

Nursing Facility Reimbursement Report

Draft as of September 1, 2009

November 2009



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Executive Summary

The 2008 Legislature created Section 409.908 (23), Florida Statutes which specified reimbursement limitations and the creation of workgroups to focus on the methodology in which reimbursement is determined. With the creation of this language, the Agency for Health Care Administration implemented the reimbursement limitations in accordance with statute and the General Appropriations Act of 2008. In addition, the Agency created the required workgroups as specified under Section 409.908 (23)(c), Florida Statutes.

409.908 (23)(c) The Agency shall create a workgroup on the hospital reimbursement, a workgroup on nursing facility reimbursement, and a workgroup on managed care plan payment. The workgroup shall evaluate alternative reimbursement and payment methodologies for hospitals, nursing facilities, and managed care plans, including prospective payment methodologies for hospitals and nursing facilities. The nursing facility workgroup shall also consider price-based methodologies for direct and acuity adjustments for direct care. The Agency shall submit a report on the evaluated alternative reimbursement methodologies to the relevant committees of the Senate and House of Representatives by November 1, 2009.

The Agency began the creation of the Nursing Home Workgroup by requesting nominations for workgroup members. The agency appointed four members to the workgroup, two association representatives, one from each association, and two provider representatives. The provider representatives are directly related to operating and participating facilities within the Florida Medicaid program. The Agency as facilitator and staff for the workgroup created and submitted a charter to the workgroup at the first meeting. The workgroup adopted the charter as the basis and direction of the workgroup. The charter specified the purpose and scope of the workgroup.

The responsibilities of this Workgroup were to evaluate, based on the above statute, alternative reimbursement and payment methodologies for nursing facilities. Based on this evaluation, the Agency for Health Care Administration developed this report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup on Nursing Facility Reimbursement also considered price-based methodologies. The Workgroup evaluated and reported only on those health programs funded through the Agency. Discussions not covered by the description above (Reimbursement and Payment Issues) are outside the scope of the Workgroup and will not be included as topics of discussion.

During the initial meetings of the workgroup the Agency provided an overview of the Medicaid program and specific information related to the nursing facilities budget and current reimbursement plan and methodology. The Medicaid program for fiscal year 2009/10 has an appropriation of \$17.5 billion of which \$2.6 billion is appropriated for services provided through

nursing facilities. As of July 1, 2009, there were 642 nursing homes participating in the Florida Medicaid program. The 642 participating nursing homes serve approximately 71,000 people. Statewide the average occupancy rate for a Medicaid participating nursing home is 89.25 percent.

Nursing homes that participate in the Florida Medicaid Program are reimbursed in accordance with The Florida Title XIX Long-Term Care Reimbursement Plan (the Plan). The Plan is incorporated by reference into Chapter 59G – 6.010 of the Florida Administrative Code (FAC) and details the methods and standards by which facilities are reimbursed.

The Plan is often referred to as a cost based prospective reimbursement plan. It is cost based because it utilizes historical data from cost reports to establish reimbursement rates. The Plan is prospective because it adjusts historical costs for inflation in establishing reimbursement rates for subsequent rate semesters.

General discussion of the Plan occurred throughout all workgroup meetings with specific focus on how the plan and areas of concern related to reimbursement and the direction of the workgroup. A general consensus that the methodology is still a valid methodology was achieved. However, within the methodology there were areas that need specific attention.

The following issues were presented to and discussed by the Workgroup in the development of this report:

- AIDS offsets
- One rate setting/One cost report submission
- Mandate initial cost report
- Targets
- Ceilings
- Acuity
- Alternative FRVS
- Ventilators

Members of the workgroup identified these issues and provided historical and prospective discussion for each. Support related to the process of other states as it related to each issue was also presented to the workgroup by members. Sections of this report provide more detailed information for each of these issues.

Three of the issues identified above were identified as primary areas of concern that without modification pose negative outcomes for the future for the nursing facilities and Medicaid program. These issues are 1) Mandate initial cost report; 2) Alternative FRVS; and 3) Ventilators.

- 1) In regards to the issue of Mandating the Initial Cost Report, currently there are inefficiencies in the change of ownership process known as “CHOW” due to the inability to enforce the required submission of the initial cost report. All providers are required to submit annual cost reports that are used as the basis for establishing reimbursement rates. When a facility is new to the program or has changed ownership, a budgeted prospective rate is calculated using a budgeted cost report as there is no actual cost report to use. After the initial year, the provider is required to submit a final initial cost report that will be used to reconcile the actual rate to the prospective rate. Significant delays in the submission of this cost report creates extended delays in the audit process that prevents the Agency from settling possible recoupment as well as delays for providers that are in the process of CHOW or purchases.
- 2) In regards to the Alternative Fair Rental Value System (FRVS), the process that is currently used to calculate FRVS has not been rebased and therefore does not reflect the changes that the state has experience related to property and building value and expenses. The workgroup expressed great concern that there is no incentive or adequate reimbursement component related to the property to maintain existing or build new facilities. Many of the facilities in Florida are nearing 40 years of age and receive minimum upgrades or renovations. Members of the workgroup provided and discussed at length the impact of the current methodology as well as provided information related to reimbursement practices of other states for FRVS and how those practices would benefit Florida nursing facilities.
- 3) In regards to the issue of Ventilators, there is currently no specific or supplemental reimbursement rate available for providers that specialize or have the facility structure and equipment to provide care for ventilator dependent residents. Therefore, there are no incentives for facilities to establish and or maintain beds that can accommodate the need for this population.

