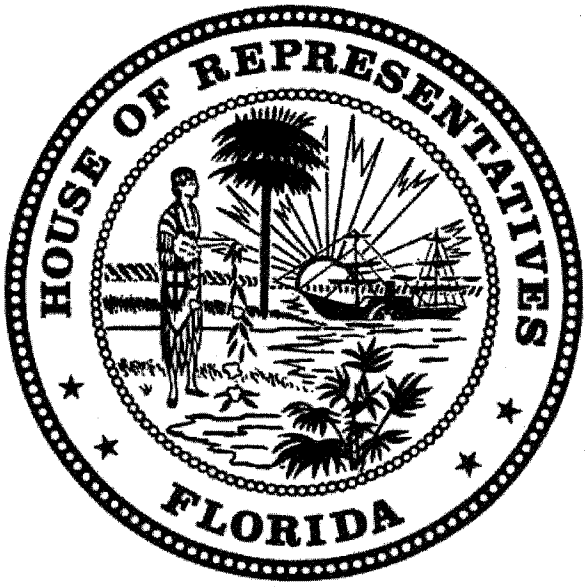

Health & Human Services Committee

Monday, April 29, 2013
8:00 AM – 9:00 AM
Morris Hall

Will Weatherford
Speaker

Richard Corcoran
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Committee

Start Date and Time:	Monday, April 29, 2013 08:00 am
End Date and Time:	Monday, April 29, 2013 09:00 am
Location:	Morris Hall (17 HOB)
Duration:	1.00 hrs

Consideration of the following bill(s):

HB 605 Workers' Compensation by Hudson
CS/HB 793 Cost-effective Purchasing of Health Care by Health Innovation Subcommittee, Diaz, J.

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Sunday, April 28, 2013.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Sunday, April 28, 2013.

NOTICE FINALIZED on 04/26/2013 18:45 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 605 Workers' Compensation
SPONSOR(S): Hudson
TIED BILLS: **IDEN./SIM. BILLS:** SB 662

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N	Poche	O'Callaghan
2) Insurance & Banking Subcommittee	10 Y, 1 N	Reilly	Cooper
3) Health & Human Services Committee		Poche	Calamas

SUMMARY ANALYSIS

Florida's workers' compensation law, ch. 440, F.S., provides medically necessary treatment and care for injured employees, including medications. Reimbursement for prescription drugs (generally to dispensing physicians and pharmacies) is the average wholesale price (AWP) plus a $4.18 dispensing fee, or at a contract rate, whichever is lower. AWP is not defined in the workers' compensation law and does not have a universally accepted definition.

Prescription drug repackaging companies are licensed by the Department of Business and Professional Regulation. Drug repackagers purchase pharmaceuticals in bulk from the manufacturer and repackage the drugs into individual prescription sizes. The repackaged drugs are then assigned a different AWP than the manufacturer's AWP, which is often substantially higher than the manufacturer's AWP. As such, the cost for a prescription filled with repackaged drugs in the workers' compensation system is generally much higher than it would have been if the prescription had been filled with the same drug that had not been repackaged. The overwhelming majority of repackaged drugs in Florida's workers' compensation system are dispensed by physicians who are authorized to dispense drugs at their office.

It is estimated that higher reimbursements for repackaged or relabeled drugs add $27.3 million annually to workers' compensation costs, and that providing the same reimbursement for the same prescription drug, regardless of whether the dispensed drug is repackaged, relabeled, or non-repackaged, will decrease system costs by 1.1%. The Office of Insurance Regulation approved a workers' compensation rate filing that provides for an overall 6.1% increase in workers' compensation premiums effective January 1, 2013.

The bill provides the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs. Specifically, reimbursement for repackaged or relabeled drugs is to be calculated by multiplying the number of units of the drug dispensed by the per-unit AWP set by the original manufacturer of the drug (which may not be the manufacturer of the repackaged or relabeled drug), plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The bill expressly prohibits the price of repackaged or relabeled drugs from exceeding the amount that would otherwise be payable had the drug not been repackaged or relabeled. This reimbursement formula was included in HB 5603 (2010), which was vetoed by Governor Crist.

The bill appears to have an indeterminate fiscal impact on state and local government.

The bill is effective July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Florida's Workers' Compensation Program

Workers' Compensation Benefits[1]

Chapter 440, F.S., is Florida's workers' compensation law. For work-related injuries, workers' compensation requires employers, or employers' insurance carriers, to pay for:

- Medically necessary remedial treatment, care, and attendance, including medicines,[2] medical supplies, durable medical equipment, and prosthetics.[3]
- Compensation for disability when the injury causes an employee to miss more than 7 days of work.[4]

The Division of Workers' Compensation (Division) within the Department of Financial Services (DFS) provides regulatory oversight of Florida's workers' compensation system.

To be eligible for payment under the workers' compensation law, health care providers who treat injured employees, except for emergency treatment, must apply for and be certified by the DFS and receive authorization from the insurer before providing treatment.[5] As of March 25, 2013, there were 37,116 certified health care providers in the workers' compensation system.[6]

Reimbursement for Prescription Drugs in Workers' Compensation

Reimbursement to pharmacies and dispensing physicians for prescription drugs in workers' compensation is provided for in s. 440.13(12)(c), F.S. Under current law, prescription drugs are reimbursed at the average wholesale price (AWP) plus a $4.18 dispensing fee, or at a contract rate, whichever is lower.[7, 8] AWP is not defined in the workers' compensation statute and does not appear to have a universally accepted definition.[9,10]

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[1] Whether an employer is required to have workers' compensation insurance depends upon the employer's industry (construction, non-construction, or agricultural) and the number of employees.

[2] Many workers' compensation insurers have implemented prescription drug programs (sometimes called "first fill" programs) designed to avoid out-of-pocket pharmacy expenses to injured employees for the initial prescription filled at the pharmacy as well as subsequent prescriptions. Under such a program, an injured employee may be given a form or card to show at a pharmacy to avoid out-of-pocket expense.

[3] Section 440.13(2) (a), F.S.

[4] Section 440.12(1), F.S.

[5] Section 440.13(3)(a), F.S.; Rule 69L-29.002, F.A.C.

[6] Florida Department of Financial Services, "Division of Workers Compensation Health Care Provider Directory," available at https://apps.fldfs.com/provider/ (last viewed April 26, 2013).

[7] Fees for pharmaceuticals and pharmaceutical services must be reimbursable at the applicable fee schedule amount. Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier must reimburse at the scheduled, negotiated, or contract price, whichever is lower. The contract may not rely on a provider that is not reasonably accessible to the employee. Section 440.13(12)(c), F.S.

