

Nursing Facility Reimbursement Report

Draft as of September 29⁴⁹, 2009

November 2009



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Executive Summary

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

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

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

The responsibilities

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

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During the initial meetings of the ~~workgroup~~Workgroup, the Agency provided an overview of the Medicaid program and specific information related to the nursing facilities' budget and current reimbursement plan and methodology. For State Fiscal Year 2009-10, the Medicaid program has an appropriation of \$17.5 billion, of which \$2.6 billion is appropriated for services

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

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

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

General discussion of the Plan occurred throughout all ~~workgroup~~ Workgroup meetings with specific focus on ~~how the plan and~~ issues of concern related to reimbursement and the ~~direction mandates~~ of the ~~workgroup~~ enabling statute. There was a general consensus among ~~workgroup~~ Workgroup members that the current components of the reimbursement plan methodology ~~is are~~ still valid. ~~However, within the methodology there were, but improvements are possible by modifying several~~ areas ~~that need specific attention.~~ of the Plan.

The following issues were among the issues raised and discussed by the Workgroup during the course of its deliberations. Only those issues which are prime appropriate for consideration of policy modification are highlighted for purposes of in this report:

- AIDS offsets
- Revised cost reporting, rate setting and auditing time frames
 - One rate setting/one per period per year
 - Uniform cost report submission time frame
 - Mandate initial cost report filing requirements
 - Audit Completion time line requirements
- Payment limits
 - Targets
 - Ceilings
- Acuity
- Alternative Fair Rental Value System (FRVS)
- Reimbursement for ventilator dependent patients

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~~Members of the workgroup identified these issues and provided historical and prospective discussion for each. Support related to the process of other states as it related to each issue~~

was also presented to the workgroup by members. Subsequent portions of this report provide detailed information regarding each of these issues.

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

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

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

The following highlights the identified alternatives for each of these issues:

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

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

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

- C) For ventilator care reimbursement, implement a fair rental value proxy approach to replace the current FRVS and cost methods and establish specific reimbursement rates for Ventilator dependent residents as part of that.

- Acuity based payment
- Revised FRV (Fair Rental Value) system
- Revised supplemental payment policy
 - AIDS Care
 - Ventilator Care
 - Bariatric Care

Members of the Workgroup provided historical and prospective discussion for each issue. Wherever appropriate, methods and processes of other states as they related to each issue were also presented to the Workgroup by members or Agency staff. Subsequent sections of this report provide detailed information regarding each of these issues.

FourFive of the issues listed above were identified as primary areas of concern. Inadequate resolution of these ~~four~~five issues will create negative outcomes for the future for the nursing facilities and Medicaid program. These issues are 1) revised rate setting time frames, 2) cost report filing and timely audit completion requirements, 3) revised FRV system, 4) modified approach to establishing peer groups and calculating ceilings and 45) revised supplemental

payments policy. The Workgroup reached a general consensus on potential solutions for these issues.

1) Cost report filing requirements - Currently there are inefficiencies in the change of ownership process (known as "CHOW") due to the Agency's inability to enforce the required submission of the initial cost report. All providers are required to submit annual cost reports that are used as the basis for establishing reimbursement rates. When a facility is new to the program or has changed ownership, an interim budgeted prospective rate is calculated using a budgeted cost report as there is no actual cost report to use. After the initial year period, the provider is required to submit a final initial cost report that will be used to reconcile the actual interim rate paid to the prospective rate calculated using actual costs from the initial cost report period. Significant delays in the submission of this initial cost report can create extended delays in the audit process that prevents the Agency from settling possible reimbursement the interim rates in a timely manner, as well as delays for providers that are in the process of CHOW or purchases. In some instances, when a second change of ownership occurs, the initial cost report is never filed. The omission of an initial cost report generally has a negative impact on the accuracy of the class ceilings.

Consensus: - The reimbursement plan should be amended to establish reasonable timeframes for cost report submissions, and for the conduct of audits and desk reviews. AHCA should be given legislative authority to enforce the initial cost reporting requirements, and providers should be given a recourse if audits or desk reviews are not conducted in a timely manner.;

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2) Revised rate setting time frames – Under the current system, cost reports are filed throughout the year and AHCA sets rates twice each year on July 1 and January 1. The rate setting process is fairly complex and time intensive for AHCA and the two rate setting periods introduce a degree of budget unpredictability for the providers. Some states require a single, uniform cost report period to ensure that cost data used for rate setting is for a common economic time frame.

Consensus – Establishment of a single rate setting period per year was supported; however, establishment of a uniform cost reporting fiscal year end was not supported.

~~*Consensus: – Changing to a uniform cost report filing would create problems for both AHCA and nursing facilities. However, but moving to a single rate setting period, preferably in September or beginning October 1st of each year, is feasible.*~~

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3) Revised FRV system - The current FRV system has never been recalibrated and therefore does not reflect the systematic changes that the state has experienced related to construction methods, building code changes, and property and building value and expenses. The workgroup expressed great concern that there is inadequate

reimbursement to attract capital to the sector for the purpose of maintaining existing facilities, or to building replacement facilities or building new facilities. Many of the facilities in Florida are nearing 40 years of age and receive minimum upgrades or renovations. (This issue was also addressed in detail in the 2000 NH Reimbursement Workgroup Study. The recommendations of that study regarding FRVS were not implemented.) Continuing with the current FRV system will result in the further deterioration of the existing buildings and will preclude the construction of new nursing homes that conform to new models of resident space and care and will perpetuate the inappropriate incentives that encourages debt financing and discourages investment in renovation or replacement of aging buildings.

Consensus: – Replace the current Florida FRV and cost-based capital payment system with a new gross FRV system. The Georgia FRV system as originally adopted (Appendix xxx) should be considered as the model for the new system. (Please note that the modeling of this alternative indicated a budget impact of at least \$40 million which is consistent with the financial impact of improvements to the capital portion of the rates recommended by a workgroup in 2001.) Continuing with the current FRV system will result in the further deterioration of the existing buildings and will preclude the construction of new nursing homes that would conform to new models of resident space and care. Further, financing of nursing homes will remain virtually impossible as financial institutions do not see a high probability of timely repayment of funds in relatively high-Medicaid caseload facilities. As an alternative a proxy appraisal-based fair rental model similar to that utilized by a number of southeastern states the Georgia FRV system should be considered.

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4) Revised methodology for establishing peer groups and setting ceilings-Under the current state plan facilities are grouped into one of six categories based on bed size and geographic location. The Workgroup conducted statistical testing on the current peer groups and found very little ability of these two variables to predict changes in cost between facilities within the same peer group.

Consensus:- Changes could be made to the peer grouping and ceiling calculation methodologies that would strengthen the Medicaid program. The Workgroup was able to model alternative approaches that appear to have far greater statistical ability to explain variance in cost between providers. However, additional modeling is needed to determine the optimal variables to be used in establishing peer groups and/or ceilings. It is possible that the modeling may support (a) use of different peer groupings for each rate component and (b) use of a pricing approach to rate setting for the Operating component of the rate.

