FOR CONSIDERATION By the Committee on Appropriations

576-02753A-23 20232510pb

1 A bill to be entitled
2 An act relating to health; amending s. 296.37, F.S.;
3 increasing the income threshold for certain
4 contributions required by residents of veterans’
5 nursing homes; amending s. 409.814, F.S.; revising
6 eligibility conditions for participation in the
7 Florida Kidcare program; amending s. 409.908, F.S.;
8 revising the payment methodology for a certain
9 component of the state Title XIX Long-Term Care
10 Reimbursement Plan for nursing home care; amending s.
11 409.909, F.S.; establishing the Slots for Doctors
12 Program for a specified purpose; requiring the Agency
13 for Health Care Administration to allocate a specified
14 amount to hospitals and qualifying institutions for
15 certain newly created resident positions for specified
16 physician specialties or subspecialties; providing
17 construction; prohibiting the use of allocated funds
18 under the program for resident positions that have
19 previously received certain other funding; amending s.
20 409.967, F.S.; revising the criteria for determining
21 achieved savings rebates for purposes of Medicaid
22 prepaid plans; amending s. 430.204, F.S.; authorizing
23 area agencies on aging to carry forward a specified
24 percentage of documented unexpended state funds from
25 one fiscal year to the next, subject to certain
26 conditions; requiring the remainder of such state
27 funds to be returned to the Department of Elderly
28 Affairs; providing an effective date.
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30 Be It Enacted by the Legislature of the State of Florida:
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32 Section 1. Subsection (1) of section 296.37, Florida
33 Statutes, is amended to read:
34 296.37 Residents; contribution to support.—
35 (1) Every resident of the home who receives a pension,
36 compensation, or gratuity from the United States Government, or
37 income from any other source of more than $160 ~~$130~~ per month,
38 shall contribute to his or her maintenance and support while a
39 resident of the home in accordance with a schedule of payment
40 determined by the administrator and approved by the director.
41 The total amount of such contributions shall be to the fullest
42 extent possible but may not exceed the actual cost of operating
43 and maintaining the home.
44 Section 2. Subsection (7) of section 409.814, Florida
45 Statutes, is amended to read:
46 409.814 Eligibility.—A child who has not reached 19 years
47 of age whose family income is equal to or below 200 percent of
48 the federal poverty level is eligible for the Florida Kidcare
49 program as provided in this section. If an enrolled individual
50 is determined to be ineligible for coverage, he or she must be
51 immediately disenrolled from the respective Florida Kidcare
52 program component.
53 (7) A child whose family income is above 200 percent of the
54 federal poverty level or a child who is excluded under ~~the~~
55 ~~provisions of~~ subsection (5) may participate in the Florida
56 Kidcare program as provided in s. 409.8132 or, if the child is
57 ineligible for Medikids by reason of age, in the Florida Healthy
58 Kids program, subject to the following:

59 (a) The family is not eligible for premium assistance
60 payments and must pay the full cost of the combined-risk
61 premium, including any administrative costs.
62 (b) The board of directors of the Florida Healthy Kids
63 Corporation may offer a reduced benefit package to these
64 children in order to limit program costs for such families.
65 Section 3. Paragraph (b) of subsection (2) of section
66 409.908, Florida Statutes, is amended to read:
67 409.908 Reimbursement of Medicaid providers.—Subject to
68 specific appropriations, the agency shall reimburse Medicaid
69 providers, in accordance with state and federal law, according
70 to methodologies set forth in the rules of the agency and in
71 policy manuals and handbooks incorporated by reference therein.
72 These methodologies may include fee schedules, reimbursement
73 methods based on cost reporting, negotiated fees, competitive
74 bidding pursuant to s. 287.057, and other mechanisms the agency
75 considers efficient and effective for purchasing services or
76 goods on behalf of recipients. If a provider is reimbursed based
77 on cost reporting and submits a cost report late and that cost
78 report would have been used to set a lower reimbursement rate
79 for a rate semester, then the provider's rate for that semester
80 shall be retroactively calculated using the new cost report, and
81 full payment at the recalculated rate shall be effected
82 retroactively. Medicare-granted extensions for filing cost
83 reports, if applicable, shall also apply to Medicaid cost
84 reports. Payment for Medicaid compensable services made on
85 behalf of Medicaid-eligible persons is subject to the
86 availability of moneys and any limitations or directions
87 provided for in the General Appropriations Act or chapter 216.

