Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate		House
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1 Representative(s) Bean offered the following:

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3 **Amendment (with title amendment)**

4 Remove the entire body and insert:

5 Section 1. Paragraph (a) of subsection (3) of section
6 400.23, Florida Statutes, is amended to read:

7 400.23 Rules; evaluation and deficiencies; licensure
8 status.--

9 (3)(a) The agency shall adopt rules providing ~~for the~~
10 minimum staffing requirements for nursing homes. These
11 requirements shall include, for each nursing home facility, a
12 minimum certified nursing assistant staffing of 2.3 hours of
13 direct care per resident per day beginning January 1, 2002,
14 increasing to 2.6 hours of direct care per resident per day
15 beginning January 1, 2003, and increasing to 2.9 hours of direct

16 care per resident per day beginning July 1, 2006 ~~2005~~. Beginning
17 January 1, 2002, no facility shall staff below one certified
18 nursing assistant per 20 residents, and a minimum licensed
19 nursing staffing of 1.0 hour of direct resident care per
20 resident per day but never below one licensed nurse per 40
21 residents. Nursing assistants employed under s. 400.211(2) may
22 be included in computing the staffing ratio for certified
23 nursing assistants only if they provide nursing assistance
24 services to residents on a full-time basis. Each nursing home
25 must document compliance with staffing standards as required
26 under this paragraph and post daily the names of staff on duty
27 for the benefit of facility residents and the public. The agency
28 shall recognize the use of licensed nurses for compliance with
29 minimum staffing requirements for certified nursing assistants,
30 provided that the facility otherwise meets the minimum staffing
31 requirements for licensed nurses and that the licensed nurses so
32 recognized are performing the duties of a certified nursing
33 assistant. Unless otherwise approved by the agency, licensed
34 nurses counted toward the minimum staffing requirements for
35 certified nursing assistants must exclusively perform the duties
36 of a certified nursing assistant for the entire shift and shall
37 not also be counted toward the minimum staffing requirements for
38 licensed nurses. If the agency approved a facility's request to
39 use a licensed nurse to perform both licensed nursing and
40 certified nursing assistant duties, the facility must allocate
41 the amount of staff time specifically spent on certified nursing
42 assistant duties for the purpose of documenting compliance with

43 minimum staffing requirements for certified and licensed nursing
44 staff. In no event may the hours of a licensed nurse with dual
45 job responsibilities be counted twice.
46 Section 2. Subsections (2) and (5) of section 409.814,
47 Florida Statutes, are amended to read:
48 409.814 Eligibility.--A child who has not reached 19 years
49 of age whose family income is equal to or below 200 percent of
50 the federal poverty level is eligible for the Florida KidCare
51 program as provided in this section. For enrollment in the
52 Children's Medical Services Network, a complete application
53 includes the medical or behavioral health screening. If,
54 subsequently, an individual is determined to be ineligible for
55 coverage, he or she must immediately be disenrolled from the
56 respective Florida KidCare program component.
57 (2) A child who is not eligible for Medicaid, but who is
58 eligible for the Florida KidCare program, may obtain health
59 benefits coverage under any of the other components listed in s.
60 409.813 if such coverage is approved and available in the county
61 in which the child resides. However, a child who is eligible for
62 Medikids, including those eligible under subsection (5), may
63 participate in the Florida Healthy Kids program only if the
64 child has a sibling participating in the Florida Healthy Kids
65 program and the child's county of residence permits such
66 enrollment.
67 (5) A child whose family income is above 200 percent of
68 the federal poverty level or a child who is excluded under the
69 provisions of subsection (4) may apply for coverage and shall be

70 allowed to participate in the Florida KidCare program, excluding
71 the Medicaid program, but is subject to the following
72 provisions:
73 (a) The family is not eligible for premium assistance
74 payments and must pay the full cost of the premium, including
75 any administrative costs.
76 (b) The agency is authorized to place limits on enrollment
77 in Medikids by these children in order to avoid adverse
78 selection. The number of children participating in Medikids
79 whose family income exceeds 200 percent of the federal poverty
80 level must not exceed 10 percent of total enrollees in the
81 Medikids program.
82 (c) The board of directors of the Florida Healthy Kids
83 Corporation is authorized to place limits on enrollment of these
84 children in order to avoid adverse selection. In addition, the
85 board is authorized to offer a reduced benefit package to these
86 children in order to limit program costs for such families. The
87 number of children participating in the Florida Healthy Kids
88 program whose family income exceeds 200 percent of the federal
89 poverty level must not exceed 10 percent of total enrollees in
90 the Florida Healthy Kids program.
91 (d) Children described in this subsection are not counted
92 in the annual enrollment ceiling for the Florida KidCare
93 program.
94 Section 3. Subsection (5) of section 409.903, Florida
95 Statutes, is amended to read:

