

1 A bill to be entitled
 2 An act relating to Medicaid services; amending s. 400.141,
 3 F.S.; conforming a cross-reference to changes made by the
 4 act; amending s. 400.23, F.S.; providing for flexibility
 5 in how to meet the minimum staffing requirements for
 6 nursing home facilities; amending s. 409.903, F.S.;
 7 eliminating eligibility and coverage for women during
 8 pregnancy and the postpartum period who live in a family
 9 that has an income at or below a specified percentage of
 10 the federal poverty level; amending s. 409.904, F.S.;
 11 revising the expiration date of provisions authorizing the
 12 federal waiver for certain persons age 65 and over or who
 13 have a disability; revising the expiration date of
 14 provisions authorizing a specified medically needy
 15 program; amending s. 409.906, F.S.; eliminating optional
 16 adult Medicaid coverage for chiropractic services for
 17 adult recipients; amending s. 409.908, F.S.; updating the
 18 formula used for calculating reimbursements to providers
 19 of prescribed drugs; amending s. 409.9082, F.S.; revising
 20 the purpose of the use of the nursing home facility
 21 quality assessment and federal matching funds; amending s.
 22 409.9083, F.S.; revising the purpose of the use of the
 23 privately operated intermediate care facilities for the
 24 developmentally disabled quality assessment and federal
 25 matching funds; amending s. 409.911, F.S.; updating the
 26 data to be used in calculating disproportionate share;
 27 revising the formula used to pay disproportionate share
 28 dollars to provider service network hospitals; amending s.

29 409.9112, F.S.; continuing the prohibition against
 30 distributing moneys under the perinatal intensive care
 31 centers disproportionate share program; amending s.
 32 409.9113, F.S.; continuing authorization for the
 33 distribution of moneys to teaching hospitals under the
 34 disproportionate share program; amending s. 409.9117,
 35 F.S.; continuing the prohibition against distributing
 36 moneys under the primary care disproportionate share
 37 program; amending s. 409.912, F.S.; updating the formula
 38 used for calculating reimbursements to providers of
 39 prescribed drugs; amending s. 430.707, F.S.; permitting
 40 the Agency for Health Care Administration, in consultation
 41 with the Department of Elderly Affairs, to accept and
 42 forward an application for expansion of service capacity
 43 to the Centers for Medicare and Medicaid Services for a
 44 specified entity that provides benefits under the Program
 45 of All-inclusive Care for the Elderly; providing an
 46 effective date.

47
 48 Be It Enacted by the Legislature of the State of Florida:

49
 50 Section 1. Paragraph (o) of subsection (1) of section
 51 400.141, Florida Statutes, is amended to read:

52 400.141 Administration and management of nursing home
 53 facilities.—

54 (1) Every licensed facility shall comply with all
 55 applicable standards and rules of the agency and shall:

56 (o)1. Submit semiannually to the agency, or more

57 frequently if requested by the agency, information regarding
 58 facility staff-to-resident ratios, staff turnover, and staff
 59 stability, including information regarding certified nursing
 60 assistants, licensed nurses, the director of nursing, and the
 61 facility administrator. For purposes of this reporting:

62 a. Staff-to-resident ratios must be reported in the
 63 categories specified in s. 400.23(3)(a) and applicable rules.
 64 The ratio must be reported as an average for the most recent
 65 calendar quarter.

66 b. Staff turnover must be reported for the most recent 12-
 67 month period ending on the last workday of the most recent
 68 calendar quarter prior to the date the information is submitted.
 69 The turnover rate must be computed quarterly, with the annual
 70 rate being the cumulative sum of the quarterly rates. The
 71 turnover rate is the total number of terminations or separations
 72 experienced during the quarter, excluding any employee
 73 terminated during a probationary period of 3 months or less,
 74 divided by the total number of staff employed at the end of the
 75 period for which the rate is computed, and expressed as a
 76 percentage.

77 c. The formula for determining staff stability is the
 78 total number of employees that have been employed for more than
 79 12 months, divided by the total number of employees employed at
 80 the end of the most recent calendar quarter, and expressed as a
 81 percentage.

82 d. A nursing facility that has failed to comply with state
 83 minimum-staffing requirements for 2 consecutive days is
 84 prohibited from accepting new admissions until the facility has

85 | achieved the minimum-staffing requirements for a period of 6
 86 | consecutive days. For the purposes of this sub-subparagraph, any
 87 | person who was a resident of the facility and was absent from
 88 | the facility for the purpose of receiving medical care at a
 89 | separate location or was on a leave of absence is not considered
 90 | a new admission. Failure to impose such an admissions moratorium
 91 | constitutes a class II deficiency.

92 | e. A nursing facility which does not have a conditional
 93 | license may be cited for failure to comply with the standards in
 94 | s. 400.23(3)(a)1.b. and c. ~~s. 400.23(3)(a)1.a.~~ only if it has
 95 | failed to meet those standards on 2 consecutive days or if it
 96 | has failed to meet at least 97 percent of those standards on any
 97 | one day.

98 | f. A facility which has a conditional license must be in
 99 | compliance with the standards in s. 400.23(3)(a) at all times.

100 | 2. This paragraph does not limit the agency's ability to
 101 | impose a deficiency or take other actions if a facility does not
 102 | have enough staff to meet the residents' needs.

103 | Section 2. Paragraph (a) of subsection (3) of section
 104 | 400.23, Florida Statutes, is amended to read:

105 | 400.23 Rules; evaluation and deficiencies; licensure
 106 | status.—

107 | (3)(a)1. The agency shall adopt rules providing minimum
 108 | staffing requirements for nursing homes. These requirements
 109 | shall include, for each nursing home facility:

110 | a. A minimum weekly average of certified nursing assistant
 111 | and licensed nursing staffing combined of 3.9 hours of direct
 112 | care per resident per day. As used in this sub-subparagraph, a

113 week is defined as Sunday through Saturday.

114 b. A minimum certified nursing assistant staffing of 2.7
 115 hours of direct care per resident per day. A facility may not
 116 staff below one certified nursing assistant per 20 residents.

117 c. A minimum licensed nursing staffing of 1.0 hour of
 118 direct care per resident per day. A facility may not staff below
 119 one licensed nurse per 40 residents.

