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; exempting certain nursing
18 home facilities from the quality assessment; amending
19 s. 409.911, F.S.; updating references to data to be
20 used for the disproportionate share program; amending
21 s. 409.9112, F.S.; extending the prohibition against
22 distributing moneys under the regional perinatal
23 intensive care centers disproportionate share program
24 for another year; amending s. 409.9113, F.S.;
25 extending the disproportionate share program for
26 teaching hospitals for another year; amending s.
27 409.9117, F.S.; extending the prohibition against
28 distributing moneys under the primary care
29 disproportionate share program for another year;

30 amending s. 409.912, F.S.; allowing the agency to
31 continue to contract for electronic access to certain
32 pharmacology drug information; eliminating the
33 requirement to implement a wireless handheld clinical
34 pharmacology drug information database for
35 practitioners; revising the factors for calculating
36 the maximum allowable fee for pharmaceutical
37 ingredient costs; amending ss. 409.9122, 409.915, and
38 409.9301, F.S.; conforming provisions to changes made
39 by the act; providing an effective date.
40
41 Be It Enacted by the Legislature of the State of Florida:
42
43 Section 1. Subsections (1) and (2) of section 409.904,
44 Florida Statutes, are amended to read:
45 409.904 Optional payments for eligible persons.—The agency
46 may make payments for medical assistance and related services on
47 behalf of the following persons who are determined to be
48 eligible subject to the income, assets, and categorical
49 eligibility tests set forth in federal and state law. Payment on
50 behalf of these Medicaid eligible persons is subject to the
51 availability of moneys and any limitations established by the
52 General Appropriations Act or chapter 216.
53 (1) ~~Effective January 1, 2006, and~~ Subject to federal
54 waiver approval, a person who is age 65 or older or is
55 determined to be disabled, whose income is at or below 88
56 percent of the federal poverty level, whose assets do not exceed
57 established limitations, and who is not eligible for Medicare
58 or, if eligible for Medicare, is also eligible for and receiving

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59 Medicaid-covered institutional care services, hospice services,
60 or home and community-based services. The agency shall seek
61 federal authorization through a waiver to provide this coverage.
62 This <u>eligibility category</u> ~~subsection~~ expires June 30, 2011.
63 <u>However, for the purpose of phasing out this category, the</u>
64 <u>agency may continue making payments through March 31, 2012.</u>
65 (2)~~(a)~~ A family, a pregnant woman, a child under age 21, a
66 person age 65 or over, or a blind or disabled person, who would
67 be eligible under any group listed in s. 409.903(1), (2), or
68 (3), except that the income or assets of such family or person
69 exceed established limitations <u>is eligible for the Medicaid</u>
70 <u>nonpoverty medical subsidy, which includes the same services as</u>
71 <u>those provided to other Medicaid recipients, with the exception</u>
72 <u>of services in skilled nursing facilities and intermediate care</u>
73 <u>facilities for the developmentally disabled</u>. For a family or
74 person in one of these coverage groups, medical expenses are
75 deductible from income in accordance with federal requirements
76 in order to make a determination of eligibility. <u>Effective April</u>
77 <u>1, 2012, a family, a person age 65 or older, or a blind or</u>
78 <u>disabled person is eligible to receive physician services only.</u>
79 ~~A family or person eligible under the coverage known as the~~
80 ~~"medically needy," is eligible to receive the same services as~~
81 ~~other Medicaid recipients, with the exception of services in~~
82 ~~skilled nursing facilities and intermediate care facilities for~~
83 ~~the developmentally disabled. This paragraph expires June 30,~~
84 ~~2011.~~
85 ~~(b) Effective July 1, 2011, a pregnant woman or a child~~
86 ~~younger than 21 years of age who would be eligible under any~~
87 ~~group listed in s. 409.903, except that the income or assets of~~

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88 ~~such group exceed established limitations. For a person in one~~
89 ~~of these coverage groups, medical expenses are deductible from~~
90 ~~income in accordance with federal requirements in order to make~~
91 ~~a determination of eligibility. A person eligible under the~~
92 ~~coverage known as the "medically needy" is eligible to receive~~
93 ~~the same services as other Medicaid recipients, with the~~
94 ~~exception of services in skilled nursing facilities and~~
95 ~~intermediate care facilities for the developmentally disabled.~~
96 Section 2. Paragraphs (d), (e), and (f) of subsection (5)
97 of section 409.905, Florida Statutes, are amended to read:
98 409.905 Mandatory Medicaid services.—The agency may make
99 payments for the following services, which are required of the
100 state by Title XIX of the Social Security Act, furnished by
101 Medicaid providers to recipients who are determined to be
102 eligible on the dates on which the services were provided. Any
103 service under this section shall be provided only when medically
104 necessary and in accordance with state and federal law.
105 Mandatory services rendered by providers in mobile units to
106 Medicaid recipients may be restricted by the agency. Nothing in
107 this section shall be construed to prevent or limit the agency
108 from adjusting fees, reimbursement rates, lengths of stay,
109 number of visits, number of services, or any other adjustments
110 necessary to comply with the availability of moneys and any
111 limitations or directions provided for in the General
112 Appropriations Act or chapter 216.
113 (5) HOSPITAL INPATIENT SERVICES.—The agency shall pay for
114 all covered services provided for the medical care and treatment
115 of a recipient who is admitted as an inpatient by a licensed
116 physician or dentist to a hospital licensed under part I of

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117 chapter 395. However, the agency shall limit the payment for
118 inpatient hospital services for a Medicaid recipient 21 years of
119 age or older to 45 days or the number of days necessary to
120 comply with the General Appropriations Act.
121 ~~(d) The agency shall implement a hospitalist program in~~
122 ~~nonteaching hospitals, select counties, or statewide. The~~
123 ~~program shall require hospitalists to manage Medicaid~~
124 ~~recipients' hospital admissions and lengths of stay. Individuals~~
125 ~~who are dually eligible for Medicare and Medicaid are exempted~~
126 ~~from this requirement. Medicaid participating physicians and~~
127 ~~other practitioners with hospital admitting privileges shall~~
128 ~~coordinate and review admissions of Medicaid recipients with the~~
129 ~~hospitalist. The agency may competitively bid a contract for~~
130 ~~selection of a single qualified organization to provide~~
131 ~~hospitalist services. The agency may procure hospitalist~~
132 ~~services by individual county or may combine counties in a~~
133 ~~single procurement. The qualified organization shall contract~~
134 ~~with or employ board-eligible physicians in Miami-Dade, Palm~~
135 ~~Beach, Hillsborough, Pasco, and Pinellas Counties. The agency is~~
136 ~~authorized to seek federal waivers to implement this program.~~
137 <u>(d)</u>~~(e)~~ The agency shall implement a comprehensive
138 utilization management program for hospital neonatal intensive
139 care stays in certain high-volume participating hospitals,
140 select counties, or statewide, and ~~shall~~ replace existing
141 hospital inpatient utilization management programs for neonatal
142 intensive care admissions. The program shall be designed to
143 manage the lengths of stay for children being treated in
144 neonatal intensive care units and must seek the earliest
145 medically appropriate discharge to the child's home or other