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5) Revised supplemental payments policy- Under the current payment methodology, supplemental reimbursement is available for the care of residents with AIDS and for the care of medically fragile children, but not for residents with ventilator care needs or specialty bariatric equipment. Generally speaking, supplemental payments (add-ons)

are appropriate when the payment system cannot take into consideration outliers in the cost of care continuum. In the past Florida ~~used to pay~~ paid an add-on for ventilator care, but discontinued ~~it~~ the program because of its high cost. AIDS cases are no longer considered outliers with regards to either care or costs. Ventilator and bariatric care, on the other hand, requires specialized high cost equipment and staffing.

Consensus: - First, eliminate the supplemental payment for AIDS patients and re-calculate the Medicaid per diem rate for affected facilities. Second, create an outlier payment methodology (supplemental payment and/or equipment fee schedule) for ventilator-dependent and other medically complex, technology-dependent residents. ~~Nursing facilities are used to working with infectious diseases. After 20 years of handling AIDS cases, facilities experience no additional burden to warrant a special add-on rate. Ventilator and bariatric care, on the other hand, represents a significant expense in both equipment and staff resources and should be treated as an outlier with a special add-on rate.~~

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Workgroup Overview

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

The responsibilities of this Workgroup were to evaluate, based on the above statute, alternative reimbursement and payment methodologies for nursing facilities. Based on ~~this evaluation, the Agency for Health Care Administration~~ [work of the Workgroup, AHCA](#) developed this report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup on Nursing Facility Reimbursement ~~also considered~~ [a series of options including acuity adjustments, fair rental payments, price-based methodologies and supplemental payments for services that require high cost equipment](#). The Workgroup ~~evaluated and reported~~ [discussed](#) only ~~on those health programs funded nursing home related issues that are funded by Medicaid~~ through the Agency. ~~Discussions not covered by the description above (reimbursement and payment issues) are issues outside the scope of the Workgroup and were not be included as topics of discussion~~ [considered](#).

~~This Workgroup consisted of~~ [Based on nominations submitted](#), four [Workgroup](#) members [were](#) appointed by the Medicaid Director, ~~based on the statute listed above~~. Agency staff served as ~~facilitator~~ [facilitators](#) and resources for, but not members of, the Workgroup.

Members of the Workgroup were:

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

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

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

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

The duties of the Workgroup included the following:

a. ~~a.~~ Evaluation of alternative reimbursement and payment methodologies for nursing facilities including prospective payment methodologies.

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b. ~~b.~~ Report findings to the Director of Medicaid as to the outcome of ~~their~~its fact finding.

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The Workgroup met ~~7~~seven times between January 2009 and September ~~2009~~ in order to accomplish the duties outlined above. Agency staff worked with members to develop supporting documentation of agenda items for each meeting. ~~All documentation~~Documentation and minutes of each meeting are posted online at:

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

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

Guiding Principles

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The Workgroup discussed its purpose and goals and agreed to adopt the following guiding principles to use in identifying potential issues for consideration and changes to the Medicaid reimbursement system.

- Ease of administration (rate setting, billing, audit process)
- Predictability
- -Budget predictability and stability for both AHCA and nursing home providers
- ~~Eliminate or reduce artificial barriers that cause significant differences in how for both AHCA and nursing home providers operate~~
- Budget predictability and stability
- ~~Political viability~~
- Elimination or reduction of ~~option~~ artificial barriers that contribute to variations in provider costs and quality of care delivered
- Viability of potential solutions

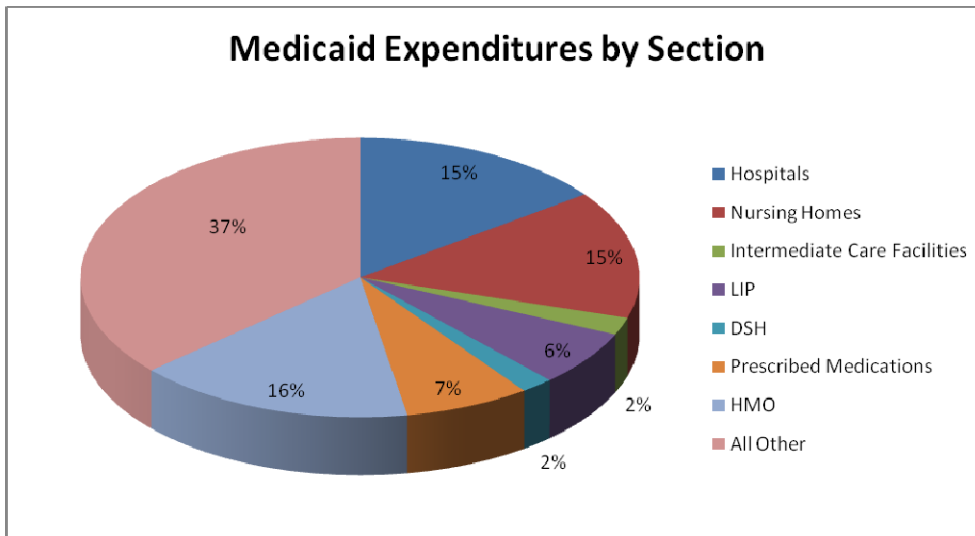
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Florida Medicaid Overview

The Medicaid program is a partnership between the State and Federal government. ~~There are federal~~ Federal requirements ~~that must be met, and those~~ are specified in the State Plan as approved by Centers for Medicare and Medicaid Services (CMS). ~~There are~~ The Medicaid Program contains mandatory and optional eligibility groups and service categories. In State Fiscal Year 2009-10, Florida Medicaid ~~has estimated~~ is projected to spend \$17.5 billion ~~spending~~. The ~~current, but time limited,~~ federal share of funding is 67.64%, while the state share is 32.36%. Forty-five percent of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled, Low Income Pool and Disproportionate Share Payments. About 10% of expenditures are for prescribed medications. (See Figure – 1.) Florida’s Medicaid budget is the fifth largest in Medicaid expenditures nationwide. There are 16 mandatory services that must be provided under the Medicaid program. These services account for a little over 41% of current year expenditures. Florida also provides 30 optional services, which account ~~for almost~~ the remaining nearly 59% of current year expenditures. Over time, the federal medical assistance percentage has generally been declining, ~~except that~~ but the American Recovery and Reinvestment Act (ARRA) (Public law 111-5) provided state fiscal relief for Medicaid funding for the period October 2008 through December 2010. During this time, Florida is receiving the enhanced Federal Medical Assistance Percentage specified above.

