Florida Senate - 2000

By Senator Diaz de la Portilla

34-1480-00 See HB 611 A bill to be entitled 1 2 An act relating to elderly pharmaceutical insurance coverage; providing a short title; 3 4 providing definitions; providing a program for 5 pharmaceutical insurance coverage for elderly 6 persons; providing for program eligibility; 7 providing for pharmaceutical insurance contracts; providing criteria and requirements; 8 9 providing contractor responsibilities; 10 providing for contractor's reports; 11 establishing an elderly pharmaceutical 12 insurance coverage board; providing for membership; providing duties of the board; 13 requiring reports; providing for an advisory 14 committee to the board; providing for 15 membership of the committee; providing for an 16 executive director of the board; providing for 17 a salary; providing duties of the executive 18 19 director; specifying program rule requirements; 20 providing dispensation limitations; providing 21 eligibility requirements for program 22 participants who qualify by paying an 23 application fee or meeting a deductible; 24 specifying the amount of the fee or deductible 25 for certain persons; providing for copayments; providing for annual determinations by the 26 board of increases in covered amounts; 27 2.8 providing for participating provider pharmacies; providing for reimbursement to 29 30 provider pharmacies; providing penalties for fraud and abuse; providing procedures for 31 1

CODING: Words stricken are deletions; words underlined are additions.

SB 1878

1	determinations by the Department of Health	
2	relating to package or form of dosage or	
3	administration of certain drugs as excluded	
4	from the program as covered drugs; providing an	
5	exception; providing for use of out of state	
6	pharmacies; providing criteria and procedures;	
7	providing an effective date.	
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9	Be It Enacted by the Legislature of the State of Florida:	
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11	Section 1. (1) SHORT TITLEThis act may be cited as	
12	the "Elderly Pharmaceutical Insurance Coverage Act".	
13	(2) DEFINITIONSFor purposes of this act, the term:	
14	(a) "Annual coverage period" means the period of 12	
15	consecutive calendar months for which an eligible program	
16	participant has met the application fee or deductible	
17	requirements of subsections (8) and (9).	
18	(b) "Board" means the Elderly Pharmaceutical Insurance	
19	Coverage Board established under subsection (5).	
20	(c) "Contractor" means a private not-for-profit or	
21	proprietary corporation that has entered into a contractual	
22	arrangement with this state to carry out the provisions of	
23	subsection (4).	
24	(d) "Covered drug" means a drug dispensed subject to a	
25	legally authorized prescription pursuant to chapter 465,	
26	Florida Statutes, or chapter 893, Florida Statutes, and	
27	insulin, an insulin syringe, or an insulin needle. Such term	
28	does not include:	
29	1. Any drug determined by the Commissioner of the	
30	Federal Food and Drug Administration to be ineffective or	
31	unsafe.	

1	2. Any drug dispensed in a package, or form of dosage
2	or administration, which the Secretary of Health finally
3	determines pursuant to subsection (13) does not constitute a
4	covered drug for purposes of this act.
5	3. Any device for the aid or correction of vision or
6	any drug, including vitamins, which is generally available
7	without a physician's prescription.
8	(e) "Executive director" means the executive director
9	of the board established under subsection (5).
10	(f) "Income" means "adjusted gross income" as defined
11	in section 420.0004, Florida Statutes, but includes only the
12	income of program applicants and spouses and excludes the
13	income of other members of the household.
14	(g) "Provider pharmacy" means a pharmacy registered in
15	this state pursuant to chapter 465, Florida Statutes, or a
16	pharmacy registered in a state bordering this state when
17	certified as necessary by the executive director pursuant to
18	subsection (14), for which an agreement to provide pharmacy
19	services for purposes of the program pursuant to subsection
20	(10) is in effect.
21	(h) "Program year" means a year beginning on October 1
22	and ending the following September 30.
23	(i) "Resident" means an individual legally domiciled
24	within this state.
25	(j) "Secretary" means the secretary of the Department
26	of Health.
27	(3) PROGRAM ELIGIBILITY
28	(a) Persons eligible for coverage under subsection (8)
29	<u>include:</u>
30	1. Any unmarried resident who is at least 65 years of
31	age and whose income for the calendar year immediately
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1 preceding the effective date of the annual coverage period is 2 less than or equal to \$12,000. 3 2. Any married resident who is at least 65 years of age and whose income for the calendar year immediately 4 5 preceding the effective date of the annual coverage period б when combined with the income in the same calendar year of 7 such married person's spouse is less than or equal to \$15,000 8 dollars. 9 10 After the initial determination of eligibility, each eligible 11 individual must be redetermined eligible at least every 24 12 months. 13 Persons eligible for coverage under subsection (9) (b) 14 include: Any unmarried resident who is at least 65 years of 15 1. age and whose income for the calendar year immediately 16 preceding the effective date of the annual coverage period is 17 18 more than \$12,000 and less than \$18,000. 19 2. Any married resident who is at least 65 years of age and whose income for the calendar year immediately 20 21 preceding the effective date of the annual coverage period when combined with the income in the same calendar year of 22 such married person's spouse is more than \$15,000 and less 23 24 than \$23,000. 25 After the initial determination of eligibility, each eligible 26 27 individual must be redetermined eligible at least every 24 28 months. 29 (c)1. Eligibility for assistance under this act shall 30 not be granted to any person who, at the time an application 31 is made, is receiving medical assistance under any other 4

