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State/Territory Name: Florida

State Plan Amendment (SPA) #: FL-25-0004

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Financial Management Group

October 28, 2026

Shevaun L. Harris
Secretary of the Agency for Health Care Administration
Agency for Health Care Administration
2727 Mahan Drive, MS #8
Tallahassee, Florida 32308

RE: TN 25-0004

Dear Secretary Harris:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Florida state plan amendment (SPA) to Attachment 4.19-D FL-25-0004, which was submitted to CMS on September 30, 2025. This plan amendment updates buy-back provisions for Intermediate Care Facilities for Individuals with Developmental Disabilities, as authorized in the General Appropriations Act for State Fiscal Year 2025-26, and makes technical and editorial changes.

We reviewed your SPA submission for compliance with statutory requirements, including sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 of the Social Security Act (the Act) as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2) of the Act and the applicable implementing federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact James Francis at 617-531-7575 or via email at James.Francis@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25 — 0004

2. STATE: FL

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024-25 $ 275,420
b. FFY 2025-26 $ 826,259

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part III, pages 1, 18, 19, 25, 26, 29, 30, ~~44~~ 30a

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part III, pages 1, 18, 19, 25, 26, 29, 30, ~~44~~ 30a

9. SUBJECT OF AMENDMENT
Intermediate Care Facility Reimbursement

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Brian Meyer

13. TITLE
Deputy Secretary for Medicaid

14. DATE SUBMITTED
9-30-25

15. RETURN TO
Mr. Brian Meyer

Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #8
Tallahassee, Florida 32308

Attention: Shanise Jackson

FOR CMS USE ONLY

16. DATE RECEIVED
9 - 30 - 2026

17. DATE APPROVED
October 28, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
7 - 1 - 2026

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
10/20/26: Florida gives CMS permission to update CMS 179 form, Blocks 7 and 8, to remove page 44 and add page 30a. (JGF)

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

VERSION XXII

EFFECTIVE DATE: July 1, 2025

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.). Effective July 1, 2026, facilities shall use cost reporting forms and instructions located on the AHCA ICF webpage: https://ahca.myflorida.com/medicaid/cost-reimbursement/intermediate-care-facility-rates.html

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.

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 Behavioral Health shall constitute the other. All providers shall allocate costs by the three 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 three 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

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.

Q. Effective July 1, 2024, each provider's established rate shall be rebased.

V. Methodology

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

l. 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 three 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 three 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

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, 2022 through June 30, 2025

1. Effective July 1, 2024, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $63,476,524 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 to establish a new level of reimbursement for clients who have severe behavioral needs.
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.

5. Effective July 1, 2024, the funding of 2. and 4. above shall be distributed as an add on calculated as a uniform percentage after establishing rates. The add ons shall be adjusted on a proportional basis using each provider's cost report period used to establish the rates. Each provider will receive an add on when rates are established, until the individual provider's cost report including June 30, 2023, falls within the cost report's beginning and ending dates. When a provider's rate is established using a cost report that includes June 30, 2023, the provider's prior period base shall be updated to be equal to the current period base.

D. Florida Medicaid Rate Calculation – For Rate Period on or After July 1, 2025

1. Effective July 1, 2025, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act, which provides funding of $65,579,724 to buy-back intermediate care facilities rate reductions, effective on or after October 1, 2008.
2. Effective July 1, 2025, the reimbursement will incorporate the funding as outlined in the annual General Appropriation Act to establish a new level of reimbursement for clients who have severe behavioral needs.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The Agency's fee schedule rate was set as of July 1, 2025 and is effective for services provided on or after that date. All rates are published on the Agency's website: https://ahca.myflorida.com/medicaid/cost-reimbursement/intermediate-care-facility-rates.

E. 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