FOR CONSIDERATION By the Committee on Appropriations

576-01868E-18 20182506pb

1 A bill to be entitled
2 An act relating to health care; amending s. 409.908,
3 F.S.; revising parameters relating to the prospective
4 payment methodology for the reimbursement of Medicaid
5 providers to be implemented for rate setting purposes;
6 requiring the Agency for Health Care Administration to
7 establish prospective payment reimbursement rates for
8 nursing home services as provided in this act and in
9 the General Appropriations Act; conforming provisions
10 to changes made by the act; amending s. 409.9082,
11 F.S.; authorizing the agency to seek certain remedies
12 from any nursing home facility provider that fails to
13 report its total number of resident days monthly,
14 including the imposition of a specified fine; amending
15 s. 409.9083, F.S.; authorizing the agency to seek
16 certain remedies from any intermediate care facility
17 for the developmentally disabled provider that fails
18 to report its total number of resident days monthly,
19 including the imposition of a specified fine;
20 requiring the agency to seek authorization from the
21 federal Centers for Medicare and Medicaid Services to
22 modify the period of retroactive Medicaid eligibility
23 in a manner that ensures that the modification becomes
24 effective by a certain date; requiring the agency to
25 contract with a nonprofit organization in Miami-Dade
26 County, which must meet certain requirements, to be a
27 site for the Program for All-inclusive Care for the
28 Elderly (PACE), subject to federal approval of the
29 application site; requiring the nonprofit organization

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30 to provide PACE services to frail elders in Miami-Dade
31 County; requiring the agency, in consultation with the
32 Department of Elderly Affairs, to approve up to a
33 certain number of initial enrollees in PACE at the new
34 site, subject to an appropriation; providing effective
35 dates.
36
37 Be It Enacted by the Legislature of the State of Florida:
38
39 Section 1. Effective October 1, 2018, subsection (2) of
40 section 409.908, Florida Statutes, as amended by section 8 of
41 chapter 2017-129, Laws of Florida, is amended to read:
42 Section 8. Effective October 1, 2018, subsection (2) of
43 section 409.908, Florida Statutes, is amended to read:
44 409.908 Reimbursement of Medicaid providers.—Subject to
45 specific appropriations, the agency shall reimburse Medicaid
46 providers, in accordance with state and federal law, according
47 to methodologies set forth in the rules of the agency and in
48 policy manuals and handbooks incorporated by reference therein.
49 These methodologies may include fee schedules, reimbursement
50 methods based on cost reporting, negotiated fees, competitive
51 bidding pursuant to s. 287.057, and other mechanisms the agency
52 considers efficient and effective for purchasing services or
53 goods on behalf of recipients. If a provider is reimbursed based
54 on cost reporting and submits a cost report late and that cost
55 report would have been used to set a lower reimbursement rate
56 for a rate semester, then the provider's rate for that semester
57 shall be retroactively calculated using the new cost report, and
58 full payment at the recalculated rate shall be effected

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59 retroactively. Medicare-granted extensions for filing cost
60 reports, if applicable, shall also apply to Medicaid cost
61 reports. Payment for Medicaid compensable services made on
62 behalf of Medicaid eligible persons is subject to the
63 availability of moneys and any limitations or directions
64 provided for in the General Appropriations Act or chapter 216.
65 Further, nothing in this section shall be construed to prevent
66 or limit the agency from adjusting fees, reimbursement rates,
67 lengths of stay, number of visits, or number of services, or
68 making any other adjustments necessary to comply with the
69 availability of moneys and any limitations or directions
70 provided for in the General Appropriations Act, provided the
71 adjustment is consistent with legislative intent.
72 (2)(a)1. Reimbursement to nursing homes licensed under part
73 II of chapter 400 and state-owned-and-operated intermediate care
74 facilities for the developmentally disabled licensed under part
75 VIII of chapter 400 must be made prospectively.
76 2. Unless otherwise limited or directed in the General
77 Appropriations Act, reimbursement to hospitals licensed under
78 part I of chapter 395 for the provision of swing-bed nursing
79 home services must be made on the basis of the average statewide
80 nursing home payment, and reimbursement to a hospital licensed
81 under part I of chapter 395 for the provision of skilled nursing
82 services must be made on the basis of the average nursing home
83 payment for those services in the county in which the hospital
84 is located. When a hospital is located in a county that does not
85 have any community nursing homes, reimbursement shall be
86 determined by averaging the nursing home payments in counties
87 that surround the county in which the hospital is located.