The workgroup obtained a general consensus of the following alternatives to address the reimbursement issues stated above. The workgroup also is of the consensus that not addressing these issues and requiring modifications to the existing reimbursement plan, Florida’s nursing facilities and Medicaid program will experience negative impacts related to both financial and services.

Identified Alternatives:

- A) The identified alternative for initial cost report submission is to Mandate the submission within a structured timeframe with sufficient penalties for non-compliance.
- B) The identified alternative for FRVS is to implement a fair rental value proxy approach to replace the current FRVS and cost methods. The gross fair rental which is established when the Rental value is multiplied by the rental rate

A gross fair rental method that has been adopted by several states including Georgia is proposed for an alternative FRVS method. The Workgroup believes the utilization of this method will accomplish their main goal of providing incentives to nursing home providers to maintain a suitable physical environment through renovations, resulting in the improvement of resident quality of life. Furthermore, they believe the gross fair rental method will:

- Differentiate reimbursement based on age/condition
- Simplify administration and allow the State to exert reasonable budget predictability and control
- Distinguish economic value over financial accounting value
- Eliminate concerns for system gaming (Example: A provider saving money by completing a related party change of ownership.)
- Promote equity investment

C) The identified alternative for Ventilator reimbursement is to implement a fair rental value proxy approach to replace the current FRVS and cost methods and establish specific reimbursement rates for Ventilator dependent residents.

Workgroup Overview

The Agency for Health Care Administration (AHCA or the Agency) Workgroup on Nursing Facility Reimbursement and was established under the authority of Section 409.908 (23)(c), Florida Statutes.

The responsibilities of this Workgroup were to evaluate, based on the above statute, alternative reimbursement and payment methodologies for nursing facilities. Based on this evaluation, the Agency for Health Care Administration developed this report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup on Nursing Facility Reimbursement also considered price-based methodologies. The Workgroup evaluated and reported only on those health programs funded through the Agency. Discussions not covered by the description above (Reimbursement and Payment Issues) are outside the scope of the Workgroup and will not be included as topics of discussion.

This Workgroup consisted of four members appointed by the Medicaid Director, based on the statute listed above. Agency staff also served as facilitator and resources for, but not members of, the Workgroup.

Members of the Workgroup were:

Erwin P. Bodo, Ph.D.
Chief Operating Officer
Florida Association of Homes and Services for the Aging

Doug Burr
Vice President of Finance, Reimbursement & Government Relations
Cypress Administrative Services, LLC

Tony Marshall
Senior Vice President & Chief Operating Officer
Florida Health Care Association

Betty Sorna
Chief Financial Officer
River Garden Hebrew Home Wolfson Health & Aging Center

The Workgroup’s fact finding was limited to those health programs funded through the Agency for Health Care Administration. The Agency is the author of this report and retains control of its content.

The duties of the Workgroup included the following:

- a. Evaluation of alternative reimbursement and payment methodologies for nursing facilities including prospective payment methodologies.
- b. Report findings to the Director of Medicaid as to the outcome of their fact finding.

The Workgroup met multiple times between January 2009 and October 2009 in order to accomplish the duties outlined above. Agency staff worked with members to develop supporting documentation of items for each meeting. All documentation and minutes of each meeting are posted online at:

http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nf_meetings.shtml

Please refer to the appendix A – Workgroup Charter for complete details of Workgroup membership, duties, meetings, etc.

