

59G-6.010 Payment Methodology for Nursing Home Services.

(1) This rule applies to all nursing facility providers rendering Florida Medicaid nursing facility services in accordance with Rule 59G-4.200, Florida Administrative Code.

(2) Definitions.

(a) Adjusted Facility Sq Ft – Component of the Fair Rental Value System (FRVS) Calculation, the Minimum, Maximum, or Actual Sq. Ft per bed, defined in Section 409.908(2)(b)1.g., Florida Statutes (F.S.).

(b) Allowable Medicaid Costs – Are defined in CMS Publication 15-1 chapter 21 under reasonable costs and costs related and not related to patient care.

(c) Budget Neutrality Factor – Budget neutrality multipliers shall be incorporated into the Prospective Payment System (PPS) to ensure that total reimbursement is as required through the General Appropriations Act. Quality Incentive Payments, Direct Care Staffing and Ventilator add-ons, and the Nursing Facility Quality Assessment are excluded.

(d) Depreciation Factor – Component of the FRVS Calculation, referred to as Obsolescence Factor, defined in Section 409.908(2)(b)1.g., F.S.

(e) Direct Care Cost Component – The direct patient care component shall include the Medicaid allowable portion of salaries and benefits of direct care staff providing nursing services including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to residents in the nursing facility, allowable therapy costs, and dietary costs adjusted for inflation.

(f) Equipment Cost – Component of the FRVS Calculation, referred to as moveable equipment allowance, defined in Section 409.908(2)(b)1.g., F.S.

(g) Exempt Providers – Pediatric, facilities operated by the Florida Department of Veterans Affairs, and government-operated facilities are exempt from reimbursement under the prospective payment methodology and shall be reimbursed on a cost-based prospective payment system, in accordance with Section 409.908(2)(b)8., Florida Statutes (F.S.). Reimbursement of direct care, indirect care, and operating costs are subject to reimbursement ceilings and targets.

(h) Fair Rental Rate – Component of the FRVS Calculation defined in Section 409.908(2)(b)1.g., F.S.

(i) Floors – Floors are calculated for the direct care and indirect care cost components for each peer group and are equal to the price times the floor percentage as defined in Section 409.908(2)(b)1.c., F.S.

(j) Floor Reduction – The difference between the floor and the provider's inflated per day cost component, if a provider's cost is below the floor.

(k) Fair Rental Value System (FRVS) Rate – A FRVS is used to reimburse providers for their facility related capital costs. A provider must submit an FRVS survey to the Agency for Health Care Administration (AHCA) using the electronic form and instructions on the Florida Nursing Home: Fair Rental Value Survey web page. The survey information is used to compute an adjusted age for each provider, based on the most recent survey received by April 30 of each year for the subsequent rate period. The nursing facility provider's FRVS survey will be used to calculate the rate for a future rate period

(l) High Medicaid Utilization and High Direct Patient Care Add-On – Providers who meet the minimum Medicaid utilization and staffing criteria outlined in Section 409.908(2)(b)6., F.S. and have a prospective payment per diem rate that is lower than their per diem rate effective September 1, 2016, shall receive the lesser of a \$20 per diem increase or a per diem increase sufficient to set their rate equal to their September 1, 2016 rate.

(m) Indirect Care Cost Component – All other allowable Medicaid patient care costs, that are not listed in the operating or direct care components, are adjusted for inflation and shall be included in the indirect patient care component.

(n) Land Allocation Percentage – Component of the FRVS Calculation, referred to as Land Valuation, defined in Section 409.908(2)(b)1.g., F.S.

(o) Medians – The mid-points of the inflated per diems for direct care, indirect care, and operating cost components of all included providers in a peer group. Beginning October 1, 2018 separate medians shall be calculated for operating, direct, and indirect cost components based on the most recent cost reports received for the September 2016 rate setting by the rate setting acceptance cut-off date, per Section 409.908(2)(b)1.b., F.S. Beginning October 1, 2021 medians shall be calculated based on the most recently finalized, audited cost report, every 4th year.

