

FOR CONSIDERATION By the Committee on Budget

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1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.904,
3 F.S.; providing for funding the Medicaid reimbursement
4 for certain persons age 65 or older while the optional
5 program is being phased out; renaming the "medically
6 needy" program as the "Medicaid nonpoverty medical
7 subsidy"; limiting certain categories of persons
8 eligible for the subsidy to only physician services
9 after a certain date; amending s. 409.905, F.S.;
10 deleting the hospitalist program; amending s. 409.908,
11 F.S.; revising the factors for calculating the maximum
12 allowable fee for pharmaceutical ingredient costs;
13 directing the Agency for Health Care Administration to
14 establish reimbursement rates for the next fiscal
15 year; amending s. 409.9082, F.S.; revising the
16 aggregated amount of the quality assessment for
17 nursing home facilities; amending s. 409.911, F.S.;
18 updating references to data to be used for the
19 disproportionate share program; amending s. 409.9112,
20 F.S.; extending the prohibition against distributing
21 moneys under the regional perinatal intensive care
22 centers disproportionate share program for another
23 year; amending s. 409.9113, F.S.; extending the
24 disproportionate share program for teaching hospitals
25 for another year; amending s. 409.9117, F.S.;
26 extending the prohibition against distributing moneys
27 under the primary care disproportionate share program
28 for another year; amending s. 409.912, F.S.; allowing
29 the agency to continue to contract for electronic

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30 access to certain pharmacology drug information;
31 eliminating the requirement to implement a wireless
32 handheld clinical pharmacology drug information
33 database for practitioners; revising the factors for
34 calculating the maximum allowable fee for
35 pharmaceutical ingredient costs; amending ss.
36 409.9122, 409.915, and 409.9301, F.S.; conforming
37 provisions to changes made by the act; providing an
38 effective date.

39
40 Be It Enacted by the Legislature of the State of Florida:

41
42 Section 1. Subsections (1) and (2) of section 409.904,
43 Florida Statutes, are amended to read:

44 409.904 Optional payments for eligible persons.—The agency
45 may make payments for medical assistance and related services on
46 behalf of the following persons who are determined to be
47 eligible subject to the income, assets, and categorical
48 eligibility tests set forth in federal and state law. Payment on
49 behalf of these Medicaid-eligible persons is subject to the
50 availability of moneys and any limitations established by the
51 General Appropriations Act or chapter 216.

52 (1) ~~Effective January 1, 2006, and~~ Subject to federal
53 waiver approval, a person who is age 65 or older or is
54 determined to be disabled, whose income is at or below 88
55 percent of the federal poverty level, whose assets do not exceed
56 established limitations, and who is not eligible for Medicare
57 or, if eligible for Medicare, is also eligible for and receiving
58 Medicaid-covered institutional care services, hospice services,

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59 or home and community-based services. The agency shall seek
60 federal authorization through a waiver to provide this coverage.
61 This eligibility category subsection expires June 30, 2011.
62 However, for the purpose of phasing out this category, the
63 agency may continue making payments through March 31, 2012.

64 (2)~~(a)~~ A family, a pregnant woman, a child under age 21, a
65 person age 65 or over, or a blind or disabled person, who would
66 be eligible under any group listed in s. 409.903(1), (2), or
67 (3), except that the income or assets of such family or person
68 exceed established limitations is eligible for the Medicaid
69 nonpoverty medical subsidy, which includes the same services as
70 those provided to other Medicaid recipients, with the exception
71 of services in skilled nursing facilities and intermediate care
72 facilities for the developmentally disabled. For a family or
73 person in one of these coverage groups, medical expenses are
74 deductible from income in accordance with federal requirements
75 in order to make a determination of eligibility. Effective April
76 1, 2012, a family, a person age 65 or older, or a blind or
77 disabled person is eligible to receive physician services only.

78 ~~A family or person eligible under the coverage known as the~~
79 ~~"medically needy," is eligible to receive the same services as~~
80 ~~other Medicaid recipients, with the exception of services in~~
81 ~~skilled nursing facilities and intermediate care facilities for~~
82 ~~the developmentally disabled. This paragraph expires June 30,~~
83 ~~2011.~~

84 ~~(b) Effective July 1, 2011, a pregnant woman or a child~~
85 ~~younger than 21 years of age who would be eligible under any~~
86 ~~group listed in s. 409.903, except that the income or assets of~~
87 ~~such group exceed established limitations. For a person in one~~

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88 ~~of these coverage groups, medical expenses are deductible from~~
89 ~~income in accordance with federal requirements in order to make~~
90 ~~a determination of eligibility. A person eligible under the~~
91 ~~coverage known as the "medically needy" is eligible to receive~~
92 ~~the same services as other Medicaid recipients, with the~~
93 ~~exception of services in skilled nursing facilities and~~
94 ~~intermediate care facilities for the developmentally disabled.~~

95 Section 2. Paragraphs (d), (e), and (f) of subsection (5)
96 of section 409.905, Florida Statutes, are amended to read:

97 409.905 Mandatory Medicaid services.—The agency may make
98 payments for the following services, which are required of the
99 state by Title XIX of the Social Security Act, furnished by
100 Medicaid providers to recipients who are determined to be
101 eligible on the dates on which the services were provided. Any
102 service under this section shall be provided only when medically
103 necessary and in accordance with state and federal law.
104 Mandatory services rendered by providers in mobile units to
105 Medicaid recipients may be restricted by the agency. Nothing in
106 this section shall be construed to prevent or limit the agency
107 from adjusting fees, reimbursement rates, lengths of stay,
108 number of visits, number of services, or any other adjustments
109 necessary to comply with the availability of moneys and any
110 limitations or directions provided for in the General
111 Appropriations Act or chapter 216.

112 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
113 all covered services provided for the medical care and treatment
114 of a recipient who is admitted as an inpatient by a licensed
115 physician or dentist to a hospital licensed under part I of
116 chapter 395. However, the agency shall limit the payment for

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117 inpatient hospital services for a Medicaid recipient 21 years of
118 age or older to 45 days or the number of days necessary to
119 comply with the General Appropriations Act.

