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LEGISLATIVE ACTION

Senate	.	House
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Floor: 1/R/2R	.	
05/02/2014 10:38 PM	.	
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Senator Grimsley moved the following:

1 **Senate Amendment (with title amendment)**
2
3 Delete everything after the enacting clause
4 and insert:
5 Section 1. Paragraph (e) of subsection (2) of section
6 395.602, Florida Statutes, is amended to read:
7 395.602 Rural hospitals.—
8 (2) DEFINITIONS.—As used in this part:
9 (e) “Rural hospital” means an acute care hospital licensed
10 under this chapter, having 100 or fewer licensed beds and an
11 emergency room, which is:

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12 1. The sole provider within a county with a population
13 density of up to ~~no greater than~~ 100 persons per square mile;
14 2. An acute care hospital, in a county with a population
15 density of up to ~~no greater than~~ 100 persons per square mile,
16 which is at least 30 minutes of travel time, on normally
17 traveled roads under normal traffic conditions, from any other
18 acute care hospital within the same county;
19 3. A hospital supported by a tax district or subdistrict
20 whose boundaries encompass a population of up to 100 persons ~~or~~
21 ~~fewer~~ per square mile;
22 4. A hospital classified as a sole community hospital under
23 42 C.F.R. s. 412.92 which has up to 340 licensed beds ~~A hospital~~
24 ~~in a constitutional charter county with a population of over 1~~
25 ~~million persons that has imposed a local option health service~~
26 ~~tax pursuant to law and in an area that was directly impacted by~~
27 ~~a catastrophic event on August 24, 1992, for which the Governor~~
28 ~~of Florida declared a state of emergency pursuant to chapter~~
29 ~~125, and has 120 beds or less that serves an agricultural~~
30 ~~community with an emergency room utilization of no less than~~
31 ~~20,000 visits and a Medicaid inpatient utilization rate greater~~
32 ~~than 15 percent~~;
33 5. A hospital with a service area that has a population of
34 up to 100 persons ~~or fewer~~ per square mile. As used in this
35 subparagraph, the term “service area” means the fewest number of
36 zip codes that account for 75 percent of the hospital’s
37 discharges for the most recent 5-year period, based on
38 information available from the hospital inpatient discharge
39 database in the Florida Center for Health Information and Policy
40 Analysis at the agency; or

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41 6. A hospital designated as a critical access hospital, as
42 defined in s. 408.07.
43
44 Population densities used in this paragraph must be based upon
45 the most recently completed United States census. A hospital
46 that received funds under s. 409.9116 for a quarter beginning no
47 later than July 1, 2002, is deemed to have been and shall
48 continue to be a rural hospital from that date through June 30,
49 2015, if the hospital continues to have up to 100 ~~or fewer~~
50 licensed beds and an emergency room~~, or meets the criteria of~~
51 ~~subparagraph 4~~. An acute care hospital that has not previously
52 been designated as a rural hospital and that meets the criteria
53 of this paragraph shall be granted such designation upon
54 application, including supporting documentation, to the agency.
55 A hospital that was licensed as a rural hospital during the
56 2010-2011 or 2011-2012 fiscal year shall continue to be a rural
57 hospital from the date of designation through June 30, 2015, if
58 the hospital continues to have up to 100 ~~or fewer~~ licensed beds
59 and an emergency room.
60 Section 2. Paragraph (a) of subsection (2) of section
61 409.911, Florida Statutes, is amended to read:
62 409.911 Disproportionate share program.—Subject to specific
63 allocations established within the General Appropriations Act
64 and any limitations established pursuant to chapter 216, the
65 agency shall distribute, pursuant to this section, moneys to
66 hospitals providing a disproportionate share of Medicaid or
67 charity care services by making quarterly Medicaid payments as
68 required. Notwithstanding the provisions of s. 409.915, counties
69 are exempt from contributing toward the cost of this special

