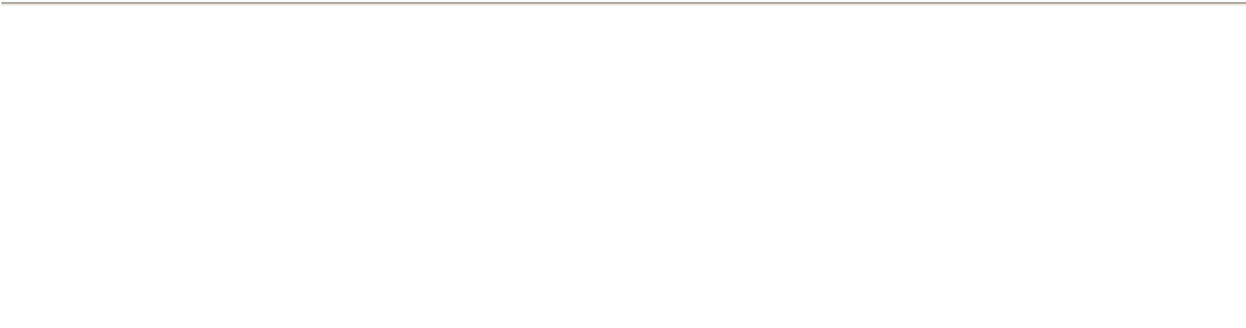
Amendment No. (for drafter's use only)

CHAMBER ACTION



1 Representative(s) Homan offered the following:

2

3 **Amendment (with directory and title amendments)**

4 Remove lines 176-701 and insert:

5 to methodologies set forth in the rules of the agency and in
6 policy manuals and handbooks incorporated by reference therein.
7 These methodologies may include fee schedules, reimbursement
8 methods based on cost reporting, negotiated fees, competitive
9 bidding pursuant to s. 287.057, and other mechanisms the agency
10 considers efficient and effective for purchasing services or
11 goods on behalf of recipients. If a provider is reimbursed based
12 on cost reporting and submits a cost report late and that cost
13 report would have been used to set a lower reimbursement rate
14 for a rate semester, then the provider's rate for that semester
15 shall be retroactively calculated using the new cost report, and

16 full payment at the recalculated rate shall be effected
17 retroactively. Medicare-granted extensions for filing cost
18 reports, if applicable, shall also apply to Medicaid cost
19 reports. Payment for Medicaid compensable services made on
20 behalf of Medicaid eligible persons is subject to the
21 availability of moneys and any limitations or directions
22 provided for in the General Appropriations Act or chapter 216.
23 Further, nothing in this section shall be construed to prevent
24 or limit the agency from adjusting fees, reimbursement rates,
25 lengths of stay, number of visits, or number of services, or
26 making any other adjustments necessary to comply with the
27 availability of moneys and any limitations or directions
28 provided for in the General Appropriations Act, provided the
29 adjustment is consistent with legislative intent.
30 (2)
31 (b) Subject to any limitations or directions provided for
32 in the General Appropriations Act, the agency shall establish
33 and implement a Florida Title XIX Long-Term Care Reimbursement
34 Plan (Medicaid) for nursing home care in order to provide care
35 and services in conformance with the applicable state and
36 federal laws, rules, regulations, and quality and safety
37 standards and to ensure that individuals eligible for medical
38 assistance have reasonable geographic access to such care.
39 1. Changes of ownership or of licensed operator do not
40 qualify for increases in reimbursement rates associated with the
41 change of ownership or of licensed operator. The agency shall
42 amend the Title XIX Long Term Care Reimbursement Plan to provide

43 that the initial nursing home reimbursement rates, for the
44 operating, patient care, and MAR components, associated with
45 related and unrelated party changes of ownership or licensed
46 operator filed on or after September 1, 2001, are equivalent to
47 the previous owner's reimbursement rate.

48 2. The agency shall amend the long-term care reimbursement
49 plan and cost reporting system to create direct care and
50 indirect care subcomponents of the patient care component of the
51 per diem rate. These two subcomponents together shall equal the
52 patient care component of the per diem rate. Separate cost-based
53 ceilings shall be calculated for each patient care subcomponent.
54 The direct care and indirect care subcomponents ~~subcomponent~~ of
55 the per diem rate ~~shall be limited by the cost-based class~~
56 ~~ceiling, and the indirect care subcomponent~~ shall be limited by
57 the lower of a ~~the~~ cost-based class ceiling, a ~~by the~~ target
58 rate class ceiling, or an ~~by the~~ individual provider target for
59 each subcomponent. ~~The agency shall adjust the patient care~~
60 ~~component effective January 1, 2002.~~ The cost to adjust the
61 direct care subcomponent shall be the net of the total funds
62 previously allocated for the case mix add-on. ~~The agency shall~~
63 ~~make the required changes to the nursing home cost reporting~~
64 ~~forms to implement this requirement effective January 1, 2002.~~