[8] In response to inquiries received by the Florida Division of Workers' Compensation (Division) as to whether employers/carriers may appropriately deny authorization or reimbursement for prescription medication that is dispensed by a physician instead of a pharmacist, the DFS issued Informational Bulletin DFS-02-2009 on August 12, 2009. The bulletin informs, in part, that the Division is unaware of any specific provisions of the workers' compensation law that addresses the issue presented; available at: http://www.myfloridacfo.com/wc/ (last viewed on April 26, 2013).

[9] *See*, for example, "Prescription Benchmarks for Florida, 2nd Edition," a 2011 study by the Workers' Compensation Research Institute (WCRI study) compared with "Impact of Physician-Dispensing of Repackaged Drugs on California Workers' Compensation, Employers Cost, and Workers' Access to Quality Care," a 2006 study conducted by Frank Neuhauser and colleagues for the California

Physician Dispensing of Drugs

The authority for a physician to dispense medicinal drugs is found in s. 465.0276, F.S. Physician dispensing is regulated by the relevant licensing boards with the Department of Health. To dispense medicinal drugs, a physician must register with the applicable professional licensing board and pay a fee of $100.[11] In addition, the physician must comply with all applicable statutes found in ch. 465, ch. 499, and ch. 893, F.S., all applicable rules, and federal laws regarding the dispensing of medicinal drugs.[12] Lastly, a physician must provide the patient with a written prescription and advise him or her, orally or in writing, that there is an option to have the prescription filled at the doctor's office or at a pharmacy.[13]

A physician may not dispense controlled substances listed in Schedule II and Schedule III, as provided in s. 893.03, F.S.[14] However, the following actions are exempted from the ban on physician dispensing:

- Dispensing complimentary medications in the normal course of practice without payment or remuneration;
- Dispensing a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure, limited to a 14 day supply;
- Dispensing a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial;
- Dispensing methadone in a methadone clinic licensed under s. 397.427, F.S.; and
- Dispensing a controlled substance listed in Schedule II or Schedule III in a hospice care facility licensed under part IV of ch. 400, F.S.[15]

Currently, there are 7,187 registered dispensing physicians in Florida.[16] The number of certified workers' compensation health care providers who are also authorized to dispense drugs is unknown.

Relabeled or Repackaged Drugs

The term "repackage," used in the context of distributing drugs in Florida, means to repack or otherwise change the container, wrapping, or labeling to further the distribution of a drug, device, or cosmetic.[17] A

Commission on Health and Safety and Workers' Compensation (California study). The WCRI defines average wholesale price as: "Published by First DataBank and Medi-Span ®. The AWP operates as an available price index that represents the most common wholesaler price charged to customers. The AWP does not necessarily represent the actual sales price in any single transaction. The payors may negotiate for lower prices. In workers' compensation systems, however, the AWP is often used as a price benchmark for pharmacy reimbursements of prescription drugs." [Note: On September 28, 2011, First DataBank discontinued publication of the "Blue Book Average Wholesale Price." *See* http://www.firstdatabank.com/Support/drug-pricing-policy.aspx.] The California study states that: "AWP is probably the most widely quoted pricing benchmark, but the least meaningful.... unlike what the name implies, the price has no relation to a wholesale price, average or otherwise. It is simply a price point established by the manufacturer, wholesaler, or repackager....The AWP...is typically much higher than the actual amounts that are paid by pharmacies and other wholesale drug purchasers...." Details on the WCRI study are available at http://www.wcrinet.org/. The California study is available at http://www.dir.ca.gov/chswc/search/query.asp?SearchType=0 (last viewed April 26, 2013).

[10] The Florida Division of Workers' Compensation informs that in the event of a reimbursement dispute it would rely on the "Drug Topics Red Book," published by Thomson Reuters (New York) to determine the average wholesale price. The "Red Book" is listed as a reference source in the "Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2008 Edition." The Reimbursement Manual is available at http://www.myfloridacfo.com/wc/ (last viewed April 26, 2013).

[11] Section 465.0276(2)(a), F.S.; Rule 64B8-3.006, F.A.C. Registration is not required for dispensing complimentary medications in the normal course of practice without payment or remuneration.

[12] Section 465.0276(2)(b), F.S.; ch. 499, F.S., contains the Florida Drug and Cosmetic Act, administered by the DBPR; ch. 893, F.S., contains the Florida Comprehensive Drug Abuse Prevention and Control Act, which was significantly amended during the 2011 Regular Legislative session; *see also* ch. 2011-141, L.O.F.

[13] Section 465.0276(2)(c), F.S.

[14] Section 465.0276(1)(b), F.S.; *see also* s. 15, ch. 2011-141, L.O.F.

[15] Sections 465.0276(1)(b)1. through 6., F.S.

[16] Email correspondence from the Florida Department of Health on file with staff of the Health and Human Services Committee, dated March 15, 2013.

[17] Section 499.03(49), F.S.

"repackager" means a person who repackages a drug, device, or cosmetic, but specifically excludes pharmacies operating in compliance with pharmacy practice standards set out in ch. 465, F.S., and under applicable rules.[18] The term "repackaged" drugs refers to pharmaceuticals that have been purchased in bulk by a repackager from a manufacturer, relabeled, and repackaged into individual prescription sizes that can be dispensed directly by physicians to patients.

Rule 61N-1.001, F.A.C., defines "repackaging or otherwise changing the container, wrapper, or labeling to further the distribution" to mean:

- Altering a packaging component that is or may be in direct contact with the drug, device, or cosmetic. For example, repackaging from bottles of 1000 pills to bottles of 100 pills.
- Altering a manufacturer's package for sale under a label different from the manufacturer. For example, a kit that contains an injectable vaccine from manufacturer A; a syringe from manufacturer B; alcohol from manufacturer C; and sterile gauze from manufacturer D packaged together and marketed as an immunization kit under a label of manufacturer Z.
- Altering a package of multiple-units, which the manufacturer intended to be distributed as one unit, for sale or transfer to a person engaged in the further distribution of the product. This does not include:
    - Selling or transferring an individual unit which is a fully labeled self-contained package that is shipped by the manufacturer in multiple units, or
    - Selling or transferring a fully labeled individual unit, by adding the package insert, by a person authorized to distribute prescription drugs to an institutional pharmacy permit, health care practitioner or emergency medical service provider for the purpose of administration and not for dispensing or further distribution.