120 ~~(d) The agency shall implement a hospitalist program in~~
121 ~~nonteaching hospitals, select counties, or statewide. The~~
122 ~~program shall require hospitalists to manage Medicaid~~
123 ~~recipients' hospital admissions and lengths of stay. Individuals~~
124 ~~who are dually eligible for Medicare and Medicaid are exempted~~
125 ~~from this requirement. Medicaid participating physicians and~~
126 ~~other practitioners with hospital admitting privileges shall~~
127 ~~coordinate and review admissions of Medicaid recipients with the~~
128 ~~hospitalist. The agency may competitively bid a contract for~~
129 ~~selection of a single qualified organization to provide~~
130 ~~hospitalist services. The agency may procure hospitalist~~
131 ~~services by individual county or may combine counties in a~~
132 ~~single procurement. The qualified organization shall contract~~
133 ~~with or employ board-eligible physicians in Miami-Dade, Palm~~
134 ~~Beach, Hillsborough, Pasco, and Pinellas Counties. The agency is~~
135 ~~authorized to seek federal waivers to implement this program.~~

136 (d)(e) The agency shall implement a comprehensive
137 utilization management program for hospital neonatal intensive
138 care stays in certain high-volume participating hospitals,
139 select counties, or statewide, and shall replace existing
140 hospital inpatient utilization management programs for neonatal
141 intensive care admissions. The program shall be designed to
142 manage the lengths of stay for children being treated in
143 neonatal intensive care units and must seek the earliest
144 medically appropriate discharge to the child's home or other
145 less costly treatment setting. The agency may competitively bid

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146 a contract for the selection of a qualified organization to
147 provide neonatal intensive care utilization management services.
148 The agency may ~~is authorized to~~ seek ~~any~~ federal waivers to
149 implement this initiative.

150 (e) ~~(f)~~ The agency may develop and implement a program to
151 reduce the number of hospital readmissions among the non-
152 Medicare population eligible in areas 9, 10, and 11.

153 Section 3. Subsections (14) and (23) of section 409.908,
154 Florida Statutes, are amended to read:

155 409.908 Reimbursement of Medicaid providers.—Subject to
156 specific appropriations, the agency shall reimburse Medicaid
157 providers, in accordance with state and federal law, according
158 to methodologies set forth in the rules of the agency and in
159 policy manuals and handbooks incorporated by reference therein.
160 These methodologies may include fee schedules, reimbursement
161 methods based on cost reporting, negotiated fees, competitive
162 bidding pursuant to s. 287.057, and other mechanisms the agency
163 considers efficient and effective for purchasing services or
164 goods on behalf of recipients. If a provider is reimbursed based
165 on cost reporting and submits a cost report late and that cost
166 report would have been used to set a lower reimbursement rate
167 for a rate semester, then the provider's rate for that semester
168 shall be retroactively calculated using the new cost report, and
169 full payment at the recalculated rate shall be effected
170 retroactively. Medicare-granted extensions for filing cost
171 reports, if applicable, shall also apply to Medicaid cost
172 reports. Payment for Medicaid compensable services made on
173 behalf of Medicaid eligible persons is subject to the
174 availability of moneys and any limitations or directions

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175 provided for in the General Appropriations Act or chapter 216.
176 Further, nothing in this section shall be construed to prevent
177 or limit the agency from adjusting fees, reimbursement rates,
178 lengths of stay, number of visits, or number of services, or
179 making any other adjustments necessary to comply with the
180 availability of moneys and any limitations or directions
181 provided for in the General Appropriations Act, provided the
182 adjustment is consistent with legislative intent.

183 (14) A provider of prescribed drugs shall be reimbursed the
184 least of the amount billed by the provider, the provider's usual
185 and customary charge, or the Medicaid maximum allowable fee
186 established by the agency, plus a dispensing fee. The Medicaid
187 maximum allowable fee for ingredient cost must ~~will~~ be based on
188 the lowest ~~lower~~ of: the average wholesale price (AWP) minus
189 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5
190 ~~4.75~~ percent, the federal upper limit (FUL), the state maximum
191 allowable cost (SMAC), or the usual and customary (UAC) charge
192 billed by the provider.

193 (a) Medicaid providers must ~~are required to~~ dispense
194 generic drugs if available at lower cost and the agency has not
195 determined that the branded product is more cost-effective,
196 unless the prescriber has requested and received approval to
197 require the branded product.

198 (b) The agency shall ~~is directed to~~ implement a variable
199 dispensing fee for ~~payments for~~ prescribed medicines while
200 ensuring continued access for Medicaid recipients. The variable
201 dispensing fee may be based upon, but not limited to, either or
202 both the volume of prescriptions dispensed by a specific
203 pharmacy provider, the volume of prescriptions dispensed to an

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204 individual recipient, and dispensing of preferred-drug-list
205 products.

206 (c) The agency may increase the pharmacy dispensing fee
207 authorized by statute and in the ~~annual~~ General Appropriations
208 Act by \$0.50 for the dispensing of a Medicaid preferred-drug-
209 list product and reduce the pharmacy dispensing fee by \$0.50 for
210 the dispensing of a Medicaid product that is not included on the
211 preferred drug list.

212 (d) The agency may establish a supplemental pharmaceutical
213 dispensing fee to be paid to providers returning unused unit-
214 dose packaged medications to stock and crediting the Medicaid
215 program for the ingredient cost of those medications if the
216 ingredient costs to be credited exceed the value of the
217 supplemental dispensing fee.

218 (e) The agency may ~~is authorized to~~ limit reimbursement for
219 prescribed medicine in order to comply with any limitations or
220 directions provided ~~for~~ in the General Appropriations Act, which
221 may include implementing a prospective or concurrent utilization
222 review program.

223 ~~(23)(a)~~ The agency shall establish rates at a level that
224 ensures no increase in statewide expenditures resulting from a
225 change in unit costs ~~for 2 fiscal years effective July 1, 2009.~~

226 (a) Reimbursement rates for the 2011-2012 state fiscal year
227 ~~2 fiscal years~~ shall be as provided in the General
228 Appropriations Act.

229 (b) This subsection applies to the following provider
230 types:

- 231 1. Inpatient hospitals.
- 232 2. Outpatient hospitals.

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233 3. Nursing homes.

234 4. County health departments.

235 5. Community intermediate care facilities for the
236 developmentally disabled.

237 6. Prepaid health plans.

