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1 A bill to be entitled
2 An act relating to Medicaid; amending s. 409.908, F.S.;
3 revising reimbursement rates for providers of Medicaid
4 prescribed drugs; amending s. 409.912, F.S.; revising
5 reimbursement rates to pharmacies for Medicaid prescribed
6 drugs; providing an effective date.

7
8 Be It Enacted by the Legislature of the State of Florida:

9
10 Section 1. Subsection (14) of section 409.908, Florida
11 Statutes, is amended to read:

12 409.908 Reimbursement of Medicaid providers.--Subject to
13 specific appropriations, the agency shall reimburse Medicaid
14 providers, in accordance with state and federal law, according
15 to methodologies set forth in the rules of the agency and in
16 policy manuals and handbooks incorporated by reference therein.
17 These methodologies may include fee schedules, reimbursement
18 methods based on cost reporting, negotiated fees, competitive
19 bidding pursuant to s. 287.057, and other mechanisms the agency
20 considers efficient and effective for purchasing services or
21 goods on behalf of recipients. If a provider is reimbursed based
22 on cost reporting and submits a cost report late and that cost
23 report would have been used to set a lower reimbursement rate
24 for a rate semester, then the provider's rate for that semester
25 shall be retroactively calculated using the new cost report, and
26 full payment at the recalculated rate shall be effected
27 retroactively. Medicare-granted extensions for filing cost
28 reports, if applicable, shall also apply to Medicaid cost

29 | reports. Payment for Medicaid compensable services made on
 30 | behalf of Medicaid eligible persons is subject to the
 31 | availability of moneys and any limitations or directions
 32 | provided for in the General Appropriations Act or chapter 216.
 33 | Further, nothing in this section shall be construed to prevent
 34 | or limit the agency from adjusting fees, reimbursement rates,
 35 | lengths of stay, number of visits, or number of services, or
 36 | making any other adjustments necessary to comply with the
 37 | availability of moneys and any limitations or directions
 38 | provided for in the General Appropriations Act, provided the
 39 | adjustment is consistent with legislative intent.

40 | (14) A provider of prescribed drugs shall be reimbursed
 41 | the least of the amount billed by the provider, the provider's
 42 | usual and customary charge, or the Medicaid maximum allowable
 43 | fee established by the agency, plus a dispensing fee. The
 44 | Medicaid maximum allowable fee for ingredient cost will be based
 45 | on the lower of: average wholesale price (AWP) minus 18.4 ~~16.4~~
 46 | percent, wholesaler acquisition cost (WAC) plus 2.75 ~~4.75~~
 47 | percent, the federal upper limit (FUL), the state maximum
 48 | allowable cost (SMAC), or the usual and customary (UAC) charge
 49 | billed by the provider. Medicaid providers are required to
 50 | dispense generic drugs if available at lower cost and the agency
 51 | has not determined that the branded product is more cost-
 52 | effective, unless the prescriber has requested and received
 53 | approval to require the branded product. The agency is directed
 54 | to implement a variable dispensing fee for payments for
 55 | prescribed medicines while ensuring continued access for
 56 | Medicaid recipients. The variable dispensing fee may be based

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57 upon, but not limited to, either or both the volume of
58 prescriptions dispensed by a specific pharmacy provider, the
59 volume of prescriptions dispensed to an individual recipient,
60 and dispensing of preferred-drug-list products. The agency may
61 increase the pharmacy dispensing fee authorized by statute and
62 in the annual General Appropriations Act by \$0.50 for the
63 dispensing of a Medicaid preferred-drug-list product and reduce
64 the pharmacy dispensing fee by \$0.50 for the dispensing of a
65 Medicaid product that is not included on the preferred drug
66 list. The agency may establish a supplemental pharmaceutical
67 dispensing fee to be paid to providers returning unused unit-
68 dose packaged medications to stock and crediting the Medicaid
69 program for the ingredient cost of those medications if the
70 ingredient costs to be credited exceed the value of the
71 supplemental dispensing fee. The agency is authorized to limit
72 reimbursement for prescribed medicine in order to comply with
73 any limitations or directions provided for in the General
74 Appropriations Act, which may include implementing a prospective
75 or concurrent utilization review program.