Repackagers may assign an AWP for a repackaged drug that differs from the AWP suggested by the original manufacturer of the drug.[19] Frequently, the AWP assigned by the drug repackager is significantly greater than the AWP suggested by the drug's manufacturer. Thus, the cost of the repackaged drug, in terms of reimbursement paid by an insurer, is often significantly greater than it would have been if the prescription had been filled with the identical non-repackaged drug.

The Florida Department of Business and Professional Regulation (DBPR), which regulates prescription drug repackagers, reports that there are 28 licensed prescription drug repackagers in the state.[20]

The Cost of Repackaged or Relabeled Prescription Drugs to Florida's Workers' Compensation System

The National Council on Compensation Insurance (NCCI) is the designated licensed rating and statistical organization for workers' compensation in Florida. Among its responsibilities, NCCI collects data from workers' compensation insurers in Florida and makes rate filings on the insurers' behalf. The workers' compensation rate filing for 2013 provides for an overall increase in workers' compensation rates of 6.1%.[21]

Using 2011 data from the Division, the NCCI has estimated that reimbursements for repackaged or relabeled prescription drugs add $27.3 million in annual costs to the workers' compensation system,

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[18] Section 499.003(50), F.S.

[19] United States Government Accountability Office, "Brand-Name Prescription Drug Pricing: Lack of Therapeutically Equivalent Drugs and Limited Competition May Contribute to Extraordinary Price Increases" (GAO-10-201, December 2009); available at http://www.gao.gov/products/GAO-10-201 (last viewed April 26, 2013).

[20] Correspondence from the Department of Business and Professional Regulation, dated March 14, 2013 (on file with staff of the Health and Human Services Committee). The DBPR also reports that as of March 2013, there were 275 "out-of-state prescription wholesaler distributor" permits issued. Such distributors are able to repackage drugs. However, the DBPR does not collect information as to whether applicants for such permits repackage drugs, as it does not have legal authority to regulate repackaging outside of the state of Florida.

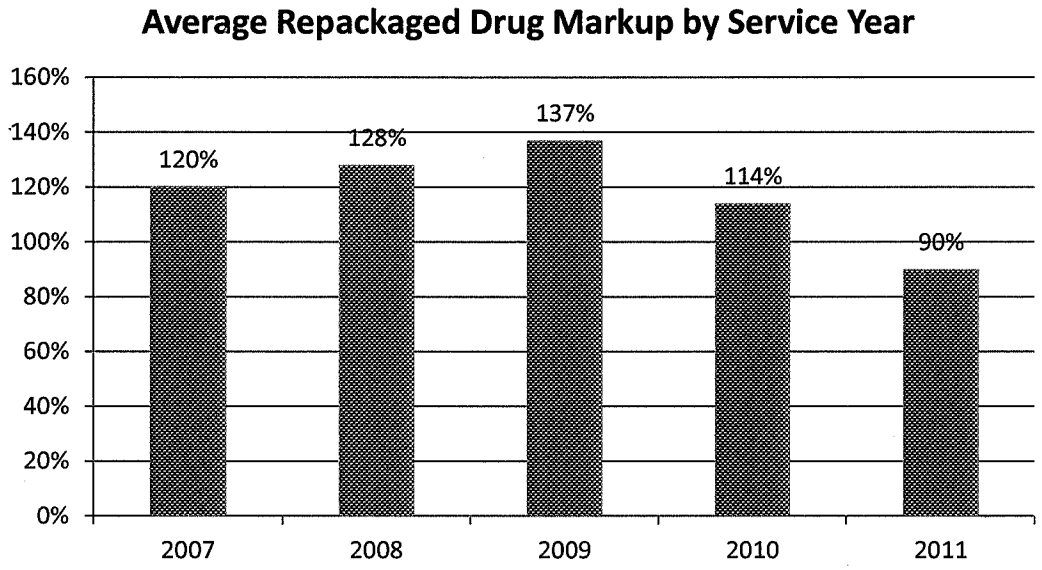
[21] Florida Office of Insurance Regulation, Office Statement, "OIR Approves Final Order for Workers' Compensation Rates" (November 5, 2012), available at http://www.floir.com/PressReleases/index.aspx (last viewed April 26, 2013).

and that elimination of the higher reimbursements available for these drugs, as compared to non-repackaged drugs, would decrease system costs by 1.1%.[22]

Additional findings about Florida's workers' compensation system include the following:

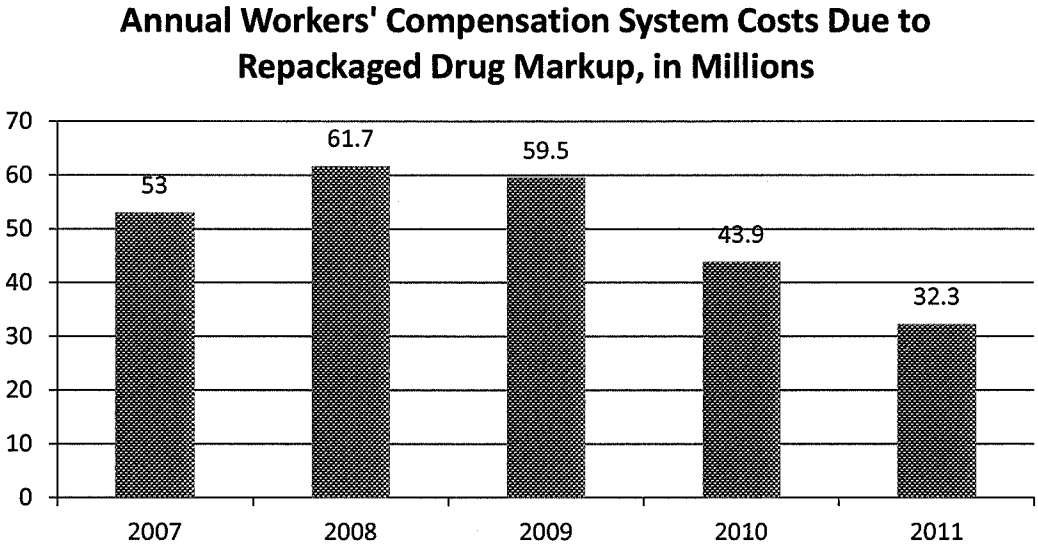
- The 10 most frequently dispensed repackaged drugs have an average markup of 54% to 625%.[23]
- Physician-dispensed drugs account for 62% of all prescription drug dollars; the second highest percentage of the 23 states in one study.[24]

The following chart illustrates the average markup of repackaged drugs from 2007 through 2011:[25]