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70 reimbursement for hospitals serving a disproportionate share of
71 low-income patients.
72 (2) The Agency for Health Care Administration shall use the
73 following actual audited data to determine the Medicaid days and
74 charity care to be used in calculating the disproportionate
75 share payment:
76 (a) The average of the 2006, 2007, and 2008 ~~2005, 2006, and~~
77 ~~2007~~ audited disproportionate share data to determine each
78 hospital's Medicaid days and charity care for the 2014-2015
79 ~~2013-2014~~ state fiscal year.
80 Section 3. Subsection (13) of section 409.962, Florida
81 Statutes, is amended to read:
82 409.962 Definitions.—As used in this part, except as
83 otherwise specifically provided, the term:
84 (13) "Provider service network" means an entity qualified
85 pursuant to s. 409.912(4)(d) of which a controlling interest is
86 owned by a health care provider~~,~~ or group of ~~affiliated~~
87 providers affiliated for the purpose of providing health care,
88 or a public agency or entity that delivers health services.
89 Health care providers include Florida-licensed health care
90 practitioners ~~professionals~~ or licensed health care facilities,
91 federally qualified health care centers, and home health care
92 agencies.
93 Section 4. Effective upon this act becoming a law, section
94 409.972, Florida Statutes, is amended to read:
95 409.972 Mandatory and voluntary enrollment.—
96 ~~(1) Persons eligible for the program known as "medically~~
97 ~~needy" pursuant to s. 409.904(2) shall enroll in managed care~~
98 ~~plans. Medically needy recipients shall meet the share of the~~

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99 ~~cost by paying the plan premium, up to the share of the cost~~
100 ~~amount, contingent upon federal approval.~~
101 (1) ~~(2)~~ The following Medicaid-eligible persons are exempt
102 from mandatory managed care enrollment required by s. 409.965,
103 and may voluntarily choose to participate in the managed medical
104 assistance program:
105 (a) Medicaid recipients who have other creditable health
106 care coverage, excluding Medicare.
107 (b) Medicaid recipients residing in residential commitment
108 facilities operated through the Department of Juvenile Justice
109 or mental health treatment facilities as defined by s.
110 394.455(32).
111 (c) Persons eligible for refugee assistance.
112 (d) Medicaid recipients who are residents of a
113 developmental disability center, including Sunland Center in
114 Marianna and Tacachale in Gainesville.
115 (e) Medicaid recipients enrolled in the home and community
116 based services waiver pursuant to chapter 393, and Medicaid
117 recipients waiting for waiver services.
118 (f) Medicaid recipients residing in a group home facility
119 licensed under chapter 393.
120 (2) ~~(3)~~ Persons eligible for Medicaid but exempt from
121 mandatory participation who do not choose to enroll in managed
122 care shall be served in the Medicaid fee-for-service program as
123 provided under ~~in~~ part III of this chapter.
124 (3) ~~(4)~~ The agency shall seek federal approval to require
125 Medicaid recipients enrolled in managed care plans, as a
126 condition of Medicaid eligibility, to pay the Medicaid program a
127 share of the premium of $10 per month.

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128 Section 5. Subsection (1) of section 409.974, Florida
129 Statutes, is amended to read:
130 409.974 Eligible plans.—
131 (1) ELIGIBLE PLAN SELECTION.—The agency shall select and
132 contract with eligible plans through the procurement process
133 described in s. 409.966. The agency shall notice invitations to
134 negotiate by ~~no later than~~ January 1, 2013.
135 (a) The agency shall procure and contract with two plans
136 for Region 1. At least one plan shall be a provider service
137 network if any provider service networks submit a responsive
138 bid.
139 (b) The agency shall procure and contract with two plans
140 for Region 2. At least one plan shall be a provider service
141 network if any provider service networks submit a responsive
142 bid.
143 (c) The agency shall procure and contract with at least
144 three plans and up to five plans for Region 3. At least one plan
145 must be a provider service network if any provider service
146 networks submit a responsive bid.
147 (d) The agency shall procure and contract with at least
148 three plans and up to five plans for Region 4. At least one plan
149 must be a provider service network if any provider service
150 networks submit a responsive bid.
151 (e) The agency shall procure and contract with at least two
152 plans and up to four plans for Region 5. At least one plan must
153 be a provider service network if any provider service networks
154 submit a responsive bid.
155 (f) The agency shall procure and contract with at least
156 four plans and up to seven plans for Region 6. At least one plan

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157 must be a provider service network if any provider service
158 networks submit a responsive bid.
159 (g) The agency shall procure and contract with at least
160 three plans and up to six plans for Region 7. At least one plan
161 must be a provider service network if any provider service
162 networks submit a responsive bid.
163 (h) The agency shall procure and contract with at least two
164 plans and up to four plans for Region 8. At least one plan must
165 be a provider service network if any provider service networks
166 submit a responsive bid.
167 (i) The agency shall procure and contract with at least two
168 plans and up to four plans for Region 9. At least one plan must
169 be a provider service network if any provider service networks
170 submit a responsive bid.
171 (j) The agency shall procure and contract with at least two
172 plans and up to four plans for Region 10. At least one plan must
173 be a provider service network if any provider service networks
174 submit a responsive bid.
175 (k) The agency shall procure and contract with at least
176 five plans and up to 10 plans for Region 11. At least one plan
177 must be a provider service network if any provider service
178 networks submit a responsive bid.
179
180 If no provider service network submits a responsive bid, the
181 agency shall procure up to ~~no more than~~ one less than the
182 maximum number of eligible plans permitted in that region and,~~.~~
183 within the next 12 months after the initial invitation to
184 negotiate, shall issue an invitation to negotiate in order ~~the~~
185 ~~agency shall attempt~~ to procure and contract with a provider