146 less costly treatment setting. The agency may competitively bid
147 a contract for the selection of a qualified organization to
148 provide neonatal intensive care utilization management services.
149 The agency may ~~is authorized to~~ seek ~~any~~ federal waivers to
150 implement this initiative.
151 (e) ~~(f)~~ The agency may develop and implement a program to
152 reduce the number of hospital readmissions among the non-
153 Medicare population eligible in areas 9, 10, and 11.
154 Section 3. Subsections (14) and (23) of section 409.908,
155 Florida Statutes, are amended to read:
156 409.908 Reimbursement of Medicaid providers.—Subject to
157 specific appropriations, the agency shall reimburse Medicaid
158 providers, in accordance with state and federal law, according
159 to methodologies set forth in the rules of the agency and in
160 policy manuals and handbooks incorporated by reference therein.
161 These methodologies may include fee schedules, reimbursement
162 methods based on cost reporting, negotiated fees, competitive
163 bidding pursuant to s. 287.057, and other mechanisms the agency
164 considers efficient and effective for purchasing services or
165 goods on behalf of recipients. If a provider is reimbursed based
166 on cost reporting and submits a cost report late and that cost
167 report would have been used to set a lower reimbursement rate
168 for a rate semester, then the provider's rate for that semester
169 shall be retroactively calculated using the new cost report, and
170 full payment at the recalculated rate shall be effected
171 retroactively. Medicare-granted extensions for filing cost
172 reports, if applicable, shall also apply to Medicaid cost
173 reports. Payment for Medicaid compensable services made on
174 behalf of Medicaid eligible persons is subject to the

175 availability of moneys and any limitations or directions
176 provided for in the General Appropriations Act or chapter 216.
177 Further, nothing in this section shall be construed to prevent
178 or limit the agency from adjusting fees, reimbursement rates,
179 lengths of stay, number of visits, or number of services, or
180 making any other adjustments necessary to comply with the
181 availability of moneys and any limitations or directions
182 provided for in the General Appropriations Act, provided the
183 adjustment is consistent with legislative intent.
184 (14) A provider of prescribed drugs shall be reimbursed the
185 least of the amount billed by the provider, the provider's usual
186 and customary charge, or the Medicaid maximum allowable fee
187 established by the agency, plus a dispensing fee. The Medicaid
188 maximum allowable fee for ingredient cost must ~~will~~ be based on
189 the lowest ~~lower~~ of: the average wholesale price (AWP) minus
190 16.4 percent, the wholesaler acquisition cost (WAC) plus 1.5
191 ~~4.75~~ percent, the federal upper limit (FUL), the state maximum
192 allowable cost (SMAC), or the usual and customary (UAC) charge
193 billed by the provider.
194 (a) Medicaid providers must ~~are required to~~ dispense
195 generic drugs if available at lower cost and the agency has not
196 determined that the branded product is more cost-effective,
197 unless the prescriber has requested and received approval to
198 require the branded product.
199 (b) The agency shall ~~is directed to~~ implement a variable
200 dispensing fee for ~~payments for~~ prescribed medicines while
201 ensuring continued access for Medicaid recipients. The variable
202 dispensing fee may be based upon, but not limited to, either or
203 both the volume of prescriptions dispensed by a specific

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pharmacy provider, the volume of prescriptions dispensed to an individual recipient, and dispensing of preferred-drug-list products.

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

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

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

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

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

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

1. Inpatient hospitals.

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233 2. Outpatient hospitals.
234 3. Nursing homes.
235 4. County health departments.
236 5. Community intermediate care facilities for the
237 developmentally disabled.
238 6. Prepaid health plans.
239 (c) The agency shall apply the effect of this subsection to
240 the reimbursement rates for nursing home diversion programs.
241 ~~(c) The agency shall create a workgroup on hospital~~
242 ~~reimbursement, a workgroup on nursing facility reimbursement,~~
243 ~~and a workgroup on managed care plan payment. The workgroups~~
244 ~~shall evaluate alternative reimbursement and payment~~
245 ~~methodologies for hospitals, nursing facilities, and managed~~
246 ~~care plans, including prospective payment methodologies for~~
247 ~~hospitals and nursing facilities. The nursing facility workgroup~~
248 ~~shall also consider price-based methodologies for indirect care~~
249 ~~and acuity adjustments for direct care. The agency shall submit~~
250 ~~a report on the evaluated alternative reimbursement~~
251 ~~methodologies to the relevant committees of the Senate and the~~
252 ~~House of Representatives by November 1, 2009.~~
253 (d) This subsection expires June 30, 2012 ~~2011~~.
254 Section 4. Subsection (2) and paragraph (d) of subsection
255 (3) of section 409.9082, Florida Statutes, are amended to read:
256 409.9082 Quality assessment on nursing home facility
257 providers; exemptions; purpose; federal approval required;
258 remedies.—
259 (2) Effective April 1, 2009, a quality assessment ~~there~~ is
260 imposed upon each nursing home facility ~~a quality assessment~~.
261 The aggregated amount of assessments for all nursing home