120 ~~a. A minimum certified nursing assistant staffing of 2.6~~
 121 ~~hours of direct care per resident per day beginning January 1,~~
 122 ~~2003, and increasing to 2.7 hours of direct care per resident~~
 123 ~~per day beginning January 1, 2007. Beginning January 1, 2002, no~~
 124 ~~facility shall staff below one certified nursing assistant per~~
 125 ~~20 residents, and a minimum licensed nursing staffing of 1.0~~
 126 ~~hour of direct care per resident per day but never below one~~
 127 ~~licensed nurse per 40 residents.~~

128 ~~b. Beginning January 1, 2007, a minimum weekly average~~
 129 ~~certified nursing assistant staffing of 2.9 hours of direct care~~
 130 ~~per resident per day. For the purpose of this sub-subparagraph,~~
 131 ~~a week is defined as Sunday through Saturday.~~

132 2. Nursing assistants employed under s. 400.211(2) may be
 133 included in computing the staffing ratio for certified nursing
 134 assistants only if their job responsibilities include only
 135 nursing-assistant-related duties.

136 3. Each nursing home must document compliance with
 137 staffing standards as required under this paragraph and post
 138 daily the names of staff on duty for the benefit of facility
 139 residents and the public.

140 4. The agency shall recognize the use of licensed nurses

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141 | for compliance with minimum staffing requirements for certified
142 | nursing assistants, provided that the facility otherwise meets
143 | the minimum staffing requirements for licensed nurses and that
144 | the licensed nurses are performing the duties of a certified
145 | nursing assistant. Unless otherwise approved by the agency,
146 | licensed nurses counted toward the minimum staffing requirements
147 | for certified nursing assistants must exclusively perform the
148 | duties of a certified nursing assistant for the entire shift and
149 | not also be counted toward the minimum staffing requirements for
150 | licensed nurses. If the agency approved a facility's request to
151 | use a licensed nurse to perform both licensed nursing and
152 | certified nursing assistant duties, the facility must allocate
153 | the amount of staff time specifically spent on certified nursing
154 | assistant duties for the purpose of documenting compliance with
155 | minimum staffing requirements for certified and licensed nursing
156 | staff. In no event may the hours of a licensed nurse with dual
157 | job responsibilities be counted twice.

158 | Section 3. Subsection (5) of section 409.903, Florida
159 | Statutes, is amended to read:

160 | 409.903 Mandatory payments for eligible persons.—The
161 | agency shall make payments for medical assistance and related
162 | services on behalf of the following persons who the department,
163 | or the Social Security Administration by contract with the
164 | Department of Children and Family Services, determines to be
165 | eligible, subject to the income, assets, and categorical
166 | eligibility tests set forth in federal and state law. Payment on
167 | behalf of these Medicaid eligible persons is subject to the
168 | availability of moneys and any limitations established by the

169 General Appropriations Act or chapter 216.

170 (5) A pregnant woman for the duration of her pregnancy and
 171 for the postpartum period as defined in federal law and rule, or
 172 a child under age 1, if either is living in a family that has an
 173 income which is at or below 150 percent of the most current
 174 federal poverty level, or, effective January 1, 2011 ~~1992~~, a
 175 child under age 1 who is living in a family that has an income
 176 which is at or below 185 percent of the most current federal
 177 poverty level. Such a person is not subject to an assets test.
 178 Further, a pregnant woman who applies for eligibility for the
 179 Medicaid program through a qualified Medicaid provider must be
 180 offered the opportunity, subject to federal rules, to be made
 181 presumptively eligible for the Medicaid program.

182 Section 4. Subsections (1) and (2) of section 409.904,
 183 Florida Statutes, are amended to read:

184 409.904 Optional payments for eligible persons.—The agency
 185 may make payments for medical assistance and related services on
 186 behalf of the following persons who are determined to be
 187 eligible subject to the income, assets, and categorical
 188 eligibility tests set forth in federal and state law. Payment on
 189 behalf of these Medicaid eligible persons is subject to the
 190 availability of moneys and any limitations established by the
 191 General Appropriations Act or chapter 216.

192 (1) Effective January 1, 2006, and subject to federal
 193 waiver approval, a person who is age 65 or older or is
 194 determined to be disabled, whose income is at or below 88
 195 percent of the federal poverty level, whose assets do not exceed
 196 established limitations, and who is not eligible for Medicare

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197 or, if eligible for Medicare, is also eligible for and receiving
 198 Medicaid-covered institutional care services, hospice services,
 199 or home and community-based services. The agency shall seek
 200 federal authorization through a waiver to provide this coverage.
 201 This subsection expires June 30, 2011 ~~December 31, 2010~~.

202 (2) (a) A family, a pregnant woman, a child under age 21, a
 203 person age 65 or over, or a blind or disabled person, who would
 204 be eligible under any group listed in s. 409.903(1), (2), or
 205 (3), except that the income or assets of such family or person
 206 exceed established limitations. For a family or person in one of
 207 these coverage groups, medical expenses are deductible from
 208 income in accordance with federal requirements in order to make
 209 a determination of eligibility. A family or person eligible
 210 under the coverage known as the "medically needy," is eligible
 211 to receive the same services as other Medicaid recipients, with
 212 the exception of services in skilled nursing facilities and
 213 intermediate care facilities for the developmentally disabled.
 214 This paragraph expires June 30, 2011 ~~December 31, 2010~~.

215 (b) Effective July 1, 2011 ~~January 1, 2011~~, a pregnant
 216 woman or a child younger than 21 years of age who would be
 217 eligible under any group listed in s. 409.903, except that the
 218 income or assets of such group exceed established limitations.
 219 For a person in one of these coverage groups, medical expenses
 220 are deductible from income in accordance with federal
 221 requirements in order to make a determination of eligibility. A
 222 person eligible under the coverage known as the "medically
 223 needy" is eligible to receive the same services as other
 224 Medicaid recipients, with the exception of services in skilled

225 nursing facilities and intermediate care facilities for the
 226 developmentally disabled.