76 Section 2. Subsection (39) of section 409.912, Florida
77 Statutes, is amended to read:

78 409.912 Cost-effective purchasing of health care.--The
79 agency shall purchase goods and services for Medicaid recipients
80 in the most cost-effective manner consistent with the delivery
81 of quality medical care. To ensure that medical services are
82 effectively utilized, the agency may, in any case, require a
83 confirmation or second physician's opinion of the correct
84 diagnosis for purposes of authorizing future services under the

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85 Medicaid program. This section does not restrict access to
86 emergency services or poststabilization care services as defined
87 in 42 C.F.R. part 438.114. Such confirmation or second opinion
88 shall be rendered in a manner approved by the agency. The agency
89 shall maximize the use of prepaid per capita and prepaid
90 aggregate fixed-sum basis services when appropriate and other
91 alternative service delivery and reimbursement methodologies,
92 including competitive bidding pursuant to s. 287.057, designed
93 to facilitate the cost-effective purchase of a case-managed
94 continuum of care. The agency shall also require providers to
95 minimize the exposure of recipients to the need for acute
96 inpatient, custodial, and other institutional care and the
97 inappropriate or unnecessary use of high-cost services. The
98 agency shall contract with a vendor to monitor and evaluate the
99 clinical practice patterns of providers in order to identify
100 trends that are outside the normal practice patterns of a
101 provider's professional peers or the national guidelines of a
102 provider's professional association. The vendor must be able to
103 provide information and counseling to a provider whose practice
104 patterns are outside the norms, in consultation with the agency,
105 to improve patient care and reduce inappropriate utilization.
106 The agency may mandate prior authorization, drug therapy
107 management, or disease management participation for certain
108 populations of Medicaid beneficiaries, certain drug classes, or
109 particular drugs to prevent fraud, abuse, overuse, and possible
110 dangerous drug interactions. The Pharmaceutical and Therapeutics
111 Committee shall make recommendations to the agency on drugs for
112 which prior authorization is required. The agency shall inform

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113 the Pharmaceutical and Therapeutics Committee of its decisions
114 regarding drugs subject to prior authorization. The agency is
115 authorized to limit the entities it contracts with or enrolls as
116 Medicaid providers by developing a provider network through
117 provider credentialing. The agency may competitively bid single-
118 source-provider contracts if procurement of goods or services
119 results in demonstrated cost savings to the state without
120 limiting access to care. The agency may limit its network based
121 on the assessment of beneficiary access to care, provider
122 availability, provider quality standards, time and distance
123 standards for access to care, the cultural competence of the
124 provider network, demographic characteristics of Medicaid
125 beneficiaries, practice and provider-to-beneficiary standards,
126 appointment wait times, beneficiary use of services, provider
127 turnover, provider profiling, provider licensure history,
128 previous program integrity investigations and findings, peer
129 review, provider Medicaid policy and billing compliance records,
130 clinical and medical record audits, and other factors. Providers
131 shall not be entitled to enrollment in the Medicaid provider
132 network. The agency shall determine instances in which allowing
133 Medicaid beneficiaries to purchase durable medical equipment and
134 other goods is less expensive to the Medicaid program than long-
135 term rental of the equipment or goods. The agency may establish
136 rules to facilitate purchases in lieu of long-term rentals in
137 order to protect against fraud and abuse in the Medicaid program
138 as defined in s. 409.913. The agency may seek federal waivers
139 necessary to administer these policies.

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140 (39) (a) The agency shall implement a Medicaid prescribed-
141 drug spending-control program that includes the following
142 components:

143 1. A Medicaid preferred drug list, which shall be a
144 listing of cost-effective therapeutic options recommended by the
145 Medicaid Pharmacy and Therapeutics Committee established
146 pursuant to s. 409.91195 and adopted by the agency for each
147 therapeutic class on the preferred drug list. At the discretion
148 of the committee, and when feasible, the preferred drug list
149 should include at least two products in a therapeutic class. The
150 agency may post the preferred drug list and updates to the
151 preferred drug list on an Internet website without following the
152 rulemaking procedures of chapter 120. Antiretroviral agents are
153 excluded from the preferred drug list. The agency shall also
154 limit the amount of a prescribed drug dispensed to no more than
155 a 34-day supply unless the drug products' smallest marketed
156 package is greater than a 34-day supply, or the drug is
157 determined by the agency to be a maintenance drug in which case
158 a 100-day maximum supply may be authorized. The agency is
159 authorized to seek any federal waivers necessary to implement
160 these cost-control programs and to continue participation in the
161 federal Medicaid rebate program, or alternatively to negotiate
162 state-only manufacturer rebates. The agency may adopt rules to
163 implement this subparagraph. The agency shall continue to
164 provide unlimited contraceptive drugs and items. The agency must
165 establish procedures to ensure that:

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

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

172 2. Reimbursement to pharmacies for Medicaid prescribed
173 drugs shall be set at the lesser of: the average wholesale price
174 (AWP) minus 18.4 ~~16.4~~ percent, the wholesaler acquisition cost
175 (WAC) plus 2.75 ~~4.75~~ percent, the federal upper limit (FUL), the
176 state maximum allowable cost (SMAC), or the usual and customary
177 (UAC) charge billed by the provider.

178 3. The agency shall develop and implement a process for
179 managing the drug therapies of Medicaid recipients who are using
180 significant numbers of prescribed drugs each month. The
181 management process may include, but is not limited to,
182 comprehensive, physician-directed medical-record reviews, claims
183 analyses, and case evaluations to determine the medical
184 necessity and appropriateness of a patient's treatment plan and
185 drug therapies. The agency may contract with a private
186 organization to provide drug-program-management services. The
187 Medicaid drug benefit management program shall include
188 initiatives to manage drug therapies for HIV/AIDS patients,
189 patients using 20 or more unique prescriptions in a 180-day
190 period, and the top 1,000 patients in annual spending. The
191 agency shall enroll any Medicaid recipient in the drug benefit
192 management program if he or she meets the specifications of this

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193 provision and is not enrolled in a Medicaid health maintenance
194 organization.

195 4. The agency may limit the size of its pharmacy network
196 based on need, competitive bidding, price negotiations,
197 credentialing, or similar criteria. The agency shall give
198 special consideration to rural areas in determining the size and
199 location of pharmacies included in the Medicaid pharmacy
200 network. A pharmacy credentialing process may include criteria
201 such as a pharmacy's full-service status, location, size,
202 patient educational programs, patient consultation, disease
203 management services, and other characteristics. The agency may
204 impose a moratorium on Medicaid pharmacy enrollment when it is
205 determined that it has a sufficient number of Medicaid-
206 participating providers. The agency must allow dispensing
207 practitioners to participate as a part of the Medicaid pharmacy
208 network regardless of the practitioner's proximity to any other
209 entity that is dispensing prescription drugs under the Medicaid
210 program. A dispensing practitioner must meet all credentialing
211 requirements applicable to his or her practice, as determined by
212 the agency.

213 5. The agency shall develop and implement a program that
214 requires Medicaid practitioners who prescribe drugs to use a
215 counterfeit-proof prescription pad for Medicaid prescriptions.
216 The agency shall require the use of standardized counterfeit-
217 proof prescription pads by Medicaid-participating prescribers or
218 prescribers who write prescriptions for Medicaid recipients. The
219 agency may implement the program in targeted geographic areas or
220 statewide.

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221 6. The agency may enter into arrangements that require
222 manufacturers of generic drugs prescribed to Medicaid recipients
223 to provide rebates of at least 15.1 percent of the average
224 manufacturer price for the manufacturer's generic products.
225 These arrangements shall require that if a generic-drug
226 manufacturer pays federal rebates for Medicaid-reimbursed drugs
227 at a level below 15.1 percent, the manufacturer must provide a
228 supplemental rebate to the state in an amount necessary to
229 achieve a 15.1-percent rebate level.

