Appropriations Conference Chairs

Bump Issues

House Health Care Appropriations Subcommittee /
Senate Appropriations Subcommittee on Health and Human Services

SENATE OFFER #1

Implementing Bill

Saturday, March 14, 2020
4:30 p.m.
212 Knott Building

FY 2020-2021 Implementing Bill
House Health Care Appropriations Subcommittee / Senate Health and Human Services Appropriations
Senate BUMP Offer #1

Line	HB 5003 Section	SB 2502 Section	Description	House Offer #1	Senate BUMP Offer #1	BUMP
1	4	13	**MEDICAID HOSPITAL FUNDING PROGRAMS.** Provides the calculations for the Medicaid Disproportionate Share Hospital, and Hospital Reimbursement programs, for the 2020-2021 fiscal year contained in the document titled "Medicaid ~~Disproportionate Share Hospital and~~ Hospital ~~Reimbursement~~ Funding Programs," are incorporated by reference for the purpose of displaying the calculations used by the Legislature.	**House Modified**	**Senate Accepts House Offer #1**	**BUMP**
2	5	14	**STATEWIDE MEDICAID MANAGED CARE REALIGNMENT- AHCA/DOH.** Authorizes AHCA & DOH to submit a budget amendment to realign funding within and between agencies based on the implementation of the Managed Medical Assistance component of the Statewide Medicaid Managed Care porgram for the Children's Medical Services program within DOH. The funding realignment shall reflect the actual enrollment changes due to the transfer of beneficiaries from fee-for-service to the capitated Children's Medical Services Network. Also authorizes AHCA to submit a request for non-operating budget authority to transfer the federal funds to the Department of Health, pursuant to s. 216.181(12), Florida Statutes.	**Identical**	**Senate Accepts House Offer #1**	**BUMP**
3	N/A	15&16	**MEDICAID NURSING HOME PROSPECTIVE PAYMENT.** Amends s. 409.908(23), F.S., relating to Medicaid rate setting for specified provider types, to specify the prospective payment system reimbursement for nursing home services will be governed by s. 409.908(2), F.S., and the General Appropriations Act. Language relating to county health department reimbursement is restructured but not changed substantively.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
4	N/A	17&18	**LOW INCOME POOL**. Amends s. 409.908(26), F.S, to include Low Income Pool (LIP) payments and requires that Letters of Agreement for LIP be received by AHCA by October 1 and the funds outlined in the Letters of Agreement be received by October 31. **Senate Modified to also inlcude Senate Attachment #1 to replace House Modified Offer**	**House Modified**	**Senate Modified - See Senate Attachment 1**	**BUMP**
5	N/A	19	**MEDICAID RETROACTIVE ELIGIBILITY.** Requires AHCA to see authorization from federal Centers for Medicare and Medicaid to eliminate the Medicaid retroactive eligibility period for nonpregnant adults in a manner that ensures that the elimination becomes effective July 1, 2020. Eligibility will continue to begin the first day of the month in which a nonpregnant adult applied for Medicaid.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**

