A bill to be entitled

An act relating to health care provider accountability; amending s. 400.141, F.S.; requiring nursing home facilities to report to the Agency for Health Care Administration common ownerships they or their parent companies share with certain entities; requiring the agency to work with stakeholders to determine how such reporting shall be conducted; requiring the agency to submit a report of such reported common ownerships to the Governor and Legislature by a specified date each year; requiring the agency to adopt rules; amending s. 400.211, F.S.; requiring the agency to submit a report on the success of the personal care attendant program to the Governor and Legislature by a specified date each year; providing requirements for the report; amending s. 409.908, F.S.; revising the rate methodology for the agency's long-term care reimbursement plan; providing an effective date.

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

Section 1. Paragraph (x) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home

facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(x) Report to the agency any common ownership the facility or its parent company shares with a staffing or management company, a vocational or physical rehabilitation company, or any other company that conducts business within the nursing home facility. The agency shall work with stakeholders to determine how this reporting shall be conducted. By January 15 of each year, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on all common ownerships reported to the agency in the preceding calendar year. The agency shall adopt rules to implement this paragraph.

Section 2. Subsection (2) of section 400.211, Florida Statutes, is amended to read:

400.211 Persons employed as nursing assistants; certification requirement; qualified medication aide designation and requirements.—

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a single consecutive period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program.

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state.

(c) Persons who have preliminarily passed the state's certification exam.

(d) Persons who are employed as personal care attendants and who have completed the personal care attendant training program developed pursuant to s. 400.141(1)(w). As used in this paragraph, the term "personal care attendants" means persons who meet the training requirement in s. 400.141(1)(w) and provide care to and assist residents with tasks related to the activities of daily living.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility. On January 1 of each year, the agency shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the success of this program including, but not limited to, how many personal care attendants take and subsequently pass the certified nursing assistant exam after the 4 months of initial employment with a single nursing facility, any adverse actions related to patient care involving personal care attendants, how many new certified nursing assistants are employed and remain employed each year after being employed as personal care attendants, and the

turnover rate of personal care attendants in nursing facilities.

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 ..... 100~~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 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) Movable 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. This act shall take effect July 1, 2024.