(p) Medicaid Adjustment Rate (MAR) – An add-on to the direct care and indirect care cost components of exempt providers with greater than 50 percent Medicaid utilization.

(q) Medicaid Bad Debt – Amounts considered to be uncollectible from accounts and notes receivable which are created or

acquired in providing services per CMS publication 15-1 chapter 3 section 302.1.

(r) Medicaid Trend Adjustment (MTA) – The MTA is a percentage reduction that is uniformly applied to all Florida Medicaid nursing facility providers each rate period which equals all recurring and nonrecurring budget reductions on an annualized basis. The MTA is built into the final Prospective Payment System rate through budget neutrality multipliers. The exempt providers' rates are reduced by the appropriate percentage allocation as compared to all Medicaid nursing facility providers. The Medicaid share of the NFQA is not subject to the MTA.

(s) Nursing Facility Quality Assessment (NFQA) – An assessment imposed on each nursing facility provider used to obtain Federal financial participation through the Medicaid program and partially fund the quality incentive payment program for nursing facilities that exceed quality benchmarks. The per diem Florida Medicaid share of the NFQA is calculated as follows:

1. Total patient days minus Medicare days (exclusive of Medicare Part A resident days) is equal to total non-Medicare days.
2. The product of total non-Medicare days, NFQA rate and Florida Medicaid days as a percentage of total days is equal to the total NFQA Florida Medicaid share.
3. Total NFQA Florida Medicaid share divided by Florida Medicaid days is equal to the per diem Florida Medicaid Share of the NFQA.

(t) Occupancy Percentage – Component of the Fair Rental Value System (FRVS) Calculation, the Minimum Occupancy, defined in Section 409.908(2)(b)1.g., F.S.

(u) Offense – Full quality assessment payment not received by the 20th day of the next succeeding calendar month.

(v) Quality Assessment Payment – Timely submission of one month's total number of resident days and rendering of Quality Assessment Fee Payment equal to the assessment rate times the reported number of days.

(w) Peer Group – Providers are divided into two peer groups defined in section 409.908(2)(b)1.a., F.S.

(x) Price – The standardized rate for each peer group that is calculated for the direct care, indirect care and operating cost components as the median times the price percentage as defined in Section 409.908(2)(b)1.b., F.S.

(y) Quality Incentive Payment – A provider is awarded points for process, outcome, structural and credentialing measures using most recently reported data on May 31 of the rate period year. To qualify for a quality incentive payment, a provider must meet the minimum threshold defined in Section 409.908(2)(b)1.f., F.S. The Quality Incentive budget is defined in Section 409.908(2)(b)1.e., F.S.

1. Process Measures – Includes Flu Vaccine, Antipsychotic, and Restraint quality metrics. Providers are ranked based on the percentage of residents who have, or do not have, a particular condition. Providers who are at or above the 90th percentile for a particular measure will be awarded 3 points, those scoring from the 75th up to 90th percentiles will be awarded 2 points, and those scoring from the 50th up to 75th percentiles will receive 1 point. Providers who score below the 50th percentile and achieve a 20 percent improvement from the previous year will receive 0.5 points. Data to calculate these quality metrics is from the Medicare Nursing Home Compare datasets using the most recent four quarter average available on May 31 of the rate period year.

2. Outcome Measures – Includes Urinary Tract Infections, Pressure Ulcers, Falls, Incontinence, and Decline in Activities of Daily Living quality metrics. Outcome Measures are scored using the same methodology as Process Measures. Data to calculate these metrics is from the Medicare Nursing Home Compare datasets.

3. Structure Measures – Includes Direct Care Staffing from the Medicaid cost report received by the rate setting cutoff date and Social Work and Activity Staff as reported on CMS 671 Reports. Structure Measures are scored using the same methodology as Process Measures and Outcome Measures.