1 provision of law of this state or to any person receiving equivalent or better coverage from any other public or private 2 3 third-party payment source or insurance plan than those benefits provided for under this act. 4 5 2. An individual who is determined eligible for б assistance under this act whose prescription costs are covered 7 in part by any public or private plan may receive reduced 8 assistance under this act. In such cases, benefits provided through this act shall be considered payments of last resort. 9 10 3. The fact that some of an individual's prescription 11 drug expenses are paid or reimbursable under Medicare shall not disqualify an individual, if he or she is otherwise 12 eligible, from receiving assistance under this act. In such 13 cases, the state shall pay the portion of the cost of those 14 prescriptions for qualified drugs for which no payment or 15 reimbursement is made by Medicare, less the participant's 16 17 copayment required on the amount not paid by Medicare. PHARMACEUTICAL INSURANCE CONTRACT. --18 (4) 19 (a) The board established under subsection (5) shall, subject to the approval of the Governor, enter into a contract 20 21 with one or more contractors to assist in carrying out the provisions of this act. Such contractual arrangements shall 22 be made subject to a competitive bidding process and shall 23 24 ensure that state payments for the contractor's necessary and 25 legitimate expenses for the administration of this program are limited to the amount specified in advance, and that such 26 27 payments shall not exceed the amount appropriated for such expenses in any fiscal year. The board shall, at each of its 28 29 regularly scheduled meetings, review the contract pricing 30 provisions to assure that the level of contract payments are in the best interest of the state, giving consideration to the 31

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1 total level of participant enrollment achieved, the volume of claims processed, and such other factors as may be relevant in 2 3 order to contain state expenditures. If the board determines that the contract payment provisions do not protect the 4 5 interests of the state, the executive director shall initiate б contract negotiations for the purpose of modifying contract 7 payments or scope requirements. 8 The responsibilities of any contractor shall (b) 9 include, but need not be limited to: 10 1. Providing for a method of determining, on an annual 11 basis and upon application by any person, the eligibility of persons pursuant to subsection (3) within a reasonable period 12 of time, including alternative methods for such determination 13 of eligibility, including, but not limited to, through the 14 mail or home visits, where reasonable or necessary, and for 15 notifying applicants of such eligibility determinations. 16 17 2. Notifying each eligible program participant in writing prior to the commencement of the annual coverage 18 19 period of such participant's cost-sharing responsibilities pursuant to subsections (8) and (9). The contractor shall 20 also notify each eligible program participant of any 21 adjustment of the copayment schedule by mail no less than 30 22 days prior to the effective date of such adjustment and shall 23 24 inform such eligible program participants of the date such 25 adjustment shall take effect. Issuing an identification card to each program 26 3. 27 participant who is eligible to purchase prescribed covered 28 drugs for an amount specified pursuant to paragraph (8)(c) or paragraph (9)(c). Cards shall be issued to participants 29 30 meeting application fee or deductible requirements on or before the effective date of the card. The dates of the annual 31

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1 coverage period shall be printed on the card. When an eligible program participant meets the annual limits on point of sale 2 3 copayments set forth in paragraph (8)(d) or paragraph (9)(d), new identification cards shall be issued to such participant 4 5 indicating waiver of such copayment requirements for the remainder of the annual coverage period or the contractor б 7 shall develop and implement an alternative method to permit 8 the purchase of covered drugs without a copayment requirement. Such participant shall be provided a means of recovering any 9 10 excess copayments made prior to their receipt of such new 11 identification cards or prior to the implementation of any such alternative method. 12 4. Developing and implementing the system for those 13 individuals electing the deductible option to record their 14 personal covered drug expenditures in accordance with 15 paragraph (9)(c). Such recordkeeping system shall be provided 16 17 to each such participant at a nominal charge which shall be subject to the approval of the board. The contractor shall 18 19 also reimburse participants for personal covered drug expenditures made in excess of their deductible requirements, 20 less the copayments required by paragraph (9)(d), made prior 21 to their receipt of an identification card issued in 22 accordance with subparagraph 3. 23 24 5. Processing of claims for reimbursement to 25 participating provider pharmacies pursuant to subsection (11). 26 Performing or causing to be performed utilization 6. 27 reviews for such purposes as may be required by the board. 7. Conducting audits and surveys of participating 28 29 provider pharmacies as specified pursuant to the terms and 30 conditions of the contract. 31

1	8. Coordinating coverage with insurance companies and
2	other public and private organizations offering such coverage
3	for those eligible program participants having partial
4	coverage for covered drugs through third-party sources, and
5	providing for recoupment of any duplicate reimbursement paid
6	by the state on behalf of such eligible program participants.
7	(c) The contractor or contractors shall be required to
8	provide such reports as may be deemed necessary by the board
9	and shall maintain files in a manner and format approved by
10	the executive director.
11	(d) The contractor or contractors may contract with
12	private not-for-profit or proprietary corporations, or with
13	entities of local government within this state, to perform
14	such obligations of the contractor or contractors as the board
15	shall permit.
16	(5) ELDERLY PHARMACEUTICAL INSURANCE COVERAGE BOARD
17	(a) The Elderly Pharmaceutical Insurance Coverage
18	Board is hereby established within the Executive Office of the
19	Governor.
20	(b) The board shall consist of the Commissioner of
21	Education, the Secretary of Health, the Insurance
22	Commissioner, the Secretary of Elderly Affairs, and the
23	Secretary of Management Services. Each board member may
24	designate an officer of his or her respective department to
25	represent and exercise all the powers of such board member as
26	the case may be at all meetings of the board from which such
27	board member may be absent.
28	(c) The Secretary of Elderly Affairs and Secretary of
29	Health shall serve as co-chairs of the board.
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1	(d) The board shall meet at such times as may be
2	requested by the co-chairs, provided that the board shall meet
3	at least four times each year.
4	(e) The board shall:
5	1. Subject to the approval of the Governor, adopt
6	program rules pursuant to subsection (7).
7	2. Determine the annual schedule of cost-sharing
8	responsibilities of eligible program participants pursuant to
9	subsections (8) and (9).
10	3. Enter into contracts pursuant to subsection (4).
11	4. Recommend and implement alternative program
12	improvements for the efficient and effective operation of the
13	program in accordance with the provisions of this act.
14	5. Establish or contract for a therapeutic drug
15	monitoring program. Such program shall monitor therapeutic
16	drug use of eligible program participants in an effort to
17	prevent the incorrect or unnecessary consumption of such
18	therapeutic drugs.
19	6. Develop and implement, in cooperation with area
20	offices for the aging, an outreach program to inform the
21	elderly of benefits they may be entitled to pursuant to this
22	act and to make available information concerning the program
23	for elderly pharmaceutical insurance coverage.
24	7. Prepare an annual report and submit such report to
25	the Governor, the President of the Senate, and the Speaker of
26	the House of Representatives no later than the first day of
27	January of each year, beginning January 1, 2002. The board
28	shall include in the report a summary of the
29	administrative-cost-containment initiatives completed during
30	the year. Such report shall, at a minimum, contain annual
31	statistical information regarding the number of persons

