

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

**VERSION XI**

**EFFECTIVE DATE: July 1, 2015**

**I. Cost Finding and Cost Reporting**

- A. Each intermediate care facility for individuals with intellectual disabilities (ICF/IID) that is not publicly owned and not publicly operated participating in the Florida Medicaid program and being reimbursed under the provisions of this reimbursement plan shall submit a cost report to the Florida Agency for Health Care Administration (AHCA) postmarked, or accepted by a common carrier, no later than five calendar months after the close of its cost reporting year. No exceptions will be granted to the filing time limits. Four complete, legible, copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Finance, Division of Cost Reimbursement, 2727 Mahan Drive, Mailstop 23, Tallahassee, FL 32308. The cost reporting forms and instructions shall be the same as used for facilities reimbursed in accordance with Rule 59G-6.040, Florida Administrative Code (F.A.C.).
- B. The most current cost report received by AHCA shall be used to establish rates effective October 1 for all facilities that were being reimbursed in accordance with Rule 59G-6.040, F.A.C., as of April 1, 1998.
- C. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. The cost report shall be prepared using the accrual basis of accounting in accordance with generally accepted accounting principles, as incorporated by reference in Rule 61H1-20.007, F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual Centers for Medicare and Medicaid Services (CMS) PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX Reimbursement Plan for Services in Facilities Not Publicly Owned and Not Publicly Operated, and State of Florida administrative rules. The CMS PUB.15-1

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Manual may be obtained from the regional CMS office in Atlanta. The person preparing the cost report shall sign the cost report as the preparer. Cost reports not signed will not be accepted.

- D. If a provider files a cost report late, after the five month period, and that cost report would have been used to set a lower reimbursement rate for a rate period had it been filed within five months, then the provider's rate for that rate period shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively.
- E. A provider who voluntarily (or involuntarily) ceases to participate in the Florida Medicaid program or experiences a change of ownership shall file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.
- F. All providers are required to maintain financial and statistical records in accordance with 42 Code of Federal Regulations (CFR), sections 413.24 (a) (b),(c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and shall be capable of being audited and available within the State of Florida for auditing by state and federal agencies and their representatives within 20 days of the request. All accounting and other records shall be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of three years following the date the cost report was filed with AHCA.
- G. Records of organizations determined by AHCA to be related as defined by 42 CFR413.17 shall be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).
- H. AHCA shall retain all uniform cost reports submitted for a period of at least three years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to filed cost reports shall be in accordance with Chapter 119, Florida Statutes (F.S.).

- I. New providers entering the program shall submit a cost report for a period of not less than 12 months for purposes of setting prospective rates. A partial-year cost report may be filed initially, but may only be used to adjust the interim budgeted rate in effect.
- J. The provisions of this reimbursement plan shall apply to all ICF-IID facilities not publicly owned and not publicly operated . These facilities shall include ICF-IID facilities that are publicly owned and the State of Florida is the Medicaid provider of record, but are operated or managed by a not-for profit or for profit organization.
- K. Unless specifically noted, the terms facility and provider shall have the same meaning for all sections of this reimbursement plan.
- L. Cost reports shall include the following statement immediately preceding the dated signature of the provider’s administrator or chief financial officer: “I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations.”
- M. AHCA reserves the right to refer providers found to be out of compliance with any of the policies and procedures regarding cost reporting to the Bureau of Medicaid Program Integrity for investigation.
- N. Providers are subject to sanctions pursuant to sections 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of sanctions can be found in Rule 59G-9.070, F.A.C. A cost report is late if it is not received by AHCA on the first cost report acceptance cut-off date after the cost report due date.

**II. Audits**

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

- A. Description of AHCA's Procedures for Audits - General
  - 1. Primary responsibility for the audit of providers shall be assumed by AHCA. The efforts of AHCA audit staff may be augmented by contracts with certified public accountant

(CPA) firms to ensure that the requirements of 42 CFR447.202 are met. AHCA shall determine the scope and format for on-site audits, desk audits of cost reports, and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the American Institute of Certified Public Accountants as incorporated by reference in Rule 61H1-20.008, F.A.C.
3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447. 202 and generally accepted auditing standards. The auditor shall express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for three years.
4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120, F.S.

**B. Desk Audit Procedures**

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Florida Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.
2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for each.

