FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION LI

EFFECTIVE DATE: October 1, 2023

I. Cost Finding and Cost Reporting

A. Each Nursing Facility provider participating in the Florida Medicaid program shall submit a uniform cost report and related documents required by this Plan. The electronic cost report and revised instructions must be used. To be considered a complete submission, the electronic version of the cost report, one hard copy of the cost report, the certification page, supplemental schedules and attachments, and the accountant's compilation letter must all be received by the Agency for Healthcare Administration (AHCA), Bureau of Medicaid Program Finance, Audit Services, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. Cost reports are due to AHCA, Bureau of Medicaid Program Finance, Audit Services, five months after the close of the provider's cost reporting year. Extensions will not be granted.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this Plan for determination of allowable costs. The cost report shall be prepared using the electronic cost report described in section I.A, and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA). The methods of reimbursement are in accordance with Title XVIII of the Social Security Act (SSA) and Center for Medicare and Medicaid Services (CMS) Publication 15-1 (CMS-PUB.15-1) incorporated herein by reference except as modified by the Florida Title XIX Long-term Care Reimbursement Plan and state of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The certified public accountant (CPA) preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of their work and opinion in conformity with AICPA Attestation

Standards. Cost reports that are not signed by a CPA or not accompanied by a separate letter signed by a CPA shall not be accepted.

C. Providers may elect, with prior approval from AHCA, Bureau of Medicaid Program Finance, Audit Services, to change their current fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same fiscal year end. All prior year cost reports must be submitted to and accepted by AHCA before the current year cost report may be submitted and accepted for rate setting by AHCA.

D. A provider that has been receiving an interim reimbursement rate, which voluntarily or involuntarily ceases to participate in the Florida Medicaid program or experiences a change of ownership or operator, shall file a final cost report in accordance with section 2414.2, CMS-PUB.15-1. The cost report is to be based on financial and statistical records maintained by the provider as required in Title 42 Code of Federal Regulations (CFR), 413.24 (a), (b), (c), and (e). Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of costs and other records in accordance with CMS-PUB.15-1, which pertain to the determination of reasonable costs and shall be capable of and available for auditing by state and federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of five years following the date of submission of the cost report to AHCA. Records of related organizations as identified by 42 CFR 413.17 shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).

E. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17.

F. Chart of Accounts: All providers must use the most recent version of the standard chart of accounts to govern the content and manner of the presentation of financial information to be submitted by Florida Medicaid long-term care providers in their cost reports. The standard chart of accounts includes specific accounts for each component of direct care staff organized by type of personnel and may not be revised without the written consent of the Auditor General.

G. Cost reports must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Florida Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

H. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

I. Providers are subject to sanctions pursuant to for late cost reports. A cost report is late if it is not received by AHCA, Bureau of Medicaid Program Finance, Audit Services on the cost report due date. Sanctions shall commence 60 days after the cost report due date. If a provider submits a cost report late because of emergency circumstances, then the provider shall not be subject to the sanctions. Emergency circumstances are limited to loss of records from fire, flood, theft, or wind.

J. Providers that have both licensed pediatric beds and community or sheltered beds must file two separate cost reports in accordance with Sections I and III in order to separate the cost of care

associated with the pediatric population. The cost reports must use cost allocation methodologies in accordance with CMS-PUB.15-1.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing facility care, in accordance with this Plan, are subject to an audit and/or desk review. AHCA reserves the right to audit any provider at any time. The performance of a desk review does not preclude the performance of an audit at a later date.

A. General Description of AHCA's Procedures for Audits

1. Primary responsibility for the audit of provider cost reports shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 will be met.
2. All audits shall be based on AICPA Attestation Standards for examining or reviewing statistical information and other data..
3. Upon completion of each examination or review, the auditors shall issue a report that meets the requirements of 42 CFR 447.202 and AICPA Attestation Standards. The examiner/reviewer shall declare an opinion or conclusion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to reimbursement for long-term care facilities. All reports shall be retained by AHCA for three years.
4. The provider's copy of the examination or review report shall include all adjustments and changes, the authority for each, and all findings. The examination or review report report shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures

Upon receipt of a cost report from the provider, prepared in accordance with instructions furnished by AHCA, AHCA will determine whether an audit or desk review is to be performed. Providers

selected for audit or desk review will be notified in writing by the AHCA audit office or CPA firm assigned to perform the audit and/or desk review.

1. Upon completion of an audit or desk review and before publication of the audit or desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least 10 days before the exit conference. If the provider fails to schedule an exit conference within 20 calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail, via teleconference call or in AHCA's office in Tallahassee.

2. Following the exit conference, the provider has 30 calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. Any documentation received after the 30 day period shall not be considered when revising adjustments. However, the 30 day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood, or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested to the address of the nursing facility and to the attention of the administrator. The provider shall have 21 calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustments or findings contained in the report by requesting an administrative hearing. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of

proof is upon the provider to affirmatively demonstrate the entitlement to the Florida Medicaid reimbursement.

4. AHCA will not consider additional documentation to support the modification of a final audit report after it has been issued except in the case of emergency circumstances. Emergency circumstances are limited to loss of records from fire, flood, theft, or wind.

III. Allowable Costs

A. All items of expense shall be included on the cost report, which providers must incur in meeting:

1. The definition of nursing facilities contained in sections 1919(a), (b), (c), and (d) of the SSA.
2. The standards prescribed by the Secretary of Health and Human Services (HHS) for nursing facilities in regulations under the SSA in 42 CFR 483, Subpart B.
3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610.
4. All therapy required by 42 CFR 409.33 and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and costs, direct or indirect, shall be included in the cost report, unless Medicaid is reimbursing for Medicare approved Part B services. Medicare approved Part B services must be excluded from the Medicaid cost report. These include physical, audiology, speech pathology, and occupational therapies. Florida Medicaid reimburses Medicare Parts A, B, and C, deductible(s), coinsurance, and copayments for dually eligible recipients based on the lesser of the amount billed or the Florida Medicaid rate for Medicare approved Part B services that are not included in the nursing facility's cost report. The Florida Medicaid rate is equal to the Medicare allowed amount for Medicare approved Part B therapy services provided in nursing facilities.

B. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing

the Title XVIII Principles of Reimbursement, CMS-PUB.15-1 and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under this Plan.

C. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items includes laundry services, nutritional services, personal care services, personal care supplies, incontinence supplies, rehabilitative and restorative care services, durable medical equipment, stock medical supplies, analgesics, antacids, laxatives, vitamins, and wound care supplies. Physician Services, dialysis services, community mental health services, dental services, podiatry services, flu and pneumonia injections, visual services, and transportation services are not included in the per diem rate as the rendering provider bills Medicaid directly.

D. Bad debts other than Title XIX of the SSA, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX of the SSA shall be limited to Title XIX of the SSA uncollectible deductible and copayments and the uncollectible portion of eligible Florida Medicaid recipients' responsibilities. Example - Daily rate is $210.00; state pays $190.00 and recipient is to pay $20.00. If Florida Medicaid recipient pays only $15.00, then $5.00 would be an allowable bad debt. All Florida Medicaid Title XIX of the SSA bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters.

E. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Title XVIII of the SSA and Chapter 10, CMS-PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

F. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The owner-administrator and owner-assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 or determined by

surveyed ranges of compensation conducted by AHCA. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and shall be updated each year by the wage and salary component of the Plan's inflation index. A new salary survey may be conducted at the discretion of AHCA.

G. Legal Fees and Related Costs

In order to be considered an allowable cost of a provider in the Florida Medicaid program, attorneys' fees, accountants' fees, consultants' fees, experts' fees and all other fees or costs incurred related to litigation, must have been incurred by a provider who was the successful party in the case on all claims, issues, rights, and causes of action in a judicial or administrative proceeding. If a provider prevails on some but less than all claims, issues, rights, and causes of action, the provider shall not be considered the successful party and all costs of the case shall be unallowable. All costs incurred on appellate review are governed in the same manner as costs in the lower tribunal. If on appeal, a provider prevails on all claims, issues, rights and causes of action, the provider is entitled to its litigation costs, in both the lower tribunal and the reviewing court, related to those claims issues, rights and causes of action in which a provider is the successful party on appeal as determined by a final non-appealable disposition of the case in a provider's favor. This provision applies to litigation between a provider and AHCA as it relates to Florida Medicaid audits and Florida Medicaid cost reimbursement cases, including administrative rules, and certificate of need cases. This provision pertains only to allowable costs for the recalculation of reimbursement rates and does not create an independent right to recovery of litigation costs and fees.

H. The direct patient care component shall include salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, certified nursing assistants (CNA), and personal care attendants (PCA) who deliver care directly to residents in the nursing facility, allowable therapy costs, and dietary costs. PCA should be reported under Direct Care with Nurse Aide expenses. Hours worked should be reported on the schedule F-2 with nurse aide hours. A detailed crosswalk of the uniform cost report accounts is available in Appendix D. Direct care staff does not include nursing administration, Minimum Data Set (MDS) and care plan coordinators, staff development, infection control preventionist, risk managers, and staffing coordinators. There shall be no costs directly or indirectly allocated to the direct care component from a home office or management company for staff who do not deliver care directly to residents in the nursing facility.

I. The operating component shall include the costs for medical records, plant operation, housekeeping, administration, Medicaid bad debt and laundry and linen.

J. All other patient care costs shall be included in the indirect patient care component.

K. Effective April 1, 2009, the Nursing Facility Quality Assessment (NFQA) fee is an allowable cost and shall be included in the cost report with required adjustments. Refer to section IV.B. of this Plan for specific details of this fee. Nursing facilities may not create a separate line-item charge for the purpose of passing through the assessment to residents.

L. Providers designated as COVID Isolation facilities shall offset COVID related expenses by the additional funding received from the Agency for Health Care under the Medicaid Supplemental Agreement. Providers shall offset these expenses following the methodology used to offset pediatric revenue. See Sections I.J and VI.A(1)(a).

IV. Reimbursement Components for All Nursing Facility Providers

This section outlines the methodologies to be used by the Florida Medicaid program in establishing reimbursement components included in the final reimbursement rates for each participating provider under both the prospective payment system and the cost-based per diem payment methodologies.

A. Fair Rental Value (Property Component)

1. A Fair Rental Value (FRV) system is used to reimburse providers for their facility related capital costs. Each provider participating in the Florida Medicaid program shall submit an FRV survey, with supporting documentation for all changes made regarding previous year submissions. to AHCA using the electronic form and instructions on the Florida Nursing Home: Fair Rental Value Survey web page. The current licensed number of beds, the square footage of the facility, date opened, bed additions and reductions, and the cost of renovations shall be included on the FRV survey. The most recent FRV survey received by April 30 of the year in which the rate period begins, or by the close of the next business day if April 30 falls on a weekend, will be used to calculate the FRV rate. Extensions will not be granted.

   a. The reporting period for the FRV survey is January 1 to December 31. Projects requiring more than one calendar year to complete should be reported in the year of completion.

   b. If a provider fails to submit an FRV survey by April 30, no adjustments to building additions, replacements, renovations, or major improvement incurred by the provider since the most recent data submission will be used in the FRV calculation for the subsequent rate period.

   c. For a provider who has never submitted an FRV survey to AHCA, the FRV calculation will use the minimum square footage per bed as the facility square footage. New providers who have not submitted data will have their FRV rate determined from information reported in the provider's budgeted cost report and/or additionally requested schedules.

d. Facilities must report each project in chronological order by date from initial construction to present. Each project must be reported separately regardless of type of project and year of completion. A project will either be a bed addition, bed replacement, or renovation/major improvement. Facilities should be prepared to define each project in such a way that makes clear the separation of individual projects. It is possible to have multiple projects of the same type in the same year. Example - a roof replacement project would be reported separately from a kitchen renovation project even if they were completed in the same year. The minimum cost of a renovation is $500 per bed. If a project does not meet this minimum threshold, it will not be used in the FRV calculation.

e. Capital costs incurred in the normal course of facility operations, that were not part of a renovation/major improvement project, should not be claimed on the FRV survey. Grouping of assets is only allowable when they are part of a clearly defined renovation/major improvement project. It is not allowable to bundle unrelated assets together for the purpose of reporting a renovation/major improvement project.

f. AHCA may perform desk reviews on the provider submitted survey data and amend the survey data based on the desk review results.

g. AHCA may also amend submitted FRVS survey data based on the results of a finalized FRVS audit or PPS audit that affects the FRVS components.

