FOR CONSIDERATION By the Committee on Appropriations

576-02672-22 20222526pb

A bill to be entitled

An act relating to health; amending s. 210.201, F.S.; providing an appropriation to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute for a specified purpose; authorizing such appropriation to be used to secure certain financing; providing construction; amending s. 381.02035, F.S.; authorizing pharmacists and wholesalers employed by or under contract with forensic facilities managed by the Agency for Persons with Disabilities to import prescription drugs under the Canadian Prescription Drug Importation Program for dispensing to clients in such facilities; amending s. 394.9082, F.S.; requiring that the Department of Children and Families' contracts with managing entities be made available on the department's website; requiring the department to conduct a specified review of managing entities every 2 years; requiring the department to submit the review to the Governor and the Legislature by a specified date; requiring managing entities to provide notice to providers before removing the provider from the provider network; amending s. 408.062, F.S.; deleting a requirement that the Agency for Health Care Administration collect and publish on its website certain data related to the retail prices of specified prescribed medicines; amending s. 409.908, F.S.; requiring the agency to base its rate of payments for nursing home care in its Title XIX Long-Term Care Reimbursement Plan in accordance with specified

minimum wage requirements; providing an effective date.

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

Section 1. Section 210.201, Florida Statutes, is amended to read:

210.201 H. Lee Moffitt Cancer Center and Research Institute facilities; establishment; funding.—

(1) The Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute shall construct, furnish, and equip, and shall covenant to complete, the cancer research and clinical and related facilities of the H. Lee Moffitt Cancer Center and Research Institute funded with proceeds from the Cigarette Tax Collection Trust Fund pursuant to s. 210.20. Moneys transferred to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute pursuant to s. 210.20 may be used to secure financing to pay costs related to constructing, furnishing, equipping, operating, and maintaining cancer research and clinical and related facilities; furnishing, equipping, operating, and maintaining other leased or owned properties; and paying costs incurred in connection with purchasing, financing, operating, and maintaining such equipment, facilities, and properties as provided in s. 210.20. Such financing may include the issuance of tax-exempt bonds or other forms of indebtedness by a local authority, municipality, or county pursuant to parts II and III of chapter 159. Such bonds shall not constitute state bonds for purposes of s. 11, Art. VII of the State Constitution, but shall constitute bonds

of a "local agency," as defined in s. 159.27(4). The cigarette tax dollars pledged to facilities pursuant to s. 210.20 may be replaced annually by the Legislature from tobacco litigation settlement proceeds.

(2) Beginning in the 2022-2023 fiscal year, and annually through the 2052-2053 fiscal year, the sum of $20 million is appropriated and shall be transferred to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute for construction and development of Moffitt's Pasco County life sciences park. Moneys transferred to the Board of Directors of the H. Lee Moffitt Cancer Center and Research Institute pursuant to this subsection may be used to secure financing to pay costs related to the construction and development of Moffitt's Pasco County life sciences park. Such financing may include the issuance of tax-exempt bonds or other forms of indebtedness by a local authority, municipality, or county pursuant to parts II and III of chapter 159. Such bonds shall not constitute state bonds for purposes of s. 11, Art. VII of the State Constitution, but shall constitute bonds of a local agency as defined in s. 159.27(4).

Section 2. Paragraph (f) is added to subsection (7) of section 381.02035, Florida Statutes, to read:

381.02035 Canadian Prescription Drug Importation Program.—

(7) ELIGIBLE IMPORTERS.—The following entities may import prescription drugs from an eligible Canadian supplier under the program:

(f) A pharmacist or wholesaler employed by or under contract with a forensic facility, as defined in s. 916.106, that is managed by the Agency for Persons with Disabilities, for

dispensing to clients treated in such facility.

Section 3. Paragraph (i) of subsection (5) of section 394.9082, Florida Statutes, is amended, and paragraphs (k) and (l) are added to subsection (4) of that section, to read:

394.9082 Behavioral health managing entities.—

(4) CONTRACT WITH MANAGING ENTITIES.—

(k) The department's contracts with managing entities must be made available in a publicly accessible format on the department's website.