230 7. The agency may establish a preferred drug list as
231 described in this subsection, and, pursuant to the establishment
232 of such preferred drug list, it is authorized to negotiate
233 supplemental rebates from manufacturers that are in addition to
234 those required by Title XIX of the Social Security Act and at no
235 less than 14 percent of the average manufacturer price as
236 defined in 42 U.S.C. s. 1936 on the last day of a quarter unless
237 the federal or supplemental rebate, or both, equals or exceeds
238 29 percent. There is no upper limit on the supplemental rebates
239 the agency may negotiate. The agency may determine that specific
240 products, brand-name or generic, are competitive at lower rebate
241 percentages. Agreement to pay the minimum supplemental rebate
242 percentage will guarantee a manufacturer that the Medicaid
243 Pharmaceutical and Therapeutics Committee will consider a
244 product for inclusion on the preferred drug list. However, a
245 pharmaceutical manufacturer is not guaranteed placement on the
246 preferred drug list by simply paying the minimum supplemental
247 rebate. Agency decisions will be made on the clinical efficacy
248 of a drug and recommendations of the Medicaid Pharmaceutical and

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249 Therapeutics Committee, as well as the price of competing
250 products minus federal and state rebates. The agency is
251 authorized to contract with an outside agency or contractor to
252 conduct negotiations for supplemental rebates. For the purposes
253 of this section, the term "supplemental rebates" means cash
254 rebates. Effective July 1, 2004, value-added programs as a
255 substitution for supplemental rebates are prohibited. The agency
256 is authorized to seek any federal waivers to implement this
257 initiative.

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

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

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

275 b. The agency, in conjunction with the Department of
276 Children and Family Services, may implement the Medicaid

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277 behavioral drug management system that is designed to improve
278 the quality of care and behavioral health prescribing practices
279 based on best practice guidelines, improve patient adherence to
280 medication plans, reduce clinical risk, and lower prescribed
281 drug costs and the rate of inappropriate spending on Medicaid
282 behavioral drugs. The program may include the following
283 elements:

284 (I) Provide for the development and adoption of best
285 practice guidelines for behavioral health-related drugs such as
286 antipsychotics, antidepressants, and medications for treating
287 bipolar disorders and other behavioral conditions; translate
288 them into practice; review behavioral health prescribers and
289 compare their prescribing patterns to a number of indicators
290 that are based on national standards; and determine deviations
291 from best practice guidelines.

292 (II) Implement processes for providing feedback to and
293 educating prescribers using best practice educational materials
294 and peer-to-peer consultation.

295 (III) Assess Medicaid beneficiaries who are outliers in
296 their use of behavioral health drugs with regard to the numbers
297 and types of drugs taken, drug dosages, combination drug
298 therapies, and other indicators of improper use of behavioral
299 health drugs.

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

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

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

309 (VII) Disseminate electronic and published materials.

310 (VIII) Hold statewide and regional conferences.

311 (IX) Implement a disease management program with a model
312 quality-based medication component for severely mentally ill
313 individuals and emotionally disturbed children who are high
314 users of care.

315 11.a. The agency shall implement a Medicaid prescription
316 drug management system. The agency may contract with a vendor
317 that has experience in operating prescription drug management
318 systems in order to implement this system. Any management system
319 that is implemented in accordance with this subparagraph must
320 rely on cooperation between physicians and pharmacists to
321 determine appropriate practice patterns and clinical guidelines
322 to improve the prescribing, dispensing, and use of drugs in the
323 Medicaid program. The agency may seek federal waivers to
324 implement this program.

325 b. The drug management system must be designed to improve
326 the quality of care and prescribing practices based on best
327 practice guidelines, improve patient adherence to medication
328 plans, reduce clinical risk, and lower prescribed drug costs and
329 the rate of inappropriate spending on Medicaid prescription
330 drugs. The program must:

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331 (I) Provide for the development and adoption of best
332 practice guidelines for the prescribing and use of drugs in the
333 Medicaid program, including translating best practice guidelines
334 into practice; reviewing prescriber patterns and comparing them
335 to indicators that are based on national standards and practice
336 patterns of clinical peers in their community, statewide, and
337 nationally; and determine deviations from best practice
338 guidelines.

339 (II) Implement processes for providing feedback to and
340 educating prescribers using best practice educational materials
341 and peer-to-peer consultation.

342 (III) Assess Medicaid recipients who are outliers in their
343 use of a single or multiple prescription drugs with regard to
344 the numbers and types of drugs taken, drug dosages, combination
345 drug therapies, and other indicators of improper use of
346 prescription drugs.

347 (IV) Alert prescribers to patients who fail to refill
348 prescriptions in a timely fashion, are prescribed multiple drugs
349 that may be redundant or contraindicated, or may have other
350 potential medication problems.

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

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

356 (VII) Disseminate electronic and published materials.

357 (VIII) Hold statewide and regional conferences.