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262 facilities in a given year may ~~shall be an amount~~ not exceed the
263 maximum percentage ~~exceeding 5.5 percent~~ of the total aggregate
264 net patient service revenue of assessed facilities allowed under
265 federal law. The agency shall calculate the quality assessment
266 rate annually on a per-resident-day basis, exclusive of those
267 resident days funded by the Medicare program, as reported by the
268 facilities. The per-resident-day assessment rate must ~~shall~~ be
269 uniform except as prescribed in subsection (3). Each facility
270 shall report monthly to the agency its total number of resident
271 days, exclusive of Medicare Part A resident days, and ~~shall~~
272 remit an amount equal to the assessment rate times the reported
273 number of days. The agency shall collect, and each facility
274 shall pay, the quality assessment each month. The agency shall
275 collect the assessment from nursing home facility providers by
276 ~~no later than~~ the 15th day of the next succeeding calendar
277 month. The agency shall notify providers of the quality
278 assessment and provide a standardized form to complete and
279 submit with payments. The collection of the nursing home
280 facility quality assessment shall commence no sooner than 5 days
281 after the agency's initial payment of the Medicaid rates
282 containing the elements prescribed in subsection (4). Nursing
283 home facilities may not create a separate line-item charge for
284 the purpose of passing ~~through~~ the assessment through to
285 residents.
286 (3)
287 (d) Effective July 1, 2011 ~~2009~~, the agency shall ~~may~~
288 exempt from the quality assessment any ~~or apply a lower quality~~
289 ~~assessment rate to a~~ qualified public, nonstate-owned or
290 operated nursing home facility whose total annual indigent

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291 census days are greater than 15 ~~25~~ percent of the facility’s
292 total annual census days.
293 Section 5. Paragraph (a) of subsection (2) of section
294 409.911, Florida Statutes, is amended to read:
295 409.911 Disproportionate share program.—Subject to specific
296 allocations established within the General Appropriations Act
297 and any limitations established pursuant to chapter 216, the
298 agency shall distribute, pursuant to this section, moneys to
299 hospitals providing a disproportionate share of Medicaid or
300 charity care services by making quarterly Medicaid payments as
301 required. Notwithstanding the provisions of s. 409.915, counties
302 are exempt from contributing toward the cost of this special
303 reimbursement for hospitals serving a disproportionate share of
304 low-income patients.
305 (2) The Agency for Health Care Administration shall use the
306 following actual audited data to determine the Medicaid days and
307 charity care to be used in calculating the disproportionate
308 share payment:
309 (a) The average of the 2004, 2005, and 2006 ~~2003, 2004, and~~
310 ~~2005~~ audited disproportionate share data to determine each
311 hospital’s Medicaid days and charity care for the 2011-2012
312 ~~2010-2011~~ state fiscal year.
313 Section 6. Section 409.9112, Florida Statutes, is amended
314 to read:
315 409.9112 Disproportionate share program for regional
316 perinatal intensive care centers.—In addition to the payments
317 made under s. 409.911, the agency shall design and implement a
318 system for making disproportionate share payments to those
319 hospitals that participate in the regional perinatal intensive

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320 care center program established pursuant to chapter 383. The
321 system of payments must conform to federal requirements and
322 distribute funds in each fiscal year for which an appropriation
323 is made by making quarterly Medicaid payments. Notwithstanding
324 s. 409.915, counties are exempt from contributing toward the
325 cost of this special reimbursement for hospitals serving a
326 disproportionate share of low-income patients. For the 2011-2012
327 ~~2010-2011~~ state fiscal year, the agency may not distribute
328 moneys under the regional perinatal intensive care centers
329 disproportionate share program.
330 (1) The following formula shall be used by the agency to
331 calculate the total amount earned for hospitals that participate
332 in the regional perinatal intensive care center program:
333
334 TAE = HDSP/THDSP
335
336 Where:
337 TAE = total amount earned by a regional perinatal intensive
338 care center.
339 HDSP = the prior state fiscal year regional perinatal
340 intensive care center disproportionate share payment to the
341 individual hospital.
342 THDSP = the prior state fiscal year total regional
343 perinatal intensive care center disproportionate share payments
344 to all hospitals.
345
346 (2) The total additional payment for hospitals that
347 participate in the regional perinatal intensive care center
348 program shall be calculated by the agency as follows:

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$$TAP = TAE \times TA$$

Where:

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

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

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

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

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

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

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

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378 (d) Agree to develop arrangements with other maternity and
379 neonatal care providers in the hospital’s region for the
380 appropriate receipt and transfer of patients in need of
381 specialized maternity and neonatal intensive care services.
382 (e) Agree to establish and provide a developmental
383 evaluation and services program for certain high-risk neonates,
384 as prescribed and defined by rule of the department.
385 (f) Agree to sponsor a program of continuing education in
386 perinatal care for health care professionals within the region
387 of the hospital, as specified by rule.
388 (g) Agree to provide backup and referral services to the
389 county health departments and other low-income perinatal
390 providers within the hospital’s region, including the
391 development of written agreements between these organizations
392 and the hospital.
393 (h) Agree to arrange for transportation for high-risk
394 obstetrical patients and neonates in need of transfer from the
395 community to the hospital or from the hospital to another more
396 appropriate facility.
397 (4) Hospitals that ~~which~~ fail to comply with any of the
398 conditions in subsection (3) or the applicable rules of the
399 Department of Health and the agency may not receive any payments
400 under this section until full compliance is achieved. A hospital
401 that ~~which~~ is not in compliance in two or more consecutive
402 quarters may not receive its share of the funds. Any forfeited
403 funds shall be distributed by the remaining participating
404 regional perinatal intensive care center program hospitals.
405 Section 7. Section 409.9113, Florida Statutes, is amended
406 to read:

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407 409.9113 Disproportionate share program for teaching
408 hospitals.—In addition to the payments made under ss. 409.911
409 and 409.9112, the agency shall make disproportionate share
410 payments to ~~statutorily defined~~ teaching hospitals, as defined
411 in s. 408.07, for their increased costs associated with medical
412 education programs and for tertiary health care services
413 provided to the indigent. This system of payments must conform
414 to federal requirements and distribute funds in each fiscal year
415 for which an appropriation is made by making quarterly Medicaid
416 payments. Notwithstanding s. 409.915, counties are exempt from
417 contributing toward the cost of this special reimbursement for
418 hospitals serving a disproportionate share of low-income
419 patients. For the 2011-2012 ~~2010-2011~~ state fiscal year, the
420 agency shall distribute the moneys provided in the General
421 Appropriations Act to statutorily defined teaching hospitals and
422 family practice teaching hospitals, as defined in s. 395.805,
423 pursuant to this section ~~under the teaching hospital~~
424 ~~disproportionate share program~~. The funds provided for
425 statutorily defined teaching hospitals shall be distributed in
426 the same proportion as the ~~state fiscal year~~ 2003-2004 state
427 fiscal year teaching hospital disproportionate share funds were
428 distributed or as otherwise provided in the General
429 Appropriations Act. The funds provided for family practice
430 teaching hospitals shall be distributed equally among family
431 practice teaching hospitals.
432 (1) On or before September 15 of each year, the agency
433 shall calculate an allocation fraction to be used for
434 distributing funds to ~~state~~ statutory teaching hospitals.
435 Subsequent to the end of each quarter of the state fiscal year,