Figure- 1



~~The Medicaid For state fiscal year 2009-10, the~~ budget for Nursing ~~homes~~Homes is \$2.6 billion ~~for State Fiscal Year 09-10~~. Over the past few years, there have been multiple ~~legislative adjustments made~~legislatively mandated modifications to ~~the~~ nursing facility reimbursement ~~such as, including~~ rate reductions and increased staffing requirements. Most recently, nursing homes received a \$75.2 million-7.8% reduction effective January 1, 2008, an \$83.8 million reduction effective January 1, 2009, a \$232.4 million reduction effective March 1, 2009 and an \$81.3 million9.1% reduction ~~effective on~~ July 1, 2009. Authority for a Nursing Facility Quality Assessment (NFQA) was implemented effective April 1, 2009. The NFQA was implemented to allow the nursing homes to ~~buy~~buy back reductions to Medicaid reimbursement. See Appendix D for more detail. ~~In addition, the economic stimulus package (ARRA) changed the Federal Medical Assistance Percentage (FMAP) to 64.67% for State fiscal year (2009-2010).~~

The increase to the FMAP due to the federal stimulus enabled ~~more budget reductions correlated buy~~buy backs to nursing homes a larger buy back of rate cuts through use of the Quality Assessment. Accordingly, an additional reduction of \$xxx.x million was required at July 1, 2009 to maximize the amount of available Federal match as authorized in the state budget. The FMAP is anticipated to reduce to 66.45% on July 1, 2010, then 54.98% on January 1, 2011. Please refer to Appendices E through K for information of how Florida Medicaid compares nationally.

Current Methodology of Nursing Home Cost Reimbursement

Introduction

As of July 1, 2009, there were 642 nursing homes participating in the Florida Medicaid program. These nursing homes account for a total of 79,841 beds, which is an average of 124 beds per facility. These same facilities account for 25,946,060 patient days a year, of which 15,530,994 (59.86%) are Medicaid days [corresponding to an average of approximately 71,000 Medicaid eligible individuals](#). The ~~range~~[number](#) of beds ~~is~~[per](#) facility ~~is~~[ranges](#) from a minimum of 20 to a maximum of 462. Statewide, the average occupancy rate for a Medicaid participating nursing home is 89.25 percent. The ~~current~~[state fiscal year 2009-10](#) budget for Medicaid Nursing Home care is \$2,589,278,217. ~~The 642 Medicaid participating~~ [A history of Florida Medicaid nursing homes serve approximately 71,000 Medicaid eligible people](#) ~~home expenditures since the inception of the program is provided in Appendix C.~~

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

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

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

Reimbursement Rates

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

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

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

- Operating
- Direct Patient Care,
- Indirect Patient Care,
- Property
- , and
- Return on equity (ROE) for money invested and used in providing patient care
-).

~~The operating component~~

~~The Operating cComponent~~ includes administration, laundry and linen, plant operations, and housekeeping expenses. It may also include Medicaid bad debt expenses. ~~The patient care component~~Direct Patient Care cComponent includes wages and benefit costs of direct care nursing staff and contracted direct care nursing staff. ~~The Indirect Patient Care component~~ includes non direct care nursing, dietary, other patient care (e.g., social services and medical records) and ancillary ~~expenses~~services. ~~The property component includes~~Property cComponent includes either: interest, depreciation and return on equity, or a fair rental value. ~~In either case the property component also includes the costs of~~ property insurance, property taxes and ~~equipment rental expenses~~home office property, or a fair rental value. ~~The return~~Return on equity component is a calculation rate of return based on the equity in the facility and is only paid to providers who receive interest and depreciation for property reimbursement. Each of these components is calculated independently and is then combined to determine the total per diem rate.

Reimbursement Ceilings

Operating, ~~patient care~~Direct and Indirect Patient Care, and ~~property~~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 ceiling classes ~~in determining these ceilings~~. The classes are based upon size (1-100 beds = small, or over 100 beds = large), and location

(North, South, or Central) of the facility within the state. The distribution of the facilities throughout the state at July 1, 2009 is as follows:

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

The ~~operating~~Operating and ~~patient care~~Patient Care (both direct and indirect) cost based class ceilings are calculated using inflation adjusted ~~operating and patient care~~Operating and Patient Care per diems for the semester for which rates are being set. The cost based class ceilings for the ~~central~~Central class ~~is-are~~ the simple ~~average~~averages of the ~~north and south~~North and South cost based ceilings. -The ~~operating~~Operating cost based class ceilings are based on the statewide operating median plus one (1) standard deviation adjusted ~~for~~by the ~~relationship~~ratio of the class median to the statewide median. -The ~~patient care~~Direct and Indirect Patient Care cost-based class ceilings are based on the statewide ~~patient care median~~Direct and Indirect Patient care medians plus a 1.75 standard deviation adjusted ~~for~~by the ~~relationship~~ratio of the class ~~median~~medians to the statewide median.

Rate Adjustments

The Medicaid Adjustment Rate (MAR) ~~and the case mix adjustment are adjustments~~is an ~~add-on~~ to the ~~patient care~~Direct and Indirect Patient Care component for qualifying facilities. ~~These adjustments are~~This ~~add-on is~~ not subject to class ceilings, targets or new provider limitations ~~and~~-. ~~They are~~it ~~is~~ added to the per diem components 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~~Direct and Indirect 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, facilities with less than 50 percent Medicaid utilization receive no MAR.

Targets

~~Effective~~On 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 was implemented. Target rates are set for class ceilings and the

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

On July 1, 2007, targets were rebased and minimum thresholds for the target system were implemented. These modifications guarantee that the provider target reimbursement limitation cannot fall below 75% of the corresponding cost based class ceiling. Similarly, target ceiling limitation cannot fall below 90% of the corresponding cost based ceilings.

Other Limitations

Facility specific new provider limitations are another limit placed on the ~~operating~~Operating and ~~patient care~~Direct and Indirect 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~~Operating and Direct and Indirect 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~~Operating and Direct and Indirect 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 2.0 times the ~~target~~ rate of inflation each semester.

Staffing

~~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 Medicaid program to recruit and retain direct care staff (RNs, LPNs, and CNAs). The funds were allocated using an inversely proportionate methodology so that those nursing homes with lower staffing ratios would receive a higher adjustment, or add-on, than those with higher staffing ratios. Total annualized payments are \$31.7 million. At April 1, 2000, individual add-ons per Medicaid patient day ranged between \$.50 and \$2.81, with an average of \$1.96.~~

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

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

With the passage of SB 1202 in 2001 nursing homes are required to maintain a minimum daily staffing level. To accommodate this statewide requirement reimbursement rates for the Direct Patient Care Component were adjusted three times between 2002 and 2007.

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

Per Diem Paid

The nursing home ~~operating~~Operating and ~~patient care~~Indirect Patient Care cost per diem paid is the lower of the following, ~~except that the patient care per diem is adjusted by the MAR, day values and the direct care staffing adjustment (DCSA) limits:~~

- ~~• Cost based class ceiling~~
- ~~• Target rate class ceiling~~
- Facility specific ~~rate~~inflated cost
- Facility specific target rate
- Facility specific new provider limitation
- ~~• Target rate class ceiling~~
- ~~• Cost-based class ceiling~~

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The nursing home Direct Patient Care cost per diem paid is the lower of the following per day values and limits:

- Facility specific rate
- Facility specific new provider limitation
- Cost based class ceiling

In addition, as explained in an earlier section, for Direct and Indirect Patient Care nursing homes with Medicaid caseloads in excess of 50 percent may be eligible for the MAR add-on.

Property Reimbursement

There are two different [methodologies](#)~~methods~~ for property reimbursement: the “cost method” (cost) and the Fair Rental Value System (FRVS). The cost ~~methodology~~~~method~~ can be described as ownership specific and facility [value](#) 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~~[determine](#) the property per diem. There are two statewide ceilings for property [under the “cost method”](#). 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~~[implemented on](#) July 1, 1985, and, in accordance with the Plan, are not recalculated at subsequent rate semesters due to the implementation of FRVS.