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358 (IX) Implement disease management programs in cooperation
 359 with physicians and pharmacists, along with a model quality-
 360 based medication component for individuals having chronic
 361 medical conditions.

362 12. The agency is authorized to contract for drug rebate
 363 administration, including, but not limited to, calculating
 364 rebate amounts, invoicing manufacturers, negotiating disputes
 365 with manufacturers, and maintaining a database of rebate
 366 collections.

367 13. The agency may specify the preferred daily dosing form
 368 or strength for the purpose of promoting best practices with
 369 regard to the prescribing of certain drugs as specified in the
 370 General Appropriations Act and ensuring cost-effective
 371 prescribing practices.

372 14. The agency may require prior authorization for
 373 Medicaid-covered prescribed drugs. The agency may, but is not
 374 required to, prior-authorize the use of a product:

- 375 a. For an indication not approved in labeling;
- 376 b. To comply with certain clinical guidelines; or
- 377 c. If the product has the potential for overuse, misuse,
 378 or abuse.

379
 380 The agency may require the prescribing professional to provide
 381 information about the rationale and supporting medical evidence
 382 for the use of a drug. The agency may post prior authorization
 383 criteria and protocol and updates to the list of drugs that are
 384 subject to prior authorization on an Internet website without
 385 amending its rule or engaging in additional rulemaking.

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386 15. The agency, in conjunction with the Pharmaceutical and
387 Therapeutics Committee, may require age-related prior
388 authorizations for certain prescribed drugs. The agency may
389 preauthorize the use of a drug for a recipient who may not meet
390 the age requirement or may exceed the length of therapy for use
391 of this product as recommended by the manufacturer and approved
392 by the Food and Drug Administration. Prior authorization may
393 require the prescribing professional to provide information
394 about the rationale and supporting medical evidence for the use
395 of a drug.

396 16. The agency shall implement a step-therapy prior
397 authorization approval process for medications excluded from the
398 preferred drug list. Medications listed on the preferred drug
399 list must be used within the previous 12 months prior to the
400 alternative medications that are not listed. The step-therapy
401 prior authorization may require the prescriber to use the
402 medications of a similar drug class or for a similar medical
403 indication unless contraindicated in the Food and Drug
404 Administration labeling. The trial period between the specified
405 steps may vary according to the medical indication. The step-
406 therapy approval process shall be developed in accordance with
407 the committee as stated in s. 409.91195(7) and (8). A drug
408 product may be approved without meeting the step-therapy prior
409 authorization criteria if the prescribing physician provides the
410 agency with additional written medical or clinical documentation
411 that the product is medically necessary because:

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412 a. There is not a drug on the preferred drug list to treat
413 the disease or medical condition which is an acceptable clinical
414 alternative;

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

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

420

421 The agency shall work with the physician to determine the best
422 alternative for the patient. The agency may adopt rules waiving
423 the requirements for written clinical documentation for specific
424 drugs in limited clinical situations.

425 17. The agency shall implement a return and reuse program
426 for drugs dispensed by pharmacies to institutional recipients,
427 which includes payment of a \$5 restocking fee for the
428 implementation and operation of the program. The return and
429 reuse program shall be implemented electronically and in a
430 manner that promotes efficiency. The program must permit a
431 pharmacy to exclude drugs from the program if it is not
432 practical or cost-effective for the drug to be included and must
433 provide for the return to inventory of drugs that cannot be
434 credited or returned in a cost-effective manner. The agency
435 shall determine if the program has reduced the amount of
436 Medicaid prescription drugs which are destroyed on an annual
437 basis and if there are additional ways to ensure more
438 prescription drugs are not destroyed which could safely be

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439 reused. The agency's conclusion and recommendations shall be
440 reported to the Legislature by December 1, 2005.

441 (b) The agency shall implement this subsection to the
442 extent that funds are appropriated to administer the Medicaid
443 prescribed-drug spending-control program. The agency may
444 contract all or any part of this program to private
445 organizations.

446 (c) The agency shall submit quarterly reports to the
447 Governor, the President of the Senate, and the Speaker of the
448 House of Representatives which must include, but need not be
449 limited to, the progress made in implementing this subsection
450 and its effect on Medicaid prescribed-drug expenditures.

451 Section 3. This act shall take effect March 1, 2009.