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88 Further, nothing in this section shall be construed to prevent
89 or limit the agency from adjusting fees, reimbursement rates,
90 lengths of stay, number of visits, or number of services, or
91 making any other adjustments necessary to comply with the
92 availability of moneys and any limitations or directions
93 provided for in the General Appropriations Act, provided the
94 adjustment is consistent with legislative intent.
95 (2)
96 (b) Subject to any limitations or directions in the General
97 Appropriations Act, the agency shall establish and implement a
98 state Title XIX Long-Term Care Reimbursement Plan for nursing
99 home care in order to provide care and services in conformance
100 with the applicable state and federal laws, rules, regulations,
101 and quality and safety standards and to ensure that individuals
102 eligible for medical assistance have reasonable geographic
103 access to such care.
104 1. The agency shall amend the long-term care reimbursement
105 plan and cost reporting system to create direct care and
106 indirect care subcomponents of the patient care component of the
107 per diem rate. These two subcomponents together shall equal the
108 patient care component of the per diem rate. Separate prices
109 shall be calculated for each patient care subcomponent,
110 initially based on the September 2016 rate setting cost reports
111 and subsequently based on the most recently audited cost report
112 used during a rebasing year. The direct care subcomponent of the
113 per diem rate for any providers still being reimbursed on a cost
114 basis shall be limited by the cost-based class ceiling, and the
115 indirect care subcomponent may be limited by the lower of the
116 cost-based class ceiling, the target rate class ceiling, or the

117 individual provider target. The ceilings and targets apply only
118 to providers being reimbursed on a cost-based system. Effective
119 October 1, 2018, a prospective payment methodology shall be
120 implemented for rate setting purposes with the following
121 parameters:
122 a. Peer Groups, including:
123 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
124 Counties; and
125 (II) South-SMMC Regions 10-11, plus Palm Beach and
126 Okeechobee Counties.
127 b. Percentage of Median Costs based on the cost reports
128 used for September 2016 rate setting:
129 (I) Direct Care Costs..........................100 percent.
130 (II) Indirect Care Costs.........................92 percent.
131 (III) Operating Costs............................86 percent.
132 c. Floors:
133 (I) Direct Care Component........................95 percent.
134 (II) Indirect Care Component..................92.5 percent.
135 (III) Operating Component............................None.
136 d. Pass-through Payments....................Real Estate and
137 ....Personal Property
138 ....Taxes and Property Insurance.
139 e. Quality Incentive Program Payment
140 Pool..................................10 ~~6~~ percent of September
141 ....2016 non-property related
142 ....payments of included facilities.
143 f. Quality Score Threshold to Quality for Quality Incentive
144 Payment...................20th percentile of included facilities.
145 g. Fair Rental Value System Payment Parameters:

146 (I) Building Value per Square Foot based on 2018 RS Means.
147 (II) Land Valuation......10 percent of Gross Building value.
148 (III) Facility Square Footage.........Actual Square Footage.
149 (IV) Moveable Equipment Allowance............$8,000 per bed.
150 (V) Obsolescence Factor........................1.5 percent.
151 (VI) Fair Rental Rate of Return..................8 percent.
152 (VII) Minimum Occupancy.........................90 percent.
153 (VIII) Maximum Facility Age........................40 years.
154 (IX) Minimum Square Footage per Bed.....................350.
155 (X) Maximum Square Footage for Bed......................500.
156 (XI) Minimum Cost of a renovation/replacements.$500 per bed.
157 h. Ventilator Supplemental payment of $200 per Medicaid day
158 of 40,000 ventilator Medicaid days per fiscal year.
159 2. The direct care subcomponent shall include salaries and
160 benefits of direct care staff providing nursing services
161 including registered nurses, licensed practical nurses, and
162 certified nursing assistants who deliver care directly to
163 residents in the nursing home facility, allowable therapy costs,
164 and dietary costs. This excludes nursing administration, staff
165 development, the staffing coordinator, and the administrative
166 portion of the minimum data set and care plan coordinators. The
167 direct care subcomponent also includes medically necessary
168 dental care, vision care, hearing care, and podiatric care.
169 3. All other patient care costs shall be included in the
170 indirect care cost subcomponent of the patient care per diem
171 rate, including complex medical equipment, medical supplies, and
172 other allowable ancillary costs. Costs may not be allocated
173 directly or indirectly to the direct care subcomponent from a
174 home office or management company.

175 4. On July 1 of each year, the agency shall report to the
176 Legislature direct and indirect care costs, including average
177 direct and indirect care costs per resident per facility and
178 direct care and indirect care salaries and benefits per category
179 of staff member per facility.
180 5. Every fourth year, the agency shall rebase nursing home
181 prospective payment rates to reflect changes in cost based on
182 the most recently audited cost report for each participating
183 provider.
184 6. A direct care supplemental payment may be made to
185 providers whose direct care hours per patient day are above the
186 80th percentile and who provide Medicaid services to a larger
187 percentage of Medicaid patients than the state average.
188 7. For the period beginning on October 1, 2018, and ending
189 on September 30, 2021, the agency shall reimburse providers the
190 greater of their September 2016 cost-based rate or their
191 prospective payment rate. Effective October 1, 2021, the agency
192 shall reimburse providers the greater of 95 percent of their
193 cost-based rate or their rebased prospective payment rate, using
194 the most recently audited cost report for each facility. This
195 subparagraph shall expire September 30, 2023.
196 8. Pediatric, Florida Department of Veterans Affairs, and
197 government-owned facilities are exempt from the pricing model
198 established in this subsection and shall remain on a cost-based
199 prospective payment system. Effective October 1, 2018, the
200 agency shall set rates for all facilities remaining on a cost-
201 based prospective payment system using each facility's most
202 recently audited cost report, eliminating retroactive
203 settlements.

