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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/28/2025	.	
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The Appropriations Committee on Health and Human Services (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete lines 224 - 430

and insert:

through (16), respectively, a new subsection (7) is added to that section, and subsections (5) and (6) of that section are amended, to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

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(5) Within 120 days after the end of its fiscal year, each nursing home as defined in s. 408.07, excluding nursing homes operated by state agencies, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports that are certified to be complete and accurate by the chief financial officer of the nursing home. However, a nursing home's actual financial experience shall be its audited actual experience. This audited actual experience must include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and must be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The financial statements must tie to the information submitted in the uniform system of financial reporting, and a crosswalk must be submitted along with the financial statements.

(6) Within 120 days after the end of its fiscal year, the home office of each nursing home as defined in s. 408.07, excluding nursing homes operated by state agencies, shall file with the agency, on forms adopted by the agency and based on the uniform system of financial reporting, its actual financial experience for that fiscal year, including expenditures, revenues, and statistical measures. Such data may be based on internal financial reports that are certified to be complete and accurate by the chief financial officer of the nursing home. However, the home office's actual financial experience shall be its audited actual experience. This audited actual experience

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must include the fiscal year-end balance sheet, income statement, statement of cash flow, and statement of retained earnings and must be submitted to the agency in addition to the information filed in the uniform system of financial reporting. The financial statements must tie to the information submitted in the uniform system of financial reporting, and a crosswalk must be submitted along with the audited financial statements.

(7)(a) Beginning January 1, 2026, the agency shall impose an administrative fine of $10,000 per violation against a nursing home or home office that fails to comply with subsection (5) or subsection (6), as applicable. For purposes of this paragraph, the term "violation" means failing to file the financial report required by subsection (5) or subsection (6), as applicable, on or before the report's due date. Failing to file the report during any subsequent 10-day period occurring after the due date constitutes a separate violation until the report has been submitted.

(b) The agency shall adopt rules to implement this subsection. The rules must include provisions for a nursing home or home office to present factors in mitigation of the imposition of the fine's full dollar amount. The agency may determine not to impose the fine's full dollar amount upon a showing that the full fine is inappropriate under the circumstances.

Section 6. Subsection (2) of section 408.08, Florida Statutes, is amended to read:

408.08 Inspections and audits; violations; penalties; fines; enforcement.—

(2) Any health care facility that refuses to file a report,

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fails to timely file a report, files a false report, or files an incomplete report and upon notification fails to timely file a complete report required under s. 408.061; that violates this section, s. 408.061, or s. 408.20, or rule adopted thereunder; or that fails to provide documents or records requested by the agency under this chapter shall be punished by a fine not exceeding $1,000 per day for each day in violation, to be imposed and collected by the agency. Pursuant to rules adopted by the agency, the agency may, upon a showing of good cause, grant a one-time extension of any deadline for a health care facility to timely file a report as required by this section, s. 408.061, or s. 408.20. A facility fined under s. 408.061(7) may not be additionally fined under this subsection for the same violation.

Section 7. 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

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.....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 Qualify ~~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 agency shall revise its methodology for calculating Quality Incentive Program payments to include the results of consumer satisfaction surveys conducted pursuant to s. 400.0225 as a measure of nursing home quality. The agency shall so revise the methodology after the surveys have been in effect for an amount of time the agency deems sufficient for statistical and scientific validity as a meaningful quality measure that may be

incorporated into the methodology.

3. 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.

4.~~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.

5.~~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.

6.~~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.

7.~~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

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percentage of Medicaid patients than the state average.

8.~~7.~~ 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.

9. By October 1, 2025, and each year thereafter, the agency shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report on each Quality Incentive Program payment made pursuant to sub-subparagraph 1.e. The report must, at a minimum, include all of the following information:

a. The name of each facility that received a Quality Incentive Program payment and the dollar amount of such payment each facility received.

b. The total number of quality incentive metric points awarded by the agency to each facility and the number of points awarded by the agency for each individual quality metric measured.

c. An examination of any trends in the improvement of the quality of care provided to nursing home residents which may be attributable to incentive payments received under the Quality Incentive Program. The agency shall include examination of trends both for the program as a whole as well as for each individual quality metric used by the agency to award program payments.

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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 8. (1) To support and enhance quality outcomes in Florida's nursing homes, the Agency for Health Care Administration shall contract with a third-party vendor to conduct a comprehensive study of nursing home quality incentive programs in other states.

(a) At a minimum, the study must include a detailed analysis of quality incentive programs implemented in each of the states examined, identify components of such programs which have demonstrably improved nursing home quality outcomes, and provide recommendations to modify or enhance this state's existing Medicaid Quality Incentive Program based on its historical performance and trends since it was first implemented.

(b) The study must also include:

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1. An in-depth review of emerging and existing technologies applicable to nursing home care and an analysis of how their adoption in this state could improve quality of care and operational efficiency; and

2. An examination of other states' Medicaid add-on payment structures related to the provision of ventilator care, bariatric services, and behavioral health services.

(2) The agency shall submit a final report on the study, including findings and actionable recommendations, to the Governor, the President of the Senate, and the Speaker of the House of Representatives by December 1, 2025.

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

And the title is amended as follows:

Delete lines 42 - 55

and insert:

408.061, F.S.; exempting nursing homes operated by state agencies from certain financial reporting requirements; requiring the agency to impose administrative fines against nursing homes and home offices of nursing homes for failing to comply with certain reporting requirements; defining the term "violation"; providing construction; requiring the agency to adopt rules; providing requirements for such rules; amending s. 408.08, F.S.; prohibiting nursing homes subject to certain administrative fines from being fined under a specified provision for the same violation; amending s. 409.908, F.S.; requiring the agency to revise its methodology for calculating


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Quality Incentive Program payments; providing requirements for such revision; requiring the agency to submit an annual report to the Governor and the Legislature on payments made under the Quality Incentive Program; specifying requirements for the report; requiring the agency to contract with a third-party vendor to conduct a comprehensive study of nursing home quality incentive programs in other states; providing minimum requirements for the report; requiring the agency to submit a final report on the study to the Governor and the Legislature by a specified date; providing an effective