

*Final Report
of the Panel
on Medicaid
Reimbursement*

December 2000



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Executive Summary

Current Nursing Home Environment

The quality of care received by nursing home residents is likely to be negatively impacted by the two issues this panel was asked to study: (a) the increasing difficulty for nursing home providers to hire and retain direct-caregivers, and (b) the lack of current incentives for nursing home providers to renovate and update existing physical plants. Facilities experience a high turnover rate in essential positions, such as certified nurse assistants (CNAs), who provide approximately 80 to 90 percent of the personal care to nursing home residents. A high turnover rate disrupts the continuity of care delivered to residents, and inadequate staffing ratios promote a lower standard of care for residents and decrease employee moral. Without consistent and adequate staffing, residents may not receive the quality of care that would otherwise be anticipated. Additionally, the current Medicaid property reimbursement methodology could be revised to offer more incentives for facilities to renovate or update existing physical plants. In certain cases, financial limitations may cause facilities to be sold or leased to a new operator who can obtain a step-up in rate and, thus, be in a better position to renovate or update the facility than the original owner or operator.

Various other factors that adversely impact the nursing home community include: (a) the extraordinary increases in the cost of general and professional liability insurance; (b) increasing frequency of litigation; (c) the large number of bankruptcies over the past two to three years; (d) reorganizations that may directly affect nursing home staff through the loss of tenure or much needed benefits; and (e) the shrinking pool of service industry employees in relation to the population in need of nursing home care. These factors directly impact the financial viability of both for-profit and non-profit nursing homes alike and greatly influence the effectiveness of the recommendations proposed by this Panel. If the Panel's guiding principles of financial stability and consideration of current research are to be realized, then factors external to the reimbursement system, such as those described above, must be addressed by policy makers. Of those external factors, solutions to the liability insurance crisis and litigation issues are the most immediate.

As stated above, as Florida's population ages and the service industry shrinks in relation to the population in need, even the most generous payment increases will have little or no impact unless there is available staff to meet the demand. While an argument can be made that with sufficient increases in Certified Nursing Assistant (CNA) salaries, compensation might then be adequate to attract new entrants into the CNA field, this is not the case with nurses. Nursing homes, hospitals, clinics, doctors' offices, and other health care providers are all competing for the same pool of nurses. As demand routinely outstrips supply, salary and benefit increases for nurses in one segment of the health care industry are, at best, a temporary remedy. If nursing homes are able to increase their rates of pay to nurses, then the initial economic response will be an increased availability of nursing staff in the nursing home setting, at the expense of other health care providers. These other providers have historically implemented

similar financial incentives and the tide simply reverses. Additionally, the increasing frequency of nursing home litigation demoralizes nursing staff, makes recruitment and retention more difficult and could potentially counteract financial enhancements. Effective long-term solutions must include both increases in the output of RNs and LPNs by the state's nursing schools, and an attempt to reduce the caseload in areas of health care most dependent on nursing staff, such as nursing homes and hospitals.

To reduce the need for additional nursing home staff, increased emphasis on alternative care settings must be fully explored. Additional funding for the Assisted Living Facility Waiver (ALF) and the Diversion Waiver projects could over time relieve some of the pressure on staffing needs in nursing homes. However, increased attention to alternative settings will be difficult to realize under the current legal and liability insurance climate. While most of the attention is focused on increases in nursing home insurance costs, assisted living facilities (ALFs) are also at risk. ALFs are being put on notice by their insurers that an extended congregate living (ECC), or similar, designation will place them in a high risk class with commensurate increases in general and professional liability insurance costs. Unfortunately, the ECC or limited nursing license is required for an ALF to provide appropriate care to potential nursing home residents and participate in the Assisted Living Waiver program.

Regardless of the type of ownership, nonprofit or for profit, continuing astronomical increases in general and professional liability insurance rates will consume funds vital to the recommendations contemplated by the Panel in the areas of staffing and property reimbursement. Because Medicaid rates reflect reported costs, if a facility spends additional money on liability insurance at the expense of patient care, for example, its next Medicaid patient care rate may be reduced if costs were to fall below targets. Additionally, its operating cost rate may increase up to or beyond the target limit. Thus, any shift of patient care related dollars to cover other expenses, such as liability insurance, will have an almost immediate negative impact on quality of care as there will be fewer resources available due to the limitations inherent in the Medicaid reimbursement system. On July 1, 2000, Medicaid covered 88 percent of total average Medicaid nursing home costs, this included 95 percent of total average patient care costs, and 80 percent of total average operating costs. However, it should, also, be noted that although on average 95 percent of patient care costs were covered, 52 percent of Medicaid nursing homes had uncovered patient care costs. For those nursing homes with patient care costs well in excess of their Medicaid rates (i.e., costs above targets and ceilings), the impact on quality of care may be the greatest. Since these providers presumably have higher staffing expenditures, and presumably provide better resident care, the impact of shifting funds away from staffing to cover increased liability expense is likely to be greater.

Panel On Medicaid Reimbursement

The 1999 Legislature passed House Bill 1971 that created the Panel on Medicaid Reimbursement. (See Appendix A for the full text of the legislation.) The panel was directed to study specific issues in relationship to the Medicaid long-term care reimbursement plan. The panel was to develop a preliminary report by

December 31, 1999, with a final report due to the legislature by December 8, 2000. The legislation directed the panel to make recommendations regarding changes in the reimbursement plan to achieve these goals:

- ◆ increase employee retention;
- ◆ create incentives for facilities to renovate and update existing physical plants, and
- ◆ create incentives for facilities to provide more direct-care staff.

The panel is composed of representatives from the Agency for Health Care Administration, the Governors' Office of Planning and Budget, the Department of Elder Affairs, the nursing home community, a consumer advocate and the public sector. (See Appendix B for a complete list of panel members.)

Initially, in evaluating the complexities of this issue, the panel examined many areas of concern. The panel primarily focused its more detailed discussions on changes to the patient care and property components of the Medicaid per diem rate and their relationship to the objectives of the panel. The Medicaid payment methodology, as presented in the Title XIX Long Term Care Reimbursement Plan, was thoroughly reviewed by the panel. (See Appendix C for an abbreviated description of the nursing home reimbursement methodology.) Additionally, the panel heard presentations from facility administrators who had helped reduce the rate of staff turnover, compared to other facilities in the same geographic area, through sound management practices, non-monetary incentives, and employee morale boosters. Examples of such non-monetary incentives for employees include turkeys at Thanksgiving, Christmas gifts, parties for employees presented and serviced by management, and monthly meetings between staff and an independent labor consultant/liaison to resolve any issues between staff and management. After hearing presentations from various sources representing the issues and goals of the legislation, the panel developed preliminary recommendations. (See Appendix L for the Preliminary Report Recommendations.)

Based on both the previously heard presentations and discussions of the panel as well as presentations made over the course of the year 2000, the panel developed the final report findings. This final report contains recommendations regarding changes to the Medicaid nursing home reimbursement plan to achieve the legislative directives. The report has a Panel Findings section that is indicative of the expansive material reviewed and the various external factors considered in arriving at the final recommendation summarized below. Section 5 of this report contains a more in-depth discussion of the final recommendation. (See Appendix M for a glossary of the terms used in this report.)

Numerous models were evaluated in determining the final recommendations of the panel. The panel felt it was necessary to narrow down the number of models used to develop the final report. Recommendations are very specific in nature and typically a small change in any of the variables in the reimbursement formulas used to calculate per diem rates could greatly impact providers. Additionally, the panel felt it was prudent to consider options that are budget neutral or could potentially result in savings that could be redirected to achieve the panel's goals.

Conceptual Framework for Recommendations

To be able to direct the recommendations toward patient care staffing, many of the models considered divided the patient care component of the per diem into two sub-components. One sub-component is comprised of direct patient care staff (RNs, LPNs, CNAs) salaries and benefits and the other, or indirect patient care, sub-component is comprised of the remaining patient care related costs, such as medical supplies, dietary, ancillary and social services. When modeling property-related considerations, some of the models attempted to substitute more realistic variables within the current methodology while others represented a change to the current rate setting methodology.

Panel Final Recommendation

The Panel's charge was to study the state's Medicaid reimbursement plan for nursing home facilities (Plan) and recommend changes to accomplish the following goals: (a) increase the rate of employee retention in individual nursing home facilities and ensure salary enhancements for staff who achieve targets of longevity; (b) create incentives for facilities to renovate and update existing physical plants, when practicable, instead of building new facilities or selling to another entity; and (c) create incentives for facilities to provide more direct-care staff and nurses.

Consequently, the panel focused on changes to the Patient Care and Property components of the nursing home per diem. Furthermore, the panel adopted a set of Guiding Principles to help facilitate a focused effort in recommending changes to the Medicaid reimbursement system. These Guiding Principles, found on page 7, by their very nature result in recommendations that have a fiscal impact, i.e. would require additional funding as described below.

The budget neutral recommendations considered had little or no effect on net reimbursement. However, one of the Guiding Principles adopted requires that the recommendations minimize the negative financial impact on individual nursing home providers. All such budget neutral recommendations had substantial negative financial impact on individual nursing home providers. The budget neutral recommendations considered changes to the reimbursement methodology of add-ons to the patient care component, specifically the Medicaid Adjustment Rate and the Case-Mix Adjustment. These add-ons were selected for consideration because add-ons do not fall within the target and ceiling limitations and, consequently, they were likely to have the least amount of negative impact on individual providers. However, as indicated above, the negative impact was significant enough that the Panel could not fulfil its mission by going forth with any of these models as a final recommendation.

The Panel's recommendation is two-fold. The recommendation includes a prioritized combination of one patient care model and three property models. If this combination recommendation were to be adopted, then an additional property-related recommendation would be put forward that would result in unfavorable results to a few individual providers, i.e., savings to the State. The final recommendation includes

components that make changes to the current reimbursement methodology and others that change the variables within the current methodology.

The recommendation of the Panel in prioritized order is as follows:

- ◆ **rebase the patient care component and case-mix adjusting the direct patient care sub-component. (Estimated Fiscal Impact: \$46.1 million)**
- ◆ **increase the FRVS inflation index by a 1.4 multiplier. (Estimated Fiscal Impact: \$11.1 million)**
- ◆ **eliminate the property component's FRVS 10-10-20 curve that allows increases in the indexed asset value. (Estimated Fiscal Impact \$12.6 million)**
- ◆ **change the FRVS occupancy rate per the Plan from 90% to the actual mean, currently 87.74%. (Estimated Fiscal Impact \$3.2 million)**

If the above combination recommendation were to be adopted in its entirety, then this recommendation would be expanded to include:

- ◆ **place all providers on the Fair Rental Value System (FRVS) (Estimated Savings \$4.9 million)***

An in-depth analysis of this combination recommendation, including each of the various components, is included in Section Five of this report. **Based on July 1, 2000 rates, the fiscal impact of this combination model, prior to the final FRVS model that would generate savings, is approximately \$75 Million.**

*Please note that the actual cost of combining the final FRVS model with the other property models has not been determined. The above savings would be less than estimated due to the increases in the FRVS component as a result of the other recommendations for those facilities currently reimbursed under the cost methodology for property.

There is a \$2.1 million difference between the impact of the combination model and the impact from the total of the individual models. The individual FRVS property models build on each other when combined into the final recommendation resulting in a greater total fiscal impact.

Additionally, the Panel considered the possibility of a phase-in of the final recommendation, similar to Medicare's phase-in of PPS. The Medicare PPS provisions were phased in over four (4) years, beginning with 25 percent of the change enacted the first year. A Medicaid phase-in period would not necessarily follow that of the Medicare phase-in period. A phase-in methodology would allow the State to gradually absorb the cost of the recommendation, yet ensure the providers that the total fiscal relief recommended would be received. However, the final recommendation of the panel does not include a phase-in provision.

Panel Guiding Principles

Three factors affecting the ability of nursing home providers to attract and retain quality direct-care staff are increasing financial limitations of various payer sources, higher expectations to improve the quality of care, and changes in owners or operators of nursing home facilities. The full costs associated with a resident's stay are not always paid by the various payer sources, such as Medicare, Medicaid and the Veterans Administration. This usually results in the provider shifting costs to other payer sources, private pay residents or absorbing the loss, often at a higher corporate level. Family members and residents want the highest possible quality-of-care while in a nursing home and it is the constant goal of the nursing home community and state regulators to reasonably meet these expectations. Additionally, facility changes in ownership or operators may impact employee relations and cause additional difficulties in attracting and retaining qualified direct care staff. Changes in ownership do not necessarily equate to improved quality of care and often result in increased costs that are borne by most, if not all, payers.

In order to facilitate a focused effort in recommending changes to the Medicaid reimbursement system, the panel created a set of Guiding Principles near the inception of its meetings. The panel referred to these principles, as needed during discussions to determine which recommendations the panel wished to have modeled. The principles are as follows:

- ◆ Changes will encourage better access to nursing home care by residents requiring Medicaid coverage.
- ◆ Changes will be made in a fair and equitable manner.
- ◆ Changes will promote long-term financial stability of the reimbursement system.
- ◆ Reimbursement plan changes will be kept to a minimum.
- ◆ Changes will be consistent with current research.
- ◆ Changes will have a minimum unintended negative impact on other components of the health care field.
- ◆ Resident/patient acuity will remain a factor in rate setting.
- ◆ Negative financial impact on individual nursing home providers will be minimized.
- ◆ Reasonable existing provider care costs will be recognized prior to setting rates in excess of costs.

Panel Methodology

The Panel on Medicaid Reimbursement met five times during the period of July 1999 through December 1999. During the meetings, the panel discussed the purpose and goals of the panel and agreed to adopt guiding principles, found in the preceding section, to use in recommending changes to the Medicaid reimbursement system. The following issues were presented to and discussed by the panel in the development of the preliminary report:

- ◆ current Florida Medicaid reimbursement policy and data;
- ◆ the property component of nursing home reimbursements;
- ◆ nursing home reimbursement in other states;
- ◆ nursing home staffing issues;
- ◆ staffing issues as experienced by nursing facilities in the state of Florida;
- ◆ the Michigan Department of Industry Health wage pass-through program for nursing home reimbursement;
- ◆ staffing survey conducted by the Iowa Caregivers Association;
- ◆ labor market projections for the health care industry; and,
- ◆ discussions of other issues, including nursing home appropriations that could influence panel recommendations.

The Appendices C through K of this report contain summaries of these presentations and discussions.

The Panel met nine times during the year 2000. These meetings expanded the discussions and studies on the findings and recommendations presented in the preliminary report. The Panel developed a matrix of potential changes to the nursing home reimbursement methodology for modeling purposes. Following discussion, specific combinations from the matrix were selected for modeling to determine the overall impact, as well as the impact on individual nursing facilities. Various summaries or roll-ups were made comparing, for example, the impact on For-Profit compared to Not For-Profit, the impact based on Medicaid utilization, Class Analysis (region and number of beds) and the number and dollar amounts of “favorable” compared to “unfavorable”.