**III. Allowable Costs**

- A. The cost report shall include all items of expense which a provider shall incur in meeting:
  1. The definition of intermediate care facility set forth in 42 CFR 440.150.
  2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act (SSA) in 42 CFR 442, Subpart C.
  3. The requirements established by AHCA under the authority of 42 CFR 431.610.

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- B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative, or other professional treatments which shall be composed of medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy, or other intellectual disability specialized services as appropriate.
- C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.
- D. All items of expense that providers incur in the provision of routine services, such as the regular room, dietary and nursing services, medical supplies, and the use of equipment and facilities, are allowable. Expenses for services covered by Florida Medicaid programs other than the ICF/IID Program are not allowable under this plan and should not be included in the ICF/IID cost report for Medicaid. These include expenses associated with prescription drugs, physicians' fees, etc. Refer to the services covered by the Medicaid ICF/IID vendor payment in the Florida Medicaid ICF/IID coverage policy. Refer to Rule 59G-4.170, F.A.C., for further clarification of allowable and non-allowable costs.
- E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily Medicaid reimbursement rate is \$50.00; State pays \$40.00 and resident is to pay \$10.00. If the Medicaid resident pays only \$8.00, then \$2.00 would be an allowable bad debt. Medicaid bad debts are allowable if revenue was earned in the prior year and two collection letters were sent to the appropriate party responsible for the debt within 12 months of revenue recognition.

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- F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider will be governed by 42 CFR 413.17, Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS PUB.15-1. Providers shall identify such related organizations and costs in their cost reports.
- G. Other allowable costs 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 as may be determined by surveys conducted by AHCA.
  2. Limitation of rents:
    - a. It is the intent of the Medicaid program to limit lease cost reimbursement (rent) to the allowable ownership costs associated with the leased land, building, and equipment. For the purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:
      - (1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;
      - (2) Sales tax on lease payments, if applicable; and
      - (3) Return on equity (ROE) that would be paid to the owner if he were the provider, as per section H. below.
    - b. Implementation of this provision shall be in accordance with the following:
      - (1) Reimbursable lease costs of existing providers will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing

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providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

- (2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for example, increases in property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.
- (2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record or the rent, whichever is lower.
- (3) For new providers entering the Medicaid program, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs shall be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.
- (4) In no case shall Florida Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a

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letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the ICF/IID properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in section III.G.(3).

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

3. Basis for depreciation and calculation:

a. Cost.

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

- b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties purchase the depreciable assets of the facility, or purchase 100 percent of the stock of the facility, and within one year, merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In compliance with section 1902(a)(13)(c) of the SSA, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for individuals with



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intellectual disabilities for facilities not publicly owned and publicly operated shall be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by the lesser of:

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

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

- (1) The acquisition cost of the facility to the new owner; or
- (2) The fair market value of the facility at the time of purchase.

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

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

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

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

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

Example:

Sales Price: \$6,000,000

Older Portion of Facility:

Number of beds = 60

Newer portion of facility:

Number of beds = 120

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

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

Sale Price = \$6,000,000

- (2) The adjusted gross recapture amounts as determined in one above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.
  - (3) The net recapture amount, if any, so determined in two above shall be paid by the former owners, to AHCA. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.
- d. Depreciation recapture resulting from leasing the facility or withdrawing from Florida Medicaid program.

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.
- a. Costs that are capitalized as per CMS PUB.15-1 provisions other than land, buildings, construction loan costs, and equipment shall not exceed what a prudent and cost-conscious buyer would pay for the given service or item. If such costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1, and this Plan to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursed under the plan. Examples of such costs include but are not limited to legal fees, developers' fees, underwriters' fees, bond discount, loan points, trustee fees, interest cost on debt reserve requirements, and costs of feasibility studies.
  - b. All allowable capitalized costs included in (a) above plus all interest costs incurred as a result of financing the land, building, and equipment, including building equipment, major movable equipment, and minor equipment as described in CMS PUB.15-1, shall be limited in total to the amount of interest cost that would be incurred if the land, building, and equipment had been

