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LEGISLATIVE ACTION

Senate

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House

Senator Flores moved the following:

Senate Amendment (with title amendment)

Between lines 503 and 504

insert:

Section 8. Effective October 1, 2018, in order to implement Specific Appropriations 217 and 218 of the 2018-2019 General Appropriations Act, section 8 of chapter 2017-129, Laws of Florida, is amended to read:

Section 8. Effective October 1, 2018, subsection (2) of section 409.908, Florida Statutes, is amended to read:

409.908 Reimbursement of Medicaid providers.—Subject to



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12 specific appropriations, the agency shall reimburse Medicaid
13 providers, in accordance with state and federal law, according
14 to methodologies set forth in the rules of the agency and in
15 policy manuals and handbooks incorporated by reference therein.
16 These methodologies may include fee schedules, reimbursement
17 methods based on cost reporting, negotiated fees, competitive
18 bidding pursuant to s. 287.057, and other mechanisms the agency
19 considers efficient and effective for purchasing services or
20 goods on behalf of recipients. If a provider is reimbursed based
21 on cost reporting and submits a cost report late and that cost
22 report would have been used to set a lower reimbursement rate
23 for a rate semester, then the provider's rate for that semester
24 shall be retroactively calculated using the new cost report, and
25 full payment at the recalculated rate shall be effected
26 retroactively. Medicare-granted extensions for filing cost
27 reports, if applicable, shall also apply to Medicaid cost
28 reports. Payment for Medicaid compensable services made on
29 behalf of Medicaid eligible persons is subject to the
30 availability of moneys and any limitations or directions
31 provided for in the General Appropriations Act or chapter 216.
32 Further, nothing in this section shall be construed to prevent
33 or limit the agency from adjusting fees, reimbursement rates,
34 lengths of stay, number of visits, or number of services, or
35 making any other adjustments necessary to comply with the
36 availability of moneys and any limitations or directions
37 provided for in the General Appropriations Act, provided the
38 adjustment is consistent with legislative intent.

39 (2)(a)1. Reimbursement to nursing homes licensed under part
40 II of chapter 400 and state-owned-and-operated intermediate care



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41 facilities for the developmentally disabled licensed under part
42 VIII of chapter 400 must be made prospectively.

43 2. Unless otherwise limited or directed in the General
44 Appropriations Act, reimbursement to hospitals licensed under
45 part I of chapter 395 for the provision of swing-bed nursing
46 home services must be made on the basis of the average statewide
47 nursing home payment, and reimbursement to a hospital licensed
48 under part I of chapter 395 for the provision of skilled nursing
49 services must be made on the basis of the average nursing home
50 payment for those services in the county in which the hospital
51 is located. When a hospital is located in a county that does not
52 have any community nursing homes, reimbursement shall be
53 determined by averaging the nursing home payments in counties
54 that surround the county in which the hospital is located.
55 Reimbursement to hospitals, including Medicaid payment of
56 Medicare copayments, for skilled nursing services shall be
57 limited to 30 days, unless a prior authorization has been
58 obtained from the agency. Medicaid reimbursement may be extended
59 by the agency beyond 30 days, and approval must be based upon
60 verification by the patient's physician that the patient
61 requires short-term rehabilitative and recuperative services
62 only, in which case an extension of no more than 15 days may be
63 approved. Reimbursement to a hospital licensed under part I of
64 chapter 395 for the temporary provision of skilled nursing
65 services to nursing home residents who have been displaced as
66 the result of a natural disaster or other emergency may not
67 exceed the average county nursing home payment for those
68 services in the county in which the hospital is located and is
69 limited to the period of time which the agency considers



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70 necessary for continued placement of the nursing home residents
71 in the hospital.

72 (b) Subject to any limitations or directions in the General
73 Appropriations Act, the agency shall establish and implement a
74 state Title XIX Long-Term Care Reimbursement Plan for nursing
75 home care in order to provide care and services in conformance
76 with the applicable state and federal laws, rules, regulations,
77 and quality and safety standards and to ensure that individuals
78 eligible for medical assistance have reasonable geographic
79 access to such care.

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

98 a. Peer Groups, including:



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- 99 (I) North-SMMC Regions 1-9, less Palm Beach and Okeechobee
- 100 Counties; and
- 101 (II) South-SMMC Regions 10-11, plus Palm Beach and
- 102 Okeechobee Counties.
- 103 b. Percentage of Median Costs based on the cost reports
- 104 used for September 2016 rate setting:
- 105 (I) Direct Care Costs.....105 ~~100~~ percent.
- 106 (II) Indirect Care Costs.....92 percent.
- 107 (III) Operating Costs.....86 percent.
- 108 c. Floors:
- 109 (I) Direct Care Component.....95 percent.
- 110 (II) Indirect Care Component.....92.5 percent.
- 111 (III) Operating Component.....None.
- 112 d. Pass-through Payments...Real Estate and Personal Property
- 113 Taxes and Property Insurance.
- 114 e. Quality Incentive Program Payment Pool...7.5 ~~6~~ percent of
- 115 September 2016 non-property related payments of included
- 116 facilities.
- 117 f. Quality Score Threshold to Quality for Quality Incentive
- 118 Payment.....20th percentile of included facilities.
- 119 g. Fair Rental Value System Payment Parameters:
- 120 (I) Building Value per Square Foot based on 2018 RS Means.
- 121 (II) Land Valuation.....10 percent of Gross Building value.
- 122 (III) Facility Square Footage.....Actual Square Footage.
- 123 (IV) Moveable Equipment Allowance.....\$8,000 per bed.
- 124 (V) Obsolescence Factor.....1.5 percent.
- 125 (VI) Fair Rental Rate of Return.....8 percent.
- 126 (VII) Minimum Occupancy.....90 percent.
- 127 (VIII) Maximum Facility Age.....40 years.