The budget neutral data models included:

1. Redirect the Medicaid Adjustment Rate (MAR) or a portion of the MAR and use the savings to achieve the Panel’s goals, e.g., longevity bonuses.
2. Increase the MAR’s minimum qualifying Medicaid utilization rate from greater than 50 percent to 65 percent and use the savings to achieve the panel’s goals.
3. Rebase the patient care component and case-mix adjust the direct patient care sub-component using a budget neutral methodology.

The fiscal Impact data models included:

1. Blend the case-mix add-on into the calculation of patient care ceiling.
2. Eliminate the property component's FRVS 10-10-20 curve that limits increases in the indexed asset value.
 - a) At July 1, 2000.
 - b) Since entrance into the Medicaid program.
3. Change the FRVS occupancy rate per the Plan from 90% to the statewide actual mean, currently 87.74%.
4. Increase the FRVS Per Bed Standard by \$3000 from \$40,292 to \$43,292.
5. Rebase the patient care component (including provider specific target, target rate class ceilings and new provider limitations) and incorporate the case-mix add-on into the patient care component.
6. Increase the FRVS FCCI index to 1.4 times the rate of inflation sorted by annual effect on individual providers. Summaries were presented by Medicaid Utilization Rate, Ownership Type (For-Profit/Not For-Profit), and Class (region and number of beds).
7. Rebase the direct patient care sub-component and case-mix adjust the patient care ceilings. Direct patient care sub-component was determined using (a) actual reported dollars and (b) statewide averages of 65% direct and 35% indirect. Summaries were presented by Medicaid Utilization Rate, Ownership Type (For-Profit/Not For-Profit) and Class (region and number of beds).
8. Combination models:
 - a) Property Only - Eliminate the FRVS 10-10-20 curve and change the occupancy rate to 87.74%.
 - b) Property Only – Eliminate the FRVS 10-10-20 curve, change the occupancy rate to 87.74%, and increase the FCCI to 1.4 times the rate of inflation.
 - c) Property and Patient Care - Eliminate the FRVS 10-10-20 curve, change the occupancy rate to 87.74%, and increase the FCCI by 1.4 times the rate of inflation. In addition, rebase the direct patient care sub-component (65-35% model) and case mix adjust the patient care class ceilings.

Panel Findings

The panel, through presentation and discussion, arrived at the following findings:

- ◆ Adequate direct-care staffing in the appropriate mix is critical to the quality of care received by nursing home residents.
- ◆ Hiring and retention of qualified staff in nursing facilities is a difficult task in Florida and across the nation.
- ◆ Changes in the Medicaid nursing home reimbursement plan that directly impact direct-care staff wages could affect the hiring and retention of qualified staff, especially in facilities with high Medicaid utilization.
- ◆ FRVS' failure to recognize replacement property costs as reported in the Medicaid cost report may contribute to more frequent facility turnover (i.e., changes in ownership or operators.)
- ◆ Changes to the Medicaid long-term care reimbursement plan could provide incentives to renovate and update current facilities. This may reduce the frequency of facility turnovers and reduce the need for more expensive new construction.
- ◆ Recent changes to the Federal Medicare reimbursement methodology has negatively impacted the quality of care in nursing homes due to lower Medicare reimbursements.
- ◆ Recent changes to the Federal Medicare reimbursement methodology are restoring, to some extent, the effect that the BBA of 1997 had on nursing home reimbursement. This will provide some financial relief to facilities that could be used to maintain staffing and quality of care.
- ◆ Flexibility in implementing new and allocating existing Florida resources could provide relief in the areas studied by this panel.
- ◆ The solutions proposed in this document must be considered in conjunction with solutions to the liability insurance issue.
- ◆ Any legitimate long-term solution must include increases in the output of the state's nursing schools and an attempt to reduce the caseload in areas of health care most dependent on nursing staff.
- ◆ To reduce the need for additional nursing home staff, increased emphasis on alternative care settings must be fully explored. However, increased attention to

alternative settings cannot be realized under the current legal and liability insurance climates.

- ◆ Employee turn-over has a costly impact, both financially and in terms of quality of care.
- ◆ Good management practices may improve staffing retention. However, in some communities, unique circumstances do not lend themselves to these types of non-monetary incentives.
- ◆ When possible, nursing homes should strive to replace costly agency, or pooled, staff, with full or part-time employees. The savings could be directed toward the recruitment and retention of staff, thus, contributing to the continuity of care.
- ◆ Between 1989 and 1997 the funding for Florida nursing homes was reduced by approximately \$127 million annually. Additionally, between 1997 and 2000 approximately \$62 million annually in funding was transferred from the nursing home budget to diversion waiver programs. These amounts represent the level of reductions for each year and have not been adjusted for inflation to represent current year dollars. (See Appendix C, page 7)
- ◆ There are several concurrent panels and task forces looking at related areas, such as the Availability and Affordability of Long Term Care, Certificate of Need, Certified Nursing Assistant Shortages in the Nursing Home Community and the Home Health Industry. The Panel on Medicaid Reimbursement has been in contact with these other groups throughout the panel's existence. This panel recognizes that implementation of our final recommendations may be impacted by the final recommendations of these other concurrent study groups and task forces.
- ◆ Florida Medicaid made changes in the nursing home reimbursement system in state fiscal years 1998-1999, 1999-2000, and 2000-2001. These changes are described below:
 - For rate periods beginning on April 1, 1999, a case-mix adjustment was implemented as an add-on to the patient care component of the facility per diem rate. When computing the case-mix add-on for Medicaid residents, the Agency adjusts for differences in the resources needed to care for different levels of acuity and other specific indicators of the residents of each home. The case-mix is based on a resident classification system as reported by the nursing facility through the Minimum Data Set (MDS) required by the Health Care Financing Administration. The MDS score takes into account the medical, behavioral and cognitive deficits of residents. This initiative is intended to enhance access to nursing home care for recipients with high acuity levels. The annualized fiscal impact of the case-mix adjustment is approximately \$40.4 million.

- Effective January 1, 2000, in accordance with the proviso language of Specific Appropriation 252, there was a partial rebasing to the patient care component of the per diem rate by raising reimbursement caps. The annualized fiscal impact of this change in the reimbursement plan is approximately \$18.1 million.
- Effective April 1, 2000, the Agency implemented the Direct Care Staffing Adjustment (DCSA) to the patient care component of the per diem rate. This adjustment was in accordance with Section 30 of the 1999 House Bill Number 1971. This add-on is intended to improve the nursing facilities' ability to recruit and retain qualified staff to provide appropriate care. A survey instrument was distributed to capture the necessary data used in developing the allocation methodology. In accordance with legislative intent, the methodology included an inversely proportionate formula in which those facilities with the lower staffing ratios received the most amount of assistance. The degree of reimbursement is dependent on Medicaid utilization and the adjustment requires additional spending by the nursing home. The annualized fiscal impact of the DCSA is approximately \$31.7 million.
- Effective July 1, 2000, in accordance with 409.908(2)(b), the Agency began to approve interim rate requests (IRR) for general and professional liability insurance. To qualify, the provider must have a Medicaid utilization rate of at least 65 percent and the increase in costs for the general and professional liability insurance must affect a change in the provider's total Medicaid per diem by at least 5 percent. As of the printing of this report, 86 providers have applied for an interim rate adjustment, 47 have been approved, 18 have been denied and 21 have been pended. Currently the average cost coverage is 72.84%. This means that for providers receiving an interim rate adjustment, Medicaid is paying an average of \$0.73 for every dollar spent by the provider.
- The patient care add-ons and January 1, 2000 partial rebasing totaled more than \$90.2 million in additional funding. The panel recognizes that these changes in nursing home reimbursement, including the provision for general and professional liability insurance, has had a positive effect on nursing home performance and viability. However, until the liability crisis is resolved, the viability of the entire nursing home community remains at risk.

Panel Final Recommendation

As indicated in the Executive Summary, the Panel's charge was to study the state's Medicaid reimbursement plan for nursing home facilities (Plan) and recommend changes to accomplish the following goals:

- ◆ increase the rate of employee retention in individual nursing home facilities and ensure salary enhancements for staff who achieve targets of longevity,
- ◆ create incentives for facilities to renovate and update existing physical plants, when practical, instead of building new facilities or selling to another entity, and
- ◆ create incentives for facilities to provide more direct care staff and nurses.

As a result, the panel focused on changes to the Patient Care and Property components of the nursing home per diem. The panel early on adopted a set of Guiding Principles. These principles not only helped to facilitate a focused effort in recommending changes to the Medicaid reimbursement system, but helped the Panel in determining which of the various models considered to include in its final recommendation.

Panel Final Recommendation (Combination)

The Panel's recommendation is a two-fold, prioritized combination model involving one patient care and initially three FRVS property components of the Medicaid per diem. All components of this recommendation have a fiscal impact and require additional funding. If this combination recommendation were to be adopted, then an additional property-related recommendation could be put forward that would result in savings to the State, with unfavorable results to a few individual providers. This final recommendation makes changes to the current reimbursement methodology as well as changes in the variables within the current methodology.

Initially the combination model of the recommendation is presented, followed by each component of the recommendation. The fiscal impact is identified in combination and then separately by each component. There is a \$2.1 million difference between the impact of the combination recommendation and the impact of the sum of the individual components. This is because the individual property components build on each other when combined into the final recommendation resulting in a greater total fiscal impact.

Methodology of Combination Model:

The components of the panel's final recommendation in prioritized order are as follows:

- **rebase the patient care component and case-mix adjusting the direct patient care sub-component;**
- **increase the FRVS inflation index by a 1.4 multiplier;**
- **eliminate the property component's FRVS 10-10-20 curve that restricts increases in the indexed asset value; and**

- **change the FRVS occupancy rate per the Plan from 90% to the actual mean, currently 87.74%.**

If the above combination recommendation were to be adopted in its entirety, then the recommendation could be expanded to include:

- **place all providers on the Fair Rental Value System (FRVS).**

Additionally, the Panel considered the possibility of a phase-in of the final recommendation, similar to Medicare's phase in of the Prospective Payment System (PPS). The Medicare PPS provisions were phased-in over four years, beginning with 25 percent of the change enacted the first year. A Medicaid phase-in period would not necessarily replicate the Medicare phase-in. A phase-in methodology would allow the State to gradually absorb the cost of the final recommendation, yet ensure the nursing home community that the total fiscal relief recommended would be received. However, the final recommendation of the panel does not include a phase-in provision.

Impact of Combination Model:

Based on July 1, 2000 rates, the fiscal impact of this combination model, excluding the final FRVS model that would generate savings, is approximately \$75 million.

***Please note that the actual cost of combining the final FRVS model with the other property models has not been determined. The savings of converting facilities from the cost methodology to FRVS would be less than that estimated separately due to the fiscal impact of the other recommendations that result in increases in the FRVS component.**

Please note that all of the models presented use actual data that was effective July 1, 2000, including the per diems, reported costs, Medicaid days and total days as reported in historical cost reports. There has been no attempt to adjust the models for inflation, and no attempts to adjust the Medicaid days (Medicaid utilization) nor the total days (occupancy rate) for future periods.

Cost Coverage - At the July 2000 rate semester, the average Medicaid per diem payment was \$114.22 (after adjusting for the costs not yet incurred for the Direct Care Staff Adjustment) and the average total Medicaid cost per diem was \$130.08, representing a cost coverage of 87.81 percent. If the final recommendation were to be adopted, the average Medicaid per diem would be \$118.67, which would enhance the cost coverage to 91.24 percent.

Furthermore, at July 2000, the facility average Medicaid patient care per diem was \$76.35, the average Medicaid patient care cost per diem was \$80.57, representing a cost coverage of 94.76 percent. If the patient care component of this prioritized final recommendation were to be adopted, it would result in a Medicaid patient care per diem of \$79.38 which would increase the cost coverage to 98.52 percent.

Tables 1 through 3 represent a summary, or roll-up, of the impact of this combination model using various sorts. There is a summary by Medicaid Utilization Percentage; Ownership Type (For-Profit or not-for-profit); and by Class (determined by geographical region and number of beds). The roll-ups are also broken out by effect (favorable to the provider, no impact or unfavorable).

The table headers are as follows: Count (number of providers), Average Per Diem Difference (the average change in per diem in each group), Sum (the estimated annual impact by group with totals for each type of effect and a grand total), Minimum (the smallest impact to an individual provider within a group), Maximum (the greatest impact to an individual provider within a group).

Medicaid Utilization – Table 1 (Combination) – Table 1 (see table on next page) shows the results of the combination recommendation based on 10 percent increments. When comparing this model to its various components, It becomes apparent that when providers realize an overall decrease in reimbursement, it is due to case-mix adjusting the patient care component. For all property models, except placing all providers on FRVS, the impact is favorable to the provider.

A review of the Medicaid Utilization Table below indicates that the 478 providers benefit, or have a favorable effect, from this model, totaling \$79.7 million. The Average per diem increases range between \$1.80 at the lowest tier to \$9.15 at the 40 to 49 percent tier. Fifteen providers are not impacted by the final recommendation. Finally, 168 providers are unfavorably impacted by the final recommendation for a total of \$4.9 million. The average per diem decreases range between a low of \$0.85 at the 60 to 69 percent tier to \$2.59 at the lowest tier. In the aggregate, the favorable effects far exceed the unfavorable effects. The overall net effect is an increase of \$75 million.

Table 1
Medicaid Utilization Analysis Table (Combination)

Effect	Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Favorable	90-99%	15	5.68	2,834,270	4,944	716,649
Favorable	80-89%	93	6.05	19,190,879	2,431	988,147
Favorable	70-79%	126	4.89	20,272,153	267	976,174
Favorable	60-69%	84	7.44	16,697,003	409	809,666
Favorable	50-59%	61	7.79	10,500,607	327	676,013
Favorable	40-49%	41	9.15	6,515,629	7,867	599,437
Favorable	30-39%	31	7.16	2,696,554	125	357,992
Favorable	20-29%	14	6.22	706,257	2,771	197,600
Favorable	10-19%	10	6.07	250,007	949	107,108
Favorable	0-9%	<u>3</u>	1.80	<u>7,478</u>	8	5,308
Total		<u>478</u>		<u>79,670,837</u>		
No Impact	90-99%	2	0.00	0.00	0.00	0.00
No Impact	80-89%	5	0.00	0.00	0.00	0.00
No Impact	70-79%	3	0.00	0.00	0.00	0.00
No Impact	60-69%	0	0.00	0.00	0.00	0.00
No Impact	50-59%	2	0.00	0.00	0.00	0.00
No Impact	40-49%	1	0.00	0.00	0.00	0.00
No Impact	30-39%	1	0.00	0.00	0.00	0.00
No Impact	20-29%	0	0.00	<u>0.00</u>	0.00	0.00
No Impact	10-19%	<u>1</u>	0.00	<u>0.00</u>	0.00	0.00
Total		<u>15</u>				
Unfavorable	90-99%	15	-1.47	-736,524	-7,888	-130,629
Unfavorable	80-89%	30	-1.28	-1,277,999	-2,163	-161,381
Unfavorable	70-79%	29	-1.18	-989,498	-915	-203,787
Unfavorable	60-69%	31	-0.85	-615,098	-738	-69,741
Unfavorable	50-59%	23	-1.14	-568,494	-2,501	-85,344
Unfavorable	40-49%	17	-1.30	-449,748	-1,625	-70,652
Unfavorable	30-39%	11	-1.40	-179,459	-5,053	-30,497
Unfavorable	20-29%	6	-1.54	-68,950	-4,624	-18,764
Unfavorable	10-19%	3	-1.57	-27,590	-5,005	-13,825
Unfavorable	0-9%	<u>3</u>	-2.59	<u>-6,740</u>	-149	-5,841
Total		<u>168</u>		<u>-4,920,100</u>		
Grand Total		<u>661</u>		<u>74,750,739</u>		

Ownership Type Analysis - Table 2 (Combination) - A review of Table 2 indicates that 88 Not-For-Profit providers would receive an average per diem increase of \$5.11 with a total increase of \$12 million. Nine (9) Not-For-Profit providers would not be impacted. Twenty-four (24) Not-For-Profit providers would receive an average per diem decrease of \$1.71 for a total decrease of \$0.9 million. The net Not-For-Profit impact would be \$11.1 million.