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

FRVS is a method used to arrive at the fair rental value for a facility [independent of financing parameters and ownership or rental arrangements](#). The value of the facility is used in the calculation of the per diem component [in lieu of depreciation, interest and rent expenses](#). The FRVS component of the [current](#) per diem rate is an aggregate of three (3) sub-components; the capital component or 80 percent component, the Return on Equity (ROE) or 20 percent component and FRVS pass-through. The FRVS calculation does not recognize capital expenditures involving replacements of equipment, furnishings or buildings. The initial FRVS rate is adjusted twice a year, at each rate semester, for inflation. Adjustments can also be made twice a year for changes in interest rates on capital debt and for capital additions or improvements, within established thresholds, with proper notice, for those facilities with a variable rate mortgage.

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. (To qualify, an expenditure must be either an addition or an enhancement of the current building. Renovation, repair, and replacement cost do not qualify.)

The calculation of the capital component or 80 percent component uses several steps. First, an annual debt service amount is determined using 80 percent of the asset value for the current semester amortized over 20 years at the facility's 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. (The Federal Centers for Medicare and Medicaid Services (CMS) provides the ROE percentages.) Second, the product from step one is divided by the annual available patient days (see above). Next, the quotient from step two is divided by the same occupancy adjustment factor used in the 80 percent capital component. The ~~amount of the~~ resulting quotient is the ROE or 20 percent component.

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

To ensure 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 was~~ less under the FRVS method than the cost method, the facility ~~would receive~~ received 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 under FRVS was~~ greater than cost based reimbursement at October 1, 1985, ~~under FRVS~~ were phased up to their FRVS rate in equal percent increments according to a schedule that was based on their date of entry into the Medicaid program. This period is referred to as the phase-in period and ranged from four years to ten years.

Findings and Issue Identification

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The Workgroup on Nursing Facility Reimbursement met 7 times during the period of January 2009 through September 2009. During the meetings, the Workgroup discussed the purpose and goals of the Workgroup and agreed to adopt guiding principles (previously stated) to use in identifying potential changes to the Medicaid reimbursement system.

There are four components of the Per-Diem Reimbursement:

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

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

The Workgroup highlighted issues where improvement to current Medicaid reimbursement policy, discussed in the previous section, could be made. Analysis of these issues were collected and evaluated by the workgroup. The following issues were among the issues raised and discussed by the Workgroup during the course of its deliberations. Only those issues which are prime for consideration of policy modification are highlighted for purposes of this report:

- AIDS offsets
- One rate setting/One cost report submission
- Mandate initial cost report

The Workgroup discussed numerous issues that were within the scope of its charter, but only the following topics were deemed appropriate for inclusion in this report:

- Revised cost reporting, rate setting and auditing time frames
 - One rate setting per period per year
 - Uniform cost report time frame
 - Cost report filing requirements
 - Audit cCompletion time line requirements
- Payment limits
 - Targets

- Ceilings
- Acuity based payment
- Revised FRV (Fair Rental Value) system
- Revised supplemental payment policy
 - AIDS Care
 - Ventilator Care
 - Bariatric Care
- Revised rate setting time frames
 - One rate setting period per year
 - Uniform cost report time frame
- Cost report filing requirements
- Payment limits
 - Targets
- Ceilings
- Acuity
- Alternative Fair Rental Value System (FRVS)
- Reimbursement for ventilator dependent patients

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The issues highlighted by the Workgroup are not recommendations by the Agency for Health Care Administration or the Workgroup. These are issues that came to light as a result of Workgroup discussions concerning the current methodology and identifying potential solutions to some of the issues raised by the Workgroup.

A. AIDS offsets

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

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

providers would have been reimbursed \$400,983.06 less had the AIDS costs been included in their regular per diem rate. See Figure—2

Figure—2

AIDS OFFSETS COMPARISON

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

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

(\$400,983.06)

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

B. One rate setting/One cost report submission

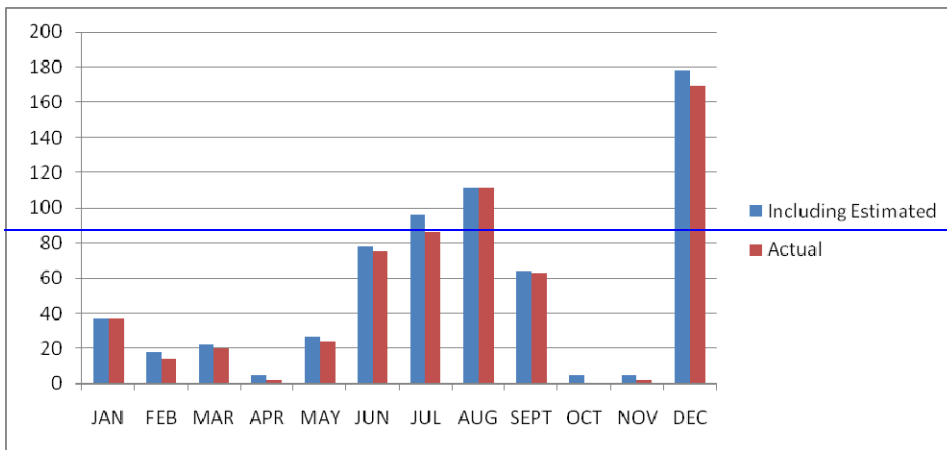
The workgroup considered moving to a single fiscal year-end reporting and a single rate semester. The Workgroup believed that a single rate setting period during September or October would benefit the providers more than any other time of the year.

Managed Care Organizations have moved to a single rate setting period, and it has worked out well. The Workgroup believed that a single rate setting/reporting period could work out well given appropriate research and analysis. One benefit of a single

rate semester/reporting period would be administrative simplification for both the agency and the industry. A second benefit would be more efficient reporting with Federal Upper Payment Limit (UPL) standards required by CMS.

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

Figure 3



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

Some problems that might occur with this change include an additional workload and possible need for additional agency staffing during the rate setting once a year. A second problem would be that inflationary ceilings and targets would be locked in for a full year, reflecting less accurately the actual costs of the providers and the economic environment. A survey was conducted of Nursing home facilities and they were opposed this change in policy. Please refer to Appendix R—FYE Cost Report Months Used for the January 2009 Rate Semester and Appendix S—Medicaid Cost Survey Results for further detail.