96 409.903 Mandatory payments for eligible persons.--The
97 agency shall make payments for medical assistance and related
98 services on behalf of the following persons who the department,
99 or the Social Security Administration by contract with the
100 Department of Children and Family Services, determines to be
101 eligible, subject to the income, assets, and categorical
102 eligibility tests set forth in federal and state law. Payment on
103 behalf of these Medicaid eligible persons is subject to the
104 availability of moneys and any limitations established by the
105 General Appropriations Act or chapter 216.
106 (5) A pregnant woman for the duration of her pregnancy and
107 for the postpartum period as defined in federal law and rule, or
108 a child under age 1, if either is living in a family that has an
109 income which is at or below 150 percent of the most current
110 federal poverty level, or, effective January 1, 1992, that has
111 an income which is at or below 185 percent of the most current
112 federal poverty level. Such a person is not subject to an assets
113 test. Further, a pregnant woman who applies for eligibility for
114 the Medicaid program through a qualified Medicaid provider must
115 be offered the opportunity, subject to federal rules, to be made
116 presumptively eligible for the Medicaid program. ~~Effective July~~
117 ~~1, 2005, eligibility for Medicaid services is eliminated for~~
118 ~~women who have incomes above 150 percent of the most current~~
119 ~~federal poverty level.~~
120 Section 4. Subsections (1) and (2) of section 409.904,
121 Florida Statutes, are amended to read:

122 409.904 Optional payments for eligible persons.--The
123 agency may make payments for medical assistance and related
124 services on behalf of the following persons who are determined
125 to be eligible subject to the income, assets, and categorical
126 eligibility tests set forth in federal and state law. Payment on
127 behalf of these Medicaid eligible persons is subject to the
128 availability of moneys and any limitations established by the
129 General Appropriations Act or chapter 216.
130 (1)(a) From July 1, 2005, through December 31, 2005,
131 inclusive, a person who is age 65 or older or is determined to
132 be disabled, whose income is at or below 88 percent of federal
133 poverty level, and whose assets do not exceed established
134 limitations.
135 (b) Effective January 1, 2006, and subject to federal
136 waiver approval, a person who is age 65 or older or is
137 determined to be disabled, whose income is at or below 88
138 percent of the federal poverty level, whose assets do not exceed
139 established limitations, and who is not eligible for Medicare,
140 or, if eligible for Medicare, is also eligible for and receiving
141 Medicaid-covered institutional care or hospice or home-based and
142 community-based services. The agency shall seek federal
143 authorization through a waiver to provide this coverage.
144 (2) A family, a pregnant woman, a child under age 21, a
145 person age 65 or over, or a blind or disabled person, who would
146 be eligible under any group listed in s. 409.903(1), (2), or
147 (3), except that the income or assets of such family or person
148 exceed established limitations. For a family or person in one of

149 these coverage groups, medical expenses are deductible from
150 income in accordance with federal requirements in order to make
151 a determination of eligibility. A family or person eligible
152 under the coverage known as the "medically needy," is eligible
153 to receive the same services as other Medicaid recipients, with
154 the exception of services in skilled nursing facilities and
155 intermediate care facilities for the developmentally disabled.
156 ~~Effective July 1, 2005, the medically needy are eligible for~~
157 ~~prescribed drug services only.~~
158 Section 5. Paragraph (b) of subsection (1) of section
159 409.906, Florida Statutes, is amended to read:
160 409.906 Optional Medicaid services.--Subject to specific
161 appropriations, the agency may make payments for services which
162 are optional to the state under Title XIX of the Social Security
163 Act and are furnished by Medicaid providers to recipients who
164 are determined to be eligible on the dates on which the services
165 were provided. Any optional service that is provided shall be
166 provided only when medically necessary and in accordance with
167 state and federal law. Optional services rendered by providers
168 in mobile units to Medicaid recipients may be restricted or
169 prohibited by the agency. Nothing in this section shall be
170 construed to prevent or limit the agency from adjusting fees,
171 reimbursement rates, lengths of stay, number of visits, or
172 number of services, or making any other adjustments necessary to
173 comply with the availability of moneys and any limitations or
174 directions provided for in the General Appropriations Act or
175 chapter 216. If necessary to safeguard the state's systems of