A review of For-Profit providers indicates 390 would receive an average per diem increase of \$6.83 for a total increase of \$67.7 million. Six (6) For-Profit providers would not be impacted. Finally, 144 providers would receive an average per diem decrease of \$1.15 for a total decrease of \$4.1 million. The net For-Profit impact would be \$63.6 million. In total, the increase for all providers would be \$75 million.

Table 2
Ownership Type Analysis Table (Combination)

Owner Type	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Not For Profit	Favorable	88	5.11	11,992,394	8	545,054
For Profit	Favorable	<u>390</u>	6.83	<u>67,678,444</u>	125	988,147
Total		<u>478</u>		<u>79,670,838</u>		
Not For Profit	No Impact	9	0.00	0.00	0.00	0.00
For Profit	No Impact	<u>6</u>	0.00	<u>0.00</u>	0.00	0.00
Total		<u>15</u>		<u>0.00</u>		
Not For Profit	Unfavorable	24	-1.71	-859,205	-149	-203,787
For Profit	Unfavorable	<u>144</u>	-1.15	<u>-4,060,894</u>	-738	-161,381
Total		<u>168</u>		<u>-4,920,099</u>		
Grand Total		<u>661</u>		<u>74,750,739</u>		

Class Analysis - Table 3 (Combination) - A review of Table 3 (see table on the next page) indicates that 370 (150+108+112) Large facilities would receive a per diem increase. The average per diem increases range from \$6.15 to \$7.75. The weighted average per diem increase based on the number of Large facilities is \$7.14, with a total increase of \$73.4 million. One hundred eight (38+35+35) Small facilities would receive a per diem increase, ranging from \$3.06 to \$5.89. The weighted average per diem increase based on the number of Small facilities is \$4.36 with a total increase of \$6.3 million. Total increases sum to \$79.7 million. There would be 15 facilities not impacted by the change.

Finally, There are 121 (36+39+46) Large facilities that would receive a per diem decrease. The average per diem decreases range from \$1.01 to \$1.41. The weighted average per diem decrease based on the number of Large facilities is \$1.18 totaling a decrease of \$4 million. Forty-seven (15+16+16) Small facilities would receive per diem decreases, ranging from \$1.21 to \$1.45. The weighted average per diem decrease based on the number of Small facilities is \$1.36, with a total decrease of \$0.9 million. This would net to a total decrease of \$4.9 million. In total the net increase would be \$75 million.

Table 3
Class Analysis Table (Combination)

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	150	7.75	30,280,954	125	772,647
Central Small	Favorable	38	5.89	3,147,787	327	446,818
North Large	Favorable	108	6.15	18,898,366	404	988,147
North Small	Favorable	35	3.06	1,584,815	1,711	403,517
South Large	Favorable	112	7.29	24,200,171	8	976,174
South Small	Favorable	<u>35</u>	4.00	<u>1,558,745</u>	2,734	246,018
Total		<u>478</u>		<u>79,670,838</u>		
Central Small	No Impact	6	0.00	0.00	0.00	0.00
North Large	No Impact	2	0.00	0.00	0.00	0.00
North Small	No Impact	4	0.00	0.00	0.00	0.00
South Large	No Impact	1	0.00	0.00	0.00	0.00
South Small	No Impact	<u>2</u>	0.00	<u>0.00</u>	0.00	0.00
Total		<u>15</u>		<u>0.00</u>		
Central Large	Unfavorable	36	-1.01	-882,731	-1,865	-85,344
Central Small	Unfavorable	15	-1.45	-255,651	-149	-56,623
North Large	Unfavorable	39	-1.06	-1,332,694	-2,163	-124,056
North Small	Unfavorable	16	-1.21	-315,263	-2,924	-62,895
South Large	Unfavorable	46	-1.41	-1,821,572	-915	-203,787
South Small	Unfavorable	<u>16</u>	-1.42	<u>-312,188</u>	-738	-71,426
Total		<u>168</u>		<u>-4,920,099</u>		
Grand Total		<u>661</u>		<u>74,750,739</u>		

As stated above, If the combination recommendation were to be adopted in its entirety, then the recommendation could be expanded to include the placement of all providers currently on the cost-based property methodology onto the Fair Rental Value System (FRVS). This would result in an approximate net savings of \$4.9 million.

Panel Final Recommendation (Components)

A detailed explanation of the individual components of the combination recommendation is presented below. The Methodology and Impact of each component of the recommendation are presented, as well as the same roll-ups presented for the combination recommendation.

Rebase the patient care component and case-mix adjust the direct patient care sub-component.

Component Methodology: Patient Care Rebasing with Case-Mix Adjusted Ceilings

This first model pertains to the patient care component and involves three distinct steps:

Step	Action
1	Rebase the patient care component.
2	Divide the patient care component into direct and indirect sub-components based on the statewide average split as reported by providers (65% direct patient care costs and 35% indirect patient care costs).
3	Case-mix adjust the direct care sub-component and add back the indirect patient care sub-component in establishing changes to the class ceilings.

To rebase the patient care component, the patient care provider targets and target rate class ceilings are eliminated. However, the patient care component of the per diem rate is not allowed to exceed the individual provider's patient care inflated costs. An advantage of case-mix adjusting the direct patient care sub-component is that it eliminates one of the add-ons to the patient care component by blending the case-mix allocation into the basic per diem calculation.

To place the emphasis on direct care staffing, the patient care component is divided into two sub-components. The direct patient care sub-component represents direct care staff (RNs, LPNs, CNAs) salaries and benefits. Its value is determined by using the statewide average ratio of direct-care costs to total patient care costs, which is 65 percent. The remaining 35 percent are referred to as the indirect patient care sub-component.

To case-mix adjust the direct care sub-component, the facility's average case-mix score is divided by the statewide case-mix median to reach the case-mix ratio.

To achieve the case-mix adjustment, the facility's direct care sub-component per diem is divided by the case-mix ratio. The indirect patient care sub-component is then added back to the case-mix adjusted direct patient care sub-component. The

statewide patient care class ceilings are then calculated in the normal manner using the case-mix adjusted patient care component. (See Appendix C for class ceiling calculations.)

To establish individual case-mix adjusted ceilings, the indirect patient care sub-component is subtracted from the class ceiling and then the difference is multiplied by the individual case-mix ratio. Finally, the indirect patient care sub-component is added to the case-mix adjusted direct patient care sub-component. The result is the individual case-mix adjusted patient care ceiling.

Component Impact: Patient Care Rebasing with Case-Mix Adjusted Ceilings

Estimated Annualized Fiscal Impact (based on 7/1/2000 rates): \$46.1 Million.

Note: This amount is in addition to the \$40 million appropriated for the of Case-Mix add-on adjustment.

The following tables represent a summary or roll-up of the impact of this patient care model using the same sorts as the combination recommendation.

Medicaid Utilization Analysis - Table 4 – Table 4 (see table on next page) shows the results of the patient care modeling based on 10 percent increments. It becomes more apparent when comparing this model to the overall combination recommendation that when providers realize an overall decrease in reimbursement, it is due to case-mix adjusting the patient care component.

A review of the Medicaid Utilization Table below indicates that the 346 providers benefit, or have a favorable effect, from this patient care model, totaling \$61.9 million. Additionally, 297 providers are unfavorably impacted by this model for a total of \$15.8 million. The unfavorable impact of this particular model is offset to some degree by the property models, accounting for the difference of this model's unfavorable effect and that of the final recommendation. The net effect of this model is \$46.1 million.

Table 4
Patient Care - Medicaid Utilization Analysis Table

Effect	Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Favorable	90-99%	12	5.69	2,189,542	3,607	716,649
Favorable	80-89%	61	6.55	13,208,900	209	987,808
Favorable	70-79%	85	5.52	14,994,547	628	751,308
Favorable	60-69%	56	9.48	13,979,745	1,843	809,351
Favorable	50-59%	48	8.27	8,552,901	7,686	676,013
Favorable	40-49%	34	9.31	5,568,687	631	557,416
Favorable	30-39%	25	8.43	2,521,392	13,797	357,992
Favorable	20-29%	14	6.17	680,015	56	185,518
Favorable	10-19%	9	6.43	236,790	1,748	101,215
Favorable	0-9%	<u>2</u>	2.33	6,473	1,483	4,990
Total		<u>346</u>		<u>61,938,992</u>		
Unfavorable	90-99%	19	-2.20	-1,495,874	-177,482	-15,879
Unfavorable	80-89%	63	-2.04	-4,820,921	-219,997	-2,471
Unfavorable	70-79%	73	-1.98	-4,014,791	-203,787	-5,810
Unfavorable	60-69%	51	-2.03	-2,559,405	-97,715	-134
Unfavorable	50-59%	39	-1.88	-1,516,338	-88,591	-1,726
Unfavorable	40-49%	25	-2.02	-928,244	-74,057	-7,908
Unfavorable	30-39%	13	-2.02	-309,056	-40,312	-2,887
Unfavorable	20-29%	6	-2.09	-88,762	-19,351	-8,923
Unfavorable	10-19%	4	-1.75	-39,404	-15,613	-345
Unfavorable	0-9%	<u>4</u>	-2.62	-9,704	-8,510	-180
Total		<u>297</u>		<u>-15,782,499</u>		
Grand Total		<u>643</u>		<u>46,156,493</u>		

Ownership Type Analysis – Table 5 - Table 5 indicates that 71 Not-For-Profit providers would receive an average per diem increase of \$5.57 with a total increase of \$8.9 million. Fifty (50) Not-For-Profit providers would receive an average decrease of \$1.96 for a total decrease of \$2.3 million. This nets to a total impact of \$6.6 million.

An analysis of For-Profit providers indicates 275 would receive an average per diem increase of \$7.80 for a total increase of \$53.1 million. The remaining 247 For-Profit providers would receive an average per diem decrease of \$2.03 for a total decrease of \$13.5 million. This nets to a total impact of \$39.6 million.

Table 5
Patient Care - Ownership Type Analysis

<u>Owner Type</u>	<u>Effect</u>	<u>Count</u>	<u>Average Per Diem Difference</u>	<u>Sum</u>	<u>Minimum</u>	<u>Maximum</u>
Not For Profit	Favorable	71	5.57	8,863,562	631	494,036
For Profit	Favorable	275	7.80	53,075,430	56	987,808
Total		<u>346</u>		<u>61,938,992</u>		
Not For Profit	Unfavorable	50	-1.96	-2,318,980	-180	-216,265
For Profit	Unfavorable	247	-2.03	-13,463,519	-134	-219,997
Total		<u>297</u>		<u>-15,782,499</u>		
Grand Total		<u>643</u>		<u>46,156,493</u>		

Class Analysis – Table 6 – Table 6 indicates that 266 Large (109+67+90) facilities would receive a per diem increase. The average per diem increase ranges from \$7.18 to \$8.48. The weighted average per diem increase based on the number of Large facilities is \$8.01, with a total increase of \$57 million. Eighty (30+22+28) Small facilities would receive a per diem increase, ranging from \$3.81 to \$6.75. The weighted average per diem increase based on the number of Small facilities is \$5.12, with a total increase of \$4.9 million.

Two hundred and nineteen (70+82+67) Large facilities would receive an average per diem decrease, ranging from \$1.83 to \$2.23. The weighted average per diem decrease based on the number of Large facilities is \$1.97, totaling a decrease of \$13.3 million. Seventy-eight (22+33+23) Small facilities would receive per diem decreases, ranging from \$1.98 to \$2.39. The weighted average per diem decrease based on the number of Small facilities is \$2.14, with a total decrease of \$2.5 million. Large and Small facilities would net to \$46.1 million.

Table 6
Patient Care - Class Analysis Table

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	109	8.48	23,015,226	313	716,649
Central Small	Favorable	30	6.75	2,515,484	56	393,096
North Large	Favorable	67	8.38	15,494,937	628	987,808
North Small	Favorable	22	3.81	1,195,748	209	333,239
South Large	Favorable	90	7.18	18,549,639	15,336	809,351
South Small	Favorable	28	4.40	<u>1,167,958</u>	631	232,273
Total		<u>346</u>		<u>61,938,992</u>		
Central Large	Unfavorable	70	-1.83	-3,879,904	-1,726	-216,265
Central Small	Unfavorable	22	-1.98	-554,083	-198	-56,623
North Large	Unfavorable	82	-1.88	-4,930,799	-2,471	-154,621
North Small	Unfavorable	33	-2.08	-1,073,978	-134	-65,130
South Large	Unfavorable	67	-2.23	-4,506,267	-180	-219,997
South Small	Unfavorable	23	-2.39	<u>-837,468</u>	-816	-71,884
Total		<u>297</u>		<u>-15,782,499</u>		
Grand Total		<u>643</u>		<u>46,156,493</u>		

Increase the FRVS inflation index to a 1.4 multiplier.Component Methodology: FRVS 1.4 Inflation Multiplier

The FRVS property calculation (See Appendix C) uses the Florida Construction Cost Inflation Index (FCCI) to inflate the asset value and to inflate the per bed standard (currently \$40,292) each semester. Community representatives and review of recent nursing home construction costs indicated that the FCCI was understating actual costs. This understatement may be a result of the change to the DRI due to the discontinuation of the Dodge Construction Index on July 1, 1991. The 1.4 factor was selected for modeling purposes because this same factor is used in calculating the target rate inflation factor for the operating and patient care components. The objective of this model is to increase indexing to each provider by applying a more accurate inflation factor. The additional reimbursement would be available to providers to update facility plant and equipment and possibly reduce CHOWs. There are no providers with an unfavorable effect in any of the property models.

Component Impact: FRVS 1.4 Inflation Multiplier**Estimated Annualized Fiscal Impact (Using July 1, 2000 Rates): \$11.1 Million**

Medicaid Utilization Analysis – Table 7 – Table 7 (see table on next page) shows the results of the FRVS 1.4 Inflation Multiplier modeling based on 10 percent increments. All tiers received increases in their average per diem and in the aggregate sum. It becomes apparent when comparing this model to the overall combination recommendation and the patient care model that when providers realize an overall decrease in reimbursement in the combination model, it is due to case-mix adjusting the patient care component with this property model helping to close the gap. As a consequence, all property models have favorable effects.