88 Reimbursement to hospitals, including Medicaid payment of
89 Medicare copayments, for skilled nursing services shall be
90 limited to 30 days, unless a prior authorization has been
91 obtained from the agency. Medicaid reimbursement may be extended
92 by the agency beyond 30 days, and approval must be based upon
93 verification by the patient's physician that the patient
94 requires short-term rehabilitative and recuperative services
95 only, in which case an extension of no more than 15 days may be
96 approved. Reimbursement to a hospital licensed under part I of
97 chapter 395 for the temporary provision of skilled nursing
98 services to nursing home residents who have been displaced as
99 the result of a natural disaster or other emergency may not
100 exceed the average county nursing home payment for those
101 services in the county in which the hospital is located and is
102 limited to the period of time which the agency considers
103 necessary for continued placement of the nursing home residents
104 in the hospital.
105 (b) Subject to any limitations or directions in the General
106 Appropriations Act, the agency shall establish and implement a
107 state Title XIX Long-Term Care Reimbursement Plan for nursing
108 home care in order to provide care and services in conformance
109 with the applicable state and federal laws, rules, regulations,
110 and quality and safety standards and to ensure that individuals
111 eligible for medical assistance have reasonable geographic
112 access to such care.
113 1. The agency shall amend the long-term care reimbursement
114 plan and cost reporting system to create direct care and
115 indirect care subcomponents of the patient care component of the
116 per diem rate. These two subcomponents together shall equal the

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117 patient care component of the per diem rate. Separate prices
118 shall be calculated for each patient care subcomponent,
119 initially based on the September 2016 rate setting cost reports
120 and subsequently based on the most recently audited cost report
121 used during a rebasing year. The direct care subcomponent of the
122 per diem rate for any providers still being reimbursed on a cost
123 basis shall be limited by the cost-based class ceiling, and the
124 indirect care subcomponent may be limited by the lower of the
125 cost-based class ceiling, the target rate class ceiling, or the
126 individual provider target. The ceilings and targets apply only
127 to providers being reimbursed on a cost-based system. Effective
128 October 1, 2018, a prospective payment methodology shall be
129 implemented for rate setting purposes with the following
130 parameters:
131 a. Peer Groups, including:
132 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
133 Counties; and
134 (II) South-SMMC Regions 10-11, plus Palm Beach and
135 Okeechobee Counties.
136 b. Percentage of Median Costs based on the cost reports
137 used for September 2016 rate setting:
138 (I) Direct Care Costs.......................105 ~~100~~ percent.
139 (II) Indirect Care Costs.........................92 percent.
140 (III) Operating Costs............................86 percent.
141 c. Floors:
142 (I) Direct Care Component........................95 percent.
143 (II) Indirect Care Component...................92.5 percent.
144 (III) Operating Component............................None.
145 d. Pass-through Payments...Real Estate and Personal Property

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146 Taxes and Property Insurance.
147 e. Quality Incentive Program Payment Pool...7.5 ~~6~~ percent of
148 September 2016 non-property related payments of included
149 facilities.
150 f. Quality Score Threshold to Quality for Quality Incentive
151 Payment..................20th percentile of included facilities.
152 g. Fair Rental Value System Payment Parameters:
153 (I) Building Value per Square Foot based on 2018 RS Means.
154 (II) Land Valuation......10 percent of Gross Building value.
155 (III) Facility Square Footage.........Actual Square Footage.
156 (IV) Moveable Equipment Allowance............$8,000 per bed.
157 (V) Obsolescence Factor.........................1.5 percent.
158 (VI) Fair Rental Rate of Return...................8 percent.
159 (VII) Minimum Occupancy.........................90 percent.
160 (VIII) Maximum Facility Age........................40 years.
161 (IX) Minimum Square Footage per Bed.....................350.
162 (X) Maximum Square Footage for Bed......................500.
163 (XI) Minimum Cost of a renovation/replacements.$500 per bed.
164 h. Ventilator Supplemental payment of $200 per Medicaid day
165 of 40,000 ventilator Medicaid days per fiscal year.
166 2. The direct care subcomponent shall include salaries and
167 benefits of direct care staff providing nursing services
168 including registered nurses, licensed practical nurses, and
169 certified nursing assistants who deliver care directly to
170 residents in the nursing home facility, allowable therapy costs,
171 and dietary costs. This excludes nursing administration, staff
172 development, the staffing coordinator, and the administrative
173 portion of the minimum data set and care plan coordinators. The
174 direct care subcomponent also includes medically necessary

