Table of Contents

State/Territory Name: Florida

State Plan Amendment (SPA) #: 11-008

This file contains the following documents in the order listed:

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

CENTERS for MEDICARE & MEDICAID SERVICES

Centers for Medicaid and CHIP Services (CMCS)

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

JUN -8 2012

RE: State Plan Amendment FL 11-008

Dear Mr. Senior:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-008. Effective July 1, 2011 this amendment proposes to adjust reimbursement for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled. Specifically this amendment proposes to reduce reimbursement rates by $6,297,463. However, the reductions will be offset by an increase in provider assessments. The net effect of the amendment will be an increase of provider payments $21,183,175 total computable ($11,849,868 FFP) for the 12 months ending September 30, 2012.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CPR Part 447. We have found that the proposed reimbursement methodology complies with applicable requirements and therefore have approved them with an effective date of July 1, 2011. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332.

Sincerely

//s//

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL **FOR: HEALTH CARE FINANCING ADMINISTRATION**	1. TRANSMITTAL NUMBER: 2011-008	2. STATE Florida
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE July 1, 2011	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447	7. FEDERAL BUDGET IMPACT: (in thousands) FFY 2011-12 $11,820
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-D Part III	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Attachment 4.19-D Part III

10. SUBJECT OF AMENDMENT: ICF/DD Reimbursement Plan for Facilities Not Publicly Owned and Operated

11. 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:
Reviewed by the Deputy Secretary for Medicaid who is the Governor's designee.

12. SIGNATURE OF STATE AGENCY OFFICIAL: //s//	16. RETURN TO: Mr. Justin M. Senior Acting Deputy Secretary for Medicaid Agency for Health Care Administration 2727 Mahan Drive, Mail Stop #8 Tallahassee, FL 32308 Attention: Robin Ingram
13. TYPED NAME: Mr. Justin M. Senior	
14. TITLE: Acting Deputy Secretary for Medicaid	
15. DATE SUBMITTED: 09/23/11	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 09/23/11	18. DATE APPROVED: 06/08/12

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 07/01/11	20. SIGNATURE OF REGIONAL OFFICIAL: //s//
21. TYPED NAME: Cindy Mann	22. TITLE: Director, CMCS

23. REMARKS:

FLORIDA TITLE XIX INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED REIMBURSEMENT PLAN FOR FACILITIES NOT PUBLICLY OWNED AND NOT PUBLICLY OPERATED (FORMERLY KNOWN AS ICF-MR/DD FACILITIES)

VERSION VII

EFFECTIVE DATE: July 1, 2011

I. Cost Finding and Cost Reporting

A. Each intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR-DD) that is not publicly owned and not publicly operated which is 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 or agency) postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time up to six months from fiscal year end for filing cost reports. An extension for filing a cost report is not an exception to the February 1, and August 1 dates in determining which cost reports are used to establish rates effective April 1 and October 1 of each year. Four complete, legible copies of the cost report shall be submitted to the Agency for Health Care Administration. The cost reporting forms and instructions shall be the same as used for facilities reimbursed in accordance with Rule 59G-6.040, F.A.C.

B. Cost reports used to establish rates effective April 1, 1998 or the most current cost report received by the agency as of August 1, 1998 shall be used to establish rates effective October 1, 1998 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 must be prepared using the accrual basis of accounting in accordance with generally accepted accounting principles, as incorporated by reference in Rule 61H1-20.007 F.A.C., the

methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual CMS PUB.15-1, incorporated by reference in Rule 59G-6.010, F.A.C., except as modified by the Florida Title XIX ICF/MR-DD Reimbursement Plan for Facilities Not Publicly Owned and Not Publicly Operated (Formerly Known as ICF-MR/DD Facilities), and State of Florida Administrative Rules. The CMS PUB.15-1 Manual may be obtained from the regional Health Care Financing Administration office in Atlanta. The person preparing the cost report must sign the cost report as the preparer. Cost reports, which are not signed, shall not be accepted.

D. If a provider submits a cost report late, after the 90 day period, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 90 days, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. A provider who does not file within 180 days of the end of his cost reporting period shall have his contract canceled.

E. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership must file a final cost report within 90 days of withdrawal from the program when that provider has been receiving an interim reimbursement rate.

F. All providers are required to maintain financial and statistical records in accordance with Title 42 Code of Federal Regulations (CFR), Sections 413.24 (a), (b), (c) and (e). The cost report is to be based on financial and statistical records maintained by the provider. Cost information must be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB.15-1 which pertain to the determination of allowable costs, and must be capable of being audited and available within the State of Florida for auditing by state and federal agencies and

their representatives within 20 days of the request. All accounting and other records must be brought up to date within 30 days of the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 3 years following the date of submission of the cost report form to AHCA.

G. Records of organizations determined by AHCA to be related as defined by 42 CFR 413.17 must be available upon demand within the State of Florida to representatives, employees, or contractors of AHCA, the Florida Auditor General, U.S. General Accounting Office (GAO), or U.S. Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17. Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I New providers entering the program must 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 submitted initially, but may be used only to adjust the interim budgeted rate in effect.