227 Section 5. Subsection (7) of section 409.906, Florida
 228 Statutes, is amended to read:

229 409.906 Optional Medicaid services.—Subject to specific
 230 appropriations, the agency may make payments for services which
 231 are optional to the state under Title XIX of the Social Security
 232 Act and are furnished by Medicaid providers to recipients who
 233 are determined to be eligible on the dates on which the services
 234 were provided. Any optional service that is provided shall be
 235 provided only when medically necessary and in accordance with
 236 state and federal law. Optional services rendered by providers
 237 in mobile units to Medicaid recipients may be restricted or
 238 prohibited by the agency. Nothing in this section shall be
 239 construed to prevent or limit the agency from adjusting fees,
 240 reimbursement rates, lengths of stay, number of visits, or
 241 number of services, or making any other adjustments necessary to
 242 comply with the availability of moneys and any limitations or
 243 directions provided for in the General Appropriations Act or
 244 chapter 216. If necessary to safeguard the state's systems of
 245 providing services to elderly and disabled persons and subject
 246 to the notice and review provisions of s. 216.177, the Governor
 247 may direct the Agency for Health Care Administration to amend
 248 the Medicaid state plan to delete the optional Medicaid service
 249 known as "Intermediate Care Facilities for the Developmentally
 250 Disabled." Optional services may include:

251 (7) CHIROPRACTIC SERVICES.—The agency may pay for manual
 252 manipulation of the spine and initial services, screening, and X

253 rays provided to a recipient under the age of 21 by a licensed
 254 chiropractic physician.

255 Section 6. Subsection (14) of section 409.908, Florida
 256 Statutes, is amended to read:

257 409.908 Reimbursement of Medicaid providers.—Subject to
 258 specific appropriations, the agency shall reimburse Medicaid
 259 providers, in accordance with state and federal law, according
 260 to methodologies set forth in the rules of the agency and in
 261 policy manuals and handbooks incorporated by reference therein.
 262 These methodologies may include fee schedules, reimbursement
 263 methods based on cost reporting, negotiated fees, competitive
 264 bidding pursuant to s. 287.057, and other mechanisms the agency
 265 considers efficient and effective for purchasing services or
 266 goods on behalf of recipients. If a provider is reimbursed based
 267 on cost reporting and submits a cost report late and that cost
 268 report would have been used to set a lower reimbursement rate
 269 for a rate semester, then the provider's rate for that semester
 270 shall be retroactively calculated using the new cost report, and
 271 full payment at the recalculated rate shall be effected
 272 retroactively. Medicare-granted extensions for filing cost
 273 reports, if applicable, shall also apply to Medicaid cost
 274 reports. Payment for Medicaid compensable services made on
 275 behalf of Medicaid eligible persons is subject to the
 276 availability of moneys and any limitations or directions
 277 provided for in the General Appropriations Act or chapter 216.
 278 Further, nothing in this section shall be construed to prevent
 279 or limit the agency from adjusting fees, reimbursement rates,
 280 lengths of stay, number of visits, or number of services, or

281 making any other adjustments necessary to comply with the
 282 availability of moneys and any limitations or directions
 283 provided for in the General Appropriations Act, provided the
 284 adjustment is consistent with legislative intent.

285 (14) A provider of prescribed drugs shall be reimbursed
 286 the least of the amount billed by the provider, the provider's
 287 usual and customary charge, or the Medicaid maximum allowable
 288 fee established by the agency, plus a dispensing fee. The
 289 Medicaid maximum allowable fee for ingredient cost shall ~~will~~ be
 290 based on the lowest ~~lower~~ of: the average wholesale price (AWP)
 291 minus 16.4 percent, the wholesaler acquisition cost (WAC) plus
 292 4.75 percent, the federal upper limit (FUL), the state maximum
 293 allowable cost (SMAC), or the usual and customary (UAC) charge
 294 billed by the provider. Effective March 1, 2011, the Medicaid
 295 maximum allowable fee for ingredient cost shall be based on the
 296 lowest of: the wholesaler acquisition cost (WAC), the federal
 297 upper limit (FUL), the state maximum allowable cost (SMAC), or
 298 the usual and customary (UAC) charge billed by the provider.
 299 Medicaid providers are required to dispense generic drugs if
 300 available at lower cost and the agency has not determined that
 301 the branded product is more cost-effective, unless the
 302 prescriber has requested and received approval to require the
 303 branded product. The agency is directed to implement a variable
 304 dispensing fee for payments for prescribed medicines while
 305 ensuring continued access for Medicaid recipients. The variable
 306 dispensing fee may be based upon, but not limited to, either or
 307 both the volume of prescriptions dispensed by a specific
 308 pharmacy provider, the volume of prescriptions dispensed to an

309 individual recipient, and dispensing of preferred-drug-list
 310 products. The agency may increase the pharmacy dispensing fee
 311 authorized by statute and in the annual General Appropriations
 312 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-
 313 list product and reduce the pharmacy dispensing fee by \$0.50 for
 314 the dispensing of a Medicaid product that is not included on the
 315 preferred drug list. The agency may establish a supplemental
 316 pharmaceutical dispensing fee to be paid to providers returning
 317 unused unit-dose packaged medications to stock and crediting the
 318 Medicaid program for the ingredient cost of those medications if
 319 the ingredient costs to be credited exceed the value of the
 320 supplemental dispensing fee. The agency is authorized to limit
 321 reimbursement for prescribed medicine in order to comply with
 322 any limitations or directions provided for in the General
 323 Appropriations Act, which may include implementing a prospective
 324 or concurrent utilization review program.

325 Section 7. Subsection (4) of section 409.9082, Florida
 326 Statutes, is amended to read:

327 409.9082 Quality assessment on nursing home facility
 328 providers; exemptions; purpose; federal approval required;
 329 remedies.—

330 (4) The purpose of the nursing home facility quality
 331 assessment is to ensure continued quality of care. Collected
 332 assessment funds shall be used to obtain federal financial
 333 participation through the Medicaid program to make Medicaid
 334 payments for nursing home facility services up to the amount of
 335 nursing home facility Medicaid rates as calculated in accordance
 336 with the approved state Medicaid plan in effect on December 31,

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337 2007. The quality assessment and federal matching funds shall be
 338 used exclusively for the following purposes and in the following
 339 order of priority:

340 (a) To reimburse the Medicaid share of the quality
 341 assessment as a pass-through, Medicaid-allowable cost;

342 (b) To increase to each nursing home facility's Medicaid
 343 rate, as needed, an amount that restores ~~the~~ rate reductions
 344 effective on or after ~~implemented~~ January 1, 2008, as provided
 345 in the General Appropriations Act; January 1, 2009; and March 1,
 346 2009; and

347 ~~(c) To increase to each nursing home facility's Medicaid~~
 348 ~~rate, as needed, an amount that restores any rate reductions for~~
 349 ~~the 2009-2010 fiscal year; and~~

350 (c) ~~(d)~~ To increase each nursing home facility's Medicaid
 351 rate that accounts for the portion of the total assessment not
 352 included in paragraphs (a) and (b) ~~(a)-(e)~~ which begins a phase-
 353 in to a pricing model for the operating cost component.