238 (c) The agency shall apply the effect of this subsection to
239 the reimbursement rates for nursing home diversion programs.

240 ~~(c) The agency shall create a workgroup on hospital~~
241 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
242 ~~and a workgroup on managed care plan payment. The workgroups~~
243 ~~shall evaluate alternative reimbursement and payment~~
244 ~~methodologies for hospitals, nursing facilities, and managed~~
245 ~~care plans, including prospective payment methodologies for~~
246 ~~hospitals and nursing facilities. The nursing facility workgroup~~
247 ~~shall also consider price-based methodologies for indirect care~~
248 ~~and acuity adjustments for direct care. The agency shall submit~~
249 ~~a report on the evaluated alternative reimbursement~~
250 ~~methodologies to the relevant committees of the Senate and the~~
251 ~~House of Representatives by November 1, 2009.~~

252 (d) This subsection expires June 30, 2012 2011.

253 Section 4. Subsection (2) of section 409.9082, Florida
254 Statutes, is amended to read:

255 409.9082 Quality assessment on nursing home facility
256 providers; exemptions; purpose; federal approval required;
257 remedies.—

258 (2) Effective April 1, 2009, a quality assessment there is
259 imposed upon each nursing home facility ~~a quality assessment~~.
260 The aggregated amount of assessments for all nursing home
261 facilities in a given year may ~~shall be an amount~~ not exceed the

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262 maximum percentage ~~exceeding 5.5 percent~~ of the total aggregate
263 net patient service revenue of assessed facilities allowed under
264 federal law. The agency shall calculate the quality assessment
265 rate annually on a per-resident-day basis, exclusive of those
266 resident days funded by the Medicare program, as reported by the
267 facilities. The per-resident-day assessment rate must ~~shall~~ be
268 uniform except as prescribed in subsection (3). Each facility
269 shall report monthly to the agency its total number of resident
270 days, exclusive of Medicare Part A resident days, and ~~shall~~
271 remit an amount equal to the assessment rate times the reported
272 number of days. The agency shall collect, and each facility
273 shall pay, the quality assessment each month. The agency shall
274 collect the assessment from nursing home facility providers by
275 ~~no later than~~ the 15th day of the next succeeding calendar
276 month. The agency shall notify providers of the quality
277 assessment and provide a standardized form to complete and
278 submit with payments. The collection of the nursing home
279 facility quality assessment shall commence no sooner than 5 days
280 after the agency's initial payment of the Medicaid rates
281 containing the elements prescribed in subsection (4). Nursing
282 home facilities may not create a separate line-item charge for
283 the purpose of passing ~~through~~ the assessment through to
284 residents.

285 Section 5. Paragraph (a) of subsection (2) of section
286 409.911, Florida Statutes, is amended to read:

287 409.911 Disproportionate share program.—Subject to specific
288 allocations established within the General Appropriations Act
289 and any limitations established pursuant to chapter 216, the
290 agency shall distribute, pursuant to this section, moneys to

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291 hospitals providing a disproportionate share of Medicaid or
292 charity care services by making quarterly Medicaid payments as
293 required. Notwithstanding the provisions of s. 409.915, counties
294 are exempt from contributing toward the cost of this special
295 reimbursement for hospitals serving a disproportionate share of
296 low-income patients.

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

301 (a) The average of the 2004, 2005, and 2006 ~~2003, 2004, and~~
302 ~~2005~~ audited disproportionate share data to determine each
303 hospital's Medicaid days and charity care for the 2011-2012
304 ~~2010-2011~~ state fiscal year.

305 Section 6. Section 409.9112, Florida Statutes, is amended
306 to read:

307 409.9112 Disproportionate share program for regional
308 perinatal intensive care centers.—In addition to the payments
309 made under s. 409.911, the agency shall design and implement a
310 system for making disproportionate share payments to those
311 hospitals that participate in the regional perinatal intensive
312 care center program established pursuant to chapter 383. The
313 system of payments must conform to federal requirements and
314 distribute funds in each fiscal year for which an appropriation
315 is made by making quarterly Medicaid payments. Notwithstanding
316 s. 409.915, counties are exempt from contributing toward the
317 cost of this special reimbursement for hospitals serving a
318 disproportionate share of low-income patients. For the 2011-2012
319 ~~2010-2011~~ state fiscal year, the agency may not distribute

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320 moneys under the regional perinatal intensive care centers
321 disproportionate share program.

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

325

326
$$\text{TAE} = \text{HDSP} / \text{THDSP}$$

327

328 Where:

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

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

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

337

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

341

342
$$\text{TAP} = \text{TAE} \times \text{TA}$$

343

344 Where:

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

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

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

351

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

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

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

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

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

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

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

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

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

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

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

397 Section 7. Section 409.9113, Florida Statutes, is amended
398 to read:

399 409.9113 Disproportionate share program for teaching
400 hospitals.—In addition to the payments made under ss. 409.911
401 and 409.9112, the agency shall make disproportionate share
402 payments to ~~statutorily defined~~ teaching hospitals, as defined
403 in s. 408.07, for their increased costs associated with medical
404 education programs and for tertiary health care services
405 provided to the indigent. This system of payments must conform
406 to federal requirements and distribute funds in each fiscal year

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407 for which an appropriation is made by making quarterly Medicaid
408 payments. Notwithstanding s. 409.915, counties are exempt from
409 contributing toward the cost of this special reimbursement for
410 hospitals serving a disproportionate share of low-income
411 patients. For the 2011-2012 ~~2010-2011~~ state fiscal year, the
412 agency shall distribute the moneys provided in the General
413 Appropriations Act to statutorily defined teaching hospitals and
414 family practice teaching hospitals, as defined in s. 395.805,
415 pursuant to this section ~~under the teaching hospital~~
416 ~~disproportionate share program~~. The funds provided for
417 statutorily defined teaching hospitals shall be distributed in
418 the same proportion as the ~~state fiscal year~~ 2003-2004 state
419 fiscal year teaching hospital disproportionate share funds were
420 distributed or as otherwise provided in the General
421 Appropriations Act. The funds provided for family practice
422 teaching hospitals shall be distributed equally among family
423 practice teaching hospitals.

