

409.908 Reimbursement of Medicaid Providers

Section 8, ch. 2017-129, amended subsection (2), effective October 1, 2018, to read:

(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

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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 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.....8.5 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.

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- (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

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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.