(l) Every 2 years, the department shall conduct a comprehensive, multiyear review of the revenues, expenditures, and financial positions of managing entities covering the most recent 2 consecutive fiscal years. The review must include a comprehensive system-of-care analysis. The department shall submit the review to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 1 of every other year, beginning in 2023.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(i) Develop a comprehensive provider network of qualified providers to deliver behavioral health services. The managing entity is not required to competitively procure network providers but shall publicize opportunities to join the provider network and evaluate providers in the network to determine if they may remain in the network. A managing entity must provide notice to a provider before the provider is removed from the network. The managing entity shall publish these processes on its website. The managing entity shall ensure continuity of care for clients if a provider ceases to provide a service or leaves the network.

Section 4. Paragraph (h) of subsection (1) of section 408.062, Florida Statutes, is amended to read:

408.062 Research, analyses, studies, and reports.—

(1) The agency shall conduct research, analyses, and studies relating to health care costs and access to and quality of health care services as access and quality are affected by changes in health care costs. Such research, analyses, and studies shall include, but not be limited to:

~~(h) The collection of a statistically valid sample of data on the retail prices charged by pharmacies for the 300 most frequently prescribed medicines from any pharmacy licensed by this state. If the drug is available generically, price data shall be reported for the generic drug and price data of a brand-named drug for which the generic drug is the equivalent shall be reported. The agency shall make available on its Internet website for each pharmacy drug prices for a 30-day supply at a standard dose. The data collected shall be reported for each drug by pharmacy and by metropolitan statistical area or region and updated monthly.~~

Section 5. Subsection (2) 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.

(2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under part VIII of chapter 400 must be made prospectively.

2. Unless otherwise limited or directed in the General Appropriations Act, reimbursement to hospitals licensed under part I of chapter 395 for the provision of swing-bed nursing home services must be made on the basis of the average statewide nursing home payment, and reimbursement to a hospital licensed

under part I of chapter 395 for the provision of skilled nursing services must be made on the basis of the average nursing home payment for those services in the county in which the hospital is located. When a hospital is located in a county that does not have any community nursing homes, reimbursement shall be determined by averaging the nursing home payments in counties that surround the county in which the hospital is located. Reimbursement to hospitals, including Medicaid payment of Medicare copayments, for skilled nursing services shall be limited to 30 days, unless a prior authorization has been obtained from the agency. Medicaid reimbursement may be extended by the agency beyond 30 days, and approval must be based upon verification by the patient's physician that the patient requires short-term rehabilitative and recuperative services only, in which case an extension of no more than 15 days may be approved. Reimbursement to a hospital licensed under part I of chapter 395 for the temporary provision of skilled nursing services to nursing home residents who have been displaced as the result of a natural disaster or other emergency may not exceed the average county nursing home payment for those services in the county in which the hospital is located and is limited to the period of time which the agency considers necessary for continued placement of the nursing home residents in the hospital.

(b) Subject to any limitations or directions in the General Appropriations Act, the agency shall establish and implement a state Title XIX Long-Term Care Reimbursement Plan for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations,

and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care.

1. The agency shall amend the long-term care reimbursement plan and cost reporting system to create direct care and indirect care subcomponents of the patient care component of the per diem rate. These two subcomponents together shall equal the patient care component of the per diem rate. Separate prices shall be calculated for each patient care subcomponent, initially based on the September 2016 rate setting cost reports and subsequently based on the most recently audited cost report used during a rebasing year. The direct care subcomponent of the per diem rate for any providers still being reimbursed on a cost basis shall be limited by the cost-based class ceiling, and the indirect care subcomponent may be limited by the lower of the cost-based class ceiling, the target rate class ceiling, or the individual provider target. The ceilings and targets apply only to providers being reimbursed on a cost-based system. Effective October 1, 2018, a prospective payment methodology shall be implemented for rate setting purposes with the following parameters:

a. Peer Groups, including:

(I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee Counties; and

(II) South-SMMC Regions 10-11, plus Palm Beach and Okeechobee Counties.

b. Percentage of Median Costs based on the cost reports used for September 2016 rate setting:

(I) Direct Care Costs.....100 percent.