204

205 It is the intent of the Legislature that the reimbursement plan
206 achieve the goal of providing access to health care for nursing
207 home residents who require large amounts of care while
208 encouraging diversion services as an alternative to nursing home
209 care for residents who can be served within the community. The
210 agency shall base the establishment of any maximum rate of
211 payment, whether overall or component, on the available moneys
212 as provided for in the General Appropriations Act. The agency
213 may base the maximum rate of payment on the results of
214 scientifically valid analysis and conclusions derived from
215 objective statistical data pertinent to the particular maximum
216 rate of payment. The agency shall base the rates of payments in
217 accordance with the minimum wage requirements as provided in the
218 General Appropriations Act.
219 Section 4. Present subsections (6) and (7) of section
220 409.909, Florida Statutes, are redesignated as subsections (7)
221 and (8), respectively, and a new subsection (6) is added to that
222 section, to read:
223 409.909 Statewide Medicaid Residency Program.—
224 (6) The Slots for Doctors Program is established to address
225 the physician workforce shortage by increasing the supply of
226 highly trained physicians through the creation of new resident
227 positions, which will increase access to care and improve health
228 outcomes for Medicaid recipients.
229 (a) The agency shall allocate $100,000 to hospitals and
230 qualifying institutions for each newly created resident position
231 that is accredited by the Accreditation Council for Graduate
232 Medical Education or the Osteopathic Postdoctoral Training

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233 Institution in an initial or established accredited training
234 program which is in a physician specialty or subspecialty in a
235 statewide supply-and-demand deficit.
236 (b) This program is designed to generate matching funds
237 under Medicaid and distribute such funds to participating
238 hospitals and qualifying institutions on a quarterly basis in
239 each fiscal year for which an appropriation is made.
240 (c) For purposes of this subsection, physician specialties
241 and subspecialties, both adult and pediatric, in statewide
242 supply-and-demand deficit are those identified as such in the
243 General Appropriations Act.
244 (d) Funds allocated pursuant to this subsection may not be
245 used for resident positions that have previously received
246 funding pursuant to subsection (1).
247 Section 5. Paragraph (f) of subsection (3) of section
248 409.967, Florida Statutes, is amended to read:
249 409.967 Managed care plan accountability.—
250 (3) ACHIEVED SAVINGS REBATE.—
251 (f) Achieved savings rebates validated by the certified
252 public accountant are due within 30 days after the report is
253 submitted. Except as provided in paragraph (h), the achieved
254 savings rebate is established by determining pretax income as a
255 percentage of revenues and applying the following income sharing
256 ratios:
257 1. One hundred percent of income up to and including 5
258 percent of revenue shall be retained by the plan.
259 2. Fifty percent of income above 5 percent and up to 10
260 percent shall be retained by the plan, and the other 50 percent
261 refunded to the state and transferred to the General Revenue

262 Fund, unallocated.
263 3. One hundred percent of income above 10 percent of
264 revenue shall be refunded to the state and adjusted for the
265 Federal Medical Assistance Percentages. The state share shall be
266 transferred to the General Revenue Fund, unallocated, and the
267 federal share shall be transferred to the Medical Care Trust
268 Fund, unallocated.
269 Section 6. Subsection (10) is added to section 430.204,
270 Florida Statutes, to read:
271 430.204 Community-care-for-the-elderly core services;
272 departmental powers and duties.—
273 (10) An area agency on aging may carry forward documented
274 unexpended state funds from one fiscal year to the next;
275 however, the cumulative amount carried forward may not exceed 10
276 percent of the area agency's planning and service area
277 allocation for the community care for the elderly program. Any
278 unexpended state funds in excess of that percentage must be
279 returned to the department.
280 (a) The funds carried forward may not be used in any manner
281 that would create increased recurring future obligations, and
282 such funds may not be used for any type of program or service
283 that is not currently authorized by existing contracts.
284 (b) Expenditures of funds carried forward must be
285 separately reported to the department.
286 (c) Any unexpended funds that remain at the end of the
287 contract period must be returned to the department.
288 (d) Funds carried forward may be retained through any
289 contract renewals and any new procurements as long as the same
290 area agency on aging is retained by the department.

291 Section 7. This act shall take effect July 1, 2023.

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