424 (1) On or before September 15 of each year, the agency
425 shall calculate an allocation fraction to be used for
426 distributing funds to ~~state~~ statutory teaching hospitals.
427 Subsequent to the end of each quarter of the state fiscal year,
428 the agency shall distribute to each statutory teaching hospital,
429 ~~as defined in s. 408.07,~~ an amount determined by multiplying
430 one-fourth of the funds appropriated for this purpose by the
431 Legislature times such hospital's allocation fraction. The
432 allocation fraction for each such hospital shall be determined
433 by the sum of the following three primary factors, divided by
434 three:

435 (a) The number of nationally accredited graduate medical

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436 education programs offered by the hospital, including programs
437 accredited by the Accreditation Council for Graduate Medical
438 Education and the combined Internal Medicine and Pediatrics
439 programs acceptable to both the American Board of Internal
440 Medicine and the American Board of Pediatrics at the beginning
441 of the state fiscal year preceding the date on which the
442 allocation fraction is calculated. The numerical value of this
443 factor is the fraction that the hospital represents of the total
444 number of programs, where the total is computed for all ~~state~~
445 statutory teaching hospitals.

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

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

458 2. The number of medical students enrolled in accredited
459 colleges of medicine and engaged in clinical activities,
460 including required clinical clerkships and clinical electives.
461 Full-time equivalents are computed using the fraction of the
462 year during which each trainee is primarily assigned to the
463 given institution, over the course of the state fiscal year
464 preceding the date on which the allocation fraction is

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465 calculated. The numerical value of this factor is the fraction
466 that the given hospital represents of the total number of full-
467 time equivalent students enrolled in accredited colleges of
468 medicine, where the total is computed for all ~~state~~ statutory
469 teaching hospitals.

470

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

473 (c) A service index that comprises three components:

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

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

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494 3. Total Medicaid payments to each hospital for direct
495 inpatient and outpatient services during the fiscal year
496 preceding the date on which the allocation factor is calculated.
497 This includes payments made to each hospital for such services
498 by Medicaid prepaid health plans, whether the plan was
499 administered by the hospital or not. The numerical value of this
500 factor is the fraction that each hospital represents of the
501 total of such Medicaid payments, where the total is computed for
502 all ~~state~~ statutory teaching hospitals.

503

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

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

510

511
$$TAP = THAF \times A$$

512

513 Where:

514 TAP = total additional payment.

515 THAF = teaching hospital allocation factor.

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

518 Section 8. Section 409.9117, Florida Statutes, is amended
519 to read:

520 409.9117 Primary care disproportionate share program.—For
521 the 2011-2012 ~~2010-2011~~ state fiscal year, the agency may ~~shall~~
522 not distribute moneys under the primary care disproportionate

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523 share program.

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

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

531

532
$$TAE = HDSP/THDSP$$

533

534 Where:

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

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

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

541

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

545

546
$$TAP = TAE \times TA$$

547

548 Where:

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

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

551 TA = total appropriation for the primary care

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552 disproportionate share program.

553

554 (4) In establishing ~~the establishment~~ and funding ~~of~~ this
555 program, the agency shall use the following criteria in addition
556 to those specified in s. 409.911, and payments may not be made
557 to a hospital unless the hospital agrees to:

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

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

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

575 (d) Contract with any federally qualified health center, if
576 one exists within the agreed geopolitical boundaries, concerning
577 the provision of primary care services, in order to guarantee
578 delivery of services in a nonduplicative fashion, and to provide
579 for referral arrangements, privileges, and admissions, as
580 appropriate. The hospital shall agree to provide ~~at an onsite or~~

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581 ~~offsite facility~~ primary care services within 24 hours at an
582 onsite or offsite facility to which all Medicaid recipients and
583 persons eligible under this paragraph who do not require
584 emergency room services are referred during normal daylight
585 hours.

586 (e) Cooperate with the agency, the county, and other
587 entities to ensure the provision of certain public health
588 services, case management, referral and acceptance of patients,
589 and sharing of epidemiological data, as the agency and the
590 hospital find mutually necessary and desirable to promote and
591 protect the public health within the agreed geopolitical
592 boundaries.

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

597 (g) Provide inpatient services to residents within the area
598 who are not eligible for Medicaid or Medicare, and who do not
599 have private health insurance, regardless of ability to pay, on
600 the basis of available space, except that hospitals may not be
601 prevented from establishing bill collection programs based on
602 ability to pay.

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

609 (i) Work with public health officials and other experts to

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610 provide community health education and prevention activities
611 designed to promote healthy lifestyles and appropriate use of
612 health services.

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

618
619 Any hospital that fails to comply with any of the provisions of
620 this subsection, or any other contractual condition, may not
621 receive payments under this section until full compliance is
622 achieved.

623 Section 9. Paragraph (b) of subsection (16) and paragraph
624 (a) of subsection (39) of section 409.912, Florida Statutes, are
625 amended to read:

626 409.912 Cost-effective purchasing of health care.—The
627 agency shall purchase goods and services for Medicaid recipients
628 in the most cost-effective manner consistent with the delivery
629 of quality medical care. To ensure that medical services are
630 effectively utilized, the agency may, in any case, require a
631 confirmation or second physician's opinion of the correct
632 diagnosis for purposes of authorizing future services under the
633 Medicaid program. This section does not restrict access to
634 emergency services or poststabilization care services as defined
635 in 42 C.F.R. part 438.114. Such confirmation or second opinion
636 shall be rendered in a manner approved by the agency. The agency
637 shall maximize the use of prepaid per capita and prepaid
638 aggregate fixed-sum basis services when appropriate and other

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639 alternative service delivery and reimbursement methodologies,
640 including competitive bidding pursuant to s. 287.057, designed
641 to facilitate the cost-effective purchase of a case-managed
642 continuum of care. The agency shall also require providers to
643 minimize the exposure of recipients to the need for acute
644 inpatient, custodial, and other institutional care and the
645 inappropriate or unnecessary use of high-cost services. The
646 agency shall contract with a vendor to monitor and evaluate the
647 clinical practice patterns of providers in order to identify
648 trends that are outside the normal practice patterns of a
649 provider's professional peers or the national guidelines of a
650 provider's professional association. The vendor must be able to
651 provide information and counseling to a provider whose practice
652 patterns are outside the norms, in consultation with the agency,
653 to improve patient care and reduce inappropriate utilization.
654 The agency may mandate prior authorization, drug therapy
655 management, or disease management participation for certain
656 populations of Medicaid beneficiaries, certain drug classes, or
657 particular drugs to prevent fraud, abuse, overuse, and possible
658 dangerous drug interactions. The Pharmaceutical and Therapeutics
659 Committee shall make recommendations to the agency on drugs for
660 which prior authorization is required. The agency shall inform
661 the Pharmaceutical and Therapeutics Committee of its decisions
662 regarding drugs subject to prior authorization. The agency is
663 authorized to limit the entities it contracts with or enrolls as
664 Medicaid providers by developing a provider network through
665 provider credentialing. The agency may competitively bid single-
666 source-provider contracts if procurement of goods or services
667 results in demonstrated cost savings to the state without