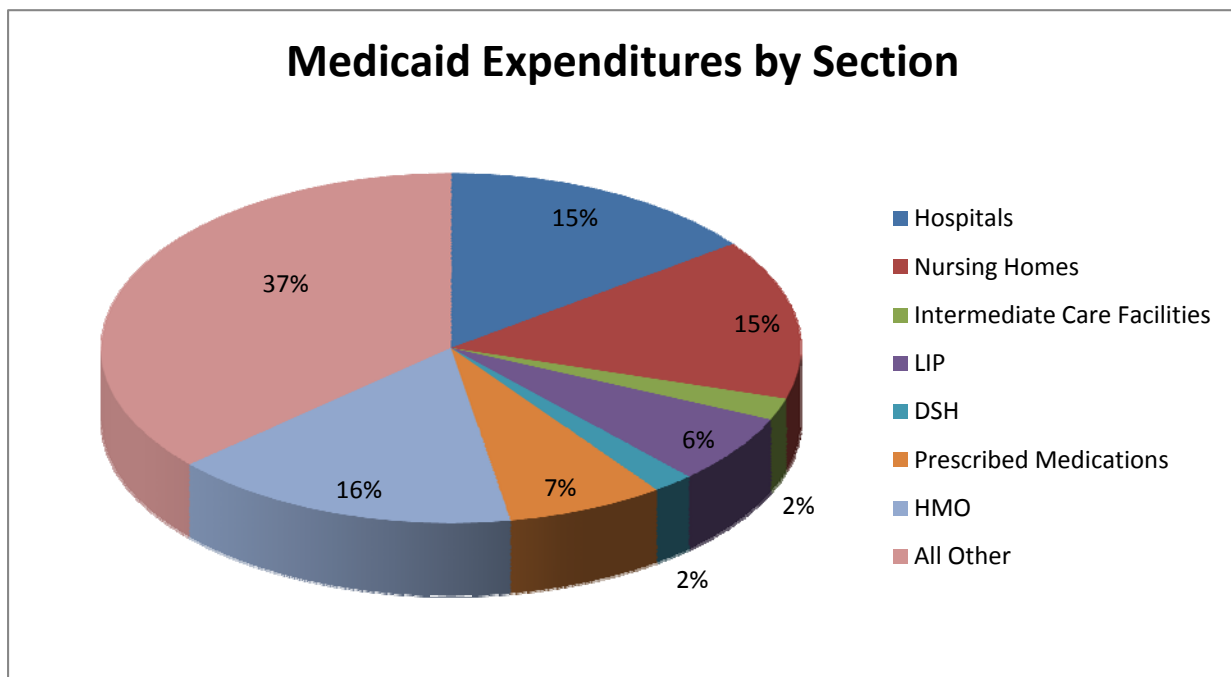
Guiding Principles

- Ease of administration (rate setting, billing, audit process)
- Budget predictability and stability
- Eliminate or reduce artificial barriers that cause significant differences in how providers operate
- Predictability
- Political viability of option

Florida Medicaid Overview

The Medicaid program is a partnership between the State and Federal government. There are federal requirements that must be met, and those are specified in the state plan as approved by Centers for Medicare and Medicaid Services (CMS). There are mandatory and optional eligibility groups and service categories. In Fiscal Year 2009-10, Florida Medicaid has estimated \$17.5 billion spending. The federal share of funding is 67.64%, while the state share is 32.36%. Forty-five percent of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled, Low Income Pool and Disproportionate Share Payments. About 10% of expenditures are for prescribed medications. See Figure – 1. Florida has the fifth largest in Medicaid expenditures nationwide. There are 16 mandatory services that must be provided under the Medicaid program. These services account for a little over 41% of current year expenditures. Florida also provides 30 optional services, which account for almost 59% of current year expenditures. Over time, the federal medical assistance percentage has been declining.

Figure- 1



The current budget for Nursing homes is \$2.6 billion dollars for state fiscal year 09-10. Over the past few years there have been multiple legislative adjustments made to the nursing facility reimbursement such as rate reductions and staffing requirements. Most recently nursing homes received a 7.8% reduction effective March 1 and 9.1% reduction on July 1. Authority for a Nursing Home Quality Assessment (NFQA) was implemented effective April 1. The NFQA was implemented to allow the nursing homes to buyback reductions to Medicaid reimbursement. See Appendix D for more detail. In addition, the economic stimulus package (ARRA) changed the Federal Medical Assistance Percentage (FMAP) to 64.67% for State fiscal year (2009-2010). The increase to the FMAP due to the federal stimulus enabled more budget reductions correlated buybacks to nursing homes. The FMAP is anticipated to reduce to 66.45% on July 1, 2010, then 54.98% on January 1, 2011. Please refer to Appendices E through K for information of how Florida Medicaid compares nationally.

Current Methodology of Nursing Home Cost Reimbursement

As of July 1, 2009, there were 642 nursing homes participating in the Florida Medicaid program. These nursing homes account for a total of 79,841 beds, which is an average of 124 beds per facility. These same facilities account for 25,946,060 patient days a year, of which 15,530,994 (59.86%) are Medicaid days. The range of beds per facility is from a minimum of 20 to a maximum of 462. Statewide the average occupancy rate for a Medicaid participating nursing home is 89.25 percent. The current budget for Medicaid Nursing Home cost is \$2,589,278,217. The 642 participating nursing homes serve approximately 71,000 people.

Nursing homes that participate in the Florida Medicaid Program are reimbursed in accordance with The Florida Title XIX Long-Term Care Reimbursement Plan (the Plan). The Plan is incorporated by reference into Chapter 59G – 6.010 of the Florida Administrative Code (FAC) and details the methods and standards by which facilities are reimbursed.

The Plan is often referred to as a cost based prospective reimbursement plan. It is cost based because it utilizes historical data from cost reports to establish reimbursement rates. The Plan is prospective because it adjusts historical costs for inflation in establishing reimbursement rates for subsequent rate semesters.

Each nursing home is required to submit an annual cost report to the Agency. Cost reports are due within five calendar months after the end of the facility's cost reporting period. The data within these cost reports is then used to establish reimbursement (per diem) rates in accordance with the Plan.

Per Diem rates are established for each facility twice a year, every January 1 and July 1, based on the latest cost reports received by October 31 and April 30, respectively. The January 1 – June 30 and July 1 – December 31 periods are referred as rate periods or rate semesters. Each semester, a single per diem rate is established for each facility that is paid for all Medicaid patient days.

Florida Medicaid nursing facility per diem reimbursement rates effective July 1, 2009, range from \$155.83 to \$259.68. The weighted average Medicaid per diem is \$204.03. The latest estimated total Medicaid expenditures for nursing homes during the current state fiscal year (2009-2010) are \$2,705,963,699 billion. A history of Florida Medicaid nursing home expenditures since the inception of the program is provided in Appendix C.

Nursing home per diem rates are facility specific and are an aggregate of four components:

- operating
- patient care
- property
- return on equity (ROE) for money invested and used in providing patient care

The operating component includes administration, laundry and linen, plant operations, and housekeeping expenses. It may also include Medicaid bad debt expenses. The patient care component includes nursing, dietary, other patient care (e.g., social services and medical records) and ancillary expenses. The property component includes interest, depreciation, insurance, property taxes and equipment rental expenses. The return on equity component is a calculation based on the equity in the facility. Each of these components is calculated independently and is then combined to determine the per diem rate.

Operating, patient care and cost-based property components are subject to limits on the maximum amount a provider can receive for the component, regardless of actual cost. These limits are called reimbursement ceilings.