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436 the agency shall distribute to each statutory teaching hospital~~,~~
437 ~~as defined in s. 408.07,~~ an amount determined by multiplying
438 one-fourth of the funds appropriated for this purpose by the
439 Legislature times such hospital's allocation fraction. The
440 allocation fraction for each such hospital shall be determined
441 by the sum of the following three primary factors, divided by
442 three:
443 (a) The number of nationally accredited graduate medical
444 education programs offered by the hospital, including programs
445 accredited by the Accreditation Council for Graduate Medical
446 Education and the combined Internal Medicine and Pediatrics
447 programs acceptable to both the American Board of Internal
448 Medicine and the American Board of Pediatrics at the beginning
449 of the state fiscal year preceding the date on which the
450 allocation fraction is calculated. The numerical value of this
451 factor is the fraction that the hospital represents of the total
452 number of programs, where the total is computed for all ~~state~~
453 statutory teaching hospitals.
454 (b) The number of full-time equivalent trainees in the
455 hospital, which comprises two components:
456 1. The number of trainees enrolled in nationally accredited
457 graduate medical education programs, as defined in paragraph
458 (a). Full-time equivalents are computed using the fraction of
459 the year during which each trainee is primarily assigned to the
460 given institution, over the state fiscal year preceding the date
461 on which the allocation fraction is calculated. The numerical
462 value of this factor is the fraction that the hospital
463 represents of the total number of full-time equivalent trainees
464 enrolled in accredited graduate programs, where the total is

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465 computed for all ~~state~~ statutory teaching hospitals.
466 2. The number of medical students enrolled in accredited
467 colleges of medicine and engaged in clinical activities,
468 including required clinical clerkships and clinical electives.
469 Full-time equivalents are computed using the fraction of the
470 year during which each trainee is primarily assigned to the
471 given institution, over the course of the state fiscal year
472 preceding the date on which the allocation fraction is
473 calculated. The numerical value of this factor is the fraction
474 that the given hospital represents of the total number of full-
475 time equivalent students enrolled in accredited colleges of
476 medicine, where the total is computed for all ~~state~~ statutory
477 teaching hospitals.
478
479 The primary factor for full-time equivalent trainees is computed
480 as the sum of these two components, divided by two.
481 (c) A service index that comprises three components:
482 1. The Agency for Health Care Administration Service Index,
483 computed by applying the standard Service Inventory Scores
484 established by the agency to services offered by the given
485 hospital, as reported on Worksheet A-2 for the last fiscal year
486 reported to the agency before the date on which the allocation
487 fraction is calculated. The numerical value of this factor is
488 the fraction that the given hospital represents of the total
489 ~~Agency for Health Care Administration Service~~ index values,
490 where the total is computed for all ~~state~~ statutory teaching
491 hospitals.
492 2. A volume-weighted service index, computed by applying
493 the standard Service Inventory Scores established by the agency

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494 ~~for Health Care Administration~~ to the volume of each service,
495 expressed in terms of the standard units of measure reported on
496 Worksheet A-2 for the last fiscal year reported to the agency
497 before the date on which the allocation factor is calculated.
498 The numerical value of this factor is the fraction that the
499 given hospital represents of the total volume-weighted service
500 index values, where the total is computed for all ~~state~~
501 statutory teaching hospitals.
502 3. Total Medicaid payments to each hospital for direct
503 inpatient and outpatient services during the fiscal year
504 preceding the date on which the allocation factor is calculated.
505 This includes payments made to each hospital for such services
506 by Medicaid prepaid health plans, whether the plan was
507 administered by the hospital or not. The numerical value of this
508 factor is the fraction that each hospital represents of the
509 total of such Medicaid payments, where the total is computed for
510 all ~~state~~ statutory teaching hospitals.
511
512 The primary factor for the service index is computed as the sum
513 of these three components, divided by three.
514 (2) By October 1 of each year, the agency shall use the
515 following formula to calculate the maximum additional
516 disproportionate share payment for statutory ~~statutorily defined~~
517 teaching hospitals:
518
519 TAP = THAF x A
520
521 Where:
522 TAP = total additional payment.

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523 THAF = teaching hospital allocation factor.
524 A = amount appropriated for a teaching hospital
525 disproportionate share program.
526 Section 8. Section 409.9117, Florida Statutes, is amended
527 to read:
528 409.9117 Primary care disproportionate share program.—For
529 the 2011-2012 ~~2010-2011~~ state fiscal year, the agency may ~~shall~~
530 not distribute moneys under the primary care disproportionate
531 share program.
532 (1) If federal funds are available for disproportionate
533 share programs in addition to those otherwise provided by law,
534 ~~there shall be created~~ a primary care disproportionate share
535 program shall be established.
536 (2) The following formula shall be used by the agency to
537 calculate the total amount earned for hospitals that participate
538 in the primary care disproportionate share program:
539
540 TAE = HDSP/THDSP
541
542 Where:
543 TAE = total amount earned by a hospital participating in
544 the primary care disproportionate share program.
545 HDSP = the prior state fiscal year primary care
546 disproportionate share payment to the individual hospital.
547 THDSP = the prior state fiscal year total primary care
548 disproportionate share payments to all hospitals.
549
550 (3) The total additional payment for hospitals that
551 participate in the primary care disproportionate share program

552 shall be calculated by the agency as follows:
553
554 TAP = TAE x TA
555
556 Where:
557 TAP = total additional payment for a primary care hospital.
558 TAE = total amount earned by a primary care hospital.
559 TA = total appropriation for the primary care
560 disproportionate share program.
561
562 (4) In establishing ~~the establishment~~ and funding ~~of~~ this
563 program, the agency shall use the following criteria in addition
564 to those specified in s. 409.911, and payments may not be made
565 to a hospital unless the hospital agrees to:
566 (a) Cooperate with a Medicaid prepaid health plan, if one
567 exists in the community.
568 (b) Ensure the availability of primary and specialty care
569 physicians to Medicaid recipients who are not enrolled in a
570 prepaid capitated arrangement and who are in need of access to
571 such physicians.
572 (c) Coordinate and provide primary care services free of
573 charge, except copayments, to all persons with incomes up to 100
574 percent of the federal poverty level who are not otherwise
575 covered by Medicaid or another program administered by a
576 governmental entity, and to provide such services based on a
577 sliding fee scale to all persons with incomes up to 200 percent
578 of the federal poverty level who are not otherwise covered by
579 Medicaid or another program administered by a governmental
580 entity, except that eligibility may be limited to persons who