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financed through a "conventional financing" debt instrument over a 25-year period, with a ten percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus two percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual down payment and a ten percent cash down payment in this financing limit method shall be included with the balance sheet average equity for the period for purposes of computing an incremental change in ROE or use allowance that would have occurred had a full ten percent down payment actually been made. If the total ROE payment would increase from zero to a positive dollar amount, then the financing cost limitation on interest expense shall increase by that positive dollar amount. If the total ROE payment would increase from a positive payment to a greater amount, then the financing cost limitation on interest expense shall increase by the difference between the two amounts. For purposes of this provision, the "conventional financing" amortization schedule used shall provide for equal installments, that is, payments, with amortization of the principal beginning in the first year, that is, a 25-year payoff schedule. The prime rate used shall be the prime rate as stated by the Chase Manhattan Bank in New York as of the date the provider received a loan commitment from the lending institution, or the date AHCA received the provider's acceptable budgeted cost proposal if no commitment date can be documented. Providers with variable rate debt instruments that are initially approved within these cost limitations shall be granted cost increases due to an increase in their interest rate, but not to exceed that cost which would be incurred at an interest rate of 15 percent per annum.

- c. Additional costs due to refinancing shall not be allowed if refinancing was not necessary in order to meet the final payments of the former debt instrument, that

is, in cases where balloon payments are due, or to finance the addition of new beds.

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

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

7. Additional costs incurred after enrollment in the program that are due to capital additions or expansion shall have prior approval by the APD Office of Developmental Services if such costs exceed one percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's CON process. Costs for specific expansions or additions that exceed the one percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in section III.G(4).
8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, ROE, or both as specified in section III of this plan.
9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider shall maintain the original owner's records of capital assets. If



the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

H. Return on Equity

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

I. Use Allowance

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

## **IV. Standards**

- A. In accordance with Chapter 120, F.S., Administrative Procedures Act (APA), this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.
- B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in section IV.L. of this plan. Further, if certain costs are determined by the Florida Medicaid program or the Florida Medicaid Division of Audit Services,

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

- C. Prospective payment rates shall be established annually on July 1. The most current acceptable cost report received by AHCA by February 1 shall be used in the rate setting process to set rates effective on July 1.
- D. Reimbursement rates shall be calculated separately for the following two levels of reimbursement:
1. Intermediate Care Facility Level of Reimbursement One - A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices  
  
and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation.
  2. Intermediate Care Facility Level of Reimbursement Two - A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device.

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

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

- F. The prospectively-determined individual provider's rates shall be adjusted retroactively to the effective date of the affected rates under the following circumstances:
1. An error was made by AHCA in the calculation of the provider's rates.
  2. A provider files an amended cost report used to determine the rates in effect. An amended cost report may be filed in the event that it would effect a change of one percent or more in the total reimbursement rate. The amended cost report shall be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 60 days after the exit conference between field audit staff and the provider has been completed.
  3. Further desk or on-site audits of cost reports used in the establishment of the prospective rates disclose a change in allowable costs in those reports.
- G. The following provisions apply to interim changes in component reimbursement rates, other than through the routine annual rate setting process described in section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections IV.H. and IV. I.
1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of one percent or more in the provider's total per diem reimbursement rate.
  2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (1) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least \$5000 and would cause a change of ten percent or more in the provider's current

total per diem rate. The provider shall submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

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

Interim rate requests resulting from (1), (2), and (3) above shall be filed within 60 days after the costs are incurred, and shall be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request, Florida Medicaid, Bureau of Medicaid Program Finance, shall determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information requested, the Bureau of Medicaid Program Finance shall approve or disapprove the interim rate within 60 days. If Florida Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

4. Interim Rate Settlement.

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

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

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

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

1. Property Costs:

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

2. Operating Costs:

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

3. Resident Care Costs:

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

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

1. Property Costs Ceiling:

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

2. Operating Costs Ceiling:

**Attachment 4.19-D**  
**Part III**

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

3. Resident Care Costs Ceiling:

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

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

Shall not exceed \$239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed \$267.02 for the Developmental Non-Ambulatory classes.

These ceiling amounts shall be inflated forward based on one times the ICF/IID inflation index utilizing the same inflation methodology as used in calculating prospective rates.

When a provider's interim cost is limited to the total cost ceiling, the ceiling shall be allocated to each component based on the percentage that each component's interim cost is to the total of all components' interim costs, including ROE.

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

- I.1. For a new provider in a facility with greater than six beds, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12 month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item shall be refunded

to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Florida Medicaid.