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668 limiting access to care. The agency may limit its network based
669 on the assessment of beneficiary access to care, provider
670 availability, provider quality standards, time and distance
671 standards for access to care, the cultural competence of the
672 provider network, demographic characteristics of Medicaid
673 beneficiaries, practice and provider-to-beneficiary standards,
674 appointment wait times, beneficiary use of services, provider
675 turnover, provider profiling, provider licensure history,
676 previous program integrity investigations and findings, peer
677 review, provider Medicaid policy and billing compliance records,
678 clinical and medical record audits, and other factors. Providers
679 shall not be entitled to enrollment in the Medicaid provider
680 network. The agency shall determine instances in which allowing
681 Medicaid beneficiaries to purchase durable medical equipment and
682 other goods is less expensive to the Medicaid program than long-
683 term rental of the equipment or goods. The agency may establish
684 rules to facilitate purchases in lieu of long-term rentals in
685 order to protect against fraud and abuse in the Medicaid program
686 as defined in s. 409.913. The agency may seek federal waivers
687 necessary to administer these policies.

688 (16)

689 (b) The responsibility of the agency under this subsection
690 includes ~~shall include~~ the development of capabilities to
691 identify actual and optimal practice patterns; patient and
692 provider educational initiatives; methods for determining
693 patient compliance with prescribed treatments; fraud, waste, and
694 abuse prevention and detection programs; and beneficiary case
695 management programs.

696 1. The practice pattern identification program shall

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697 evaluate practitioner prescribing patterns based on national and
698 regional practice guidelines, comparing practitioners to their
699 peer groups. The agency and its Drug Utilization Review Board
700 shall consult with the Department of Health and a panel of
701 practicing health care professionals consisting of the
702 following: the Speaker of the House of Representatives and the
703 President of the Senate shall each appoint three physicians
704 licensed under chapter 458 or chapter 459; and the Governor
705 shall appoint two pharmacists licensed under chapter 465 and one
706 dentist licensed under chapter 466 who is an oral surgeon. Terms
707 of the panel members shall expire at the discretion of the
708 appointing official. The advisory panel shall be responsible for
709 evaluating treatment guidelines and recommending ways to
710 incorporate their use in the practice pattern identification
711 program. Practitioners who are prescribing inappropriately or
712 inefficiently, as determined by the agency, may have their
713 prescribing of certain drugs subject to prior authorization or
714 may be terminated from all participation in the Medicaid
715 program.

716 2. The agency shall also develop educational interventions
717 designed to promote the proper use of medications by providers
718 and beneficiaries.

719 3. The agency shall implement a pharmacy fraud, waste, and
720 abuse initiative that may include a surety bond or letter of
721 credit requirement for participating pharmacies, enhanced
722 provider auditing practices, the use of additional fraud and
723 abuse software, recipient management programs for beneficiaries
724 inappropriately using their benefits, and other steps that ~~will~~
725 eliminate provider and recipient fraud, waste, and abuse. The

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726 initiative shall address enforcement efforts to reduce the
727 number and use of counterfeit prescriptions.

728 4. ~~By September 30, 2002,~~ The agency may ~~shall~~ contract
729 with an entity in the state to provide Medicaid providers with
730 electronic access to Medicaid prescription refill data and
731 information relating to the Medicaid Preferred Drug List
732 ~~implement a wireless handheld clinical pharmacology drug~~
733 ~~information database for practitioners.~~ The initiative shall be
734 designed to enhance the agency's efforts to reduce fraud, abuse,
735 and errors in the prescription drug benefit program and to
736 otherwise further the intent of this paragraph.

737 5. ~~By April 1, 2006,~~ The agency shall contract with an
738 entity to design a database of clinical utilization information
739 or electronic medical records for Medicaid providers. The
740 database ~~This system~~ must be web-based and allow providers to
741 review on a real-time basis the utilization of Medicaid
742 services, including, but not limited to, physician office
743 visits, inpatient and outpatient hospitalizations, laboratory
744 and pathology services, radiological and other imaging services,
745 dental care, and patterns of dispensing prescription drugs in
746 order to coordinate care and identify potential fraud and abuse.

747 6. The agency may apply for any federal waivers needed to
748 administer this paragraph.

749 (39) (a) The agency shall implement a Medicaid prescribed-
750 drug spending-control program that includes the following
751 components:

752 1. A Medicaid preferred drug list, which is ~~shall be~~ a
753 listing of cost-effective therapeutic options recommended by the
754 Medicaid Pharmacy and Therapeutics Committee established

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755 pursuant to s. 409.91195 and adopted by the agency for each
756 therapeutic class on the preferred drug list. At the discretion
757 of the committee, and when feasible, the preferred drug list
758 should include at least two products in a therapeutic class. The
759 agency may post the preferred drug list and updates to the
760 ~~preferred drug~~ list on an Internet website without following the
761 rulemaking procedures of chapter 120. Antiretroviral agents are
762 excluded from the preferred drug list. The agency shall also
763 limit the amount of a prescribed drug dispensed to no more than
764 a 34-day supply unless the drug products' smallest marketed
765 package is greater than a 34-day supply, or the drug is
766 determined by the agency to be a maintenance drug in which case
767 a 100-day maximum supply may be authorized. The agency may ~~is~~
768 ~~authorized to~~ seek any federal waivers necessary to implement
769 these cost-control programs and to continue participation in the
770 federal Medicaid rebate program, or alternatively to negotiate
771 state-only manufacturer rebates. The agency may adopt rules to
772 administer ~~implement~~ this subparagraph. The agency shall
773 continue to provide unlimited contraceptive drugs and items. The
774 agency must establish procedures to ensure that:

775 a. There is a response to a request for prior consultation
776 by telephone or other telecommunication device within 24 hours
777 after receipt of a request for prior consultation; and

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

781 2. Reimbursement to pharmacies for Medicaid prescribed
782 drugs shall be set at the lowest ~~lesser~~ of: the average
783 wholesale price (AWP) minus 16.4 percent, the wholesaler

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784 acquisition cost (WAC) plus 1.5 ~~4.75~~ percent, the federal upper
785 limit (FUL), the state maximum allowable cost (SMAC), or the
786 usual and customary (UAC) charge billed by the provider.