176 providing services to elderly and disabled persons and subject
177 to the notice and review provisions of s. 216.177, the Governor
178 may direct the Agency for Health Care Administration to amend
179 the Medicaid state plan to delete the optional Medicaid service
180 known as "Intermediate Care Facilities for the Developmentally
181 Disabled." Optional services may include:
182 (1) ADULT DENTAL SERVICES.--
183 (b) ~~Beginning January 1, 2005,~~ The agency may pay for
184 dentures, the procedures required to seat dentures, and the
185 repair and reline of dentures, provided by or under the
186 direction of a licensed dentist, for a recipient who is 21 years
187 of age or older. ~~This paragraph is repealed effective July 1,~~
188 ~~2005.~~
189 Section 6. Effective January 1, 2006, section 409.9065,
190 Florida Statutes, is repealed.
191 Section 7. Paragraph (b) of subsection (2) and subsection
192 (14) of section 409.908, Florida Statutes, are amended to read:
193 409.908 Reimbursement of Medicaid providers.--Subject to
194 specific appropriations, the agency shall reimburse Medicaid
195 providers, in accordance with state and federal law, according
196 to methodologies set forth in the rules of the agency and in
197 policy manuals and handbooks incorporated by reference therein.
198 These methodologies may include fee schedules, reimbursement
199 methods based on cost reporting, negotiated fees, competitive
200 bidding pursuant to s. 287.057, and other mechanisms the agency
201 considers efficient and effective for purchasing services or
202 goods on behalf of recipients. If a provider is reimbursed based

203 on cost reporting and submits a cost report late and that cost
204 report would have been used to set a lower reimbursement rate
205 for a rate semester, then the provider's rate for that semester
206 shall be retroactively calculated using the new cost report, and
207 full payment at the recalculated rate shall be effected
208 retroactively. Medicare-granted extensions for filing cost
209 reports, if applicable, shall also apply to Medicaid cost
210 reports. Payment for Medicaid compensable services made on
211 behalf of Medicaid eligible persons is subject to the
212 availability of moneys and any limitations or directions
213 provided for in the General Appropriations Act or chapter 216.
214 Further, nothing in this section shall be construed to prevent
215 or limit the agency from adjusting fees, reimbursement rates,
216 lengths of stay, number of visits, or number of services, or
217 making any other adjustments necessary to comply with the
218 availability of moneys and any limitations or directions
219 provided for in the General Appropriations Act, provided the
220 adjustment is consistent with legislative intent.

221 (2)

222 (b) Subject to any limitations or directions provided for
223 in the General Appropriations Act, the agency shall establish
224 and implement a Florida Title XIX Long-Term Care Reimbursement
225 Plan (Medicaid) for nursing home care in order to provide care
226 and services in conformance with the applicable state and
227 federal laws, rules, regulations, and quality and safety
228 standards and to ensure that individuals eligible for medical
229 assistance have reasonable geographic access to such care.

230 1. Changes of ownership or of licensed operator do not
231 qualify for increases in reimbursement rates associated with the
232 change of ownership or of licensed operator. The agency shall
233 amend the Title XIX Long Term Care Reimbursement Plan to provide
234 that the initial nursing home reimbursement rates, for the
235 operating, patient care, and MAR components, associated with
236 related and unrelated party changes of ownership or licensed
237 operator filed on or after September 1, 2001, are equivalent to
238 the previous owner's reimbursement rate.

239 2. The agency shall amend the long-term care reimbursement
240 plan and cost reporting system to create direct care and
241 indirect care subcomponents of the patient care component of the
242 per diem rate. These two subcomponents together shall equal the
243 patient care component of the per diem rate. Separate cost-based
244 ceilings shall be calculated for each patient care subcomponent.
245 The direct care and indirect care subcomponents ~~subcomponent~~ of
246 the per diem rate ~~shall be limited by the cost-based class~~
247 ~~ceiling, and the indirect care subcomponent~~ shall be limited by
248 the lower of a ~~the~~ cost-based class ceiling, a ~~by the~~ target
249 rate class ceiling, or an ~~by the~~ individual provider target for
250 each subcomponent. ~~The agency shall adjust the patient care~~
251 ~~component effective January 1, 2002.~~ The cost to adjust the
252 direct care subcomponent shall be the net of the total funds
253 previously allocated for the case mix add-on. ~~The agency shall~~
254 ~~make the required changes to the nursing home cost reporting~~
255 ~~forms to implement this requirement effective January 1, 2002.~~

256 3. The direct care subcomponent shall include salaries and
257 benefits of direct care staff providing nursing services
258 including registered nurses, licensed practical nurses, and
259 certified nursing assistants who deliver care directly to
260 residents in the nursing home facility. This excludes nursing
261 administration, MDS, and care plan coordinators, staff
262 development, and staffing coordinator.
263 4. All other patient care costs shall be included in the
264 indirect care cost subcomponent of the patient care per diem
265 rate. There shall be no costs directly or indirectly allocated
266 to the direct care subcomponent from a home office or management
267 company.
268 5. On July 1 of each year, the agency shall report to the
269 Legislature direct and indirect care costs, including average
270 direct and indirect care costs per resident per facility and
271 direct care and indirect care salaries and benefits per category
272 of staff member per facility.
273 6. In order to offset the cost of general and professional
274 liability insurance, the agency shall amend the plan to allow
275 for interim rate adjustments to reflect increases in the cost of
276 general or professional liability insurance for nursing homes.
277 This provision shall be implemented to the extent existing
278 appropriations are available.
279
280 It is the intent of the Legislature that the reimbursement plan
281 achieve the goal of providing access to health care for nursing
282 home residents who require large amounts of care while