- I.2. For a new provider in a facility with six beds or less, AHCA shall establish the cost basis for calculation of prospective rates using the first acceptable historical cost report covering at least a 12- month period filed by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item subject to base year ceilings in section V.B. of this plan shall be refunded to AHCA. Underpayment as a result of the difference between the budgeted interim rate and actual allowable costs subject to base year ceilings in section V.B. of this plan shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at the lesser of 100 percent of the total allowable costs or the ceilings as determined by Florida Medicaid.
- J. Incentives for rates paid on and after October 1, 1998, shall be paid to providers whose annual rates of cost increase for operating costs or resident care costs from one cost reporting period to the next are less than 1.4 times the average cost increase for the applicable period documented by the ICF/IID Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in section V.A.(7). of this plan.
- K. To encourage high-quality care while containing costs, incentive payments shall be paid to those facilities which are not out of compliance with any condition of participation. Cost containment operating and resident care incentives shall be prorated for the percentage of days that a provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set.
- L. A provider's reimbursement for service provided under the Florida Medicaid program shall be the lower of: the provider's usual and customary charges to the general public for such services, except for public facilities rendering such services free of charge or at a nominal charge, that is,

less than or equal to 50 percent of costs; or the rates established for the provider under this reimbursement plan.

- M. The use of a target rate of inflation for cost increases shall be used as a measure of efficient operation for purposes of this reimbursement plan. The target rate of inflation principle is that a provider's operating and resident care per diems by reimbursement class should not increase from one fiscal period, that is, year, to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida ICF/IID Cost Inflation Index for the same period. If a provider's per diem costs for either reimbursement class for operating or resident care exceeds the target rate of inflation, then the allowable per diem costs of the period in which the excessive costs occurred shall be limited to a level equal to the prior period's allowable per diem costs inflated by the target rate percentage. Only allowable per diem costs shall be used for prospective rate setting purposes and for future target rate comparisons.
- N. Aggregate test comparing Florida Medicaid to Medicare according to 42 CFR section 447.253(c)(2), Florida Medicaid estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.
- O. Base Costs:  
The initial base costs for each provider shall be the allowable costs documented by the cost report used to establish the rate being set. For new providers entering the Florida Medicaid program the initial base costs shall be established in accordance with section IV.I. of this plan. Prospective rates calculated using unaudited costs shall be retroactively adjusted when audit results become available.
- P. Effective July 1, 2011 through June 30, 2015, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.



## V. Methodology

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

1. For rate periods beginning on July 1 of a given year, the prospective rates shall be set using the most current acceptable cost report on file with AHCA as of February 1 of that year.
2. Review and adjust each provider's cost report referred to in section IV.N. to reflect the results of desk or on-site audits, if available.
3. Determine total allowable cost by reimbursement class for property cost, resident care cost, operating cost, and ROE or use allowance if applicable. See the glossary section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. Costs for providers with six beds or less shall be allocated to each reimbursement class by the methodology shown in Appendix A-1.
4. Calculate per diems for each of the four cost components for the two reimbursement classes by dividing the component's cost by the appropriate number of resident days.
5. Calculate the target rate of inflation factor representing the allowable increase in operating and resident care costs from the prior cost reporting period. The target rate of inflation factor is calculated by multiplying 1.4 times the simple average of the monthly Florida ICF/IID Cost Inflation Indices associated with the more recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.
6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet state or federal rules, laws,

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**Part III**

regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the \$5,000 and one percent threshold under the interim rate provisions in section IV.G., then an adjustment shall be made to the current base year costs such that the calculation of the target cost appropriately accounts for cost incurred in meeting laws, rules, or regulations. For such an adjustment to be made, the provider shall furnish adequate supporting documentation with the cost report. Multiply the adjusted base cost components for operating and resident care costs for each reimbursement class by the target rate factor computed in step five above to reflect the allowable change in costs.

7. Compare the operating and resident care cost per diems resulting from step six with the respective per diems from step four for each reimbursement class.
  - a. If the operating per diem for either reimbursement class from step four is less than the respective operating per diem from step six, then establish the new operating base per diem as the per diem from step four plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the step four per diem. The operating incentive shall be prorated for the percentage of days that the provider is out of compliance with any Condition of Participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a Condition of Participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the operating per diem from step four is greater than the step six per diem, then establish the new operating base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.