A review of the Medicaid Utilization Table below indicates that 416 providers have a Medicaid Utilization Rate of 60 percent or above. The average per diem differences by group range from \$0.72 to \$1.02. Using a weighted average by number of providers, the average per diem increase is \$0.85, for a total increase of \$9.3 million. Providers with a Medicaid Utilization Rate between 10 and 59 percent number 215. Their average increase by group ranges from \$0.26 to \$0.66. Using a weighted average by number of providers, the average per diem increase is \$0.58, for a total of \$1.8 million. The 6 providers with a Medicaid Utilization Rate below 10 percent would receive an average per diem increase of \$0.37 for a total increase of \$526. This nets to the entire \$11.1 million. The remaining 141 providers are not impacted by this change.

Table 7**Property FRVS - 1.4 Multiplier Model Medicaid Utilization Analysis**

Effect	Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
No Impact	90-99%	12	0	0	0	0
No Impact	80-89%	25	0	0	0	0
No Impact	70-79%	40	0	0	0	0
No Impact	60-69%	17	0	0	0	0
No Impact	50-59%	12	0	0	0	0
No Impact	40-49%	13	0	0	0	0
No Impact	30-39%	4	0	0	0	0
No Impact	20-29%	7	0	0	0	0
No Impact	10-19%	7	0	0	0	0
No Impact	0-9%	4	0	0	0	0
Total		<u>141</u>		<u>0</u>		
Favorable	90-99%	19	0.76	520,532	4,944	60,738
Favorable	80-89%	98	1.02	3,967,765	2,811	1,052,095
Favorable	70-79%	117	0.83	3,153,228	1,395	185,846
Favorable	60-69%	88	0.72	1,668,473	2,579	56,752
Favorable	50-59%	73	0.66	1,101,392	95	70,759
Favorable	40-49%	46	0.65	499,271	1,479	28,263
Favorable	30-39%	34	0.41	169,725	53	20,666
Favorable	20-29%	13	0.26	21,875	51	5,181
Favorable	10-19%	6	0.53	9,551	371	2,573
Favorable	0-9%	2	0.37	526	179	347
Total		<u>496</u>		<u>11,112,338</u>		
Grand Total		<u>637</u>		<u>11,112,338</u>		

Ownership Type Analysis – Table 8 – Table 8 shows an analysis of the FRVS 1.4 Inflation Multiplier indicating that 83 Not-For-Profit providers would receive an average per diem increase of \$0.64 with a total increase of \$1.7 million. The remaining 38 Not-For-Profit providers would have no rate impact.

An analysis of For-Profit providers indicates 413 would receive an average per diem increase of \$0.78 for a total increase of \$9.4 million. The remaining 103 For-Profit providers would have no rate impact.

Table 8
Property FRVS - 1.4 Multiplier Model Ownership Type Analysis

<u>Owner Type</u>	<u>Effect</u>	<u>Count</u>	<u>Average Per Diem Difference</u>	<u>Sum</u>	<u>Minimum</u>	<u>Maximum</u>
Not For Profit	Favorable	83	0.64	1,665,718	53	85,883
For Profit	Favorable	413	0.78	9,446,620	51	1,052,095
Total		496		11,112,338		
Not For Profit	No Impact	38	0.00	0.00	0.00	0.00
For Profit	No Impact	103	0.00	0.00	0.00	0.00
Total		141		0.00		
Grand Total		637		11,112,338		

Class Analysis – Table 9 – Table 9 indicates that 383 Large (150+115+118) facilities would receive a per diem increase. The average per diem increases range from \$0.68 to \$0.99. The weighted average per diem increase based on the number of Large facilities is \$0.80, with a total increase of \$10.1 million. Small facilities numbering 113 (36+40+37) would receive a per diem increase, ranging from \$0.47 to \$0.73. The weighted average per diem increase based on the number of Small facilities is \$0.61, with a total increase of \$1 million. The remaining 141 facilities are not impacted by the proposed change in the inflation multiplier. The total impact is \$11.1 million.

Table 9
Property FRVS - 1.4 Multiplier Model Class Analysis

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	150	0.68	3,169,273	95	81,180
Central Small	Favorable	36	0.47	237,596	53	20,320
North Large	Favorable	115	0.75	2,721,873	203	84,379
North Small	Favorable	40	0.73	447,959	242	31,638
South Large	Favorable	118	0.99	4,191,506	772	1,052,095
South Small	Favorable	37	0.63	344,131	51	37,566
Total		<u>496</u>		<u>11,112,338</u>		
Central Large	No Impact	28	0.00	0.00	0.00	0.00
Central Small	No Impact	16	0.00	0.00	0.00	0.00
North Large	No Impact	34	0.00	0.00	0.00	0.00
North Small	No Impact	12	0.00	0.00	0.00	0.00
South Large	No Impact	37	0.00	0.00	0.00	0.00
South Small	No Impact	14	0.00	0.00	0.00	0.00
Total		<u>141</u>		<u>0.00</u>		
Grand Total		<u>637</u>		<u>11,112,338</u>		

Eliminate the property component's FRVS 10-10-20 curve that limits increases in the indexed asset value.Component Methodology: Eliminate The FRVS 10-10-20 Curve Component

The 10-10-20 curve limits the amount of inflation applied to the FRVS asset values. Each provider is on a separate cycle based on their entry date into the Medicaid program. During the first 10 years, the provider is on an increasing percentage of inflation in 10 percent increments per year until they reach 100 percent. During the next 10 years, they will receive 100 percent of inflation. Finally during the last 20 years, the provider will receive decreasing percentages of inflation in 5 percent increments until they reach zero. The advantage of this model is that it would simplify the current FRVS reimbursement system and the additional reimbursement would be available to providers to update facility plant and equipment and possibly reduce the frequency of changes in ownership (CHOWs - See Appendix C).

Component Impact: Eliminate The FRVS 10-10-20 Curve**Estimated Annualized Fiscal Impact (Using July 1, 2000 Rates): \$12.6 Million**

Medicaid Utilization Analysis - Table 10 – Table 10 (see table on next page) displays the results of eliminating the FRVS 10-10-20 curve. All tiers received increases in their average per diem and in the aggregate sum. It becomes apparent when comparing this model to the overall combination recommendation and the patient care model that when providers realize an overall decrease in reimbursement in the combination model, it is due to case-mix adjusting the patient care component with this property model, also, helping to close the gap. As a consequence, all property models have favorable effects so the tables have no need to break out the effect separately.

A review of the Medicaid Utilization Table below indicates that the 416 providers have a Medicaid Utilization Rate of 60 percent or above. The average per diem differences by group range from \$0.53 to \$0.96. Using a weighted average by number of providers, the average per diem increase is \$0.79, for a total increase of \$10.9 million. Providers with a Medicaid Utilization Rate between 10 and 59 percent number 215. Their average increase by group ranges from \$0.09 to \$0.58. Using a weighted average by number of providers, the average per diem increase is \$0.45, for a total of \$1.7 million. The 6 providers with a Medicaid Utilization Rate below 10 percent would receive an average per diem increase of \$0.30 for a total increase of \$2,258. This nets to the entire \$12.6 million.

Table 10
Elimination of the Property FRVS Component's
10-10-20 Curve Medicaid Utilization Analysis

Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
90-99%	31	0.53	706,854	0	153,447
80-89%	123	0.96	4,391,832	0	197,294
70-79%	157	0.71	3,589,539	0	244,165
60-69%	105	0.79	2,178,491	0	93,619
50-59%	85	0.58	1,062,075	0	74,275
40-49%	59	0.49	482,168	0	65,343
30-39%	38	0.38	175,674	0	43,298
20-29%	20	0.09	13,919	0	3,650
10-19%	13	0.12	8,035	0	4,546
0-9%	6	0.30	2,258	0	2,224
	<u>637</u>		<u>12,610,845</u>		

Ownership Type Analysis - Table 11 - Table 11 shows an analysis of eliminating the FRVS 10-10-20 curve indicating that 81 Not-For-Profit providers would receive an average per diem increase of \$0.94, with a total increase of \$2.3 million. The remaining 40 Not-For-Profit providers would have no rate impact.

An analysis of For-Profit providers indicates 380 would receive an average per diem increase of \$0.93 for a total increase of \$10.3 million. The remaining 136 For-Profit providers would have no rate impact. The total impact is \$12.6 million.

Table 11
Elimination of the Property FRVS Component's
10-10-20 Curve Ownership Type Analysis

<u>Owner Type</u>	<u>Effect</u>	<u>Count</u>	<u>Average Per Diem Difference</u>	<u>Sum</u>	<u>Minimum</u>	<u>Maximum</u>
Not For Profit	Favorable	81	0.94	2,287,949	34	244,165
For Profit	Favorable	380	0.93	10,322,896	51	153,447
Total		461		12,610,845		
Not For Profit	No Impact	40	0.00	0.00	0.00	0.00
For Profit	No Impact	136	0.00	0.00	0.00	0.00
Total		176		0.00		
Grand Total		<u>637</u>		<u>12,610,845</u>		

Class Analysis – Table 12 – Table 12 indicates that 356 Large (141+108+107) facilities would receive a per diem increase. The average per diem increases range from \$0.86 to \$0.99. The weighted average per diem increase based on the number of Large facilities is \$0.95, with a total increase of \$11.1 million. Small facilities numbering 105 (34+38+33) would receive a per diem increase, ranging from \$0.78 to \$1.01. The weighted average per diem increase based on the number of Small facilities is \$0.88, with a total increase of \$1.5 million. The remaining 176 facilities are not impacted by the proposed elimination of the 10-10-20 curve. The total impact is the \$12.6 million.

Table 12
Elimination of the Property FRVS Component's
10-10-20 Curve Class Analysis

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	141	0.99	4,506,192	372	197,294
Central Small	Favorable	34	0.78	425,239	34	50,538
North Large	Favorable	108	0.99	3,468,253	102	118,865
North Small	Favorable	38	0.89	555,341	182	63,241
South Large	Favorable	107	0.86	3,094,153	182	244,165
South Small	Favorable	33	1.01	561,667	51	77,831
Total		<u>461</u>		<u>12,610,845</u>		
Central Large	No Impact	37	0.00	0.00	0.00	0.00
Central Small	No Impact	18	0.00	0.00	0.00	0.00
North Large	No Impact	41	0.00	0.00	0.00	0.00
North Small	No Impact	14	0.00	0.00	0.00	0.00
South Large	No Impact	48	0.00	0.00	0.00	0.00
South Small	No Impact	18	0.00	0.00	0.00	0.00
Total		<u>176</u>		<u>0.00</u>		
Grand Total		<u>637</u>		<u>12,610,845</u>		

Change the FRVS occupancy rate per the Plan from 90% to the statewide actual mean, currently 87.74%.Component Methodology: Occupancy Rate Change

The occupancy rate in Florida nursing homes has been slowly, but steadily declining. For example in 1988 through 1990, the occupancy rate was approximately 91 percent. At July 1, 2000, the occupancy rate was down to 87.74 percent. In calculating the FRVS per diem the occupancy rate is used as an adjustment factor in the capital component (80 percent of indexed asset value) and equity component (20 percent of indexed asset value). (See Appendix C for a detailed discussion.) The current adjustment factor assumes that a stabilized facility should operate at 90 percent of patient capacity. The advantage of this model is that it uses the current occupancy mean and the occupancy adjustment factor could be revised in subsequent rate semesters to reflect the actual occupancy mean within limitations to be developed. As like the other property component models, there are no unfavorable results for providers reimbursed under this FRVS model.

Component Impact: FRVS Occupancy Rate Change**Estimated Annualized Fiscal Impact (Using July 1, 2000 Rates): \$3.2 Million**

Utilization Analysis – Table 13 – Table 13 (see table on next page) shows the results of adjusting the FRVS occupancy rate to the current mean. All tiers received increases in their average per diem and in the aggregate sum. It becomes apparent when comparing this model to the overall combination recommendation and the patient care model that when providers realize an overall decrease in reimbursement in the combination model, it is due to case-mix adjusting the patient care component with this property model, also, helping to close the gap. As a consequence, all property models have favorable effects so the tables have no need to break out the effect separately.

A review of the Medicaid Utilization Table below indicates that the 416 providers have a Medicaid Utilization Rate of 60 percent or above. The average per diem differences by group range from \$0.16 to \$0.21. Using a weighted average by number of providers, the average per diem increase is \$0.19, for a total increase of \$2.5 million. Providers with a Medicaid Utilization Rate between 10 and 59 percent number 215. Their average increase by group ranges from \$0.19 to \$0.22. Using a weighted average by number of providers, the average per diem increase is \$0.21, for a total of \$0.7 million. The 6 providers with a Medicaid Utilization Rate below 10 percent would receive an average per diem increase of \$0.22 for a total increase of \$1,292. This sums to the entire \$3.2 million.

Table 13
Occupancy Adjustment Rate - Medicaid Utilization Analysis

Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
90-99%	31	0.16	168,436	0	19,256
80-89%	123	0.18	839,012	0	27,286
70-79%	157	0.18	897,220	0	30,835
60-69%	105	0.21	570,327	0	15,317
50-59%	85	0.22	404,605	0	18,984
40-49%	59	0.22	214,383	0	8,911
30-39%	38	0.20	94,161	0	6,567
20-29%	20	0.19	29,376	0	6,621
10-19%	13	0.21	10,668	0	1,788
0-9%	<u>6</u>	0.22	<u>1,292</u>	14	387
	<u>637</u>		<u>3,229,480</u>		

Ownership Type Analysis – Table 14 – Table 14 shows an analysis of adjusting the FRVS occupancy rate indicating that 95 Not-For-Profit providers would receive an average per diem increase of \$0.24, with a total increase of \$0.6 million. The remaining 26 Not-For-Profit providers would have no rate impact.

An analysis of For-Profit providers indicates 414 would receive an average per diem increase of \$0.25 for a total increase of \$2.6 million. The remaining 102 For-Profit providers would have no rate impact. The total impact is the \$3.2 million.

Table 14
Occupancy Adjustment Rate - Ownership Type Analysis

Owner Type	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Not For Profit	Favorable	95	0.24	583,779	14	25,611
For Profit	Favorable	414	0.25	<u>2,645,701</u>	66	30,835
Total		509		<u>3,229,480</u>		
Not For Profit	No Impact	26	0.00	0.00	0.00	0.00
For Profit	No Impact	102	0.00	<u>0.00</u>	0.00	0.00
Total		128		<u>0.00</u>		
Grand Total		<u>637</u>		<u>3,229,480</u>		

Class Analysis - Table 15 – Table 15 (see table on next page) shows an analysis that adjusts the FRVS occupancy rate indicating that 389 Large (154+116+119) facilities would receive a per diem increase. The average per diem increases range from \$0.23 to \$0.26. Due to the small incremental difference in the per diems, no calculation of the weighted average per diem was performed. Large facilities would receive an increase of \$2.9 million in total. Small facilities numbering 120 (38+40+42) would receive a per diem increase, ranging from \$0.21 to \$0.25. Again, no weighted average per diem increase was calculated. Small facilities would receive with a total increase of \$0.3 million. The remaining 128 facilities are not impacted by the proposed adjustment to the occupancy rate. The total impact is the \$3.2 million.