Nursing homes are divided into six classes in determining these ceilings. The classes are based upon size (1-100 beds = small, or over 100 beds = large), and location (North, South, or Central) of the facility within the state.

The distribution of the facilities throughout the state at July 1, 2009 is as follows:

Class	Location	# of Homes
Class 1	North/Small	43
Class 2	North/Large	157
Class 3	South/Small	53
Class 4	South/Large	164
Class 5	Central/Small	45
Class 6	Central/Large	180

The operating and patient care cost based class ceilings are calculated using inflation adjusted operating and patient care per diems for the current semester. The cost based class ceilings for the central class is the simple average of the north and south cost based ceilings. The operating cost-based class ceilings are based on the statewide operating median plus one (1) standard deviation adjusted for the relationship of the class median to the statewide median. The patient care cost -based class ceilings are based on the statewide patient care median plus a 1.75 standard deviation adjusted for the relationship of the class median to the statewide median.

The Medicaid Adjustment Rate (MAR) and the case-mix adjustment are adjustments to the patient care component for qualifying facilities. These adjustments are not subject to class ceilings, targets or new provider limitations. They are added to the per diem component after any limitations have been applied.

To qualify for the MAR a provider must have other than conditional ratings one year prior to the rate semester and have Medicaid utilization greater than 50 percent. The calculation of the MAR is 4.5 percent of the patient care per diem multiplied by (non-conditional days / total days). The MAR is then prorated for facilities with between 50 and 90 percent Medicaid utilization. Providers with 90 percent or greater Medicaid utilization receive the full MAR.

Effective January 1, 1988, a nursing home target rate system was implemented that limits the rate of increase in operating and patient care per diem rates from one rate semester to the next. Target rates are set for class ceilings and the operating and patient care components for each facility. Targets are inflated from one semester to the next by the target rate of inflation, which is 1.4 times the rate of inflation. . Effective July 1, 2007 targets were rebased and from that point forward, the provider target reimbursement limitation shall not fall below 75% (provider target limitation below 90%) of the cost based class ceiling for each rate setting as calculated. Effective January 1, 2008 the provider specific target multiplier was increased to 2.0. Inflation is based on Standard & Poor's DRI Nursing Home Market Basket Index published in the Health Care Cost Review. The DRI is a nationally recognized Health Care Market Basket Index.

Facility specific new provider limitations are another limit placed on the operating and patient care components for new facilities and facilities that undergo a change of ownership. The limit for new facilities is the average operating and patient care per diem in the district in which the facility is located plus 50% of the difference between the average district per diem and the facility class ceiling. Providers with no cost history resulting from a change of ownership or operator, where the previous provider participated in the Medicaid program, the limit is the previous providers' operating and patient care cost per diem, plus 50% of the difference between the previous providers' per diem and the class ceiling. These limitations are also increased by the target rate of inflation each semester.

The Direct Care Staff Adjustment was implemented effective April 1, 2000 as an adjustment to the patient care component. The adjustment is intended to assist nursing homes who choose to participate in the program to recruit and retain direct care staff (RNs, LPNs, and CNAs). The funds were allocated using an inversely proportionate methodology so that those nursing homes with lower staffing ratios would receive a higher adjustment, or add-on, than those with higher staffing ratios. Total annualized payments are \$31.7 million. At April 1, 2000 individual add-ons per Medicaid patient day ranged between \$.50 and \$2.81, with an average of \$1.96.

This gross adjustment for direct care staffing was increased four times from between 2001 to 2007.

- 1.7 hours (1/1/1990 – 12/31/2001)
- 2.3 hours (1/1/2002 – 12/31/2002)
- 2.6 hours (1/1/2003 – 12/31/2006)
- 2.9 hours (1/1/2007 – Current)

The nursing home operating and patient care cost per diem paid is the lower of the following, except that the patient care per diem is adjusted by the MAR, the, and the direct care staffing adjustment (DCSA).

- cost based class ceiling
- target rate class ceiling
- facility specific rate
- facility specific target rate
- facility specific new provider limitation

There are two different methodologies for property reimbursement: the “cost method” (cost) and the Fair Rental Value System (FRVS). The cost methodology can be described as ownership specific and facility neutral. The reimbursement rate is affected more by ownership costs of the operator than by the value of the facility. The cost method uses allowable property costs (depreciation, interest on property, rent on property, insurance on property and taxes on property) divided by total patient days to equal the property per diem. There are two statewide ceilings for property. For facilities with 18 months or less operating experience the ceiling is \$18.62. For facilities with more than 18 months experience the ceiling is \$13.65. A weighted average property ceiling is used for facilities that have a significant bed addition that meets Plan requirements. These property cost ceilings were calculated at July 1, 1985, and in accordance with the Plan are not recalculated at subsequent rate semesters due to the implementation of FRVS.

The Fair Rental Value System (FRVS) methodology can be described as facility specific and ownership neutral. The reimbursement rate is affected more by the value of the facility than changes in ownership costs. FRVS was implemented effective October 1, 1985. FRVS was simultaneously negotiated with the Plan changes required by the Deficit Reduction Act of 1984 (DEFRA). DEFRA enacted on July 18, 1984, amended sections of the Social Security Act (the Act) by adding new provisions concerning the valuation of assets. The new methodology changed the way the allowable property basis was calculated for facilities that undergo a change of ownership (CHOW) on or after July 18, 1984. This change was implemented to reduce facility turnover caused by the possible increase of reimbursement from a CHOW. States were required to provide assurances that the payment methodology utilized by the State would not increase payments to facilities solely as a result of a CHOW, in excess of the increase that would result from the application of the new DEFRA requirements of the Act.

