FOR CONSIDERATION By the Committee on Appropriations

576-02671B-14 20147100__

A bill to be entitled

An act relating to Medicaid; amending s. 395.602, F.S.; revising the definition of rural hospital; amending s. 409.911, F.S.; updating references to data to be used for calculations under the disproportionate share program; amending s. 409.962, F.S.; revising the term "provider service network"; amending s. 409.972, F.S.; deleting a requirement relating to medically needy recipients; amending s. 409.974, F.S.; expressly providing for contracting with eligible managed care plans; revising provisions relating to procuring a provider service network in a region; providing requirements for termination of a contract with certain managed care plans; requiring the Children's Medical Services Network to operate as a fee-for-service provider service network under certain conditions; amending s. 409.975, F.S.; deleting a requirement that a managed care plan accept certain medically needy recipients; providing effective dates.

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

Section 1. Paragraph (e) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

(2) DEFINITIONS.—As used in this part:

(e) "Rural hospital" means an acute care hospital licensed under this chapter, having 100 or fewer licensed beds and an emergency room, which is:

1. The sole provider within a county with a population density of up to ~~no greater than~~ 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to ~~no greater than~~ 100 persons per square mile, which is at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from any other acute care hospital within the same county;

3. A hospital supported by a tax district or subdistrict whose boundaries encompass a population of up to 100 persons ~~or fewer~~ per square mile;

4. A hospital classified as a sole community hospital under 42 C.F.R. s. 412.92 which has up to 340 licensed beds ~~A hospital in a constitutional charter county with a population of over 1 million persons that has imposed a local option health service tax pursuant to law and in an area that was directly impacted by a catastrophic event on August 24, 1992, for which the Governor of Florida declared a state of emergency pursuant to chapter 125, and has 120 beds or less that serves an agricultural community with an emergency room utilization of no less than 20,000 visits and a Medicaid inpatient utilization rate greater than 15 percent~~;

5. A hospital with a service area that has a population of up to 100 persons ~~or fewer~~ per square mile. As used in this subparagraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the agency; or

6. A hospital designated as a critical access hospital, as defined in s. 408.07.

Population densities used in this paragraph must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have up to 100 ~~or fewer~~ licensed beds and an emergency room~~, or meets the criteria of subparagraph 4~~. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this paragraph shall be granted such designation upon application, including supporting documentation, to the agency. A hospital that was licensed as a rural hospital during the 2010-2011 or 2011-2012 fiscal year shall continue to be a rural hospital from the date of designation through June 30, 2015, if the hospital continues to have up to 100 ~~or fewer~~ licensed beds and an emergency room.

Section 2. Paragraph (a) of subsection (2) of section 409.911, Florida Statutes, is amended to read:

409.911 Disproportionate share program.—Subject to specific allocations established within the General Appropriations Act and any limitations established pursuant to chapter 216, the agency shall distribute, pursuant to this section, moneys to hospitals providing a disproportionate share of Medicaid or charity care services by making quarterly Medicaid payments as required. Notwithstanding the provisions of s. 409.915, counties are exempt from contributing toward the cost of this special

reimbursement for hospitals serving a disproportionate share of low-income patients.

(2) The Agency for Health Care Administration shall use the following actual audited data to determine the Medicaid days and charity care to be used in calculating the disproportionate share payment:

(a) The average of the 2006, 2007, and 2008 ~~2005, 2006, and 2007~~ audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2014-2015 ~~2013-2014~~ state fiscal year.

Section 3. Subsection (13) of section 409.962, Florida Statutes, is amended to read:

409.962 Definitions.—As used in this part, except as otherwise specifically provided, the term:

(13) "Provider service network" means an entity qualified pursuant to s. 409.912(4)(d) of which a controlling interest is owned by a health care provider~~,~~ or group of ~~affiliated~~ providers affiliated for the purpose of providing health care, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care practitioners ~~professionals~~ or licensed health care facilities, federally qualified health care centers, and home health care agencies.

