CHAMBER ACTION

Senate	House
Floor: WD/2R 05/02/2007 04:59 PM	

Senator Saunders moved the following amendment:

Senate Amendment (with title amendment)

On page 8, between lines 15 and 16,

insert:

Section 4. Section (53) is added to section 409.912, Florida Statutes, to read:

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

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

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

(53)(a) A pharmacist may not dispense a drug for immunosuppressive therapy following transplant unless the drug is the specific formulation and manufactured by the specific manufacturer as prescribed by the patient's physician.

(b) A pharmacist may substitute a drug product that is generically equivalent for immunosuppressive therapy following transplant only if, before making the substitution, the pharmacist obtains a signed authorization from the prescribing physician.

(c) This subsection does not apply to generic

equivalents for immunosuppressive drugs currently on the Medicaid preferred drug list, generic equivalents for immunosuppressive drugs currently under review by the Pharmaceutical and Therapeutics Committee and the agency, or to any patient enrolled in the Medicaid program that is currently receiving generically equivalent immunosuppressive drugs.

(Redesignate subsequent sections.)

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

And the title is amended as follows:

On page 1, line 24, after the semicolon,

insert:

amending s. 409.912, F.S.; providing limitations on the dispensing of certain drugs following transplants;