Total workers' compensation system costs as a result of the markup on repackaged drugs were $250 million over the last five years.[26] The following chart shows the annual system costs attributed to the markup of repackaged drugs from 2007 to 2011:[27]

[22] National Council on Compensation Insurance, "Pricing of Workers Compensation Proposals 2013," page 8 (on file with staff of the Health and Human Services Committee); *see also* National Council on Compensation Insurance, "Analysis of Florida Proposal to Revise Reimbursement for Repackaged or Relabeled Prescription Drugs Effective Upon Adoption," September 25, 2012, page 1 (on file with staff of the Health and Human Services Committee).
[23] *Id.* at page 12. The 10 drugs are Meloxicam, Carisoprodol, Lidoderm®, Tramadol HCL, Omeprazole, Gabapentin, Ranitidine HCL, Cyclobenzaprine HCL, Naproxen, and Lyrica.
[24] Workers Compensation Research Institute, Wang, D., "Physician Dispensing in Workers' Compensation," July 2012, page 8, table A.
[25] *See supra*, FN 22 at page 10.
[26] *Id.* at page 14.
[27] *Id.*



The Three Member Panel (Panel) Biennial Report for 2013 makes the following observation regarding reimbursement to physicians in the workers' compensation system who are repackaging and dispensing medications:

> "...the current statutory benchmark of reimbursing prescription drugs at the Average Wholesale Price has led to a pricing environment that is not conducive to the self-execution of the workers' compensation system and does not provide reimbursement clarity and uniformity, which is a detriment to the payers and payees. The result has been a dramatic increase in the number of petitions for reimbursement dispute filed by physicians in FY 2011/2012 (up 872% over FY 2010/2011 from 1,308 to 12,718, respectively) primarily due to disputes involving physician dispensed medication."

The Panel believes that the Division will continue to see great numbers of petitions for reimbursement dispute being filed until a legislative and/or regulatory solution is achieved.[28,29]

Findings of the Workers' Compensation Research Institute[30]

In July 2011, the Workers' Compensation Research Institute (WCRI) published "Prescription Benchmarks for Florida, 2nd Edition,"[31] a study that compares the cost, price, and use of pharmaceuticals in workers' compensation in Florida with 16 other states.[32] Among the study's findings on Florida:

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[28] *Id.* at page 6.
[29] The three-member panel is comprised of the Chief Financial Officer, or the CFO's designee, and two members appointed by the Governor, subject to confirmation by the Senate. The two appointed members represent employers and employees, respectively, The panel determines statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment under Florida's workers' compensation system. See s. 440.13(12), F.S.
[30] WCRI is an independent research organization that analyzes workers' compensation systems for states with which it contracts. WCRI provides information through studies and data collection efforts, and does not take positions on the issues it researches.
[31] WCRI study, *supra* note 7.
[32] The 17 states in the WCRI study are California, Florida, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin.

- For 2007/2008, the average payment per workers' compensation claim for prescription drugs was $536, the second highest cost of the 17 states studied, and 45% higher than the median[33] of the states studied.[34]
- Between 2005/2006 and 2007/2008, the average cost per claim for prescription drugs in Florida increased by 14%, but remained relatively stable in the other study states.
- Higher and growing costs of prescription drugs in Florida were largely due to more frequent and higher-priced physician dispensing.
- Over a four-year period (from 2004/2005 and 2007/2008), the percentage of payments for physician-dispensed prescriptions increased from 17% to 46% of all prescription payments.
- In 2007/2008, for many common drugs, physicians were paid 40% to 80% more than pharmacies for the same prescription.
- 65% of physician-dispensed prescriptions were for pain medications.

Further, the WCRI study identifies and addresses two concerns that have been raised in response to proposals to eliminate higher reimbursements for repackaged drugs, and to provide the same rate of reimbursement for the same drug, whether it is repackaged or non-repackaged. The first concern is that prescription drug costs would increase. This position is based on the following assumptions: that physician dispensing would decrease and that physicians dispense generic drugs more frequently than pharmacies. For the most commonly dispensed drugs, the WCRI found that physicians and pharmacies almost always dispense generic drugs, and that physicians are paid much higher prices per pill than pharmacies for the same prescription.

A second concern with providing the same reimbursement for repackaged and non-repackaged drugs is that physicians would stop dispensing drugs, and patients who do not have prescriptions filled by their doctor are less likely to take their medicine as prescribed, which would be detrimental to the patient. For California, the 2011 WCRI study reports that physician dispensing decreased from 50% to 25% of all prescriptions immediately following enactment of a reform to provide the same reimbursement for repackaged and non-repackaged drugs.[35] In a subsequent study, "Physician Dispensing in Workers' Compensation," published in July 2012, the WCRI reports that three years after the California reform nearly half of all prescriptions in that state were dispensed by physicians.[36]

Effect of Proposed Changes

The bill provides the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs. Specifically, reimbursement for repackaged or relabeled drugs is to be calculated by multiplying the number of units of the drug dispensed by the per-unit AWP set by the original manufacturer of the drug (which may not be the manufacturer of the repackaged or relabeled drug), plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The bill expressly prohibits the price of repackaged or relabeled drugs from exceeding the amount that would otherwise be payable had the drug not been repackaged or relabeled.

B. SECTION DIRECTORY:

Section 1: Amends s. 440.13, F.S., relating to medical services and supplies; penalty for violations; limitations.
Section 2: Provides an effective date of July 1, 2013.

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[33] The Merriam-Webster Dictionary online defines median as "a value in an ordered set of values below and above which there is an equal number of values or which is the arithmetic mean of the two middle values if there is no one middle number...." *See* http://www.merriam-webster.com/dictionary.htm.
[34] WCRI study, *supra* note 7, informs that physician dispensing is not generally allowed in three of the states in its study - Massachusetts, New York, and Texas.
[35] Data from the first quarter of 2008. Subsequent dispensing patterns are not addressed in this study.
[36] *See* http://www.wcrinet.org/.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

To the extent that repackaged drugs are dispensed by physicians to state government employees who suffer a workplace injury, the bill will lower the costs that state government pays for prescription drugs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

To the extent that repackaged drugs are dispensed by physicians to local government employees who suffer a workplace injury, the bill will lower the costs that local governments pay for prescription drugs. Also, for local governments that have procured workers' compensation insurance coverage, there may be a reduction in insurance premiums to reflect system-wide savings of 1.1%, as estimated by the NCCI.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providing the same rate of reimbursement for repackaged or relabeled drugs as for non-repackaged drugs could save Florida employers $27.3 million annually in workers' compensation costs, a 1.1% system savings.[37]

Physicians that dispense prescription drugs under the workers' compensation system will continue to receive a $4.18 dispensing fee for each prescription they fill, but will no longer derive additional income from current higher reimbursements.