J. The provisions of this reimbursement plan shall apply to all ICF-MR/DD Facilities Not Publicly Owned and Not Publicly Operated (Formerly Known as ICF-MR/DD Facilities). These facilities shall include ICF-MR/DD facilities that are publicly owned and the State of Florida is the Medicaid provider of record, but are operated and/or managed by a not-for profit or for profit organization.

K. Unless specifically noted the term's facility and provider shall have the same meaning for all sections of this reimbursement plan.

L. Cost reports submitted on or after July 1, 2004, must include the following statement immediately preceding the dated signature of the provider's administrator or chief financial officer: "I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

Medicaid reimbursements and payments, and that the services identified in this cost report were provided in compliance with such laws and regulations."

M. The Agency 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 s. 409.913(15)(c) and 409.913(16)(c), F.S., for late cost reports. The amount of sanctions can be found in 59G-9.070, Florida Administrative Code. A cost report is late if it is not received by the Agency on the first cost report acceptance cut-off date after the cost report due date.

II. Audits

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

A. Description of AHCA's Procedures for Audits - General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 are met. AHCA shall determine the scope and format for on-site audits and desk audits of cost reports and financial records of providers.

2. All audits shall be based on generally accepted auditing standards of the AICPA, as incorporated by reference in Rule 61H1-20.008, F.A.C.

3. Upon completion of each field audit, the auditors shall issue a report which meets the requirements of 42 CFR 447. 202 and generally accepted auditing standards. The auditor must express an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all federal and state regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.

4. Providers shall have the right to petition for an administrative hearing in accordance with Chapter 120.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

B. Desk Audit Procedures

1. Cost reports shall be reviewed for completeness, accuracy, consistency, and compliance with Medicaid regulations. Necessary adjustments shall be made. All findings and adjustments shall be summarized in writing.

2. A concurrence letter will be prepared and sent to the provider, showing all adjustments and changes and the authority for such.

III. Allowable Costs

A. The cost report must include all items of expense which a provider must incur in meeting:

1. The definition of intermediate care facility set forth in Section 42 CFR 440.150;

2. The standards prescribed by the Secretary of HHS for intermediate care facilities in regulations under the Social Security Act in 42 CFR 442, Subpart C;

3. The requirements established by the state agency responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610.

B. All therapy required by Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapeutic opportunities shall include habilitative, rehabilitative or other professional treatments which shall be composed of, for example, medical, dental, nutritional, nursing, pharmacy, physical therapy, occupational therapy, psychological, recreational, social work, speech therapy or other mental retardation specialized services as appropriate.

C. Implicit in any definition of allowable costs is that those costs do not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII principles of reimbursement, CMS PUB.15-1, and this plan, to exceed what a prudent buyer would pay, then the excess costs shall not be reimbursable under this plan.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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/MR-DD Program are not allowable under this plan and should not be included in the ICF/MR-DD cost report for Medicaid. These include expenses associated with prescription drugs, physicians' fees, etc. Refer to the services covered by the Medicaid ICF/MR-DD vendor payment in the Florida Medicaid ICF/MR-DD Services Coverage and Limitations Handbook. Refer to 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 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.

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 must identify such related organizations and costs in their cost reports.

G. Other costs which are 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 as may be determined by surveys conducted by AHCA.

2. Limitation of rents:

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

a. It is the intent of the Medicaid program to limit lease cost reimbursement, that is, rent, to the allowable ownership costs associated with the leased land, building, and equipment. For the purposes of this provision, allowable ownership costs of the leased property shall be defined as the sum of:

(1) Depreciation, property-related interest, property taxes including personal and real property, property insurance, and other property-related costs as allowed under the provisions of this plan;

(2) Sales tax on lease payments, if applicable; and

(3) Return on equity that would be paid to the owner if he were the provider, as per Section H. below.

b. Implementation of this provision shall be in accordance with the following:

(1) Reimbursable lease costs of existing providers as of July 18, 1984 will remain unchanged until such time as the provider documents that ownership costs, as defined above, exceed the Medicaid rent costs allowed. No other upward adjustments shall be made to allowable lease costs, that is, increased rent associated with negotiated or renewed leases of existing providers shall not be allowed, except for those legally binding agreements entered into by the lessee and lessor before July 18, 1984.

(2a) For currently participating non-leased facilities that subsequently are operated under a lease agreement commencing on or after July 18, 1984 with no change in ownership, the Medicaid rent costs allowed for reimbursement will be the lesser of actual rent paid or the allowable ownership costs of the leased property immediately prior to the commencement of the lease arrangement, adjusted subsequently only for cost increases that would have been allowable for the owner, for

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

example, increases in property taxes. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(2b) For leased facilities that subsequently undergo a change of ownership, the lease costs shall be limited to the ownership costs of the original owner of record as of July 18, 1984 or the rent, whichever is lower.