4. Credentialing Measures – Includes CMS Overall 5-Star, Florida Gold Seal, Joint Commission Accreditation, and American Health Care Association National Quality Award. Facilities assigned a rating of 3, 4, or 5 stars in the CMS 5-Star program will receive 1, 3, or 5 points, respectively. For each rate period, the CMS 5-Star Rating Measure will be calculated using the most recent overall rating from the Star Ratings dataset from the Nursing Home Compare datasets provided by CMS as of May 31 of the year in which the rate period begins. Facilities that have either a Florida Gold Seal, Joint Commission Accreditation, or the silver or gold American Health Care Association National Quality Award on May 31 of the current year will be awarded 5 points. Recipients of the Florida Gold Seal Award can be viewed on Florida Health Finder website, recipients of the Joint Commission Accreditation can be viewed on the Joint Commission website, and recipients of the American Health Care Association National Quality Award can be viewed on the American Health Care Association website.

(z) Rate Period – October 1 – September 30.

(aa) Rate Setting Acceptance Cost Report Cutoff Date – The cost report cutoff date is April 30, or the next business day if April

30 falls on a weekend, of the year in which the rate period begins.

(bb) Rebase Rate Semester – Direct care, indirect care, and operating cost components will be rebased every fourth year by using the most recently finalized, audited cost report available by the rate setting acceptance cut-off date beginning October 1, 2021.

(cc) Reimbursement Ceiling – The upper rate limits, calculated based on all Medicaid Nursing Facility providers, for operating, direct care, and indirect care components applicable to exempt nursing facility providers in a peer group.

(dd) Reimbursement Targets – Provider specific per diem limitations, for the operating and indirect care cost components for exempt providers.

(ee) RSMeans Data – The industry-standard materials, labor, and equipment cost information database used by contractors and other professionals to accurately estimate construction project costs.

(ff) Subsequent Offense – any offense within a period of five years preceding the most recent quality assessment due date.

(gg) Ventilator Supplemental Payment – Effective October 1, 2019, claims and encounter data with diagnosis code Z99.11, dependence on respirator (ventilator) status, with dates of service in the prior calendar year will be used to calculate the ventilator supplemental payment. The sum of claims and encounters with diagnosis code Z99.11 for the facility will be divided by annualized Medicaid days from the most recently submitted cost report received by the Rate Setting Acceptance Cost Report Cutoff Date, then multiplied by \$200.00. The result will be added to the rate setting per diem.

(3) Reimbursement. Effective each October 1 the AHCA will reimburse for Florida Medicaid nursing facility services rendered by nursing facilities using the Prospective Payment System (PPS) methodology in accordance with Section 409.908 (2)(b), F.S. Exempt providers will be reimbursed using a cost based methodology.

(4) Reimbursement Methodology.

(a) PPS Calculation. The calculation is as follows:

$$(\text{Operating Price} + \text{Direct Care Price} - \text{Floor Reduction} + \text{Indirect Care Price} - \text{Floor Reduction} + \text{FRVS Rate} + \text{Pass Through Payments}) * \text{Budget Neutrality Factor} + \text{Quality Incentive Payment} + \text{Medicaid Share of NFQA} + \text{Ventilator Supplemental Payment} + \text{High Medicaid Utilization and High Direct Patient Care Add-On}$$

(b) Quality Incentive Payment Calculation. The calculation is as follows:

$$\text{Facility Annualized Medicaid Days} / \text{Average Annualized Medicaid Days of All Facilities} * \text{Quality Points with Lower Limit} / \text{Sum of Total Points Awarded to All Facilities} * \text{Total Quality Budget} / \text{Facility Annualized Medicaid Days}$$