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175 dental care, vision care, hearing care, and podiatric care.
176 3. All other patient care costs shall be included in the
177 indirect care cost subcomponent of the patient care per diem
178 rate, including complex medical equipment, medical supplies, and
179 other allowable ancillary costs. Costs may not be allocated
180 directly or indirectly to the direct care subcomponent from a
181 home office or management company.
182 4. On July 1 of each year, the agency shall report to the
183 Legislature direct and indirect care costs, including average
184 direct and indirect care costs per resident per facility and
185 direct care and indirect care salaries and benefits per category
186 of staff member per facility.
187 5. Every fourth year, the agency shall rebase nursing home
188 prospective payment rates to reflect changes in cost based on
189 the most recently audited cost report for each participating
190 provider.
191 6. A direct care supplemental payment may be made to
192 providers whose direct care hours per patient day are above the
193 80th percentile and who provide Medicaid services to a larger
194 percentage of Medicaid patients than the state average.
195 7. For the period beginning on October 1, 2018, and ending
196 on September 30, 2021, the agency shall reimburse providers the
197 greater of their September 2016 cost-based rate or their
198 prospective payment rate. Effective October 1, 2021, the agency
199 shall reimburse providers the greater of 95 percent of their
200 cost-based rate or their rebased prospective payment rate, using
201 the most recently audited cost report for each facility. This
202 subparagraph shall expire September 30, 2023.
203 8. Pediatric, Florida Department of Veterans Affairs, and

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204 government-owned facilities are exempt from the pricing model
205 established in this subsection and shall remain on a cost-based
206 prospective payment system. Effective October 1, 2018, the
207 agency shall set rates for all facilities remaining on a cost-
208 based prospective payment system using each facility's most
209 recently audited cost report, eliminating retroactive
210 settlements.
211
212 It is the intent of the Legislature that the reimbursement plan
213 achieve the goal of providing access to health care for nursing
214 home residents who require large amounts of care while
215 encouraging diversion services as an alternative to nursing home
216 care for residents who can be served within the community. The
217 agency shall base the establishment of any maximum rate of
218 payment, whether overall or component, on the available moneys
219 as provided for in the General Appropriations Act. The agency
220 may base the maximum rate of payment on the results of
221 scientifically valid analysis and conclusions derived from
222 objective statistical data pertinent to the particular maximum
223 rate of payment.
224 Section 2. Effective October 1, 2018, subsection (23) of
225 section 409.908, Florida Statutes, is amended to read:
226 409.908 Reimbursement of Medicaid providers.—Subject to
227 specific appropriations, the agency shall reimburse Medicaid
228 providers, in accordance with state and federal law, according
229 to methodologies set forth in the rules of the agency and in
230 policy manuals and handbooks incorporated by reference therein.
231 These methodologies may include fee schedules, reimbursement
232 methods based on cost reporting, negotiated fees, competitive