(3) For new providers entering the Medicaid program on or after July 18, 1984, lease payments shall be the lesser of actual rent paid or allowable ownership costs as determined by the provisions of this plan. Allowable ownership costs must be adequately documented by the provider. This provision does not apply to lease costs for equipment that is not being leased from the owner of the facility.

(4) In no case shall Medicaid reimburse a provider for costs not properly documented per the provisions of this plan. Providers showing rent costs, with the exception of providers who have entered into legally binding lease agreements prior to July 18, 1984, shall not be reimbursed for such costs if proper documentation of the owner's costs are not submitted to AHCA. The owner shall be required to sign a letter to AHCA which states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner must also state that the owner agrees to make his books and records of original entry related to the ICF/MR-DD properties available to auditors or official representatives of AHCA, and that he agrees to abide by the depreciation recapture provisions of this plan set forth in Section III.G.3. below.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

(5) AHCA shall not make a determination that a provider has shown adequate proof of financial ability to operate if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (4) above.

3. Basis for depreciation and calculation:

a. Cost.

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

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 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 Social Security Act, in a case in which a change in ownership of a provider's or lessor's depreciable assets occurs, and if a bona fide sale is established, the valuation of capital assets for determining payment rates for intermediate care facilities for the mentally retarded and developmentally disabled 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 H.H.S.) in the current Dodge Construction Systems Cost

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

(2) One-half of the percentage increase (as measured over the same period of time) in the current consumer price index for all urban consumers (United States city average).

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

(1) The acquisition cost of the facility to the new owner; or

(2) The fair market value of the facility at the time of purchase.

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

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

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

c. Recapture of depreciation resulting from sale of assets. The sale of depreciable assets, or a substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in, a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement indicates the fact that depreciation used for the purpose of

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

computing allowable costs was greater than the actual economic depreciation. The amount of the recapture shall be determined as follows:

(1) The gross recapture amount shall be the lesser of the actual gain on the sale or the Medicaid portion of accumulated depreciation after the effective date of January 1, 1972.

The gross recapture amount shall be reduced by .877193 percent for each month in excess of forty-eight (48) months participation in the Medicaid program. Additional beds and other related depreciable assets put into service after July 1, 1990 shall be subject to the same thirteen and one-half (13 1/2) year depreciation recapture phase out schedule beginning at the time the additional beds are put into service. The gross recapture amount related to the additional beds shall be reduced by .877193 percent for each month in excess of forty-eight (48) months' participation in the Medicaid program subsequent to the date the additional beds were put into service. To determine the amount of gain associated with additional beds, the portion of the sale price associated with all depreciable assets shall be allocated to the older and new portions of a facility as follows: For each part of the facility, determine the proportion of beds to the facility's total number of beds. Multiply the proportion of beds in that part of the facility by the sale price. The result is the portion of the sales price allocable to that part of the facility.

Example:

Sales Price: $6,000,000

Older Portion of Facility:

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

Number of beds = 60

Newer portion of facility:

Number of beds = 120

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

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

Sale Price = $6,000,000

(2) The adjusted gross recapture amounts as determined in (1) above shall be allocated for fiscal periods from January 1, 1972, through the date of sale. The adjusted gross recapture amounts shall be allocated to each fiscal period in the same ratio as depreciation amounts claimed for the respective portions of the facility. Allowable costs shall be computed for each period after depreciation recapture. The recomputed allowable costs shall be used to determine if there should be an adjustment to the payment rate, and any resulting overpayment shall be recovered.

(3) The net recapture amount, if any, so determined in (2) above shall be paid by the former owners, to the State. If the net recapture amount is not paid by the former owner, in total or in part, the amount not paid shall be deducted from the future payments by AHCA to the buyer until the net recapture has been received. AHCA shall grant terms of extended payment when the facts and circumstances of the unrecovered recapture from the seller justify the extension.

d. Depreciation recapture resulting from leasing the facility or withdrawing from Medicaid program.

(1) In cases where an owner-operator withdraws from the Medicaid program as the provider, but does not sell the facility, the depreciation paid by Medicaid to the owner during the same time he was the

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

Medicaid provider shall be subject to the depreciation recapture provisions of this plan when the owner sells the facility. This includes cases where an owner-provider leases a facility to another, unrelated, licensed operator after having operated the facility as the licensed Medicaid provider. In addition, if an owner-operator elects to withdraw from the Medicaid program and lease the facility to an operator who continues to participate in the Medicaid program, the portion of the reimbursable rent payment that represents depreciation expenses shall be subject to the depreciation recapture provisions of this plan, Section III.G.3.c, at the time the facility is sold. On or after July l, l984, all owner-providers that withdraw from the Medicaid program shall be required to sign a contract with the department creating an equitable lien on the owner's capital assets. This lien shall be filed by the department with the clerk of the circuit court in the judicial circuit within which the facility is located. The contract shall specify that the method for computing depreciation recapture shall be in accordance with the provisions of this plan, and the contract shall state that such recapture so determined shall be due to the agency upon sale of the facility. In the event that a provider fails to sign and return the contract to the department, the Proof of Financial Ability which is required for the prospective operator of the facility to be licensed shall not be approved.

