A bill to be entitled

An act relating to Medicaid; amending s. 395.602, F.S.; revising the definition of the term "rural hospital"; extending the designation of certain critical access hospitals as rural hospitals until a specified date; amending s. 409.908, F.S.; removing community intermediate care facilities for the developmentally disabled from a restriction on changes in reimbursement rates; amending s. 409.911, F.S.; updating references to data used for calculating disproportionate share program payments to certain hospitals; providing for continuance of Medicaid disproportionate share distributions for certain nonstate government owned or operated hospitals; amending s. 409.967, F.S.; providing that certain achieved savings rebates be placed in the General Revenue Fund, unallocated; providing for the deposit of contributions by managed care plans to support Medicaid and indigent care; amending s. 409.975, F.S.; removing a requirement that the Agency for Health Care Administration support Healthy Start services with public expenditures and federal matching funds; amending s. 409.983, F.S.; specifying factors that the agency must consider to reconcile payments to long-term care managed care plans; repealing s. 409.97, F.S., relating to state and local Medicaid

partnerships; prohibiting the agency from entering into out-of-state partnerships for certain fiscal services; specifying exclusivity of the Florida Medicaid Management Information System and Decision Support System to the state; 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 100 persons per square mile;

2. An acute care hospital, in a county with a population density of up to 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 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;~~

4.~~5.~~ A hospital with a service area that has a population of up to 100 persons 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

5.~~6.~~ A hospital designated as a critical access hospital, as defined in s. 408.07(15) ~~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, 2021 ~~2015~~, if the hospital continues to have up to 100 licensed beds and an emergency room. 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,

2021 ~~2015~~, if the hospital continues to have up to 100 licensed beds and an emergency room.

Section 2. Paragraph (c) of subsection (23) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers efficient and effective for purchasing services or goods on behalf of recipients. If a provider is reimbursed based on cost reporting and submits a cost report late and that cost report would have been used to set a lower reimbursement rate for a rate semester, then the provider's rate for that semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Medicare-granted extensions for filing cost reports, if applicable, shall also apply to Medicaid cost reports. Payment for Medicaid compensable services made on behalf of Medicaid eligible persons is subject to the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. Further, nothing in this section shall be construed to prevent

or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, provided the adjustment is consistent with legislative intent.

(23)

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

1. Inpatient hospitals.

2. Outpatient hospitals.

3. Nursing homes.

4. County health departments.

~~5. Community intermediate care facilities for the developmentally disabled.~~

5.~~6.~~ Prepaid health plans.

Section 3. Paragraph (a) of subsection (2) and paragraph (d) of subsection (4) of section 409.911, Florida Statutes, are 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 ~~2005,~~ 2006, ~~and~~ 2007, and 2008 audited disproportionate share data to determine each hospital's Medicaid days and charity care for the 2015-2016 ~~2014-2015~~ state fiscal year.

(4) The following formulas shall be used to pay disproportionate share dollars to public hospitals:

(d) Any nonstate government owned or operated hospital eligible for payments under this section on July 1, 2011, remains eligible for payments during the 2015-2016 ~~2014-2015~~ state fiscal year.

Section 4. Paragraph (f) of subsection (3) and paragraph (c) of subsection (4) of section 409.967, Florida Statutes, are amended to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a

percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state and transferred to the General Revenue Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and transferred to the General Revenue Fund, unallocated.

(4) MEDICAL LOSS RATIO.—If required as a condition of a waiver, the agency may calculate a medical loss ratio for managed care plans. The calculation shall use uniform financial data collected from all plans and shall be computed for each plan on a statewide basis. The method for calculating the medical loss ratio shall meet the following criteria:

(c) Prior to final determination of the medical loss ratio for any period, a plan may contribute to a designated state trust fund for the purpose of supporting Medicaid and indigent care and have the contribution counted as a medical expenditure for the period. Funds contributed for this purpose shall be deposited into the Grants and Donations Trust Fund.

Section 5. Paragraph (a) of subsection (4) 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.

(4) MOMCARE NETWORK.—

(a) The agency shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. ~~The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.~~

Section 6. Subsection (6) of section 409.983, Florida Statutes, is amended to read:

409.983 Long-term care managed care plan payment.—In addition to the payment provisions of s. 409.968, the agency shall provide payment to plans in the long-term care managed care program pursuant to this section.

(6) The agency shall establish nursing-facility-specific payment rates for each licensed nursing home based on facility

costs adjusted for inflation and other factors as authorized in the General Appropriations Act. Payments to long-term care managed care plans shall be reconciled to reimburse actual payments to nursing facilities resulting from changes in nursing home per diem rates, but may not be reconciled to actual days experienced by the long-term care managed care plans.

Section 7. Section 409.97, Florida Statutes, is repealed.

Section 8. Effective upon this act becoming a law, the Agency for Health Care Administration shall not partner with any other state or territory for the purposes of providing Medicaid fiscal agent operations. The Florida Medicaid Management Information System and Decision Support System shall be for use only by the State of Florida.

Section 9. 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, 2015.