Table 15
Occupancy Adjustment Rate - Class Analysis

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	154	0.23	1,035,548	503	25,611
Central Small	Favorable	38	0.21	93,748	14	6,014
North Large	Favorable	116	0.25	884,030	1,025	20,136
North Small	Favorable	40	0.25	150,893	236	8,299
South Large	Favorable	119	0.26	945,861	188	30,835
South Small	Favorable	42	0.24	119,399	66	8,730
Total		<u>509</u>		<u>3,229,480</u>		
Central Large	No Impact	24	0.00	0.00	0.00	0.00
Central Small	No Impact	14	0.00	0.00	0.00	0.00
North Large	No Impact	33	0.00	0.00	0.00	0.00
North Small	No Impact	12	0.00	0.00	0.00	0.00
South Large	No Impact	36	0.00	0.00	0.00	0.00
South Small	No Impact	9	0.00	0.00	0.00	0.00
Total		<u>128</u>		<u>0.00</u>		
Grand Total		<u>637</u>		<u>3,229,480</u>		

Place all providers on the Fair Rental Value System (FRVS).Component Methodology: Place all providers on FRVS

This recommendation is made in an effort to simplify the property reimbursement methodology and is **only** recommended by the Panel in conjunction with the implementation of all the property recommendations combined. When FRVS was implemented, it was anticipated that in time all providers would be placed on and remain on FRVS. However, based on a Plan revision effective July 1995, some providers receive cost until the hold harmless liability is satisfied. At July 1, 2000, 84 percent of providers were on full FRVS, 10 percent were on payback, and 6 percent were on cost. (See Appendix C for further discussion of the FRVS and cost systems.)

Component Impact: Place All Providers On FRVS**Estimated Annualized Savings (Using July 1, 2000 Rates): \$4.9 million**

The total savings stated above would not be realized due to the increases in the FRVS property component models, all of which result in a fiscal impact, and all of which build upon each other. Although not modeled in combination with the other property models, it is still anticipated that there would be net savings with this model if it were to be incorporated prior to application of the other property recommendations. Additionally, the reimbursement methodology would be simplified if providers were no longer shifting between the two property reimbursement methodologies.

Medicaid Utilization Analysis - Table 16 – Table 16 (see table on next page) shows the results of placing all providers on FRVS, i.e., eliminating the cost methodology for property. A review of Table 16 indicates that the 27 providers would receive per diem increases ranging between \$0.55 to \$4.52, with a total increase of \$1.6 million. Those providers receiving increases would be those currently on payback and receiving less than FRVS. For 559 providers there would be no fiscal impact. For the remaining 85 providers there would be a decrease in their per diem, ranging between \$0.39 to \$3.84, with a total decrease of \$6.5 million. Providers receiving decreases would be those receiving cost which is higher than FRVS and those on payback when FRVS is less than cost. The net impact is a total decrease in projected costs of \$4.9 million.

Table 16
Place all providers on FRVS - Medicaid Utilization Analysis

Effect	Medicaid Utilization	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Favorable	90-99%	2	0.55	38,522	11,297	27,225
Favorable	80-89%	2	1.77	161,795	20,127	141,668
Favorable	70-79%	9	2.05	537,463	4,007	130,103
Favorable	60-69%	8	1.91	427,494	351	120,371
Favorable	50-59%	3	4.52	284,557	46,704	137,239
Favorable	40-49%	2	2.42	113,693	26,864	86,829
Favorable	20-29%	<u>1</u>	2.98	<u>31,916</u>	31,916	31,916
Total		<u>27</u>		<u>1,595,440</u>		
No Impact	90-99%	20	0.00	0.00	0.00	0.00
No Impact	80-89%	103	0.00	0.00	0.00	0.00
No Impact	70-79%	120	0.00	0.00	0.00	0.00
No Impact	60-69%	110	0.00	0.00	0.00	0.00
No Impact	50-59%	76	0.00	0.00	0.00	0.00
No Impact	40-49%	46	0.00	0.00	0.00	0.00
No Impact	30-39%	47	0.00	0.00	0.00	0.00
No Impact	20-29%	18	0.00	0.00	0.00	0.00
No Impact	10-19%	13	0.00	0.00	0.00	0.00
No Impact	0-9%	<u>6</u>	0.00	<u>0.00</u>	0.00	0.00
Total		<u>559</u>		<u>0.00</u>		
Unfavorable	90-99%	8	-3.27	-1,013,124	-12,417	-325,032
Unfavorable	80-89%	18	-2.75	-1,899,940	-944	-315,601
Unfavorable	70-79%	28	-2.18	-1,829,228	-8,420	-177,390
Unfavorable	60-69%	9	-1.59	-365,117	-12,419	-69,656
Unfavorable	50-59%	8	-3.84	-834,255	-5,402	-176,090
Unfavorable	40-49%	10	-2.62	-498,574	-6,240	-109,957
Unfavorable	30-39%	3	-1.83	-63,875	-15,454	-31,205
Unfavorable	20-29%	<u>1</u>	-0.39	<u>-1,915</u>	-1,915	-1,915
Total		<u>85</u>		<u>-6,506,028</u>		
Grand Total		<u>671</u>		<u>-4,910,588</u>		

Ownership Type Analysis – Table 17 - Table 17 shows an analysis that places all providers on FRVS indicating 5 Not-For-Profit providers would receive an average per diem increase of \$1.45, totaling \$0.2 million. There would be no fiscal impact for 95 Not-For-Profit providers. The remaining 12 Not-For-Profit providers would receive an average per diem decrease of \$2.51, with a total decrease of \$1.1 million. The net impact on Not-For-Profit providers is a decrease of \$0.9 million.

An analysis of For-Profit providers indicates 22 receive an average per diem increase of \$2.39, totaling \$1.4 million. There would be no impact for 464 For-Profit providers. The remaining 73 For-Profit providers would receive an average per diem decrease of \$2.52, with a total decrease of \$5.4 million. The net impact on For-Profit providers is a decrease of \$4 million. In total, Not-For-Profit and For-Profit sum to a decrease of \$4.9 million.

Table 17**Place all providers on FRVS - Ownership Type Analysis**

<u>Owner Type</u>	<u>Effect</u>	<u>Count</u>	<u>Average Per Diem Difference</u>	<u>Sum</u>	<u>Minimum</u>	<u>Maximum</u>
Not For Profit	Favorable	5	1.45	172,817	4,007	70,004
For Profit	Favorable	22	2.39	1,422,622	351	141,668
Total		27		1,595,440		
Not For Profit	No Impact	95	0.00	0.00	0.00	0.00
For Profit	No Impact	464	0.00	0.00	0.00	0.00
Total		559		0.00		
Not For Profit	Unfavorable	12	-2.51	-1,146,706	-1,915	-234,436
For Profit	Unfavorable	73	-2.52	-5,359,322	-944	-325,032
Total		85		-6,506,028		
Grand Total		<u>671</u>		<u>-4,910,588</u>		

Class Analysis –Table 18 – Table 18 shows an analysis that places all providers on FRVS and indicates that 23 Large (6+5+12) facilities would receive a per diem increase. The average per diem increases range from \$2.09 to \$2.59, totaling \$1.5 million. Due to the small numbers of facilities affected, no calculation of the weighted average per diem was performed. A total of 68 Large providers (18+26+24) providers would receive a per diem decrease. The average per diem decreases range from \$2.00 to \$3.45, totalling \$6 million. The overall impact on Large providers would be a net decrease of \$4.5 million.

Small facilities numbering four (2+2) would receive a per diem increase, ranging from \$0.83 to \$0.1.99, totaling \$0.1 million. Again, no weighted average per diem increase was calculated. A total of 17 (6+6+5) Small providers would receive a per diem decrease. The average per diem decreases range from \$1.06 to \$2.36, totaling \$0.5 million. The overall impact on Small providers would be a decrease of \$0.4 million. There would be no fiscal impact on 559 providers. Total net impact is a decrease of \$4.9 million.

Table 18
Place all providers on FRVS - Class Analysis

Class	Effect	Count	Average Per Diem Difference	Sum	Minimum	Maximum
Central Large	Favorable	6	2.10	282,709	351	100,614
Central Small	Favorable	2	1.99	77,245	10,208	67,037
North Large	Favorable	5	2.09	319,711	11,297	105,007
South Large	Favorable	12	2.59	870,213	1,717	141,668
South Small	Favorable	<u>2</u>	0.83	<u>45,560</u>	18,336	27,225
Total		<u>27</u>		<u>1,595,440</u>		
Central Large	No Impact	170	0.00	0.00	0.00	0.00
Central Small	No Impact	51	0.00	0.00	0.00	0.00
North Large	No Impact	116	0.00	0.00	0.00	0.00
North Small	No Impact	49	0.00	0.00	0.00	0.00
South Large	No Impact	127	0.00	0.00	0.00	0.00
South Small	No Impact	<u>46</u>	0.00	<u>0.00</u>	0.00	0.00
Total		<u>559</u>		<u>0.00</u>		
Central Large	Unfavorable	18	-3.45	-1,813,068	-10,003	-315,601
Central Small	Unfavorable	6	-2.05	-218,155	-944	-96,676
North Large	Unfavorable	26	-2.82	-2,552,219	-8,420	-325,032
North Small	Unfavorable	6	-1.06	-123,238	-1,517	-32,465
South Large	Unfavorable	24	-2.00	-1,626,242	-5,402	-234,436
South Small	Unfavorable	<u>5</u>	-2.36	<u>-173,105</u>	-1,915	-67,381
Total		<u>85</u>		<u>-6,506,028</u>		
Grand Total		<u>671</u>		<u>-4,910,588</u>		

Appendices

Appendix A.....Panel Authorizing Legislation
Appendix B.....Panel Members
Appendix C.....Current Medicaid Nursing Home Reimbursement
Appendix D.....Florida Compared Nationally
Appendix E.....Staffing in Nursing Homes—Summary of Data and Research
Appendix F.....Recruitment and Retention in Nursing Facilities
Appendix G.....CNA Satisfaction Survey
Appendix H.....Michigan Wage-Pass Through
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Appendix K.....Additional Points of Discussion
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Legislative Direction**House Bill 1971, Section 27. Panel on Medicaid Reimbursement.**

- (1) There is created a panel on Medicaid reimbursement to study the state's Medicaid reimbursement plan for nursing home facilities and recommend changes to accomplish the following goals:
 - (a) Increase the rate of employee retention in individual nursing home facilities and in the field of long-term care, and ensure salary enhancements for staff who achieve targets of longevity with a nursing home facility.
 - (b) Create incentives for facilities to renovate and update existing physical plants, when practicable, instead of building new facilities or selling to another entity.
 - (c) Create incentives for facilities to provide more direct-care staff and nurses.

- (2) The panel shall be administratively attached to and supported by the Agency for Health Care Administration and shall be composed of the following members: the Director for Medicaid of the Agency for Health Care Administration and two Agency staff persons competent in the technical and policy aspects of Medicaid reimbursement; one representative from the Governor's Office of Planning and Budgeting; one representative from the Florida Association of Homes for the Aging; one representative from the Florida Health Care Association; one representative from the Department of Elder Affairs, and one consumer representative appointed by the secretary of that department; and a consumer's advocate for senior citizens and two persons with expertise in the field of quality management, financing, or public sector accountability, appointed by the Governor.

- (3) The panel shall hold its first meeting by August 1, 1999, and shall report its preliminary findings and recommendations to the Legislature no later than December 31, 1999, by submitting a copy of its report to the President of the Senate, the Speaker of the House of Representatives, and the majority and minority offices of each chamber. The panel shall report its final findings and recommendations to those persons and offices no later than December 8, 2000. The panel shall cease to exist and its operation shall terminate on January 1, 2001.

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Additionally, there were several interested individuals from the private sector and from state agencies who participated in the discussions and presented materials to the Panel for consideration.

Current Florida Medicaid Nursing Home Reimbursement System

As of July 1, 2000, there were 648 nursing homes participating in the Florida Medicaid program. These nursing homes account for a total of 79,334 beds, which is an average of 123 beds per facility. These same facilities account for 25,401,001 patient days a year, of which 16,475,089 (64.86%) 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 87.74 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 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 three 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 September 30 and March 31, 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, 2000, range from \$89.16 to \$147.83. The average Medicaid per diem is \$116.02. The latest estimated total Medicaid expenditures for nursing homes during the current state fiscal year (2000-2001) is \$1.6 billion. A history of Florida Medicaid nursing home expenditures since the inception of the program is provided in a table on page 6 of this section.

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

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

The operating component includes administration, laundry and linen, plant operations, and house keeping 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, 2000 is as follows:

Class	Location	# of Homes
Class 1	North/Small	55
Class 2	North/Large	148
Class 3	South/Small	51
Class 4	South/Large	158
Class 5	Central/Small	55
Class 6	Central/Large	181

The operating and patient care cost based class ceilings are calculated using inflated 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. 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 yet 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 1998-99 Appropriations Act provided funding for the phase-in of a case-mix reimbursement methodology. The case-mix adjustment is based on a resident classification system that recognizes patient acuity levels. The resident specific information is from the Minimum Data Set (MDS) assessments. The Resource Utilization Group (RUGS III Grouper) determines a RUGS III score for each Medicaid resident. An average case-mix score is then calculated for each nursing facility and statewide. The case-mix adjustment to the per diem is calculated by first dividing the total appropriation for case-mix by Medicaid patient days. The resulting case-mix add-ons are adjusted based on the relationship of each facility's average case-mix to the facility statewide average case-mix. For the rate period beginning on April 1, 1999, through June 30, 1999, and for rate periods beginning on or after July 1, 1999, a case-mix adjustment was calculated and paid as an add-on to the patient care component of the per diem rate. The case-mix adjustments for the July 1, 2000, rate semester ranged from \$0.72 to \$4.75 per Medicaid patient day and the average was \$2.42.

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.

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 case-mix adjustment, and the direct care staffing adjustment (DCSA).

- ◆ cost based class ceiling,
- ◆ target rate class ceiling,
- ◆ facility specific rate,
- ◆ facility specific target rate, or
- ◆ 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 complex 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-throughs. 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, 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 and property insurance. 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

Supplemental payments are available to providers who receive pre-approval for the additional expenses associated with the care provided to AIDS patients and Medically Fragile Patients Under Age 21. These supplemental payments are in addition to the facility's normal per diem. Effective July 1, 2000, the supplemental payment rates are \$106.75 per Medicaid day for AIDS patients and \$192.41 per Medicaid day for Medically Fragile Patients Under Age 21.

Providers may apply for a special rate calculation between normal rate semesters (a component interim rate), if their costs increase in an allowable manner and if the amount of change in costs meets specific guidelines. Other changes in per diem rates from one semester to the next may result from:

- ◆ use of more current cost reports;
- ◆ changes in reimbursement ceilings;
- ◆ changes in inflation; and
- ◆ audits of cost reports.