(2) For lessees entering the Medicaid program after July l, l984 and for existing Medicaid providers who are granted an upward adjustment to their allowable lease costs after July l, l984, the portion of the Medicaid reimbursement rent payment that represents depreciation expense shall

TN No: 2011-008
Supersedes: 2010-009
Approval Date:
Effective Date: July 1, 2011

be subject to the depreciation recapture provisions of the plan at the time the facility is sold.

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

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

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

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

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

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

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

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

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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

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

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

6. Property-related costs allowed for reimbursement purposes shall be limited by the following provisions.

a. Costs that are capitalized as per CMS PUB.15-1 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 financed through a "conventional financing" debt instrument over a 25-year period, with a l0 percent cash down payment, at an interest rate equal to the lesser of 15 percent or the prime rate plus 2 percent. In cases where the provider obtained greater than 90 percent financing, the difference between the actual

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

down payment and a 10 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 return on equity or use allowance that would have occurred had a full 10 percent down payment actually been made. If the total ROE payment would increase from zero payment 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 Office of Developmental Services, it is in

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

the best interest of the State. Exceptions to the financing limitations shall be considered when it has been demonstrated through the Certificate of Need or Request for Proposal process that financing within the limitations of this plan is not available.

Should that decision be made, the DCF Office of Developmental Services shall issue a new Request for Proposal allowing other financing options. DCF shall reject any or all proposals which are made in response to a new Request for Proposal if the department determines that the rejection is in the best interest of the State.

7. After June 30, 1984, additional costs incurred after enrollment in the program that are due to capital additions or expansion must have prior approval by the DCF Office of Developmental Services if such costs exceed 1 percent of the provider's current total reimbursement rate, with the exception of the addition of new beds which are approved through the state's Certificate of Need process. Costs for specific expansion or additions that exceed the 1 percent limit shall not be reimbursable if not previously approved. Further, financing costs for approved expansions or additions shall be limited by the prudent buyer limits established in Section III.G.4. above.

8. Depreciable basis as a result of capital improvements. If capital improvements are made to a facility after July 18, 1984, the actual cost of the improvements shall be added to the owner's basis, allowing the owner reimbursement of interest, return on equity, or both as specified in Section III of this plan.

9. Retirement and replacement of outdated equipment. Upon a change of ownership of a facility, the new provider must maintain the original owner's records of capital assets. If the new owner subsequently retires outdated equipment, the original owner's cost minus any depreciation shall be an allowable write-off. Replacement equipment costs shall be allowed according to capital improvement rules as specified above.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

H. Return on equity

A reasonable return on equity capital (ROE) invested and used in providing resident care shall be defined for purposes of this plan as an allowable cost. This return on equity 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 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, Florida Statutes, Administrative Procedures Act, this plan shall be made available for public inspection, and a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the plan.

B. Reimbursement rates shall be established prospectively for each individual provider based on the most recent historic costs, but historic costs shall be limited to allowable percentage increases from period to period, as described in L. below. Further, if certain costs are determined by the AHCA Office of Medicaid or the AHCA Office of Audit Services, utilizing the Title XVIII Principles of Reimbursement, CMS PUB.15-1 and this Plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

C. Prospective payment rates shall be established semi-annually on April 1 and October 1. The most current acceptable cost report received by the agency by February 1 and August 1 shall be used in the rate-setting process to set rates effective on April 1 and October 1, respectively. The rate-setting process is detailed in Section V of this plan. The same cost reports used for the April 1, 1998 rate semester or the most current cost report received by August 1, 1998 by the agency shall be used to establish rates effective October 1, 1998 through March 31, 1999.

D. Reimbursement rates shall be calculated separately for two classes. The classes shall be based on the four types of ICF/MR-DD care as defined in Rule 59G-4.170 F.A.C. The four types of care, listed in ascending order of handicap severity, are Developmental Residential, Developmental Institutional, Developmental Non-ambulatory, and Developmental Medical. Developmental Residential and Developmental Institutional shall constitute one class for reimbursement purposes, while Developmental Non-ambulatory and Developmental Medical shall constitute the other. All providers must allocate costs by the four types of care in their cost reports. The agency shall monitor placements of clients to determine whether discrimination against clients with higher cost or more complex service needs is occurring. If the agency determines that such placement discrimination is occurring, this plan may be amended to provide for payments based on four types of care.

E. For the two classes described in 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 return on equity 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.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

2. A provider submits an amended cost report used to determine the rates in effect. An amended cost report may be submitted in the event that it would effect a change of 1 percent or more in the total reimbursement rate. The amended cost report must be filed by the filing date of the subsequent cost report. An audited cost report may not be amended. A cost report shall be deemed audited 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 semi-annual rate setting process described in Section V, as well as to changes in a provider's allowable cost basis. These provisions are not applicable to new providers' first year interim rates, which are addressed in sections H. and I. below.