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- b. If the resident care per diem for either reimbursement class from step four is less than the respective resident care per diem from step six then establish the new resident care base per diem as the per diem from step four plus an incentive calculated as 50 percent of the difference between the step four per diem and the step six per diem, not to exceed three percent of the step four per diem. The resident care incentive shall be prorated for the percentage of days that the provider is out of compliance with any condition of participation during the rate period in effect one year prior to the rate period being set. For example, a provider not out of compliance with a condition of participation shall receive 100% of the incentive amount. A provider that is out of compliance for 60 days of a 365-day rate period shall receive 83.61% of the incentive amount based on 305 days divided by 365 days. If the resident care per diem from step four is greater than the step six per diem, then establish the new resident care base per diem as the step four per diem, not to exceed the base cost per diem from step six inflated by the target rate factor.
- c. If different operating cost rate components are produced in this rate setting methodology, the total operating rate cost component incentive that is determined shall be allocated to both classes by weighting with patient days of each class. This shall equalize the operating rate cost components and allow for more meaningful trend comparison between cost reporting periods.
8. The new base per diems for property and ROE or use allowance shall be the per diems established in step four above.
9. Using the appropriate current base per diem for resident care and operating costs from step seven above, calculate the prospective operating and resident care per diems for the new rate period by multiplying each of the base per diems by the fraction:

Simple average of the Florida ICF/IID monthly cost inflation indices for the prospective rate period divided by the simple average of the Florida ICF/IID monthly cost inflation indices for the cost report period used to calculate current base per diems.

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

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

1. Effective July 1, 2014, reimbursement rates for intermediate care facilities will be set July 1 of each year. Between July 1, 2014 and April 30, 2016, providers may elect to change their fiscal year end and file a new cost report for a period of not less than 6 months and not greater than 18 months due to the transition to an annual rate setting. Cost report fiscal year end changes for this purpose are allowed even if a recent change has occurred and cost reports have not been filed with the same fiscal year end for two years.
2. Effective July 1, 2015, \$38,358,293 is provided to buy-back intermediate care facilities rate reductions, effective on or after October 1, 2008.
3. The recurring methodology to establish rates taking into consideration the cuts imposed on or after October 1, 2008, shall be to compare the legislative unit cost with the rate setting unit cost as follows:
  - 1) The legislative unit cost shall be determined by dividing the total appropriation for intermediate care facilities by the total bed days for the past fiscal year;
  - 2) The total actual cost as generated based on the July 1 rate settings shall be divided by the total bed days for the past fiscal year to determine the rate setting unit cost;

- 3) The rate setting unit cost shall be reduced to a “reduced rate setting unit cost” by the same percentage used to calculate the legislative unit cost to account for client participation contributions;
- 4) No negative adjustment to the rates paid to providers shall occur so long as the reduced rate setting unit cost is equal to or less than the legislative unit cost; and
- 5) In the event the reduced rate setting unit cost is greater than the legislative unit cost, a prorated reduction shall be imposed on all rates after all quality assessment fee funds have been exhausted to cover the rate reductions.

**C. Base year ceilings for new providers in facilities with six beds or less**

1. Property costs per diems shall not be in excess of the ceiling limitations established in section III.
2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/IID providers that have prospective rates. This ceiling shall be recalculated for every rate period beginning July 1- of each year.
3. Resident care costs per diems shall not exceed the highest per resident day cost for the respective reimbursement class of any other currently participating provider having a prospective rate. The ceiling shall be recalculated for every rate period beginning July 1 of each year.
4. Total costs per diem ceilings (including ROE):  
  
Shall not exceed the total costs per diem ceilings for interim cost per diems in section IV.H.(2)(D.). multiplied times 1.04. When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including ROE, in the base year.

Example:	Interim Cost	Percent to Total	Ceiling
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TN No: 2015-011  
Supersedes: 2014-014  
Approval Date: \_\_\_\_\_  
Effective Date: July 1, 2015

Operating	58.15	23.26	55.82
Resident Care	158.89	63.56	152.54
Property	25.70	10.28	24.67
ROE	7.26	2.9	6.97
Total	250	100%	240

## **VI. Payment Assurance**

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

## **VII. Provider Participation**

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

## **VIII. Payment in Full**

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

or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Florida Medicaid resident and shall be deemed to be out of compliance with 42 CFR section 447.15.