C. Mandate initial cost report

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

— Ceilings

- Acuity based payment
- Revised FRV (Fair Rental Value) system
- Revised supplemental payments policy
 - AIDS Care
 - Ventilator Care

A. Revised Rate Setting Time Frames

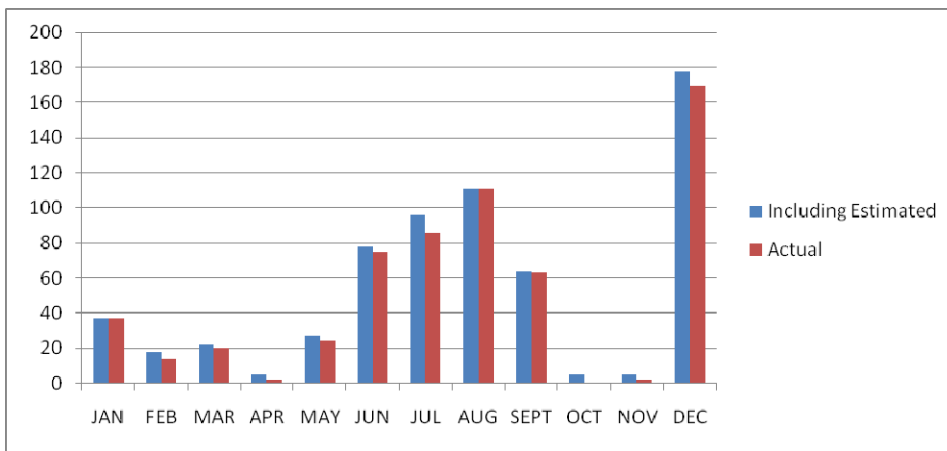
Under the current system, cost reports are filed throughout the year and AHCA sets reimbursement rates twice each year on July 1 and January 1. The rate setting process is fairly complex and time intensive for AHCA and ~~the two rate setting periods introduces~~ a degree of budget unpredictability ~~for the providers~~. Some states require a single, uniform cost report period to ensure that cost data used for rate setting is for a common economic time frame.

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[Figure- 23](#) shows the current distribution of providers by fiscal year end. [December is the most prevalent fiscal year end for nursing homes.](#)

Figure -2



[Based on Figure – 2, December is the most prevalent fiscal year end for nursing homes.](#)

[The Workgroup considered moving to a uniform fiscal year end cost reporting and a single annual rate setting. Administrative simplification for both the Agency and the providers industry is a perceived benefit of a single rate setting and uniform reporting period. A uniform cost reporting period could also yield more accurate reporting of the Federal Upper Payment Limit \(UPL\) standards required by CMS.](#)

[On the other hand, a uniform cost reporting period and a single rate setting period may concentrate the AHCA rate setting work to such an extent that increased staffing may be required. A single rate setting period would also lock in provider rates for a full year and, therefore, may not be as responsive to economic changes as is the current system.](#)

[AHCA has implemented a single rate setting period for Managed Care Organizations. This change has been beneficial for both AHCA and the Managed Care Industry and](#)

the problems noted above did not materialize. The number of Managed Care Organizations, however, is significantly smaller (by an order of magnitude) than the number of nursing homes.

The Workgroup initially believed that a single rate setting and a uniform cost reporting period could work out well for nursing homes also. FAHSA and FHCA surveyed their members regarding this issue. Based on the results of the survey and further analysis, the Workgroup found that a single rate setting period ~~during September or October~~ would be supported, but that having a single ~~benefit the providers more than any other time of the year~~ but a uniform cost report fiscal year end requirement would create problems for both nursing homes and the Agency.

It is important to note that a change to a single rate setting period would only be possible if providers were also able to change their cost reporting fiscal year ends. Otherwise, rates for certain providers would be established using data that is not reflective of current economic conditions and/or reflective of current regulatory requirements.

Please refer to Appendix R- FYE Cost Report Months Used for the January 2009 Rate Semester and Appendix S – Medicaid Cost Survey Results for further detail.

Consensus – Establishment of Changing to a uniform cost report filing would create problems for both AHCA and nursing facilities, but moving to a single rate setting period per year was supported; however, establishment of a uniform cost reporting fiscal year end was not supported preferably in September or October, is feasible.

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B. Cost Report Filing Requirements

Each nursing home provider participating in the Florida Medicaid program is required to submit a uniform cost report and related documents annually. Cost reports are due five months after the close of the provider's cost reporting year. Extensions are not granted. The provider's cost reporting year is established by the filing of an initial cost report of a least six months, but not more than 18 months by a new provider in a newly constructed facility, an existing provider entering the Medicaid program, an existing provider in a newly constructed replacement facility, or a new provider resulting from a change of ownership or operator.

When a new provider enters the Medicaid program, reimbursement for the initial months of operation is based on a pro forma cost report. If the provider remains in the Medicaid program then a valid cost report must be filed and cost settlement for the initial budgeted period takes place. Some providers leave the Medicaid program soon after they entered it and never file a valid "initial" cost report.

The Workgroup determined that providers not submitting an initial cost report in a timely manner (or at all) was one element ~~ere~~ slowing down the cost settlement and audit process. This slow down is leading to increases in the amounts of overpayment and delays in ~~changes~~ subsequent changes of ownerships being delayed waiting for settlement to be processed.

The only enforceable time requirement to file an initial cost report in the State Long Term plan is:

Version 33, Section I. B

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

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AHCA has little legal recourse, however, to force a provider that has left the Medicaid program to file an initial cost report. The absence of a more timely and enforceable rule has had several adverse consequences. The agency cannot cost settle or conduct an audit until the initial cost report has been filed sometimes delaying both of these processes by up to nine years to finalize an audit. The longer the longer cost settlement/audit process takes the results in larger the overpayment balance can be causing the provider balances and causes providers to realize a larger larger current liability all at once.

~~Another consequence involves~~ Additionally, not filing an initial cost report causes delays in ~~the any subsequent~~ Changes of Ownership (CHOW, which are being) process. Licensure of the new operator may be held up indefinitely at the licensure level if the seller has not filed an initial cost report. This hold up delay can disrupt the CHOW process because both parties are unable to determine Medicaid liability causing artificial barriers that cause significant differences in how providers operate.

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Since an initial Medicaid cost reporting period can be between six and eighteen months, setting the deadline five months after their fiscal year end completion of the 18 month period (or until the next rate setting submission date whichever is longer) should not impose undue hardship on the facility or provider. Progressively increasing penalties such as partial or full withholding of reimbursement would have to be a part of any enforceable mandate.

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

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The Workgroup found that target limits cause differenceschanges in facility operations, particularly by provider-specific target limits-but did not reach a consensus on how they might be changed. As noted earlier, there is a greater than \$100 per day difference between the lowest and the highest daily Medicaid rates. Facilities operating with greater Medicaid occupancy levels are particularly constrained by provider-specific target limits and the rebasing on July 1, 2007 had little positive impact for those facilities operating with constrained spending.

Consensus: - Eliminate provider-specific targets that limit the ability of individual providers to spend at equivalent levels which may be harmful to patient care. Amend the State Plan to establish specific timeframes for the rebasing of global targets that artificially limit rate growth.

D. Ceilings

Ceilings were created as means to control payment rates for each major cost component. To take into consideration economies of scale and geographic economic differences, ceilings vary according to location and size and are grouped into six classes.

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The workWork group evaluated the current Ceilings-ceilings method to determine if the ceiling could be more representative bybetter groupings for geographic area- and size could be developed. Ceiling analyses consisted of two distinct techniques. In the first type of analysis, simple class averages were computed and compared to the current system averages. The second analysis attempted to employ statistical techniques to determine which variables and what class definitions have predictive power for provider costs.