1. Requests for rate adjustments for increases in property-related costs due to capital additions, expansion, replacements, or repairs shall not be considered in the interim between cost report submissions, except for the addition of new beds or if the cost of the specific expansion, addition, repair, or replacement would cause a change of 1 percent or more in the provider's total per diem reimbursement rate.

2. Requests for interim rate changes reflecting increased costs occurring as a result of resident care or administration changes or capital replacement other than that specified in (l) above shall be considered only if such changes were made to comply with existing state or federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of l.0 percent or more in the provider's current total per diem rate. The provider must submit documentation showing that the changes made were necessary to meet existing state or federal requirements.

3. In the event that new state or federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

certification requirements require all affected providers to make changes that result in increased or decreased resident care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All affected providers' budgets submitted shall be reviewed by the agency and shall be the basis for establishing reasonable cost parameters.

4. Vacancy interim rates will be prohibited unless the bed(s) in question has been empty for at least 90 days (the waiting period), the facility has an occupancy rate of at least 95%, and the affected reimbursement rate is based upon patient days that included occupancy of the bed(s). The vacancy interim rate will not cover the 90-day waiting period.

5. Interim rate requests resulting from (l), (2), (3) and (4) above must be submitted within 60 days after the costs are incurred, and must be accompanied by a 12-month budget which reflects changes in services and costs. An interim reimbursement rate, if approved, shall be established for estimated additional costs retroactive to the time of the change in services or the time the costs are incurred, but not to exceed 60 days before the date AHCA receives the interim rate request. The interim per diem rate shall reflect only the estimated additional costs, and the total reimbursement rate paid to the provider shall be the sum of the previously-established prospective rates plus the interim rate. A discontinued service would offset the appropriate components of the prospective per diem rates currently in effect for the provider. Upon receipt of a valid interim rate request subsequent to June 30, 1984, the AHCA Office of Medicaid must determine whether additional information is needed from the provider and request such information within 30 days. Upon receipt of the complete, legible additional information as requested, the AHCA Office of Medicaid must approve or disapprove the interim rate within 60 days. If the Office of Medicaid does not make such determination within the 60 days, the interim rate request shall be deemed approved.

6. Interim Rate Settlement.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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

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

7. 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:

   Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

2. Operating Costs:

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

3. Resident Care Costs:

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

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:

   Must be approved by the AHCA Office of Medicaid and shall not be in excess of the limitations established in Section III. of this plan.

2. Operating Costs Ceiling:

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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

3. Resident Care Costs 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 return on equity):

Shall not exceed $ 239.09 for the Developmental Residential/Developmental Institutional classes and shall not exceed $267.02 for the Developmental Non-Ambulatory classes as of April 1, 1998. For subsequent rate semesters, these ceiling amounts shall be inflated forward based on one times the ICF/MR-DD 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 return on equity.

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

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

and actual allowable costs shall be refunded to the provider. The basis for calculating prospective rates shall be the first year settled cost report. Basis shall be set at 100 percent of the total allowable costs as determined by Medicaid.

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 submitted by the provider. Overpayment as a result of the difference between the approved budgeted interim rate and actual allowable costs of the budgeted item 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 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/MR-DD Cost Inflation Index used in this plan. Calculation of incentives shall be as detailed in Section V.A.7. of this plan.

3. 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 semester in effect one year prior to the rate semester being set.

K. 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,

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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

L 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/MR-DD 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.

M. Aggregate test comparing Medicaid to Medicare according to 42 CFR 447.253(c)(2) , the Medicaid agency's estimated average proposed payment rate is reasonably expected to pay no more in the aggregate for long-term care facility services than the amount that would be paid for the services under the Medicare principles of reimbursement. At any rate-setting period, if the aggregate reimbursement to be paid is higher than would be paid under Medicare principles, incentives shall be reduced or eliminated as necessary to meet the aggregate test.

N. 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 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.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

V. Methodology

A. Rate-setting method for rate semesters beginning on or after October 1, 1998.

1. For rate semesters beginning on April 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. For rate semesters beginning on October 1 of a given year, the prospective rates will be set using the most current acceptable cost report on file with AHCA as of August 1 of that year. For the rate semester October 1, 1998 through March 31, 1999, the same cost reports used in setting April 1, 1998 rates or the most current cost report received by the agency by August 1, 1998 shall be used.

2. Review and adjust each provider's cost report referred to in Section IV.N. above 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 return on equity or use allowance if applicable. See the Definitions section of this plan for the definitions of allowable costs for each of the cost components. Costs shall be allocated to each reimbursement class by the methodology shown in Appendix A. 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/MR-DD 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.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

6. This step presumes that the cost components of the cost reporting period immediately prior to the current cost report have been adjusted for base year ceiling limitations, inflation target rate limits and incentives, and that they now represent the allowable base costs against which the current costs are to be evaluated. If the current year cost report includes new costs that were incurred in order to meet State or Federal rules, laws, regulations, or licensure and certification standards, and the provider did not request an interim rate adjustment for those costs during that cost reporting period or if the costs did not meet the $5,000 and 1 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 must 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 5 above to reflect the allowable change in costs. For the October 1, 1998 rate semester the components for the operating and resident care costs shall be the base costs established for the April 1, 1998 rate semester.