D. FISCAL COMMENTS:

The bill will result in significant savings to state and local governments and lower workers' compensation costs for Florida employers.

[37] *See supra* at FN 22.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to require counties or municipalities to spend funds or take an action requiring the expenditure of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; revising requirements for determining the amount of a reimbursement for repackaged or relabeled prescription medication; providing limitations; providing an effective date.

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

Section 1. Paragraph (c) of subsection (12) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(c) As to reimbursement for a prescription medication, regardless of the location from which or the provider from whom the claimant receives the prescription medication, the reimbursement amount ~~for a prescription~~ shall be the average wholesale price plus $4.18 for the dispensing fee, unless ~~except where~~ the carrier has contracted for a lower amount. If the drug has been repackaged or relabeled, the reimbursement amount shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug, which may not be the manufacturer of the repackaged or relabeled drug, plus a $4.18 dispensing fee, unless the carrier has contracted for a lower amount. The repackaged or relabeled drug price may not exceed

the amount otherwise payable had the drug not been repackaged or relabeled. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount. If ~~Where~~ the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. ~~No~~ Such contract may not ~~shall~~ rely on a provider that is not reasonably accessible to the employee.

Section 2. This act shall take effect July 1, 2013.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED	__ (Y/N)
ADOPTED AS AMENDED	__ (Y/N)
ADOPTED W/O OBJECTION	__ (Y/N)
FAILED TO ADOPT	__ (Y/N)
WITHDRAWN	__ (Y/N)
OTHER	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Hudson offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (12) of section 440.13, Florida Statutes, is amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.—

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor, subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a

representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work-hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a schedule of per diem rates, to be approved by the three-member panel no later than March 1, 1994, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours. All compensable charges for hospital outpatient care shall be reimbursed at 75 percent of usual and customary charges, except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.

4. Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

5. Maximum reimbursement for surgical procedures shall be increased to 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

(c) As to reimbursement for a prescription medication, the reimbursement amount for a prescription shall be the average wholesale price plus $4.18 for the dispensing fee~~, except where the carrier has contracted for a lower amount~~. For repackaged or relabeled prescription medications dispensed by a dispensing practitioner as provided in s. 465.0276, the fee schedule for reimbursement shall be 112.5 percent of the average wholesale price, plus $8.00 for the dispensing fee. For purposes of this

subsection, the average wholesale price shall be calculated by multiplying the number of units dispensed times the per-unit average wholesale price set by the original manufacturer of the underlying drug dispensed by the practitioner, based upon the published manufacturer's average wholesale price published in the Medi-Span Master Drug Database as of the date of dispensing. All pharmaceutical claims submitted for repackaged or relabeled prescription medications must include the National Drug Code of the original manufacturer. Fees for pharmaceuticals and pharmaceutical services shall be reimbursable at the applicable fee schedule amount except where the employer or carrier, or a service company, third party administrator, or any entity acting on behalf of the employer or carrier directly contracts with the provider seeking reimbursement for a lower amount. ~~Where the employer or carrier has contracted for such services and the employee elects to obtain them through a provider not a party to the contract, the carrier shall reimburse at the schedule, negotiated, or contract price, whichever is lower. No Such contract shall rely on a provider that is not reasonably accessible to the employee.~~

(d) Reimbursement for all fees and other charges for such treatment, care, and attendance, including treatment, care, and attendance provided by any hospital or other health care provider, ambulatory surgical center, work-hardening program, or pain program, must not exceed the amounts provided by the uniform schedule of maximum reimbursement allowances as determined by the panel or as otherwise provided in this section. This subsection also applies to independent medical

examinations performed by health care providers under this chapter. In determining the uniform schedule, the panel shall first approve the data which it finds representative of prevailing charges in the state for similar treatment, care, and attendance of injured persons. Each health care provider, health care facility, ambulatory surgical center, work-hardening program, or pain program receiving workers' compensation payments shall maintain records verifying their usual charges. In establishing the uniform schedule of maximum reimbursement allowances, the panel must consider:

1. The levels of reimbursement for similar treatment, care, and attendance made by other health care programs or third-party providers;

2. The impact upon cost to employers for providing a level of reimbursement for treatment, care, and attendance which will ensure the availability of treatment, care, and attendance required by injured workers;

3. The financial impact of the reimbursement allowances upon health care providers and health care facilities, including trauma centers as defined in s. 395.4001, and its effect upon their ability to make available to injured workers such medically necessary remedial treatment, care, and attendance. The uniform schedule of maximum reimbursement allowances must be reasonable, must promote health care cost containment and efficiency with respect to the workers' compensation health care delivery system, and must be sufficient to ensure availability of such medically necessary remedial treatment, care, and attendance to injured workers; and

4. The most recent average maximum allowable rate of increase for hospitals determined by the Health Care Board under chapter 408.

(e) In addition to establishing the uniform schedule of maximum reimbursement allowances, the panel shall:

1. Take testimony, receive records, and collect data to evaluate the adequacy of the workers' compensation fee schedule, nationally recognized fee schedules and alternative methods of reimbursement to certified health care providers and health care facilities for inpatient and outpatient treatment and care.

2. Survey certified health care providers and health care facilities to determine the availability and accessibility of workers' compensation health care delivery systems for injured workers.

3. Survey carriers to determine the estimated impact on carrier costs and workers' compensation premium rates by implementing changes to the carrier reimbursement schedule or implementing alternative reimbursement methods.

4. Submit recommendations on or before January 1, 2003, and biennially thereafter, to the President of the Senate and the Speaker of the House of Representatives on methods to improve the workers' compensation health care delivery system.

The department, as requested, shall provide data to the panel, including, but not limited to, utilization trends in the workers' compensation health care delivery system. The department shall provide the panel with an annual report regarding the resolution of medical reimbursement disputes and

any actions pursuant to subsection (8). The department shall provide administrative support and service to the panel to the extent requested by the panel. For prescription medication purchased under the requirements of this subsection, a dispensing practitioner shall not possess such medication unless payment has been made by the practitioner, the practitioner's professional practice, or the practitioner's practice management company or employer to the supplying manufacturer, wholesaler, distributor, or drug repackager within 60 days of the dispensing practitioner taking possession of that medication.

Section 2. This act shall take effect July 1, 2013.