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581 reside within a more limited area, as agreed to by the agency
582 and the hospital.
583 (d) Contract with any federally qualified health center, if
584 one exists within the agreed geopolitical boundaries, concerning
585 the provision of primary care services, in order to guarantee
586 delivery of services in a nonduplicative fashion, and to provide
587 for referral arrangements, privileges, and admissions, as
588 appropriate. The hospital shall agree to provide ~~at an onsite or~~
589 ~~offsite facility~~ primary care services within 24 hours at an
590 onsite or offsite facility to which all Medicaid recipients and
591 persons eligible under this paragraph who do not require
592 emergency room services are referred during normal daylight
593 hours.
594 (e) Cooperate with the agency, the county, and other
595 entities to ensure the provision of certain public health
596 services, case management, referral and acceptance of patients,
597 and sharing of epidemiological data, as the agency and the
598 hospital find mutually necessary and desirable to promote and
599 protect the public health within the agreed geopolitical
600 boundaries.
601 (f) In cooperation with the county in which the hospital
602 resides, develop a low-cost, outpatient, prepaid health care
603 program to persons who are not eligible for the Medicaid
604 program, and who reside within the area.
605 (g) Provide inpatient services to residents within the area
606 who are not eligible for Medicaid or Medicare, and who do not
607 have private health insurance, regardless of ability to pay, on
608 the basis of available space, except that hospitals may not be
609 prevented from establishing bill collection programs based on

610 ability to pay.
611 (h) Work with the Florida Healthy Kids Corporation, the
612 Florida Health Care Purchasing Cooperative, and business health
613 coalitions, as appropriate, to develop a feasibility study and
614 plan to provide a low-cost comprehensive health insurance plan
615 to persons who reside within the area and who do not have access
616 to such a plan.
617 (i) Work with public health officials and other experts to
618 provide community health education and prevention activities
619 designed to promote healthy lifestyles and appropriate use of
620 health services.
621 (j) Work with the local health council to develop a plan
622 for promoting access to affordable health care services for all
623 persons who reside within the area, including, but not limited
624 to, public health services, primary care services, inpatient
625 services, and affordable health insurance generally.
626
627 Any hospital that fails to comply with any of the provisions of
628 this subsection, or any other contractual condition, may not
629 receive payments under this section until full compliance is
630 achieved.
631 Section 9. Paragraph (b) of subsection (16) and paragraph
632 (a) of subsection (39) of section 409.912, Florida Statutes, are
633 amended to read:
634 409.912 Cost-effective purchasing of health care.—The
635 agency shall purchase goods and services for Medicaid recipients
636 in the most cost-effective manner consistent with the delivery
637 of quality medical care. To ensure that medical services are
638 effectively utilized, the agency may, in any case, require a

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639 confirmation or second physician's opinion of the correct
640 diagnosis for purposes of authorizing future services under the
641 Medicaid program. This section does not restrict access to
642 emergency services or poststabilization care services as defined
643 in 42 C.F.R. part 438.114. Such confirmation or second opinion
644 shall be rendered in a manner approved by the agency. The agency
645 shall maximize the use of prepaid per capita and prepaid
646 aggregate fixed-sum basis services when appropriate and other
647 alternative service delivery and reimbursement methodologies,
648 including competitive bidding pursuant to s. 287.057, designed
649 to facilitate the cost-effective purchase of a case-managed
650 continuum of care. The agency shall also require providers to
651 minimize the exposure of recipients to the need for acute
652 inpatient, custodial, and other institutional care and the
653 inappropriate or unnecessary use of high-cost services. The
654 agency shall contract with a vendor to monitor and evaluate the
655 clinical practice patterns of providers in order to identify
656 trends that are outside the normal practice patterns of a
657 provider's professional peers or the national guidelines of a
658 provider's professional association. The vendor must be able to
659 provide information and counseling to a provider whose practice
660 patterns are outside the norms, in consultation with the agency,
661 to improve patient care and reduce inappropriate utilization.
662 The agency may mandate prior authorization, drug therapy
663 management, or disease management participation for certain
664 populations of Medicaid beneficiaries, certain drug classes, or
665 particular drugs to prevent fraud, abuse, overuse, and possible
666 dangerous drug interactions. The Pharmaceutical and Therapeutics
667 Committee shall make recommendations to the agency on drugs for

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668 which prior authorization is required. The agency shall inform
669 the Pharmaceutical and Therapeutics Committee of its decisions
670 regarding drugs subject to prior authorization. The agency is
671 authorized to limit the entities it contracts with or enrolls as
672 Medicaid providers by developing a provider network through
673 provider credentialing. The agency may competitively bid single-
674 source-provider contracts if procurement of goods or services
675 results in demonstrated cost savings to the state without
676 limiting access to care. The agency may limit its network based
677 on the assessment of beneficiary access to care, provider
678 availability, provider quality standards, time and distance
679 standards for access to care, the cultural competence of the
680 provider network, demographic characteristics of Medicaid
681 beneficiaries, practice and provider-to-beneficiary standards,
682 appointment wait times, beneficiary use of services, provider
683 turnover, provider profiling, provider licensure history,
684 previous program integrity investigations and findings, peer
685 review, provider Medicaid policy and billing compliance records,
686 clinical and medical record audits, and other factors. Providers
687 shall not be entitled to enrollment in the Medicaid provider
688 network. The agency shall determine instances in which allowing
689 Medicaid beneficiaries to purchase durable medical equipment and
690 other goods is less expensive to the Medicaid program than long-
691 term rental of the equipment or goods. The agency may establish
692 rules to facilitate purchases in lieu of long-term rentals in
693 order to protect against fraud and abuse in the Medicaid program
694 as defined in s. 409.913. The agency may seek federal waivers
695 necessary to administer these policies.
696 (16)

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697 (b) The responsibility of the agency under this subsection
698 includes ~~shall include~~ the development of capabilities to
699 identify actual and optimal practice patterns; patient and
700 provider educational initiatives; methods for determining
701 patient compliance with prescribed treatments; fraud, waste, and
702 abuse prevention and detection programs; and beneficiary case
703 management programs.