787 3. The agency shall develop and implement a process for
788 managing the drug therapies of Medicaid recipients who are using
789 significant numbers of prescribed drugs each month. The
790 management process may include, but is not limited to,
791 comprehensive, physician-directed medical-record reviews, claims
792 analyses, and case evaluations to determine the medical
793 necessity and appropriateness of a patient's treatment plan and
794 drug therapies. The agency may contract with a private
795 organization to provide drug-program-management services. The
796 Medicaid drug benefit management program shall include
797 initiatives to manage drug therapies for HIV/AIDS patients,
798 patients using 20 or more unique prescriptions in a 180-day
799 period, and the top 1,000 patients in annual spending. The
800 agency shall enroll any Medicaid recipient in the drug benefit
801 management program if he or she meets the specifications of this
802 provision and is not enrolled in a Medicaid health maintenance
803 organization.

804 4. The agency may limit the size of its pharmacy network
805 based on need, competitive bidding, price negotiations,
806 credentialing, or similar criteria. The agency shall give
807 special consideration to rural areas in determining the size and
808 location of pharmacies included in the Medicaid pharmacy
809 network. A pharmacy credentialing process may include criteria
810 such as a pharmacy's full-service status, location, size,
811 patient educational programs, patient consultation, disease
812 management services, and other characteristics. The agency may

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813 impose a moratorium on Medicaid pharmacy enrollment if ~~when~~ it
814 is determined that it has a sufficient number of Medicaid-
815 participating providers. The agency must allow dispensing
816 practitioners to participate as a part of the Medicaid pharmacy
817 network regardless of the practitioner's proximity to any other
818 entity that is dispensing prescription drugs under the Medicaid
819 program. A dispensing practitioner must meet all credentialing
820 requirements applicable to his or her practice, as determined by
821 the agency.

822 5. The agency shall develop and implement a program that
823 requires Medicaid practitioners who prescribe drugs to use a
824 counterfeit-proof prescription pad for Medicaid prescriptions.
825 The agency shall require the use of standardized counterfeit-
826 proof prescription pads by Medicaid-participating prescribers or
827 prescribers who write prescriptions for Medicaid recipients. The
828 agency may implement the program in targeted geographic areas or
829 statewide.

830 6. The agency may enter into arrangements that require
831 manufacturers of generic drugs prescribed to Medicaid recipients
832 to provide rebates of at least 15.1 percent of the average
833 manufacturer price for the manufacturer's generic products.
834 These arrangements shall require that if a generic-drug
835 manufacturer pays federal rebates for Medicaid-reimbursed drugs
836 at a level below 15.1 percent, the manufacturer must provide a
837 supplemental rebate to the state in an amount necessary to
838 achieve a 15.1-percent rebate level.

839 7. The agency may establish a preferred drug list as
840 described in this subsection, and, pursuant to the establishment
841 of such preferred drug list, ~~it is authorized to~~ negotiate

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842 supplemental rebates from manufacturers that are in addition to
843 those required by Title XIX of the Social Security Act and at no
844 less than 14 percent of the average manufacturer price as
845 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
846 the federal or supplemental rebate, or both, equals or exceeds
847 29 percent. There is no upper limit on the supplemental rebates
848 the agency may negotiate. The agency may determine that specific
849 products, brand-name or generic, are competitive at lower rebate
850 percentages. Agreement to pay the minimum supplemental rebate
851 percentage ~~will~~ guarantee a manufacturer that the Medicaid
852 Pharmaceutical and Therapeutics Committee will consider a
853 product for inclusion on the preferred drug list. However, a
854 pharmaceutical manufacturer is not guaranteed placement on the
855 preferred drug list by simply paying the minimum supplemental
856 rebate. Agency decisions will be made on the clinical efficacy
857 of a drug and recommendations of the Medicaid Pharmaceutical and
858 Therapeutics Committee, as well as the price of competing
859 products minus federal and state rebates. The agency may ~~is~~
860 ~~authorized to~~ contract with an outside agency or contractor to
861 conduct negotiations for supplemental rebates. For the purposes
862 of this section, the term "supplemental rebates" means cash
863 rebates. ~~Effective July 1, 2004,~~ Value-added programs as a
864 substitution for supplemental rebates are prohibited. The agency
865 may ~~is authorized to~~ seek any federal waivers to implement this
866 initiative.

867 8. The agency ~~for Health Care Administration~~ shall expand
868 home delivery of pharmacy products. To assist Medicaid
869 recipients ~~patients~~ in securing their prescriptions and reduce
870 program costs, the agency shall expand its current mail-order-

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871 pharmacy diabetes-supply program to include all generic and
872 brand-name drugs used by Medicaid recipients ~~patients~~ with
873 diabetes. Medicaid recipients in the current program may obtain
874 nondiabetes drugs on a voluntary basis. This initiative is
875 limited to the geographic area covered by the current contract.
876 The agency may seek and implement any federal waivers necessary
877 to implement this subparagraph.

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

880 10.a. The agency may implement a Medicaid behavioral drug
881 management system. The agency may contract with a vendor that
882 has experience in operating behavioral drug management systems
883 to implement this program. The agency may ~~is authorized to~~ seek
884 federal waivers to implement this program.

885 b. The agency, in conjunction with the Department of
886 Children and Family Services, may implement the Medicaid
887 behavioral drug management system that is designed to improve
888 the quality of care and behavioral health prescribing practices
889 based on best practice guidelines, improve patient adherence to
890 medication plans, reduce clinical risk, and lower prescribed
891 drug costs and the rate of inappropriate spending on Medicaid
892 behavioral drugs. The program may include the following
893 elements:

894 (I) Provide for the development and adoption of best
895 practice guidelines for behavioral health-related drugs such as
896 antipsychotics, antidepressants, and medications for treating
897 bipolar disorders and other behavioral conditions; translate
898 them into practice; review behavioral health prescribers and
899 compare their prescribing patterns to a number of indicators

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900 that are based on national standards; and determine deviations
901 from best practice guidelines.