2. The Fair Rental Value rate is calculated as:

Components		Source
RSMeans Parameter	RSMeans Cost per Square Foot	The most recent Square Foot Costs with RSMeans Data, Gordian Publication available on March 31 of the year in which the rate period begins.
	RSMeans Location Factor Index	
	Means Historical Cost Index	
Facility Information	Square Feet Per Bed*	FRV Survey submitted in accordance with Section IV.A.1.
	Number of Beds	
	Renovation amounts, bed additions and year of project completion	

	Facility Age in Years*	FRV Survey submitted in accordance with Section IV.A.1. and adjusted for renovations and bed additions as calculated in Section IV.A.3.
	Occupancy*	Most recent Medicaid Nursing Home cost report submitted prior to the rate setting acceptance cutoff date. For new facilities in their first year of operation, , the occupancy is 75%.
Policy Parameters	Land Percentage	
	Equipment Cost per Bed	
	Depreciation Factor	
	Fair Rental Rate	
Calculation of Rate Per Bed Day	Building Value	(RSMeans Cost Per Square Foot) * (RSMeans Location Factor) * (Square Feet Per Bed)
	Land Value	(Building Value) * (Land Percentage)
	Equipment Value	(Equipment Cost per Bed allowance)
	Depreciation	[(Building Value) + (Equipment Value)] * (Facility Age) * (Depreciation Factor)
	Fair Rental Value	(Building Value) + (Land Value) + (Equipment Value) – (Depreciation)
	FRV Reimbursement	(Fair Rental Value) * (Fair Rental Rate)
	Applicable Occupancy	Greater of Facility Occupancy and Minimum Occupancy
	Occupancy Per Year Per Bed	(Applicable Occupancy) * (365.25)
	FRV Rate	(FRV Reimbursement) / (Occupancy Per Year Per Bed)

3. A provider's age shall be adjusted for renovations that meet the minimum cost per bed. For renovations that do not add beds, the calculation of adjusted age is:

Components	Calculation
Replacement Cost Per Bed	Building Value × $\frac{\text{RSMeans Historical Cost Index for Year of Renovation}}{\text{RSMeans Historical Cost Index for Current Year}}$
Accumulated Depreciation Per Bed	(Renovation Year – Base Year) * Replacement Cost Per Bed * Depreciation Factor
New Bed Equivalent	Renovation Amount / Accumulated Depreciation Per Bed
New Base Year	Renovation Year – $\frac{\text{(Current Number of Beds – New Bed Equivalent) * (Renovation Year – Base Year)}}{\text{Current Number of Beds}}$
Adjusted Age	Rate Year – New Base Year

For renovations that do add beds, the calculation of adjusted age is:

Components	Calculation
New Bed Age	Rate Year – Modification Year
Adjusted Age	$\left(\frac{\text{Current Number of Beds}}{\text{New Total Number of Beds}} \times \text{Facility Age}\right) + \left(\frac{\text{Number of Added Beds}}{\text{New Total Number of Beds}} \times \text{New Bed Age}\right)$

B. Nursing Facility Quality Assessment (NFQA)

Effective April 1, 2009 AHCA, shall implement methodologies revising reimbursement to nursing facilities that will create a pass-through of the Florida Medicaid share of the assessment, restore prior reductions as allowed, and provide for a quality incentive payment as a phase-in to a pricing model. The funding for reimbursement improvements is provided through the NFQA fee. The funds shall exclusively be for the following purposes and in the following order of priority:

1. To reimburse the Florida Medicaid share of the NFQA fee as a pass through. The per diem Florida Medicaid share of the NFQA is calculated as follows:
   a. Total patient days minus Medicare and Medicare Advantage days is equal to total non-Medicare days.
   b. The product of total non-Medicare days, NFQA rate and Florida Medicaid utilization to is equal to the total NFQA Florida Medicaid share.
   c. Total NFQA Florida Medicaid share divided by Florida Medicaid days is equal to the per diem Florida Medicaid Share of the NFQA.
2. To increase each nursing facility's Florida Medicaid rate, an amount that restores the rate reductions effective on or after January 1, 2008.
3. To partially fund the quality incentive payment as described in section V.B. that accounts for the remainder of the total assessment not included in sections IV.B.1 through 2. The quality payment is calculated by taking total funds remaining after sections IV.B.1 through 2. Then, subtract budgeted administrative cost and funds required for Hospice rate cut restoration to equal total quality assessment funds remaining.

Each provider shall report monthly to AHCA its total number of resident days, exclusive of Medicare resident days, and remit an amount equal to the assessment rate times the reported number

of days. Facilities are required to submit their assessment by the 20th day of the next succeeding calendar month.

C. Pass-Through Payments

Real Estate and Personal Property Taxes and Property Insurance shall each be reimbursed as a pass-through payment calculated as the total cost divided by the total patient days. The most current acceptable cost reports received by AHCA, Bureau of Medicaid Program Finance, Audit Services by the close of the business day on April 30 of each year, or by the close of the next business day if April 30 falls on a weekend shall be used for the pass-through calculation components. For new facilities, the pass-through components shall be determined from information reported in the provider's budgeted cost report and/or additionally requested schedules.

D. Cost Settlement

Providers will not be subject to a retrospective cost settlement.

E. Emergency Payments

AHCA may establish a methodology to reimburse providers in the event of a governor proclaimed state emergency when funding is appropriated by the legislature for that purpose.

V. Prospective Payment System

Effective October 1, 2018 a prospective payment methodology shall be implemented for rate setting purposes. This section outlines the methodology used in establishing the reimbursement components for the Nursing Facility providers participating in the prospective payment system.

A. Operating, Direct, and Indirect Patient Care Components

Beginning October 1, 2018 separate medians and standardized prices shall be calculated for each patient care subcomponent (operating, direct patient care, and indirect patient care) based on the most recent cost reports received by the rate setting acceptance cut-off date for the September 2016 rate setting. For providers with no actual cost report used for the September 1, 2016 rate period as a result of a change of ownership, the previous provider's cost report used for the September 1, 2016 rate period will be used. New facilities shall receive the standardized price for

the direct, indirect, and operating components of the per diem equal to the standardized price for their respective peer groups, without the per diem floor, until an audited cost report is received by AHCA prior to the rate setting acceptance cut-off date. Beginning October 1, 2021, and every 4th subsequent year updated medians, standardized prices, and floors shall be based on the most recently audited cost reports finalized prior to April 30 of the rebase year.

1. Each nursing home provider shall be classified into one of two provider peer groups.

A. Peer groups are defined as:

(I) North- Statewide Medicaid Managed Care (SMMC) Regions 1-9, less Palm Beach and Okeechobee Counties; and

(II) South- Statewide Medicaid Managed Care (SMMC) Regions 10-11, plus Palm Beach and Okeechobee Counties.

2. AHCA shall determine standardized per diem values for each component within each peer group using the following process:

a. Calculate provider specific cost per diems separately for the direct, indirect, and operating components by dividing the components' allowable costs by the total number of Florida Medicaid patient days from the cost report.

b. Adjust a provider's operating, direct care, and indirect care per diem costs that resulted from section V.A.2.a. for the effects of inflation by multiplying these per diem costs by the fraction:

Florida Nursing Facility Cost Inflation Index at midpoint of prospective rate period	÷	Florida Nursing Facility Cost Inflation Index at midpoint of provider's cost report period

c. The calculation of the Florida Nursing Facility Cost Inflation Index is displayed in Appendix A. Calculate the medians from the provider-specific values for each peer group and component using the inflated per diems calculated in section V.A.2.b.

d. Calculate the standardized price for the direct, indirect, and operating components of the per diem as a percentage of the median costs for providers within each peer group.

e. Calculate the floor per diem for the direct and indirect components by multiplying the standardized price as calculated in section V.A.2.d. by the floor percentage.

f. For each component, providers will be reimbursed the standardized price defined for their peer group if their individual per diem as calculated in section V.A.2.b. is above the floor as calculated in section V.A.2.e.

g. If a provider's per diem as calculated in section V.A.2.b. is below the floor, their component per diem is calculated as follows:

$$Floor\ Adjustment = \ Floor\ Per\ Diem - Inflated\ Per\ Diem\ Cost$$

$$Per\ Diem = Standardized\ Price - Floor\ Adjustment$$

B. Quality Incentive Component

The prospective payment system includes a quality incentive add-on component consisting of process, outcome, structural and credentialing measures. For each measure, a provider is awarded points. The points are adjusted based on provider total Medicaid patient days and the resulting adjusted point value is used to determine a provider's portion of Quality Incentive funds. The quality measure percentiles will be recalculated during rebase years. During non rebase years the quality measure percentiles will be frozen. For new facilities, quality incentive payments will be applied at a value equal to the 50th percentile quality score for Florida Medicaid providers included in the prospective payment methodology. A New Facility is a provider who does not have data available to calculate quality scores available for all measures. If a provider does not have the following information, they will be treated as a New Facility:

a. The data available for the most recently available four quarter average score from MDS Quality Measures from the Nursing Home Compare as of May 31 of the year in which the rate period begins.

b. Budgeted cost report submitted by April 30th of the rate period year. The licensed nursing and CNA staffing measure will be calculated using the total combined RN, LPN, and CNA productive hours per patient day as reported in the most recent budgeted or actual Medicaid cost report submitted prior to the cost report cutoff date.

c. CMS Facility Staffing Payroll Based Journal as of May 31 of the year in which the rate period begins.

d. Most recent overall rating from the Star Ratings dataset from the Nursing Home Compare datasets provided by CMS as of May 31 of the year in which the rate period begins.

1. Process Measures

For each process measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the process measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

a. Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine

b. Percentage of long-stay residents who received an antipsychotic medication

c. Percentage of long-stay residents who were physically restrained

d. In the event that a provider has one or more measures without actual data, the prior year's CMS data will be pulled until actual data is available.

i. Actual data is defined as providers who do not have a footnote of 9 or 10 for their fourth quarter average score.

ii. Providers who do not have actual data in ALL measures for the rate period (As of May 31) will have data from their most recent four quarter average used to calculate their quality score.

2. Outcome Measures

For each outcome measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology. For each rate period, the outcome measures will be calculated using the most recent four quarter average from the MDS Quality Measures from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

a. Percentage of long-stay residents with a urinary tract infection

b. Percentage of high risk long-stay residents with pressure ulcers

i. On October 1, 2018 CMS changed the pressure ulcer measure from code 403 to 453.

ii. At the October 1, 2019 rate setting period a 3 quarter average of 2018 data will be used to calculate the quality incentive score.

iii. For the October 1, 2020 rate setting period the quality measure percentile for pressure ulcers will be recalculated.

c. Percentage of long-stay residents experiencing one or more falls with major injury

d. Percentage of low risk long-stay residents who lose control of their bowels or bladder

e. Percentage of long-stay residents whose need for help with daily activities has increased

f. In the event that a provider has one or more measures without actual data, the prior year's CMS data will be pulled until actual data is available.

i. Actual data is defined as providers who do not have a footnote of 9 or 10 for their fourth quarter average score.

ii. Providers who do not have actual data in ALL measures for the rate period (As of May 31) will have data from their most recent four quarter average used to calculate their quality score.

3. Structural Measures

For each structural measure, each provider will be ranked and points will be awarded based on the percentile in which the provider scores in relation to other Florida Medicaid providers included in the prospective payment methodology.

a. Hours of licensed nursing (RN, LPN) and CNA staffing

The licensed nursing and CNA staffing measure will be calculated using the total combined RN, LPN, and CNA productive hours per patient day as reported in the most recent Medicaid cost report submitted prior to the cost report cutoff date. For a new provider with no cost history resulting from a change of ownership or operator, the measure will be calculated using the prior provider's cost report submitted prior to the rate setting acceptance cutoff date.

b. Employees of social work and activities staff

The employees of social work and activities staff measure will be calculated using the total number of qualified activities professionals and qualified social workers, including therapeutic recreation specialists employed by the provider on a full time basis, part time basis, or under contract to a provider per resident day. As of May 31, 2019, the most recent one year average will be collected from the published CMS Facility Staffing Payroll-Based Journal data as of May 31 of the year in which the rate period begins. This data will be evaluated on a per resident day basis.

4. Credential Measures

a. CMS 5 Star Rating

For the CMS 5 Star Rating, providers will be awarded points based on their rating. For each rate period, the CMS 5 Star Rating Measure will be calculated using the most recent overall rating from the Star Ratings dataset from the Nursing Home Compare datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate period begins.

b. Providers will be awarded points if they qualify for at least one of the following three certifications/accreditations:

i. Nursing Home Gold Seal Award

For each rate period, the Nursing Home Gold Seal Award measure will be calculated using the licensees with the Gold Seal designation as of May 31 of the year in which the rate period begins.

ii. Joint Commission Accreditation

For each rate period, the Joint Commission Accreditation measure will be calculated using the providers with accreditation as of May 31 of the year in which the rate period begins.

iii. American Health Care Association (AHCA) National Quality Award

For each rate period, the AHCA National Quality Award measure will be calculated and points will be awarded for providers achieving the gold or silver level award as of May 31 of the year in which the rate period begins.