## **IX. Intermediate Care Facility Quality Assessment Fee (ICFQAF)**

- A. In accordance with section 409.9083, F.S., there is imposed upon each ICF/IID, a quality assessment. The aggregated amount of assessments for all ICF/IIDs in a given year shall be an amount not exceeding the maximum percentage allowed under federal law of the total aggregate net patient service revenue of assessed facilities. AHCA shall calculate the quality assessment rate annually on a per resident-day basis as reported by the facilities. The per-resident-per day assessment rate shall be uniform. Each facility shall report monthly to AHCA its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. AHCA shall collect, and each facility shall pay, the quality assessment each month. AHCA shall collect the assessment from facility providers no later than the 15<sup>th</sup> of the next succeeding calendar month. AHCA shall notify providers of the quality assessment rate and provide a standardized form to complete and submit with payments. The collection of the quality assessment shall commence no sooner than 15 days after the agency's initial payment to the facilities that implement the increased Florida Medicaid rates containing the elements prescribed in section B below and monthly thereafter. Intermediate care facilities for individuals with intellectual disabilities may increase their rates to incorporate the assessment but may not create a separate line-item charge for the purpose of passing through the assessment to residents.
- B. The purpose of the facility quality assessment is to ensure continued quality of care. Collected assessment funds shall be used to obtain federal financial participation through the Florida Medicaid program to make Florida Medicaid payments for ICF/IID services up to the amount of the Florida Medicaid rates for such facilities as calculated in accordance with the approved state Florida Medicaid plan in effect on April 1, 2008. The quality assessment and federal matching funds shall be used exclusively for the following purposes and in the following order of priority to:

- (a) Reimburse the Florida Medicaid share of the quality assessment as a pass through, Florida Medicaid-allowable cost.
  - (b) Increase each privately operated ICF/IID Florida Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.
  - (c) Increase each ICF/IID Florida Medicaid rate, as needed, by an amount that restores any rate reductions for the 2008-2009 fiscal year and the 2009-2010 fiscal year.
  - (d) Increase payments to such facilities to fund covered services to Florida Medicaid beneficiaries.
- C. Upon termination of the quality assessment, all collected assessment revenues, less any amounts expended by AHCA, shall be returned on a pro rata basis to the facilities that paid such assessments.

## **X. Glossary**

- A. Acceptable cost report- A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.
- B. APD - Agency for Persons with Disabilities.
- C. AHCA - Agency for Health Care Administration.
- D. Client participation contributions - See (M) Patient Responsibility.
- E. CMS PUB.15-1- also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Florida Medicaid Services.
- F. Filing due date - No later than five calendar months after the close of the ICF's cost-reporting year.
- G. ICF/IID operating costs - Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.
- H. ICF/IID resident care costs - Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.
- I. ICF/IID property costs - Those costs related to the ownership or leasing of an ICF/IID. Such costs may include property taxes, insurance, interest and depreciation, or rent.



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**Part III**

- J. ICF/IID return on equity or use allowance costs - See sections III.H. and III.I. of this plan.
- K. Late cost report - A cost report is late when it is filed with AHCA, Bureau of Medicaid Program Analysis after the filing due date and after the rate setting due date.
- L. Legislative unit cost - The weighted average per diem of the state anticipated expenditure.
- M. Patient Responsibility- Florida Medicaid deducts the portion of a recipient's monthly income, as determined by the Department of Children and Families (DCF), that the recipient is required to pay.
- N. Quality assessment fee - Pursuant to section 409.9083, F.S., a per-resident-day basis assessment is imposed upon each intermediate care facility.
- O. Title XVIII - Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the SSA (42 U.S.C. 1395-1395pp).
- P. Title XIX - Grants to States for Medical Assistance Programs (Medicaid) as provided for in the SSA (42 U.S.C. 1396-1396i)
- Q. Medicaid interim reimbursement rate - A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.
- R. Rate setting due date - All cost reports received by AHCA by February 1 shall be used to establish the reimbursement rates.
- S. Rate setting unit cost - The weighted average per diem based on filed cost reports.
- T. Reduced rate setting unit cost - The rate setting unit cost after it is reduced by the same percentage that was used to calculate the legislative unit cost in order to account for the client participation contributions.