354 Section 8. Subsection (3) of section 409.9083, Florida
 355 Statutes, is amended to read:

356 409.9083 Quality assessment on privately operated
 357 intermediate care facilities for the developmentally disabled;
 358 exemptions; purpose; federal approval required; remedies.—

359 (3) The purpose of the facility quality assessment is to
 360 ensure continued quality of care. Collected assessment funds
 361 shall be used to obtain federal financial participation through
 362 the Medicaid program to make Medicaid payments for ICF/DD
 363 services up to the amount of the Medicaid rates for such
 364 facilities as calculated in accordance with the approved state

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365 Medicaid plan in effect on April 1, 2008. The quality assessment
 366 and federal matching funds shall be used exclusively for the
 367 following purposes and in the following order of priority to:

368 (a) Reimburse the Medicaid share of the quality assessment
 369 as a pass-through, Medicaid-allowable cost.

370 (b) Increase each privately operated ICF/DD Medicaid rate,
 371 as needed, by an amount that restores ~~the~~ rate reductions
 372 effective on or after ~~implemented on~~ October 1, 2008, as
 373 provided in the General Appropriations Act.

374 ~~(c) Increase each ICF/DD Medicaid rate, as needed, by an~~
 375 ~~amount that restores any rate reductions for the 2008-2009~~
 376 ~~fiscal year and the 2009-2010 fiscal year.~~

377 ~~(c)-(d)~~ Increase payments to such facilities to fund
 378 covered services to Medicaid beneficiaries.

379 Section 9. Paragraph (a) of subsection (2) and subsection
 380 (5) of section 409.911, Florida Statutes, are amended to read:

381 409.911 Disproportionate share program.—Subject to
 382 specific allocations established within the General
 383 Appropriations Act and any limitations established pursuant to
 384 chapter 216, the agency shall distribute, pursuant to this
 385 section, moneys to hospitals providing a disproportionate share
 386 of Medicaid or charity care services by making quarterly
 387 Medicaid payments as required. Notwithstanding the provisions of
 388 s. 409.915, counties are exempt from contributing toward the
 389 cost of this special reimbursement for hospitals serving a
 390 disproportionate share of low-income patients.

391 (2) The Agency for Health Care Administration shall use
 392 the following actual audited data to determine the Medicaid days

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393 and charity care to be used in calculating the disproportionate
394 share payment:

395 (a) The average of the ~~2003,~~ 2004, ~~and~~ 2005, and 2006
396 audited disproportionate share data to determine each hospital's
397 Medicaid days and charity care for the 2010-2011 ~~2009-2010~~ state
398 fiscal year.

399 (5) The following formula shall be used to pay
400 disproportionate share dollars to provider service network (PSN)
401 hospitals:

402
$$DSHP = TAAPSNH \times \left(\frac{IHPSND}{THPSND} \right) \del{IHPSND \times THPSND}$$

403 Where:

404 DSHP = Disproportionate share hospital payments.

405 TAAPSNH = Total amount available for PSN hospitals.

406 IHPSND = Individual hospital PSN days.

407 THPSND = Total of all hospital PSN days.

408 For purposes of this subsection, the PSN inpatient days shall be
409 provided in the General Appropriations Act.

410 Section 10. Section 409.9112, Florida Statutes, is amended
411 to read:

412 409.9112 Disproportionate share program for regional
413 perinatal intensive care centers.—In addition to the payments
414 made under s. 409.911, the agency shall design and implement a
415 system for making disproportionate share payments to those
416 hospitals that participate in the regional perinatal intensive
417 care center program established pursuant to chapter 383. The
418 system of payments must conform to federal requirements and
419 distribute funds in each fiscal year for which an appropriation
420 is made by making quarterly Medicaid payments. Notwithstanding

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421 s. 409.915, counties are exempt from contributing toward the
 422 cost of this special reimbursement for hospitals serving a
 423 disproportionate share of low-income patients. For the 2010-2011
 424 ~~2009-2010~~ state fiscal year, the agency may not distribute
 425 moneys under the regional perinatal intensive care centers
 426 disproportionate share program.

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

$$TAE = HDSP/THDSP$$

431 Where:

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

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

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

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

$$TAP = TAE \times TA$$

444 Where:

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

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

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

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

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

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

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

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

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

476 (f) Agree to sponsor a program of continuing education in

477 perinatal care for health care professionals within the region
 478 of the hospital, as specified by rule.

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

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

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

496 Section 11. Section 409.9113, Florida Statutes, is amended
 497 to read:

498 409.9113 Disproportionate share program for teaching
 499 hospitals.—In addition to the payments made under ss. 409.911
 500 and 409.9112, the agency shall make disproportionate share
 501 payments to statutorily defined teaching hospitals for their
 502 increased costs associated with medical education programs and
 503 for tertiary health care services provided to the indigent. This
 504 system of payments must conform to federal requirements and

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505 distribute funds in each fiscal year for which an appropriation
 506 is made by making quarterly Medicaid payments. Notwithstanding
 507 s. 409.915, counties are exempt from contributing toward the
 508 cost of this special reimbursement for hospitals serving a
 509 disproportionate share of low-income patients. For the 2010-2011
 510 ~~2009-2010~~ state fiscal year, the agency shall distribute the
 511 moneys provided in the General Appropriations Act to statutorily
 512 defined teaching hospitals and family practice teaching
 513 hospitals under the teaching hospital disproportionate share
 514 program. The funds provided for statutorily defined teaching
 515 hospitals shall be distributed in the same proportion as the
 516 state fiscal year 2003-2004 teaching hospital disproportionate
 517 share funds were distributed or as otherwise provided in the
 518 General Appropriations Act. The funds provided for family
 519 practice teaching hospitals shall be distributed equally among
 520 family practice teaching hospitals.