5. Quality Incentive Add-on Calculations

a. Quality Measure Percentiles are calculated each rebase rate period. Structural measures percentiles are recalculated every rate period. Points are awarded to a provider for each quality measure using the following criteria:

Process Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points Per Provider
Flu Vaccine	20% year-over-year improvement. Improvement is calculated as the change from the year preceding the current year to the current year measurement.	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
Antipsychotic		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Restrained		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Antianxiety or Hypnotic Medication		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Outcome Measures	**0.5 Points**	**1 Point**	**2 Points**	**3 Points**	**Max Points Per**
Urinary Tract Infections	20% year-over-year improvement. Improvement is calculated as the change from the year preceding the current year to the current year measurement.	Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Pressure Ulcers		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Falls		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Incontinence		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Activities of Daily Living		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Hospitalization		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Registered Nurse Turnover		Below 50th Percentile	Below 25th Percentile	Below 10th Percentile	3
Structure Measures	**No Points Awarded To Those Under Median**	**1 Point**	**2 Points**	**3 Points**	**Max Points Per**
Combined Direct Care Staffing (RN, LPN, CNA)	N/A	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
Social Work and Activity	N/A	Above 50th Percentile	Above 75th Percentile	Above 90th Percentile	3
Credentials		**1 Point**	**3 Points**	**5 Points**	**Max Points Per**
CMS 5 Star Rating	N/A	3 Stars	4 Stars	5 Stars	5
Florida Gold Seal	A total of five points is awarded if one or more of these three accreditations are attained.	N/A	N/A	Awarded	5
Joint Commission Accreditation		N/A	N/A	Awarded	
AHCA National Quality Award		N/A	N/A	Silver or Gold Award	
Total Quality Points Possible					**49**

b. Half points for year-over-year improvement are only awarded to providers who do not meet the criteria to earn 1-3 points within the measure.

c. Providers must have a quality score of at least the quality score threshold to qualify for a quality incentive payment.

d. The weighted provider score for each qualifying provider is calculated by multiplying the provider quality points by the number of annualized Medicaid days as reported in the most recent cost report received by AHCA by the rate setting acceptance cut-off date. The payment per quality point is established by dividing the total quality budget by the sum of all weighted provider scores. The per diem quality incentive component is calculated by multiplying a provider's weighted quality score by the payment per quality point.

C. Add-ons

1. Ventilator Supplemental Payment

Providers shall receive a ventilator supplemental payment of $200 per Medicaid patient day. Effective October 1, 2018, provider submitted data and claims data with diagnosis code Z99.11, dependence on respirator (ventilator) status, with dates of service in the prior calendar year will be used to calculate the ventilator supplemental payment. Effective October 1, 2019, claims data with diagnosis code Z99.11, dependence on respirator (ventilator) status, with dates of service in the prior calendar year will be used to calculate the ventilator supplemental payment.

2. High Medicaid Utilization and High Direct Patient Care

Providers who meet the minimum Medicaid utilization and staffing criteria may receive the High Medicaid Utilization and High Direct Patient Care add-on. If a provider's prospective payment per diem rate is lower than their per diem rate effective September 1, 2016, they shall receive the lesser of a $20 per diem increase or a per diem increase sufficient to set their rate equal to their September 1, 2016 rate. Providers with rates at or above the September 1, 2016 per diem rate do not qualify for this add-on.

D. Budget Neutrality

Budget Neutrality multipliers shall be incorporated into the prospective payment system to ensure that total reimbursement is as required.

E. Rate Calculation

1. Compute the total prospective payment system per diem for a provider as the sum of:
    a. The sum of the direct patient care, indirect patient care, and operating components established in section V.A.
    b. The quality incentive component established in section V.B.
    c. The add-ons established in section V.C.
    d. The reimbursement components for all providers established in section IV.
    e. Apply the budget neutrality multipliers as established in section V.D.

F. Transition

Beginning October 1, 2018 AHCA shall reimburse providers the greater of their cost-based rate effective September 1, 2016, hereinafter referred to as "hold harmless rate", or their prospective payment rate.

1. The hold harmless rate will be the most current rate published to AHCA's web page with a September 1, 2016 effective date on May 31 for the subsequent rate period.
2. For providers with no published rate effective September 1, 2016, the hold harmless rate will be the prior provider's most current rate published to AHCA's web page with a September 1, 2016 effective date on May 31 for the subsequent rate period.
3. New facilities that began operation after September 1, 2016 will not qualify for the transition payment and will receive their prospective payment rate.
4. Effective October 1, 2021, providers shall receive the greater of their prospective payment rate or 95% of their hold harmless rate.
5. Effective October 1, 2023, providers will no longer receive the "hold harmless rate," per F.S. 409.908(2)(b)1.

VI. Methodology for Providers Exempt from Prospective Payment System

Exempt providers shall remain on a cost-based system. The following outlines the reimbursement rate components for exempt providers with the inclusion of the aforementioned reimbursement components in section IV.

A. Exempt Facilities

1. Pediatric, facilities operated by the Florida Department of Veterans Affairs, and government-operated facilities are exempt from reimbursement under the prospective payment methodology.

   a. Pediatric facilities are those facilities with licensed pediatric beds. For providers that have both licensed pediatric beds and community or sheltered beds, only the costs associated with the pediatric population are exempt from the prospective payment system. See section I.J. for the cost reporting requirements.

2. In the event of a change of ownership, exempt providers shall receive the prior provider's rate for the current rate year. New exempt facility rates shall be calculated based on the submitted budgeted cost report and any additionally requested schedules.

B. Operating Costs, Direct Care Costs, and Indirect Costs

To set reimbursement per diems and ceilings, AHCA shall:

1. Review and adjust each provider's cost report referred to in section I.A. to reflect the result of desk or on-site audits, if available. The most current cost reports received by AHCA, Bureau of Medicaid Program Finance, Audit Services by the close of the business day on April 30 of each year, or by the close of the next business day if April 30 falls on a weekend, shall be used to establish the operating, direct care, and indirect care per diems as well as ceilings.

2. Reduce a provider's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30.

3. Determine allowable Florida Medicaid operating costs, direct care costs, and indirect care costs. A detailed crosswalk of the uniform cost report accounts is available in Appendix D.

4. Calculate per diems for each of the three cost components listed in section 3. by dividing the components' costs by the total number of Florida Medicaid patient days from the cost report.

5. Adjust a provider's operating, direct care, and indirect care per diem costs that resulted from section 4 for the effects of inflation by multiplying these per diem costs by the fraction:

Florida Nursing Facility Cost Inflation Index at midpoint of prospective rate period	÷	Florida Nursing Facility Cost Inflation Index at midpoint of provider's cost report period

The calculation of the Florida Nursing Facility Cost Inflation Index is displayed in Appendix A.

C. Ceilings

1. Ceilings shall be determined prospectively and shall be effective on the first day of the rate period. The most current finalized audited cost reports received by AHCA, Bureau of Medicaid Program Finance, Audit Services by the close of the business day on April 30 of each year, or by the close of the next business day if April 30 falls on a weekend, and the provider's most recent reimbursement rates shall be used to establish the operating, direct care, and indirect care ceilings.

2. For the purpose of establishing reimbursement limits for operating, direct care, and indirect care costs, two peer groups based on geographic location were developed.

3. Determine the median inflated operating, direct care, and indirect care costs per diems for each of the peer groups and for the entire state. For each of the per diems, calculate the ratios for each of the peer group medians to the state medians.

4. Divide individual provider operating, direct care, and indirect care cost per diems that resulted from section VI.B.4 by the ratio calculated for the provider's peer group in section VI.C.3.

5. Determine the statewide median for the per diems obtained in section VI.C.4.

6. For each of the operating, direct care, and indirect care per diems, exclude the lower and upper 10 percent of the per diems of section 4 and calculate the standard deviation for the remaining 80 percent.

7. Establish the statewide cost-based reimbursement ceiling for the operating cost per diem as the sum of the median plus one standard deviation and for the direct care and indirect care cost per diems as the sum of the median plus 1.75 standard deviations that resulted from sections VI.C.5 and VI.C.6.

8. Establish the cost-based peer group reimbursement ceilings for:

   a. The operating, direct care, and indirect care costs per diems for the two peer groups defined in section VI.C.2 by multiplying the statewide ceilings in section VI.C.7. by the ratios calculated for that peer group in section VI.C.3.

9. Establish the effective peer group reimbursement ceilings for operating, direct care, and indirect care cost per diems for each peer group as the lesser of:

   a. The cost-based peer group reimbursement ceiling determined in section VI.C.8.

   b. The target rate peer group reimbursement ceiling as calculated in VI.C.9.b, from the previous rate period, inflated forward with 1.4 (the peer group target inflation multiplier) times the rate of increase in the Florida Nursing Facility Cost Inflation Index through a calculation similar to that given in section VI.D.1. No reimbursement ceiling can increase in excess of 15 percent annually. The direct care component shall not be limited to the target rate peer group reimbursement ceiling. The target rate peer group reimbursement ceiling shall not fall below 90 percent of

the cost-based peer group ceiling for each rate period as calculated in section VI.C.8. Effective October 1, 2018 the target limitation shall be rebased.

D. Targets

1. Establish the provider target reimbursement rate for operating and indirect care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and indirect care cost from the previous rate period, excluding the MAR, with the quantity:

$$1 + 2.0 \times \left[\frac{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Facility Cost Inflation Index at the midpoint of the current rate period}} - 1 \right]$$

In the above calculation, the 2.0 shall be referred to as the provider specific target reimbursement rate inflation multiplier. The provider target reimbursement rate limitation shall not fall below 75 percent of the cost-based peer group reimbursement ceiling for each rate setting as calculated in section VI.C.8. The direct care component shall not be limited to the target reimbursement rate. Effective October 1, 2018 the target limitation shall be rebased.

E. Medicaid Adjustment Rate (MAR)

The MAR for direct care and indirect care shall be calculated as follows:

1. Providers with 90 percent or greater Florida Medicaid utilization shall have their MAR equal their WBR as determined in section E.3.
2. Providers with 50 percent or less Medicaid utilization shall receive no MAR.
3. Providers between 50 percent and 90 percent Medicaid utilization shall have their MAR as determined by the following formula:

$$MAR = WBR \times MA$$

$$WBR = (BR \times MAW) \times \frac{(Superior + Standard)}{All}$$

$$MA = (Medicaid\ Utilization\% - MIN) \div (MAX - MIN)$$

Definitions:

MAR - Medicaid Adjustment Rate

WBR - Weighted Base Rate

MA - Medicaid Adjustment

BR - Base Rate, which is set as the result of sections V.G.1.a. and b.

MAW - Medicaid Adjustment Weight, which is set at .045

Superior - Number of Superior Days as described in 4.

Standard - Number of Standard Days as described in 4.

All - All superior, standard, and conditional days

MIN - Minimum Medicaid utilization amount which is set at 50 percent

MAX - Maximum Florida Medicaid utilization amount which is set at 90 percent

4. Determine the number of days one year prior to the rate period for which the facility held each of the three possible licensure ratings: superior, standard, and conditional.

Example - For the rate period January 1, 2014 through June 30, 2014, the period one year prior is January 1, 2013 to June 30, 2013. During that prior period, the provider's licensure ratings were:

RATING	PERIOD	DAYS
Superior	1/1/2013 – 1/31/2013	31
Conditional	2/1/2013 – 3/31/2013	59
Standard	4/1/2013 – 6/30/2013	91
TOTAL		**181**

a. The result of these calculations will represent the MAR to which the provider is entitled. This rate is to be included in the direct care and indirect care component of the provider's total reimbursement rate.

F. Medicaid Trend Adjustment (MTA)

The MTA is a percentage cut that is uniformly applied to all Florida Medicaid providers each rate period. The MTA is built into the final prospective payment rates through budget neutrality multipliers. The exempt providers' rates are reduced by the appropriate percentage allocation as compared to exempt Medicaid nursing home providers.

G. Rate Calculation

1. Compute the total cost-related per diem for a provider as the sum of:

a. The lesser of the operating cost per diem obtained in section VI.B.5, the effective operating peer group ceiling obtained in section VI.C.9, and the provider's operating provider target rate in section VI.D.1.

b. The lesser of the direct care cost per diem obtained in section VI.B.5 or the direct care cost-based peer group ceiling obtained in section VI.C.8.

c. The lesser of the indirect care cost per diem obtained in section VI.B.5, the provider's indirect care provider target rate in section VI.D.1, and the indirect care effective peer group ceiling obtained in section VI.C.9.

d. The MAR as described in section VI.E.

2. Establish the prospective per diem for a provider as the result of the sum of this section and the reimbursement components for all providers in section IV.

H. Supplemental Payment for Special Care

In order to receive a supplemental payment in excess of the peer group ceilings, a provider must demonstrate to AHCA that unique medical care requirements exist which require extraordinary outlays of funds. Circumstances which shall require such an outlay of funds in order to receive a supplemental payment shall be limited to patients under age 21 with complex medical needs based

upon a level of care established by AHCA's designee. The period of reimbursement in excess of the peer group ceiling shall not exceed 12 months. A flat rate shall be paid for the specific patients identified, in addition to the per diem paid to the provider. The flat rate supplemental payment shall be trended forward each rate period using the IHS Healthcare Cost Review indices used to compute the operating and patient care ceilings. These incremental costs shall be included in the cost reports submitted to AHCA, but shall not be included in the calculation of future prospective rates. The cost of the patients shall be adjusted out based upon the flat rate payments made to the provider, in lieu of separately identifying actual costs. Special billing procedures shall be obtained by the provider from the Bureau of Medicaid Policy. The peer group ceilings may also be exceeded in cases where Florida Medicaid patients are placed by AHCA in hospitals or in non-Florida Medicaid participating institutions on a temporary basis pending relocation to participating nursing facilities, for example, upon closure of a participating nursing facility. The CMS Regional Office shall be notified in writing at least 10 days in advance in all situations to which this exception is to be applied, and shall be advised of the rationale for the decision, the financial impact, including the proposed rates, and the number of facilities and patients involved. AHCA shall extend the peer group ceiling exception for subsequent allowable periods upon making a determination that a need for the exception still exists and upon providing the CMS Regional Office with another advance written notification as stated above.