**APPENDIX A  
CALCULATION OF PROVIDER COST ALLOCATION**

Provider Number FY: 09/30/84  
 Provider Name Audit Status Unaudited  
 Address

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

**Attachment 4.19-D**

**Part III**

1.	Operating Component	19.460	19.460	209897
2.	Resident Care Component	48.985	58.378	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078

**APPENDIX A-1**

CALCULATION OF PROVIDER COST ALLOCATION

Provider Number	FY: 09/30/84			
Provider Name	Audit Status Unaudited			
Address				
	<table border="0" style="width: 100%; margin: 0 auto;"> <tr> <td style="width: 33%; text-align: center;">COL A Resid./ Inst.</td> <td style="width: 33%; text-align: center;">COL B Non-amb./ Medical</td> <td style="width: 33%; text-align: center;">COL C  TOTAL</td> </tr> </table>	COL A Resid./ Inst.	COL B Non-amb./ Medical	COL C  TOTAL
COL A Resid./ Inst.	COL B Non-amb./ Medical	COL C  TOTAL		
<b>A. Alloc of Exp (Excl B&amp;C)</b>				
1. Resident Days	2461	8325	10786	
2. OPER. EXPENSE COMP				
a. Administration	-	-	120482	
b. Plant Operation	-	-	45060	
c. Laundry	-	-	15265	
d. Housekeeping	-	-	29090	
e. Oper. Exp. Comp and Per Diem	19.460	19.460	209897	
3. Resident Care Expense				
a. Dietary -	-	74861		
b. Other -	-		34188	
c. Nursing -	-	86018		
d. Res. Care Exp. and Per Diem	18.0852	18.0852	195067	
4. PROP. EXP. COMP. AND PER DIEM	8.605	8.605	92812	
5. ROE/UA COMP & PER DIEM	6.604	6.604	71236	
<b>B. DIRECT CARE EXPENSE</b>				
1. Staffing .75	1.	-		
2. Total Staffing Required	1845.75	8325	10,171	
3. Staffing Percent	18.148%	81.852%	100%	
4. Alloc. of Direct Care	55,334.34	249,571.66	304906	
5. Dir. Care Exp. Per Diem	22.484	29.979		
<b>C. ADDITIONAL SERVICES EXPENSE</b>				
1. Medicaid Patient Days	2461	8275	10736	
2. Add. Ser. (Sch.AM-6)	36780	69380	106160	
3. Add. Ser. Exp. Per Diem	14.951	8.3839		
<b>D. MEDICAID PER DIEM COST</b>				
1. Operating Component	19.460	19.460	209897	

**Attachment 4.19-D**

**Part III**

2.	Resident Care Component	55.520	56.448	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	90.189	91.117	980078

APPENDIX B

CALCULATION OF THE  
FLORIDA ICF/IID COST INFLATION INDEX

1. Weights.

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

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

2. Inflation index for each component

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

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

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

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

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

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

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

3. Quarterly and monthly indices.

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

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

$$\begin{aligned} \text{April 30 Index} &= (\text{June 30 Index}/\text{March 31 Index})^{1/3} \times (\text{March 31 Index}) \\ &= (1.042/1.032)^{1/3} \times 1.032 \\ &= 1.035 \end{aligned}$$

$$\begin{aligned} \text{May 30 Index} &= (\text{June 30 Index}/\text{March 31 Index})^{2/3} \times (\text{March 31 Index}) \\ &= (1.042/1.032)^{2/3} \times 1.032 \\ &= 1.039 \end{aligned}$$

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

4. Inflation Factors

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

Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.

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

$$\begin{aligned} & (.994 + .999 + 1.004 + 1.009 + 1.014 + \\ & 1.018 + 1.023 + 1.026 + 1.029 + 1.032 + \\ & = 1.035 + 1.039 + 1.042)/13 \\ & (.950 + .954 + .958 + .962 + .966 + .971 + \\ & .975 + .979 + .982 + .986 + .989 \\ & .992 + .994)/13 \\ & = 1.020 \\ & .974 \\ & = 1.047 \end{aligned}$$

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



APPENDIX C

Florida Medicaid Trend Adjustment Percentages

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

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11.	April 1, 2014		
	Rate Adjustment	0.00%	\$0.00
	Rate Freeze Cut	.002146435%	\$545,283
12.	July 1, 2014		
	Rate Adjustment	0.00%	\$0.00
	Rate Freeze Cut	.016149365%	\$4,144,015
13.	July 1, 2015		
	Rate Adjustment	2.7853567%	\$7,301,407

**APPENDIX D**

Upper Payment Limit Methodology

**ICF/IID Upper Payment Limit (UPL) Methodology**

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

**Determine Medicare Cost Per Day**

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

**Determine Medicare UPL Payment**

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

**Determine Medicaid Payment**

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

**Determine UPL Difference in Payments**

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