521 (1) On or before September 15 of each year, the agency
 522 shall calculate an allocation fraction to be used for
 523 distributing funds to state statutory teaching hospitals.
 524 Subsequent to the end of each quarter of the state fiscal year,
 525 the agency shall distribute to each statutory teaching hospital,
 526 as defined in s. 408.07, an amount determined by multiplying
 527 one-fourth of the funds appropriated for this purpose by the
 528 Legislature times such hospital's allocation fraction. The
 529 allocation fraction for each such hospital shall be determined
 530 by the sum of the following three primary factors, divided by
 531 three:

532 (a) The number of nationally accredited graduate medical

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

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

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

556 2. The number of medical students enrolled in accredited
 557 colleges of medicine and engaged in clinical activities,
 558 including required clinical clerkships and clinical electives.
 559 Full-time equivalents are computed using the fraction of the
 560 year during which each trainee is primarily assigned to the

561 | given institution, over the course of the state fiscal year
 562 | preceding the date on which the allocation fraction is
 563 | calculated. The numerical value of this factor is the fraction
 564 | that the given hospital represents of the total number of full-
 565 | time equivalent students enrolled in accredited colleges of
 566 | medicine, where the total is computed for all state statutory
 567 | teaching hospitals.

568 |
 569 | The primary factor for full-time equivalent trainees is computed
 570 | as the sum of these two components, divided by two.

571 | (c) A service index that comprises three components:

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

582 | 2. A volume-weighted service index, computed by applying
 583 | the standard Service Inventory Scores established by the Agency
 584 | for Health Care Administration to the volume of each service,
 585 | expressed in terms of the standard units of measure reported on
 586 | Worksheet A-2 for the last fiscal year reported to the agency
 587 | before the date on which the allocation factor is calculated.
 588 | The numerical value of this factor is the fraction that the

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589 | given hospital represents of the total volume-weighted service
 590 | index values, where the total is computed for all state
 591 | statutory teaching hospitals.

592 | 3. Total Medicaid payments to each hospital for direct
 593 | inpatient and outpatient services during the fiscal year
 594 | preceding the date on which the allocation factor is calculated.
 595 | This includes payments made to each hospital for such services
 596 | by Medicaid prepaid health plans, whether the plan was
 597 | administered by the hospital or not. The numerical value of this
 598 | factor is the fraction that each hospital represents of the
 599 | total of such Medicaid payments, where the total is computed for
 600 | all state statutory teaching hospitals.

601 |
 602 | The primary factor for the service index is computed as the sum
 603 | of these three components, divided by three.

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

$$TAP = THAF \times A$$

608 |
 609 | Where:

610 | TAP = total additional payment.

611 | THAF = teaching hospital allocation factor.

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

614 | Section 12. Section 409.9117, Florida Statutes, is amended
 615 | to read:

616 | 409.9117 Primary care disproportionate share program.—For

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617 the 2010-2011 ~~2009-2010~~ state fiscal year, the agency shall not
 618 distribute moneys under the primary care disproportionate share
 619 program.

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

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

$$TAE = HDSP/THDSP$$

628 Where:

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

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

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

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

$$TAP = TAE \times TA$$

639 Where:

640 TAP = total additional payment for a primary care hospital.

641 TAE = total amount earned by a primary care hospital.

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

644 (4) In the establishment and funding of this program, the

645 agency shall use the following criteria in addition to those
 646 specified in s. 409.911, and payments may not be made to a
 647 hospital unless the hospital agrees to:

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

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

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

665 (d) Contract with any federally qualified health center,
 666 if one exists within the agreed geopolitical boundaries,
 667 concerning the provision of primary care services, in order to
 668 guarantee delivery of services in a nonduplicative fashion, and
 669 to provide for referral arrangements, privileges, and
 670 admissions, as appropriate. The hospital shall agree to provide
 671 at an onsite or offsite facility primary care services within 24
 672 hours to which all Medicaid recipients and persons eligible

673 | under this paragraph who do not require emergency room services
 674 | are referred during normal daylight hours.

675 | (e) Cooperate with the agency, the county, and other
 676 | entities to ensure the provision of certain public health
 677 | services, case management, referral and acceptance of patients,
 678 | and sharing of epidemiological data, as the agency and the
 679 | hospital find mutually necessary and desirable to promote and
 680 | protect the public health within the agreed geopolitical
 681 | boundaries.

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

686 | (g) Provide inpatient services to residents within the
 687 | area who are not eligible for Medicaid or Medicare, and who do
 688 | not have private health insurance, regardless of ability to pay,
 689 | on the basis of available space, except that hospitals may not
 690 | be prevented from establishing bill collection programs based on
 691 | ability to pay.

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

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

701 health services.

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

707
 708 Any hospital that fails to comply with any of the provisions of
 709 this subsection, or any other contractual condition, may not
 710 receive payments under this section until full compliance is
 711 achieved.

712 Section 13. Paragraph (a) of subsection (39) of section
 713 409.912, Florida Statutes, is amended to read:

714 409.912 Cost-effective purchasing of health care.—The
 715 agency shall purchase goods and services for Medicaid recipients
 716 in the most cost-effective manner consistent with the delivery
 717 of quality medical care. To ensure that medical services are
 718 effectively utilized, the agency may, in any case, require a
 719 confirmation or second physician's opinion of the correct
 720 diagnosis for purposes of authorizing future services under the
 721 Medicaid program. This section does not restrict access to
 722 emergency services or poststabilization care services as defined
 723 in 42 C.F.R. part 438.114. Such confirmation or second opinion
 724 shall be rendered in a manner approved by the agency. The agency
 725 shall maximize the use of prepaid per capita and prepaid
 726 aggregate fixed-sum basis services when appropriate and other
 727 alternative service delivery and reimbursement methodologies,
 728 including competitive bidding pursuant to s. 287.057, designed