FRVS is a method used to arrive at the fair rental value for a facility. The value of the facility is used in the calculation of the per diem component. The FRVS component of the per diem rate is an aggregate of three (3) sub-components, the capital component or 80 percent component, the ROE or 20 percent component and FRVS pass-through. The FRVS calculation does not recognize capital expenditures involving replacements of equipment, furnishings or buildings. The initial FRVS rate is adjusted twice a year, at each rate semester, for inflation. Adjustments can also be made twice a year for changes in interest rates on capital debt and for capital additions or improvements, within established thresholds.

To calculate an FRVS rate the facility asset value must first be determined. The calculation of the asset value is based on the original allowable acquisition costs, subject to limitations in the Plan. These costs would include the costs of land, building, equipment and soft costs associated with the original acquisition. This amount is subject to limitations and is inflated forward each semester. Any qualifying capital expenditures in the current cost report are added to the asset base value.

The calculation of the capital component or 80 percent component uses several steps. First, an annual debt service amount is determined using 80 percent of the asset value for the current semester amortized over 20 years at the facilities allowable interest rate. Second, this annual amount is divided by annual available patient days (number of beds on last day of cost report multiplied by 365). Next, the quotient from step two is divided by an occupancy adjustment factor of .90 (.75 for facilities with less than 1 year of operating experience or a weighted average for facilities with significant bed additions). The amount of the resulting quotient is the 80 percent capital component. The adjustment factor assumes that a stabilized facility should operate at 90 percent of patient capacity.

The ROE or 20 percent component uses a similar calculation. First, 20 percent of the asset value is multiplied by the ROE factor for the current cost report. (HCFA provides the ROE percentages.) Second, the product from step one is divided by the annual available patient days (see above). Next, the quotient from step two is divided by the same occupancy adjustment factor used in the 80 percent capital component. The amount of the resulting quotient is the ROE or 20 percent component.

The pass-through component of the FRVS rate includes property taxes, property insurance, and home office property cost allotments. The total cost of each item is divided by the total patient days provided in the cost report being used. The pass-through amounts are added to the FRVS calculation to complete the FRVS component of the per diem rate. There are no ceilings or target limitations to the FRVS pass-through amounts.

To insure that facility specific reimbursement would not be reduced due to the implementation of FRVS, a hold harmless provision was developed in conjunction with a phase-in provision. For facilities at October 1, 1985, if reimbursement would be less under the FRVS method than the cost method, the facility would receive reimbursement under the cost method until such time as the net difference in total payments between cost and FRVS is zero. Facilities whose reimbursement would have been greater at October 1, 1985, under FRVS were phased up to their FRVS rate in equal percent increments according to a schedule that was based on their date of entry into the Medicaid program. This period is referred to as the phase-in period and ranged from four years to ten years.

Findings and Issue Identification

The Workgroup on Nursing Facility Reimbursement met multiple times during the period of January 2009 through October 2009. During the meetings, the Workgroup discussed the purpose and goals of the Workgroup and agreed to adopt guiding principles, (found on page 4) to use in identifying potential changes to the Medicaid reimbursement system.

There are four components of the Reimbursement Per Diem:

- Operating
- Patient care – Direct and Indirect,
- Property – Cost based and Fair Rental Value System
- Return on equity (ROE)

These Components are subject to Target and Ceilings used to control cost. Each of the reimbursement components were evaluated by the Workgroup based on trends in Medicaid Nursing Home reimbursement and the industry. A detailed report on Medicaid Nursing Home reimbursement trends can be found in Appendix B. - Medicaid Cost Reimbursement Nursing Home Trends 1998- 2009.

The Workgroup highlighted issues where improvement to current Medicaid reimbursement policy, discussed in the previous section, could be made. Analysis of these issues were collected and evaluated by the workgroup. The following issues were presented to and discussed by the Workgroup in the development of this report:

- AIDS offsets
- One rate setting/One cost report submission
- Mandate initial cost report
- Targets
- Ceilings
- Acuity
- Alternative FRVS
- Ventilators

The issues highlighted by the Workgroup are not recommendations by the Agency for Healthcare Administration or the Workgroup. These are issues that came together as a result of discussing concerns with the current methodology and finding possible solutions to some of the issues raised by the Workgroup.

A. AIDS offsets

In evaluating the direct care component of the current reimbursement method, the Workgroup asked the question “Is a separate aids reimbursement rate still necessary in the current Medicaid environment?” Currently Medicaid reimburses nursing homes at a higher rate for Medicaid recipients with AIDS. Nursing homes remove direct care cost related to the AIDS days from the Medicaid cost report so that the AIDS costs are not reimbursed though the regular per diem rate causing a double billing effect.

