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State/Territory Name: Florida

State Plan Amendment (SPA) #: FL-25-0016

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

11/5/2026

Shevaun L. Harris
Secretary of the Agency for Health Care Administration
Agency for Health Care Administration
2727 Mahan Drive, MS #1
Tallahassee, Florida 32308

RE: TN 25-0016

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-25-0016, which was submitted to CMS on December 23, 2025. This plan amendment makes updates to the prospective payment system, removing rate period calculations in the process and outcome measures, and removing the hold harmless rate.

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 October 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: 25-0016

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
October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447 Subpart F

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY ~~2024-25~~2025-26 $ ~~0~~ 9,613,038
b. FFY ~~2025-26~~2026-27 $ ~~9,613,038~~ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D Part I pages 1,4,16,17,18,19,23,32,40

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D Part I pages 1,4,16,17,18,19,23,32,40

9. SUBJECT OF AMENDMENT
This state plan amendment includes updates to the prospective payment system, removing rate period calculations in the process and outcome measures, and removing the hold harmless rate.

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 12-23-2025

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
12 / 23 / 2025

17. DATE APPROVED
11/5/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
10 / 1 / 2025

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
On 2/10/2026, Florida gave permission for a pen-and-ink correction to Block 6, as follows:
Federal Budget Impacts: 2025-26 $9,613,038 and 2026-27 $0. (JGF)

FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION LIII

EFFECTIVE DATE: October 1, 2025

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

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 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

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 rate period, the process and outcome measures will be calculated using the most recent four quarter average from https://www.cms.gov/medicare/quality/nursing-home-improvement/quality-measures from the https://www.medicare.gov/care-compare/ datasets provided by the Centers for Medicare and Medicaid Services as of May 31 of the year in which the rate. 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

a. 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. 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. Percentage of long-stay residents who received an antianxiety or hypnotic medication

e. 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 have a footnote of zero 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

a. 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. 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. Number of hospitalizations per 1000 long-stay resident days

g. Registered Nurse Turnover

h. 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

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. AHCA Nursing Home rates are set annually as of October 1st 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/nursing-home-rates.html

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

A. 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.

B. 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.

VII. 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 https://ahca.myflorida.com/medicaid/cost-reimbursement/sextant-electronic-cost-reporting-for-nursing-homes .

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.

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.

F. On October 1, 2024, Florida increased October 1, 2024 rates by $18,701,029 to provide a nursing home reimbursement rate increase.

G. On October 1, 2025, an additional increase in the amount of 3,679,243, and a non-recurring increase in the amount of $5,933,795 was included to provide a nursing home enhancement by increasing quality incentive payments for October 1, 2025 rates.