By the Committee on Appropriations

576-03180-23 20232510__

A bill to be entitled

An act relating to health; amending s. 296.37, F.S.; increasing the income threshold for certain contributions required by residents of veterans' nursing homes; amending s. 409.814, F.S.; revising eligibility conditions for participation in the Florida Kidcare program; amending s. 409.908, F.S.; revising the payment methodology for a certain component of the state Title XIX Long-Term Care Reimbursement Plan for nursing home care; amending s. 409.909, F.S.; establishing the Slots for Doctors Program for a specified purpose; requiring the Agency for Health Care Administration to allocate a specified amount to hospitals and qualifying institutions for certain newly created resident positions for specified physician specialties or subspecialties; providing construction; prohibiting the use of allocated funds under the program for resident positions that have previously received certain other funding; amending s. 409.967, F.S.; revising the criteria for determining achieved savings rebates for purposes of Medicaid prepaid plans; amending s. 430.204, F.S.; authorizing area agencies on aging to carry forward a specified percentage of documented unexpended state funds to a subsequent fiscal year, subject to certain conditions; requiring the remainder of such state funds to be returned to the Department of Elderly Affairs; providing an effective date.

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

Section 1. Subsection (1) of section 296.37, Florida Statutes, is amended to read:

296.37 Residents; contribution to support.—

(1) Every resident of the home who receives a pension, compensation, or gratuity from the United States Government, or income from any other source of more than $160 ~~$130~~ per month, shall contribute to his or her maintenance and support while a resident of the home in accordance with a schedule of payment determined by the administrator and approved by the director. The total amount of such contributions shall be to the fullest extent possible but may not exceed the actual cost of operating and maintaining the home.

Section 2. Subsection (7) of section 409.814, Florida Statutes, is amended to read:

409.814 Eligibility.—A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. If an enrolled individual is determined to be ineligible for coverage, he or she must be immediately disenrolled from the respective Florida Kidcare program component.

(7) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under ~~the provisions of~~ subsection (5) may participate in the Florida Kidcare program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program, subject to the following:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the combined-risk premium, including any administrative costs.

(b) The board of directors of the Florida Healthy Kids Corporation may offer a reduced benefit package to these children in order to limit program costs for such families.

Section 3. Paragraph (b) of 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)

(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.....10 ~~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 4. Present subsections (6) and (7) of section 409.909, Florida Statutes, are redesignated as subsections (7) and (8), respectively, and a new subsection (6) is added to that section, to read:

409.909 Statewide Medicaid Residency Program.—

(6) The Slots for Doctors Program is established to address the physician workforce shortage by increasing the supply of highly trained physicians through the creation of new resident positions, which will increase access to care and improve health outcomes for Medicaid recipients.

(a) The agency shall allocate $100,000 to hospitals and qualifying institutions for each newly created resident position that is accredited by the Accreditation Council for Graduate Medical Education or the Osteopathic Postdoctoral Training

Institution in an initial or established accredited training program which is in a physician specialty or subspecialty in a statewide supply-and-demand deficit.

(b) This program is designed to generate matching funds under Medicaid and distribute such funds to participating hospitals and qualifying institutions on a quarterly basis in each fiscal year for which an appropriation is made.

(c) For purposes of this subsection, physician specialties and subspecialties, both adult and pediatric, in statewide supply-and-demand deficit are those identified as such in the General Appropriations Act.

(d) Funds allocated pursuant to this subsection may not be used for resident positions that have previously received funding pursuant to subsection (1).

Section 5. Paragraph (f) of subsection (3) of section 409.967, Florida Statutes, is amended to read:

409.967 Managed care plan accountability.—

(3) ACHIEVED SAVINGS REBATE.—

(f) Achieved savings rebates validated by the certified public accountant are due within 30 days after the report is submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent shall be refunded to the state and adjusted for the Federal

Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state and adjusted for the Federal Medical Assistance Percentages. The state share shall be transferred to the General Revenue Fund, unallocated, and the federal share shall be transferred to the Medical Care Trust Fund, unallocated.

Section 6. Subsection (10) is added to section 430.204, Florida Statutes, to read:

430.204 Community-care-for-the-elderly core services; departmental powers and duties.—

(10) An area agency on aging may carry forward documented unexpended state funds from one fiscal year to the next; however, the cumulative amount carried forward may not exceed 10 percent of the area agency's planning and service area allocation for the community care for the elderly program. Any unexpended state funds in excess of that percentage must be returned to the department.

(a) The funds carried forward may not be used in any manner that would create increased recurring future obligations, and such funds may not be used for any type of program or service that is not currently authorized by existing contracts.

(b) Expenditures of funds carried forward must be separately reported to the department.

(c) Any unexpended funds that remain at the end of the contract period must be returned to the department.

(d) Funds carried forward may be retained through any contract renewals and any new procurements as long as the same area agency on aging is retained by the department.

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