Two analyses were performed on this issue, the first analysis was a comparison of providers reporting AIDS offsets for the January 1 2009 rate semester. The comparison was between the current reimbursement that those providers received for AIDS and what their increase in reimbursement would have been had the AIDS costs been included in their regular cost report. The analysis showed that the providers would have been reimbursed \$400,983.06 less had the AIDS costs been included in their regular per diem rate. See Figure - 2

Figure - 2

AIDS OFFSETS COMPARISON

Medicaid Number	Rate Semester	Proposed Dollar Amounts
210617	200901	\$4,752,502.83
212903	200901	\$3,899,041.92
214035	200901	\$4,877,716.23
223808	200901	\$5,037,947.67
252433	200901	\$3,955,650.93
259918	200901	\$2,714,663.49
263982	200901	\$5,132,609.51
281743	200901	\$13,854,203.40
		\$44,224,335.98

Medicaid Number	Rate Semester	Current Total Dollar Amount
210617	200901	\$4,813,882.89
212903	200901	\$3,977,913.27
214035	200901	\$5,130,188.86
223808	200901	\$5,057,321.68
252433	200901	\$3,952,138.21
259918	200901	\$2,717,554.55
263982	200901	\$5,142,966.42
281743	200901	\$13,833,353.16
		\$44,625,319.04

(\$400,983.06)

The second analysis examined all providers reporting AIDS claims for state fiscal year 07-08. The analysis showed that more providers were billing for AIDS level care than were reporting the AIDS offsets on their cost reports. Please refer to Appendix P – Skilled AIDS and Appendix Q – AIDS Offset Comparison for further detail.

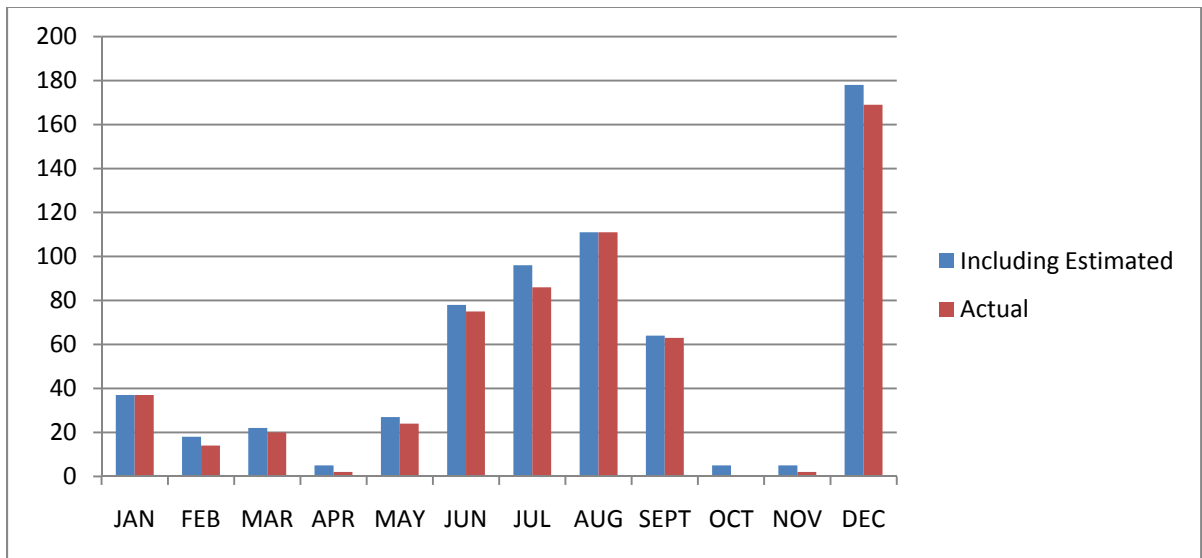
B. One rate setting/One cost report submission

The workgroup considered moving to a single fiscal year end reporting and a single rate semester. The Workgroup believed that a single rate setting period during September or October would benefit the providers more than any other time of the year.

Managed Care Organizations have moved to a single rate setting period, and it has worked out well. The Workgroup believed that a single rate setting/reporting period could work out well given appropriate research and analysis. One benefit of a single rate semester/reporting period would be administrative simplification for both the agency and the industry. A second benefit would be more efficient reporting with Federal Upper Payment Limit (UPL) standards required by CMS.

Figure- 3 shows current distribution of providers by fiscal year end.

Figure -3



Based on Figure - 2, December has the most providers with a fiscal year end.

Some problems that might occur with this change include an additional workload and possible need for additional agency staffing during the rate setting once a year.

A second problem would be that inflationary ceilings and targets would be locked in for a full year, reflecting less accurately the actual costs of the providers and the economic environment. A survey was conducted of Nursing home facilities and they were opposed this change in policy. Please refer to Appendix R- FYE Cost Report Months Used for the January 2009 Rate Semester and Appendix S – Medicaid Cost Survey Results for further detail.

C. Mandate initial cost report

There is need to speed up the Audit and Change of Ownership (CHOW) process. The Workgroup surmised that providers not submitting cost reports in a timely manner were slowing down the cost settlement, audit process. This slow down was leading to CHOWs being hold up for settlement to be processed. The only enforceable time requirement to file an initial cost report in the State Long Term plan is:

Version 33, Section I. B

For changes of ownership or licensed operator filed on or after September 1, 2001, the provider will be required to file an initial cost report.

The absence of a more timely and enforceable rule has had several adverse consequences. The agency cannot cost settle or conduct an audit until the initial cost report has been filed sometimes delaying both these processes by up to 9 years to finalize an audit. The longer the cost settlement/audit process takes the larger the overpayment balance can be causing the provider to realize a large current liability all at once.

Another consequence involves Changes of Ownership CHOW, which are being held up indefinitely at the licensure level if the seller has not filed an initial cost report. This hold up can disrupt CHOW process because both parties are unable to determine Medicaid liability causing artificial barriers that cause significant differences in how providers operate.

Since an initial Medicaid cost reporting period can be between six and eighteen months, setting the deadline 5 months after their fiscal year end (or until the next rate setting submission date whichever is longer) should not impose undue hardship onto the facility or provider. Penalties such as withholding of reimbursement would have to be a part of any enforceable mandate.