65 3. The direct care subcomponent shall include salaries and
66 benefits of direct care staff providing nursing services
67 including registered nurses, licensed practical nurses, and
68 certified nursing assistants who deliver care directly to
69 residents in the nursing home facility. This excludes nursing

70 administration, MDS, and care plan coordinators, staff
71 development, and staffing coordinator.
72 4. All other patient care costs shall be included in the
73 indirect care cost subcomponent of the patient care per diem
74 rate. There shall be no costs directly or indirectly allocated
75 to the direct care subcomponent from a home office or management
76 company.
77 5. On July 1 of each year, the agency shall report to the
78 Legislature direct and indirect care costs, including average
79 direct and indirect care costs per resident per facility and
80 direct care and indirect care salaries and benefits per category
81 of staff member per facility.
82 6. In order to offset the cost of general and professional
83 liability insurance, the agency shall amend the plan to allow
84 for interim rate adjustments to reflect increases in the cost of
85 general or professional liability insurance for nursing homes.
86 This provision shall be implemented to the extent existing
87 appropriations are available.
88
89 It is the intent of the Legislature that the reimbursement plan
90 achieve the goal of providing access to health care for nursing
91 home residents who require large amounts of care while
92 encouraging diversion services as an alternative to nursing home
93 care for residents who can be served within the community. The
94 agency shall base the establishment of any maximum rate of
95 payment, whether overall or component, on the available moneys
96 as provided for in the General Appropriations Act. The agency

97 may base the maximum rate of payment on the results of
98 scientifically valid analysis and conclusions derived from
99 objective statistical data pertinent to the particular maximum
100 rate of payment.

101 (14) A provider of prescribed drugs shall be reimbursed
102 the least of the amount billed by the provider, the provider's
103 usual and customary charge, or the Medicaid maximum allowable
104 fee established by the agency, plus a dispensing fee.

105 (a) For pharmacies with less than $75,000 in average
106 aggregate monthly payments, the Medicaid maximum allowable fee
107 for ingredient cost will be based on the lower of: average
108 wholesale price (AWP) minus 15.4 percent, wholesaler acquisition
109 cost (WAC) plus 5.75 percent, the federal upper limit (FUL), the
110 state maximum allowable cost (SMAC), or the usual and customary
111 (UAC) charge billed by the provider.

112 (b) For pharmacies with $75,000 or more in average
113 aggregate monthly payments, the Medicaid maximum allowable fee
114 for ingredient cost will be based on the lower of: average
115 wholesale price (AWP) minus 17 percent, wholesaler acquisition
116 cost (WAC) plus 3.5 percent, the federal upper limit (FUL), the
117 state maximum allowable cost (SMAC), or the usual and customary
118 (UAC) charge billed by the provider.

119 (c) Medicaid providers are required to dispense generic
120 drugs if available at lower cost and the agency has not
121 determined that the branded product is more cost-effective,
122 unless the prescriber has requested and received approval to
123 require the branded product. The agency is directed to implement

124 a variable dispensing fee for payments for prescribed medicines
125 while ensuring continued access for Medicaid recipients. The
126 variable dispensing fee may be based upon, but not limited to,
127 either or both the volume of prescriptions dispensed by a
128 specific pharmacy provider, the volume of prescriptions
129 dispensed to an individual recipient, and dispensing of
130 preferred-drug-list products. The agency may increase the
131 pharmacy dispensing fee authorized by statute and in the annual
132 General Appropriations Act by $0.50 for the dispensing of a
133 Medicaid preferred-drug-list product and reduce the pharmacy
134 dispensing fee by $0.50 for the dispensing of a Medicaid product
135 that is not included on the preferred drug list. The agency may
136 establish a supplemental pharmaceutical dispensing fee to be
137 paid to providers returning unused unit-dose packaged
138 medications to stock and crediting the Medicaid program for the
139 ingredient cost of those medications if the ingredient costs to
140 be credited exceed the value of the supplemental dispensing fee.
141 The agency is authorized to limit reimbursement for prescribed
142 medicine in order to comply with any limitations or directions
143 provided for in the General Appropriations Act, which may
144 include implementing a prospective or concurrent utilization
145 review program.
146
147 =========== D I R E C T O R Y A M E N D M E N T ==========
148 Remove line 171 and insert:
149 Section 6. Paragraph (b) of subsection (2) and subsection
150 (14) of section 409.908, Florida Statutes, are amended

151

152 ================ T I T L E A M E N D M E N T =============

153 Remove lines 14 and 15 and insert:

154 F.S.; revising provisions