283 encouraging diversion services as an alternative to nursing home
284 care for residents who can be served within the community. The
285 agency shall base the establishment of any maximum rate of
286 payment, whether overall or component, on the available moneys
287 as provided for in the General Appropriations Act. The agency
288 may base the maximum rate of payment on the results of
289 scientifically valid analysis and conclusions derived from
290 objective statistical data pertinent to the particular maximum
291 rate of payment.
292 (14) A provider of prescribed drugs shall be reimbursed
293 the least of the amount billed by the provider, the provider's
294 usual and customary charge, or the Medicaid maximum allowable
295 fee established by the agency, plus a dispensing fee.
296 <u>(a) For pharmacies with less than $75,000 in average</u>
297 <u>aggregate monthly payments,</u> the Medicaid maximum allowable fee
298 for ingredient cost will be based on the lower of: average
299 wholesale price (AWP) minus 15.4 percent, wholesaler acquisition
300 cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the
301 state maximum allowable cost (SMAC), or the usual and customary
302 (UAC) charge billed by the provider.
303 <u>(b) For pharmacies with $75,000 or more in average</u>
304 <u>aggregate monthly payments, the Medicaid maximum allowable fee</u>
305 <u>for ingredient cost will be based on the lower of: average</u>
306 <u>wholesale price (AWP) minus 17 percent, wholesaler acquisition</u>
307 <u>cost (WAC) plus 3.75 percent, the federal upper limit (FUL), the</u>
308 <u>state maximum allowable cost (SMAC), or the usual and customary</u>
309 <u>(UAC) charge billed by the provider.</u>

310 (c) Medicaid providers are required to dispense generic
311 drugs if available at lower cost and the agency has not
312 determined that the branded product is more cost-effective,
313 unless the prescriber has requested and received approval to
314 require the branded product. The agency is directed to implement
315 a variable dispensing fee for payments for prescribed medicines
316 while ensuring continued access for Medicaid recipients. The
317 variable dispensing fee may be based upon, but not limited to,
318 either or both the volume of prescriptions dispensed by a
319 specific pharmacy provider, the volume of prescriptions
320 dispensed to an individual recipient, and dispensing of
321 preferred-drug-list products. The agency may increase the
322 pharmacy dispensing fee authorized by statute and in the annual
323 General Appropriations Act by $0.50 for the dispensing of a
324 Medicaid preferred-drug-list product and reduce the pharmacy
325 dispensing fee by $0.50 for the dispensing of a Medicaid product
326 that is not included on the preferred drug list. The agency may
327 establish a supplemental pharmaceutical dispensing fee to be
328 paid to providers returning unused unit-dose packaged
329 medications to stock and crediting the Medicaid program for the
330 ingredient cost of those medications if the ingredient costs to
331 be credited exceed the value of the supplemental dispensing fee.
332 The agency is authorized to limit reimbursement for prescribed
333 medicine in order to comply with any limitations or directions
334 provided for in the General Appropriations Act, which may
335 include implementing a prospective or concurrent utilization
336 review program.

337 Section 8. Paragraph (a) of subsection (39) of section
338 409.912, Florida Statutes, is amended, and subsections (50) and
339 (51) are added to said section, to read:
340 409.912 Cost-effective purchasing of health care.--The
341 agency shall purchase goods and services for Medicaid recipients
342 in the most cost-effective manner consistent with the delivery
343 of quality medical care. To ensure that medical services are
344 effectively utilized, the agency may, in any case, require a
345 confirmation or second physician's opinion of the correct
346 diagnosis for purposes of authorizing future services under the
347 Medicaid program. This section does not restrict access to
348 emergency services or poststabilization care services as defined
349 in 42 C.F.R. part 438.114. Such confirmation or second opinion
350 shall be rendered in a manner approved by the agency. The agency
351 shall maximize the use of prepaid per capita and prepaid
352 aggregate fixed-sum basis services when appropriate and other
353 alternative service delivery and reimbursement methodologies,
354 including competitive bidding pursuant to s. 287.057, designed
355 to facilitate the cost-effective purchase of a case-managed
356 continuum of care. The agency shall also require providers to
357 minimize the exposure of recipients to the need for acute
358 inpatient, custodial, and other institutional care and the
359 inappropriate or unnecessary use of high-cost services. The
360 agency may mandate prior authorization, drug therapy management,
361 or disease management participation for certain populations of
362 Medicaid beneficiaries, certain drug classes, or particular
363 drugs to prevent fraud, abuse, overuse, and possible dangerous