D. Targets

The work group evaluated targets to see if they were artificial barriers that cause significant differences in how providers operate. Targets have been around since 1988, as a means to limit the rate of increase in operating and patient care per diem rates from one rate semester to the next. Targets were created as a means to control the costs of individual nursing home providers. Targets were eliminated on July 1, 2007. The change in rate from prior rate semester was 4.25%. This was a 239% increase over the three year average rate of increase 1.78%. The targets were reinstated on January 1, 2008. Refer to Figure - 4

Figure - 4

Change in Average Per Diem 07/04 to 01/08		
Rate Semester	Weighted AVG Per Diem	Change from Prior R/S
Jul-04	\$149.67	-1.71%
Jan-05	\$154.44	3.19%
Jul-05	\$159.50	3.28%
Jan-06	\$160.45	0.60%
Jul-06	\$162.72	1.41%
Jan-07	\$169.09	3.91%
Jul-07	\$176.27	4.25%
Jan-08	\$174.60	-0.95%

E. Ceilings

The work group evaluated the current Ceilings method to determine if the ceiling could be more representative by geographic area. Because the central class ceilings are calculated by using the simple average of the north and south cost based ceilings, a more accurate, alternate method of separately calculating the central class ceilings was viewed. This was achieved by comparing the January 1, 2009 rate semester ceilings to what the ceilings would have been using the alternate method. Since there was a significant impact to ceilings for some of the classes, this alternate method was not wanted by the Workgroup. Refer to Figure - 5

Figure - 5

200901 Ceilings Comparison						
	Class 1 - North Small			Class 2 - North Large		
	Operating	Direct PC	Indirect PC	Operating	Direct PC	Indirect PC
Current method Central Class AVG	51.7829	92.1601	61.0735	45.6558	95.6638	55.8941
Alternative method Central Class calculated	48.0047	91.3487	59.4930	45.2162	94.3283	55.6671

	Class 3 - South Small			Class 4 - South Large		
	Operating	Direct PC	Indirect PC	Operating	Direct PC	Indirect PC
Current method Central Class AVG	63.1547	101.1525	72.2052	50.6670	96.7213	60.5459
Alternative method Central Class calculated	63.4198	100.9099	72.3977	51.4625	97.6958	60.9220

	Class 5 - Central Small			Class 6 - Central Large		
	Operating	Direct PC	Indirect PC	Operating	Direct PC	Indirect PC
Current method Central Class AVG	57.4688	96.6563	66.6393	48.1614	96.1926	58.2200
Alternative method Central Class calculated	55.0061	92.5551	63.8077	45.5249	95.8568	55.7189

Ceilings were created as means to control costs over an area of providers. They vary according to location and size and are grouped into 6 classes. The Workgroup agrees that these ceilings are reasonable. Refer to page 10 for a review of how ceilings are calculated.

Another method for calculating ceilings was discussed. This was to change the outliers that could affect the statewide standard deviation and medians and ultimately the class ceilings. Currently, a normalized rate from every provider is used for calculations of the standard deviations and medians of the operating, direct care, and indirect care components. The highest 10% normalized rates and the lowest 10% normalized rates are eliminated to guard against significant outliers. The January 1, 2009 rate semester data was analyzed to view how ceilings would be affected by changing the outliers from 10% to 5%, and then to 5% high and 0% low (see appendix V – Ceilings Comparison Chart). Again, there was a significant impact to ceilings for some of the classes, so the Workgroup was not in favor of changing the outliers.

F. Acuity

The Workgroup questioned if the Direct Care Staff Adjustment was still needed. The Direct Care Staff Adjustment was implemented effective April 1, 2000 as an adjustment to the patient care component. The adjustment or gross up was intended to assist nursing homes who choose to participate in the program to recruit and retain direct care staff (RNs, LPNs, and CNAs). Please refer to the prior section for more detail on current methodology.

The workgroup reviewed the Preliminary Analyses on Outcomes of Increased Nurse Staffing Policies in Florida Nursing Homes: Staffing Levels, Quality and Costs (2002-2007), Appendix T. Based on the findings of the report:

“This preliminary report finds evidence that quality of care has substantially improved in Florida nursing homes since the introduction of increased nurse staffing levels and other quality standards since 2001. Average deficiencies per facility have decreased. Importantly, the citations for the more serious deficiencies have decreased dramatically and remain lower than the national average”.

The Workgroup agrees with the findings of the report. Please refer to Appendices T and U for more detail.

G. Alternative FRVS

Currently, there are 598 providers under the Fair Rental Value System and 44 providers under the cost method. The Workgroup would like all providers to have their property components reimbursed by utilizing one alternative FRVS method.

This could be achieved by a proxy or actual appraisal. Because of the high costs and inaccuracies that an actual appraisal carries, the unanimous consensus was to continue to use proxy appraisals. These are appraisal model simulations using standardized values and depreciation factors consistent with commercial valuation systems.

A fair rental value proxy approach is proposed to replace the current FRVS and cost methods. Three fair rental approaches were discussed:

- 1) Gross fair rental - Rental value is multiplied by the rental rate
- 2) Net fair rental – Rental rate is paid on difference between fair rental value and allowable debt
- 3) Hybrid – Fair rental value sets maximum level of capital reimbursement

A gross fair rental method that has been adopted by several states including Georgia is proposed for an alternative FRVS method. The Workgroup believes the utilization of this method will accomplish their main goal of providing incentives to nursing home providers to maintain a suitable physical environment through renovations, resulting in the improvement of resident quality of life. Furthermore, they believe the gross fair rental method will:

- Differentiate reimbursement based on age/condition
- Simplify administration and allow the State to exert reasonable budget predictability and control
- Distinguish economic value over financial accounting value
- Eliminate concerns for system gaming (Example: A provider saving money by completing a related party change of ownership.)
- Promote equity investment

Please see Appendices W, X and Y for more information on the Georgia FRVS method.

