Rule Number 59G-6.040
Payment Methodology for ICF/MR-DD Facilities Publicly Owned and Operated

Plan Version VIII
Effective Date: July 1, 2004

Plan Version IV Change Summary

Legislative Authority: In compliance with § 409.9131(6) F.S., the Agency for Health Care Administration adopted the following changes:

1. In accordance with 2004-344 Laws of Florida (SB 1064, 2004-05 Florida Legislature) Section 7(6), COST REPORTS--For any Medicaid provider submitting a cost report to the agency by any method, and in addition to any other certification, the following statement must immediately precede the dated signature of the provider's administrator or chief financial officer on such cost report: "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."

2. Editorial updates to Florida Statute, Florida Administrative Code, and Code of Federal Regulation references.

3. Adopted in rule number 59G-6.090 (F.A.C.) on November 21, 2004.

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 l80 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 43l.l7 . Access to submitted cost reports shall be in conformity with Chapter ll9, Florida Statutes.

I. New providers entering the program must submit a cost report for a period of not less than l2 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

l. 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

l. 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:

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

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 43l.6l0 ; 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 $l0.00. 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 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 must identify such related organizations and costs in their cost reports.

G. Other costs which are allowable 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 (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:

(1) 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 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 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:

(1) 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.

(1) 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 l, l984, 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 l, l984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July l, l984, 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 l20, 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 l and October l. The most current acceptable cost report received by the agency by February l and August l shall be used in the rate-setting process to set rates effective on April l and October l, 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:

l. 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 l.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, l984, 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:

1. 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.

2. 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.

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.

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 l2- 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 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. For rate semesters beginning on October l of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August l 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.l5 .

IX. Definitions

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, also known as the agency.

C. 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.

D. DCF: Department of Children and Family Services

E. 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.

F. 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.

G. Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. l395-l395pp).

H. Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. l396-l396i)

I. 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 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 B

CALCULATION OF THE
FLORIDA ICF/MR-DD 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

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
l984:l	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 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 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 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.

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

(.994 + .999 + l.004 + l.009 + l.0l4 +
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.

s:\ruleplan\plans\icf\v7cod.doc