364 drug interactions. The Pharmaceutical and Therapeutics Committee
365 shall make recommendations to the agency on drugs for which
366 prior authorization is required. The agency shall inform the
367 Pharmaceutical and Therapeutics Committee of its decisions
368 regarding drugs subject to prior authorization. The agency is
369 authorized to limit the entities it contracts with or enrolls as
370 Medicaid providers by developing a provider network through
371 provider credentialing. The agency may limit its network based
372 on the assessment of beneficiary access to care, provider
373 availability, provider quality standards, time and distance
374 standards for access to care, the cultural competence of the
375 provider network, demographic characteristics of Medicaid
376 beneficiaries, practice and provider-to-beneficiary standards,
377 appointment wait times, beneficiary use of services, provider
378 turnover, provider profiling, provider licensure history,
379 previous program integrity investigations and findings, peer
380 review, provider Medicaid policy and billing compliance records,
381 clinical and medical record audits, and other factors. Providers
382 shall not be entitled to enrollment in the Medicaid provider
383 network. The agency is authorized to seek federal waivers
384 necessary to implement this policy.
385 (39)(a) The agency shall implement a Medicaid prescribed-
386 drug spending-control program that includes the following
387 components:
388 1. Medicaid prescribed-drug coverage for brand-name drugs
389 for adult Medicaid recipients is limited to the dispensing of
390 three ~~four~~ brand-name drugs and three generic drugs per month

391 per recipient. Children are exempt from this restriction.
392 ~~Antiretroviral agents are excluded from this limitation. No~~
393 ~~requirements for prior authorization or other restrictions on~~
394 ~~medications used to treat mental illnesses such as~~
395 ~~schizophrenia, severe depression, or bipolar disorder may be~~
396 ~~imposed on Medicaid recipients. Medications that will be~~
397 ~~available without restriction for persons with mental illnesses~~
398 ~~include atypical antipsychotic medications, conventional~~
399 ~~antipsychotic medications, selective serotonin reuptake~~
400 ~~inhibitors, and other medications used for the treatment of~~
401 ~~serious mental illnesses.~~ The agency shall also limit the amount
402 of a prescribed drug dispensed to no more than a 34-day supply.
403 ~~The agency shall continue to provide unlimited generic drugs,~~
404 ~~contraceptive drugs and items, and diabetic supplies.~~ Although a
405 drug may be included on the preferred drug formulary, it would
406 not be exempt from the three-brand ~~four-brand~~ limit or the
407 generic drug limit. ~~The agency may authorize exceptions to the~~
408 ~~brand-name-drug restriction based upon the treatment needs of~~
409 ~~the patients, only when such exceptions are based on prior~~
410 ~~consultation provided by the agency or an agency contractor, but~~
411 ~~the agency must establish procedures to ensure that:~~
412 ~~a. There will be a response to a request for prior~~
413 ~~consultation by telephone or other telecommunication device~~
414 ~~within 24 hours after receipt of a request for prior~~
415 ~~consultation;~~

416 ~~b. A 72-hour supply of the drug prescribed will be~~
417 ~~provided in an emergency or when the agency does not provide a~~
418 ~~response within 24 hours as required by sub-subparagraph a.; and~~
419 ~~c. Except for the exception for nursing home residents and~~
420 ~~other institutionalized adults and except for drugs on the~~
421 ~~restricted formulary for which prior authorization may be sought~~
422 ~~by an institutional or community pharmacy, prior authorization~~
423 ~~for an exception to the brand-name-drug restriction is sought by~~
424 ~~the prescriber and not by the pharmacy. When prior authorization~~
425 ~~is granted for a patient in an institutional setting beyond the~~
426 ~~brand-name-drug restriction, such approval is authorized for 12~~
427 ~~months and monthly prior authorization is not required for that~~
428 ~~patient.~~
429 2. Reimbursement to pharmacies for Medicaid prescribed
430 drugs shall be set at the lesser of:
431 a. The average wholesale price (AWP) minus 15.4 percent,
432 the wholesaler acquisition cost (WAC) plus 5.75 percent, the
433 federal upper limit (FUL), the state maximum allowable cost
434 (SMAC), or the usual and customary (UAC) charge billed by the
435 provider for pharmacies with less than $75,000 in average
436 aggregate monthly payments.
437 b. The average wholesale price (AWP) minus 17 percent,
438 wholesaler acquisition cost (WAC) plus 3.75 percent, the federal
439 upper limit (FUL), the state maximum allowable cost (SMAC), or
440 the usual and customary (UAC) charge billed by the provider for
441 pharmacies with $75,000 or more in average aggregate monthly
442 payments.