902 (II) Implement processes for providing feedback to and
903 educating prescribers using best practice educational materials
904 and peer-to-peer consultation.

905 (III) Assess Medicaid beneficiaries who are outliers in
906 their use of behavioral health drugs with regard to the numbers
907 and types of drugs taken, drug dosages, combination drug
908 therapies, and other indicators of improper use of behavioral
909 health drugs.

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

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

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

919 (VII) Disseminate electronic and published materials.

920 (VIII) Hold statewide and regional conferences.

921 (IX) Implement a disease management program with a model
922 quality-based medication component for severely mentally ill
923 individuals and emotionally disturbed children who are high
924 users of care.

925 11.~~a~~. The agency shall implement a Medicaid prescription
926 drug management system.

927 a. The agency may contract with a vendor that has
928 experience in operating prescription drug management systems in

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929 order to implement this system. Any management system that is
930 implemented in accordance with this subparagraph must rely on
931 cooperation between physicians and pharmacists to determine
932 appropriate practice patterns and clinical guidelines to improve
933 the prescribing, dispensing, and use of drugs in the Medicaid
934 program. The agency may seek federal waivers to implement this
935 program.

936 b. The drug management system must be designed to improve
937 the quality of care and prescribing practices based on best
938 practice guidelines, improve patient adherence to medication
939 plans, reduce clinical risk, and lower prescribed drug costs and
940 the rate of inappropriate spending on Medicaid prescription
941 drugs. The program must:

942 (I) Provide for the ~~development and~~ adoption of best
943 practice guidelines for the prescribing and use of drugs in the
944 Medicaid program, including translating best practice guidelines
945 into practice; reviewing prescriber patterns and comparing them
946 to indicators that are based on national standards and practice
947 patterns of clinical peers in their community, statewide, and
948 nationally; and determine deviations from best practice
949 guidelines.

950 (II) Implement processes for providing feedback to and
951 educating prescribers using best practice educational materials
952 and peer-to-peer consultation.

953 (III) Assess Medicaid recipients who are outliers in their
954 use of a single or multiple prescription drugs with regard to
955 the numbers and types of drugs taken, drug dosages, combination
956 drug therapies, and other indicators of improper use of
957 prescription drugs.

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958 (IV) Alert prescribers to recipients ~~patients~~ who fail to
959 refill prescriptions in a timely fashion, are prescribed
960 multiple drugs that may be redundant or contraindicated, or may
961 have other potential medication problems.

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

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

967 (VII) Disseminate electronic and published materials.

968 (VIII) Hold statewide and regional conferences.

969 (IX) Implement disease management programs in cooperation
970 with physicians and pharmacists, along with a model quality-
971 based medication component for individuals having chronic
972 medical conditions.

973 12. The agency may ~~is authorized to~~ contract for drug
974 rebate administration, including, but not limited to,
975 calculating rebate amounts, invoicing manufacturers, negotiating
976 disputes with manufacturers, and maintaining a database of
977 rebate collections.

978 13. The agency may specify the preferred daily dosing form
979 or strength for the purpose of promoting best practices with
980 regard to the prescribing of certain drugs as specified in the
981 General Appropriations Act and ensuring cost-effective
982 prescribing practices.

983 14. The agency may require prior authorization for
984 Medicaid-covered prescribed drugs. The agency may, ~~but is not~~
985 ~~required to,~~ prior-authorize the use of a product:

986 a. For an indication not approved in labeling;

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- 987 b. To comply with certain clinical guidelines; or
988 c. If the product has the potential for overuse, misuse, or
989 abuse.

990
991 The agency may require the prescribing professional to provide
992 information about the rationale and supporting medical evidence
993 for the use of a drug. The agency may post prior authorization
994 criteria and protocol and updates to the list of drugs that are
995 subject to prior authorization on an Internet website without
996 amending its rule or engaging in additional rulemaking.

997 15. The agency, in conjunction with the Pharmaceutical and
998 Therapeutics Committee, may require age-related prior
999 authorizations for certain prescribed drugs. The agency may
1000 preauthorize the use of a drug for a recipient who may not meet
1001 the age requirement or may exceed the length of therapy for use
1002 of this product as recommended by the manufacturer and approved
1003 by the Food and Drug Administration. Prior authorization may
1004 require the prescribing professional to provide information
1005 about the rationale and supporting medical evidence for the use
1006 of a drug.

1007 16. The agency shall implement a step-therapy prior
1008 authorization approval process for medications excluded from the
1009 preferred drug list. Medications listed on the preferred drug
1010 list must be used within the previous 12 months before ~~prior to~~
1011 the alternative medications that are not listed. The step-
1012 therapy prior authorization may require the prescriber to use
1013 the medications of a similar drug class or for a similar medical
1014 indication unless contraindicated in the Food and Drug
1015 Administration labeling. The trial period between the specified

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1016 steps may vary according to the medical indication. The step-
1017 therapy approval process shall be developed in accordance with
1018 the committee as stated in s. 409.91195(7) and (8). A drug
1019 product may be approved without meeting the step-therapy prior
1020 authorization criteria if the prescribing physician provides the
1021 agency with additional written medical or clinical documentation
1022 that the product is medically necessary because:

1023 a. There is not a drug on the preferred drug list to treat
1024 the disease or medical condition which is an acceptable clinical
1025 alternative;

1026 b. The alternatives have been ineffective in the treatment
1027 of the beneficiary's disease; or

1028 c. Based on historic evidence and known characteristics of
1029 the patient and the drug, the drug is likely to be ineffective,
1030 or the number of doses have been ineffective.

1031
1032 The agency shall work with the physician to determine the best
1033 alternative for the patient. The agency may adopt rules waiving
1034 the requirements for written clinical documentation for specific
1035 drugs in limited clinical situations.