The pass-through of taxes, home office, and insurance, under the current FRVS method, would remain with the alternative, gross fair rental method. Therefore, the proposed method would only replace the current FRVS method's capital component (80%) and ROE component (20%). Additionally, it would eliminate the cost method.

To demonstrate how the calculations would work under the gross fair rental method, two models have been constructed. These models were created by mimicking the current Georgia gross fair rental method. Appendix Z illustrates a simplified example using a sample of 50 nursing home providers, while Appendix AA is a more detailed illustration.

In order to implement this alternative FRVS method, there are constant variables and parameters that would need to be agreed on initially. There would be an opening for these variables to be manipulated each rate semester or year, however. The overall calculation stems from RS Means cost per square foot data. Every July 1, a new RS Means cost per square foot book is released allowing this data to be obtained. For July 1, 2009, the cost per square foot is \$141.10. This number is combined with the facility total square feet and the location factor to receive an RS Means value. Fifty facilities provided square feet, but in figure B, the other facility square feet are estimated according to number of beds. With the proposed method, providers would have to report facility total square feet to coincide with the RS Means cost per square feet. The location factor varies by the cost of property in a given area.

The cost of equipment is calculated by multiplying the number of beds by an agreed upon equipment allowance per bed. This would be in lieu of the current FRVS method, where providers report assets on Schedule T of their cost reports. Next, depreciation is subtracted from the RS Means value and equipment allowance. Appendix Z uses a straight-line depreciation of 2%, while Appendix AA uses a tiered depreciation method. Appendix Z has a maximum depreciation of 1/3 the value of the RS Means plus equipment value, and Appendix AA uses a maximum facility age of 32.5. The current year is used for facility aging purposes. The facility age is adjusted to account for nursing home renovations. A provider receives credit for renovations by reducing the facility age, thus reducing depreciation. Because land does not depreciate, it is added after the depreciation calculation as a percentage of the RS Means value to show the rental value. This value is multiplied by the rental rate to illustrate the fair rental.

H. Ventilators

To coincide with implementation of the alternative FRVS method, a special ventilator rate is proposed. Currently, ventilators are reported by providers in their cost reports under Schedule T as assets. The alternative FRVS method would eliminate Schedule T and replace it with an equipment allowance per bed. Because the cost of ventilators would significantly exceed the equipment allowance per bed amount, nursing homes with patients that require ventilators would have their reimbursement rates increased.

There is precedent of special rates for nursing home providers with special patients. Currently, providers with AIDS patients and fragile under 21 (pediatric) patients receive higher reimbursement rates based on staffing data, which are reported on Schedule F-3 in the cost reports. The special ventilator rates would be reimbursed similarly to the AIDS and pediatric rates, where they are displayed separately from normal per diem rate. However, the ventilators will be reimbursed based on the cost of the equipment (ventilators), while the AIDS and pediatrics are based on staffing costs.

Appendices

Appendix A – [Workgroup Charter](#)

History and Trends

Appendix B- [Medicaid Cost Reimbursement Nursing Home Trends 1998-2009](#)

Appendix C – [History of Florida Nursing Home Reimbursement](#)

Appendix D - [Nursing Homes Cuts and Buybacks](#)

National Comparisons

Appendix E – [Medicaid Spending on Long Term Care, FY2006, sorted by Nursing Facility](#)

Appendix F - [Medicaid Spending on Long Term Care, FY2006, sorted by Total](#)

Appendix G - [Medicaid Payments per Enrollee, FY2005, sorted by Total](#)

Appendix H - [Total Medicaid Spending, FY2006](#)

Appendix I - [2007 Number of Nursing Facilities and Beds](#)

Appendix J - [Pages from CMS RTI Report on OSCAR](#)

Appendix K - [NF Beds per 1,000 Persons Over Ages 65 and 75](#)

Direct Care

Appendix L - [2008 Wage Estimates](#)

Appendix M - [Florida CBSA Wage Index](#)

Operating and Indirect Care

Appendix N - [Summary Operating and Indirect Care Cost 200901](#)

Appendix O - [Detailed Operating and Indirect Cost for 200901](#)

AIDS Offsets

Appendix P – [Skilled AIDS](#)

Appendix Q - [AIDS Offset Comparison](#)

One rate setting/One cost report submission

Appendix R – [FYE Cost Report Months Used for the January 2009 Rate Semester](#)

Appendix S – [Medicaid Cost Survey Results](#)

Acuity

Appendix T -

[Preliminary Analyses on Outcomes of Increased Nurse Staffing Policies in Florida Nursing Homes: Staffing Levels, Quality, and Costs \(2002-2007\), February 2009](#)

Appendix U - [Overview of the Nursing Home Staffing Report](#)

Ceilings

Appendix V – [Ceilings Comparison Chart](#)

Alternative FRVS

Appendix W - [Public Notice Nursing Facility Services](#)

Appendix X - [Nursing Facility Property Payment, April 8, 2008](#)

Appendix Y - [Nursing Facility Property Payment, October 24, 2007](#)

Appendix Z – [Review proposed model parameters on square feet and renovation utility](#)

Appendix AA - [Alternate Fair Rental Method-2](#)