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

Remove everything before the enacting clause and insert:

A bill to be entitled

An act relating to workers' compensation; amending s. 440.13, F.S.; revising requirements for determining the amount of a reimbursement for repackaged or relabeled prescription medication; providing an exception; prohibiting a dispensing manufacturer from possession of a medicinal drug until certain persons are paid; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 793 Cost-effective Purchasing of Health Care
SPONSOR(S): Health Innovation Subcommittee; Diaz
TIED BILLS: **IDEN./SIM. BILLS:** SB 896

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 1 N, As CS	McElroy	Shaw
2) Health & Human Services Committee		McElroy	Calamas

SUMMARY ANALYSIS

Medicaid currently covers dental services for children, and, on a more limited basis, for adults. Dental services are provided through both fee-for-service and managed care delivery systems.

Pursuant to s. 409.912(41)(a), F.S., dental services are delivered to Medicaid recipients on a prepaid or fee-for-service basis through prepaid dental health plans (PDHPs), in counties not participating in the 5-county Medicaid reform pilot program. Under s. 409.912(41)(b), F.S., the Agency for Health Care Administration (AHCA) must provide a fee-for-service option as well.

Separate from this requirement, s. 409.912(41)(b), F.S., authorizes the AHCA to use PDHPs for dental services in Miami-Dade County, and does not require a fee-for-service option. The General Appropriations Act (GAA) for Fiscal Year 2012-2013 provides similar authority for PDHPs in Miami-Dade County, but is specific to children and requires that three plans be offered.

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental. Dental services will be provided by comprehensive managed care organizations (provider service networks and health maintenance organizations) instead of being delivered as a separate benefit under a separate managed care contract, and the fee-for-service option will be eliminated. The SMMC program must be fully implemented by October, 2014. Pursuant to this change in policy, s. 409.912(41)(b), F.S., sunsets July 1, 2013, and s. 409.912(41)(a), F.S., sunsets October 1, 2014. The repeal of these subsections eliminates a conflict with the intent of the SMMC program.

The bill amends s. 409.912(41)(a), F.S., to postpone its scheduled expiration until October 1, 2017. The bill amends s. 409.912(41)(b), F.S., to authorize the AHCA to provide a Medicaid prepaid dental program in Miami-Dade on a permanent basis. This creates a conflict with the SMMC program for which the bill provides an exemption. The bill's provisions either create an exemption to the SMMC program, or create overlapping dental service programs. In either instance, the bill may materially change the AHCA's ongoing contract negotiations for the SMMC program, and could delay the implementation of the SMMC program.

The bill also requires that the AHCA provide an annual report to the Governor and Legislature which compares the utilization, benefit and cost data from Medicaid dental contractors as well as compliance reports and access to care to the state's overall Medicaid dental population.

The bill has an indeterminate fiscal impact on state government.

The bill provides an effective date of July 1, 2013.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Medicaid

Medicaid is a joint federal- and state-funded program that provides health care for low-income Floridians, administered by the AHCA under ch. 409, F.S. Federal law establishes the mandatory services to be covered in order to receive federal matching funds. Benefit requirements can vary by eligibility category. For example, more benefits are required for children than for the adult population. Florida's mandatory and optional benefits are prescribed in state law under ss. 409.905, and 409.906 F.S., respectively.

Dental services are an optional Medicaid benefit. Florida provides full dental services for children, and emergency dental services for adults.[1]

Presently Florida Medicaid recipients receive their benefits through either a fee-for-service or managed care delivery system.

Prepaid Dental Health Plans

A prepaid dental health plan (PDHP) is:

> A managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), F.S., in the state and is paid a prospective per-member, per-month payment by the agency.[2]

In 2001, proviso language in the General Appropriations Act (GAA) authorized the AHCA to initiate a PDHP pilot program in Miami-Dade County.[3] Similar statutory authority was provided in 2003.[4] The AHCA implemented the program in Miami-Dade County in July 2004 for Medicaid children under age 21.[5] In the 2010-2011 General Appropriations Act (GAA), the Legislature directed the AHCA to provide enrollees with a choice of at least two licensed plans in Miami-Dade County and increased the number to three in the 2011-2012 and 2012-2013 GAAs.[6] Currently, two PDHPs serve Medicaid recipients in Miami-Dade County.[7]

In 2003, the Legislature expanded the PDHP initiative beyond Miami-Dade County by authorizing the AHCA to contract with PDHPs without specifying the county or the population.[8] The 2010-2011 GAA proviso specifically authorized the AHCA to contract with PDHPs on either a regional or statewide

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[1] S. 409.906(1), (6), F.S.
[2] S. 409.962, F.S., *See* Agency for Health Care Administration, *Model Statewide Prepaid Dental Health Plan (SPDHP) Contract, Attachment II-Core Contract Provisions*, p. 17, http://ahca.myflorida.com/medicaid/pdhp/docs/120120_Attachment_II_Core.pdf (last visited Mar. 24, 2013). PDHPs are classified as prepaid ambulatory health plans by 42 CFR Part 438.
[3] *See* Specific Proviso 135A, General Appropriations Act 2001-2002 (Conference Report on CS/SB 2C).
[4] Chapter 2003-405, s. 18.
[5] Agency for Health Care Administration, *Statewide Prepaid Dental Program,* http://ahca.myflorida.com/Medicaid/index.shtml#pdhp (last visited: Mar. 24, 2013).
[6] See, Specific Proviso, line 204, General Appropriations Act for Fiscal Year 2010-2011 (Conference Report on HB 5001); Specific Proviso, line 192, General Appropriations Act for Fiscal Year 2011-2012 (Conference Report on SB 5000); Specific Proviso, line 186, General Appropriations Act for Fiscal Year 2021-2013 (Conference Report on HB 5001). Note, however, "an appropriations bill must not change or amend existing law on subjects other than appropriations". Brown v. Firestone, 382 So.2d 654 (Fla., 1980).
[7] AHCA, *supra,* note 5.
[8] S. 409.912(42), F.S. (2003).

basis.[9] This authority was not limited to children, and the contracts were not to exceed 2 years. The authority excluded Miami-Dade County from this contracting process but did permit the AHCA the option of including the Medicaid reform pilot counties in the procurement.[10] The AHCA elected not to include those counties. (Children enrolled in managed care plans in the reform counties receive their dental benefits through comprehensive managed care plans; not through PDHPs.)[11]

The statewide proviso language was repeated in the 2011-2012 GAA,[12] and similar language was enacted in s. 409.912(41)(a), F.S. However, these provisions made PDHP contracting mandatory, not discretionary, outside the reform counties (and Miami-Dade county). However, s. 409.912(41)(b), F.S., limits the use of PHDPs by requiring that the ACHA may not limit dental services to PDHPs and must allow dental services to be provided on a fee-for-service basis as well.