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

724 2. The agency shall also develop educational interventions
725 designed to promote the proper use of medications by providers

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and beneficiaries.

3. The agency shall implement a pharmacy fraud, waste, and abuse initiative that may include a surety bond or letter of credit requirement for participating pharmacies, enhanced provider auditing practices, the use of additional fraud and abuse software, recipient management programs for beneficiaries inappropriately using their benefits, and other steps that ~~will~~ eliminate provider and recipient fraud, waste, and abuse. The initiative shall address enforcement efforts to reduce the number and use of counterfeit prescriptions.

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

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

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

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784 by telephone or other telecommunication device within 24 hours
785 after receipt of a request for prior consultation; and
786 b. A 72-hour supply of the drug prescribed is provided in
787 an emergency or when the agency does not provide a response
788 within 24 hours as required by sub-subparagraph a.
789 2. Reimbursement to pharmacies for Medicaid prescribed
790 drugs shall be set at the lowest ~~lesser~~ of: the average
791 wholesale price (AWP) minus 16.4 percent, the wholesaler
792 acquisition cost (WAC) plus 1.5 ~~4.75~~ percent, the federal upper
793 limit (FUL), the state maximum allowable cost (SMAC), or the
794 usual and customary (UAC) charge billed by the provider.
795 3. The agency shall develop and implement a process for
796 managing the drug therapies of Medicaid recipients who are using
797 significant numbers of prescribed drugs each month. The
798 management process may include, but is not limited to,
799 comprehensive, physician-directed medical-record reviews, claims
800 analyses, and case evaluations to determine the medical
801 necessity and appropriateness of a patient’s treatment plan and
802 drug therapies. The agency may contract with a private
803 organization to provide drug-program-management services. The
804 Medicaid drug benefit management program shall include
805 initiatives to manage drug therapies for HIV/AIDS patients,
806 patients using 20 or more unique prescriptions in a 180-day
807 period, and the top 1,000 patients in annual spending. The
808 agency shall enroll any Medicaid recipient in the drug benefit
809 management program if he or she meets the specifications of this
810 provision and is not enrolled in a Medicaid health maintenance
811 organization.
812 4. The agency may limit the size of its pharmacy network

813 based on need, competitive bidding, price negotiations,
814 credentialing, or similar criteria. The agency shall give
815 special consideration to rural areas in determining the size and
816 location of pharmacies included in the Medicaid pharmacy
817 network. A pharmacy credentialing process may include criteria
818 such as a pharmacy's full-service status, location, size,
819 patient educational programs, patient consultation, disease
820 management services, and other characteristics. The agency may
821 impose a moratorium on Medicaid pharmacy enrollment if ~~when~~ it
822 is determined that it has a sufficient number of Medicaid-
823 participating providers. The agency must allow dispensing
824 practitioners to participate as a part of the Medicaid pharmacy
825 network regardless of the practitioner's proximity to any other
826 entity that is dispensing prescription drugs under the Medicaid
827 program. A dispensing practitioner must meet all credentialing
828 requirements applicable to his or her practice, as determined by
829 the agency.
830 5. The agency shall develop and implement a program that
831 requires Medicaid practitioners who prescribe drugs to use a
832 counterfeit-proof prescription pad for Medicaid prescriptions.
833 The agency shall require the use of standardized counterfeit-
834 proof prescription pads by Medicaid-participating prescribers or
835 prescribers who write prescriptions for Medicaid recipients. The
836 agency may implement the program in targeted geographic areas or
837 statewide.
838 6. The agency may enter into arrangements that require
839 manufacturers of generic drugs prescribed to Medicaid recipients
840 to provide rebates of at least 15.1 percent of the average
841 manufacturer price for the manufacturer's generic products.

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842 These arrangements shall require that if a generic-drug
843 manufacturer pays federal rebates for Medicaid-reimbursed drugs
844 at a level below 15.1 percent, the manufacturer must provide a
845 supplemental rebate to the state in an amount necessary to
846 achieve a 15.1-percent rebate level.
847 7. The agency may establish a preferred drug list as
848 described in this subsection, and, pursuant to the establishment
849 of such preferred drug list, ~~it is authorized to~~ negotiate
850 supplemental rebates from manufacturers that are in addition to
851 those required by Title XIX of the Social Security Act and at no
852 less than 14 percent of the average manufacturer price as
853 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
854 the federal or supplemental rebate, or both, equals or exceeds
855 29 percent. There is no upper limit on the supplemental rebates
856 the agency may negotiate. The agency may determine that specific
857 products, brand-name or generic, are competitive at lower rebate
858 percentages. Agreement to pay the minimum supplemental rebate
859 percentage ~~will~~ guarantee a manufacturer that the Medicaid
860 Pharmaceutical and Therapeutics Committee will consider a
861 product for inclusion on the preferred drug list. However, a
862 pharmaceutical manufacturer is not guaranteed placement on the
863 preferred drug list by simply paying the minimum supplemental
864 rebate. Agency decisions will be made on the clinical efficacy
865 of a drug and recommendations of the Medicaid Pharmaceutical and
866 Therapeutics Committee, as well as the price of competing
867 products minus federal and state rebates. The agency may ~~is~~
868 ~~authorized to~~ contract with an outside agency or contractor to
869 conduct negotiations for supplemental rebates. For the purposes
870 of this section, the term “supplemental rebates” means cash

rebates. Effective July 1, 2004, Value-added programs as a substitution for supplemental rebates are prohibited. The agency may is authorized to seek any federal waivers to implement this initiative.

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

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

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

b. The agency, in conjunction with the Department of Children and Family Services, may implement the Medicaid behavioral drug management system that is designed to improve the quality of care and behavioral health prescribing practices based on best practice guidelines, improve patient adherence to medication plans, reduce clinical risk, and lower prescribed drug costs and the rate of inappropriate spending on Medicaid

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900 behavioral drugs. The program may include the following
901 elements:
902 (I) Provide for the development and adoption of best
903 practice guidelines for behavioral health-related drugs such as
904 antipsychotics, antidepressants, and medications for treating
905 bipolar disorders and other behavioral conditions; translate
906 them into practice; review behavioral health prescribers and
907 compare their prescribing patterns to a number of indicators
908 that are based on national standards; and determine deviations
909 from best practice guidelines.
910 (II) Implement processes for providing feedback to and
911 educating prescribers using best practice educational materials
912 and peer-to-peer consultation.
913 (III) Assess Medicaid beneficiaries who are outliers in
914 their use of behavioral health drugs with regard to the numbers
915 and types of drugs taken, drug dosages, combination drug
916 therapies, and other indicators of improper use of behavioral
917 health drugs.
918 (IV) Alert prescribers to patients who fail to refill
919 prescriptions in a timely fashion, are prescribed multiple same-
920 class behavioral health drugs, and may have other potential
921 medication problems.
922 (V) Track spending trends for behavioral health drugs and
923 deviation from best practice guidelines.
924 (VI) Use educational and technological approaches to
925 promote best practices, educate consumers, and train prescribers
926 in the use of practice guidelines.
927 (VII) Disseminate electronic and published materials.
928 (VIII) Hold statewide and regional conferences.