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729 | to facilitate the cost-effective purchase of a case-managed
730 | continuum of care. The agency shall also require providers to
731 | minimize the exposure of recipients to the need for acute
732 | inpatient, custodial, and other institutional care and the
733 | inappropriate or unnecessary use of high-cost services. The
734 | agency shall contract with a vendor to monitor and evaluate the
735 | clinical practice patterns of providers in order to identify
736 | trends that are outside the normal practice patterns of a
737 | provider's professional peers or the national guidelines of a
738 | provider's professional association. The vendor must be able to
739 | provide information and counseling to a provider whose practice
740 | patterns are outside the norms, in consultation with the agency,
741 | to improve patient care and reduce inappropriate utilization.
742 | The agency may mandate prior authorization, drug therapy
743 | management, or disease management participation for certain
744 | populations of Medicaid beneficiaries, certain drug classes, or
745 | particular drugs to prevent fraud, abuse, overuse, and possible
746 | dangerous drug interactions. The Pharmaceutical and Therapeutics
747 | Committee shall make recommendations to the agency on drugs for
748 | which prior authorization is required. The agency shall inform
749 | the Pharmaceutical and Therapeutics Committee of its decisions
750 | regarding drugs subject to prior authorization. The agency is
751 | authorized to limit the entities it contracts with or enrolls as
752 | Medicaid providers by developing a provider network through
753 | provider credentialing. The agency may competitively bid single-
754 | source-provider contracts if procurement of goods or services
755 | results in demonstrated cost savings to the state without
756 | limiting access to care. The agency may limit its network based

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757 on the assessment of beneficiary access to care, provider
 758 availability, provider quality standards, time and distance
 759 standards for access to care, the cultural competence of the
 760 provider network, demographic characteristics of Medicaid
 761 beneficiaries, practice and provider-to-beneficiary standards,
 762 appointment wait times, beneficiary use of services, provider
 763 turnover, provider profiling, provider licensure history,
 764 previous program integrity investigations and findings, peer
 765 review, provider Medicaid policy and billing compliance records,
 766 clinical and medical record audits, and other factors. Providers
 767 shall not be entitled to enrollment in the Medicaid provider
 768 network. The agency shall determine instances in which allowing
 769 Medicaid beneficiaries to purchase durable medical equipment and
 770 other goods is less expensive to the Medicaid program than long-
 771 term rental of the equipment or goods. The agency may establish
 772 rules to facilitate purchases in lieu of long-term rentals in
 773 order to protect against fraud and abuse in the Medicaid program
 774 as defined in s. 409.913. The agency may seek federal waivers
 775 necessary to administer these policies.

776 (39) (a) The agency shall implement a Medicaid prescribed-
 777 drug spending-control program that includes the following
 778 components:

779 1. A Medicaid preferred drug list, which shall be a
 780 listing of cost-effective therapeutic options recommended by the
 781 Medicaid Pharmacy and Therapeutics Committee established
 782 pursuant to s. 409.91195 and adopted by the agency for each
 783 therapeutic class on the preferred drug list. At the discretion
 784 of the committee, and when feasible, the preferred drug list

785 | should include at least two products in a therapeutic class. The
 786 | agency may post the preferred drug list and updates to the
 787 | preferred drug list on an Internet website without following the
 788 | rulemaking procedures of chapter 120. Antiretroviral agents are
 789 | excluded from the preferred drug list. The agency shall also
 790 | limit the amount of a prescribed drug dispensed to no more than
 791 | a 34-day supply unless the drug products' smallest marketed
 792 | package is greater than a 34-day supply, or the drug is
 793 | determined by the agency to be a maintenance drug in which case
 794 | a 100-day maximum supply may be authorized. The agency is
 795 | authorized to seek any federal waivers necessary to implement
 796 | these cost-control programs and to continue participation in the
 797 | federal Medicaid rebate program, or alternatively to negotiate
 798 | state-only manufacturer rebates. The agency may adopt rules to
 799 | implement this subparagraph. The agency shall continue to
 800 | provide unlimited contraceptive drugs and items. The agency must
 801 | establish procedures to ensure that:

802 | a. There is a response to a request for prior consultation
 803 | by telephone or other telecommunication device within 24 hours
 804 | after receipt of a request for prior consultation; and

805 | b. A 72-hour supply of the drug prescribed is provided in
 806 | an emergency or when the agency does not provide a response
 807 | within 24 hours as required by sub-subparagraph a.

808 | 2. Reimbursement to pharmacies for Medicaid prescribed
 809 | drugs shall be set at the lowest ~~lesser~~ of: the average
 810 | wholesale price (AWP) minus 16.4 percent, the wholesaler
 811 | acquisition cost (WAC) plus 4.75 percent, the federal upper
 812 | limit (FUL), the state maximum allowable cost (SMAC), or the

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813 usual and customary (UAC) charge billed by the provider.
814 Effective March 1, 2011, the Medicaid maximum allowable fee for
815 ingredient cost shall be based on the lowest of: the wholesaler
816 acquisition costs (WAC), the federal upper limit (FUL), the
817 state maximum allowable cost (SMAC), or the usual and customary
818 (UAC) charge billed by the provider.

819 3. The agency shall develop and implement a process for
820 managing the drug therapies of Medicaid recipients who are using
821 significant numbers of prescribed drugs each month. The
822 management process may include, but is not limited to,
823 comprehensive, physician-directed medical-record reviews, claims
824 analyses, and case evaluations to determine the medical
825 necessity and appropriateness of a patient's treatment plan and
826 drug therapies. The agency may contract with a private
827 organization to provide drug-program-management services. The
828 Medicaid drug benefit management program shall include
829 initiatives to manage drug therapies for HIV/AIDS patients,
830 patients using 20 or more unique prescriptions in a 180-day
831 period, and the top 1,000 patients in annual spending. The
832 agency shall enroll any Medicaid recipient in the drug benefit
833 management program if he or she meets the specifications of this
834 provision and is not enrolled in a Medicaid health maintenance
835 organization.

836 4. The agency may limit the size of its pharmacy network
837 based on need, competitive bidding, price negotiations,
838 credentialing, or similar criteria. The agency shall give
839 special consideration to rural areas in determining the size and
840 location of pharmacies included in the Medicaid pharmacy

841 network. A pharmacy credentialing process may include criteria
842 such as a pharmacy's full-service status, location, size,
843 patient educational programs, patient consultation, disease
844 management services, and other characteristics. The agency may
845 impose a moratorium on Medicaid pharmacy enrollment when it is
846 determined that it has a sufficient number of Medicaid-
847 participating providers. The agency must allow dispensing
848 practitioners to participate as a part of the Medicaid pharmacy
849 network regardless of the practitioner's proximity to any other
850 entity that is dispensing prescription drugs under the Medicaid
851 program. A dispensing practitioner must meet all credentialing
852 requirements applicable to his or her practice, as determined by
853 the agency.

