By the Committee on Appropriations

576-02708-18 20182506__

A bill to be entitled

An act relating to health care; amending s. 381.915, F.S.; increasing the number of years that a cancer center may participate in Tier 3 of the Florida Consortium of National Cancer Institute Centers Program; increasing the number of years after qualification that a certain Tier 3 cancer center may pursue specified NCI designations; amending s. 409.908, F.S.; removing the Agency for Health Care Administration's authority to establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for Class III psychiatric hospitals; revising parameters relating to the prospective payment methodology for the reimbursement of Medicaid providers to be implemented for rate setting purposes; requiring the agency to establish prospective payment reimbursement rates for nursing home services as provided in this act and in the General Appropriations Act; conforming provisions to changes made by the act; amending s. 409.9082, F.S.; authorizing the agency to seek certain remedies from any nursing home facility provider that fails to report its total number of resident days monthly, including the imposition of a specified fine; amending s. 409.9083, F.S.; authorizing the agency to seek certain remedies from any intermediate care facility for the developmentally disabled provider that fails to report its total number of resident days monthly, including the imposition of a specified fine; amending

s. 409.909, F.S.; revising the definition of the term "qualifying institution" to include certain licensed substance abuse treatment facilities for purposes of the Statewide Medicaid Residency Program; amending s. 409.968, F.S.; revising the rate-setting methodology used in the reimbursement of Class III psychiatric hospitals; amending s. 409.906, F.S.; conforming a cross-reference; requiring the agency to seek authorization from the federal Centers for Medicare and Medicaid Services to modify the period of retroactive Medicaid eligibility in a manner that ensures that the modification becomes effective by a certain date; requiring the agency to contract with a nonprofit organization in Miami-Dade County, which must meet certain requirements, to be a site for the Program for All-inclusive Care for the Elderly (PACE), subject to federal approval of the application site; requiring the nonprofit organization to provide PACE services to frail elders in Miami-Dade County; requiring the agency, in consultation with the Department of Elderly Affairs, to approve up to a certain number of initial enrollees in PACE at the new site, subject to an appropriation; providing effective dates.

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

Section 1. Paragraph (c) of subsection (4) of section 381.915, Florida Statutes, is amended to read:

381.915 Florida Consortium of National Cancer Institute Centers Program.—

(4) Tier designations and corresponding weights within the Florida Consortium of National Cancer Institute Centers Program are as follows:

(c) Tier 3: Florida-based cancer centers seeking designation as either a NCI-designated cancer center or NCI-designated comprehensive cancer center, which shall be weighted at 1.0.

1. A cancer center shall meet the following minimum criteria to be considered eligible for Tier 3 designation in any given fiscal year:

a. Conducting cancer-related basic scientific research and cancer-related population scientific research;

b. Offering and providing the full range of diagnostic and treatment services on site, as determined by the Commission on Cancer of the American College of Surgeons;

c. Hosting or conducting cancer-related interventional clinical trials that are registered with the NCI's Clinical Trials Reporting Program;

d. Offering degree-granting programs or affiliating with universities through degree-granting programs accredited or approved by a nationally recognized agency and offered through the center or through the center in conjunction with another institution accredited by the Commission on Colleges of the Southern Association of Colleges and Schools;

e. Providing training to clinical trainees, medical trainees accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, and

postdoctoral fellows recently awarded a doctorate degree; and

f. Having more than $5 million in annual direct costs associated with their total NCI peer-reviewed grant funding.

2. The General Appropriations Act or accompanying legislation may limit the number of cancer centers which shall receive Tier 3 designations or provide additional criteria for such designation.

3. A cancer center's participation in Tier 3 shall be limited to 6 ~~5~~ years.

4. A cancer center that qualifies as a designated Tier 3 center under the criteria provided in subparagraph 1. by July 1, 2014, is authorized to pursue NCI designation as a cancer center or a comprehensive cancer center for 6 ~~5~~ years after qualification.

Section 2. Paragraph (a) of subsection (1) 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.

(1) Reimbursement to hospitals licensed under part I of chapter 395 must be made prospectively or on the basis of negotiation.

(a) Reimbursement for inpatient care is limited as provided in s. 409.905(5), except as otherwise provided in this subsection.

1. If authorized by the General Appropriations Act, the agency may modify reimbursement for specific types of services or diagnoses, recipient ages, and hospital provider types.

2. The agency may establish an alternative methodology to the DRG-based prospective payment system to set reimbursement rates for:

a. State-owned psychiatric hospitals.

b. Newborn hearing screening services.

c. Transplant services for which the agency has established a global fee.

d. Recipients who have tuberculosis that is resistant to therapy who are in need of long-term, hospital-based treatment pursuant to s. 392.62.