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929 (IX) Implement a disease management program with a model
930 quality-based medication component for severely mentally ill
931 individuals and emotionally disturbed children who are high
932 users of care.
933 11.~~a.~~ The agency shall implement a Medicaid prescription
934 drug management system.
935 a. The agency may contract with a vendor that has
936 experience in operating prescription drug management systems in
937 order to implement this system. Any management system that is
938 implemented in accordance with this subparagraph must rely on
939 cooperation between physicians and pharmacists to determine
940 appropriate practice patterns and clinical guidelines to improve
941 the prescribing, dispensing, and use of drugs in the Medicaid
942 program. The agency may seek federal waivers to implement this
943 program.
944 b. The drug management system must be designed to improve
945 the quality of care and prescribing practices based on best
946 practice guidelines, improve patient adherence to medication
947 plans, reduce clinical risk, and lower prescribed drug costs and
948 the rate of inappropriate spending on Medicaid prescription
949 drugs. The program must:
950 (I) Provide for the ~~development and~~ adoption of best
951 practice guidelines for the prescribing and use of drugs in the
952 Medicaid program, including translating best practice guidelines
953 into practice; reviewing prescriber patterns and comparing them
954 to indicators that are based on national standards and practice
955 patterns of clinical peers in their community, statewide, and
956 nationally; and determine deviations from best practice
957 guidelines.

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958 (II) Implement processes for providing feedback to and
959 educating prescribers using best practice educational materials
960 and peer-to-peer consultation.
961 (III) Assess Medicaid recipients who are outliers in their
962 use of a single or multiple prescription drugs with regard to
963 the numbers and types of drugs taken, drug dosages, combination
964 drug therapies, and other indicators of improper use of
965 prescription drugs.
966 (IV) Alert prescribers to recipients ~~patients~~ who fail to
967 refill prescriptions in a timely fashion, are prescribed
968 multiple drugs that may be redundant or contraindicated, or may
969 have other potential medication problems.
970 (V) Track spending trends for prescription drugs and
971 deviation from best practice guidelines.
972 (VI) Use educational and technological approaches to
973 promote best practices, educate consumers, and train prescribers
974 in the use of practice guidelines.
975 (VII) Disseminate electronic and published materials.
976 (VIII) Hold statewide and regional conferences.
977 (IX) Implement disease management programs in cooperation
978 with physicians and pharmacists, along with a model quality-
979 based medication component for individuals having chronic
980 medical conditions.
981 12. The agency may ~~is authorized to~~ contract for drug
982 rebate administration, including, but not limited to,
983 calculating rebate amounts, invoicing manufacturers, negotiating
984 disputes with manufacturers, and maintaining a database of
985 rebate collections.
986 13. The agency may specify the preferred daily dosing form

987 or strength for the purpose of promoting best practices with
988 regard to the prescribing of certain drugs as specified in the
989 General Appropriations Act and ensuring cost-effective
990 prescribing practices.
991 14. The agency may require prior authorization for
992 Medicaid-covered prescribed drugs. The agency may~~, but is not~~
993 ~~required to,~~ prior-authorize the use of a product:
994 a. For an indication not approved in labeling;
995 b. To comply with certain clinical guidelines; or
996 c. If the product has the potential for overuse, misuse, or
997 abuse.
998
999 The agency may require the prescribing professional to provide
1000 information about the rationale and supporting medical evidence
1001 for the use of a drug. The agency may post prior authorization
1002 criteria and protocol and updates to the list of drugs that are
1003 subject to prior authorization on an Internet website without
1004 amending its rule or engaging in additional rulemaking.
1005 15. The agency, in conjunction with the Pharmaceutical and
1006 Therapeutics Committee, may require age-related prior
1007 authorizations for certain prescribed drugs. The agency may
1008 preauthorize the use of a drug for a recipient who may not meet
1009 the age requirement or may exceed the length of therapy for use
1010 of this product as recommended by the manufacturer and approved
1011 by the Food and Drug Administration. Prior authorization may
1012 require the prescribing professional to provide information
1013 about the rationale and supporting medical evidence for the use
1014 of a drug.
1015 16. The agency shall implement a step-therapy prior

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1016 authorization approval process for medications excluded from the
1017 preferred drug list. Medications listed on the preferred drug
1018 list must be used within the previous 12 months before ~~prior to~~
1019 the alternative medications that are not listed. The step-
1020 therapy prior authorization may require the prescriber to use
1021 the medications of a similar drug class or for a similar medical
1022 indication unless contraindicated in the Food and Drug
1023 Administration labeling. The trial period between the specified
1024 steps may vary according to the medical indication. The step-
1025 therapy approval process shall be developed in accordance with
1026 the committee as stated in s. 409.91195(7) and (8). A drug
1027 product may be approved without meeting the step-therapy prior
1028 authorization criteria if the prescribing physician provides the
1029 agency with additional written medical or clinical documentation
1030 that the product is medically necessary because:
1031 a. There is not a drug on the preferred drug list to treat
1032 the disease or medical condition which is an acceptable clinical
1033 alternative;
1034 b. The alternatives have been ineffective in the treatment
1035 of the beneficiary’s disease; or
1036 c. Based on historic evidence and known characteristics of
1037 the patient and the drug, the drug is likely to be ineffective,
1038 or the number of doses have been ineffective.
1039
1040 The agency shall work with the physician to determine the best
1041 alternative for the patient. The agency may adopt rules waiving
1042 the requirements for written clinical documentation for specific
1043 drugs in limited clinical situations.
1044 17. The agency shall implement a return and reuse program