Line	HB 5003 Section	SB 2502 Section	Description	House Offer #1	Senate BUMP Offer #1	BUMP
6	N/A	20	**RETROACTIVE MEDICAID ELIGIBILTY REPORT.** Requires AHCA to submit ~~a report~~ the Medicaid Managed Care waiver independent evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the impact of the waiver on Medicaid retroactive eligibility on beneficiaries and providers. Senate Modified Language: In order to implement Specific Appropriations 207, 211, 212, 214, 216, and 225 of the 2020-2021 General Appropriations Act, by March 1, 2021, the Agency for Health Care Administration shall submit the Medicaid Managed Care waiver independent evaluation to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the impact of the waiver of Medicaid retroactive eligibility on beneficiaries and providers. The evaluation shall include, but is not limited to: (1) Analysis of how the waiver of Medicaid retroactive eligibility impacted enrollment continuity. (2) Information on how hospitals and nursing facilities have changed their enrollment procedures following the waiver of Medicaid retroactive eligibility. (3) The impact of the waiver of retroactive eligibility on enrollee financial burden. (4) The impact of the waiver of retroactive eligibility on provider uncompensated care. (5) The impact of the waiver of retroactive eligibility on provider financial performance. (6) Additional recommendations to improve outreach to nonpregnant adults who would be eligible for Medicaid if they applied before an event that requires hospital or nursing facility care. This section expires July 1, 2021.	**House No Language**	**Senate Modified Language**	**BUMP**
7	N/A	21&22	**FLORIDA HEALTHY KIDS CORPORATION/MEDICAL LOSS RATIO.** Amends s. 624.91(5)(b). F.S., to require the Florida Healthy Kids Corporation to validate and calculate a refund amount for Title XXI providers who achieve a Medical Loss Ratio below 85 percent. These refunds shall be deposited into the General Revenue Fund, unallocated.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
8	N/A	23&24	**FLORIDA CONSORTIUM OF NATIONAL CANCER INSTITUTE CENTERS PROGRAM.** Amends s. 381.915, F.S. to provide that a cancer center's participation in Tier 3 may not extend beyond July 1, 2021.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
9	N/A	25	**PRESCRIPTION DRUG MONITORING PROGRAM.** Prohibits use of settlement funds for program.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
10	N/A	26-28	**DISPROPORTIONATE SHARE HOSPITAL PROGRAM.** Amends s. 409.911, F.S. to direct AHCA to distribute moneys to hospitals providing a disproportionate share of Medicaid or charity care services as provided in the General Appropriations Act (GAA). Also modifies years of audited data that shall be used in calculating disproportionate share payment. Amends s. 409.9113, F.S., to direct AHCA to make disproportionate share payments to teaching hospitals as provided in the GAA. Amends s. 409.9119, F.S. to direct AHCA to make disproportionate share payments to specialty hospitals for children.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
11	6	29	**AHCA-MEDICAID BUDGET AMENDMENT.** Authorization for AHCA to realign Medicaid Expenditure categories without LBC approval to maximize use of state trust funds and pay expenditures in the appropriate category.	**Identical**	**Senate Accepts House Offer #1**	**BUMP**
12	N/A	30	**PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.** Provides for PACE organization to serve persons in Escambia, Okaloosa and Santa Rosa Counties.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**