Because the central class-Central Class ceilings are calculated by using the simple average of the north and southNorth and South cost based ceilings, a more accurate, alternate method of separately calculating the central class ceilings was viewed.examined. This was achieved by comparing the January 1, 2009 rate semester ceilings to what the ceilings would have been using the alternate method. Since there was a significant impact to ceilings for some of the classes, this alternate method was rejectednot wanted by the Workgroup noting that additional analysis was necessary. Refer to Figure - 5

Figure - 5

200901 Ceilings Comparison

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

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

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

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

Another method for calculating ceilings was discussed. This was to change the outliers that could affect the statewide standard deviation and medians and ultimately the class ceilings. When the ceiling methodology was developed in the early 1980, provider costs were not very homogeneous and a reasonable method for excluding the outliers from the ceiling calculations was required. As the provider

community learned to adapt to the new system, and to whatever extent the new system actually controlled spending behavior, the relative range of per day costs has contracted and fewer and fewer facilities have cost that could be termed "outliers."

Currently, a normalized rate from every provider is used for calculations of calculating the standard deviations and medians of the operating, direct care, and indirect care components. The highest 10% normalized rates and the lowest 10% normalized rates are eliminated to guard against significant outliers. Operating, Direct Care, and Indirect Care components. The upper and lower 10% of the normalized rates are labeled as "outliers" and are eliminated from ceiling calculation.. The Workgroup suggested considering two alternatives:

1. Reducing the percent outliers from the current 20% to 10%, and
2. Eliminating only the upper 5% of the normalized cost per diems from ceiling calculations.

The January 1, 2009 rate semester data was analyzed to view determine how ceilings would be affected by changing the outliers from 10% to 5%, and then to 5% high and 0% low these two alternatives. (see appendix V – Ceilings Comparison Chart). Again, there was a significant impact to ceilings for some of the classes, so the Workgroup was not in favor of changing the outliers.

Additionally, the Workgoup decided that another analytical investigation was appropriate to determine if there is a more accurate way of grouping facilities into classes to account for geographic cost variations and to determine if there is a more accurate way of grouping facilities into classes to account for size related cost variations. Data was utilized to develop two separate statistical models (linear regression and ANOVA). Based upon the results of the models the following observations can be made:

1. Differenc~~t~~ geographic and size classes should be developed for each of the three cost component per diems. The three cost components should be broken down into subcomponents to determine what ceilings size and geographic groups are the most appropriate for each subcomponent.
2. There is no way to measure the artificial impact the existing system's constraints impart on the individual facility costs.

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Direct Patient Care Component

1. The current and the potential alternative size class groupings do not provide adequate predictive strength or class group differentiation to be used for ceiling calculations.
2. Statistical differences would indicate that enough geographic differences exist to retain for ceiling calculations although additional analysis will be required to refine the classes. In particular, data for the subcomponents of

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salaries and wages and benefits should be obtained which will allow additional refinement for ceiling development.

Indirect Patient Care & Operating Components

1. There are statistical differences among geographic and both current and alternative size classes and they should be retained for setting ceilings for both components; however, subcomponents of both of these cost components should be analyzed as it expected that some subcomponents will not vary with either geography or size and should be excluded from the ceiling calculation.
2. Other independent variables contribute significantly to the predictive strength of the full models and may be important if a pricing system is considered.

Additionally, the Workgroup noted that a single rate could be established for the Operating component for all providers (pricing model) as long as that rate were developed using the findings of the statistical analysis. Particularly, subcomponents, such as utilities, that have significant variances among providers should be excluded from the pricing component and paid as a pass-through cost just as property taxes and property insurance is paid.

Consensus:- Changes could be made to the peer grouping and ceiling calculation methodologies that would strengthen the Medicaid program. The Workgroup was able to model alternative approaches that appear to have far greater statistical ability to explain variance in cost between providers. However, additional modeling is needed to determine the optimal variables to be used in establishing peer groups and/or ceilings. It is possible that the modeling may support (a) use of different peer groupings for each rate component and (b) use of a pricing approach to rate setting for the Operating component of the rate. Consensus: The Workgroup agreed that significant further work is required to develop alternative or modified ceiling methodologies and was not in favor of changing the ceiling calculation method at this time.

E. Acuity Based Payment

The Workgroup questioned if the Direct Care Staff Adjustment was still needed. The Direct Care Staff Adjustment was implemented effective April 1, 2000 as an adjustment to the patient care component. The adjustment or gross-up was intended to assist nursing homes who choose to participate in the program to recruit and retain direct care staff (RNs, LPNs, and CNAs). Please refer to the prior section for more detail on current methodology. The enabling language for the Workgroup specifically mentions the consideration of acuity-based payment systems and the Workgroup spent a considerable amount of time debating the merits of such a system.

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Acuity-based payment systems (or more correctly, resource groupings-based systems), such as the one used by Medicare, establish a global payment rate for classes (resource groups) of residents based on the amount of care and services the residents need. The global group rates are then adjusted to take into consideration geographic labor cost variations.

Prior to the implementation of the Florida minimum staffing standards in 2002~~1~~, the nursing home payment system had a minor rate component that was related to acuity. This add-on payment component was eliminated when the new staffing standards were funded.

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

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

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

Consensus: - The Workgroup agreed that since Florida has the nation's nations highest mandated staffing standard, variations in direct care costs are minimized and the complexity of an acuity-based payment system would not yield more accurate or more appropriate payment rates.

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F. Alternative FRVS

Currently, there are 598 providers paid under the Fair Rental Value System and 44 providers paid under the cost method. Having providers paid under two separate methodologies, including t~~The Workgroup would like all providers to have their property components reimbursed by utilizing one alternative FRVS method~~The perpetuation of an~~the~~ antiquated cost based property payment system, creates~~introduces~~ inequities into the Florida payment system. The current Florida FRV system also creates inappropriate incentives that encourages debt financing and discourages investment in renovation or replacement of aging buildings.

This could be achieved by a proxy or actual appraisal. Because of the high costs and inaccuracies that an actual appraisal carries, the unanimous consensus was to continue to use proxy appraisals. These are appraisal model simulations using standardized values and depreciation factors consistent with commercial valuation systems. The Workgroup evaluated various components of the current Florida property payment system and considered modification of the current system as well as implementation of a new system modeled after ones currently utilized by several southeastern states including Georgia, Mississippi, North Carolina and Louisiana. The Workgroup noted that while there were improvements that could be made in the current system, ultimately, members agreed that a new FRV approach was necessary to fix the inequities and disincentives of the current system. The Workgroup believes the utilization of an FRV system, similar to that used in Georgia, will accomplish the main goal of providing incentives to both attract capital to the sector and to nursing home providers to maintain a suitable physical environment through renovations, which will result in the improvement of resident quality of life. Continuing with the current FRV system will result in the further deterioration of the existing buildings and will preclude the construction of new nursing homes that would conform to new models of resident space and care. Further, under the current FRV approach, financing of nursing homes will remain virtually impossible as financial institutions do not see a high probability of timely repayment of funds in relatively high Medicaid caseload facilities.