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1045 for drugs dispensed by pharmacies to institutional recipients,
1046 which includes payment of a $5 restocking fee for the
1047 implementation and operation of the program. The return and
1048 reuse program shall be implemented electronically and in a
1049 manner that promotes efficiency. The program must permit a
1050 pharmacy to exclude drugs from the program if it is not
1051 practical or cost-effective for the drug to be included and must
1052 provide for the return to inventory of drugs that cannot be
1053 credited or returned in a cost-effective manner. The agency
1054 shall determine if the program has reduced the amount of
1055 Medicaid prescription drugs which are destroyed on an annual
1056 basis and if there are additional ways to ensure more
1057 prescription drugs are not destroyed which could safely be
1058 reused. ~~The agency’s conclusion and recommendations shall be~~
1059 ~~reported to the Legislature by December 1, 2005.~~
1060 Section 10. Paragraph (a) of subsection (2) of section
1061 409.9122, Florida Statutes, is amended to read:
1062 409.9122 Mandatory Medicaid managed care enrollment;
1063 programs and procedures.—
1064 (2)(a) The agency shall enroll all Medicaid recipients in a
1065 managed care plan or MediPass ~~all Medicaid recipients~~, except
1066 ~~those Medicaid~~ recipients who are~~:~~ in an institution, receiving
1067 a Medicaid nonpoverty medical subsidy,~~; enrolled in the Medicaid~~
1068 ~~medically needy Program;~~ or eligible for both Medicaid and
1069 Medicare. Upon enrollment, recipients may ~~individuals will be~~
1070 ~~able to~~ change their managed care option during the 90-day opt
1071 out period required by federal Medicaid regulations. The agency
1072 may ~~is authorized to~~ seek the necessary Medicaid state plan
1073 amendment to implement this policy. ~~However, to the extent~~

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1074 1. If permitted by federal law, the agency may enroll ~~in a~~
1075 ~~managed care plan or MediPass~~ a Medicaid recipient who is exempt
1076 from mandatory managed care enrollment in a managed care plan or
1077 MediPass if~~, provided that~~:
1078 a.~~1.~~ The recipient's decision to enroll in a managed care
1079 plan or MediPass is voluntary;
1080 b.~~2.~~ ~~If~~ The recipient chooses to enroll in a managed care
1081 plan, the agency has determined that the ~~managed care~~ plan
1082 provides specific programs and services that ~~which~~ address the
1083 special health needs of the recipient; and
1084 c.~~3.~~ The agency receives the ~~any~~ necessary waivers from the
1085 federal Centers for Medicare and Medicaid Services.
1086 2. The agency shall develop rules to establish policies by
1087 which exceptions to the mandatory managed care enrollment
1088 requirement may be made on a case-by-case basis. The rules must
1089 ~~shall~~ include the specific criteria to be applied when
1090 determining ~~making a determination as to~~ whether to exempt a
1091 recipient from mandatory enrollment ~~in a managed care plan or~~
1092 ~~MediPass~~.
1093 3. School districts participating in the certified school
1094 match program pursuant to ss. 409.908(21) and 1011.70 shall be
1095 reimbursed by Medicaid, subject to the limitations of s.
1096 1011.70(1), for a Medicaid-eligible child participating in the
1097 services ~~as~~ authorized in s. 1011.70, as provided ~~for~~ in s.
1098 409.9071, regardless of whether the child is enrolled in
1099 MediPass or a managed care plan. Managed care plans must ~~shall~~
1100 make a good faith effort to execute agreements with school
1101 districts regarding the coordinated provision of services
1102 authorized under s. 1011.70.

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1103 4. County health departments delivering school-based
1104 services pursuant to ss. 381.0056 and 381.0057 shall be
1105 reimbursed by Medicaid for the federal share for a Medicaid-
1106 eligible child who receives Medicaid-covered services in a
1107 school setting, regardless of whether the child is enrolled in
1108 MediPass or a managed care plan. Managed care plans shall make a
1109 good faith effort to execute agreements with county health
1110 departments that coordinate the ~~regarding the coordinated~~
1111 provision of services to a Medicaid-eligible child. To ensure
1112 continuity of care for Medicaid patients, the agency, the
1113 Department of Health, and the Department of Education shall
1114 develop procedures for ensuring that a student's managed care
1115 plan or MediPass provider receives information relating to
1116 services provided in accordance with ss. 381.0056, 381.0057,
1117 409.9071, and 1011.70.
1118 Section 11. Paragraph (a) of subsection (1) of section
1119 409.915, Florida Statutes, is amended to read:
1120 409.915 County contributions to Medicaid.—Although the
1121 state is responsible for the full portion of the state share of
1122 the matching funds required for the Medicaid program, in order
1123 to acquire a certain portion of these funds, the state shall
1124 charge the counties for certain items of care and service as
1125 provided in this section.
1126 (1) Each county shall participate in the following items of
1127 care and service:
1128 (a) For both health maintenance members and fee-for-service
1129 beneficiaries, payments for inpatient hospitalization in excess
1130 of 10 days, but not in excess of 45 days, with the exception of
1131 pregnant women and children whose income is greater than ~~in~~

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1132 ~~excess of~~ the federal poverty level and who do not receive a
1133 Medicaid nonpoverty medical subsidy under s. 409.904(2)
1134 ~~participate in the Medicaid medically needy Program~~, and for
1135 adult lung transplant services.
1136 Section 12. Subsections (1) and (2) of section 409.9301,
1137 Florida Statutes, are amended to read:
1138 409.9301 Pharmaceutical expense assistance.—
1139 (1) PROGRAM ESTABLISHED.—A program is established in the
1140 agency ~~for Health Care Administration~~ to provide pharmaceutical
1141 expense assistance to individuals diagnosed with cancer or
1142 individuals who have obtained ~~received~~ organ transplants who
1143 received a Medicaid nonpoverty medical subsidy before ~~were~~
1144 ~~medically needy recipients prior to~~ January 1, 2006.
1145 (2) ELIGIBILITY.—Eligibility for the program is limited to
1146 an individual who:
1147 (a) Is a resident of this state;
1148 (b) Was a Medicaid recipient who received a Medicaid
1149 nonpoverty medical subsidy before ~~under the Florida Medicaid~~
1150 ~~medically needy program prior to~~ January 1, 2006;
1151 (c) Is eligible for Medicare;
1152 (d) Is a cancer patient or an organ transplant recipient;
1153 and
1154 (e) Requests to be enrolled in the program.
1155 Section 13. This act shall take effect June 30, 2011.