1036 17. The agency shall implement a return and reuse program
1037 for drugs dispensed by pharmacies to institutional recipients,
1038 which includes payment of a \$5 restocking fee for the
1039 implementation and operation of the program. The return and
1040 reuse program shall be implemented electronically and in a
1041 manner that promotes efficiency. The program must permit a
1042 pharmacy to exclude drugs from the program if it is not
1043 practical or cost-effective for the drug to be included and must
1044 provide for the return to inventory of drugs that cannot be

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1045 credited or returned in a cost-effective manner. The agency
1046 shall determine if the program has reduced the amount of
1047 Medicaid prescription drugs which are destroyed on an annual
1048 basis and if there are additional ways to ensure more
1049 prescription drugs are not destroyed which could safely be
1050 reused. ~~The agency's conclusion and recommendations shall be~~
1051 ~~reported to the Legislature by December 1, 2005.~~

1052 Section 10. Paragraph (a) of subsection (2) of section
1053 409.9122, Florida Statutes, is amended to read:

1054 409.9122 Mandatory Medicaid managed care enrollment;
1055 programs and procedures.—

1056 (2) (a) The agency shall enroll all Medicaid recipients in a
1057 managed care plan or MediPass ~~all Medicaid recipients~~, except
1058 ~~those Medicaid recipients who are~~ in an institution, receiving
1059 a Medicaid nonpoverty medical subsidy, ~~enrolled in the Medicaid~~
1060 ~~medically needy Program,~~ or eligible for both Medicaid and
1061 Medicare. Upon enrollment, recipients may ~~individuals will be~~
1062 ~~able to~~ change their managed care option during the 90-day opt
1063 out period required by federal Medicaid regulations. The agency
1064 may ~~is authorized to~~ seek the necessary Medicaid state plan
1065 amendment to implement this policy. ~~However, to the extent~~

1066 1. ~~If permitted by federal law, the agency may enroll in a~~
1067 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
1068 from mandatory managed care enrollment in a managed care plan or
1069 MediPass if, provided that:

1070 a.1. ~~The recipient's decision to enroll in a managed care~~
1071 ~~plan or MediPass is voluntary;~~

1072 b.2. ~~If~~ The recipient chooses to enroll in a managed care
1073 plan, the agency has determined that the ~~managed care plan~~

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1074 provides specific programs and services that ~~which~~ address the
1075 special health needs of the recipient; and

1076 c.3- The agency receives the ~~any~~ necessary waivers from the
1077 federal Centers for Medicare and Medicaid Services.

1078 2. The agency shall develop rules to establish policies by
1079 which exceptions to the mandatory managed care enrollment
1080 requirement may be made on a case-by-case basis. The rules must
1081 ~~shall~~ include the specific criteria to be applied when
1082 determining ~~making a determination as to~~ whether to exempt a
1083 recipient from mandatory enrollment ~~in a managed care plan or~~
1084 MediPass.

1085 3. School districts participating in the certified school
1086 match program pursuant to ss. 409.908(21) and 1011.70 shall be
1087 reimbursed by Medicaid, subject to the limitations of s.
1088 1011.70(1), for a Medicaid-eligible child participating in the
1089 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
1090 409.9071, regardless of whether the child is enrolled in
1091 MediPass or a managed care plan. Managed care plans must ~~shall~~
1092 make a good faith effort to execute agreements with school
1093 districts regarding the coordinated provision of services
1094 authorized under s. 1011.70.

1095 4. County health departments delivering school-based
1096 services pursuant to ss. 381.0056 and 381.0057 shall be
1097 reimbursed by Medicaid for the federal share for a Medicaid-
1098 eligible child who receives Medicaid-covered services in a
1099 school setting, regardless of whether the child is enrolled in
1100 MediPass or a managed care plan. Managed care plans shall make a
1101 good faith effort to execute agreements with county health
1102 departments that coordinate the ~~regarding the coordinated~~

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1103 provision of services to a Medicaid-eligible child. To ensure
1104 continuity of care for Medicaid patients, the agency, the
1105 Department of Health, and the Department of Education shall
1106 develop procedures for ensuring that a student's managed care
1107 plan or MediPass provider receives information relating to
1108 services provided in accordance with ss. 381.0056, 381.0057,
1109 409.9071, and 1011.70.

1110 Section 11. Paragraph (a) of subsection (1) of section
1111 409.915, Florida Statutes, is amended to read:

1112 409.915 County contributions to Medicaid.—Although the
1113 state is responsible for the full portion of the state share of
1114 the matching funds required for the Medicaid program, in order
1115 to acquire a certain portion of these funds, the state shall
1116 charge the counties for certain items of care and service as
1117 provided in this section.

1118 (1) Each county shall participate in the following items of
1119 care and service:

1120 (a) For both health maintenance members and fee-for-service
1121 beneficiaries, payments for inpatient hospitalization in excess
1122 of 10 days, but not in excess of 45 days, with the exception of
1123 pregnant women and children whose income is greater than ~~in~~
1124 ~~excess of~~ the federal poverty level and who do not receive a
1125 Medicaid nonpoverty medical subsidy under s. 409.904(2)
1126 ~~participate in the Medicaid medically needy Program,~~ and for
1127 adult lung transplant services.

1128 Section 12. Subsections (1) and (2) of section 409.9301,
1129 Florida Statutes, are amended to read:

1130 409.9301 Pharmaceutical expense assistance.—

1131 (1) PROGRAM ESTABLISHED.—A program is established in the

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1132 agency ~~for Health Care Administration~~ to provide pharmaceutical
1133 expense assistance to individuals diagnosed with cancer or
1134 individuals who have obtained ~~received~~ organ transplants who
1135 received a Medicaid nonpoverty medical subsidy before ~~were~~
1136 ~~medically needy recipients prior to~~ January 1, 2006.

1137 (2) ELIGIBILITY.—Eligibility for the program is limited to
1138 an individual who:

1139 (a) Is a resident of this state;

1140 (b) Was a Medicaid recipient who received a Medicaid
1141 nonpoverty medical subsidy before ~~under the Florida Medicaid~~
1142 ~~medically needy program prior to~~ January 1, 2006;

1143 (c) Is eligible for Medicare;

1144 (d) Is a cancer patient or an organ transplant recipient;

1145 and

1146 (e) Requests to be enrolled in the program.

1147 Section 13. This act shall take effect June 30, 2011.