VII. Standards

A. This Plan shall be made available for public inspection, and a public hearing, if requested, shall also be held so that interested members of the public shall be afforded the opportunity to review and comment on the Plan.

B. The Florida Medicaid program shall pay a single level of payment rate for all levels of nursing care. This single per diem shall be based upon each provider's reimbursement rate subject to the rate setting methodology in sections IV-VI.

C. Aggregate Test Comparing Florida Medicaid to Medicare

42 CFR 447.272 provides that states must ensure CMS that AHCA's estimated average proposed payment rate pay no more in the aggregate by category for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate period if the aggregate reimbursement to be paid is higher than the amount that would be paid under Medicare reimbursement principles the following steps shall be taken in order to meet the aggregate test:

1. The property reimbursement for FRVS shall be reduced until the upper limit test is met for that rate period. The amount of the property reimbursement rate paid under FRVS shall be reduced, but not below a 20% reduction.
2. The high Medicaid utilization and high staffing add-on for provider's reimbursed using the prospective payment system methodology and the MAR for provider's exempt from the prospective payment system shall be reduced on a pro rata basis until Florida Medicaid aggregate payments are equal to or less than the amount that would be paid for services under the Medicare reimbursement principles.
3. If the provisions 1 and 2 above are implemented in order to meet the upper limit test, for a period of one year, this Plan shall be reanalyzed and formally amended to conform to the necessary program cost limits.

D. Payments made under this Plan are subject to retroactive adjustment if approval of this Plan or any part of this Plan is not received from CMS. The retroactive adjustments made shall reflect only the federal financial participation portions of payments due to elements of this Plan not authorized by CMS.

E. Payment Assurance

The State shall pay each nursing facility for services provided in accordance with the requirements of the Florida Title XIX State Plan, section 1902 of the SSA. The payment amount shall be

determined for each nursing facility according to the standards and methods set forth in the Florida Title XIX Long-Term Care Reimbursement Plan.

F. Provider Participation

This Plan is designed to assure adequate participation of nursing facilities in the Florida Medicaid program and the availability of high quality nursing facility services for recipients which are comparable to those available to the general public.

G. Payment in Full

Any provider participating in the Florida Medicaid program who knowingly and willfully charges money or other consideration, for any service provided to the patient under the state plan in excess of the rates established by the State Plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State Plan approved under this title, any gift, money, donation or other consideration other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient as a condition of admitting a patient to a nursing facility, or as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein is paid for in whole or in part under the State Plan, shall be construed to be soliciting supplementation of the State's payment for services. Payments made as a condition of admitting a patient or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid patient and shall be deemed to be out of compliance with 42 CFR 447.15.

VIII. Glossary

A. Acceptable cost report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. AHCA - Agency for Health Care Administration.

C. Audit - A direct examination of the books, records, and accounts supporting amounts reported in the cost report to determine correctness and propriety.

D. Audit adjustment - Any adjustment within the Florida Medicaid audit report or Florida Medicaid desk review report.

E. Audit finding - Any adjustment within the Florida Medicaid audit report or Florida Medicaid desk review report not listed.

F. Bed - A licensed Nursing Facility bed.

G. Bed Addition - A bed addition involves a project resulting in the addition of licensed beds to the nursing facility.

H. Bed Replacement - A replacement of beds occurs when new construction is completed, however, instead of increasing the number of licensed beds of the facility, a portion of the existing licensed beds are relocated to the new construction.

I. CMS-PUB.l5-1 - Health Insurance Manual No. l5, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

J. Cost report due date – A provider's cost report is due five calendar months after the close of the provider's cost reporting year.

K. Desk review - An examination of the amounts reported in the cost report to determine correctness and propriety. This examination is conducted from AHCA reviewer's office and is focused on documentation solicited from the provider or documents otherwise available to the reviewer.

L. Facility - The physical grounds and buildings where a provider operates a licensed nursing facility.

M. Fair Rental Value (FRV) System –A gross valuation of a nursing facility's property using a standardized approach that takes into account the age, RSMeans indeces, bed additions, renovations and size of the facility.

N. Floor – A floor is calculated for the direct care and indirect care cost components listed in section VI.B. and is equal to the standardized price times the floor percentage..

O. Government-operated facility – A nursing facility operated by a city, county, state or federal government entity including hospital districts owned by city or county government entities.

P. Late cost report - A cost report that is not received by AHCA on the cost report due date.

Q. Legislative unit cost - The weighted average per diem of the state anticipated expenditure after all rate reductions.

R. Median – The mid-point of the inflated per diems for all providers in each peer group.

S. Medicaid Adjustment Rate (MAR) - An add-on to the direct care and indirect care cost components of exempt providers with greater than 50 percent Florida Medicaid utilization to encourage high quality care while containing costs. The MAR per diem calculation is detailed in section VI.E of this Plan.

T. Medicaid nursing facility direct and indirect patient care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to patient care, such as activity costs, social services, and all medically-ordered therapies.

U. Medicaid nursing facility operating costs - Those costs not directly related to patient care or property costs, such as administrative, plant operation, laundry and housekeeping costs. Return on Equity (ROE) or use allowance costs are not included in operating costs.

V. Medicaid nursing facility property costs - Those costs related to the ownership or leasing of a nursing facility. Such costs may include property taxes and insurance.

W. Peer Groups -

a. North - Statewide Medicaid Managed Care (SMMC) Regions 1-9, less Palm Beach and Okeechobee Counties;

b. South - Statewide Medicaid Managed Care (SMMC) Regions 10-11, plus Palm Beach and Okeechobee Counties.

X. Price – The standardized rate for each peer group that is calculated for the operating, direct, and indirect care cost components.

Y. Provider - A person or entity licensed and/or certified under state law to deliver health care or related services, which services are reimbursable under the Florida Medicaid program.

Z. Quality Measure Percentile – The percentile for each quality incentive component measure that will be used to rank and award points to providers in relation to other Florida Medicaid providers included in the prospective payment methodology.

AA. Rate period - October 1 – September 30

BB. Rate setting acceptance cut-off date - The rate setting acceptance cut-off date is April 30 or the next business day if April 30 falls on a weekend of the year in which the rate period begins.

CC. Rate setting unit cost - The weighted average per diem after all rate reductions based on submitted cost reports.

DD. Region - AHCA shall plan and administer its programs of health, social, and rehabilitative services through 11 service areas composed of the following counties:

1. Region 1 - Escambia, Okaloosa, Santa Rosa, and Walton counties
2. Region 2 - Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington counties
3. Region 3 - Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwanee, and Union counties
4. Region 4 - Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties
5. Region 5 - Pasco and Pinellas counties
6. Region 6 - Hardee, Highlands, Hillsborough, Manatee, and Polk counties
7. Region 7 - Brevard, Orange, Osceola, and Seminole counties
8. Region 8 - Charlotte, Collier, Desoto, Glades, Hendry, Lee, and Sarasota counties
9. Region 9 - Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie counties
10. Region 10 - Broward county
11. Region 11 - Dade and Monroe counties

EE. Reimbursement ceilings - The upper rate limits for a Florida Medicaid nursing facility's operating and patient care reimbursement for nursing home providers in a specified reimbursement peer group for the providers exempt from the prospective payment system.

FF. Reimbursement ceiling period - October 1 – September 30

GG. Renovation - A renovation/major improvement shall mean a capital expenditure that exceeds $500 per existing licensed bed. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider Reimbursement Manual (CMS 15-1) or are betterments or improvements

which meet the criteria of §108.2 of the Provider Reimbursement Manual (CMS 15-1). Allowable capital expenditures includes items capitalized as either building, building improvement, land improvements, equipment, and leasehold improvements that are not associated with the addition or replacement of beds. If a renovation/major improvement project involved construction activities in both the licensed nursing facility and the non-nursing sections of the facility, only those construction costs associated with the licensed nursing facility section of the facility should be included. Documentation must be maintained to demonstrate how construction costs were allocated between the licensed nursing facility and the non-nursing sections of the facility.

HH. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare, as provided for in the SSA, as certified by 42, United States Code U.S.C. 1395-1395pp).

II. Title XIX - Grants to States for Medical Assistance Programs (Medicaid, as provided for in the SSA, as certified by 42, U.S.C. 1396-1396i).

Appendix A: Calculation of Florida Nursing Facility Cost Inflation Index

The following example uses data from the October 1, 2018 rate period. For this rate period the percentage weights for the cost components are:

Component	Direct Patient Care	Indirect Patient Care	Operating
Salaries and Benefits	93.11%	66.71%	66.71%
Dietary	5.36%	0.00%	0.00%
Others	1.53%	33.29%	33.29%

An inflation index for each of these components is developed from IHS Healthcare Cost Review quarterly index, Skilled Nursing Facility without Capital Market Basket table, using the following routine services costs inflation indices:

Component	IHS Index
Salaries and Benefits	Wage & Salary combined with Employee Benefits
Dietary	Food
All Others	Utilities combined with All Other Expenses

The IHS indices are combined by summing the products of each index times the ratio of the respective Global Insight budget share to total budget share represented by the combined indices.

The following example uses data from the first quarter of 2018 Healthcare Cost Review publication to calculate the first quarter of 2016 Salaries and Benefits component. The All Others Index is calculated in the same manner.

Year: Quarter	Index Name	Index Value
2016:01	Wage and Salary Index	1.041
2016:01	Budget Share of Wage & Salary Index	0.545
2016:01	Employee Benefits	1.029
2016:01	Budget Share of Employee Benefits	0.113

The Weighted Salaries and Benefits index is calculated using the following formula:

(1.041 X 0.545/(0.545+0.113)) + (1.029 X 0.113/(0.545+0.113)) = 1.039

A Combined Quarterly Index is then constructed by summing the products of the weights and quarterly component indices.

The Combined Quarterly Index is calculated using the following formula:

(Weighted Salaries & Benefits Index X percentage weight) + (Dietary Index X percentage weight) + (Weighted All Others Index X percentage weight)

(1.039 X 66.71%) + (0.965 X 0.00%) + (1.042 X 33.29%) = 1.03999870

The Weighted Salaries and Benefits Index and the Combined Quarterly Index is utilized to obtain monthly indices called the Florida Nursing Facility Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

The Average combined quarterly index for direct care, indirect care, and operating costs for months with end dates that correspond with the end date of a quarter is calculated using the following formula.

Average Combined Quarterly Index for Direct Care = [(Combined Quarterly Index for current quarter + Combined Quarterly Index for following quarter) / 2]

2016:1 = [(1.035+1.040)/2] = 1.038

Quarter	Average Combined Quarterly Index for Direct Care	Average Combined Quarterly Index for Indirect Care and Operating	Corresponding Month
2016:1	1.038	1.043	March 31
2016:2	1.044	1.050	June 30
2016:3	1.051	1.057	September 30
2016:4	1.056	1.064	December 31

The Average Combined Quarterly Indexes for months that do not end on the end date of a quarter are calculated as follows:

April 2016 Average Combined Quarterly Index for Direct Care

= (June 30 Index/March 31 Index)$^{1/3}$ X (March 31 Index)

= (1.044/1.038)$^{1/3}$ X 1.038 = 1.040

May 2016 Average Combined Quarterly Index for Direct Care

= (June 30 Index/March 31 Index)$^{2/3}$ X (March 31 Index)

= (1.044/1.038)$^{2/3}$ X 1.038 = 1.042

These indices will be updated prior to each rate setting.

Appendix B: Rate Changes

A. On October 1, 2018, the Prospective Payment System methodology was implemented with $132,166,796 to fund the transition to the Prospective Payment System methodology.

B. On October 1, 2019 additional non-recurring funding was included for October 1, 2019 rates in the amount of $15,915,813 to fund the quality incentive payments.

C. On October 1, 2022 additional recurring funding was included for the October 1, 2022 rates in the amount of $290,730,362 to fund the legislatively mandated $15 Minimum Wage increase.

D. On October 1, 2023, additional recurring funding was included for the October 1, 2023 rates in the amount of $93,183,354 to increase Medicaid rates by increasing the quality component of the Medicaid rates from 6% of non-property funds to 10% of non-property funds.

E. On October 1, 2023, additional recurring funding was included for the October 1, 2023 rates in the amount of $31,840,734 to fund a nursing home reimbursement rate increase.

Appendix C: Upper Payment Limit (UPL) Methodology

A. Pursuant to 42 CFR 447.272, AHCA shall use a cost-based demonstration to ensure Florida Medicaid expenditures do not exceed the Upper Payment Limit (UPL), a reasonable estimate of the amount that would be paid for the services furnished under Medicare payment principles. The UPL shall be determined separately for state government, non-state government, and privately owned or operated nursing facilities. The UPL calculation requires the compilation of Medicare and Florida Medicaid data for all nursing facilities that participate in the Florida Medicaid program. Medicare data shall be acquired from the most recently available, filed Medicare cost report, Form #CMS 2540, from a reporting period no more than two years prior to the current rate year. The following fields from the Medicare cost report are used in the UPL calculation:

1. Total Medicare Routine Cost found on Worksheet B or Worksheet D.
2. Ancillary Medicare Charges, Ancillary Medicare Cost, Drug Charges, and Drug Cost found on Worksheet C.
3. Medicare Days found on Worksheet D or Worksheet S.