~~e. Class III psychiatric hospitals.~~

3. The agency shall modify reimbursement according to other methodologies recognized in the General Appropriations Act.

The agency may receive funds from state entities, including, but not limited to, the Department of Health, local governments, and other local political subdivisions, for the purpose of making special exception payments, including federal matching funds, through the Medicaid inpatient reimbursement methodologies. Funds received for this purpose shall be separately accounted for and may not be commingled with other state or local funds in any manner. The agency may certify all local governmental funds used as state match under Title XIX of the Social Security Act, to the extent and in the manner authorized under the General Appropriations Act and pursuant to an agreement between the agency and the local governmental entity. In order for the agency to certify such local governmental funds, a local governmental entity must submit a final, executed letter of agreement to the agency, which must be received by October 1 of each fiscal year and provide the total amount of local governmental funds authorized by the entity for that fiscal year under this paragraph, paragraph (b), or the General Appropriations Act. The local governmental entity shall use a certification form prescribed by the agency. At a minimum, the

certification form must identify the amount being certified and describe the relationship between the certifying local governmental entity and the local health care provider. The agency shall prepare an annual statement of impact which documents the specific activities undertaken during the previous fiscal year pursuant to this paragraph, to be submitted to the Legislature annually by January 1.

Section 3. Effective October 1, 2018, subsection (2) of section 409.908, Florida Statutes, as amended by 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 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.....105 ~~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...7.5 ~~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.

Section 4. Effective October 1, 2018, subsection (23) 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.

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

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

2. ~~(c)~~ Base rate reimbursement for outpatient services under an enhanced ambulatory payment group methodology shall be

provided in the General Appropriations Act.

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

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

~~1. Nursing homes.~~

~~2. County health departments.~~

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

Section 5. Subsection (7) of section 409.9082, Florida Statutes, is amended to read:

409.9082 Quality assessment on nursing home facility providers; exemptions; purpose; federal approval required; remedies.—

(7) The agency may seek any of the following remedies for failure of any nursing home facility provider to report its total number of resident days monthly or to pay its assessment timely:

(a) Withholding any medical assistance reimbursement payments until such time as the assessment amount is recovered;

(b) Suspension or revocation of the nursing home facility license; and

(c) Imposition of a fine of up to $1,000 per day for each offense ~~delinquent payment~~, not to exceed the amount of the assessment.

Section 6. Subsection (6) of section 409.9083, Florida Statutes, is amended to read:

409.9083 Quality assessment on privately operated

intermediate care facilities for the developmentally disabled; exemptions; purpose; federal approval required; remedies.—

(6) The agency may seek any of the following remedies for failure of any ICF/DD provider to report its total number of resident days monthly or to timely pay its assessment:

(a) Withholding any medical assistance reimbursement payments until the assessment amount is recovered.

(b) Suspending or revoking the facility's license.

(c) Imposing a fine of up to $1,000 per day for each offense ~~delinquent payment~~, not to exceed the amount of the assessment.

Section 7. Paragraph (c) of subsection (2) of section 409.909, Florida Statutes, is amended to read:

409.909 Statewide Medicaid Residency Program.—

(2) On or before September 15 of each year, the agency shall calculate an allocation fraction to be used for distributing funds to participating hospitals and to qualifying institutions as defined in paragraph (c). On or before the final business day of each quarter of a state fiscal year, the agency shall distribute to each participating hospital one-fourth of that hospital's annual allocation calculated under subsection (4). The allocation fraction for each participating hospital is based on the hospital's number of full-time equivalent residents and the amount of its Medicaid payments. As used in this section, the term:

(c) "Qualifying institution" means a federally Qualified Health Center holding an Accreditation Council for Graduate Medical Education institutional accreditation or a substance abuse treatment facility licensed under chapter 397 which has

housed residents and fellows since 2013.

Section 8. Present subsections (4) and (5) of section 409.968, Florida Statutes, are redesignated as subsections (5) and (6), respectively, and a new subsection (4) is added to that section, to read:

409.968 Managed care plan payments.—

(4) Reimbursement for Class III psychiatric hospitals is not defined by the agency's inpatient hospital APR-DRG compensation methodology and must be established using the federal Centers for Medicare and Medicaid Services prospective payment system pricing methodology or be limited to compensation amounts agreed to by the plan and the hospital.

Section 9. Paragraph (d) of subsection (13) of section 409.906, Florida Statutes, is amended to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. 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 or

chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(13) HOME AND COMMUNITY-BASED SERVICES.—

(d) The agency shall seek federal approval to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. Payments may be made as enhanced capitation rates or incentive payments to managed care plans that meet the requirements of s. 409.968(5) ~~s. 409.968(4)~~.

Section 10. The Agency for Health Care Administration shall seek authorization from the federal Centers for Medicare and Medicaid Services to modify the period of retroactive Medicaid eligibility from 90 days to 30 days in a manner that ensures that the modification becomes effective on July 1, 2018.

Section 11. Effective July 1, 2018, and subject to federal approval of the application to be a site for the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with an additional nonprofit organization to serve individuals and families in Miami-Dade County. The nonprofit organization must have a history of serving primarily the Hispanic population by providing primary care services, nutrition, meals, and adult day care to the senior population. The nonprofit organization shall leverage existing community-based care providers and health care

organizations to provide PACE services to frail elders who reside in Miami-Dade County. The organization is exempt from the requirements of chapter 641, Florida Statutes. The agency, in consultation with the Department of Elderly Affairs and subject to an appropriation, shall approve up to 250 initial enrollees in the PACE site established by this organization to serve frail elders who reside in Miami-Dade County.

Section 12. Except as expressly provided in this act, this act shall take effect upon becoming a law.