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128 (IX) Minimum Square Footage per Bed.....350.

129 (X) Maximum Square Footage for Bed.....500.

130 (XI) Minimum Cost of a renovation/replacements.\$500 per bed.

131 h. Ventilator Supplemental payment of \$200 per Medicaid day
132 of 40,000 ventilator Medicaid days per fiscal year.

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

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

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

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



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157 provider.

158 6. A direct care supplemental payment may be made to
159 providers whose direct care hours per patient day are above the
160 80th percentile and who provide Medicaid services to a larger
161 percentage of Medicaid patients than the state average.

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

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

178

179 It is the intent of the Legislature that the reimbursement plan
180 achieve the goal of providing access to health care for nursing
181 home residents who require large amounts of care while
182 encouraging diversion services as an alternative to nursing home
183 care for residents who can be served within the community. The
184 agency shall base the establishment of any maximum rate of
185 payment, whether overall or component, on the available moneys



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186 as provided for in the General Appropriations Act. The agency
187 may base the maximum rate of payment on the results of
188 scientifically valid analysis and conclusions derived from
189 objective statistical data pertinent to the particular maximum
190 rate of payment.

191 Section 9. Effective October 1, 2018, in order to implement
192 Specific Appropriations 217 and 218 of the 2018-2019 General
193 Appropriations Act, subsection (23) of section 409.908, Florida
194 Statutes, is amended to read:

195 409.908 Reimbursement of Medicaid providers.—Subject to
196 specific appropriations, the agency shall reimburse Medicaid
197 providers, in accordance with state and federal law, according
198 to methodologies set forth in the rules of the agency and in
199 policy manuals and handbooks incorporated by reference therein.
200 These methodologies may include fee schedules, reimbursement
201 methods based on cost reporting, negotiated fees, competitive
202 bidding pursuant to s. 287.057, and other mechanisms the agency
203 considers efficient and effective for purchasing services or
204 goods on behalf of recipients. If a provider is reimbursed based
205 on cost reporting and submits a cost report late and that cost
206 report would have been used to set a lower reimbursement rate
207 for a rate semester, then the provider's rate for that semester
208 shall be retroactively calculated using the new cost report, and
209 full payment at the recalculated rate shall be effected
210 retroactively. Medicare-granted extensions for filing cost
211 reports, if applicable, shall also apply to Medicaid cost
212 reports. Payment for Medicaid compensable services made on
213 behalf of Medicaid eligible persons is subject to the
214 availability of moneys and any limitations or directions



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215 provided for in the General Appropriations Act or chapter 216.
216 Further, nothing in this section shall be construed to prevent
217 or limit the agency from adjusting fees, reimbursement rates,
218 lengths of stay, number of visits, or number of services, or
219 making any other adjustments necessary to comply with the
220 availability of moneys and any limitations or directions
221 provided for in the General Appropriations Act, provided the
222 adjustment is consistent with legislative intent.

223 (23) (a) The agency shall establish rates at a level that
224 ensures no increase in statewide expenditures resulting from a
225 change in unit costs for county health departments effective
226 July 1, 2011. Reimbursement rates shall be as provided in the
227 General Appropriations Act.

228 (b) 1. Base rate reimbursement for inpatient services under
229 a diagnosis-related group payment methodology shall be provided
230 in the General Appropriations Act.

231 2. ~~(e)~~ Base rate reimbursement for outpatient services under
232 an enhanced ambulatory payment group methodology shall be
233 provided in the General Appropriations Act.

234 3. Prospective payment system reimbursement for nursing
235 home services shall be as provided in subsection (2) and in the
236 General Appropriations Act

237 ~~(d) This subsection applies to the following provider~~
238 ~~types:~~

239 ~~1. Nursing homes.~~

240 ~~2. County health departments.~~

241 ~~(e) The agency shall apply the effect of this subsection to~~
242 ~~the reimbursement rates for nursing home diversion programs.~~

243 Section 10. The amendments made by this act to ss.



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244 409.908(2) and (23), Florida Statutes, expire July 1, 2019, and
245 the text of those subsections shall revert to that in existence
246 on October 1, 2018, not including any amendments made by this
247 act, except that any amendments to such text enacted other than
248 by this act shall be preserved and continue to operate to the
249 extent that such amendments are not dependent upon the portions
250 of text which expire pursuant to this section.

251 Section 11. Effective upon this act becoming a law, in
252 order to implement Specific Appropriations 199, 203, 204, 206,
253 208, and 217 of the 2018-2019 General Appropriations Act, the
254 Agency for Health Care Administration shall seek authorization
255 from the federal Centers for Medicare and Medicaid Services to
256 modify the period of retroactive Medicaid eligibility from 90
257 days to 30 days in a manner that ensures that the modification
258 becomes effective on July 1, 2018.

259
260 ===== T I T L E A M E N D M E N T =====

261 And the title is amended as follows:

262 Between lines 47 and 48

263 insert:

264 amending s. 409.908, F.S.; revising parameters
265 relating to the prospective payment methodology for
266 the reimbursement of Medicaid providers to be
267 implemented for rate-setting purposes; requiring the
268 agency to establish prospective payment reimbursement
269 rates for nursing home services as provided in this
270 act and in the General Appropriations Act; providing
271 for the future expiration and reversion of specified
272 statutory text; requiring the Agency for Health Care



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273 Administration to seek authorization from the federal
274 Centers for Medicare and Medicaid Services to modify
275 the period of retroactive Medicaid eligibility in a
276 manner that ensures that the modification becomes
277 effective by a certain date;