History of Florida Nursing Home Reimbursement

ALL LEVELS OF NURSING HOME CARE								
FISCAL YEAR	TOTAL COST MEDICAID NURSING HOME	% INCREASE FROM PREVIOUS YEAR	AVERAGE MONTHLY CASELOAD	% INCREASE FROM PREVIOUS YEAR	AVERAGE UNIT COST	TOTAL MEDICAID DAYS	AVERAGE MEDICAID PAYMENT PER DAY	% INCREASE FROM PREVIOUS YEAR
2000-01 (1)	\$1,660,259,419	7%	46,921	0%	\$2,948.68	17,126,165	\$96.94	7%
1999-00 (1)	\$1,551,225,276	11%	46,921	1%	\$2,755.03	17,173,086	\$90.33	10%
1998-99	\$1,393,357,698	5%	46,415	-0.5%	\$2,501.63	16,941,475	\$82.25	5%
1997-98	\$1,329,864,014	7%	46,639	1%	\$2,376.17	17,023,235	\$78.12	6%
1996-97	\$1,241,232,796	4%	46,312	2%	\$2,233.46	16,903,880	\$73.43	3%
1995-96	\$1,194,738,895	8%	45,573	2%	\$2,184.66	16,634,145	\$71.63	5%
1994-95	\$1,110,158,488	6%	44,582	2%	\$2,075.12	16,272,430	\$68.22	4%
1993-94	\$1,043,439,021	6%	43,513	2%	\$1,998.33	15,882,245	\$65.70	3%
1992-93	\$987,290,516	15%	42,541	4%	\$1,934.00	15,527,465	\$63.58	12%
1991-92	\$855,278,015	13%	40,980	5%	\$1,739.22	14,998,680	\$57.02	7%
1990-91	\$758,982,651	23%	38,952	8%	\$1,623.76	14,217,480	\$53.38	14%
1989-90	\$616,298,806	13%	35,999	9%	\$1,426.66	13,139,635	\$46.90	4%
1988-89	\$543,460,728	10%	33,040	4%	\$1,370.71	12,059,600	\$45.06	6%
1987-88	\$493,762,150	19%	31,698	9%	\$1,298.09	11,601,468	\$42.56	9%
1986-87	\$415,645,051	17%	29,112	9%	\$1,189.79	10,625,880	\$39.12	8%
1985-86	\$354,878,544	17%	26,776	8%	\$1,104.47	9,773,240	\$36.31	8%
1984-85	\$304,504,726	19%	24,763	8%	\$1,024.73	9,038,495	\$33.69	11%
1983-84	\$256,112,509	27%	22,985	6%	\$928.55	8,412,510	\$30.44	19%
1982-83	\$200,938,757	14%	21,587	3%	\$775.69	7,879,255	\$25.50	10%
1981-82	\$176,912,290	13%	20,918	5%	\$704.78	7,635,070	\$23.17	8%
1980-81	\$156,651,906	18%	19,970	5%	\$653.70	7,289,050	\$21.49	12%
1979-80	\$132,873,094	20%	18,958	7%	\$584.07	6,938,628	\$19.15	12%
1978-79	\$111,016,820		17,755		\$521.06	6,480,575	\$17.13	

(1) November 9, 2000 Social Services Estimating Conference

CHANGES IN FUNDING FOR MEDICAID NURSING HOME SERVICES

FUNDING REDUCTIONS:

Fiscal Year	Reduction Issue	Reduction Amount
1989-90	Eliminate Price Level Increases 1/1/90	\$29,094,657
1991-92	Place Limit on New Nursing Home Rates	\$10,003,835
1991-92	Further Modify Nursing Home Rates in Special Session	\$31,533,873
1992-93	Annualize the 1991-92 Reduction	\$20,000,000
1995-96	Eliminate Pressure Ulcer Therapy Program	\$6,091,137
1995-96	Reduce Nursing Home Incentive Payments	\$13,574,661
1996-97	Nursing Home Reimbursement Reforms	\$16,964,488
	TOTAL REDUCTION AMOUNT	\$127,262,651

FUNDING DIVERSIONS FROM NURSING HOME SERVICES:

Fiscal Year	Reduction Issue	Reduction Amount
1997-98	Reduce Nursing Home Funding-Diversion Waiver	\$23,505,907
1998-99	Reduce Nursing Home Funding-Diversion Waiver	\$11,314,777
1999-2000	Reduce Nursing Home Funding-Diversion Waiver	\$27,656,142
	TOTAL DIVERSION AMOUNT	\$62,476,826

FUNDING ENHANCEMENTS:

Fiscal Year	Enhancement Issue	Amount
1998-99	Case Mix Adjustment	\$40,445,034
1999-2000	Partial Re-basing of Patient Care Targets	\$18,103,644
	TOTAL ENHANCEMENTS	\$58,548,678

FUNDING ENHANCEMENTS (REQUIRING NEW SPENDING):

Fiscal Year	Enhancement Issue	Amount
1999-2000	Recruitment and Retention of Direct Care Staff	\$31,681,376

Florida Compared Nationally

Recent nursing facility data shown in the charts that follow compare Florida to most other states in the nation. Five other states reporting have more nursing facilities and more nursing home beds than the state of Florida. Among these states, the average number of facilities is 344; the average number of beds is 35,555; and, the average occupancy rate is 91 percent. Florida has a higher than average number of facilities and beds, but a lower than average occupancy rate.

1998-1999 Number of Nursing Facilities and Beds

STATE	HOMES	BEDS	OCCUP. RATE	STATE	HOMES	BEDS	OCCUP. RATE
Alabama	232	25,776	93%	Nevada	29	3,777	88%
Alaska	15	720	82%	New Hampshire	83	8,157	96%
Arizona	167	17,907	N/A	New Jersey	355	49,841	90%
Arkansas	238	27,960	84%	New Mexico	76	7,638	90%
Colorado	189	18,283	87%	New York	681	116,660	97%
Connecticut	265	32,078	96%	North Carolina	420	40,500	94%
Delaware	45	4,800	88%	North Dakota	88	7,020	96%
Florida	676	82,820	88%	Ohio	1,439	119,142	87%
Georgia	375	39,879	95%	Pennsylvania	824	97,977	N/A
Hawaii	46	3,948	93%	Rhode Island	106	10,878	94%
Illinois	1,249	112,400	82%	South Carolina	193	18,406	93%
Iowa	431	34,191	95%	Tennessee	362	39,659	95%
Kansas	490	31,651	85%	Texas	1,161	126,969	80%
Kentucky	422	26,478	99%	Vermont	48	3,848	92%
Maine	133	9,099	87%	Virginia	265	30,326	93%
Maryland	272	30,761	92%	Washington	289	27,561	84%
Michigan	447	51,751	92%	Washington D. C.	23	3,124	96%
Minnesota	441	46,243	94%	West Virginia	105	9,836	96%
Mississippi	178	16,914	98%	Wisconsin	471	53,059	90%
Missouri	631	59,000	83%	Wyoming	37	3,092	82%
Montana	108	7,609	84%				

Source for Table 1 and Figures 1 and 2: HCIA 1998-1999, *Guide to the Nursing Home Industry*.

Data for the following states were not available: California, Indiana, Massachusetts, Louisiana, Oregon, Idaho, South Dakota, Utah, Nebraska and Oklahoma.

Figure 1: States with the Highest Number of Nursing Homes

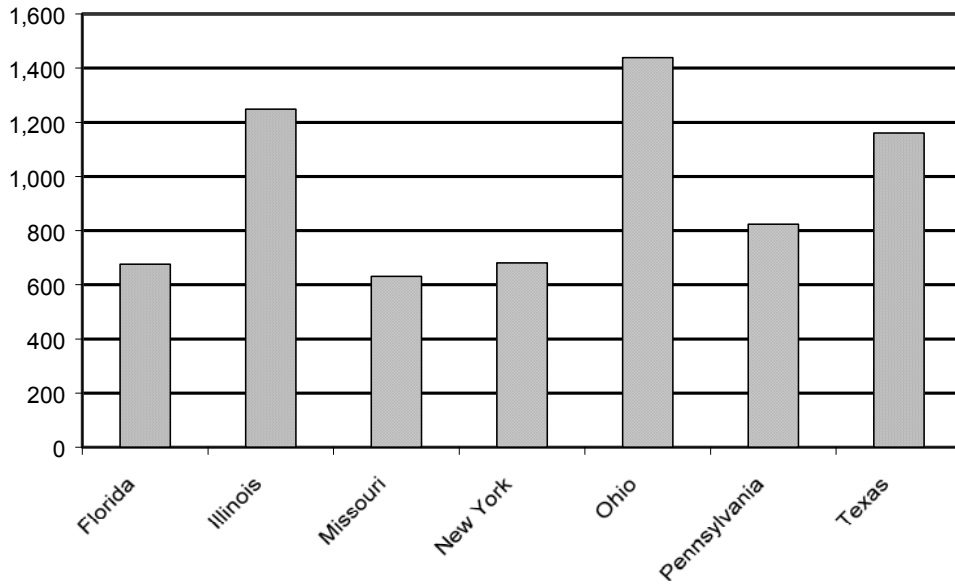
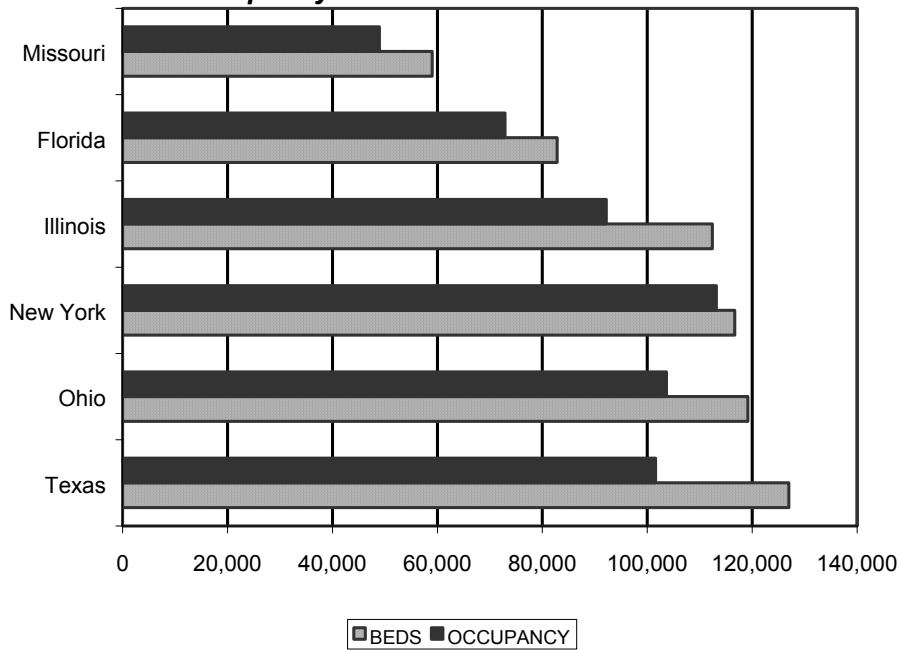


Figure 2: States with Highest Number of Beds and Their Occupancy Rate



Staffing in Nursing Homes

Summary of Data and Research by Robbie Roberts, Ph.D., Agency for Health Care Administration.

The quality of care in nursing homes has concerned health care professionals, policy makers and consumers for a number of years. In response to expressed concerns, Congress and state legislatures have authorized numerous studies of the status of nursing homes. These studies have consistently confirmed that there is a positive relationship between nursing staff level and quality of nursing care, indicating a strong need to increase the overall level of nursing staff in nursing homes.

There is strong evidence to suggest quality-of-care issues are closely associated with staffing patterns in nursing homes. Florida, with the sixth largest number of nursing home facilities in the country, is especially sensitive to these issues. Joining forces with national efforts, Florida is aggressively working to address growing concerns for the health and safety of nursing home residents. The 1999 Florida Legislature assisted through enactment of sweeping nursing home reforms, including nursing home legislation that mandates the adoption of rules for minimum staffing requirements.

In light of these findings, this panel requested a focused analysis related to staffing in nursing homes. Florida data are compared with data from eleven states—California, Connecticut, Georgia, Illinois, Kansas, Michigan, New York, Ohio, Pennsylvania, Texas and Virginia.

Table 2 compares the growth of the nursing home industry between 1991 and 1998 of the selected states and gives the ranking of the selected states in relationship to the entire United States and the District of Columbia.

Table 1
Total Number of Certified Nursing Facilities in the U. S.
Selected States by Calendar Year

State	1991	1992	1993	1994	1995	1996	1997	1997 Rank*
California	843	1,126	1,138	1,295	1,252	1,311	1,298	1
Connecticut	155	220	243	255	251	228	253	25
Georgia	225	325	339	338	353	353	299	20
Florida	356	526	572	616	569	586	620	6
Illinois	559	741	764	772	832	838	837	4
Kansas	273	391	417	361	390	354	368	17
Michigan	264	404	380	412	366	411	406	12
New York	391	538	524	609	547	558	532	9
Ohio	667	906	846	875	884	973	918	3
Pennsylvania	470	644	628	710	640	722	775	5
Texas	825	1,062	883	1,185	1,109	1,198	1,175	2
Virginia	174	240	244	263	238	252	237	26
United States	10,562	14,501	14,226	15,288	15,182	15,603	15,661	

* US and District of Columbia

Source: Harrington, C., Carrillo, H., Thollaug, S. & Summers, P., *Nursing Facilities, Staffing, Residents, and Facilities Deficiencies, 1991 through 1998*, University of California San Francisco, January 1997.

Nursing home data generated from the Health Care Financing Administration's (HCFA) On-line, Certification, and Reporting System (OSCAR) for 1991 through 1997 revealed a somewhat mixed picture of progress for Florida, as well as other states, during this period. Nationally, as well as in Florida, states increased registered nursing hours while licensed practical/vocational nurses and assistant hours have remained largely unchanged. Nursing assistants continue to provide the largest portion of total hours of care.

In line with this trend, deficiency citations relating to nursing services—sufficient nursing staff and RN staff—declined significantly from 1991 to 1997. In fact, no deficiency citations relating to nursing services have appeared among the top ten deficiencies, nationally, over the past several years. There was wide variation, however, among the selected states concerning "Sufficient Nursing Staff." Six states followed the national trend, reducing the percentage of deficiencies. Six states, including Florida, reversed the national trend, with increases in the percent of deficiencies. Moreover, in 1997, Florida had the third highest percentage of deficiencies among all the states and District of Columbia, with 10.8 percent. This was an increase from 3.7 percent in 1991—an indication much work remains.

Trends from deficiency citations, overall, present a similar picture as the average number of deficiencies per facility has clearly trended lower during the six-year period and the percent of facilities with no deficiencies increased. For most of the states, there was either a decline in the average number of deficiencies accompanied by an increase in the percent of facilities with no deficiencies, or an increase in the average number of

deficiencies per facility accompanied by a decrease in the percentage of facilities with no deficiencies. California, New York and Florida, however, declined in both areas, indicating more facilities are being cited for deficiencies, but each facility cited is having fewer citations, overall. One possible explanation is recent pressure for nursing facilities to improve the quality of care and, simultaneously, implementation of more rapid response system to complaints.