B. Florida Medicaid charges and days reported in the Florida Medicaid cost reports, which are used for the October 1, 2022 rate setting, shall be used for the fiscal year 2022-2023 UPL calculation. The state shall only include Florida Medicaid charges from in-state Florida Medicaid residents and shall exclude crossover claims, physician service charges, and other professional service charges. Estimated Florida Medicaid expenditures for the applicable fiscal year shall be calculated based on the nursing facility per diem rates effective October 1, 2021 and October 1, 2022. The average of the rates will be multiplied by annualized Florida Medicaid days to determine total estimated Florida Medicaid expenditures. The Florida Medicaid expenditures shall be the net actual total expenditures excluding patient responsibility. The Florida Medicaid expenditures include base payments through Florida Medicaid reimbursement to the provider. Payments shall be identified separately as private, state government, and non-state government. The dollar amount of payments for the UPL base period shall equal the claimed amounts on the CMS-64, a quarterly expense report.

C. The total UPL for each provider shall be trended from the midpoint of the corresponding Medicare cost report to the midpoint of the state fiscal year. The data shall be trended to inflate historical Medicare costs to reflect current period expenses. The trending factors shall come from the IHS Healthcare Cost Review, the Skilled Nursing Facility Total Market Basket Index, and the %MOVAVG line.

D. The Total Trended Upper Payment Limit shall be calculated for each facility as follows:

Total Trended Upper Payment Limit = Total Upper Payment Limit X Trend Factor

Total Upper Payment Limit = Routine UPL Cost + Ancillary UPL Cost

$$\text{Routine UPL Cost} = \frac{\text{Total Medicare Routine Cost}}{\text{Medicare Days}} \times \text{Annualized Florida Medicaid Days}$$

$$\text{Ancillary UPL Cost} = \frac{\text{(Ancillary Medicare Cost – Medicare Drug Cost)}}{\text{(Ancillary Medicare Charges – Medicare Drug Charges)}} \times \text{Ancillary Florida Medicaid Charges}$$

Note: The Ancillary UPL Cost shall be calculated by removing costs and charges for drugs to account for differences in Medicare and Florida Medicaid costs and charges.

Appendix D: Chart of Accounts to Cost Component Crosswalk

The direct care, indirect care, and operating components include allowable costs reported in the following accounts on the Medicaid uniform cost report.

Chart of Accounts Categories	Account Number	Per Diem Component
DPC = Direct Care of Resident Care Costs	81xxxx	Direct
PT = Physical Therapy	921xxx	Direct
S/AT = Speech and Audiological Therapy	922xxx	Direct
OT = Occupational Therapy	923xxx	Direct
PEN = Parenteral/Enteral (PEN) Therapy	924xxx	Direct
I/RT = Inhalation/Respiratory Therapy	927xxx	Direct
IV = IV Therapy	928xxx	Direct
DIET = Dietary	912xxx	Direct
IPC = Indirect Care of Resident Care Costs (Nursing Services, employee related expenses)	91xxxx	Indirect
ACT = Activities Services	914xxx	Indirect
SOC = Social Services	915xxx	Indirect
COM = Complex Medical Equipment	925xxx	Indirect
MEDS = Medical Supplies Charges to Residents	926xxx	Indirect
AA = Other Allowable Ancillary Cost Centers	929xxx	Indirect
CENT = Central Supply Services	917xxx	Indirect
MEDR = Medical Records	916xxx	Operating
PO = Plant Operation	71xxxx	Operating
HSK = Housekeeping	72xxxx	Operating
ADM = Administration	73xxxx	Operating
L&L = Laundry and Linen	918xxx	Operating

FLORIDA TITLE XIX INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED REIMBURSEMENT PLAN FOR PUBLICLY OWNED AND PUBLICLY OPERATED FACILITIES

VERSION VIII

EFFECTIVE DATE: July 1, 2004

I. Cost Finding and Cost Reporting

A. Each intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR-DD) provider participating in the Florida Medicaid program shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time up to six months from fiscal year end for filing cost reports. An extension for filing a cost report is not an exception to the February 1, and August 1 dates in determining which cost reports are used to establish rates effective April 1 and October 1 of each year. The cost reporting year adopted for the purpose of this plan shall be the same as that for Title XVIII cost reporting, if applicable. Four complete, legible copies of the cost report shall be submitted to the Agency for Health Care Administration.

B. Cost reports used to establish rates effective April 1, 1991 shall be used to establish rates effective July 1, 1991 for all providers enrolled in the Medicaid program as of April 1, 1991.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report must be prepared using the accrual basis of

accounting in accordance with generally accepted accounting principles, as incorporated by reference in Rule 61H1-20.007 F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual CMS PUB.15-1 , incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities, and State of Florida Administrative Rules. The CMS PUB.15-1 Manual may be obtained from the regional Health Care Financing Administration office in Atlanta. For government-owned and operated facilities operating on a cash method of accounting, data based on such a method of accounting will be acceptable. The person preparing the cost report must sign the cost report as the preparer. Cost reports which are not signed shall not be accepted.

D. If a provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 90 days, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. A provider who does not file within 180 days of the end of his cost reporting period shall have his contract canceled.

E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership must file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with Title 42 Code of Federal Regulations (CFR), Sections 413.24 (a),(b),(c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information must be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all

ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and must be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records must be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 3 years following the date of submission of the cost report form to AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 must be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17 . Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I. New providers entering the program must submit a cost report for a period of not less than 12 months for purposes of setting prospective rates. A partial-year cost report may be submitted initially, but may be used only to adjust the interim budgeted rate in effect.

J. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

II. Audits

All cost reports submitted by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits and desk audits of cost reports and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447. 202 and generally accepted auditing standards. The auditor must express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, Florida Statutes..

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for such.

III. Allowable Costs

A. The cost report must include all items of expense which a provider must incur in meeting:

1. The definition of intermediate care facility set forth in Section 42 CFR 440.150 ;
2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act in 42 CFR 442, Subpart C;
3. The requirements established by the state agency responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610 ; and
4. Any other requirements for licensing under laws in the state which are necessary for providing long-term care facility services, as applicable.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative or other professional treatments which shall be composed of, for example, medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy or other mental retardation specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII principles of reimbursement, CMS PUB.15-1 (1993), and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses for services covered by Florida Medicaid programs other than the ICF/MR-DD Program are not allowable

under this plan and should not be included in the ICF/MR-DD cost report for Medicaid. These include expenses associated with prescription drugs, physicians' fees, etc. Refer to the services covered by the Medicaid ICF/MR-DD vendor payment in the Florida Medicaid ICF/MR-DD Services Coverage and Limitations Handbook. Refer to Chapter 59G-4.170, F.A.C., for further clarification of allowable and non-allowable costs.

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay $10.00. If Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt. Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17 Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS PUB.15-1 . Providers must identify such related organizations and costs in their cost reports.

G. Other costs which are allowable shall be limited by the following provisions:

1. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 (1993) or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:

   a. It is the intent of the Medicaid program to limit lease cost reimbursement, that is, rent, to the allowable ownership costs associated with the leased land, building, and equipment. For the

purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:

(1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;

(2) Sales tax on lease payments, if applicable; and

(3) Return on equity that would be paid to the owner if he were the provider, as per Section H. below.

b. Implementation of this provision shall be in accordance with the following:

(l) Reimbursable lease costs of existing providers as of July 18, 1984 will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement commencing on or after July 18, 1984 with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in

property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record as of July 18, 1984 or the rent, whichever is lower.

(3) For new providers entering the Medicaid program on or after July 18, 1984, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs must be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner must also state that the owner agrees to make his books and records of original entry related to the ICF/MR-DD properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in Section III.G.3. below.

(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (4) above.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of b. below. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 (1993) will be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within one year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with Section 1902(a)(13)(c) of the Social Security Act, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for the mentally retarded and developmentally disabled shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

(1) One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated

retrospectively by the Secretary of H.H.S.) in the current Dodge Construction Systems Cost for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(2) One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

In any change in ownership, the total valuation of capital assets allowed for determining payment rates shall not exceed the lessor of:

(1) The acquisition cost of the facility to the new owner; or

(2) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital indebtedness, and, if applicable, return on equity.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new owner purchases the facility in 1990 for $700,000. The increase in the Dodge Construction Index and the Consumer Price Index from the date of acquisition by the seller to the date of change in ownership is 25% and 20% respectively. The new owner's allowable depreciable basis is $550,000.

Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner's allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of

Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(l) The gross recapture amount shall be the lesser of the actual gain on the sale or the Medicaid portion of accumulated depreciation after the effective date of January l, l972. The gross recapture amount shall be reduced by .877193 percent for each month in excess of forty-eight (48) months participation in the Medicaid program. Additional beds and other related depreciable assets put into service after July 1, 1990 shall be subject to the same thirteen and one-half (13 1/2) year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of forty-eight (48) months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sales Price: $6,000,000

Older Portion of Facility:

Number of beds = 60

Newer portion of facility:

Number of beds = 120

Allocation to older portion: (60/180) x 6,000,000 = $2,000,000

Allocation to new portion: (120/180) x 6,000,000 = $4,000,000

Sale Price = $6,000,000

(2) The adjusted gross recapture amounts as determined in (1) above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in (2) above shall be paid by the former owners, to the State. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Medicaid program.

(l) In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the same time he was the Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another, unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. In addition, if an owner-operator elects to withdraw from the Medicaid program and lease the facility to an operator who continues to participate in the Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, Section III.G.3.c, at the time the facility is sold. On or after July 1, 1984, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the department creating an equitable lien on the owner's capital assets. This lien shall be filed by the department with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the agency upon sale of the facility. In the event that a provider fails to sign and return the contract to the department, the Proof of Financial Ability which is required for the prospective operator of the facility to be licensed shall not be approved.

(2) For lessees entering the Medicaid program after July 1, 1984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July 1, 1984, the portion of the Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Medicaid during the months that he was the Medicaid provider or a lessor to a Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's

allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on return on equity ROE. Return on equity is also limited by the new owner's allowed acquisition cost. The new owner can receive a return on equity based upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

   a. Costs that are capitalized as per CMS PUB.15-1 (1993) provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993), and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Use Allowance

A use allowance shall not be paid for publicly owned and publicly operated facilities.

IV. Standards

A. In accordance with Chapter 120, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if

requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs. If certain costs are determined by the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 (1993) and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established semi-annually on April 1 and October 1. The most current acceptable cost report received by the agency by February 1 and August 1 shall be used in the rate-setting process to set rates effective on April 1 and October 1, respectively. The rate-setting process is detailed in Section V of this plan. The same cost reports used for the April 1, 1991 rate semester shall be used to establish rates effective July 1, 1991 through March 31, 1992. There shall not be a rate semester for October 1, 1991.

D. Reimbursement rates shall be calculated separately for two classes. The classes shall be based on the four levels of ICF/MR-DD care as defined in Chapter 59G-4.170 of the Florida Administrative Code. The four levels of care, listed in ascending order of handicap severity, are Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical. Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers must allocate costs by the four levels of care in their cost reports. The agency shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If the agency determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four levels of care.

E. For the two classes described in D. above, three components of the total reimbursement rate shall be calculated separately. These three components are operating costs, resident care costs, property costs Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

1. An error was made by AHCA in the calculation of the provider's rates.

2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 30 days after the exit conference between field audit staff and the provider has been completed.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (l) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Interim rate requests resulting from (l), (2), and (3) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in

effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

5. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Under-payment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per Section I. below.

6. The right to request interim rates shall not be granted for fiscal periods that have ended.

H. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

A. Property Costs:

Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

B. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that currently have prospective rates.

C. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

I. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid and the Developmental Services Program Office.

J. Base Costs:

The initial base costs for each provider

shall be allowable costs documented by the cost report used

to establish the rate being set. For new providers entering the Medicaid program the

initial base costs shall be established in accordance with Section IV.I. of this plan. Prospective rates calculated using unadited costs shall be retroactively adjusted when audit results become available.

K. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(6) , the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement.

At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, property cost shall be reduced or eliminated as necessary to meet the aggregate test.

V. Methodology

A. Prospective rate-setting method for rate semesters beginning on or after July 1, 1991.

1. For rate semesters beginning on April 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester July 1, 1991 through March 31, 1992, the same cost reports used in setting April 1, 1991, rates shall be used. There shall not be a rate semester for October 1, 1991.

2. Review and adjust the provider's current cost report on file to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, and operating cost. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A.

4. Calculate per diems for each of the three cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. The new base per diem for property shall be the per diem established in step 4 above.

6. Using the appropriate current per diem for resident care and operating costs from Step 4 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:

   Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective July 1, 1991, the prospective rate semester used in calculating the above fraction shall be the period July 1, 1991 through March 31, 1992.

7. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from Step 6 plus the current approved per diem for property, from Step5.

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Publicly Owned and Publicly Operated Facilities

VII. Provider Participation

This plan is designed to assure adequate participation of Publicly Owned and Publicly Operated ICF/MR-DD providers in the Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or

charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the State plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to a Publicly Owned and Publicly Operated ICF/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15 .

IX. Definitions

Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

AHCA: Agency for Health Care Administration, also known as the agency.