7. Compare the operating and resident care cost per diems resulting from Step 6 with the respective per diems from Step 4 for each reimbursement class.

   a. If the operating per diem for either reimbursement class from Step 4 is less than the respective operating per diem from Step 6, then establish the new operating base per diem as the per diem from Step 4 plus an incentive of one-half of the difference between the two per diems, not to exceed 10 percent of the Step 4 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 semester in effect one year prior to the rate semester being set. For example, a provider not out of compliance with a Condition of Participation

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

shall receive 100% of the incentive amount. A provider that is out of compliance for 30 days of a 183-day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the operating per diem from Step 4 is greater than the Step 6 per diem, then establish the new operating base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 inflated by the target rate factor.

b. If the resident care per diem for either reimbursement class from Step 4 is less than the respective resident care per diem from Step 6 then establish the new resident care base per diem as the per diem from Step 4 plus an incentive calculated as 50 percent of the difference between the Step 4 per diem and the Step 6 per diem, not to exceed 3 percent of the Step 4 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 semester in effect one year prior to the rate semester 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 30 days of a 183-day rate semester shall receive 83.61% of the incentive amount based on 153 days divided by 183 days. If the resident care per diem from Step 4 is greater than the Step 6 per diem, then establish the new resident care base per diem as the Step 4 per diem, not to exceed the base cost per diem from Step 6 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.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

8. The new base per diems for property and return on equity or use allowance shall be the per diems established in step 4 above.

9. Using the appropriate current base per diem for resident care and operating costs from Step 7 above, calculate the prospective operating and resident care per diems for the new rate semester by multiplying each of the base per diems by the fraction:
Simple average of the Florida ICF/MR-DD monthly cost inflation indices for the prospective rate semester divided by the simple average of the Florida ICF/MR-DD monthly cost inflation indices for the cost report period used to calculate current base per diems. For rates effective October 1, 1998, the prospective rate semester used in calculating the above fraction shall be the period October 1, 1998 through March 31, 1999.

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 9 plus the current approved per diems for property and return on equity or use allowance, if applicable, from Step 8.

11. Effective October 1, 2004 through June 30, 2005, the proportional reduction shall be calculated as follows:
    a. Set the reimbursement rates as described in Section V. of this plan.
    b. Apply the same percentage reduction to all rates, as determined in (a) above, until estimated payments (based upon annualized Medicaid days as estimated per the cost reports used in setting the rates in (a) above) are reduced by an estimated $4,788,000 through June 30, 2005.

12. Effective October 1, 2005, a percentage reimbursement rate reduction based on weighted average rates shall be established to achieve an annual aggregate total estimated savings of $4,958,526 for the period ending June 30, 2006. The weighted average per diem rates as of October 1, 2005 and April 1, 2006 shall be the bases for the determination of these savings, and shall be compared to the weighted average per diem as of July 1, 2005. The

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

full savings will be assumed realized if the combined weighted average rate for the periods October 1, 2005 and April 1, 2006 does not exceed the weighted average rate as of July 1, 2005. Effective July 1, 2006, the annual aggregate amount the rates were reduced during the period October 1, 2005 through June 30, 2006 shall become a recurring annual reduction not to exceed $4,958,526. This recurring reduction, called the Medicaid Trend Adjustment, shall be applied proportionally to all rates on an annual basis.

B. Medicaid Trend Adjustment (MTA)

A Medicaid Trend Adjustment is a percentage reduction that is uniformly applied to all Medicaid Intermediate Care Facility providers each rate semester which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is applied to all components after targets and ceilings are applied. Below are all the recurring reductions that are included in the Medicaid Trend Adjustment. In addition, please reference Appendix C for each MTA percentage by rate semester.

1. Effective October 1, 2008, the Agency for Health Care Administration shall implement a recurring methodology to achieve a $6,160,256 reduction. In establishing rates through the normal process, prior to including this reduction, if the unit cost is equal to or less than the unit cost used in establishing the budget, no additional reduction in rates is necessary. In establishing rates through the normal process, prior to including this reduction, if the unit cost is greater than the unit cost used in establishing the budget, then rates shall be reduced by an amount required to achieve this reduction, but shall not be reduced below the unit cost used in establishing the budget. The recurring methodology is designed to reduce individual Medicaid Intermediate Care Facility rates proportionally until the required reduction is achieved.
2. Effective October 1, 2008, the Agency for Health Care Administration shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs for two fiscal years effective July 1, 2009.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