(II) Indirect Care Costs.....92 percent.
(III) Operating Costs.....86 percent.
c. Floors:
(I) Direct Care Component.....95 percent.
(II) Indirect Care Component.....92.5 percent.
(III) Operating Component.....None.
d. Pass-through Payments.....Real Estate and .....Personal Property .....Taxes and Property Insurance.
e. Quality Incentive Program Payment Pool.....6 percent of September .....2016 non-property related .....payments of included facilities.
f. Quality Score Threshold to Quality for Quality Incentive Payment.....20th percentile of included facilities.
g. Fair Rental Value System Payment Parameters:
(I) Building Value per Square Foot based on 2018 RS Means.
(II) Land Valuation.....10 percent of Gross Building value.
(III) Facility Square Footage.....Actual Square Footage.
(IV) Moveable Equipment Allowance.....$8,000 per bed.
(V) Obsolescence Factor.....1.5 percent.
(VI) Fair Rental Rate of Return.....8 percent.
(VII) Minimum Occupancy.....90 percent.
(VIII) Maximum Facility Age.....40 years.
(IX) Minimum Square Footage per Bed.....350.
(X) Maximum Square Footage for Bed.....500.
(XI) Minimum Cost of a renovation/replacements.$500 per bed.
h. Ventilator Supplemental payment of $200 per Medicaid day of 40,000 ventilator Medicaid days per fiscal year.

2. The direct care subcomponent shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing home facility, allowable therapy costs, and dietary costs. This excludes nursing administration, staff development, the staffing coordinator, and the administrative portion of the minimum data set and care plan coordinators. The direct care subcomponent also includes medically necessary dental care, vision care, hearing care, and podiatric care.

3. All other patient care costs shall be included in the indirect care cost subcomponent of the patient care per diem rate, including complex medical equipment, medical supplies, and other allowable ancillary costs. Costs may not be allocated directly or indirectly to the direct care subcomponent from a home office or management company.

4. On July 1 of each year, the agency shall report to the Legislature direct and indirect care costs, including average direct and indirect care costs per resident per facility and direct care and indirect care salaries and benefits per category of staff member per facility.

5. Every fourth year, the agency shall rebase nursing home prospective payment rates to reflect changes in cost based on the most recently audited cost report for each participating provider.

6. A direct care supplemental payment may be made to providers whose direct care hours per patient day are above the 80th percentile and who provide Medicaid services to a larger percentage of Medicaid patients than the state average.

7. For the period beginning on October 1, 2018, and ending on September 30, 2021, the agency shall reimburse providers the greater of their September 2016 cost-based rate or their prospective payment rate. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate or their rebased prospective payment rate, using the most recently audited cost report for each facility. This subparagraph shall expire September 30, 2023.

8. Pediatric, Florida Department of Veterans Affairs, and government-owned facilities are exempt from the pricing model established in this subsection and shall remain on a cost-based prospective payment system. Effective October 1, 2018, the agency shall set rates for all facilities remaining on a cost-based prospective payment system using each facility's most recently audited cost report, eliminating retroactive settlements.

It is the intent of the Legislature that the reimbursement plan achieve the goal of providing access to health care for nursing home residents who require large amounts of care while encouraging diversion services as an alternative to nursing home care for residents who can be served within the community. The agency shall base the establishment of any maximum rate of payment, whether overall or component, on the available moneys as provided for in the General Appropriations Act. The agency may base the maximum rate of payment on the results of scientifically valid analysis and conclusions derived from objective statistical data pertinent to the particular maximum rate of payment. The agency shall base the rates of payments in

accordance with the minimum wage requirements as provided in the General Appropriations Act.

Section 6. This act shall take effect July 1, 2022.