enrolled in the program by marital status and income level; 1 the total and per capita number of prescriptions filled and 2 3 total state reimbursement and participant copayment expenditures, by income levels; the total numbers of 4 5 prescriptions filled with generic drugs, brand name drugs, and б sole source drugs; the authorization and substitution rate for 7 the total numbers of prescriptions filled with generic, brand 8 name, and sole source drugs; the distribution of the top 300 most commonly used drugs by volume and cost; a distribution of 9 10 all prescriptions by volume and price; the annual percentage 11 increase in the cost of such drugs, numbers of participating provider pharmacies, recipients, and payments by county; the 12 amount of cost recoveries for the period covered in the 13 report; projections of program costs for the following 2 14 years; and an evaluation of the performance of the program 15 contractor or contractors and of the cost-effectiveness of all 16 17 outreach efforts. Prepare an evaluation report on the experience of 18 8. 19 the program for the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than 20 October 1, 2001. Such report shall include the 21 recommendations of the board concerning the continuation of 22 23 the program. 24 (f) Board members shall receive no compensation for 25 their services as board members. 26 There shall be an advisory committee to the board (g) 27 comprised of twelve persons. Four members shall be appointed by the Governor, three members shall be appointed by the 28 29 President of the Senate, one member shall be appointed by the minority leader of the Senate, three members shall be 30 appointed by the Speaker of the House of Representatives, and 31 10

1 one member shall be appointed by the minority leader of the House of Representatives. The committee members shall be 2 3 representatives of consumers, pharmacists, pharmaceutical drug manufacturers, and pharmaceutical wholesalers. No less than 4 5 50 percent of the committee membership shall represent the б consumers of this state. The executive director shall consult 7 the advisory committee and consider its recommendations 8 concerning the implementation of this program and the policies 9 governing the continued operation of this program. Committee 10 members shall receive no compensation for their services but 11 shall be allowed their actual and necessary expenses incurred in the performance of their duties. 12 (6) EXECUTIVE DIRECTOR.--Upon the recommendation of 13 the co-chairs, the Governor shall appoint an executive 14 director of the board. The executive director shall receive an 15 annual salary fixed by the Governor within the amount 16 17 available therefor by appropriation and shall be entitled to reimbursement for reasonable expenses incurred in connection 18 19 with the performance of his or her duties. The executive 20 director shall: (a) Monitor the provision of services pursuant to 21 contractual arrangements entered into pursuant to subsection 22 (4) and examine and review all documents and other information 23 24 to assure compliance with all provisions of this act, whether 25 such documents or other information are under the control of a contractor or a participating provider pharmacy. 26 27 (b) Appoint staff and request the assistance of any department or other agency of the state in performing such 28 29 functions as may be necessary to carry out the provisions of 30 this act. 31