854 5. The agency shall develop and implement a program that
855 requires Medicaid practitioners who prescribe drugs to use a
856 counterfeit-proof prescription pad for Medicaid prescriptions.
857 The agency shall require the use of standardized counterfeit-
858 proof prescription pads by Medicaid-participating prescribers or
859 prescribers who write prescriptions for Medicaid recipients. The
860 agency may implement the program in targeted geographic areas or
861 statewide.

862 6. The agency may enter into arrangements that require
863 manufacturers of generic drugs prescribed to Medicaid recipients
864 to provide rebates of at least 15.1 percent of the average
865 manufacturer price for the manufacturer's generic products.
866 These arrangements shall require that if a generic-drug
867 manufacturer pays federal rebates for Medicaid-reimbursed drugs
868 at a level below 15.1 percent, the manufacturer must provide a

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869 supplemental rebate to the state in an amount necessary to
870 achieve a 15.1-percent rebate level.

871 7. The agency may establish a preferred drug list as
872 described in this subsection, and, pursuant to the establishment
873 of such preferred drug list, it is authorized to negotiate
874 supplemental rebates from manufacturers that are in addition to
875 those required by Title XIX of the Social Security Act and at no
876 less than 14 percent of the average manufacturer price as
877 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
878 the federal or supplemental rebate, or both, equals or exceeds
879 29 percent. There is no upper limit on the supplemental rebates
880 the agency may negotiate. The agency may determine that specific
881 products, brand-name or generic, are competitive at lower rebate
882 percentages. Agreement to pay the minimum supplemental rebate
883 percentage will guarantee a manufacturer that the Medicaid
884 Pharmaceutical and Therapeutics Committee will consider a
885 product for inclusion on the preferred drug list. However, a
886 pharmaceutical manufacturer is not guaranteed placement on the
887 preferred drug list by simply paying the minimum supplemental
888 rebate. Agency decisions shall ~~will~~ be made on the clinical
889 efficacy of a drug and recommendations of the Medicaid
890 Pharmaceutical and Therapeutics Committee, as well as the price
891 of competing products minus federal and state rebates. The
892 agency is authorized to contract with an outside agency or
893 contractor to conduct negotiations for supplemental rebates. For
894 the purposes of this section, the term "supplemental rebates"
895 means cash rebates. Effective July 1, 2004, value-added programs
896 as a substitution for supplemental rebates are prohibited. The

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897 agency is authorized to seek any federal waivers to implement
 898 this initiative.

899 8. The Agency for Health Care Administration shall expand
 900 home delivery of pharmacy products. To assist Medicaid patients
 901 in securing their prescriptions and reduce program costs, the
 902 agency shall expand its current mail-order-pharmacy diabetes-
 903 supply program to include all generic and brand-name drugs used
 904 by Medicaid patients with diabetes. Medicaid recipients in the
 905 current program may obtain nondiabetes drugs on a voluntary
 906 basis. This initiative is limited to the geographic area covered
 907 by the current contract. The agency may seek and implement any
 908 federal waivers necessary to implement this subparagraph.

909 9. The agency shall limit to one dose per month any drug
 910 prescribed to treat erectile dysfunction.

911 10.a. The agency may implement a Medicaid behavioral drug
 912 management system. The agency may contract with a vendor that
 913 has experience in operating behavioral drug management systems
 914 to implement this program. The agency is authorized to seek
 915 federal waivers to implement this program.

916 b. The agency, in conjunction with the Department of
 917 Children and Family Services, may implement the Medicaid
 918 behavioral drug management system that is designed to improve
 919 the quality of care and behavioral health prescribing practices
 920 based on best practice guidelines, improve patient adherence to
 921 medication plans, reduce clinical risk, and lower prescribed
 922 drug costs and the rate of inappropriate spending on Medicaid
 923 behavioral drugs. The program may include the following
 924 elements:

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925 (I) Provide for the development and adoption of best
926 practice guidelines for behavioral health-related drugs such as
927 antipsychotics, antidepressants, and medications for treating
928 bipolar disorders and other behavioral conditions; translate
929 them into practice; review behavioral health prescribers and
930 compare their prescribing patterns to a number of indicators
931 that are based on national standards; and determine deviations
932 from best practice guidelines.

933 (II) Implement processes for providing feedback to and
934 educating prescribers using best practice educational materials
935 and peer-to-peer consultation.

936 (III) Assess Medicaid beneficiaries who are outliers in
937 their use of behavioral health drugs with regard to the numbers
938 and types of drugs taken, drug dosages, combination drug
939 therapies, and other indicators of improper use of behavioral
940 health drugs.

941 (IV) Alert prescribers to patients who fail to refill
942 prescriptions in a timely fashion, are prescribed multiple same-
943 class behavioral health drugs, and may have other potential
944 medication problems.

945 (V) Track spending trends for behavioral health drugs and
946 deviation from best practice guidelines.

947 (VI) Use educational and technological approaches to
948 promote best practices, educate consumers, and train prescribers
949 in the use of practice guidelines.

950 (VII) Disseminate electronic and published materials.

951 (VIII) Hold statewide and regional conferences.

952 (IX) Implement a disease management program with a model

953 | quality-based medication component for severely mentally ill
 954 | individuals and emotionally disturbed children who are high
 955 | users of care.

956 | 11.a. The agency shall implement a Medicaid prescription
 957 | drug management system. The agency may contract with a vendor
 958 | that has experience in operating prescription drug management
 959 | systems in order to implement this system. Any management system
 960 | that is implemented in accordance with this subparagraph must
 961 | rely on cooperation between physicians and pharmacists to
 962 | determine appropriate practice patterns and clinical guidelines
 963 | to improve the prescribing, dispensing, and use of drugs in the
 964 | Medicaid program. The agency may seek federal waivers to
 965 | implement this program.

966 | b. The drug management system must be designed to improve
 967 | the quality of care and prescribing practices based on best
 968 | practice guidelines, improve patient adherence to medication
 969 | plans, reduce clinical risk, and lower prescribed drug costs and
 970 | the rate of inappropriate spending on Medicaid prescription
 971 | drugs. The program must:

972 | (I) Provide for the development and adoption of best
 973 | practice guidelines for the prescribing and use of drugs in the
 974 | Medicaid program, including translating best practice guidelines
 975 | into practice; reviewing prescriber patterns and comparing them
 976 | to indicators that are based on national standards and practice
 977 | patterns of clinical peers in their community, statewide, and
 978 | nationally; and determine deviations from best practice
 979 | guidelines.