Table 2
Average Number of Deficiencies Per Certified Nursing Facility and
Percent of Facilities with No Deficiencies
Selected States—1991 and 1997 Comparisons

State	Average Number Deficiencies Per Facility			Percent of Facilities with No Deficiencies						
	1991	1997	% Inc/Dec	1991	1992	1993	1994	1995	1996	1997
California	14.2	10.7	-24.6	4.4	2.8	2.4	1.2	3.3	4.0	3.0
Connecticut	7.6	2.1	-72.4	3.9	13.6	13.6	18.0	37.1	46.5	33.6
Florida	7.7	6.4	-16.9	14.9	16.2	16.4	10.9	10.5	15.2	11.0
Georgia	9.8	2.6	-73.5	6.2	12.0	15.6	14.8	17.3	34.3	32.1
Illinois	9.5	6.0	-36.8	3.0	3.9	5.1	4.0	5.5	9.0	6.9
Kansas	13.4	5.5	-59.0	0.4	1.0	4.6	8.6	5.4	11.3	11.4
Michigan	16.0	8.6	-46.3	1.5	1.2	1.0	0.7	1.4	3.7	2.7
New York	2.8	2.2	-21.4	36.3	36.4	31.9	31.5	27.6	31.4	35.3
Ohio	6.6	4.0	-39.4	10.9	22.6	8.4	7.1	10.6	17.2	22.2
Pennsylvania	7.1	3.2	-54.9	11.9	14.0	12.9	11.6	21.4	27.8	25.0
Texas	12.2	4.2	-65.6	1.5	3.3	4.9	9.5	14.2	23.2	23.2
Virginia	1.6	3.1	93.8	50.0	40.8	21.7	24.7	27.3	35.7	36.3
United States *	8.8	4.9	-44.3	10.8	12.4	11.4	12.6	15.2	20.8	21.6

* US and District of Columbia

Source: Harrington, C., Carrillo, H., Thollaug, S. & Summers, P., *Nursing Facilities, Staffing, Residents, and Facilities Deficiencies, 1991 through 1998*, University of California San Francisco, January 1997.

Recruitment and Retention in Nursing Facilities

Presented by David Sylvester, V. P., Long-Term Care at Health Central Park, presentation to the Panel, September 1999.

Long-term care work is a profession of choosing and requires special dedication. Research indicates that the majority of the staff who works in long-term care choose their profession in order to provide care for the nursing home residents. This research also shows that in large part, there is less loyalty to the facility and more loyalty shown to the residents by many direct-care staff members. In order for staff to maintain morale and continue to work in long-term care, they require positive support from the facility management, as well as, residents and their families. Long-term care work also allows licensed nursing professionals to use the assessment and intervention skills learned in training, which helps create job satisfaction. In other words, long-term care workers have special qualities, not just a set of skills.

There are many obstacles in the recruitment and retention of long-term care workers. Some of the hurdles are monetary in nature.

- ◆ Nationally, the unemployment rate is at an all time low. While this is good news for the economy, it makes recruiting and retaining employees much more difficult. In parts of Florida the unemployment rate for service related jobs is even lower. These factors combine to create competition for staff and drive up the hourly rate.
- ◆ Facilities have become their own worst enemy by trying to lure staff with sign-on bonuses. This practice tends to make staff disloyal and inclined to move on to the next facility. Retention of experienced employees becomes more difficult.
- ◆ Even facilities that offer better benefit packages will lose employees to facilities that offer the higher hourly rates.
- ◆ Medicare's Prospective Payment System (PPS) has caused facilities to tighten staffing patterns.

In addition to dealing with the monetary issues, facilities must face a growing number of non-financial hurdles in order to recruit and retain qualified staff. Whether real or perceived, there seems to be a lack of respect for those who choose a long-term care profession. The resulting lowered morale leaves those employees feeling unappreciated—with no value. This low morale can manifest itself in a variety of ways including a lack of involvement or an inability to work together as a team. When any employee feels that their hard work is not acknowledged or appreciated, the results can spell disaster. Employees also cite childcare concerns and family responsibilities as reasons for job dissatisfaction. It is incumbent on management to maintain open communication so that a more positive environment can be ensured.

In addition, many things outside the control of the facility create non-financial hurdles for staff recruitment and retention. The ability of nursing facilities to retain employees is affected by increases in documentation requirements, training standards and a more

involved survey. Added to these barriers are frequent lawsuits and the bad press that inevitably follows. The state has a stake in the public perception of long-term care.

The turnover of staff in a nursing facility is high. Resources are needed to provide orientation to the facility as well as new employee processing. Time is required for new employees to learn the routines, which can create a loss of productivity and continuity of care provided to the residents. The industry average turnover rate exceeds 125 percent. At Health Central Park, the turnover rate is more than 60 percent.

The situations all combine to provide a unique challenge in nursing facilities. Facilities must pay for better care now or pay for lawsuits later that may result.

In order to address these concerns, the following recommendations are made.

- ◆ Increase reimbursement for direct nursing care costs.
- ◆ Provide maximum flexibility to facility operators to expend these additional staffing dollars.
- ◆ Consider counting Nursing Assistants and Certified Nursing Assistants in training in the overall-staffing pattern.
- ◆ Provider incentives for retention of staff as measured by reduction of turnover rates.
- ◆ Work with industry to improve perception of long-term care facilities.
- ◆ Expedite background and abuse checks.
- ◆ Career paths for workers.
- ◆ Incentives for staffing special care units.
- ◆ Additional incentives for education and training.
- ◆ Increase utilization of technology.
- ◆ Consider incentives for physician extenders
 - ◆ Geriatric Nurse Practitioners
 - ◆ Physician Assistants.
- ◆ Consider incentives for on-site child care programs.
- ◆ Consider approval of proposed staffing patterns.
- ◆ The nursing home community's "Eden Alternative" is a plan that would:
 - ◆ Decrease turnover
 - ◆ Involve staff in self scheduling
 - ◆ Decrease medication usage
 - ◆ Increase satisfaction of all stakeholders.

CNA Satisfaction Survey—A Facility Case Study

Mount Sinai—St. Francis Nursing and Rehabilitation Center conducted a satisfaction survey among the CNAs on staff.

Of the CNAs that responded, most were pleased with their job and relationship with their supervisor. The majority responded that they work at this particular facility because of the reputation of the facility.

Mount Sinai—St. Francis reports a 5 percent CNA turnover rate. The following positive management practices are in force at this facility:

- (a) A labor consultant visits the facility monthly to talk with employees. He brings problems to management's attention so that they may be resolved in a timely manner. Often, employees are more comfortable talking to him than to management. Assures a good line of communication.
- (b) Periodically, the Director of Nursing (DON) will review wages of CNAs to assure that they are being paid fairly in relation to their peers. Where appropriate, an adjustment is made. This is done automatically, without request by the CNAs.
- (c) Monthly, an Employee of the Month is chosen. This individual receives recognition, a certificate, \$75.00, a month's worth of meal tickets, and a preferred parking space. This individual is then eligible for Employee of the Year—\$150.00.
- (d) During the year, our Pastoral Care Department raises money for employee gifts. At Christmas, every employee receives a gift.
- (e) At Thanksgiving, every employee receives a turkey.
- (f) Monthly, the Executive Director holds a general staff meeting with employees. He communicates with them everything that is going on in the building, dispels rumors and fields employee questions—good communication. For example, at one meeting, the CNAs mentioned that we only had two VanderLifts for three units and thought we should have one for each unit. Within two weeks, we had a third VanderLift—\$6,000.
- (g) Every Wednesday, the facility makes popcorn in its industrial popcorn maker.
- (h) In preparation for JCAHO, employees were quizzed on JCAHO questions. Employees received from \$1.00 to \$20.00 for each question answered correctly.
- (i) Monthly, the facility directors have a 7:00 a.m. breakfast with the 11 p.m.—7 a.m. shift. They are told what is going on in the building and the directors are available to resolve any issues. This way, the staff does not feel like the "forgotten shift."
- (j) At least three times a year, a facility party is held for the staff. The directors serve the staff and take care of the clean up.
- (k) Always have a celebration for CNA Week.
- (l) One weekend, the CNAs were short-staffed and worked especially hard. Each one of them received a letter of thanks and a gift certificate.
- (m) Last year, our health insurer increased employee premiums by approximately 20 percent. The facility absorbed the entire increase in premiums.
- (n) The Executive Director maintains an open-door policy. Any employee may speak with him about any issue.
- (o) For the facility anniversary party last year, a contest was held to design the logo for the anniversary T-shirt. The employee who designed the winning logo received a gift certificate.

Michigan Wage-Pass Through—A Policy Proposal

In the 1998-1999 budget year, Michigan instituted a wage pass-through program for long-term care providers. Although several states have recently initiated wage pass-through programs, Michigan's is the longest running and most successful to date. The emphasis of this policy is employee retention. Under this plan, providers are paid a wage pass-through outside the prospective rate. There is recognition of base wage and new benefit increase up to \$0.75 per employee hour. The program has been continued in Michigan for the 1999-2000 budget year.

A maximum of \$0.75 per hour inclusive of wages, new benefits and new associated costs is allowed for the pass-through. The reimbursement limit is to be applied on a per-employee basis. The actual cost reporting for wage pass-through must reflect actual wages, new benefit costs and associated payroll costs.

All nursing facility employees are eligible for wage increases resulting in pass-through except for the following: home office, contract, pool or other temporary staff; home office staff serving as consultants to facilities; and temporary managers or monitors appointed by the state under the enforcement system.

In order to be eligible for inclusion in the wage pass-through, there must be an increase in the wage or benefit structure. Bonuses or other temporary increases in wages or benefits are not eligible. New benefits that are eligible are health insurance for the first time or improving an existing package, permanent changes in longevity payments, increases due to the cost of additional paid leave time (sick, vacation or personal time) and adding quality of life benefits such as day care services. Benefit costs increases that are not eligible for pass-through reimbursement are increased cost of providing existing benefits, increased premiums for an existing health care insurance program and temporary increases in longevity payments.

Providers being paid a per diem rate that includes the wage pass-through allowance must pay the facility employees the increased wage levels immediately upon issuance of the increased rate and payment processing of the rate on the Medicaid payment system. Michigan also has a very stringent monitoring system to ensure compliance with program requirements.

Iowa Caregiver Association—Excerpts from a Study

CERTIFIED NURSING ASSISTANT (CNA)—RECRUITMENT AND RETENTION PILOT PROJECT CONCLUSIONS AND RECOMMENDATIONS—FOR SERVICE PROVIDERS AND OTHERS

Conclusion 1	Short staffing along with compensation and benefits appear from this study to be the main reasons CNAs quit their jobs. Better staffing and compensation/benefits are also the two main things CNAs indicate they need to do their job better. In addition, likelihood of injury appears related to staffing.
Recommendation 1	Make staffing, compensation, and benefits priority issues while simultaneously addressing other key issues raised by this research.
Conclusion 2	A majority of CNAs in this study indicates that at the time they interviewed for their current job, they got the impression that the job they would be doing was important and valued.
Recommendation 2	Continue to support the value of CNAs' work during the initial interview and throughout their employment.
Conclusion 3	Lack of solicitation of and appreciation for CNAs' input regarding such important areas as resident/patient care and organization of the daily work appear in several areas of this study as factors contributing to dissatisfaction.
Recommendation 3	Find ways to solicit, use, and express appreciation for the input provided by CNAs regarding resident/patient care and organization of the work itself (including scheduling). See also Recommendation 5.2.
Conclusion 4	Injuries, particularly back injuries, are a main reason CNAs in this study have left the profession entirely. A proportion of working CNAs also have to take time off due to back injuries.
Recommendation 4.1	Address short staffing, as it does appear from this study that at least some of the injuries are related to this.
Recommendation 4.2	Consider other ways such as education and training and the provision of appropriate equipment as a way of reducing injuries.
Conclusion 5	Almost one-fourth of CNAs in this study indicate they do not have sufficient supplies and equipment to do a good job. Location of supplies and equipment also appears to be an issue for many CNAs.
Recommendation 5.1	Assure CNAs have the supplies and equipment they need to provide good resident/patient care.
Recommendation 5.2	Consult with CNAs regarding the location of supplies and equipment so that CNAs can be as efficient as possible.
Conclusion 6	Relationship with supervisor appears from this study to be a key factor in retention of CNAs. Role modeling by the administrator also appears to be a factor, e.g. administrator demonstrating by what she/he says and does that she/he expects excellent care.
Recommendation 6	Identify and implement creative ways to improve both supervisory and administrative relationships with CNAs.

Labor Market Information—Presented by the Department of Elder Affairs

Data was gathered from the Department of Labor and Employment Security, Bureau of Labor Market and Performance regarding the growth of health care occupation in Florida, projections for growth to the year 2006, average wages for health care occupations and most common occupations in nursing homes in Florida.

Health care occupations in Florida are among the top one hundred fastest growing jobs. The following chart shows the growth ranking for common health care occupations, their growth rate and average current hourly rate of pay.

Table 1
Health Care Occupations in Florida

Rank	Occupational Title	Growth Rate*	Job Growth*	Average Hourly Rate**
3	Physical, Corrective Therapy Assistant	86.20	3,997	\$11.68
5	Home Health Aide	79.97	23,182	\$8.07
6	Medical Assistant	75.57	10,842	\$10.05
7	Physical Therapist	69.16	4,719	\$26.05
8	Emergency Medical Technician	68.21	5,433	\$10.60
10	Respiratory Therapist	63.28	4,076	\$16.43
11	Medical Records Technician	60.63	3,607	\$9.28
12	Personal and Home Care Aide	58.70	2,645	\$7.64
13	Radiologic Technologist	56.53	2,653	\$15.13
19	Dental Hygienist	48.49	3,626	\$19.52
32	Dental Assistant	38.53	4,576	\$11.06
41	Medicine and Health Service Manager	35.86	4,040	\$23.77
42	Medical Secretary	35.25	5,683	\$10.27
52	Medical/Clinical Laboratory Technician	32.63	2,020	\$11.92
53	Radiologic Technician	32.22	2,593	not available
62	Registered Nurse	29.34	35,406	\$19.79
78	Nursing Aide and Orderly	25.94	18,366	\$7.74
89	Physician	24.50	8,017	\$52.00
90	Licensed Practical Nurse	24.28	11,880	\$13.33
93	Pharmacist	23.74	2,589	\$19.43

*Florida Industry and Occupational Employment Projections 1996—2006 fall 1998

**Florida Occupational Employment Statistics Wage Report 1999 Edition (1997 Wage Survey)

The education and training requirements vary with the most common health care occupations, but most require at least a high school diploma or completion of the GED requirements, in addition to specialized training for the field. According to the Florida Department of Education, in the 1996—1997 school year 108,465 persons receive high school diplomas or GEDs representing a 73.18 percent graduation rate. In the same year, there were 589,068 total students in the state in grades nine through twelve. Assuming the same rate of graduation, approximately 431,080 people will be added to the work force in the years between 1997 and 2001. Projected new jobs for the health care industry alone are 159,950. With a current unemployment rate of 3.9 percent, it may be difficult to fill the new jobs for the following occupations in the coming years.