1	(c) Perform such other functions as may be
2	specifically required by this act, as assigned by the board,
3	or necessary to ensure the efficient operation of the program.
4	(7) RULES
5	(a) The board shall adopt program rules that shall:
б	1. Provide for a process of determining and
7	redetermining eligibility for participation in the program,
8	including provisions for submission of proof of income, age,
9	and residency and information on existing complete or partial
10	coverage of prescription drug expenses under a third-party
11	assistance or insurance plan.
12	2. Provide for a fair-hearing process pursuant to an
13	agreement with the Department of Health for individuals and
14	participating provider pharmacies to appeal determinations or
15	actions of the contractors.
16	3. Establish procedures for the state to recover the
17	value of benefits or payments made under this act, if any,
18	which were based on applications or claims submitted in
19	violation of any provision of this act.
20	(b) For purposes of this act, except as otherwise
21	provided in this act, a covered drug shall be dispensed in
22	quantities no greater than a 30-day supply or 100 units,
23	whichever is greater. In the case of a drug dispensed in a
24	form of administration other than a tablet or capsule, the
25	maximum allowed quantity shall be a 30-day supply. The board
26	is authorized to approve exceptions to such limits for
27	specific products following consideration of recommendations
28	from pharmaceutical or medical experts regarding commonly
29	packaged quantities, unusual forms of administration, length
30	of treatment, or cost-effectiveness.
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2QUALIFYING BY PAYMENT OF AN APPLICATION FEE3(a) Each eligible individual meeting the application4fee requirements of this subsection may purchase covered drugs5for an amount specified by paragraph (c).6(b) An eligible individual electing to meet the7requirements of this subsection shall pay a one-time8application fee of \$10 in a manner and form determined by the9executive director prior to the beginning of a participant's10first annual coverage period.11(c)1.a. Upon payment of the application fee pursuant12to paragraph (b), an eligible program participant shall, at13the time of each purchase of a covered drug, pay the lesser of14a point-of-sale copayment as set forth in sub-subparagraph b.15or the actual cost of the drug purchased. Such copayment shall16hot be waived or reduced in whole or in part, subject to the11limits provided by paragraph (d).12b. The point-of-sale copayment amounts that are to be19charged eligible program participants shall be in accordance10with the following schedule:11(I) For each purchase of a covered drug costing \$29.9912or less, \$6.00.13(II) For each purchase of a covered drug costing \$29.9914sa0.00 or more, \$15.00.15For the purposes of such schedule of point-of-sale copayments,16roosting" means the amount of reimbursement which shall be19paid by the state to a participating provider pharmacy	1	(8) ELIGIBILITY REQUIREMENTS FOR PARTICIPANTS
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<pre>16 not be waived or reduced in whole or in part, subject to the 17 limits provided by paragraph (d). 18 b. The point-of-sale copayment amounts that are to be 19 charged eligible program participants shall be in accordance 20 with the following schedule: 21 (I) For each purchase of a covered drug costing \$29.99 22 or less, \$6.00. 23 (II) For each purchase of a covered drug costing 24 \$30.00 or more, \$15.00. 25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.</pre>	14	a point-of-sale copayment as set forth in sub-subparagraph b.
17 limits provided by paragraph (d). 18 b. The point-of-sale copayment amounts that are to be 19 charged eligible program participants shall be in accordance 20 with the following schedule: 21 (I) For each purchase of a covered drug costing \$29.99 22 or less, \$6.00. 23 (II) For each purchase of a covered drug costing 24 \$30.00 or more, \$15.00. 25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.	15	or the actual cost of the drug purchased. Such copayment shall
18b. The point-of-sale copayment amounts that are to be19charged eligible program participants shall be in accordance20with the following schedule:21(I) For each purchase of a covered drug costing \$29.9922or less, \$6.00.23(II) For each purchase of a covered drug costing24\$30.00 or more, \$15.00.252626For the purposes of such schedule of point-of-sale copayments,27"costing" means the amount of reimbursement which shall be28paid by the state to a participating provider pharmacy in29accordance with subsection (11) plus the point-of-sale30copayment, calculated as of the date of sale.	16	not be waived or reduced in whole or in part, subject to the
<pre>19 charged eligible program participants shall be in accordance 20 with the following schedule: 21 (I) For each purchase of a covered drug costing \$29.99 22 or less, \$6.00. 23 (II) For each purchase of a covered drug costing 24 \$30.00 or more, \$15.00. 25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.</pre>	17	limits provided by paragraph (d).
with the following schedule: (I) For each purchase of a covered drug costing \$29.99 or less, \$6.00. (II) For each purchase of a covered drug costing \$30.00 or more, \$15.00. For the purposes of such schedule of point-of-sale copayments, "costing" means the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with subsection (11) plus the point-of-sale copayment, calculated as of the date of sale.	18	b. The point-of-sale copayment amounts that are to be
(I) For each purchase of a covered drug costing \$29.99 Or less, \$6.00. (II) For each purchase of a covered drug costing \$30.00 or more, \$15.00. For the purposes of such schedule of point-of-sale copayments, rcosting" means the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with subsection (11) plus the point-of-sale copayment, calculated as of the date of sale.	19	charged eligible program participants shall be in accordance
22 <u>or less, \$6.00.</u> (II) For each purchase of a covered drug costing 24 \$30.00 or more, \$15.00. 25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.	20	with the following schedule:
(II) For each purchase of a covered drug costing 5 For the purposes of such schedule of point-of-sale copayments, r costing" means the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with subsection (11) plus the point-of-sale copayment, calculated as of the date of sale.	21	(I) For each purchase of a covered drug costing \$29.99
<pre>24 \$30.00 or more, \$15.00. 25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.</pre>	22	<u>or less, \$6.00.</u>
25 26 For the purposes of such schedule of point-of-sale copayments, 27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.	23	(II) For each purchase of a covered drug costing
For the purposes of such schedule of point-of-sale copayments, "costing" means the amount of reimbursement which shall be paid by the state to a participating provider pharmacy in accordance with subsection (11) plus the point-of-sale copayment, calculated as of the date of sale.	24	\$30.00 or more, \$15.00.
<pre>27 "costing" means the amount of reimbursement which shall be 28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.</pre>	25	
28 paid by the state to a participating provider pharmacy in 29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.	26	For the purposes of such schedule of point-of-sale copayments,
<pre>29 accordance with subsection (11) plus the point-of-sale 30 copayment, calculated as of the date of sale.</pre>	27	"costing" means the amount of reimbursement which shall be
30 copayment, calculated as of the date of sale.	28	paid by the state to a participating provider pharmacy in
	29	accordance with subsection (11) plus the point-of-sale
31	30	copayment, calculated as of the date of sale.
	31	

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1	2. Commencing October 1, 2001, and every year
2	thereafter, the board shall determine the percentage increase
3	in the average wholesale price per unit of medication for
4	approved claims for the top 500 drugs most commonly used
5	during the prior program year, weighted for volume of claims.
6	If the increase in the average wholesale price, as determined
7	by the board, is greater than the percentage increase in the
8	prescription drug component of the consumer price index
9	measured for the same period, the board may increase the
10	point-of-sale copayment per purchase of a covered drug set
11	forth in this subdivision, or the corresponding ranges of
12	program prices in effect at the time such adjustment is made,
13	or both, by an amount not to exceed the lesser of the
14	percentage increase in:
15	a. The average wholesale price per unit weighted for
16	volume of claim approved during the previous program year; or
17	b. The prescription drug component of the consumer
18	price index during the previous program year.
19	
20	The determination to increase the amount of point of sale
21	copayments or corresponding range of program prices in effect
22	shall follow a review of such factors as the relative
23	financial capacity of the state and such eligible program
24	participants to support such adjustments and changes in the
25	cost-of-living adjustment made in social security benefits.
26	Such increase shall not take effect sooner than 60 days after
27	the board makes such determination. Notwithstanding any
28	inconsistent provision of this subparagraph, the board may
29	adjust the point-of-sale copayment schedule to reflect the
30	relative financial capacity of the state, and in no event
31	shall such adjustment reduce the state share of the cost of