Section 409.912(41)(b), F.S., continues the AHCA's discretionary authority to use PDHPs in Miami-Dade County for Fiscal Year 2012-2013. This language prohibits the use of fee-for-service in Miami-Dade County during this time period (if the discretionary authority is exercised).

Statewide Medicaid Managed Care

In 2011, Florida established the Statewide Medicaid Managed Care (SMMC) program as Part IV of Chapter 409, F.S. The SMMC requires the AHCA to create an integrated managed care program for Medicaid enrollees to provide all the mandatory and optional Medicaid benefits for primary and acute care, including dental. Dental services will be provided by comprehensive managed care organizations (provider service networks and health maintenance organizations) instead of being delivered as a separate benefit under a separate managed care contract, and the fee-for-service option will be eliminated.[13] The AHCA must implement the SMMC program by October, 2014.

The SMMC program will be the primary method of delivery for Medicaid services. The program's enacting laws repeal many sections of current Medicaid law effective upon the implementation of the SMMC program. Pursuant to this change in policy, the PDHP laws will sunset as well. Section 409.912(41)(b), F.S., sunsets July 1, 2013, and s. 409.912(41)(a), F.S., sunsets October 1, 2014.

The sunset of these subsections eliminates a conflict with the SMMC program. Even if they were not repealed, they would be preempted by the SMMC program: s. 409.961, F.S., requires any conflict between the SMMC program law and pre-reform laws to be resolved in favor of the SMMC laws.

On December 28, 2012, the ACHA released an Invitation to Negotiate (ITN) to competitively procure managed care plans on a statewide basis, and is currently negotiating contracts for the SMMC program.[14] The ACHA anticipates that the Notice of Intent to Award will be posted by September 16,

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[9] *See* Specific Proviso 204, General Appropriations Act 2010-2011 (Conference Report on HB 5001).

[10] In 2005, the Legislature enacted laws to reform the delivery and payment of services through the Medicaid program and directed AHCA to seek a federal waiver for a Medicaid managed care pilot program over five years. The program began in Broward and Duval counties in 2006 and later expanded to Baker, Clay and Nassau counties in 2007, as authorized in statute. The five year waiver was set to expire June 30, 2011, but has been renewed through June 30, 2014.

[11] Agency for Health Care Administration, Capitated Health Plan Contract, Scope of Services, Attachment I, http://ahca.myflorida.com/mchq/Managed_Health_Care/MHMO/docs/contract/1215_Contract/2012-2015/Sept1-Versions/2012-15_HP-ContractAtt-I-CAP-CLEAN-SEPT2012.pdf (last visited: Mar. 24, 2013).

[12] *See* Chapter 2011-69; Specific Proviso for Line Item 192, General Appropriations Act 2011-2012, (Conference Report on SB 2000).

[13] S. 409.973, F.S.

[14] ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, *Addendum 2* Solicitations Number: ACHA ITN 017-12/13; dated February 26, 2013. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013); ACHA Invitation to Negotiate, *Statewide Medicaid Managed Care*, Solicitation Number: ACHA ITN 017-12/13; dated December 28, 2012. http://myflorida.com/apps/vbs/vbs_www.ad.view_ad?advertisement_key_num=105774 (last visited March 24, 2013). The deadline for written inquires on the ITN was February 12, 2013, and the deadline for the ACHA's responses is March 29, 2013. The negotiations for the plans will be conducted from July 8, 2013, through September 6, 2013.

2013.[15] Pursuant to s. 409.973, F.S., the ITN lists dental services as one of the services to be offered by the managed care plans.[16]

The ITN is currently in a statutorily imposed "blackout period" until 72 hours after the award and the ACHA cannot provide interpretation or additional information not included in the ITN documents. Specifically, s. 287.057(23), F.S., provides:

> Respondents to this solicitation or persons acting on their behalf may not contact, between the release of the solicitation and the end of the 72-hour period following the agency posting the notice of intended award, excluding Saturdays, Sundays, and state holidays, any employee or officer of the executive or legislative branch concerning any aspect of this solicitation, except in writing to the procurement officer or as provided in the solicitation documents. Violation of this provision may be grounds for rejecting a response.

Final approval of the necessary Medicaid waiver by the federal government has not yet been received; however, on February 20, 2013, the AHCA and the Centers for Medicare and Medicaid Services reached an "Agreement in Principle" on the proposed plan.[17]

Effect of the Proposed Changes

Section 409.912 (41)(a), F.S., requires that the ACHA contract with PDHPs, and sunsets October 1, 2014.[18] The bill postpones the repeal to October 1, 2017. In addition, the bill eliminates the requirement that the AHCA continue to allow fee-for-service dental as an option, making PDHPS the exclusive delivery method for those services.

Section 409.912(41)(b), F.S., authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade for Fiscal Year 2012-2013, and expires July, 1, 2013.[19] The bill deletes the current fiscal year reference and authorizes the AHCA to provide a Medicaid prepaid dental program in Miami-Dade County on a permanent basis. This action would allow the AHCA to continue to provide a separate Medicaid prepaid dental plan in Miami-Dade County.

The bill's provisions would exclude dental services from the integrated SMMC, creating an exception to the comprehensive reform of Medicaid. In the alternative, they would create redundant dental benefits obligating the ACHA to contract with two managed care organizations to provide the same services to the same group of recipients.

The bill's provisions conflict with the SMMC statutory requirement that SMMC plans provide comprehensive care (including dental). To address this, the bill expressly exempts its provisions from the conflict resolution language in s. 409.961, F.S.

The bill creates a requirement that the AHCA provide an annual report to the Governor and Legislature which compares the utilization, benefit and cost data from Medicaid dental contractors as well as compliance reports and access to care to the state's overall Medicaid dental population.

B. SECTION DIRECTORY:

Section 1. Amends s. 409.912, F.S., relating to cost effective purchasing of health care.
Section 2. Provides an effective date of July 1, 2013.

