

## **Table of Contents**

**State/Territory Name: Florida**

**State Plan Amendment (SPA) #: FL-22-0001**

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 S3-14-28  
Baltimore, Maryland 21244-1850



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**Financial Management Group**

May 17, 2022

Mr. Tom Wallace  
Deputy Secretary for Medicaid  
Agency for Health Care Administration  
2727 Mahan Drive, MS #8  
Tallahassee, Florida 32308

RE: State Plan Amendment (SPA) FL-22-0001

Dear Mr. Wallace:

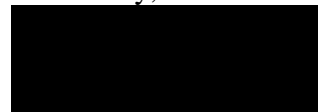
We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 22-0001. This state plan amendment specifies the reporting period of the Nursing Facility provider Fair Rental Value (FRV) survey, sets out the procedures for reporting FRV projects, and clarifies the scope of capital costs that can be reported as part of a project. It also updates the glossary entries for relevant terms.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment FL-22-0001 is approved effective January 1, 2022. The CMS-179 and the amended plan pages are attached.

If you have any additional questions or need further assistance, please contact James Francis at [james.francis@cms.hhs.gov](mailto:james.francis@cms.hhs.gov).

Sincerely,



Rory Howe  
Director

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER <u>2 2 — 0 0 0 1</u>	2. STATE <u>FL</u>
	3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT <input checked="" type="radio"/> XIX <input type="radio"/> XXI	
TO: CENTER DIRECTOR CENTERS FOR MEDICAID & CHIP SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE <b>January 1, 2022</b>	
5. FEDERAL STATUTE/REGULATION CITATION <b>42 CFR 447 Subpart F</b>	6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY <del>2021</del> <b>2022</b> \$ 0 b. FFY <del>2022</del> <b>2023</b> \$ 0	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <b>Attachment 4.19-D Part I</b>	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <b>Attachment 4.19-D Part I</b>	


9. SUBJECT OF AMENDMENT

**Long-Term Care Reimbursement Fair Rental Value**

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 	15. RETURN TO Mr. Tom Wallace Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308
12. TYPED NAME Tom Wallace	Attn: Cole Giering
13. TITLE Deputy Secretary for Medicaid	
14. DATE SUBMITTED <b>2/18/2022</b>	

**FOR CMS USE ONLY**

16. DATE RECEIVED <b>02 / 18 / 2022</b>	17. DATE APPROVED <b>May 17, 2022</b>
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**PLAN APPROVED - ONE COPY ATTACHED**

18. EFFECTIVE DATE OF APPROVED MATERIAL <b>01 / 01 / 2022</b>	19. SIGNATURE OF APPROVING OFFICIAL 
20. TYPED NAME OF APPROVING OFFICIAL <b>Rory Howe</b>	21. TITLE OF APPROVING OFFICIAL <b>Director, Financial Management Group</b>

22. REMARKS  
On 5/10/22, the State authorized a pen-and-ink change to CMS 179 form box 6, fields a. and b. to state "2022" and "2023" respectively. (JGF).

**FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN**

**VERSION XLIX**

**EFFECTIVE DATE: January 1, 2022**

**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

Amendment 2022-0001  
Effective 1/1/2022  
Supersedes 2021-0008  
Approval May 17, 2022

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 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.

2. The Fair Rental Value rate is calculated as:

Components		Source
<b>RSMeans Parameter</b>	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	
<b>Facility Information</b>	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	FRV Survey submitted in accordance with Section IV.A.1. and adjusted for renovations and bed additions as calculated in Section IV.A.3.
	Facility Age in Years*	
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%.	
<b>Policy Parameters</b>	Land Percentage	
	Equipment Cost per Bed	

**Long-term Care Version XLVI**

Attachment 4.19-D

Part I

	Depreciation Factor	
	Fair Rental Rate	
<b>Calculation of Rate Per Bed Day</b>	Building Value	(RSMMeans Cost Per Square Foot) * (RSMMeans 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)
	<b>FRV Rate</b>	(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
<b>Replacement Cost Per Bed</b>	$\text{Building Value} \times \frac{\text{RSMMeans Historical Cost Index for Year of Renovation}}{\text{RSMMeans Historical Cost Index for Current Year}}$
<b>Accumulated Depreciation Per Bed</b>	$(\text{Renovation Year} - \text{Base Year}) * \text{Replacement Cost Per Bed} * \text{Depreciation Factor}$
<b>New Bed Equivalent</b>	$\text{Renovation Amount} / \text{Accumulated Depreciation Per Bed}$
<b>New Base Year</b>	$\text{Renovation Year} - \frac{(\text{Current Number of Beds} - \text{New Bed Equivalent}) * (\text{Renovation Year} - \text{Base Year})}{\text{Current Number of Beds}}$
<b>Adjusted Age</b>	$\text{Rate Year} - \text{New Base Year}$