1 covered drugs at the time of purchase to an average amount of 2 less than 65 percent. 3 (d) During each annual coverage period, no point-of-sale copayment as set forth in paragraph (c) shall be 4 5 required to be made for the remainder of such period by any б eligible program participant who has already incurred 7 copayments in excess of the following limits: 8 1. On copayments by an unmarried individual who is an eligible program participant: 9 10 Individual income of \$5,000 or less, no more than a. 11 \$400. Individual income of \$5,001 to \$6,000, no more than 12 b. 13 \$480. 14 Individual income of \$6,001 to \$7,000, no more than с. 15 \$560. d. Individual income of \$7,001 to \$8,000, no more than 16 17 \$640. Individual income of \$8,001 to \$9,000, no more than 18 e. 19 \$720. Individual income of \$9,001 to \$10,000, no more 20 f. 21 than \$800. 22 g. Individual income of \$10,001 to \$11,000, no more 23 than \$880. 24 h. Individual income of \$11,001 to \$12,000, no more 25 than \$960. 26 2. On copayments by each married individual who is an 27 eligible program participant: 28 Joint income of \$5,000 or less, no more than \$300. a. 29 Joint income of \$5,001 to \$6,000, no more than b. \$360. 30 31

1		с.	Joint income of \$6,001 to \$7,000, no more than
2	\$420.		
3		<u>d.</u>	Joint income of \$7,001 to \$8,000, no more than
4	\$480.		
5		e.	Joint income of \$8,001 to \$9,000, no more than
6	\$540.		
7		<u>f</u> .	Joint income of \$9,001 to \$10,000, no more than
8	\$600.		
9		g.	Joint income of \$10,001 to \$11,000, no more than
10	\$660.		
11		<u>h.</u>	Joint income of \$11,001 to \$12,000, no more than
12	\$720.		
13		<u>i.</u>	Joint income of \$12,001 to \$13,000, no more than
14	\$780.		
15		j.	Joint income of \$13,001 to \$14,000, no more than
16	\$840.		
17		k.	Joint income of \$14,001 to \$15,000, no more than
18	\$900.		
19		(9)	ELIGIBILITY REQUIREMENT FOR PARTICIPANTS
20	QUALIF	YING	BY MEETING A DEDUCTIBLE
21		(a)	Each eligible individual meeting the deductible
22	requir	emen	ts of this subsection may purchase covered drugs for
23	an amo	unt	specified by paragraph (c).
24	-	(b)	Each eligible individual approved for coverage
25	under	this	subsection who shall incur during any annual
26	covera	ge p	eriod \$150 of personal covered drug expenditures
27	that a	re n	ot reimbursed by any other public or private
28	third-	part	y payment source or insurance plan shall be deemed
29	to hav	e me	t his or her deductible requirements for the
30	remain	der	of such annual coverage period.
31			

1	(c)1.a. Upon satisfaction of the deductible
2	requirements of paragraph (b), an eligible program participant
3	shall, at the time of each purchase of a covered drug, pay the
4	lesser of a point-of-sale copayment as set forth in
5	sub-subparagraph b. or the actual cost of the drug purchased.
6	Such copayment shall not be waived or reduced in whole or in
7	part, subject to the limits provided by paragraph (d).
8	b. The point-of-sale copayment amounts that are to be
9	charged eligible program participants shall be in accordance
10	with the following schedule:
11	(I) For each purchase of a covered drug costing \$29.99
12	<u>or less, \$6.</u>
13	(II) For each purchase of a covered drug costing \$30
14	<u>or more, \$15.</u>
15	
16	For purposes of such schedule, "costing" means the amount of
17	reimbursement which shall be paid by the state to a
18	participating provider pharmacy in accordance with subsection
19	(11) plus the point-of-sale copayment, calculated as of the
20	date of sale.
21	2. Commencing October 1, 2001, and every year
22	thereafter, the board shall determine the percentage increase
23	in the average wholesale price per unit of medication for
24	approved claims for the top 500 drugs most commonly used
25	during the prior program year, weighted for volume of claims.
26	If the increase in the average wholesale price, as determined
27	by the board, is greater than the percentage increase in the
28	prescription drug component of the consumer price index
29	measured for the same period, the board may increase the point
30	of sale copayment per purchase of a covered drug set forth in
31	this paragraph, or the corresponding ranges of program prices
	17

1 in effect at the time such adjustment is made, or both, by an amount not to exceed the lesser of the percentage increase in: 2 3 a. The average wholesale price per unit weighted for volume of claims approved during the previous program year; or 4 The prescription drug component of the consumer 5 b. б price index during the previous program year. 7 8 The determination to increase the amount of point-of-sale 9 copayments or corresponding range of program prices in effect 10 shall follow a review of such factors as the relative 11 financial capacity of this state and such eligible program participants to support such adjustments and changes in the 12 cost-of-living adjustment made in social security benefits. 13 Such increase shall not take effect sooner than 60 days after 14 the board makes such determination. Notwithstanding any 15 inconsistent provision of this subparagraph, the board may 16 17 adjust the point-of-sale copayment schedule to reflect the relative financial capacity of the state, and in no event 18 19 shall such adjustment reduce the state share of the cost of covered drugs at the time of purchase to an average amount of 20 less than 65 percent. 21 During each annual coverage period, no 22 (d) point-of-sale copayments as set forth in paragraph (c) shall 23 24 be required to be made for the remainder of such period by any 25 eligible program participant meeting the personal covered drug expenditure requirements of paragraph (b) in excess of the 26 27 following limits: 28 On copayments by each unmarried individual who is 1. 29 an eligible program participant: 30 a. Individual income of \$10,000 or less, no more than 31 \$575.