443 3. The agency shall develop and implement a process for
444 managing the drug therapies of Medicaid recipients who are using
445 significant numbers of prescribed drugs each month. The
446 management process may include, but is not limited to,
447 comprehensive, physician-directed medical-record reviews, claims
448 analyses, and case evaluations to determine the medical
449 necessity and appropriateness of a patient's treatment plan and
450 drug therapies. The agency may contract with a private
451 organization to provide drug-program-management services. The
452 Medicaid drug benefit management program shall include
453 initiatives to manage drug therapies for HIV/AIDS patients,
454 patients using 20 or more unique prescriptions in a 180-day
455 period, and the top 1,000 patients in annual spending. The
456 agency shall enroll any Medicaid recipient in the drug benefit
457 management program if he or she meets the specifications of this
458 provision and is not enrolled in a Medicaid health maintenance
459 organization.
460 4. The agency may limit the size of its pharmacy network
461 based on need, competitive bidding, price negotiations,
462 credentialing, or similar criteria. The agency shall give
463 special consideration to rural areas in determining the size and
464 location of pharmacies included in the Medicaid pharmacy
465 network. A pharmacy credentialing process may include criteria
466 such as a pharmacy's full-service status, location, size,
467 patient educational programs, patient consultation, disease-
468 management services, and other characteristics. The agency may
469 impose a moratorium on Medicaid pharmacy enrollment when it is

470 determined that it has a sufficient number of Medicaid-
471 participating providers.
472 5. The agency shall develop and implement a program that
473 requires Medicaid practitioners who prescribe drugs to use a
474 counterfeit-proof prescription pad for Medicaid prescriptions.
475 The agency shall require the use of standardized counterfeit-
476 proof prescription pads by Medicaid-participating prescribers or
477 prescribers who write prescriptions for Medicaid recipients. The
478 agency may implement the program in targeted geographic areas or
479 statewide.
480 6. The agency may enter into arrangements that require
481 manufacturers of generic drugs prescribed to Medicaid recipients
482 to provide rebates of at least 15.1 percent of the average
483 manufacturer price for the manufacturer's generic products.
484 These arrangements shall require that if a generic-drug
485 manufacturer pays federal rebates for Medicaid-reimbursed drugs
486 at a level below 15.1 percent, the manufacturer must provide a
487 supplemental rebate to the state in an amount necessary to
488 achieve a 15.1-percent rebate level.
489 7. The agency may establish a preferred drug formulary in
490 accordance with 42 U.S.C. s. 1396r-8, and, pursuant to the
491 establishment of such formulary, it is authorized to negotiate
492 supplemental rebates from manufacturers that are in addition to
493 those required by Title XIX of the Social Security Act and at no
494 less than 14 percent of the average manufacturer price as
495 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
496 the federal or supplemental rebate, or both, equals or exceeds

497 29 percent. There is no upper limit on the supplemental rebates
498 the agency may negotiate. The agency may determine that specific
499 products, brand-name or generic, are competitive at lower rebate
500 percentages. Agreement to pay the minimum supplemental rebate
501 percentage will guarantee a manufacturer that the Medicaid
502 Pharmaceutical and Therapeutics Committee will consider a
503 product for inclusion on the preferred drug formulary. However,
504 a pharmaceutical manufacturer is not guaranteed placement on the
505 formulary by simply paying the minimum supplemental rebate.
506 Agency decisions will be made on the clinical efficacy of a drug
507 and recommendations of the Medicaid Pharmaceutical and
508 Therapeutics Committee, as well as the price of competing
509 products minus federal and state rebates. The agency is
510 authorized to contract with an outside agency or contractor to
511 conduct negotiations for supplemental rebates. For the purposes
512 of this section, the term "supplemental rebates" means cash
513 rebates. Effective July 1, 2004, value-added programs as a
514 substitution for supplemental rebates are prohibited. The agency
515 is authorized to seek any federal waivers to implement this
516 initiative.

517 8. The agency shall establish an advisory committee for
518 the purposes of studying the feasibility of using a restricted
519 drug formulary for nursing home residents and other
520 institutionalized adults. The committee shall be comprised of
521 seven members appointed by the Secretary of Health Care
522 Administration. The committee members shall include two
523 physicians licensed under chapter 458 or chapter 459; three

524 pharmacists licensed under chapter 465 and appointed from a list
525 of recommendations provided by the Florida Long-Term Care
526 Pharmacy Alliance; and two pharmacists licensed under chapter
527 465.
528 9. The Agency for Health Care Administration shall expand
529 home delivery of pharmacy products. To assist Medicaid patients
530 in securing their prescriptions and reduce program costs, the
531 agency shall expand its current mail-order-pharmacy diabetes-
532 supply program to include all generic and brand-name drugs used
533 by Medicaid patients with diabetes. Medicaid recipients in the
534 current program may obtain nondiabetes drugs on a voluntary
535 basis. This initiative is limited to the geographic area covered
536 by the current contract. The agency may seek and implement any
537 federal waivers necessary to implement this subparagraph.
538 10. The agency shall limit to one dose per month any drug
539 prescribed to treat erectile dysfunction.
540 11.a. The agency shall implement a Medicaid behavioral
541 drug management system. The agency may contract with a vendor
542 that has experience in operating behavioral drug management
543 systems to implement this program. The agency is authorized to
544 seek federal waivers to implement this program.
545 b. The agency, in conjunction with the Department of
546 Children and Family Services, may implement the Medicaid
547 behavioral drug management system that is designed to improve
548 the quality of care and behavioral health prescribing practices
549 based on best practice guidelines, improve patient adherence to
550 medication plans, reduce clinical risk, and lower prescribed