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12a	N/A	TBD	**PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.** Provides for PACE organization to serve persons in Hillsborough, Hernando, or Pasco Counties. Proposed Language: Subject to federal approval of an application to be a provider of the Program of All-inclusive Care for the Elderly (PACE), the Agency for Health Care Administration shall contract with a private organization that has demonstrated the ability to operate PACE centers in more than one state and that serves more than 500 eligible PACE participants, to provide PACE services to frail elders who reside in Hillsborough, Hernando or Pasco Counties. 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 the appropriation of funds by the Legislature, shall approve up to 500 initial enrollees in the PACE program established by the organization to serve frail elders who reside in Hillsborough, Hernando or Pasco Counties.		**Senate New Language**	
13	7	31	**AHCA BUDGET AMENDMENTS FOR FLORIDA KIDCARE.** Authorization for AHCA and DOH to realign KidCare expenditure categories without LBC approval to maximize use of state trust funds and pay expenditures in the appropriate category.	**Identical**	**Senate Accepts House Offer #1**	**BUMP**
14	8	32-33	**DEPARTMENT OF HEALTH RULE ADOPTION - MEDICAL MARIJUANA.** Amends s. 381.986, F.S. to provide that the Department of Health is not required to prepare a statement of estimated regulatory costs when promulgating rules relating to medical marijuana testing laboratories, and any such rules adopted prior to July 1, 2021, are exempt from the legislative ratification provision of s. 120.541(3), F.S. Medical marijuana treatment centers are authorized to use a laboratory that has not been certified by the department until rules relating to medical marijuana testing laboratories are adopted by the department, but no later than July 1, 2021. Senate bill: Also amends s. 381.988, F.S.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
15	N/A	34-35	**DEPARTMENT OF HEALTH RULE ADOPTION - MEDICAL MARIJUANA.** Amends subsection (1) of section 14 of chapter 2017-232, Laws of Florida, to provide emergency rulemaking authority to the Department of Health to adopt rules necessary to implement provisions of s. 381.986, F.S., and to provide that rules adopted under the nonremergency rulemating procedures of the Administrative Procedures Act to replace emergency rules adopted under section 14 of ch. 2017-232, L.O.F., are exempt from the legislative ratification provisions of ss. 120.54(3)(b) and 120.541, F.S.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
16	9	37	**DCF BUDGET AMENDMENTS.** Allows the DCF to submit a budget amendment to realign funding within appropriations for the Guardianship Assistance Program.	**Identical**	**Senate Accepts House Offer #1**	**BUMP**
17	10	38	**PATH FORWARD INITIATIVE.** Authorizes the DCF to establish a formula to distribute funding for the Path Forward initiative due to the expiration of the federal Title IV-E Waiver.	**House**	**Senate Accepts House Offer #1**	**BUMP**
18	N/A	39	**DVA PERSONAL NEEDS ALLOWANCE INCREASE.** Allows a resident of a State Veterans' Nursing Home to retain $130/month as a personal needs allowance rather than $105/month.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**
19	11	n/a	**DOH BUDGET AMENDMENT - HIV/AIDS PREVENTION AND TREATMENT.** Authorizes DOH to submit a budget amendment to increase budget authority for the HIV/AIDS Prevention and Treatment Program if additional federal revenues become available.	**House**	**Senate Accepts House Offer #1**	**BUMP**
20	n/a	40	**SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.** Authorizes DCF to submit budget amendment to increase budget authority if additional federal revenue specific to the program becomes available.	**Senate**	**Senate Accepts House Offer #1**	**BUMP**

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21	12	41	**DCF BUDGET AMENDMENTS - FAMILY SAFETY PROGRAM.** Authorizes DCF to submit a budget amendment to realign funding between specific appropriation categories within the Family Safety Program to bring funding in line with Title IV-E federal program requirements and maximize the use of federal funds.	**Identical**	**Senate Accepts House Offer #1**	**BUMP**
22	13	n/a	**MANAGED CARE PLAN PAYMENTS.** Amends s. 409.968, F.S. to require AHCA to set aside a portion of the managed care rates from the rate cells for special needs and home health services in the managed medical assistance and managed long term care programs to implement a home health performance incentive program. The agency must direct Medicaid managed care plans to submit to the agency proposals to ensure all covered and authorized home health services are provided to recipients, methods for measuring provider compliance and mechanisms for documenting compliance to the agency. Plans must implement a method for families and caregivers to report provider failures to provide services in real time. The agency may disburse the withheld portion of rate in the last quarter of the fiscal year only upon a documented determination by the agency that the plans ensured all covered and authorized home health services were provided.	**House**	**Senate Accepts House Offer #1**	**BUMP**
23	14	36	**FLORIDA MEDICAID MANAGEMENT INFORMATION SYSTEM.** Requires AHCA to replace the current Florida Medicaid Management Information System and provides requirements of the system. This section also establishes the executive steering committee (ESC) membership, duties and the process for ESC meetings and decisions.	**House New** **See Attachment #1**	**Senate Accepts House Offer #1**	**BUMP**
24	N/A	N/A	**NURSING HOME LEASE BOND ALTERNATIVE THRESHOLD REDUCTION.** Reduces the Medicaid nursing home lease bond alternative collection threshold from $25 million to $10 million.	**House New**	**Senate Accepts House Offer #1**	**BUMP**
25	N/A	N/A	**FLORIDA NURSING HOME UNIFORM REPORTING SYSTEM.** Requires nursing homes and home offices to report audited financial information to the Agency for Health Care's uniform reporting system.	**House New** **See Attachment #2**	**Senate No Language**	**BUMP**
26	N/A	N/A	**DEFINITIONS.** Defines Florida Nursing Home Uniform Reporting System (FNHURS) and home office. 408.07 Definitions.—As used in this chapter, with the exception of ss. 408.031-408.045, the term: (19) "FNHURS" means the Florida Nursing Home Uniform Reporting System developed by the agency. (29) "Home office" has the same meaning as provided in the Provider Reimbursement Manual, Part 1 (Centers for Medicare and Medicaid Services, Pub. 15-1), as that definition exists on the 288 effective date of this act.	**House New**	**Senate No Language**	**BUMP**
27	N/A	N/A	**TECHNICAL CORRECTIONS.** Provides for technical corrections to statutory cross references in Managed Care Plan Accountability and Appropriations to First Accredited Medical Schools due to the change in the number of definitions listed in s. 408.07, F.S.	**House New**	**Senate No Language**	**BUMP**
28	N/A	N/A	**PROVIDER AUTOMATIC ENROLLMENT AND CERTIFICATION OF VIABILITY.** ~~Amends AHCA's automatic enrollment policies for Medicaid managed care to ensure new managed care plans and provider service networks can obtain a viable enrollment level and AHCA Secretary's certification of viable enrollment~~. Amends AHCA's automatic enrollment process in the Long-Term Care Managed Care Plan for dually eligible recipients.	**House New** **See Attachment #3**	**Senate Modified Language - See Senate Attachment 2**	**BUMP**