18

1	b.	Individual income of \$10,001 to \$11,000, no more
2	than \$633.	
3	<u>c</u> .	Individual income of \$11,001 to \$12,000, no more
4	than \$690.	
5	<u>d</u> .	Individual income of \$12,001 to \$13,000, no more
6	than \$748.	
7	<u>e.</u>	Individual income of \$13,001 to \$14,000, no more
8	than \$805.	
9	<u>f</u> .	Individual income of \$14,001 to \$15,000, no more
10	than \$863.	
11	ā.	Individual income of \$15,001 to \$16,000, no more
12	than \$920.	
13	h.	Individual income of \$16,001 to \$17,000, no more
14	than \$978.	
15	i.	Individual income of \$17,001 to \$18,000, no more
16	than \$1035	<u>.</u>
17	2.	On copayments by each married individual who is an
18	eligible p	rogram participant:
19	a.	
	<u>u.</u>	Joint income of \$13,000 or less, no more than \$561.
20	b.	
	b.	
21 22	<u>b.</u> \$603.50.	Joint income of \$13,001 to \$14,000, no more than
21 22	<u>b.</u> \$603.50. <u>c.</u>	Joint income of \$13,001 to \$14,000, no more than
21 22 23 24	<u>b.</u> <u>\$603.50.</u> <u>c.</u> \$647.	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than
21 22 23 24	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than
21 22 23 24 25 26	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than Joint income of \$15,001 to \$16,000, no more than
21 22 23 24 25 26	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u> <u>e.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than Joint income of \$15,001 to \$16,000, no more than
21 22 23 24 25 26 27	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u> <u>e.</u> <u>\$733.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than Joint income of \$15,001 to \$16,000, no more than Joint income of \$16,001 to \$17,000, no more than
21 22 23 24 25 26 27 28	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u> <u>e.</u> <u>\$733.</u> <u>f.</u> <u>\$776.50.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than Joint income of \$15,001 to \$16,000, no more than Joint income of \$16,001 to \$17,000, no more than
21 22 23 24 25 26 27 28 29 30	<u>b.</u> <u>\$603.50.</u> <u>c.</u> <u>\$647.</u> <u>d.</u> <u>\$690.</u> <u>e.</u> <u>\$733.</u> <u>f.</u> <u>\$776.50.</u>	Joint income of \$13,001 to \$14,000, no more than Joint income of \$14,001 to \$15,000, no more than Joint income of \$15,001 to \$16,000, no more than Joint income of \$16,001 to \$17,000, no more than Joint income of \$17,001 to \$18,000, no more than

1 h. Joint income of \$19,001 to \$20,000, no more than 2 \$862.50. 3 Joint income of \$20,001 to \$21,000, no more than i. 4 \$906. 5 Joint income of \$21,001 to \$22,000, no more than j. \$949. б 7 Joint income of \$22,001 to \$23,000, no more than k. \$992. 8 9 (10) PARTICIPATING PROVIDER PHARMACIES.--10 (a) The state shall offer an opportunity to 11 participate in this program to all pharmacies as defined in 12 subsection (2). To participate in this program, a pharmacy shall 13 (b) be required to enter into a provider agreement and shall abide 14 by such terms and conditions as shall be prescribed in the 15 agreement, including the release of financial information for 16 17 the purpose of program audits and surveys. (11) REIMBURSEMENT TO PARTICIPATING PROVIDER 18 19 PHARMACIES.--(a) The amount of reimbursement which shall be paid by 20 the state to a participating provider pharmacy for any covered 21 drug filled or refilled for any eligible program participant 22 shall be equal to the lower of: 23 24 1. The usual and customary charge of the pharmacy for 25 such drugs minus the point-of-sale copayment as required by 26 subsections (8) and (9); 27 The pharmacy's charge to the general public at the 2. time of purchase, taking into consideration any quantity and 28 promotional discounts, minus the point-of-sale copayment as 29 30 required by subsections (8) and (9); or 31

1	3. The average wholesale price based on the quantities
2	participating pharmacies buy most frequently, provided such
3	average wholesale prices shall be discounted by 5 percent for
4	any participating provider pharmacy or group of provider
5	pharmacies with common ownership whose total prescription
6	volume for the preceding calendar year was at least 100,000
7	prescriptions dispensed,
8	
9	plus a dispensing fee of \$2.75, except that such dispensing
10	fee shall be \$3 for participating provider pharmacies that
11	provide 24-hour emergency prescription service, emergency
12	delivery service at no cost to the consumer, and direct
13	patient consultation with each prescription and that maintain
14	a patient drug profile card on each eligible program
15	participant, and minus the point-of-sale copayment as required
16	by subsections (8) and (9).
17	(b) For purposes of determining the amount of
17 18	(b) For purposes of determining the amount of reimbursement which shall be paid to a participating provider
18	reimbursement which shall be paid to a participating provider
18 19	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined,
18 19 20	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each
18 19 20 21	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most
18 19 20 21 22	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor
18 19 20 21 22 23	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale
18 19 20 21 22 23 24	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using
18 19 20 21 22 23 24 25	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using nationally recognized and most recently revised sources. Such
18 19 20 21 22 23 24 25 26	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating
18 19 20 21 22 23 24 25 26 27	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based
 18 19 20 21 22 23 24 25 26 27 28 	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is
 18 19 20 21 22 23 24 25 26 27 28 29 	reimbursement which shall be paid to a participating provider pharmacy, the board shall determine or cause to be determined, through a statistically valid survey, the quantities of each covered drug which participating provider pharmacies buy most frequently. Using the results of such survey, the contractor shall update every 30 days the list of average wholesale prices upon which such reimbursement is determined, using nationally recognized and most recently revised sources. Such price revisions shall be made available to all participating provider pharmacies. The pharmacist shall be reimbursed based on the price in effect at the time the covered drug is dispensed.

