" means, at a minimum,
13 software that electronically generates and securely transmits,
14 in real time, a patient prescription to a pharmacy. The
15 department may adopt rules necessary to implement this
16 subsection. This subsection expires July 1, 2008.
17 Section 18. Section 459.0092, Florida Statutes, is
18 amended to read:
19 459.0092 Fees.--
20 (1) The board shall set fees according to the
21 following schedule:
22 (a)~~(1)~~ The fee for application or certification
23 pursuant to ss. 459.007, 459.0075, and 459.0077 shall not
24 exceed $500.
25 (b)~~(2)~~ The fee for application and examination
26 pursuant to s. 459.006 shall not exceed $175 plus the actual
27 per applicant cost to the department for purchase of the
28 examination from the National Board of Osteopathic Medical
29 Examiners or a similar national organization.
30 (c)~~(3)~~ The fee for biennial renewal of licensure or
31 certification shall not exceed $500.

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1 (2) The Department of Health shall waive the biennial
2 license renewal fee for up to 10,000 allopathic or osteopathic
3 physicians, in the aggregate, who have a valid, active license
4 to practice under chapter 458 or this chapter; whose primary
5 practice address, as reported under s. 456.041, is located
6 within the state; and who submit to the department, prior to
7 the applicable license renewal date, a sworn affidavit that
8 the physician is prescribing medications exclusively through
9 the use of electronic prescribing software at the physician's
10 primary practice address. For purposes of this subsection, the
11 term "electronic prescribing software" means, at a minimum,
12 software that electronically generates and securely transmits,
13 in real time, a patient prescription to a pharmacy. The
14 department may adopt rules necessary to implement this
15 subsection. This subsection expires July 1, 2008.
16 Section 19. This act shall take effect July 1, 2007.
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