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233 bidding pursuant to s. 287.057, and other mechanisms the agency
234 considers efficient and effective for purchasing services or
235 goods on behalf of recipients. If a provider is reimbursed based
236 on cost reporting and submits a cost report late and that cost
237 report would have been used to set a lower reimbursement rate
238 for a rate semester, then the provider's rate for that semester
239 shall be retroactively calculated using the new cost report, and
240 full payment at the recalculated rate shall be effected
241 retroactively. Medicare-granted extensions for filing cost
242 reports, if applicable, shall also apply to Medicaid cost
243 reports. Payment for Medicaid compensable services made on
244 behalf of Medicaid eligible persons is subject to the
245 availability of moneys and any limitations or directions
246 provided for in the General Appropriations Act or chapter 216.
247 Further, nothing in this section shall be construed to prevent
248 or limit the agency from adjusting fees, reimbursement rates,
249 lengths of stay, number of visits, or number of services, or
250 making any other adjustments necessary to comply with the
251 availability of moneys and any limitations or directions
252 provided for in the General Appropriations Act, provided the
253 adjustment is consistent with legislative intent.
254 (23)(a) The agency shall establish rates at a level that
255 ensures no increase in statewide expenditures resulting from a
256 change in unit costs for county health departments effective
257 July 1, 2011. Reimbursement rates shall be as provided in the
258 General Appropriations Act.
259 (b)1. Base rate reimbursement for inpatient services under
260 a diagnosis-related group payment methodology shall be provided
261 in the General Appropriations Act.

262 <u>2.</u>~~(c)~~ Base rate reimbursement for outpatient services under
263 an enhanced ambulatory payment group methodology shall be
264 provided in the General Appropriations Act.
265 <u>3. Prospective payment system reimbursement for nursing</u>
266 <u>home services shall be as provided in subsection (2) and in the</u>
267 <u>General Appropriations Act</u>
268 ~~(d) This subsection applies to the following provider~~
269 ~~types:~~
270 ~~1. Nursing homes.~~
271 ~~2. County health departments.~~
272 ~~(e) The agency shall apply the effect of this subsection to~~
273 ~~the reimbursement rates for nursing home diversion programs~~.
274 Section 3. Subsection (7) of section 409.9082, Florida
275 Statutes, is amended to read:
276 409.9082 Quality assessment on nursing home facility
277 providers; exemptions; purpose; federal approval required;
278 remedies.—
279 (7) The agency may seek any of the following remedies for
280 failure of any nursing home facility provider <u>to report its</u>
281 <u>total number of resident days monthly or</u> to pay its assessment
282 timely:
283 (a) Withholding any medical assistance reimbursement
284 payments until such time as the assessment amount is recovered;
285 (b) Suspension or revocation of the nursing home facility
286 license; and
287 (c) Imposition of a fine of up to $1,000 per day for each
288 <u>offense</u> ~~delinquent payment~~, not to exceed the amount of the
289 assessment.
290 Section 4. Subsection (6) of section 409.9083, Florida

291 Statutes, is amended to read:
292 409.9083 Quality assessment on privately operated
293 intermediate care facilities for the developmentally disabled;
294 exemptions; purpose; federal approval required; remedies.—
295 (6) The agency may seek any of the following remedies for
296 failure of any ICF/DD provider to report its total number of
297 resident days monthly or to timely pay its assessment:
298 (a) Withholding any medical assistance reimbursement
299 payments until the assessment amount is recovered.
300 (b) Suspending or revoking the facility's license.
301 (c) Imposing a fine of up to $1,000 per day for each
302 offense ~~delinquent payment~~, not to exceed the amount of the
303 assessment.
304 Section 5. The Agency for Health Care Administration shall
305 seek authorization from the federal Centers for Medicare and
306 Medicaid Services to modify the period of retroactive Medicaid
307 eligibility from 90 days to 30 days in a manner that ensures
308 that the modification becomes effective on July 1, 2018.
309 Section 6. Effective July 1, 2018, and subject to federal
310 approval of the application to be a site for the Program of All-
311 inclusive Care for the Elderly (PACE), the Agency for Health
312 Care Administration shall contract with an additional nonprofit
313 organization to serve individuals and families in Miami-Dade
314 County. The nonprofit organization must have a history of
315 serving primarily the Hispanic population by providing primary
316 care services, nutrition, meals, and adult day care to the
317 senior population. The nonprofit organization shall leverage
318 existing community-based care providers and health care
319 organizations to provide PACE services to frail elders who

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320 reside in Miami-Dade County. The organization is exempt from the
321 requirements of chapter 641, Florida Statutes. The agency, in
322 consultation with the Department of Elderly Affairs and subject
323 to an appropriation, shall approve up to 250 initial enrollees
324 in the PACE site established by this organization to serve frail
325 elders who reside in Miami-Dade County.
326 Section 7. Except as expressly provided in this act, this
327 act shall take effect upon becoming a law.

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