59G-6.045 Payment Methodology for Services in Facilities Not Publicly Owned and Not Publicly Operated (Facilities Formerly Known as ICF-MR/DD Facilities).

(1) This rule applies to participating intermediate care facilities for individuals with intellectual disabilities (ICF/IID) not publicly owned and not publicly operated rendering Florida Medicaid services to recipients in accordance with Rule 59G 4.170, Florida Administrative Code (F.A.C.).

(2) Definitions.

(a) Acceptable cost report – A completed, accurate and legible cost report that contains all relevant schedules, worksheets and supporting documents in accordance with cost reporting instructions.

(b) AHCA – Agency for Health Care Administration.

(c) Eligibility Factor – The percentage of days that a provider is in compliance with all conditions of participation during the rate period in effect one year prior to the rate period being set.

(d) Filing due date (cost report) – No later than five calendar months after the close of the ICF/IID's cost reporting year.

(e) Incentive – An amount 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.

(f) Interim cost per diem – A reimbursement rate or a portion of an overall reimbursement rate that is calculated from budgeted cost data divided by the total resident days.

(g) Medicaid Trend Adjustment (MTA) – The MTA is a percentage reduction that is uniformly applied to all Florida Medicaid providers each rate period when the rate setting unit cost is greater than the legislative unit cost and all quality assessment funds have been exhausted.

(h) Operating cost per diem – Those costs not directly related to resident care, property costs, or Return on Equity (ROE). Operating costs include administrative, plant operation, laundry, and housekeeping costs divided by the total resident days.

(i) Patient Responsibility – The amount a recipient is required to pay the ICF/IID, as determined by the Department of Children and Families (DCF), based upon the recipient's monthly income.

(j) Property cost per diem – A calculation based upon those costs related to the ownership or leasing of an ICF/IID. Such costs may include property taxes, insurance, interest and depreciation, or rent divided by the total resident days.

(k) Quality Assessment – Pursuant to section 409.9083, Florida Statutes (F.S.), a per-resident-day basis assessment is imposed upon each ICF/IID.

(l) Rate setting due date – February 1 of each year shall be the rate setting due date. All cost reports received by AHCA on or before February 1 shall be used to establish the reimbursement rates for the upcoming rate period. If February 1 falls on the weekend, the due date shall be the first business day following February 1.

(m) Reimbursement Class – Designated provider reimbursement level for the provision of services to recipients residing in an ICF/IID, as follows:

1. Developmental Residential and Developmental Institutional – A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and who can transfer themselves without human assistance but may require assistance and oversight to ensure safe evacuation.

2. Developmental Non-ambulatory and Developmental Medical – A reimbursement level for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision.

(n) Resident care cost per diem – 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 divided by the total resident days.

(o) Return on Equity (ROE) or use allowance cost per diem – Net Income or Profits or Shareholder's Equity divided by the total resident days.

(p) Target Rate Factor – 1.4 times the simple average of the monthly Florida ICF/IID Cost Inflation Indices associated with the most recent cost reporting period divided by the simple average of the monthly indices associated with the prior cost reporting period.

(3) Reimbursement. Each July 1, AHCA will reimburse for Florida Medicaid services rendered by facilities not publicly owned and not publicly operated in accordance with Section 409.906, F.S.

(4) Reimbursement Methodology.

(a) Rate setting method.

1. Determine Inflated Prior Period Costs of Operating and Resident Care components

Prior Period Inflated Costs Per Diem = (Prior Period Base *Target Rate of Inflation)/Resident Days

2. Current Period Costs Per Diem = Total Allowable Cost of Component/Resident Days

3. Determine the Incentive Basis for Operating and Resident Care component per diems

If Prior Period Inflated Costs Per Diem > Current Period Costs Per Diem,

Incentive Basis = Prior Period Inflated Costs Per Diem – Current Period Costs Per Diem

4. Final Incentive Per Diem

a. For Operating component = Eligibility Factor *Minimum of:

(I) Incentive Basis for Operating Component *50%

(II) Incentive Basis for Operating Component – Current Period Costs Per Diem *10%

b. For Resident Care component = Eligibility Factor *Minimum of:

(I) Incentive Basis for Resident Care Component *50%

(II) Incentive Basis for Resident Care Component – Current Period Costs Per Diem *3%

5. Current Period Base Per Diem = Current Period Costs Per Diem + Final Incentive Per Diem

6. Prospective Rate Per Diem = Current Period Base Per Diem *(Simple average of the monthly cost inflation indices for the prospective rate period/Simple average of the monthly cost inflation indices for the cost report period used to calculate current base per diems)

7. Total Prospective per diem = Prospective Rate of Operating per diem + Prospective Rate of Resident Care per diem + Property per diem + ROE or use allowance + Interim Components + MTA + Quality Assessment.

(b) 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 established ceiling limitations.

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 multiplied times 4% (l.04). When a provider is limited to the total ceiling in the base year, the total ceiling shall be allocated to each component to cost settle interim rates and to calculate prospective rates based on the percentage that each component's actual allowable cost is to the total actual allowable cost for all components, including ROE, in the base year.

(5) Intermediate Care Facility Quality Assessment Fee (QAF). In accordance with Section 409.9083, F.S., there is imposed upon each ICF/IID, a quality assessment. The aggregate 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 services revenue of assessed facilities.

(a) Participating ICF/IIDs shall use the Facility Quality Assessment form (only accepted electronically), AHCA Form 5000-3548, October 2013, incorporated by reference, for the submission of its monthly quality assessment. This form can be accessed at https://apps.ahca.myflorida.com/nfqa/, and at http://www.flrules.org/Gateway/reference.asp?No=Ref-13532.

(b) Each facility shall report monthly to the Agency its total number of resident days and remit an amount equal to the assessment rate times the reported number of days. Facilities are required to submit their full quality assessment payment by the 15th day of the next succeeding calendar month.

(6) Sanctions. Providers are subject to the following monetary fines pursuant to Section 409.9083(6), F.S., for failure to timely pay a quality assessment:

(a) For a facility’s first offense, a fine of $500 per day shall be imposed until the quality assessment is paid in full, but in no event shall the fine exceed the amount of the quality assessment.

(b) For any offense subsequent to a first offense, a fine of $1,000 per day shall be imposed until the quality assessment is paid in full, but in no event shall the fine exceed the amount of the quality assessment. A subsequent offense is defined as any offense within a period of five years preceding the most recent quality assessment due date.

(c) An offense is defined as one month's quality assessment payment not received by the 20th day of the next succeeding calendar month.

(d) In the event that a provider fails to report their total number of resident days as defined in Section 409.9083(1)(c), F.S., by the 20th day of the next succeeding calendar month, the fines in paragraphs (a)-(b) apply and the maximum amount of the fines shall be equal to their last submitted quality assessment amount, but no greater than $1000 per day, and in no event shall the total fine exceed the amount of the quality assessment.

(e) In addition to the aforementioned fines, providers are also subject to the non-monetary remedies enumerated in Section 409.9083(6), F.S. Imposition of the non-monetary remedies by the Agency will be as follows:

1. For a third subsequent offense, the Agency will withhold any medical assistance reimbursement payments until the assessment is recovered.

2. For a fourth or greater subsequent offense, the Agency will seek suspension or revocation of the facility's license.

(7) Sanctions for failure to timely submit a quality assessment are non-allowable costs for reimbursement purposes and shall not be included in the provider's Medicaid per diem rate.

(8) The facility may amend any previously submitted quality assessment data, but in no event may an amendment occur more than twelve months after the due date of the assessment. The deadline for submitting an amended assessment shall not relieve the facility from their obligation to pay any amount previously underpaid and shall not waive the Agency's right to recoup any underpaid assessments.

(9) This rule is effective for 5 years after its effective date.

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