Line	HB 5003 Section	SB 2502 Section	Description	House Offer #1	Senate BUMP Offer #1	BUMP
29	N/A	N/A	**DOH BUDGET AMENDMENT - DECLARED PUBLIC HEALTH EMERGENCIES**. Authorizes DOH to submit a budget amendment to increase budget authority for the response to a public health emergency upon additional federal revenues become available. Effective upon becoming law, in order to implement Specific Appropriations 424 through 542 of the 2019-2020 General Appropriations Act and Specific Appropriations 426 through 545 of the 2020-2021 General Appropriations Act, and notwithstanding ss. 216.181 and 216.292, Florida Statutes, the Department of Health may submit a budget amendment, subject to the notice, review, and objection procedures of s. 216.177, Florida Statutes, to increase budget authority for public health emergencies declared pursuant to s. 381.00315, Florida Statutes, if additional federal revenues specific to response to a declared public health emergency become available in the 2019-2020 or 2020-2021 fiscal year. This section expires July 1, 2021.	**House New**	**Senate Accepts House Offer #1**	**BUMP**
30			**PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY.** Provides for PACE organization to serve persons in Miami-Dade County. Section XX. 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 one private, not-for-profit hospital located in Miami-Dade County to provide comprehensive services to frail and elderly persons residing in Northwest Miami-Dade County, as defined by the agency. 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 appropriation, shall approve up to 100 initial enrollees in the Program of All-inclusive Care for the Elderly established by this organization to serve persons in Northwest Miami-Dade County.		**Senate New Language**	**Senate New**
31			**Nursing Home Rate Increase.** Provides methodology to spread nursing home rate increase across all providers, even if the provider is held to the September 2016 rate.		**See Senate Attachment #3**	**Senate New**
32			**DOMESTIC VIOLENCE BUDGET AMENDMENTS - CURRENT YEAR.** Provides DCF with authority to submit budget amendments should FY 2019-20 appropriations for the domestic violence programs require realignment in light of the department no longer contracting with the Florida Coalition for Domestic Violence. Effective upon becoming a law, in order to implement Specific Appropriation 316, section 3 of chapter 2019-115, Laws of Florida, and notwithstanding ss. 216.181 and 216.292, the Department of Children and Families may submit a budget amendment, subject to the notice, review and objection procedures of section 216.177, Florida Statutes, to realign use of the funds appropriated in Specific Appropriation 316 for the implementation of programs and the management and delivery of services for the state's domestic violence program, including implementation of statutory directives contained in chapter 39, Florida Statutes, as amended by chapter 2020-6, Laws of Florida, implementation of special projects, coordination of a strong families and domestic violence campaign, implementation of the child welfare and domestic violence co-location projects, and conducting training and providing technical assistance to certified domestic violence centers and allied professionals and which remain unobligated and unexpended as of April 29, 2020, within, among, and between budget categories in the Family Safety Program.		**Senate New Language**	**Senate New**