Section 4. Effective upon becoming law, Section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

~~(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2) shall enroll in managed care plans. Medically needy recipients shall meet the share of the~~

~~cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.~~

(1)~~(2)~~ The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).

(c) Persons eligible for refugee assistance.

(d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in Marianna and Tacachale in Gainesville.

(e) Medicaid recipients enrolled in the home and community based services waiver pursuant to chapter 393, and Medicaid recipients waiting for waiver services.

(f) Medicaid recipients residing in a group home facility licensed under chapter 393.

(2)~~(3)~~ Persons eligible for Medicaid but exempt from mandatory participation who do not choose to enroll in managed care shall be served in the Medicaid fee-for-service program as provided under ~~in~~ part III of this chapter.

(3)~~(4)~~ The agency shall seek federal approval to require Medicaid recipients enrolled in managed care plans, as a condition of Medicaid eligibility, to pay the Medicaid program a share of the premium of $10 per month.

Section 5. Subsection (1) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select and contract with eligible plans through the procurement process described in s. 409.966. The agency shall notice invitations to negotiate by ~~no later than~~ January 1, 2013.

(a) The agency shall procure and contract with two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure and contract with two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure and contract with at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(d) The agency shall procure and contract with at least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(e) The agency shall procure and contract with at least two plans and up to four plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) The agency shall procure and contract with at least four plans and up to seven plans for Region 6. At least one plan

must be a provider service network if any provider service networks submit a responsive bid.

(g) The agency shall procure and contract with at least three plans and up to six plans for Region 7. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(h) The agency shall procure and contract with at least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(i) The agency shall procure and contract with at least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(j) The agency shall procure and contract with at least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(k) The agency shall procure and contract with at least five plans and up to 10 plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

If no provider service network submits a responsive bid, the agency shall procure up to ~~no more than~~ one less than the maximum number of eligible plans permitted in that region and,~~.~~ within the next 12 months after the initial invitation to negotiate, shall issue an invitation to negotiate in order ~~the agency shall attempt~~ to procure and contract with a provider

service network. In a region in which the agency has contracted with only one provider service network and changes in the ownership or business structure of the network result in the network no longer meeting the definition of a provider service network under s. 409.962, the agency must, within the next 12 months, terminate the contract, provide ~~shall~~ notice of another invitation to negotiate, and procure and contract ~~only~~ with a provider service network in that region ~~networks in those regions where no provider service network has been selected~~.

Section 6. Effective upon becoming law, subsection (4) of section 409.974, Florida Statutes, is amended to read:

409.974 Eligible plans.—

(4) CHILDREN'S MEDICAL SERVICES NETWORK.— Participation by the Children's Medical Services Network shall be pursuant to a single, statewide contract with the agency that is not subject to the procurement requirements or regional plan number limits of this section. Following the successful completion of a readiness review, the Children's Medical Services Network shall operate as a fee-for-service provider service network with periodic reconciliations until July 1 of the fiscal year following the date on which the network qualifies to operate as a prepaid plan. While operating as a fee-for-service provider service network, the Children's Medical Services Network shall use the agency's third-party administrator for paying claims and related duties. The Children's Medical Services Network must meet all other plan requirements for the managed medical assistance program.

Section 7. Effective upon becoming law, subsection (7) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

~~(7) MEDICALLY NEEDY ENROLLEES.—Each managed care plan must accept any medically needy recipient who selects or is assigned to the plan and provide that recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the enrollee shall pay the plan a portion of the monthly premium equal to the enrollee's share of the cost as determined by the department. The agency shall pay any remaining portion of the monthly premium. Plans are not obligated to pay claims for medically needy patients for services provided before enrollment in the plan. Medically needy patients are responsible for payment of incurred claims that are used to determine eligibility. Plans must provide a grace period of at least 90 days before disenrolling recipients who fail to pay their shares of the premium.~~

Section 8. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming law, this act shall take effect July 1, 2014.