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[15] Id.
[16] AHCA, *supra* note 16.
[17] *See* Correspondence between Agency for Health Care Administration and the Centers for Medicare and Medicaid Services, http://ahca.myflorida.com/Medicaid/statewide_mc/pdf/mma/Letter_from_CMS_re_Agreement_in_Principal_2013-02-20.pdf (last visited Mar. 24, 2013).
[18] Section 409.912 (41)(a), F.S.
[19] Section 409.912(41)(b), F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The fiscal impact of this bill is indeterminate at this time.[20] Any potential savings which might occur if the fee-for-service option is eliminated would become a minor component of capitation rate calculations in the SMMC program.[21]

   If the effect of the bill is to create two dental coverage programs, the AHCA would be required to contract with both PDHPs and SMMC managed care organizations for these services, which could increase expenditures. If the effect of the bill is to exempt dental services from the SMMC program, the lack of comprehensive care coordination could result in higher than expected costs in the SMMC program.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

[20] Agency for Health Care Administration, *House Bill 793 Bill Analysis and Economic Impact Statement*,(Mar. 14, 2013) (on file with the House of Representatives Health and Human Services Committee).
[21] Id.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Statewide implementation of the SMMC program is expected to be completed by October 1, 2014. Dental benefits are a required benefit in the program. Extending the requirement that the AHCA contract with PDHPs to October 1, 2017, may result in redundant dental services contracts.

The changes proposed by the bill conflict with the SMMC ITN. Specifically, the bill creates a question as to whether dental services are to be provided as part of the managed care services under the ITN or whether they are to be provided pursuant to s. 409.912, F.S. Parties interested in responding to the ITN cannot ask for clarification on this issue as the ITN is currently in a statutorily imposed "blackout period". The bill may increase the potential for a procurement challenge, as it may make a material change to the terms and conditions of the ITN. The ACHA could reissue the ITN and address this issue. Either outcome would delay the expected date for the implementation of the SMMC.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 28, 2013, the Health Innovation Subcommittee adopted an amendment to HB 793. The amendment:

- Exempting the provision from the statutory construction requirements of s. 409.961, F.S.
- Requiring AHCA to provide the Governor, President of the Senate and Speaker of the House of Representatives with a report that compares benefits, utilization and costs of the contracted dental plans.

The bill was reported favorably as a Committee Substitute. The analysis reflects the Committee Substitute.

A bill to be entitled

An act relating to cost-effective purchasing of health care; amending s. 409.912, F.S.; extending the authorization period for the Agency for Health Care Administration to enter into contracts on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services; limiting agency authorization for the provision of prepaid dental health programs to Miami-Dade County; requiring an annual report to the Governor and Legislature; providing an effective date.

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

Section 1. Paragraphs (a) and (b) of subsection (41) of section 409.912, Florida Statutes, are amended to read:

409.912 Cost-effective purchasing of health care.—The agency shall purchase goods and services for Medicaid recipients in the most cost-effective manner consistent with the delivery of quality medical care. To ensure that medical services are effectively utilized, the agency may, in any case, require a confirmation or second physician's opinion of the correct diagnosis for purposes of authorizing future services under the Medicaid program. This section does not restrict access to emergency services or poststabilization care services as defined in 42 C.F.R. part 438.114. Such confirmation or second opinion shall be rendered in a manner approved by the agency. The agency shall maximize the use of prepaid per capita and prepaid

aggregate fixed-sum basis services when appropriate and other alternative service delivery and reimbursement methodologies, including competitive bidding pursuant to s. 287.057, designed to facilitate the cost-effective purchase of a case-managed continuum of care. The agency shall also require providers to minimize the exposure of recipients to the need for acute inpatient, custodial, and other institutional care and the inappropriate or unnecessary use of high-cost services. The agency shall contract with a vendor to monitor and evaluate the clinical practice patterns of providers in order to identify trends that are outside the normal practice patterns of a provider's professional peers or the national guidelines of a provider's professional association. The vendor must be able to provide information and counseling to a provider whose practice patterns are outside the norms, in consultation with the agency, to improve patient care and reduce inappropriate utilization. The agency may mandate prior authorization, drug therapy management, or disease management participation for certain populations of Medicaid beneficiaries, certain drug classes, or particular drugs to prevent fraud, abuse, overuse, and possible dangerous drug interactions. The Pharmaceutical and Therapeutics Committee shall make recommendations to the agency on drugs for which prior authorization is required. The agency shall inform the Pharmaceutical and Therapeutics Committee of its decisions regarding drugs subject to prior authorization. The agency is authorized to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The agency may competitively bid single-

source-provider contracts if procurement of goods or services results in demonstrated cost savings to the state without limiting access to care. The agency may limit its network based on the assessment of beneficiary access to care, provider availability, provider quality standards, time and distance standards for access to care, the cultural competence of the provider network, demographic characteristics of Medicaid beneficiaries, practice and provider-to-beneficiary standards, appointment wait times, beneficiary use of services, provider turnover, provider profiling, provider licensure history, previous program integrity investigations and findings, peer review, provider Medicaid policy and billing compliance records, clinical and medical record audits, and other factors. Providers are not entitled to enrollment in the Medicaid provider network. The agency shall determine instances in which allowing Medicaid beneficiaries to purchase durable medical equipment and other goods is less expensive to the Medicaid program than long-term rental of the equipment or goods. The agency may establish rules to facilitate purchases in lieu of long-term rentals in order to protect against fraud and abuse in the Medicaid program as defined in s. 409.913. The agency may seek federal waivers necessary to administer these policies.

(41)(a) Notwithstanding s. 409.961, the agency shall contract on a prepaid or fixed-sum basis with appropriately licensed prepaid dental health plans to provide dental services. This paragraph expires October 1, 2017 ~~2014~~.

(b) Notwithstanding paragraph (a) ~~and for the 2012-2013 fiscal year only~~, the agency is authorized to provide a Medicaid

prepaid dental health program in Miami-Dade County. The agency shall provide an annual report by January 15 to the Governor, the President of the Senate, and the Speaker of the House of Representatives that compares the combined reported annual benefits utilization and encounter data from all contractors, along with the agency's findings with respect to projected and budgeted annual program costs, the extent to which each contracting entity is complying with all contract terms and conditions, the effect that each entity's operation is having on access to care for Medicaid recipients in the contractor's service area, and the statistical trends associated with indicators of good oral health among all recipients served in comparison with the state's population as a whole. ~~For all other counties, the agency may not limit dental services to prepaid plans and must allow qualified dental providers to provide dental services under Medicaid on a fee-for-service reimbursement methodology. The agency may seek any necessary revisions or amendments to the state plan or federal waivers in order to implement this paragraph. The agency shall terminate existing contracts as needed to implement this paragraph. This paragraph expires July 1, 2013.~~

Section 2. This act shall take effect July 1, 2013.