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33			**DOMESTIC VIOLENCE BUDGET AMENDMENTS - FY 2020-21.** Provides DCF with authority to submit budget amendments should appropriations for the domestic violence programs require realignment in light of the department no longer contracting with the Florida Coalition for Domestic Violence. In order to implement Specific Appropriation 321 of the 2020-2021 General Appropriations Act, and notwithstanding ss. 216.181 and 216.292, the Department of Children and Families may submit a budget amendment, subject to the notice, review and objection procedures of section 216.177, Florida Statutes, to realign use of the funds appropriated in Specific Appropriation 321 for the implementation of programs and the management and delivery of services for the state's domestic violence program, including implementation of statutory directives contained in chapter 39, Florida Statutes, as amended by chapter 2020-6, Laws of Florida, implementation of special projects, coordination of a strong families and domestic violence campaign, implementation of the child welfare and domestic violence co-location projects, and conducting training and providing technical assistance to certified domestic violence centers and allied professionals, within, among, and between budget categories in the Family Safety Program.		**Senate New Language**	**Senate New**

Senate Attachment #1

Essential Providers: Implementing Bill

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.

(26) 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 and Low Income Pool Program payments, including federal matching funds. 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 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. Local governmental funds outlined in the letters of agreement must be received by the agency no later than October 31 of each fiscal year in which such funds are pledged, unless an alternative plan is specifically approved by the agency. To be eligible for low-income pool funding or other forms of supplemental payments funded by

intergovernmental transfers, and in addition to any other applicable requirements, essential providers under s. 409.975(1)(a)2. must offer to contract with each managed care plan in their region and essential providers under s. 409.975(1)(b)1.and 3. must offer to contract with each managed care plan in the state. Before releasing such supplemental payments, in the event the parties have not executed network contracts, the agency shall evaluate the parties' efforts to complete negotiations. If such efforts continue to fail, the agency shall withhold such supplemental payments beginning in the third quarter of the fiscal year if it determines that, based upon the totality of the circumstances, the essential provider has negotiated with the managed care plan in bad faith. If the agency determines that an essential provider has negotiated in bad faith, it must notify the essential provider at least 90 days in advance of the start of the third quarter of the fiscal year, and afford the essential provider hearing rights in accordance with Chapter 120, Florida Statutes.

Senate Attachment #2

Duals/Collaboration Agreements

Proposed Language Amending s. 409.984, F.S. Enrollment in a long-term care managed care plan.

(1) The agency shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan pursuant to s. 409.969. The agency shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established pursuant to s. 409.967 and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards. If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. For a dually eligible recipient receiving Medicare services from an entity qualified under 42 C.F.R. part 422 not participating in the long-term care managed care program, the agency shall automatically enroll the dually eligible recipient in a long-term care plan that has established a collaboration and coordination agreement with that non-participating entity, if the agency determines the agreement is sufficient to ensure provision of all required services in a manner consistent with state and federal requirements. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

Senate Attachment #3

Chapter 409.908 – Reimbursement of Medicaid Providers

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.....6.5 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 July 1, 2020, the agency shall establish a unit cost increase as an equal percentage for each nursing home.

8. 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 plus the July 1, 2020 unit cost increase or their prospective payment rate plus the July 1, 2020 unit cost increase. Effective October 1, 2021, the agency shall reimburse providers the greater of 95 percent of their cost-based rate plus the July 1, 2020 unit cost increase or their rebased prospective payment rate plus the July 1, 2020 unit cost increase, using the most recently audited cost report for each facility. This subparagraph shall expire September 30, 2023.

[2](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. 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.