3. Effective October 1, 2009, the Agency shall implement a recurring methodology in the Title XIX Intermediate Care Facility for the Developmentally Disabled for Community Owned and Operated Facilities Reimbursement Plan to achieve a $17,373,303 reduction. Subsequent to B.1, the recurring methodology is designed to reduce individual Medicaid Intermediate Care Facility rates proportionally until the required reduction is achieved.
4. Effective October 1, 2009, a buy back provision will be applied to the Medicaid trend adjustment that is being applied against the Medicaid Intermediate Care Facility rates.
5. Effective October 1, 2011, budget authority for $6,297,463 is provided for implementing a recurring rate reduction for intermediate care facilities for the developmentally disabled. Subsequent to B.3, the recurring methodology is designed to reduce individual Medicaid Intermediate Care Facility rates proportionally until the required reduction is achieved.
6. Effective July 1, 2011, budget authority for $27,480,638 is provided to buy back the Medicaid trend adjustment for intermediate care facilities for the developmentally disabled rate reductions that began on or after October 1, 2008. The methodology is designed to increase individual Medicaid Intermediate Care Facility rates proportionally until the required buy back budget authority is achieved.
7. Effective July 1, 2011, the Agency shall establish rates at a level that ensures no increase in statewide expenditures resulting from a change in unit costs.

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. of this plan.
2. Operating costs per diems shall not be in excess of the 90th percentile of per resident day costs of all currently participating ICF/MR-DD providers that have prospective rates. This ceiling shall be recalculated for every rate semester beginning April 1 and October 1 of each year.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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 semester beginning April 1 and October 1 of each year.

4. Total costs per diem ceilings (including return on equity):

   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 return on equity, in the base year.

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

VI. Payment Assurance

The state shall pay each provider for services provided in accordance with the requirements of the Florida Title XIX state plan and applicable state or federal rules and regulations. The payment amount shall be determined for each provider according to the standards and methods set forth in this Florida Title XIX ICF/MR-DD Reimbursement Plan for Facilities Not Publicly Owned and Not Publicly Operated (Formerly Known as ICF-MR/DD Facilities).

VII. Provider Participation

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

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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/MR-DD facility; or as a requirement for the resident's continued stay in such a facility, when the cost of the services provided therein is paid for, in whole or in part, under the state plan, shall be construed to be supplementation of the state's payment for services. Payments made as a condition of admitting a resident or as a requirement for continued stay in a facility shall be deemed to be payments to meet the cost of care of the Medicaid resident and shall be deemed to be out of compliance with 42 CFR 447.15.

IX. Intermediate Care Facility Quality Assessment Fee (ICFQAF)

A. Effective October 1, 2009, in accordance with section 409.9083, F.S., there is imposed upon each intermediate care facility for the developmentally disabled, a quality assessment. The aggregated amount of assessments for all ICF/DDs 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. The Agency 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 the agency its total number of resident days and shall remit an amount equal to the assessment rate times the reported number of days. The agency shall collect, and each facility shall pay, the quality assessment each month. The agency shall collect the assessment from facility providers no later than the 15th of the next succeeding calendar month. The agency 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 Medicaid rates containing the

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

elements prescribed in section B below and monthly thereafter. Intermediate care facilities for the developmentally disabled 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 Medicaid program to make Medicaid payments for ICF/DD services up to the amount of the Medicaid rates for such facilities as calculated in accordance with the approved state 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 Medicaid share of the quality assessment as a pass through, Medicaid-allowable cost.

(b) Increase each privately operated ICF/DD Medicaid rate, as needed, by an amount that restores the rate reductions implemented on October 1, 2008.

(c) Increase each ICF/DD 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 Medicaid beneficiaries.

C. Upon termination of the quality assessment, all collected assessment revenues, less any amounts expended by the agency, shall be returned on a pro rata basis to the facilities that paid such assessments.

D. The agency may seek any of the following remedies for failure of any ICF/DD provider to timely pay its assessment:

(a) Withholding any medical assistance reimbursement payments until the assessment amount is recovered.

(b) Suspending or revoking the facility's license.

(c) Imposing a fine of up to $1,000 per day for each delinquent payment, not to exceed the amount of the assessment.

X. Definitions

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

A. Acceptable Cost Report: A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

B. AHCA: Agency for Health Care Administration, also known as the Agency.

C. CMS PUB.15-1: also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Centers for Medicare and Medicaid Services.

D. DCF: Department of Children and Family Services, also known as the Department.

E. Filing Due Date - No later than three (3) calendar months after the close of the ICF's cost-reporting year.

F. ICF/MR-DD Operating Costs: Those costs not directly related to resident care or property costs. Operating costs include administrative, plant operation, laundry and housekeeping costs. Return on equity or use allowance costs are not included in operating costs.

G. ICF/MR-DD Resident Care Costs: Those costs directly attributed to nursing services, dietary costs, and other costs directly related to resident care such as activity costs, social services, and all medically-ordered therapies.

H. ICF/MR-DD Property Costs: Those costs related to the ownership or leasing of an ICF/MR-DD. Such costs may include property taxes, insurance, interest and depreciation, or rent.

I. ICF/MR-DD Return on Equity or Use Allowance Costs: See Sections III.H. and III.I. of this plan.

J. 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.

K. Title XVIII: Health Insurance for the Aged, Blind or Disabled (Medicare) as provided for in the Social Security Act (42 U.S.C. 1395-1395pp).