(c) FRVS Calculation. The calculation is as follows:

$$\text{Building} = \text{Current Year RSMeans Cost Per Sq Ft} * \text{Adjusted Facility Sq Ft} * \text{Zip Code Location Factor}$$

$$\text{Land} = \text{Building} * \text{Land Allocation Percentage}$$

$$\text{Undepreciated Value} = \text{Building} + \text{Land} + \text{Equipment}$$

$$\text{Depreciation} = (\text{Building} + \text{Equipment}) * \text{Depreciation Factor} * \text{Facility Adjusted Age}$$

$$\text{FRVS Rate} = (\text{Undepreciated Value} - \text{Depreciation}) * \text{Fair Rental Rate} / (\text{Occupancy Percentage} * 365.25)$$

1. Current Year RSMeans Cost Per Sq Ft and Zip Code Location Factor are defined in the latest Gordian Building Construction Costs publication with RSMeans Data available on March 31 of the year in which the rate period begins.

2. Facility Adjusted Age is calculated using FRVS survey data.

(d) Exempt Calculation. The calculation is as follows:

$$\text{Operating Cost Component} + \text{Direct Care Cost Component} + \text{Indirect Care Cost Component} + \text{MAR} + \text{FRVS Rate} + \text{Pass Through Payments} + \text{Medicaid Share of NFQA} - \text{MTA}$$

1. Exempt Providers rate components will be limited to Reimbursement Targets and Reimbursement Ceilings

(5) NFQA

(a) Participating nursing facilities shall use the Nursing Facility Quality Assessment form (only accepted electronically), AHCA Form 5000-3549, Revised October 2013, incorporated by reference, for the submission of its monthly quality assessment. This form can be accessed at <http://ahca.myflorida.com/QAF/index.shtml>.

(b) Each facility shall report monthly to AHCA its Quality Assessment Payment. Facilities are required to submit their full Quality Assessment Payment no later than 20 days from the next succeeding calendar month.

(c) Providers are subject to the following monetary fines pursuant to Section 409.9082(7), F.S., for failure to timely submit the Quality Assessment Payment:

1. For a facility's first offense, a fine of \$500 per day shall be imposed until the total number of resident days is submitted and quality assessment is paid in full, but in no event shall the fine exceed the amount of the quality assessment.

2. For any offense subsequent to a first offense, a fine of \$1,000 per day shall be imposed until the Quality Assessment Payment is paid in full, but in no event shall the fine exceed the amount of the quality assessment.

3. In the event that a provider fails to report their total number of resident days as defined in Section 409.9082(1)(c), F.S., by the 20th day of the next succeeding calendar month, the fines in paragraphs (a)-(c), apply and the maximum amount of the fines shall be equal to their last submitted quality assessment amount but in no event shall the total fine exceed the amount of the quality assessment.

(d) In addition to the aforementioned fines, providers are also subject to the non-monetary remedies enumerated in Section 409.9082(7), F.S. Imposition of the non-monetary remedies by AHCA will be as follows:

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

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

(e) 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.

(f) 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 AHCA's right to recoup any underpaid assessments.

(6) The Florida Medicaid rate is equal to the Medicare allowed amount for Medicare approved Part B therapy services provided in nursing facilities.

Rulemaking Authority 409.919, 409.9082 FS. Law Implemented 409.908, 409.9082, 409.913 FS. History—New 7-1-85, Amended 10-1-85, Formerly 10C-7.482, Amended 7-1-86, 1-1-88, 3-26-90, 9-30-90, 12-17-90, 9-15-91, 3-26-92, 10-22-92, 4-13-93, 6-27-93, Formerly 10C-7.0482, Amended 4-10-94, 9-22-94, 5-22-95, 11-27-95, 11-6-97, 2-14-99, 10-17-99, 1-11-00, 4-24-00, 9-20-00, 11-20-01, 2-20-02, 7-14-02, 1-8-03, 6-11-03, 12-3-03, 2-16-04, 7-21-04, 10-12-04, 4-19-06, 7-1-06, 8-26-07, 2-12-08, 9-22-08, 3-3-10, 2-23-11, 5-3-12, 2-13-14, 1-19-15, 5-3-15, 7-17-16, 8-6-17, 3-25-18, 4-15-20.