Social Security Act, has entered into a rebate agreement with 1 the Department of Health or with the Federal Secretary of 2 3 Health and Human Services on behalf of the Department of Health under s. 1927 of the Federal Social Security Act, the 4 5 program for elderly pharmaceutical insurance coverage shall б reimburse for covered drugs that are dispensed under the 7 program by a provider pharmacy only pursuant to the terms of 8 the rebate agreement between the program and such manufacturer; however, the program may reimburse for any 9 10 covered drugs pursuant to paragraphs (a) and (b) which are 11 rated 1-A by the Federal Food and Drug Administration and which are determined by the board to be essential to the 12 health of persons participating in the program. 13 The rebate agreement between such manufacturer and 14 2. the program for elderly pharmaceutical insurance coverage 15 shall use for covered single-source drugs and innovator 16 17 multiple-source drugs the identical formula used to determine the basic rebate for federal financial participation for 18 19 single-source drugs and innovator multiple-source drugs, pursuant to s. 1927(c)(1) of the Federal Social Security Act, 20 to determine the amount of the rebate pursuant to this 21 paragraph. The rebate agreement between such manufacturer and 22 the program for elderly pharmaceutical insurance coverage 23 24 shall use for non-innovator multiple-source drugs, the identical formula used to determine the basic rebate for 25 federal financial participation for non-innovator 26 27 multiple-source drugs, pursuant to s. 1927(c)(3) of the Federal Social Security Act, to determine the amount of the 28 29 rebate pursuant to this subparagraph. The amount of rebate 30 shall be calculated by multiplying the required rebate formulas by the total number of units of each dosage form and 31

22

strength dispensed. The rebate agreement shall also provide 1 for periodic payment of the rebate, provision of information 2 3 to the program, audits, verification of data, and confidentiality of information. 4 5 The program, in providing utilization data to a 3. manufacturer as provided for under s. 1927(b) of the Federal б 7 Social Security Act, shall provide such data by zip code, if 8 requested, for the top 300 most commonly used drugs by volume 9 covered under a rebate agreement. 10 4. Any funds collected pursuant to any rebate 11 agreements entered into with a manufacturer pursuant to this paragraph shall be deposited into the General Revenue Fund. 12 13 (12) PENALTIES FOR FRAUD AND ABUSE. --(a) Any person who knowingly makes a false statement 14 or representation, or who, by deliberate concealment of any 15 material fact or by impersonation or other fraudulent device, 16 17 obtains or attempts to obtain or aids or abets any person to obtain any benefit under this act to which he or she is not 18 19 entitled, commits a misdemeanor of the first degree, punishable as provided in section 775.082 or section 775.083, 20 Florida Statutes. 21 Any person who, having made application to receive 22 (b) any benefit under this act for the use and benefit of another 23 24 and having received such benefit, knowingly and willfully 25 converts such benefit or any part of such benefit to a use other than for the use and benefit of such other person 26 27 commits a misdemeanor of the first degree, punishable as provided in section 775.082 or section 775.083, Florida 28 29 Statutes. 30 (c) Any person who, with intent to defraud, presents 31 for allowance or payment any false or fraudulent claim for 23

1	furnishing services or merchandise, or knowingly submits false
2	information for the purpose of obtaining greater compensation
3	than that to which such person is legally entitled for
4	furnishing services or merchandise, or knowingly submits false
5	information for the purpose of obtaining authorization for
6	furnishing services or merchandise under this act commits a
7	misdemeanor of the first degree, punishable as provided in
8	section 775.082 or section 775.083, Florida Statutes.
9	(13) PROCEDURES FOR DETERMINATIONS RELATING TO
10	PACKAGE, OR FORM OF DOSAGE OR ADMINISTRATION, OF CERTAIN
11	DRUGS
12	(a) If the Secretary of Health makes an initial
13	determination that a particular package, or form of dosage or
14	administration, of a drug does not constitute a covered drug
15	for purposes of this act due to the availability of a less
16	expensive package, or form of dosage or administration, that
17	is pharmaceutically equivalent and equivalent in its
18	therapeutic effect for the general health characteristics of
19	the eligible program participant population, the department
20	shall notify the manufacturer of such drug product that the
21	department intends to exclude such package, or form of dosage
22	or administration, from the program and shall provide such
23	manufacturer with the reasons for such exclusion together with
24	the facts that the department relies upon to support its
25	initial determination. The manufacturer shall have 15 days
26	after receiving such exclusion notice to notify the department
27	of an intent to appeal the decision. If the manufacturer fails
28	to notify the department of an intent to appeal within the
29	time specified in this subsection, the Secretary of Health
30	shall immediately thereafter determine whether the package, or
31	form of dosage or administration, shall be excluded from the

program. If the manufacturer notifies the department of an 1 intent to appeal, the manufacturer shall submit to the 2 3 department, within 45 days after receiving such exclusion notice, the basis of the manufacturer's appeal. Within 15 days 4 5 after receiving such submission from the manufacturer, the б department shall provide to the manufacturer any additional 7 facts concerning the drug product which the department relies 8 upon to support its initial determination. Within 10 days after receiving such facts, the manufacturer may submit 9 10 additional facts concerning the drug package, or form of 11 dosage or administration. Based on the facts submitted pursuant to this subsection, the Secretary of Health shall 12 make a final determination as to whether or not the package, 13 or form of dosage or administration, of the drug product 14 constitutes a covered drug for the purposes of this act. A 15 determination that a drug package, or form of dosage or 16 17 administration, does not constitute a covered drug for purposes of this act is subject to judicial review. 18 19 (b) Notwithstanding paragraph (a), the Department of 20 Health shall establish by rule an appropriate process for 21 allowing drug packages, or forms of dosage or administration, finally determined under this subsection not to be covered 22 drugs for the purposes of this act to be dispensed to program 23 24 participants for whom such drug packages, or forms of dosage or administration, are medically indicated as certified to by 25 a physician treating such participant. Any such drug package, 26 27 or form of dosage or administration, so certified as medically indicated for a specific participant in accordance with such 28 29 rules shall be a covered drug for the purpose of this act. 30 (14) USE OF OUT-OF-STATE PROVIDER PHARMACIES; 31 NECESSITY AND CONVENIENCE .--