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There are certain fundamentals to any FRV system. First, a price will be calculated for use of space representing the economic value of that space irrespective of the actual accounting cost. Second, the price will be calculated by multiplying the facility value which increases over time based upon replacement cost and proper upkeep times a rental rate. Third, there must be a component to adjust the value for obsolescence in lieu of accounting depreciation. And fourth, the value must be based upon professional standards using either a professional market appraisal or a proxy appraisal (a simulated appraisal value using commercial valuation systems such as Marshall Swift/Boeckh or RS Means).

Furthermore, the Workgroup agreed that the principles of a well constructed fair rental method will:

- Differentiate reimbursement based on age/condition,
- Provide incentives to generate capital resources for renovation and replacement,
- Simplify administration and allow the State to exert reasonable budget predictability and control,
- Utilize economic value instead of financial accounting value,
- Eliminate concerns for system gaming,
- Promote equity investment, and

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- Eliminate the inequities of the current Florida system that give preference to a particular form of financing.

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

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

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Ultimately, the Workgroup focused on a gross fair rental method and suggested that ~~has been adopted by several states including Georgia is proposed for the value of the building and property be determined via an independently established proxy such as RS Means, as an alternative to the current FRVS method and cost methods.~~

~~Detailed analyses based on the Georgia FRV system were conducted. The Workgroup believes the utilization of this an FRV system, similar to that used in Georgia, method will accomplish their main goal of providing incentives to both attract capital to the sector and to nursing home providers to maintain a suitable physical environment through renovations, resulting which will result in the improvement of resident quality of life. Furthermore, they believe the gross fair rental method will:~~

~~Furthermore, the Workgroup agreed that the principles of a well constructed a Georgia like fair rental method will:~~

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

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

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

Detailed analyses based on the Georgia FRV system were conducted. Please see Appendices W, X and Y for more information on the Georgia FRVS method.

To demonstrate how the calculations would work under the gross fair rental method, two models were have been constructed. These models were created by mimicking the current Georgia gross fair rental method. The first model was calculated Appendix Z illustrates a simplified example using a sample of only 50 nursing home providers (using actual square footage information), while a more complex model was calculated using the FRV data from the current system (with estimated square footage information) for all nursing homes. Appendix AA is a more detailed illustration.

In order to implement this alternative FRVS method, there are constant variables and parameters that would need to be agreed on initially. There would be an opening for opportunity to fine tune these variables to be manipulated at each rate semestereach time Medicaid rates are recalculated or year, however. The overall calculation stems from RS Means cost per square foot data, which can be obtained each-Every July 1 when -a new RS Means-Means- cost per square foot book is released-allowing this data to be obtained. For July 1, 2009, the cost per square foot is \$141.10. This number is multiplied by combined- with the facility's total square feet and is adjusted by a geographicthe location factor to receive-calculate an RS Means value. As noted, f Fifty facilities provided square feet, but in figure Figure B (WHERE IS FIGURE B?), the floor space of all other facility square feet facilities wasare estimated according to based upon their number of beds. (-UnderWith the proposed method, providers would be required have to report facility total square feet to coincide with the RS Means cost per square feet.) The location factor varies by the cost of property in a given geographic area.

The cost of equipment is calculated by multiplying the number of beds by an agreed upon equipment allowance per bed. This would be in lieu of the current FRVS method, where providers report assets on Schedule T of their cost reports. Next, depreciation is subtracted from the RS Means value and equipment allowance. Other parameters related to depreciation such as a maximum depreciation amount and maximum facility age may be established. One of the models used by the Workgroup Appendix Z usesd a straight-line depreciation of 2%, while the second model Appendix AA usesd a tiered depreciation method. Also the first model used Appendix Z has- a maximum depreciation of 1/3 the value of the RS Means plus equipment value, and the second model Appendix AA usesd a maximum facility age

of 32.5 years. The current year is used for facility aging purposes. The facility age is was also adjusted to account for nursing home renovations. A provider receives credit for renovations by reducing the facility age, thus reducing depreciation. Because land does not depreciate, it is added after the depreciation calculation as a percentage of the RS Means value to show the rental value. This value is multiplied by the rental rate to ~~illustrate~~ determine the fair rental.

(I WOULD INSERT THE FAIR RENTAL EXAMPLE FROM THE LUBARSKY PRESENTATION – PAGE 8 – AS A FIGURE HERE OR WE MAY WANT TO INCLUDE THE ENTIRE LUBARSKY PRESENTATION AS APPENDIX. I WOULD NOT INCLUDE ANY OF THE MODELS IN THE APPENDICES.)

G. Ventilators

To coincide

Consensus – Continuing with implementation the current FRV system will result in the further deterioration of the alternative FRVS method, a special ventilator rate is proposed. Currently, ventilators are reported by providers in their cost reports under Schedule T as assets. The alternative FRVS method would eliminate Schedule T existing buildings and replace it with an equipment allowance per bed. Because the cost will preclude the construction of ventilators would significantly exceed the equipment allowance per bed amount, new nursing homes with patients that require ventilators would have their reimbursement rates increased.

There is precedent would conform to new models of special rates for nursing home providers with special patients. Currently, providers with AIDS patients and fragile under 21 (pediatric) patients receive higher reimbursement rates based on staffing data, which are reported on Schedule F-3 in the cost reports. The special ventilator rates would be reimbursed similarly to the AIDS and pediatric rates, where they are displayed separately from normal per diem rate. However, the ventilators will be reimbursed based on the cost of the equipment (ventilators), while the AIDS and pediatrics are based on staffing costs resident space and care. Further, financing of nursing homes will remain virtually impossible as financial institutions do not see a high probability of timely repayment of funds in relatively high Medicaid caseload facilities. Replace the current Florida FRV and cost-based capital payment system with a new gross FRV system. As an alternative the Georgia FRV system as originally adopted system (Appendix xxx) should be considered as the model for the new system. (Please note that the modeling of this alternative indicated a budget impact of at least \$40 million which is consistent with the financial impact of improvements to the capital portion of the rates recommended by a workgroup in 2001.)

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G. Revised supplemental payments policy

~~Under the current payment methodology~~ In addition to the per diem payment, Medicaid pays a supplemental payment for reimbursement is available for the care of residents with Acquired Immune Deficiency Syndrome (AIDS) and for the care of medically-fragile recipients under age 21 children, but not for the care of medically complex, technologically dependent adults - usually residents with ventilator dependent care. Generally speaking, supplemental payments (add-ons) are appropriate when the payment system cannot take into consideration outliers in the cost of care continuum. Florida ~~used to pay~~ paid an add-on for ventilator care which was ~~but discontinued~~ discontinued in 1987 primarily because of its potential budget impact ~~because of its high cost~~.

AIDS Care

In evaluating the direct care component of the current reimbursement method, the Workgroup asked the question “Is a separate ~~aids~~ AIDS reimbursement rate still necessary in the current Medicaid care environment (universal precautions)?” ~~Currently~~ While Medicaid reimburses nursing homes at a higher rate for Medicaid recipients with AIDS, ~~the~~ nursing homes are required to remove the direct care additional costs related to the AIDS days from the Medicaid cost report (usually a direct offset of the revenue collected) to insure ~~so~~ that the AIDS costs are not reimbursed through the regular per diem rate causing a double payment ~~billing~~ effect.