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

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

- 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 4<sup>th</sup> 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
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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:

$$\text{Floor Adjustment} = \text{Floor Per Diem} - \text{Inflated Per Diem Cost}$$

$$\text{Per Diem} = \text{Standardized Price} - \text{Floor Adjustment}$$

**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 50<sup>th</sup> 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 30<sup>th</sup> 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
<b>Flu Vaccine</b>	20% year-over-year improvement. Improvement is calculated as the change from the year preceding the current year to the current year measurement.	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
<b>Antipsychotic</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Restrained</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
Outcome Measures	0.5 Points	1 Point	2 Points	3 Points	Max Points Per Provider
<b>Urinary Tract Infections</b>	20% year-over-year improvement. Improvement is calculated as the change from the year preceding the current year to the current year measurement.	Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Pressure Ulcers</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Falls</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Incontinence</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3
<b>Activities of Daily Living</b>		Below 50 <sup>th</sup> Percentile	Below 25 <sup>th</sup> Percentile	Below 10 <sup>th</sup> Percentile	3

**Long-term Care Version XLVI**

Attachment 4.19-D

Part I

Structure Measures	No Points Awarded To Those Under Median	1 Point	2 Points	3 Points	Max Points Per Provider
<b>Combined Direct Care Staffing (RN, LPN, CNA)</b>	N/A	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
<b>Social Work and Activity Staff</b>	N/A	Above 50 <sup>th</sup> Percentile	Above 75 <sup>th</sup> Percentile	Above 90 <sup>th</sup> Percentile	3
Credentials		1 Point	3 Points	5 Points	Max Points Per Provider
<b>CMS 5 Star Rating</b>	N/A	3 Stars	4 Stars	5 Stars	5
<b>Florida Gold Seal</b>	A total of five points is awarded if one or more of these three accreditations are attained.	N/A	N/A	Awarded	5
<b>Joint Commission Accreditation</b>		N/A	N/A	Awarded	
<b>AHCA National Quality Award</b>		N/A	N/A	Silver or Gold Award	
<b>Total Quality Points Possible</b>					<b>40</b>

- 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.

## **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
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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:

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

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:

$$\text{MAR} = \text{WBR} \times \text{MA}$$

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

$$\text{MA} = \frac{(\text{Medicaid Utilization}\% - \text{MIN})}{(\text{MAX} - \text{MIN})}$$

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
<b>TOTAL</b>		<b>181</b>

- 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.15-1](#) - Health Insurance Manual No. 15, 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 indices, 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:

<b>Component</b>	<b>Direct Patient Care</b>	<b>Indirect Patient Care</b>	<b>Operating</b>
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:

<b>Component</b>	<b>IHS Index</b>
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.

<b>Year: Quarter</b>	<b>Index Name</b>	<b>Index Value</b>
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:

$$(1.041 \times 0.545 / (0.545 + 0.113)) + (1.029 \times 0.113 / (0.545 + 0.113)) = 1.039$$

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:

$$\begin{aligned} & (\text{Weighted Salaries \& Benefits Index} \times \text{percentage weight}) + (\text{Dietary Index} \times \text{percentage weight}) \\ & + (\text{Weighted All Others Index} \times \text{percentage weight}) \end{aligned}$$

$$(1.039 \times 66.71\%) + (0.965 \times 0.00\%) + (1.042 \times 33.29\%) = 1.03999870$$

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.

$$\text{Average Combined Quarterly Index for Direct Care} = [(\text{Combined Quarterly Index for current quarter} + \text{Combined Quarterly Index for following quarter}) / 2]$$

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



<b>Quarter</b>	<b>Average Combined Quarterly Index for Direct Care</b>	<b>Average Combined Quarterly Index for Indirect Care and Operating</b>	<b>Corresponding Month</b>
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

$$= (\text{June 30 Index} / \text{March 31 Index})^{1/3} \times (\text{March 31 Index})$$

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

May 2016 Average Combined Quarterly Index for Direct Care

$$= (\text{June 30 Index} / \text{March 31 Index})^{2/3} \times (\text{March 31 Index})$$

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

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.

**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, 2021 rate setting, shall be used for the fiscal year 2021-2022 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, 2020 and October 1, 2021. 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:

$$\text{Total Trended Upper Payment Limit} = \text{Total Upper Payment Limit} \times \text{Trend Factor}$$

$$\text{Total Upper Payment Limit} = \text{Routine UPL Cost} + \text{Ancillary UPL Cost}$$

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

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

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.

<b>Chart of Accounts Categories</b>	<b>Account Number</b>	<b>Per Diem Component</b>
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