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which are in close proximity to Alabama or Georgia and which are determined by the executive director to be inadequately served by provider pharmacies registered in this state, the executive director may approve as provider pharmacies, pharmacies located in Alabama or Georgia. Such approvals may be made only after: 1. Consideration of the convenience and necessity of residents of this state in the rural areas served by such pharmacies. 1. 2. Consideration of the quality of service of such pharmacies and the standing of such pharmacies with the governmental board or agency of the state in which the pharmacies and the standing of such pharmacies. 3. The executive director has given all licensed pharmacies within the county notice of his intention to approve such out-of-state provider pharmacies. 4. The executive director has held a public hearing at which he or she has determined factually that the licensed pharmacies within such county are not adequately serving as provider pharmacies. 2. (b) The executive director shall investigate and determine within 90 days after the filing of an application for certification by the governing body of any municipality claiming to be lacking adequate pharmaceutical service within a county determined by the executive director to be not adequately served by provider pharmacies registered in this state pursuant to paragraph (a) whether to grant certification.	1	(a) In counties having a population of 75,000 or less
served by provider pharmacies registered in this state, the executive director may approve as provider pharmacies, pharmacies located in Alabama or Georgia. Such approvals may be made only after: 1 1. Consideration of the convenience and necessity of residents of this state in the rural areas served by such pharmacies. 2. Consideration of the quality of service of such pharmacies and the standing of such pharmacies with the governmental board or agency of the state in which the pharmacies within the county notice of his intention to approve such out-of-state provider pharmacies. 3. The executive director has given all licensed pharmacies within the county notice of his intention to approve such out-of-state provider pharmacies. 4. The executive director has held a public hearing at which he or she has determined factually that the licensed pharmacies within such county are not adequately serving as provider pharmacies. (b) The executive director shall investigate and determine within 90 days after the filing of an application for certification by the governing body of any municipality claiming to be lacking adequate pharmacies registered in this state pursuant to paragraph (a) whether to grant certification.	2	which are in close proximity to Alabama or Georgia and which
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6pharmacies located in Alabama or Georgia. Such approvals may be made only after:7be made only after:81. Consideration of the convenience and necessity of residents of this state in the rural areas served by such9pharmacies.112. Consideration of the quality of service of such pharmacies and the standing of such pharmacies with the governmental board or agency of the state in which the pharmacy is located.153. The executive director has given all licensed pharmacies within the county notice of his intention to approve such out-of-state provider pharmacies.184. The executive director has held a public hearing at which he or she has determined factually that the licensed pharmacies.20(b) The executive director shall investigate and determine within 90 days after the filing of an application for certification by the governing body of any municipality claiming to be lacking adequate pharmacies registered in this adequately served by provider pharmacies registered in this state pursuant to paragraph (a) whether to grant certification.30	4	served by provider pharmacies registered in this state, the
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8 1. Consideration of the convenience and necessity of 9 residents of this state in the rural areas served by such 10 pharmacies. 11 2. Consideration of the quality of service of such 12 pharmacies and the standing of such pharmacies with the 13 governmental board or agency of the state in which the 14 pharmacy is located. 15 3. The executive director has given all licensed 16 pharmacies within the county notice of his intention to 17 approve such out-of-state provider pharmacies. 18 4. The executive director has held a public hearing at 19 which he or she has determined factually that the licensed 19 pharmacies. 20 (b) The executive director shall investigate and 21 determine within 90 days after the filing of an application 22 (b) The executive director shall investigate and 23 determine within 90 days after the filing of an application 24 for certification by the governing body of any municipality 25 claiming to be lacking adequate pharmacies registered in this 28 state pursuant to paragraph (a) whether to grant 29 </td <td>6</td> <td>pharmacies located in Alabama or Georgia. Such approvals may</td>	6	pharmacies located in Alabama or Georgia. Such approvals may
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27 adequately served by provider pharmacies registered in this 28 state pursuant to paragraph (a) whether to grant 29 certification. 30	25	claiming to be lacking adequate pharmaceutical service within
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29 <u>certification.</u> 30	27	adequately served by provider pharmacies registered in this
30	28	state pursuant to paragraph (a) whether to grant
	29	certification.
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1	(c) Each certification granted pursuant to this
2	subsection shall expire not more than 5 years after its date
3	of issuance.
4	Section 2. This act shall take effect October 1, 2000.
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7	LEGISLATIVE SUMMARY
8	Duranidar a unarrow for shares contined in success concerns
9	Provides a program for pharmaceutical insurance coverage for elderly persons. Provides for eligibility,
10	pharmaceutical insurance contracts, an elderly pharmaceutical insurance coverage board and an advisory committee to the board, program requirements, eligibility
11	requirements for program participants, participating
12	provider pharmacters, penalties for fraud and abuse, procedures for determinations by the Department of Health
13	requirements for program participants, participating provider pharmacies, penalties for fraud and abuse, procedures for determinations by the Department of Health relating to package or form of dosage or administration of drugs as excluded drugs, and use of out-of-state pharmacies. (See bill for details.)
14	pharmacres. (See Diff for details.)
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