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186 service network. In a region in which the agency has contracted
187 with only one provider service network and changes in the
188 ownership or business structure of the network result in the
189 network no longer meeting the definition of a provider service
190 network under s. 409.962, the agency must, within the next 12
191 months, terminate the contract, provide ~~shall~~ notice of another
192 invitation to negotiate, and procure and contract ~~only~~ with a
193 provider service network in that region ~~networks in those~~
194 ~~regions where no provider service network has been selected~~.
195 Section 6. Effective upon this act becoming a law,
196 subsection (4) of section 409.974, Florida Statutes, is amended
197 to read:
198 409.974 Eligible plans.—
199 (4) CHILDREN’S MEDICAL SERVICES NETWORK.— Participation by
200 the Children’s Medical Services Network shall be pursuant to a
201 single, statewide contract with the agency that is not subject
202 to the procurement requirements or regional plan number limits
203 of this section. Following the successful completion of a
204 readiness review, the Children’s Medical Services Network shall
205 operate as a fee-for-service provider service network with
206 periodic reconciliations until July 1 of the fiscal year
207 following the date on which the network qualifies to operate as
208 a prepaid plan. While operating as a fee-for-service provider
209 service network, the Children’s Medical Services Network shall
210 use the agency’s third-party administrator for paying claims and
211 related duties. The Children’s Medical Services Network must
212 meet all other plan requirements for the managed medical
213 assistance program.
214 Section 7. Effective upon this act becoming a law,

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215 subsection (7) of section 409.975, Florida Statutes, is amended
216 to read:
217 409.975 Managed care plan accountability.—In addition to
218 the requirements of s. 409.967, plans and providers
219 participating in the managed medical assistance program shall
220 comply with the requirements of this section.
221 ~~(7) MEDICALLY NEEDY ENROLLEES.—Each managed care plan must~~
222 ~~accept any medically needy recipient who selects or is assigned~~
223 ~~to the plan and provide that recipient with continuous~~
224 ~~enrollment for 12 months. After the first month of qualifying as~~
225 ~~a medically needy recipient and enrolling in a plan, and~~
226 ~~contingent upon federal approval, the enrollee shall pay the~~
227 ~~plan a portion of the monthly premium equal to the enrollee's~~
228 ~~share of the cost as determined by the department. The agency~~
229 ~~shall pay any remaining portion of the monthly premium. Plans~~
230 ~~are not obligated to pay claims for medically needy patients for~~
231 ~~services provided before enrollment in the plan. Medically needy~~
232 ~~patients are responsible for payment of incurred claims that are~~
233 ~~used to determine eligibility. Plans must provide a grace period~~
234 ~~of at least 90 days before disenrolling recipients who fail to~~
235 ~~pay their shares of the premium.~~
236 Section 8. Except as otherwise expressly provided in this
237 act and except for this section, which shall take effect upon
238 this act becoming a law, this act shall take effect July 1,
239 2014.
240
241 ================= T I T L E A M E N D M E N T ================
242 And the title is amended as follows:
243 Delete everything before the enacting clause

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244 and insert:
245 A bill to be entitled
246 An act relating to Medicaid; amending s. 395.602,
247 F.S.; revising the definition of “rural hospital”;
248 amending s. 409.911, F.S.; updating references to data
249 to be used for calculations under the disproportionate
250 share program; amending s. 409.962, F.S.; revising the
251 term “provider service network”; amending s. 409.972,
252 F.S.; deleting a requirement relating to medically
253 needy recipients; amending s. 409.974, F.S.; expressly
254 providing for contracting with eligible managed care
255 plans; revising provisions relating to procuring a
256 provider service network in a region; providing
257 requirements for termination of a contract with
258 certain managed care plans; requiring the Children’s
259 Medical Services Network to operate as a fee-for-
260 service provider service network under certain
261 conditions; amending s. 409.975, F.S.; deleting a
262 requirement that a managed care plan accept certain
263 medically needy recipients; providing effective dates.