551 drug costs and the rate of inappropriate spending on Medicaid
552 behavioral drugs. The program shall include the following
553 elements:
554 (I) Provide for the development and adoption of best
555 practice guidelines for behavioral health-related drugs such as
556 antipsychotics, antidepressants, and medications for treating
557 bipolar disorders and other behavioral conditions; translate
558 them into practice; review behavioral health prescribers and
559 compare their prescribing patterns to a number of indicators
560 that are based on national standards; and determine deviations
561 from best practice guidelines.
562 (II) Implement processes for providing feedback to and
563 educating prescribers using best practice educational materials
564 and peer-to-peer consultation.
565 (III) Assess Medicaid beneficiaries who are outliers in
566 their use of behavioral health drugs with regard to the numbers
567 and types of drugs taken, drug dosages, combination drug
568 therapies, and other indicators of improper use of behavioral
569 health drugs.
570 (IV) Alert prescribers to patients who fail to refill
571 prescriptions in a timely fashion, are prescribed multiple same-
572 class behavioral health drugs, and may have other potential
573 medication problems.
574 (V) Track spending trends for behavioral health drugs and
575 deviation from best practice guidelines.

576 (VI) Use educational and technological approaches to
577 promote best practices, educate consumers, and train prescribers
578 in the use of practice guidelines.
579 (VII) Disseminate electronic and published materials.
580 (VIII) Hold statewide and regional conferences.
581 (IX) Implement a disease management program with a model
582 quality-based medication component for severely mentally ill
583 individuals and emotionally disturbed children who are high
584 users of care.
585 c. If the agency is unable to negotiate a contract with
586 one or more manufacturers to finance and guarantee savings
587 associated with a behavioral drug management program by
588 September 1, 2004, the four-brand drug limit and preferred drug
589 list prior-authorization requirements shall apply to mental
590 health-related drugs, notwithstanding any provision in
591 subparagraph 1. The agency is authorized to seek federal waivers
592 to implement this policy.
593 12. The agency is authorized to contract for drug rebate
594 administration, including, but not limited to, calculating
595 rebate amounts, invoicing manufacturers, negotiating disputes
596 with manufacturers, and maintaining a database of rebate
597 collections.
598 13. The agency may specify the preferred daily dosing form
599 or strength for the purpose of promoting best practices with
600 regard to the prescribing of certain drugs as specified in the
601 General Appropriations Act and ensuring cost-effective
602 prescribing practices.

603 14. The agency may require prior authorization for the
604 off-label use of Medicaid-covered prescribed drugs as specified
605 in the General Appropriations Act. The agency may, but is not
606 required to, preauthorize the use of a product for an indication
607 not in the approved labeling. Prior authorization may require
608 the prescribing professional to provide information about the
609 rationale and supporting medical evidence for the off-label use
610 of a drug.
611 15. The agency shall implement a return and reuse program
612 for drugs dispensed by pharmacies to institutional recipients,
613 which includes payment of a $5 restocking fee for the
614 implementation and operation of the program. The return and
615 reuse program shall be implemented electronically and in a
616 manner that promotes efficiency. The program must permit a
617 pharmacy to exclude drugs from the program if it is not
618 practical or cost-effective for the drug to be included and must
619 provide for the return to inventory of drugs that cannot be
620 credited or returned in a cost-effective manner.
621 (50) The agency may implement a program of all-inclusive
622 care for children to reduce the need for hospitalization of
623 children, as appropriate. The purpose of the program is to
624 provide in-home hospice-like support services to children
625 diagnosed with a life-threatening illness who are enrolled in
626 the Children's Medical Services Network. The agency, in
627 consultation with the Department of Health, may implement the
628 program of all-inclusive care for children after obtaining
629 approval from the Centers for Medicare and Medicaid Services.

630 (51) By July 1, 2005, the agency shall develop a plan for
631 implementing the delivery of comprehensive vision care services
632 to Medicaid recipients through a capitated prepaid arrangement.
633 The plan shall include contracting with a private entity or
634 entities to provide for the comprehensive vision care services
635 through a capitated prepaid arrangement. However, the entity
636 must:
637 (a) Be licensed under chapter 627.
638 (b) Have sufficient financial resources.
639 (c) Have a contracted provider network that has statewide
640 coverage.
641 (d) Have experience in providing medical and surgical
642 vision care services.
643 (e) Have experience with the implementation of large
644 statewide contracts. As used in this section, the term "vision
645 care services" means covered vision services, including routine,
646 medical, and surgical vision care services that are available to
647 Medicaid recipients. If necessary, the agency shall seek federal
648 approval to contract with a single entity meeting these
649 requirements to provide vision care services to all Medicaid
650 recipients. The entity must offer sufficient choice of providers
651 within its network to ensure access to care for the recipient
652 and the opportunity to select a provider with whom the recipient
653 is satisfied.
654 Section 9. Paragraph (k) of subsection (2) of section
655 409.9122, Florida Statutes, is amended to read:

656 409.9122 Mandatory Medicaid managed care enrollment;
657 programs and procedures.--
658 (2)
659 (k) When a Medicaid recipient does not choose a managed
660 care plan or MediPass provider, the agency shall assign the
661 Medicaid recipient to a managed care plan, except in those
662 counties in which there are fewer than two managed care plans
663 accepting Medicaid enrollees, in which case assignment shall be
664 to a managed care plan or a MediPass provider. Medicaid
665 recipients in counties with fewer than two managed care plans
666 accepting Medicaid enrollees who are subject to mandatory
667 assignment but who fail to make a choice shall be assigned to
668 managed care plans until an enrollment of 40 percent in MediPass
669 and 60 percent in managed care plans is achieved. Once that
670 enrollment is achieved, the assignments shall be divided in
671 order to maintain an enrollment in MediPass and managed care
672 plans which is in a 40 percent and 60 percent proportion,
673 respectively. ~~In geographic areas where the agency is~~
674 ~~contracting for the provision of comprehensive behavioral health~~
675 ~~services through a capitated prepaid arrangement, recipients who~~
676 ~~fail to make a choice shall be assigned equally to MediPass or a~~
677 ~~managed care plan.~~ For purposes of this paragraph, when
678 referring to assignment, the term "managed care plans" includes
679 exclusive provider organizations, provider service networks,
680 Children's Medical Services Network, minority physician
681 networks, and pediatric emergency department diversion programs
682 authorized by this chapter or the General Appropriations Act.

683 When making assignments, the agency shall take into account the
684 following criteria:
685 1. A managed care plan has sufficient network capacity to
686 meet the need of members.
687 2. The managed care plan or MediPass has previously
688 enrolled the recipient as a member, or one of the managed care
689 plan's primary care providers or MediPass providers has
690 previously provided health care to the recipient.
691 3. The agency has knowledge that the member has previously
692 expressed a preference for a particular managed care plan or
693 MediPass provider as indicated by Medicaid fee-for-service
694 claims data, but has failed to make a choice.
695 4. The managed care plan's or MediPass primary care
696 providers are geographically accessible to the recipient's
697 residence.
698 5. The agency has authority to make mandatory assignments
699 based on quality of service and performance of managed care
700 plans.
701 Section 10. Subsections (6) and (7) are added to section
702 409.9124, Florida Statutes, to read:
703 409.9124 Managed care reimbursement.--
704 (6) The agency shall develop rates for children age 0-3
705 months and separate rates for children age 4-12 months. The
706 agency shall amend the payment methodology for participating
707 Medicaid-managed health care plans to comply with this
708 subsection.

709 (7) The agency shall not pay rates at per-member per-month
710 averages higher than that allowed for in the General
711 Appropriations Act.
712 Section 11. Except as otherwise provided herein, this act
713 shall take effect July 1, 2005.
714
715
716 ================ T I T L E A M E N D M E N T ================
717 Remove the entire title and insert:
718 A bill to be entitled
719 An act relating to health care; amending s. 400.23, F.S.;
720 delaying a nursing home staffing increase; amending s.
721 409.814, F.S.; granting more children access to the
722 Florida KidCare program; amending s. 409.903, F.S.;
723 deleting a provision eliminating eligibility for Medicaid
724 services for certain women; amending s. 409.904, F.S.;
725 providing for the Agency for Health Care Administration to
726 pay for medical assistance for certain Medicaid-eligible
727 persons; deleting a limitation on eligibility for coverage
728 under the medically needy program; amending s. 409.906,
729 F.S.; deleting a repeal of a provision that provides adult
730 denture services; repealing s. 409.9065, F.S., relating to
731 pharmaceutical expense assistance; amending s. 409.908,
732 F.S.; revising provisions relating to the long-term care
733 reimbursement and cost reporting system; revising
734 provisions relating to the Medicaid maximum allowable fee
735 for certain pharmacies; amending s. 409.912, F.S.;

736 revising components of the Medicaid prescribed-drug
737 spending-control program; authorizing the agency to
738 implement a program of all-inclusive care for certain
739 children; authorizing the agency to adopt rules; requiring
740 a plan for comprehensive vision care services; amending s.
741 409.9122, F.S.; deleting assignment requirement for
742 recipients in areas with capitated behavioral health
743 services; amending s. 409.9124, F.S.; requiring the agency
744 to develop managed care rates for children of specified
745 ages and to amend the methodology for reimbursing managed
746 care plans to comply therewith; limiting the amount of
747 reimbursement; providing effective dates.