



CHARLIE CRIST
GOVERNOR

ANDREW C. AGWUNOBI, M.D.
SECRETARY

June 29, 2007

Dear Nursing Facility Provider:

Senate Bill 2800 (Chapter 2007-72, Laws of Florida) is the General Appropriations Act (GAA) for State Fiscal Year 2007-08. Proviso language contained in Specific Appropriation 242 modifies how Medicaid funds nursing home services.

Effective with July 1, 2007 dates of service, Medicaid will limit payment of nursing home Medicare Part A coinsurance. Medicaid will pay no portion of Medicare coinsurance when payment that Medicare has made for the service equals or exceeds what Medicaid would have paid if it had been the sole payer.

The savings associated with the Medicare Part A coinsurance change will be used to fund an increase in the Nursing Home Medicaid per diem rates. This increase will include the following provisions:

- Rebase the operating and indirect patient care component targets and target rate class ceilings of the Medicaid nursing home per diem rate.
- Establish a target rate class ceiling floor equal to 90 percent of the cost-based class ceiling.
- Establish an individual provider-specific target floor equal to 75 percent of the cost-based class ceiling.
- Modify the inflation multiplier to equal 2.0 times inflation for the individual provider-specific target. (The inflation multiplier for the target rate class ceiling shall remain at 1.4 times inflation.)
- Modify the calculation of the change of ownership target to equal the previous providers' operating and indirect patient care cost per diem (excluding incentives), plus 50 percent of the difference between the previous providers' per diem (excluding incentives) and the effective class ceiling and use an inflation multiplier of 2.0 times inflation.

As a means of capturing adequate information needed for implementation, beginning with your Medicaid billing for July 2007 dates of service, Medicare reimbursement information will be required on your Medicaid claim form. For each dual eligible where the Medicare coinsurance applies (residents for which you are billing level of care X), please provide the Medicare rate on the claim form. If the Medicare rate for a resident changed during the month, please provide the weighted average Medicare rate (weighted based on the number of days each rate is paid). The respective Medicare per diem should be placed in field number 12 of the Institutional 021 claim form, or for electronic filing using the 837i use segment CN102 within loop 2300, for each level of care X billed to Medicaid. The Medicaid Patient Responsibility amount must also be included for each level of care X billed to Medicaid, identical to a regular Medicaid claim, unless the individual is a Qualified Medicare Beneficiary (QMB) only recipient or a recipient eligible for QMB and full Medicaid (QMB+). There is no patient responsibility for QMB or QMB+ nursing

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facility recipients during the Medicare coinsurance period. Contact the local Department of Children and Family Services office to confirm QMB eligibility.

Please maintain in your records documentation supporting the calculation of the Medicare per diem for each dual eligible resident for each month.

As with all revisions to nursing home reimbursement methodology, these changes are subject to approval by the federal Centers for Medicare and Medicaid Services.

Should you have any questions regarding this letter, please contact Wes Hagler by phone at 850-487-1243 or via e-mail at haglerw@ahca.myflorida.com.

We appreciate the services you continue to provide to Florida's Medicaid recipients.

Sincerely,

A handwritten signature in black ink, appearing to read "T. W. Arnold".

Thomas W. Arnold
Deputy Secretary for Medicaid

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