CMS PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

DCF: Department of Children and Family Services

ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

APPENDIX A

Provider Number FY: 09/30/84

Provider Name Audit Status Unaudited

Address

	COL C	COL A Resid./ Inst.	COL B Non-amb./ Medical	TOTAL
A.	Alloc of Exp (Excl B&C)			
1.	Resident Days	02461	8325	10786
2.	OPER. EXPENSE COMP			
a.	Administration	-	-	120482
b.	Plant Operation	-	-	45060
c.	Laundry	-	-	15265
d.	Housekeeping	-	-	29090
e.	Oper. Exp. Comp and Per Diem	19.460	19.460	209897
3.	Resident Care Expense			
a.	Dietary	-	-	74861
b.	Other -	-	34188	
c.	Nursing	-	-	86018
d.	Res. Care Exp. and Per Diem	18.0852	18.0852	19.5067
4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812
5.	ROE/UA COMP & PER DIEM	6.604	6.604	71236
B.	DIRECT CARE EXPENSE			
1.	Staffing	.5	1.	-
2.	Total Staffing Required	1230.5	8325	95555
3.	Staffing Percent	12.877%	87.123	100%
4.	Alloc. of Direct Care	39263.97	26542.03	304906
5.	Dir. Care Exp. Per Diem	15.945	31.9090	
C.	ADDITIONAL SERVICES EXPENSE			
1.	Medicaid Patient Days	2461	8275	10736
2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST			
1.	Operating Component	19.460	19.460	209897
2.	Resident Care Component	48.985	58.378	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078

APPENDIX B

CALCULATION OF THE
FLORIDA ICF/MR-DD COST INFLATION INDEX

1. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in 1983. These percentage weights are:

Salaries and Benefits	65.66%
Dietary	4.94%
All Other	29.40%
	100.00%

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

COMPONENT	DRI INDEX
Salaries and Benefits with Employee Benefits	Wages and Salaries, combined
Dietary	Food
All Others with other expenses	Fuel and Utilities, combined

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of 1984 using Health Care Costs, Third Quarter 1983 Series, p. 15:

DRI Wages and Salaries index = 1.043; Budget Share = .602

DRI Employee Benefits index = 1.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =
(1.043 x (.602/(.602 + .084))) + (1.073 x (.084/
(.602 + .084))) = 1.047

3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/MR-DD Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

Quarter Midpoint Quarter	Index	Average Index	Corresponding Month
1984:1	1.029		
		1.032	March 31
184:2	1.035		
		1.042	June 30
1984:3	1.048		
		1.054	September 30
1984:4	1.059		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.042/1.032)1/3 x 1.032
= 1.035

May 30 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.042/1.032)2/3 x 1.032
= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 13 indices in order to recognize full inflation for a 12-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend must start with the index as of the last day of the month prior to the 12-month period.
Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.

$$\text{1984 Target factor} = \frac{\text{average of inflation indices from June 1983 through June 1984}}{\text{average of inflation indices from June 1982 through June 1983}}$$

$$\frac{(.994 + .999 + 1.004 + 1.009 + 1.014 + 1.018 + 1.023 + 1.026 + 1.029 + 1.032 + 1.035 + 1.039 + 1.042)/13}{(.950 + .954 + .958 + .962 + .966 + 971 + .975 + .979 + .982 + .986 + .989 .992 + .994)/13}$$

$$= \frac{1.020}{.974}$$

$$= 1.047$$

In the example above, the indices for June 30, 1982, .994, and June 30, 1983, .950 are taken to represent the relative level of costs on July 1, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the 13 indices are used to capture a complete 12-month period.

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FLORIDA TITLE XIX REIMBURSEMENT PLAN FOR SERVICES IN FACILITIES NOT PUBLICLY OWNED AND NOT PUBLICLY OPERATED

VERSION XX

EFFECTIVE DATE: July 1, 2023

I. Cost Finding and Cost Reporting

A. Each intermediate care facility for individuals with intellectual disabilities (ICF/IID) that is not publicly owned and not publicly operated participating in the Florida Medicaid program and being reimbursed under the provisions of this reimbursement plan shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked, or accepted by a common carrier, no later than five calendar months after the close of its cost reporting year. No exceptions will be granted to the filing time limits. Two complete, legible, copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. The cost reporting forms and instructions shall be the same as used for facilities reimbursed in accordance with Rule 59G-6.040, Florida Administrative Code (F.A.C.).

B. The most current cost report received by AHCA on or before February 1st each year shall be used to establish rates effective July 1 for all facilities that were being reimbursed in accordance with Rule 59G-6.040, F.A.C.

C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report shall be prepared using the accrual basis of accounting in accordance with generally accepted accounting principles and the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual Centers for Medicare and Medicaid Services (CMS) PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated, and State of Florida administrative rules. The CMS PUB.15-1 Manual may be obtained from the regional CMS office in Atlanta.

Amendment: 2023-0005
Supersedes: 2022-0012
Approval Date: July 25, 2024
Effective Date: July 1, 2023

The person preparing the cost report shall sign the cost report as the preparer and include contact information. Cost reports not signed will not be accepted.

D. If a provider files a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been filed within five months, then the provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively.

E. A provider who voluntarily (or involuntarily) ceases to participate in the Florida Medicaid program or experiences a change of ownership (CHOW) shall file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with 42 Code of Federal Regulations (CFR), sections 413.24 (a), (b), (c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and shall be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records shall be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of three years following the date the cost report was filed with AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 shall be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431. 17. Access to filed cost reports shall be in accordance with Chapter 119, Florida Statutes (F.S.).

I New providers entering the program shall submit a cost report for a period of not less than 12 months and not greater than 23 months for purposes of setting prospective rates. Initial cost report must be filed not than 5 calendar months after the cost of the provider's fiscal year end and are due not later than 23 months after the provider's CHOW effective date. A partial-year cost report may be filed initially, but may only be used to adjust the interim budgeted rate in effect.

J. The provisions of this reimbursement plan shall apply to all ICF/IID facilities not publicly owned and not publicly operated. These facilities shall include ICF/IID facilities that are publicly owned and the State of Florida is the Medicaid provider of record, but are operated or managed by a not-for profit or for profit organization.

K. Unless specifically noted, the terms facility and provider shall have the same meaning for all sections of this reimbursement plan.

L. Cost reports shall include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

M. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.

N. Providers are subject to sanctions pursuant to sections 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

All cost reports filed by the providers shall be either field or desk audited at the discretion of AHCA.

A. Description of AHCA's Procedures for Audits - General

1. Primary responsibility for the audit of providers shall be assumed by AHCA. The efforts of AHCA audit staff may be augmented by contracts with certified public accountant (CPA) firms to ensure that the requirements of 42 CFR447.202 are met. AHCA shall determine the scope and format for on-site audits, desk audits of cost reports, and financial records of providers.
2. All audits shall be based on American Institute of Certified Public Accountants(AICPA) Attestation Standards for examining or reviewing statistical information and other data.
3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447. 202 and AICPA Attestation Standards. The auditor shall express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for three years.
4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, F.S.

B. Desk Audit Procedures

l. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Florida Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for each.

III. Allowable Costs

A. The cost report shall include all items of expense which a provider shall incur in meeting:

l. The definition of intermediate care facility set forth in 42 CFR 440.l50.

2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act (SSA) in 42 CFR 442, Subpart C.

3. The requirements established by AHCA under the authority of 42 CFR 431.610.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative, or other professional treatments which shall be composed of medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy, or other intellectual disability specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

D. All items of expense that providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses excluded from the cost report and reimbursable outside the per diem rate include:

- Practitioner services for acute events, including one visit per month for chronic care management
- Dialysis services rendered in the outpatient hospital or freestanding dialysis center setting
- Podiatry services
- Flu and pneumonia vaccines

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily Medicaid reimbursement rate is $50.00; State pays $40.00 and resident is to pay

$l0.00. If the Medicaid resident pays only $8.00, then $2.00 would be an allowable bad debt. Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters were sent to the appropriate party responsible for the debt within l2 months of revenue recognition.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17, Medicare (Title XVIII) Principles of Reimbursement, and Chapter l0, CMS PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.

G. Other allowable costs shall be limited by the following provisions:

l. The owner administrator and owner assistant administrator compensation shall be limited to reasonable levels determined in accordance with CMS PUB.15-1 or as may be determined by surveys conducted by AHCA.

2. Limitation of rents:

a. It is the intent of the Medicaid program to limit lease cost reimbursement (rent) to the allowable ownership costs associated with the leased land, building, and equipment. For the purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:

(1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;

(2) Sales tax on lease payments, if applicable; and

(3) Return on equity (ROE) that would be paid to the owner if he were the provider, as per section H. below.

b. Implementation of this provision shall be in accordance with the following:

(1) Reimbursable lease costs of existing providers will remain unchanged until such time as the provider documents that ownership costs, as

defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record or the rent, whichever is lower.

(3) For new providers entering the Medicaid program, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs shall be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Florida Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered

into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the ICF/IID properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in section III.G.(3).

(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per four above.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost subject to the provisions of subsection b. All other provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS PUB.15-1 shall be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase l00 percent of the stock of the facility, and within one year, merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with section 1902(a)(13)(c) of the SSA, in a case in

which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for individuals with intellectual disabilities for facilities not publicly owned and publicly operated shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

(1) One-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary of HHS.) in the current Dodge Construction Systems Cost for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year; or

(2) One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

In any change in ownership, the total valuation of capital assets allowed for determining payment rates shall not exceed the lessor of:

(1) The acquisition cost of the facility to the new owner; or

(2) The fair market value of the facility at the time of purchase.

This valuation shall be used to calculate depreciation, interest on capital indebtedness, and, if applicable, ROE.

Example 1: The allowable acquisition cost of the facility to the seller in 1985 was $500,000. A new owner purchases the facility in 1990 for $700,000. The increase in the Dodge Construction Index and the Consumer Price Index from the date of acquisition by the seller to the date of change in ownership is 25% and 20% respectively. The new owner's allowable depreciable basis is $550,000.

Example 2: The allowable acquisition cost of the facility to the seller in 1985 was $1,500,000. A new owner purchases the facility in 1990 for $1,250,000. The new owner's allowable depreciable basis is $1,250,000.

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates the fact that depreciation used for the purpose of computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(1) The gross recapture amount shall be the lesser of the actual gain on the sale or the Florida Medicaid portion of accumulated depreciation. The gross recapture amount shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program. Additional beds and other related depreciable assets put into service shall be subject to the same thirteen and one-half year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of 48 months participation in the Florida Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the

proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sales Price: $6,000,000

Older Portion of Facility:

Number of beds = 60

Newer portion of facility:

Number of beds = 120

Allocation to older portion: (60/180) x 6,000,000 = $2,000,000

Allocation to new portion: (120/180) x 6,000,000 = $4,000,000

Sale Price = $6,000,000

(2) The adjusted gross recapture amounts as determined in one above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in two above shall be paid by the former owners, to AHCA. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of

extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Florida Medicaid program.

(1) In cases where an owner-operator withdraws from the Florida Medicaid program as the provider, but does not sell the facility, the depreciation paid by Florida Medicaid to the owner during the same time he was the Florida Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another unrelated licensed operator after having operated the facility as the licensed Florida Medicaid provider. In addition, if an owner-operator elects to withdraw from the Florida Medicaid program and lease the facility to an operator who continues to participate in the Florida Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, section III.G.3.c, at the time the facility is sold. All owner-providers that withdraw from the Florida Medicaid program shall be required to sign a contract with the Agency for Persons with Disabilities (APD) creating an equitable lien on the owner's capital assets. This lien shall be filed by APD with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to AHCA upon sale of the facility. In the event that a provider fails to

sign and return the contract to APD, the Proof of Financial Ability, which is required for the prospective operator of the facility to be licensed, shall not be approved.

(2) For lessees entering the Florida Medicaid program and for existing Florida Medicaid providers who are granted an upward adjustment to their allowable lease costs, the portion of the Florida Medicaid reimbursement rent payment that represents depreciation expense shall be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

The recapture amount owed by the owner shall be computed using the amount of depreciation claimed by the owner and allowed by Florida Medicaid during the months that he was the Florida Medicaid provider or a lessor to a Florida Medicaid provider, or both.

4. Limitations on interest. For reimbursement purposes, the amount of interest allowed to a new provider in a change of ownership is limited by the allowed basis for depreciation. If the new owner's equity in the facility is less than the allowed basis for depreciation, the owner shall be allowed interest expense on the difference between the allowed basis and the equity. If the new owner's equity in the facility is more than the allowed basis for depreciation, no interest shall be allowed.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting $500,000 down and financing $1,500,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000, and he can be reimbursed interest on $500,000 at 15 percent, that is, $1,000,000 - $500,000 = $500,000 at current rate of 15 percent.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting $1,250,000 down and financing $750,000 at 15 percent. The new owner's allowable depreciation basis is $1,000,000 which is less than the equity, so he receives no interest reimbursement.

5. Limitations on ROE. ROE is also limited by the new owner's allowed acquisition cost. The new owner can receive an ROE upon his actual equity, up to the allowed acquisition cost.

Example 1: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $750,000. The new owner's allowable depreciation basis is $1,000,000, and he can receive an ROE reimbursement on the $750,000.

Example 2: The original owner's acquisition cost is $1,000,000.

A new owner purchases the facility in 1985 for $2,000,000, putting down $1,250,000. His equity amount for reimbursement purposes shall be limited to $1,000,000.