Table 2
Selected Health Care Occupations

Occupational Title	Average Hourly Rate	Education and or Training Requirements
Home Health Aide	\$8.07	Completion of Home Health Aide Training course required. A minimum of 75 hours is required for aides employed by a Medicare or Medicaid agency.
Nursing Aide and Orderly	\$7.74	(For Certified Nurse Assistant) Completion of state approved training program is desired. A satisfactory background check is required. Note: Nurse Aides who may be uncertified and Orderlies are included in this group by the Department of Labor for job and wage projections.
Licensed Practical Nurse	\$13.33	Certificate of completion from an approved professional or practical nursing program. Satisfactory background check is required.
Medical Assistant	\$10.05	High School or GED; Community college or technical school course work in medical assisting and office administration is desired.
Personal and Home Care Aide	\$7.64	Usually requires High School diploma or GED. May require some vocational training or job-related course work such as elder care companion, homemaker aide, childcare worker/provider and custodial home service workers.

*Florida Industry and Occupational Employment Projections 1996—2006 fall 1998

**Florida Occupational Employment Statistics Wage Report 1999 Edition (1997 Wage Survey)

Competition for these workers will be intense, due in part to the variation in the anticipated annual wages.

Table 3
Average Annual Wages—1997

All Industries	\$25,796
Health Services	\$31,708
Home Health Care Services	\$21,595
Nursing Homes	\$18,996

Source: U. S. Department of Labor, Bureau of Labor Statistics and Florida Department of Labor and Employment Security, Division of Jobs and Benefits, Bureau of Labor Market and Performance Information.

Additional Points of Panel Discussions

Impact of the Balanced Budget Act (BBA) of 1997

On August 5, 1999, President Clinton signed the Balanced Budget Act of 1997 that was designed to reduce the growth in Medicare and Medicaid spending over five years (from FFY 1998 to FFY 2002) by \$116 billion and \$13 billion, respectively. The Medicare savings derive primarily from slowing the growth in payments to hospitals (\$44 billion), physicians, home health agencies, nursing homes, managed care organizations, therapists and medical equipment suppliers.

About 7.1 percent of the nation's Medicare population (2.6 million) reside in Florida. Florida's per beneficiary Medicare spending is the highest in the nation at about \$5,376 per beneficiary in 1998. It is expected that the BBA reforms would be felt especially hard in Florida because of the high Medicare expenditures per beneficiary.

The BBA has already affected nursing facilities in several ways. The primary change has been the three-year phase in of a case-mixed prospective payment system, which replaces the cost based reimbursement system. Before BBA, nursing facilities billed Medicare for routine nursing care and ancillary services separately. After BBA, nursing homes will be reimbursed a flat fee that includes all components of care for each resident. Medicare will provide for an annual inflationary increase. According to a preliminary survey of 149 nursing facilities in Florida by the Florida Health Care Association, Medicare revenues in Florida have already declined 16 percent for an average of \$60 per day per resident, and some facilities are in the first year of the three-year phase in. The drop in Medicare rate has been greater in Florida than the national average. One study estimated that the average national Medicare per diem rate has fallen from \$343 to \$293, whereas Florida's rate dropped from \$384 to \$322, which represents \$49 million statewide or \$329,000 per facility in 1998.

Although the full affect of the BBA is unknown at this time, potential impacts could include:

- ◆ Facilities will have significant incentive to reduce costs because of reduced rates and the new procedures under which nursing homes must operate. This has prompted concerns among advocacy groups about quality-of-care issues. Nursing facilities may compensate for the Medicare revenue losses by eliminating nonessential staff, which may have an impact on quality of care, particularly consumer satisfaction.
- ◆ Facilities are refusing services to high acuity Medicare residents because of reductions in Medicare reimbursement, limiting some patient's options for appropriate care.
- ◆ Some facilities are facing further declines in their occupancy rates with the loss of Medicare residents and, in some cases, are being forced to close.
- ◆ Investor confidence has continued to erode among publicly traded long-term care companies since enactment of BBA of 1997, driving market capitalization for these companies to very low levels. Multiple health care chains have been dropped from the New York Stock Exchange and several others have declared bankruptcy or have begun selling divisions to remain solvent.

Balanced Budget Refinement Act of 1999

On November 19, 1999, the Senate approved the approximately \$390 billion spending package the House had previously approved. The President signed the budget package November 29, 1999. Included are Medicare restorations (from the BBA of 1997) of approximately \$16 billion to hospitals, nursing homes, home health care agencies and other care providers over the next five years. Because of the givebacks, Medicare monthly premiums will rise about \$1 a month for beneficiaries, beginning in 2001. The 2000 premium has already been set at \$45.50 a month, the same as this year. By law, money raised from Medicare Part B premiums must cover a quarter of the total annual cost of Medicare.

Highlights of Provisions That Affect Nursing Facilities

TITLE 1—PROVISIONS RELATING TO PART A

Subtitle C Adjustments to PPS Payments for Skilled Nursing Facilities

- ◆ Temporary increase in payment for certain high cost patients.
- ◆ Market basket increase.
- ◆ Authorizing facilities to elect immediate transition to Federal rate.
- ◆ Part A pass-through payment for certain ambulance services, prostheses and chemotherapy drugs.
- ◆ Provision for part B add-ons for facilities participating in the NHCMQ demonstration project.
- ◆ Special consideration for facilities serving specialized patient populations.
- ◆ MedPAC study on special payment for facilities located in Hawaii and Alaska.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle C Other

- ◆ Application of separate caps to physical and speech therapy services.
- ◆ Transitional outlier payments for therapy services for certain high acuity patients.
- ◆ Update in renal dialysis composite rate.
- ◆ Temporary update in durable medical equipment and oxygen rates.
- ◆ Requirement for new proposed rulemaking for implementation of inherent reasonableness policy.
- ◆ Increase in reimbursement for pap smears.
- ◆ Refinement of ambulance services demonstration project.
- ◆ Phase-in of PPS for ambulatory surgical centers.
- ◆ Extension of Medicare benefits for immunosuppressive drugs.
- ◆ Additional studies.

Financial Impact of Provisions

As previously noted, little information relating to the fiscal details is available at this time. According to some reports of the version that passed the House, \$16 billion will be restored to hospitals, nursing homes, home health care agencies and other care providers over the next five years. \$3.9 billion is included for a “drafting error” in the BBA of 1997 regarding hospital outpatient payments. As part of the package, hospitals will receive \$3.3 billion, nursing homes \$2.1 billion, home health and hospice providers \$1.3 billion and \$300 million to dialysis and durable medical equipment providers. Managed care plans will receive \$1.9 billion in “direct relief” because of changes in the phase-in of a “risk adjuster” that would lower payments for healthier enrollees.

Panel Preliminary Recommendations

The panel agreed that further review and study is needed before any changes to the Medicaid nursing home reimbursement plan are recommended. Many of the study areas are consistent with current legislative authority. The study areas represent changes that will either require no additional funding, a reallocation of current funding or additional funding.

Patient Care

- 1. Continue to study and analyze how the current case-mix adjustment to the per diem could be modified to achieve the goals of the panel. The modifications to study range from incorporating case-mix into class ceilings and rates to a full case-mix payment system based on the acuity levels of residents.***

CURRENT PLAN PROVISIONS—The case-mix adjustment is paid as an adjustment to the patient care component of the per diem rate.

- 2. Study alternatives to stabilize the patient care component of the reimbursement plan by modifying or eliminating the target.***

CURRENT PLAN PROVISIONS—The target system limits the rate of growth in patient care per diems and ceilings between rate semesters. The current target system limitation is up to 1.4 times the rate of inflation.

- 3. Study the procedures for component interim rates changes. With recent additional funding and any new changes, it may be appropriate to make changes ranging from minimal modifications up to eliminating the provision for component interim rates.***

CURRENT PLAN PROVISIONS—Component interim rate requests reflecting increased costs due to patient care or operating changes are considered only if such changes are made to comply with existing State or Federal rules, laws, or standards, and if the change is at least \$5000 and would cause a change of one percent or more in the provider's current total per diem rate.

- 4. Study how the Medicaid Adjustment Rate (MAR) or a portion of the MAR could be redirected to provide additional reimbursement for salary increases or bonuses to staff with longevity in the facility.***

CURRENT PLAN PROVISIONS—Prospective providers with over fifty percent Medicaid utilization are eligible to receive an adjustment of up to 4.5 percent of their patient care per diem as the MAR.

5. ***Study the feasibility of dividing the patient care component into two sub-components. One sub-component would separately identify direct patient care costs, the other sub-component would be all other patient care costs.***

CURRENT PLAN PROVISIONS—All patient care costs are reimbursed through a single patient care component.

6. ***Study the feasibility of establishing a wage pass-through program for direct-care staff as a component of reimbursement.***

CURRENT PLAN PROVISIONS—none.

Property

Study the current property reimbursement systems, Cost versus Fair Rental Value System (FRVS), to identify any changes that would help meet the goals of the panel. Areas for study should include but not be limited to the following:

- ◆ ***The adequacy of the current per bed standard under the FRVS;***
- ◆ ***Allowing replacements under FRVS;***
- ◆ ***Asset indexing methodology;***
- ◆ ***Simplify the FRVS methodology;***
- ◆ ***Review COBRA provisions; and,***
- ◆ ***Have all providers reimbursed under one system.***

Glossary

1. **Budget Neutral:** A term used to describe a formal recommendation made by the panel that requires no additional funding or appropriations to accomplish. These recommendations have no definitive, direct cost associated with them.
2. **Case-Mix Adjusted Ceilings:** The case mix allocation is included in the ceiling calculations by blending the Case-Mix Adjustment into the calculation of the class ceilings.
3. **Case-Mix Adjustment:** Case-mix is a facility-specific dollar amount that is added to the Patient Care Component of the nursing home per diem rate. Data is collected from each nursing facility regarding their residents' functional capacities. The data identifies the resident's medical, nursing, mental and psychological needs. This data collection is called the Minimum Data Set (MDS). These resident assessments are classified by the Agency into 34 categories using the current version of Resource Utilization Grouper (RUGS III). The case-mix add-on is then calculated in the following steps:

Step:	Action:
1.	A case-mix score is calculated for each category in the MDS for a Medicaid resident.
2.	The total case-mix score for each resident is weighted by the number of days covered by the MDS assessment.
3.	An <u>average case-mix score</u> is computed for the facility using all Medicaid residents.
4.	A <u>statewide average case-mix score</u> is computed using all Medicaid facilities.
5.	An <u>average case-mix rate</u> is calculated by dividing the available dollars appropriated for the case-mix adjustment by the projected number of Medicaid days in the prospective rate period.
6.	The case-mix add-on for each facility is computed as follows: $\frac{\text{average case-mix rate} * \text{facility's average case-mix score}}{\text{the statewide average case-mix score}}$

For the rate period April 1, 1999 through June 30, 1999, only those nursing facilities participating in the Medicaid program as of February 28, 1999 will receive case-mix. Facilities participating in the Medicaid program as of April 15 and October 15 preceding the July 1 and January 1 rate semesters, respectively will receive case-mix.

4. **CHOW:** Change of Ownership.

5. **Class 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 operating and patient care cost based class ceilings are calculated using inflated 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 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 1.75 standard deviation adjusted for the relationship of the class median to the statewide median.
6. **Component:** One of four cost center calculations that are included in the per diem rate. These include the Operating, Patient Care, Property, and Return on Equity components.
7. **COBRA: Consolidated Omnibus Reconciliation Act of 1984.** COBRA is enforced by the Department of Labor and Treasury. COBRA is used by Medicare for property reimbursement and allows for a partial increase in the valuation of property for depreciation and interest calculations previously limited by DEFRA. Florida nursing home reimbursement has not adopted COBRA.
8. **DEFRA: Deficit Reduction Act of 1984.** Enacted to reduce the federal deficit DEFRA mandated significant changes to Medicare reimbursement of CHOW transactions occurring on or after July 18, 1984 for hospitals and skilled nursing facilities limiting the revaluation of assets. The practical effect of DEFRA was that Medicare would no longer allow a “write-up” from the historical cost basis of the acquired depreciable assets. It was, however, possible for a “write down” of assets to occur.
9. **Dodge Construction Index:** An index used to display detailed profiles of construction activity and comprehensive narrative analysis of key market trends and economic conditions. Provides market potential and performance measures for both residential and nonresidential construction, and covers the new construction and repair/remodeling markets.
10. **Fiscal Impact:** A term used to describe a formal recommendation made by the panel that requires additional funding or appropriations. These recommendations have a quantified, direct cost associated with them.
11. **FCCI: Florida Construction Cost Inflation Index.** An Index used to measure and project the rate of inflation that will affect the costs of new construction. Prior to July 1, 1991, the FCCI was based upon the Dodge Construction Index. Effective July 1, 1991, the FCCI is based upon the DRI/CPI All Urban All Items Regional Index for the South Region.

12. **FRVS: Fair Rental Value System.** Implemented October 1, 1985, as an alternative system to the cost methodology of property reimbursement in response to DEFRA. The FRVS system is based on a cost per bed standard (currently \$40,292) as opposed to the cost method that is based on facility cost (depreciation, interest, taxes, insurance).
13. **HCFA:** The Health Care Financing Administration, of the Department of Health and Human Services.
14. **Medicaid Adjustment Rate (MAR):** The Medicaid Adjustment Rate (MAR) is an adjustment to the patient care component for qualifying facilities. To be eligible for the MAR, a provider must have above 50 percent Medicaid utilization and other than Conditional ratings one year prior to the rate semester. The MAR is calculated as follows:

WHEN a facility's Medicaid utilization rate is ...	THEN the MAR is...
90% or greater	4.5% of the patient care per diem multiplied by (non-conditional days / total days).
above 50% and less than 90%	4.5% of the patient care per diem multiplied by (non-conditional days / total days) and prorated using the following formula: Medicaid utilization - 50% / 40%
50% or less	zero.

15. **Medicaid Operating Costs:** Those costs associated with Medicaid residents that are not directly related to patient care or property costs. These include administrative (includes general and professional liability insurance), plant operations, laundry and linen, housekeeping costs, and bad debt.
16. **Medicaid Patient Care Costs:** Those costs associated with Medicaid residents that are directly attributed to patient care. These include nursing services, dietary costs, other patient care costs (social services, activities, etc.), and therapies.
17. **Medicaid Property Costs:** Those costs related to the ownership or leasing of a nursing home. Such costs may include property taxes, insurance, interest and depreciation, or rent.
18. **Rebase:** Elimination of provider targets and the target rate class ceilings. This results in an increase in per diem rate except for those provides being reimbursed at

cost. In subsequent semesters increases in the provider targets and target rate class ceilings will be realized.

19. **Reimbursement Ceiling Period:** January 1 through June 30 of a given year or July 1 through December 31 of a given year.
20. **Reimbursement Ceilings:** The upper limits for Medicaid nursing home operating and patient care reimbursement rates in a specified reimbursement class and the upper limit for nursing home property cost reimbursement for all nursing homes statewide.
21. **Reimbursement Targets:** Limits applied to the Operating and Patient Care Components of the per diem designed to limit the rate of increase based on the rate of inflation. Targets include individual provider targets, target rate class ceilings, and new provider limitations.
22. **Roll-up:** A method of extracting data from a source (either single or multiple) and summarizing, reorganizing, and /or rearranging the data into a new format. The purpose of a roll-up is to display the data in a more usable, possibly clearer format than the original data source.