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Two analyses were performed on this issue. ~~The~~ The first analysis was a comparison of providers reporting AIDS offsets for the January 1 2009 rate semester. The comparison was between the current reimbursement that those providers received for AIDS and what their ~~increase~~ change in reimbursement would have been had the AIDS costs been included in their regular cost report. The analysis showed that in the aggregate providers would have been reimbursed \$400,983.06 less ~~had~~ if the AIDS costs had been included in their regular per diem rate. See Figure - 6

Figure - 6

AIDS OFFSETS COMPARISON

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

<u>Medicaid Number</u>	<u>Rate Semester</u>	<u>Current Total Dollar Amount</u>
<u>210617</u>	<u>200901</u>	<u>\$4,813,882.89</u>
<u>212903</u>	<u>200901</u>	<u>\$3,977,913.27</u>
<u>214035</u>	<u>200901</u>	<u>\$5,130,188.86</u>
<u>223808</u>	<u>200901</u>	<u>\$5,057,321.68</u>
<u>252433</u>	<u>200901</u>	<u>\$3,952,138.21</u>
<u>259918</u>	<u>200901</u>	<u>\$2,717,554.55</u>
<u>263982</u>	<u>200901</u>	<u>\$5,142,966.42</u>
<u>281743</u>	<u>200901</u>	<u>\$13,833,353.16</u>
		<u>\$44,625,319.04</u>
		<u>(\$400,983.06)</u>

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

These findings support a conclusion that the costs of treating an AIDS patient do not warrant the continuation of the AIDS supplemental payment. It should be noted that the discontinuance of the supplemental payment will have a negative impact on certain individual nursing facilities and would require the recalculation of the Medicaid rates, including the adjustment of targets and ceilings, for all impacted facilities to insure that the costs which have been offset are reimbursed through the normal per diem payment.

Ventilator Care

Ventilator care is expensive and staff intensive in nursing homes. Nearly all of the cases are transfers from hospitals or special care units. The Florida payment system ~~used to provide~~ provided a supplemental payment for ventilator care during 1985 and 1986, but this supplement was ~~phased out~~ discontinued in 1987 because of ~~due to its high cost~~ budget impact. Many ventilator-dependent adults are cannot be discharged from an acute care hospital and be placed in a nursing facility because of inadequate funding. Nursing facilities are not able to accept these individuals at the current Medicaid per diem rate which is inadequate to cover the additional costs of staff and equipment necessary to care for these medically complex adults. Therefore, most of the medically complex adults are forced to remain in a hospital setting, sometimes for years, due to a lack of placement options and the hospitals are forced to absorb the costs, often in excess of one million dollars annually for each ventilator dependent patient. Many hospitals have been willing to establish agreements with their local nursing facilities to provide support for these patients;

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however, Federal anti-supplementation requirements preclude the payment of such assistance.

A comprehensive 2003 report on ventilator care funding in nursing homes commissioned by the Florida Department of Health (Appendix ???) found:

“The use of a supplemental payment for NFs providing care to Medicaid recipients who are ventilator-dependent is the preferred and recommended reimbursement method for this project. Supplemental payments permit a state to provide additional funding to a provider without having to revise the existing cost-based reimbursement methodology, a process that is generally complex and subject to various pitfalls including legal challenges by providers. In addition, supplemental payments may be paid to a NF even if the NF’s per diem rate is limited by existing ceilings. Finally, supplemental payments are relatively easy to implement and administer and are already utilized for two other groups of individuals residing in NFs (individuals with AIDS and medically fragile children).

No major revision of the current NF reimbursement plan is required. Only a new Medicaid billing code for a supplemental payment is required.

The amount of the supplemental payment must be both sufficient to ensure that NFs can provide the necessary care and must also be cost-effective. The determination of what constitutes an adequate and cost-effective rate must be determined by the State of Florida. Exhibit 1 contains several tables which provide a comparison of what several other states pay to NFs for a regular NF per diem payment and the enhanced payment made for NF services provided to ventilator-dependent Medicaid recipients. The sufficiency and cost-effectiveness of these payments are subject to various interpretations beyond the scope of this report.”

Currently, ventilator care related equipment costs are reported by providers in their cost reports under Schedule T as assets. Other ventilator care related costs are reported in other sections of the cost report, usually comingled with general care, since a special supplemental payment is not available. To implement a supplemental payment methodology for ventilator care Florida would have to obtain additional data from those provider who currently provide this type of care (primarily nursing homes associated with acute care hospitals) and develop both a statewide average supplemental rate and standards of care. This work was not within the scope and time limitations of the Workgroup. One possible solution is to provide a comprehensive all-inclusive supplemental payment to nursing facilities willing to serve adults who are medically complex, technologically dependent and require that these nursing facilities meet specific standards in order to be eligible to receive this supplemental rate. Another alternative would be to develop a

supplemental payment for the extraordinary costs of increased staffing and a separate fee schedule payment system for the equipment.

Either of these alternatives will result in more Medicaid beneficiaries being placed in a more appropriate level of care and in a less costly setting while allowing Medicaid recipients to reside closer to their families and social support systems. Additionally, new technology is being introduced that will assist some individuals to be weaned off ventilators either permanently or periodically during the day, increasing their ability to return home. This new technology may eliminate or reduce the amount of time that an individual would need services in a nursing facility.

The development of a statewide average supplemental rate and/or equipment fee schedules and standards of care were outside the scope and time limitations of this Workgroup; however, the Department of Health has developed standards of care for individuals who are ventilator dependent and implemented a pilot project in February 2008 that uses the standards.

Specialty Equipment/Bariatric Equipment

The current Medicaid payment system does not provide adequate funding when other specialty equipment, such as bariatric equipment for the treatment of wounds, is required for the care of residents. Creation of a separate outlier fee schedule for such equipment would allow for adequate funding necessary to improve the quality of care for technology-dependent residents.

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Consensus — First, eliminate the supplemental payment for AIDS patients and re-calculate the Medicaid per diem rate for affected facilities. ~~Nursing facilities are used to working with infectious diseases.~~ Second, create an outlier payment methodology (supplemental payment and/or equipment fee schedule) for ventilator-dependent and other medically complex, technology-dependent residents. ~~After 20 years of handling AIDS cases, facilities experience no additional burden to warrant a special add-on rate. Ventilator care, on the other hand represents a significant expense in both equipment and staff resources and should be treated as an outlier with a special add-on rate.~~

Appendices

Appendix A – [Workgroup Charter](#)

History and Trends

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

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

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

National Comparisons

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

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

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

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

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

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

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

Direct Care

Appendix L - [2008 Wage Estimates](#)

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

Operating and Indirect Care

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

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

AIDS Offsets

Appendix P – [Skilled AIDS](#)

Appendix Q - [AIDS Offset Comparison](#)

One rate setting/One cost report submission

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

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

Acuity

Appendix T -

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

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

Ceilings

Appendix V – [Ceilings Comparison Chart](#)

Alternative FRVS

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

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

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

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

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

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