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

   a. Costs that are capitalized as per CMS PUB.15-1 provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.

   b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including

building equipment, major movable equipment, and minor equipment as described in CMS PUB.15-1, shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been financed through a "conventional financing" debt instrument over a 25-year period, with a ten percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus two percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a ten percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in ROE or use allowance that would have occurred had a full ten percent down payment actually been made. If the total ROE payment would increase from zero to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments, with amortization of the principal beginning in the first year, that is, a 25-year payoff schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of the date the provider received a loan commitment from the lending institution, or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an

increase in their interest rate, but not to exceed that cost which would be incurred at an interest rate of l5 percent per annum.

c. Additional costs due to refinancing shall not be allowed if refinancing was not necessary in order to meet the final payments of the former debt instrument, that is, in cases where balloon payments are due, or to finance the addition of new beds.

d. AHCA shall make exceptions to the financing limitations set forth in (a) and (b) above when, in consultation with the Agency for Persons with Disabilities (APD), it is in the best interest of the State. Exceptions to the financing limitations shall be considered when it has been demonstrated through the Certificate of Need (CON) or Request for Proposal (RFP) process that financing within the limitations of this plan is not available.

Should that decision be made, the APD shall issue a new RFP allowing other financing options. APD shall reject any or all proposals which are made in response to a new RFP if APD determines that the rejection is in the best interest of the State.

7. Additional costs incurred after enrollment in the program that are due to capital additions or expansion shall have prior approval by the APD Office of Developmental Services if such costs exceed one percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's CON process. Costs for specific expansions or additions that exceed the one percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in section III.G(4).

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility, the actual cost of the improvements shall be added to the owner's basis,

allowing the owner reimbursement of interest, ROE, or both as specified in section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider shall maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Return on Equity

A reasonable ROE invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This ROE shall use the principles stated in Chapter 12, CMS PUB.15-1, except that the rate of return shall be equal to the average of the rates of interest on special issues of public debt obligations issued to the Federal Hospital Insurance Trust Fund for each of the months during the provider's reporting period or portion thereof covered under the Florida Medicaid program. ROE shall be limited to those providers who are organized and operated with the expectation of earning a profit for the owners, as distinguished from providers organized and operated on a non-profit basis.

I. Use Allowance

A use allowance on equity capital invested and used in providing resident care shall be defined for purposes of the plan as an allowable cost. The use allowance shall be allowed only for non-profit providers, except for those facilities which are government-owned. This use allowance shall use the principles established in section H. above.

IV. Standards

A. In accordance with Chapter l20, F.S., Administrative Procedures Act (APA), this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in section IV.L. of this plan. Further, if certain costs are determined by the Florida Medicaid program or the Florida Medicaid Division of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

C. Prospective payment rates shall be established annually on July 1. The most current acceptable cost report received by AHCA by February l shall be used in the rate setting process to set rates effective on July l.

D. Reimbursement rates shall be calculated separately for the following levels of reimbursement:

1. Intermediate Care Facility Level of Reimbursement One - A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation.

2. Intermediate Care Facility Level of Reimbursement Two - A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.

3. Intermediate Care Facility Level of Reimbursement Three - A reimbursement level for recipients who are developmental disable, severe maladaptive behaviors and co-ocurring complex medical conditions or a dual diagnosis of developmental disability and mental illness.

Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute another class and Behavorial Health shall constitue the other. All providers shall allocate costs by the two levels of care in their cost reports. AHCA shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If AHCA determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on types of care.

E. For the classes described in section D. above, four components of the total reimbursement rate shall be calculated separately. These four components are operating costs, resident care costs, property costs, and ROE costs or use allowance, if applicable. Inflation allowances used in the rate-setting process shall be applied to the operating and resident care cost components independently for the two reimbursement classes.

F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:

l. An error was made by AHCA in the calculation of the provider's rates.

2. A provider files an amended cost report used to determine the rates in effect. An amended cost report may be filed in the event that it would effect a change of one percent or more in the total reimbursement rate. The amended cost report shall be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 60 days after the exit conference between field audit staff and the provider has been completed.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.

G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine annual rate setting process described in section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections IV.H. and IV. I.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of one percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (l) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of ten percent or more in the provider's current total per diem rate. The provider shall submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by AHCA and shall be the basis for establishing reasonable cost parameters.

Interim rate requests resulting from (l), (2), and (3) above shall be filed within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, Florida Medicaid, Bureau of Medicaid Program Finance, shall determine whether additional information is needed from the provider and request such information

within 30 days. Upon receipt of the complete, legible additional information requested, the Bureau of Medicaid Program Finance shall approve or disapprove the interim rate within 60 days. If Florida Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement.

Overpayment as a result of the difference between the approved budgeted interim rate and actual costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider.

After the interim rate is settled, a provider's cost basis shall be restricted to the same limits as those of a new provider per section I.

5. The right to request interim rates shall not be granted for fiscal periods that have ended.

H.1. For a new provider in a facility with greater than six beds, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited as follows:

1. Property Costs:

Shall be approved by Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. Operating Costs:

Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. Resident Care Costs:

Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

H.2. For a new provider in a facility with six beds or less, the interim cost per diems for each reimbursement class shall be the budgeted component cost rates approved by AHCA. These initial cost estimates shall be limited by ceilings as follows:

1. Property Costs Ceiling:

   Shall be approved by the Florida Medicaid and shall not be in excess of the limitations established in section III. of this plan.

2. Operating Costs Ceiling:

   Shall not exceed the 90th percentile of per resident day costs of all currently participating ICF/IID providers that currently have prospective rates.

3. Resident Care Costs Ceiling:

   Shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate.

4. Total costs per diem ceiling (including ROE):

   Shall not exceed $239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed $267.02 for the Developmental Non-Ambulatory classes, which are the base rates for rate semester April 1998. For subsequent rate semesters. these ceiling amounts shall be inflated forward based on one times the ICF/IID inflation index utilizing the same inflation methodology as used in calculating prospective rates. When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including ROE.

Example:	Interim Cost	Percent to Total	Ceiling
Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67

ROE	7.26	2.9	6.97
Total	250	100%	240

I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12 month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Florida Medicaid.

I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in section V.B. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Florida Medicaid.

J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/IID Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in section V.A.(7). of this plan.

K. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any condition of participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set.

L. A provider's reimbursement for service provided under the Florida Medicaid program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is, less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

M. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida ICF/IID Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.

N. Aggregate test comparing Florida Medicaid to Medicare according to 42 CFR section 447.253(c)(2), Florida Medicaid estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.

O. Base Costs:

The initial base costs for each provider shall be the allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Florida Medicaid program the initial base costs shall be established in accordance with section IV.I. of this plan. Prospective rates calculated using unaudited costs shall be retroactively adjusted when audit results become available.

P. Effective July 1, 2011 through June 30, 2015, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

V. Methodology

A. Rate-setting method for rate periods beginning on or after July 1, 2014.

1. For rate periods beginning on July l of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February l of that year.

2. Review and adjust each provider's cost report referred to in section IV.N. to reflect the results of desk or on-site audits, if available.

3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and ROE or use allowance if applicable. See the glossary section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.

4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.

5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly Florida ICF/IID Cost Inflation Indices associated with the more recent cost reporting

period divided by the simple average of the monthly indices associated with the prior cost reporting period.

6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet state or federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and one percent threshold under the interim rate provisions in section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider shall furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in step five above to reflect the allowable change in costs.

7. Compare the operating and resident care cost per diems resulting from step six with the respective per diems from step four for each reimbursement class.

   a. If the operating per diem for either reimbursement class from step four is less than the respective operating per diem from step six, then establish the new operating base per diem as the per diem from step four plus an incentive of one-half of the difference between the two per diems, not to exceed l0 percent of the step four per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a Condition of

Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the operating per diem from step four is greater than the step six per diem, then establish the new operating base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

b. If the resident care per diem for either reimbursement class from step four is less than the respective resident care per diem from step six then establish the new resident care base per diem as the per diem from step four plus an incentive calculated as 50 percent of the difference between the step four per diem and the step six per diem, not to exceed three percent of the step four per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a condition of participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the resident care per diem from step four is greater than the step six per diem, then establish the new resident care base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

c. If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of each class. This shall equalize the operating rate cost components and allow for more meaningful trend comparison between cost reporting periods.

8. The new base per diems for property and ROE or use allowance shall be the per diems established in step four above.

9. Using the appropriate current base per diem for resident care and operating costs from step seven above, calculate the prospective operating and resident care per diems for the new rate period by multiplying each of the base per diems by the fraction:
Simple average of the Florida ICF/IID monthly cost inflation indices for the prospective rate period divided by the simple average of the Florida ICF/IID monthly cost inflation indices for the cost report period used to calculate current base per diems.

10. Establish the total prospective per diem for each reimbursement class as the sum of the appropriate operating and resident care per diems resulting from step nine plus the current approved per diems for property and ROE or use allowance, if applicable, from step eight.

B. Florida Medicaid Trend Adjustment (MTA) – For Rate Periods on or After July 1, 2014 through June 30, 2022

1. Effective July 1, 2014, reimbursement rates for intermediate care facilities will be set July 1 of each year. Between July 1, 2014 and April 30, 2016, providers may elect to change their fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months due to the transition to an annual rate setting. Cost report fiscal year end changes for this purpose are allowed even if a recent change has occurred and cost reports have not been filed with the same fiscal year end for two years.

2. Effective July 1, 2021 the reimbursement methodology will incorporate the funding as outlined in the annual General Appropriation Act, which provides fundingof $44,710,177 to buy-back intermediate care facilities rate reductions, effective on or after October 1, 2008.

3. The recurring methodology to establish rates taking into consideration the cuts imposed on or after October 1, 2008, shall be to compare the legislative unit cost with the rate setting unit cost as follows:

1) The legislative unit cost shall be determined by dividing the total appropriation for intermediate care facilities by the total bed days for the past fiscal year;
2) The total actual cost as generated based on the July 1 rate settings shall be divided by the total bed days for the past fiscal year to determine the rate setting unit cost;
3) The rate setting unit cost shall be reduced to a "reduced rate setting unit cost" by the same percentage used to calculate the legislative unit cost to account for client participation contributions;
4) No negative adjustment to the rates paid to providers shall occur so long as the reduced rate setting unit cost is equal to or less than the legislative unit cost; and
5) In the event the reduced rate setting unit cost is greater than the legislative unit cost, a prorated reduction shall be imposed on all rates after all quality assessment fee funds have been exhausted to cover the rate reductions.

C. Florida Medicaid Rate Calculation – For Rate Period on or After July 1, 2023

1. Effective July 1, 2023, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $60,434,025 to buy-back intermediate care facilities rate reductions, effective on or after October 1, 2008.
2. Effective July 1, 2022, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $29,613,463 for an intermediate care facilities rate increase.
3. Effective July 1, 2023, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $23,249,062 to establish a new level of reimbursement for clients who have severe behavioral needs. The Agency shall submit budget amendment requesting release of the funds held in reserve pursuant to Chapter 216, Florida Statutes.
4. Effective July 1, 2023, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $34,991,119 to adjust fee of raising wages of direct care employee to at least $15.00 per hour.

D Base year ceilings for new providers in facilities with six beds or less

1. Property costs per diems shall not be in excess of the ceiling limitations established in section III.

2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/IID providers that have prospective rates. This ceiling shall be recalculated for every rate period beginning July 1 of each year.

3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate period beginning July 1 of each year.

4. Total costs per diem ceilings (including ROE):

   Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.(2)(.D.). multiplied times l.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including ROE, in the base year.

Example:	Interim Cost	Percent to Total	Ceiling
Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67
ROE	7.26	2.9	6.97
Total	250	100%	240

VI. Payment Assurance

AHCA shall pay each provider for services provided in accordance with the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX Reimbursement Plan for IID Services in Facilities Not Publicly Owned and Not Publicly Operated.

VII. Provider Participation

This plan is designed to assure adequate participation of ICF/IID providers in the Florida Medicaid program, the availability of high-quality services for recipients, and for services which are comparable to those available to the general public.

VIII. Payment in Full

Payments made to any provider participating in the Florida Medicaid program who knowingly and willfully charges, for any service provided to the resident under the state plan, money or other consideration in excess of the rates established by the state plan, or charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under the state plan approved under this title, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the resident: as a condition of admitting a resident to an ICF/IID facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid resident and shall be deemed to be out of compliance with 42 CFR section 447.15.

IX. Intermediate Care Facility Quality Assessment Fee (ICFQAF)

A. In accordance with section 409.9083, F.S., there is imposed upon each ICF/IID, a quality assessment. The aggregated amount of assessments for all ICF/IID's in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service

revenue of assessed facilities. AHCA shall calculate the quality assessment rate annually on a per-resident-day basis as reported by the facilities. The per-resident-day assessment rate shall be uniform. Each facility shall report monthly to AHCA its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. AHCA shall collect, and each facility shall pay, the quality assessment each month. AHCA shall collect the assessment from facility providers no later than the 15th of the next succeeding calendar month. AHCA shall notify providers of the quality assessment rate and provide a standardized form to complete and submit with payments. The collection of the quality assessment shall commence no sooner than 15 days after the agency's initial payment to the facilities that implement the increased Florida Medicaid rates containing the elements prescribed in section B below and monthly thereafter. Intermediate care facilities for individuals with intellectual disabilities may increase their rates to incorporate the assessment but may not create a separate line-item charge for the purpose of passing through the assessment to residents.