L. Title XIX: Grants to States for Medical Assistance Programs (Medicaid) as provided for in the Social Security Act (42 U.S.C. 1396-1396i)

M. Medicaid Interim Reimbursement Rate: A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data.

N. Rate Setting Due Date - April Rate Period; All cost reports received by AHCA by February 1 shall be used to establish the reimbursement rates;

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

October Rate Period; All cost reports received by AHCA by April 1 shall be used to establish the reimbursement rates.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

APPENDIX A

Provider Number FY: 09/30/84

Provider Name Audit Status Unaudited

Address

			COL A Resid./ Inst.	COL B Non-amb./ Medical	TOTAL	COL C
A.	Alloc of Exp (Excl B&C)					
	1.	Resident Days	02461	8325		10786
	2.	OPER. EXPENSE COMP				
		a. Administration	-	-		120482
		b. Plant Operation	-	-		45060
		c. Laundry	-	-		15265
		d. Housekeeping	-	-		29090
		e. Oper. Exp. Comp and Per Diem	19.460	19.460		209897
	3.	Resident Care Expense				
	a.	Dietary -	-	74861		
	b.	Other -	-	34188		
	c.	Nursing -	-	86018		
	d.	Res. Care Exp. and Per Diem	18.0852	18.0852		19.5067
	4.	PROP. EXP. COMP. AND PER DIEM	8.605	8.605		92812
	5.	ROE/UA COMP & PER DIEM	6.604	6.604		71236
B.	DIRECT CARE EXPENSE					
	1.	Staffing .5	1.	-		
	2.	Total Staffing Required	1230.5	8325		95555
	3.	Staffing Percent	12.877%	87.123		100%
	4.	Alloc. of Direct Care	39263.97	26542.03		304906
	5.	Dir. Care Exp. Per Diem	15.945	31.9090		
C.	ADDITIONAL SERVICES EXPENSE					
	1.	Medicaid Patient Days	2461	8275		10736
	2.	Add. Ser. (Sch.AM-6)	36780	69380		106160
	3.	Add. Ser. Exp. Per Diem	14.951	8.3839		
D.	MEDICAID PER DIEM COST					
	1.	Operating Component	19.460	19.460		209897
	2.	Resident Care Component	48.985	58.378		606133
	3.	Property Cost Component	8.605	8.605		92812

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

	Subtotal (Schedule BM)	.-	.-	-
4.	ROE/USE ALLOW Comp.	6.604	6.604	71236
5.	TOTAL PER DIEM COST	83.654	93.047	980078

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

APPENDIX A-1

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	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	34188
b.	Other -	-		
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.	DIRECT CARE EXPENSE			
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	
C.	ADDITIONAL SERVICES EXPENSE			
1.	Medicaid Patient Days	2461	8275	10736
2.	Add. Ser. (Sch.AM-6)	36780	69380	106160
3.	Add. Ser. Exp. Per Diem	14.951	8.3839	
D.	MEDICAID PER DIEM COST			
1.	Operating Component	19.460	19.460	209897
2.	Resident Care Component	55.520	56.448	606133
3.	Property Cost Component	8.605	8.605	92812
	Subtotal (Schedule BM)	.-	.-	-

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

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/MR-DD 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 x (.602/(.602 + .084))) + (1.073 x (.084/
(.602 + .084))) = 1.047

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

3. Quarterly and monthly indices.

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

Quarter Midpoint Quarter	Index	Average Index	Corresponding Month
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		

April 30 Index = (June 30 Index/March 31 Index)$^{1/3}$ x (March 31 Index)
= (1.042/1.032)1/3 x 1.032
= 1.035

May 30 Index = (June 30 Index/March 31 Index)$^{2/3}$ x (March 31 Index)
= (1.042/1.032)2/3 x 1.032
= 1.039

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

4. Inflation Factors

The inflation factors used to set both target rates of inflation and prospective payment rates utilize 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 must start with the index as of the last day of the month prior to the 12-month period.
Example: Calculation of target rate of inflation factor for provider with a June 30 fiscal year end.

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011

APPENDIX C TO FLORIDA TITLE XIX ICF REIMBURSEMENT PLAN

Medicaid Trend Adjustment Percentages

	Effective Date	Percentages	Reduction Amount
1.	October 1, 2008	.8200%	~~$6,160,256~~ 1,524,597
3.	October 1, 2009		
	First Cut	.7577%	$1,524,597
	Second Cut	8.7004%	$17,373,303
4.	April 1, 2010		
	First Cut	.8145%	$1,524,597
	Second Cut	9.3580%	$17,373,303
5.	October 1, 2010		
	First Cut	.7878%	$1,524,597
	Second Cut	9.0489%	$17,373,303
6.	October 1, 2011		
First Cut		.8555%	$1,524,597
Second Cut		9.8325%	$17,373,303
Third Cut		3.9527%	$6,297,463

TN No: 2011-008
Supersedes: 2010-009
Approval Date: JUN - 8 2012
Effective Date: July 1, 2011