980 | (II) Implement processes for providing feedback to and

981 educating prescribers using best practice educational materials
 982 and peer-to-peer consultation.

983 (III) Assess Medicaid recipients who are outliers in their
 984 use of a single or multiple prescription drugs with regard to
 985 the numbers and types of drugs taken, drug dosages, combination
 986 drug therapies, and other indicators of improper use of
 987 prescription drugs.

988 (IV) Alert prescribers to patients who fail to refill
 989 prescriptions in a timely fashion, are prescribed multiple drugs
 990 that may be redundant or contraindicated, or may have other
 991 potential medication problems.

992 (V) Track spending trends for prescription drugs and
 993 deviation from best practice guidelines.

994 (VI) Use educational and technological approaches to
 995 promote best practices, educate consumers, and train prescribers
 996 in the use of practice guidelines.

997 (VII) Disseminate electronic and published materials.

998 (VIII) Hold statewide and regional conferences.

999 (IX) Implement disease management programs in cooperation
 1000 with physicians and pharmacists, along with a model quality-
 1001 based medication component for individuals having chronic
 1002 medical conditions.

1003 12. The agency is authorized to contract for drug rebate
 1004 administration, including, but not limited to, calculating
 1005 rebate amounts, invoicing manufacturers, negotiating disputes
 1006 with manufacturers, and maintaining a database of rebate
 1007 collections.

1008 13. The agency may specify the preferred daily dosing form

1009 or strength for the purpose of promoting best practices with
 1010 regard to the prescribing of certain drugs as specified in the
 1011 General Appropriations Act and ensuring cost-effective
 1012 prescribing practices.

1013 14. The agency may require prior authorization for
 1014 Medicaid-covered prescribed drugs. The agency may, but is not
 1015 required to, prior-authorize the use of a product:

- 1016 a. For an indication not approved in labeling;
- 1017 b. To comply with certain clinical guidelines; or
- 1018 c. If the product has the potential for overuse, misuse,
 1019 or abuse.

1020
 1021 The agency may require the prescribing professional to provide
 1022 information about the rationale and supporting medical evidence
 1023 for the use of a drug. The agency may post prior authorization
 1024 criteria and protocol and updates to the list of drugs that are
 1025 subject to prior authorization on an Internet website without
 1026 amending its rule or engaging in additional rulemaking.

1027 15. The agency, in conjunction with the Pharmaceutical and
 1028 Therapeutics Committee, may require age-related prior
 1029 authorizations for certain prescribed drugs. The agency may
 1030 preauthorize the use of a drug for a recipient who may not meet
 1031 the age requirement or may exceed the length of therapy for use
 1032 of this product as recommended by the manufacturer and approved
 1033 by the Food and Drug Administration. Prior authorization may
 1034 require the prescribing professional to provide information
 1035 about the rationale and supporting medical evidence for the use
 1036 of a drug.

1037 16. The agency shall implement a step-therapy prior
 1038 authorization approval process for medications excluded from the
 1039 preferred drug list. Medications listed on the preferred drug
 1040 list must be used within the previous 12 months prior to the
 1041 alternative medications that are not listed. The step-therapy
 1042 prior authorization may require the prescriber to use the
 1043 medications of a similar drug class or for a similar medical
 1044 indication unless contraindicated in the Food and Drug
 1045 Administration labeling. The trial period between the specified
 1046 steps may vary according to the medical indication. The step-
 1047 therapy approval process shall be developed in accordance with
 1048 the committee as stated in s. 409.91195(7) and (8). A drug
 1049 product may be approved without meeting the step-therapy prior
 1050 authorization criteria if the prescribing physician provides the
 1051 agency with additional written medical or clinical documentation
 1052 that the product is medically necessary because:

1053 a. There is not a drug on the preferred drug list to treat
 1054 the disease or medical condition which is an acceptable clinical
 1055 alternative;

1056 b. The alternatives have been ineffective in the treatment
 1057 of the beneficiary's disease; or

1058 c. Based on historic evidence and known characteristics of
 1059 the patient and the drug, the drug is likely to be ineffective,
 1060 or the number of doses have been ineffective.

1061
 1062 The agency shall work with the physician to determine the best
 1063 alternative for the patient. The agency may adopt rules waiving
 1064 the requirements for written clinical documentation for specific

1065 | drugs in limited clinical situations.

1066 | 17. The agency shall implement a return and reuse program
 1067 | for drugs dispensed by pharmacies to institutional recipients,
 1068 | which includes payment of a \$5 restocking fee for the
 1069 | implementation and operation of the program. The return and
 1070 | reuse program shall be implemented electronically and in a
 1071 | manner that promotes efficiency. The program must permit a
 1072 | pharmacy to exclude drugs from the program if it is not
 1073 | practical or cost-effective for the drug to be included and must
 1074 | provide for the return to inventory of drugs that cannot be
 1075 | credited or returned in a cost-effective manner. The agency
 1076 | shall determine if the program has reduced the amount of
 1077 | Medicaid prescription drugs which are destroyed on an annual
 1078 | basis and if there are additional ways to ensure more
 1079 | prescription drugs are not destroyed which could safely be
 1080 | reused. The agency's conclusion and recommendations shall be
 1081 | reported to the Legislature by December 1, 2005.

1082 | Section 14. Subsection (3) is added to section 430.707,
 1083 | Florida Statutes, to read:

1084 | 430.707 Contracts.—

1085 | (3) Any entity that provides or is authorized by state law
 1086 | to provide benefits pursuant to the Program of All-inclusive
 1087 | Care for the Elderly on or before July 1, 2010, may submit an
 1088 | application for an expansion of service capacity sufficient to
 1089 | meet the needs of potentially eligible program enrollees within
 1090 | the service area designated by state law. The agency, in
 1091 | consultation with the department, shall accept and forward to
 1092 | the Centers for Medicare and Medicaid Services the application

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1093 for an expansion of service capacity for additional enrollees
1094 from an entity that provides benefits pursuant to the Program of
1095 All-inclusive Care for the Elderly and that is in good standing
1096 with the agency, the department, and the Centers for Medicare
1097 and Medicaid Services.

1098 Section 15. This act shall take effect July 1, 2010.