B. The purpose of the facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Florida Medicaid program to make Florida Medicaid payments for ICF/IID services up to the amount of the Florida Medicaid rates for such facilities as calculated in accordance with the approved state Florida Medicaid plan in effect on April 1, 2008. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority to:

(a) Reimburse the Florida Medicaid share of the quality assessment as a pass through, Florida Medicaid-allowable cost.

(b) Increase each privately operated ICF/IID Florida Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.

(c) Increase each ICF/IID Florida Medicaid rate, as needed, by an amount that restores any rate reductions for the 2008-2009 fiscal year and the 2009-2010 fiscal year.

(d) Increase payments to such facilities to fund covered services to Florida Medicaid beneficiaries.

C. Upon termination of the quality assessment, all collected assessment revenues, less any amounts expended by AHCA, shall be returned on a pro rata basis to the facilities that paid such assessments.

X. Glossary

A. Acceptable cost report- A completed, accurate and legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. APD - Agency for Persons with Disabilities.

C. AHCA - Agency for Health Care Administration.

D. Client participation contributions - See (M) Patient Responsibility.

E. CMS PUB.15-1- also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Florida Medicaid Services.

F. Filing due date (Cost Report) - No later than five calendar months after the close of the ICF's cost-reporting year.

G. ICF/IID operating costs - Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

H. ICF/IID resident care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

I. ICF/IID property costs - Those costs related to the ownership or leasing of an ICF/IID. Such costs may include property taxes, insurance, interest and depreciation, or rent.

J. ICF/IID return on equity or use allowance costs - See sections III.H. and III.I. of this plan.

K. Initial cost report – The ICF/IID first filed cost report containing actual costs following the budget interim period associated with their fiscal year end.

L. Late cost report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program. Analysis after the filing due date and after the rate setting due date.

M. Legislative unit cost - The weighted average per diem of the state anticipated expenditure.

N. Medicaid interim reimbursement rate – A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

O. Patient Responsibility- Florida Medicaid deducts the portion of a recipient's monthly income, as determined by the Department of Children and Families (DCF), that the recipient is required to pay.

P. Quality assessment fee - Pursuant to section 409.9083, F.S., a per-resident-day basis assessment is imposed upon each intermediate care facility.

Q. Medicaid interim reimbursement rate - A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

R. Rate setting due date - All cost reports received by AHCA by February 1 shall be used to establish the reimbursement rates. If the due date falls on the weekend, the rate setting due date is the first business day following February 1.

S. Rate setting unit cost - The weighted average per diem based on filed cost reports.

T. Reduced rate setting unit cost - The rate setting unit cost after it is reduced by the same percentage that was used to calculate the legislative unit cost in order to account for the client participation contributions.

U. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the SSA (42 U.S.C. 1395-1395pp).

V. Title XIX - Grants to States for Medical Assistance Programs (Medicaid) as provided for in the SSA (42 U.S.C. 1396-1396i).

APPENDIX A

CALCULATION OF PROVIDER COST ALLOCATION

Provider Number FY: 09/30/84

Provider Name Audit Status Unaudited

Address

			COL A Resid./ Inst.	COL B Non-amb./ Medical	COL C TOTAL
A.	Alloc of Exp (Excl B&C)				
	1.	Resident Days	02461	8325	10786
	2.	OPER. EXPENSE COMP			
		a. Administration	-	-	120482
		b. Plant Operation	-	-	45060
		c. Laundry	-	-	15265
		d. Housekeeping	-	-	29090
		e. Oper. Exp. Comp and Per Diem	19.460	19.460	209897
	3.	Resident Care Expense			
	a.	Dietary -	-	74861	
	b.	Other -	-	34188	
	c.	Nursing -	-	86018	
	d.	Res. Care Exp. and Per Diem	18.0852	18.0852	19.5067
	4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812
	5.	ROE/UA COMP & PER DIEM	6.604	6.604	71236
B.	DIRECT CARE EXPENSE				
	1.	Staffing .5	1.	-	
	2.	Total Staffing Required	1230.5	8325	95555
	3.	Staffing Percent	12.877%	87.123	100%
	4.	Alloc. of Direct Care	39263.97	26542.03	304906
	5.	Dir. Care Exp. Per Diem	15.945	31.9090	
C.	ADDITIONAL SERVICES EXPENSE				
	1.	Medicaid Patient Days	2461	8275	10736
	2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
	3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST				
	1.	Operating Component	19.460	19.460	209897

2.	Resident Care Component	48.985	58.378	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078

APPENDIX A-1

CALCULATION OF PROVIDER COST ALLOCATION

Provider Number FY: 09/30/84

Provider Name Audit Status Unaudited

Address

			COL A Resid./ Inst.	COL B Non-amb./ Medical	COL C TOTAL
A.	Alloc of Exp (Excl B&C)				
	1.	Resident Days	2461	8325	10786
	2.	OPER. EXPENSE COMP			
		a. Administration	-	-	120482
		b. Plant Operation	-	-	45060
		c. Laundry	-	-	15265
		d. Housekeeping	-	-	29090
		e. Oper. Exp. Comp and Per Diem	19.460	19.460	209897
	3.	Resident Care Expense			
	a.	Dietary -	-	74861	
	b.	Other -	-		34188
	c.	Nursing -	-	86018	
	d.	Res. Care Exp. and Per Diem	18.0852	18.0852	195067
	4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812
	5.	ROE/UA COMP & PER DIEM	6.604	6.604	71236
B.	DIRECT CARE EXPENSE				
	1.	Staffing .75	1.	-	
	2.	Total Staffing Required	1845.75	8325	10,171
	3.	Staffing Percent	18.148%	81.852%	100%
	4.	Alloc. of Direct Care	55,334.34	249,571.66	304906
	5.	Dir. Care Exp. Per Diem	22.484	29.979	
C.	ADDITIONAL SERVICES EXPENSE				
	1.	Medicaid Patient Days	2461	8275	10736
	2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
	3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST				
	1.	Operating Component	19.460	19.460	209897
	2.	Resident Care Component	55.520	56.448	606133

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Supersedes: 2022-0012
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Effective Date: July 1, 2023

3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	90.189	91.117	980078

APPENDIX B

CALCULATION OF THE
FLORIDA ICF/IID COST INFLATION INDEX

l. Weights.

Percentage weights for cost components shall be based on cost reports filed for fiscal years ending in l983. These percentage weights are:

Salaries and Benefits	65.66%
Dietary	4.94%
All Other	29.40%
	l00.00%

2. Inflation index for each component

An inflation index for each of these components is developed from the Data Resources, Inc. (DRI) Skilled Nursing Facility Market Basket of Routine Services Costs inflation indices as follows:

COMPONENT	DRI INDEX
Salaries and Benefits with Employee Benefits	Wages and Salaries, combined
Dietary	Food
All Others with other expenses	Fuel and Utilities, combined

The DRI indices that are combined are merged by summing the products of each index times the ratio of the respective DRI budget share to the total share represented by the combined indices.

Example: Calculation of the Salaries and Benefits combined index for the third quarter of l984 using Health Care Costs, Third Quarter l983 Series, p. l5:

DRI Wages and Salaries index = l.043; Budget Share = .602

DRI Employee Benefits index = l.073; Budget share = .084

Weighted Combination (Salaries and Benefits) =
(l.043 x (.602/(.602 + .084))) + (l.073 x (.084/(.602 + .084))) = l.047

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3. Quarterly and monthly indices.

A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is used to obtain monthly indices called the Florida ICF/IIDIID Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages as follows:

Quarter Midpoint Quarter	Index	Average Index	Corresponding Month
l984:1	l.029		
		l.032	March 3l
l84:2	l.035		
		l.042	June 30
l984:3	l.048		
		l.054	September 30
l984:4	1.059		

April 30 Index = (June 30 Index/March 3l Index)$^{1/3}$ x (March 3l Index)
= (l.042/l.032)1/3 x l.032
= l.035

May 30 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31Index)
= (1.042/1.032)2/3 x 1.032
= 1.039

All other monthly indices can be calculated in a similar fashion.

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize l3 indices in order to recognize full inflation for a l2-month period. This is necessary because each index represents the relative level of costs at the end of the month, so that a complete 12-month inflation trend shall start with the index as of the last day of the month prior to the 12-month period.
Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.

average of inflation indices from
l984 Target factor = June 1983 through June 1984
average of inflation indices from
June 1982 through June 1983

(.994 + .999 + l.004 + l.009 + l.014 +
l.0l8 + l.023 + l.026 + l.029 + l.032 +
= l.035 + l.039 + l.042)/13
(.950 + .954 + .958 + .962 + .966 + 97l +
.975 + .979 + .982 + .986 + .989
.992 + .994)/13

= l.020
.974
= l.047

In the example above, the indices for June 30, l982, .994, and June 30, l983, .950 are taken to represent the relative level of costs on July l, the beginning of the fiscal year, and the end of the fiscal year, respectively. Hence, in order to measure the change in the relative level of costs for a fiscal year ending June 30, the l3 indices are used to capture a complete l2-month period.

APPENDIX C

Florida Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	October 1, 2008	0.8200%	$1,524,597
2.	October 1, 2009		
	First Cut	0.7577%	$1,524,597
	Second Cut	8.7004%	$17,373,303
3.	April 1, 2010		
	First Cut	0.8145%	$1,524,597
	Second Cut	9.3580%	$17,373,303
4.	October 1, 2010		
	First Cut	0.7878%	$1,524,597
	Second Cut	9.0489%	$17,373,303
5.	April 1, 2011		
	First Cut	0.8539%	$1,524,597
	Second Cut	9.8141%	$17,373,303
6.	October 1, 2011		
	First Cut	0.8555%	$1,524,597
	Second Cut	9.8325%	$17,373,303
	Third Cut	3.9527%	$6,297,463
7.	April 1, 2012		
	First Cut	0.4245%	$762,299
	Second Cut	9.7180%	$17,373,303
	Third Cut	3.0000%	$3,590,754
8.	October 1, 2012		
	Rate Adjustment	1.667%	$4,605,776
	Rate Freeze Cut	0.9335%	$2,368,814
9.	April 1, 2013		
	Rate Adjustment	1.117617%	$3,026,468
	Rate Freeze Cut	1.2163%	$3,086,633
10.	October 1, 2013		
	Rate Adjustment	0.00715156%	$1,984,589
	Rate Freeze Cut	1.2776396%	$3,247,165

11.	April 1, 2014		
	Rate Adjustment	0.00%	$0.00
	Rate Freeze Cut	.002146435%	$545,283
12.	July 1, 2014		
	Rate Adjustment	0.00%	$0.00
	Rate Freeze Cut	.016149365%	$4,144,015
13.	July 1, 2015		
	Rate Adjustment	2.7853567%	$7,301,407
14.	July 1, 2016		
	Rate Adjustment	0.00%	$0.00
15.	July 1, 2017		
	Rate Adjustment	2.72709484%	$7,451,82
16.	July 1, 2018		
	Rate Adjustment	0.00%	$0.00
17.	July 1, 2019		
	Rate Adjustment	0.00%	$0.00
18.	July 1, 2020		
	Rate Adjustment	2.419311%	$6,870,843
19.	July 1, 2021		
	Rate Adjustment	9.1876444%	$29,613,463
20.	July 1, 2022		
	Rate Adjustment	8.6204403%	$29,613,463
21.	July 1, 2023		
	Rate Adjustment	7.6640205%	$29,613,463

APPENDIX D

Upper Payment Limit Methodology

ICF/IID Upper Payment Limit (UPL) Methodology

The UPL is an estimation of the amount that would be paid under Medicare payment principles (the Medicare UPL) which is basis for the following UPL methodology:

Determine Medicare Cost Per Day

1. Utilizing cost and utilization data from ICF/IID cost reports for fiscal year 2013-2014 (the Medicare UPL base year)
2. Compute 112% of the weighted mean cost per patient day (the 112% amount).
3. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
4. The Weighted Mean Cost Per Day will be trended forward to state fiscal year 2013-2014 by applying a rate change equal to the CMS Nursing Home Price Index (Fourth Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2013-2014.
5. Calculations for future fiscal years – 1) By trending the Weighted Mean Cost Per Day forward by the CMS Nursing Home Price Index or 2) A new Medicare UPL base year will be designated and a new Weighted Mean Cost Per Day will be trended forward.

Determine Medicare UPL Payment

1. To determine the Medicare UPL for each state fiscal year beginning with the base year. For this UPL demonstration, State Fiscal Year 2013-2014 is the base. A 2012 Weighted Mean Cost Per Day is calculated and trended. This figure is multiplied by the 2012 Medicaid days.

Determine Medicaid Payment

1. To determine the Florida Medicaid payment for each state fiscal year beginning with state fiscal year 2012-14, take the total actual paid amount from the Florida Medicaid Management Information System (FMMIS) for each ICF/IID Florida Medicaid provider.

Determine UPL Difference in Payments

1. The difference is determined by subtracting the Medicare UPL payment from the Florida Medicaid payment for each year.