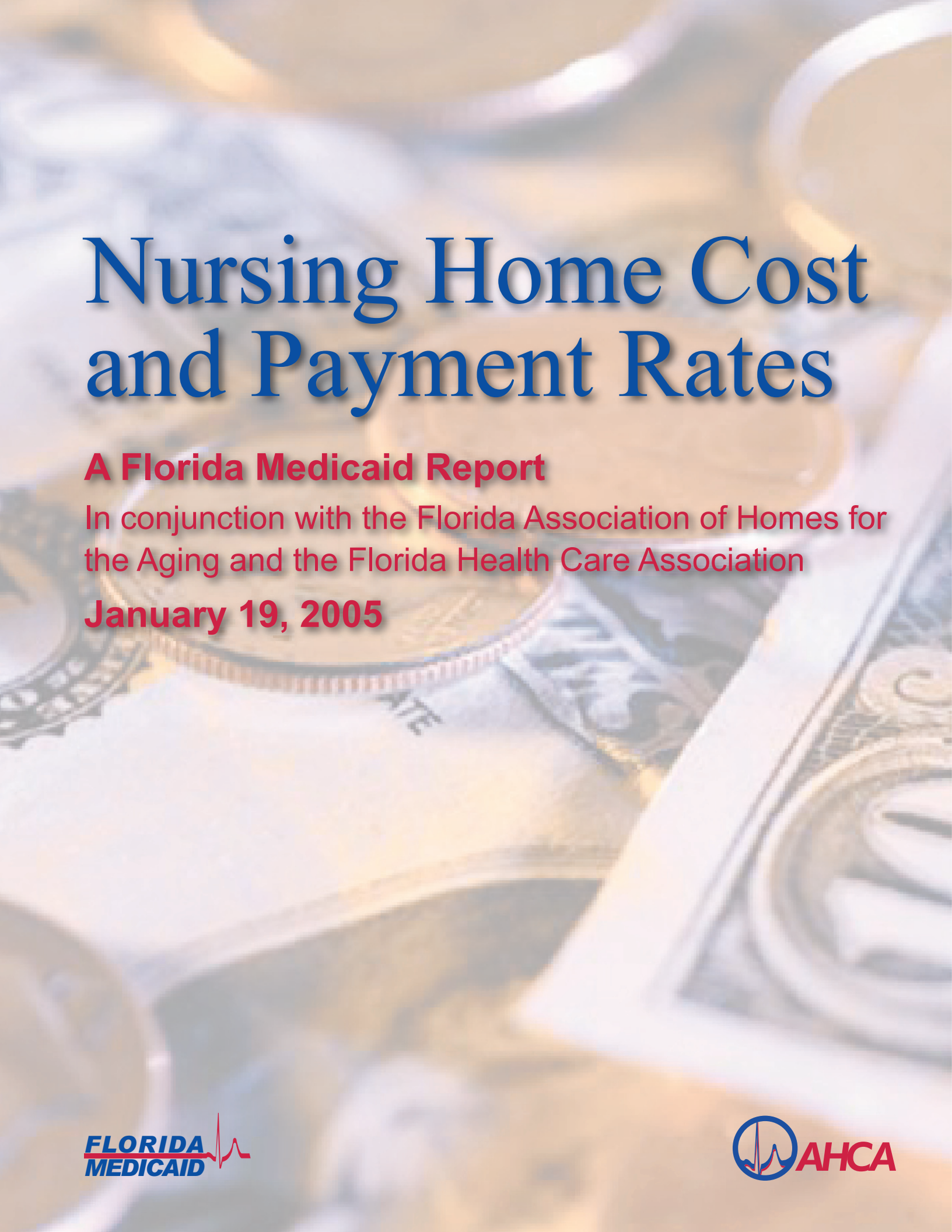

Nursing Home Cost and Payment Rates

A Florida Medicaid Report

In conjunction with the Florida Association of Homes for the Aging and the Florida Health Care Association

January 19, 2005

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EXECUTIVE SUMMARY

Background

Pursuant to HB 1837, Section 20, passed by the 2004 Florida Legislature, the Agency for Health Care Administration, in conjunction with the Florida Association of Homes for the Aging and the Florida Health Care Association, is required to evaluate the reimbursement methodology for Medicaid nursing home services to determine the adequacy of the current payment rates in meeting the costs of providing care to Florida's Medicaid residents. The report must make recommendations for changes in the current payment methodology or for development of a new payment methodology necessary to ensure a stable financial environment in which reimbursement is adequate to meet the costs of providing nursing home care for Florida's Medicaid residents served by a majority of nursing home providers. The Agency shall report its findings to the Speaker of the House of Representatives, the President of the Senate, and the Governor by December 1, 2004.

Analysis

The majority of the 643 Medicaid nursing homes in Florida are not being reimbursed 100% of their costs. This is particularly true for the Operating and Indirect Patient Care components of the per diem rate.

Before the rate reduction effective July 2004, the following received 100% of costs within the identified components of the per diem rates: 17.57% or 113 providers for the Operating component; 52.9% or 340 providers for the Indirect Patient Care component, after incentives; and 82.9% or 533 providers for the Direct Patient Care component, after incentives. After the rate reduction, there were no providers receiving their cost in the Operating component, 0.31% or 2 providers were receiving their cost in the Indirect Patient Care component after incentives, and the same 82.9% or 533 providers receiving cost in the Direct Patient Care component after incentives.

A comparison of providers' actual costs for January 1, 2003 through December 31, 2003 to the Medicaid actual reimbursement for the same period concluded that irrespective of their Medicaid utilization and component, the majority of providers did not have their actual Medicaid period costs covered by their actual Medicaid revenues.

A historical analysis of provider reimbursement rates versus cost, concluded that over the course of the past eleven years, the gap between provider costs and their provider target limitations has been slowly widening. Particularly, in the last five years, the Operating component has had the largest variance between cost and provider target limitations. See page seven for discussion of provider target limitations.

The reason that the Operating and Indirect Patient Care components are not receiving a majority of their costs is primarily due to the provider target limitation system. The target limitations within the Operating component have not been re-based since January 1993. A target re-basing simply resets the provider target limitations based on each provider's most recent costs multiplied by the inflation target factor. Without periodic re-basing to the target limitations, the difference between the growth rate of the costs versus the growth rate of the target inflation will continually increase, thereby creating a situation where eventually many, if not all, providers will be limited by target limitations. For these components, if the provider target limitations were higher, providers would receive reimbursement for a higher percentage of their costs.

While the provider target limitation system has resulted in providers not receiving a higher percentage of their costs, it should be noted that the target limitation system is quite stable and assumes a very steady rate of growth. Factors outside of the target rate of inflation methodology influence costs resulting in a higher rate of growth than the target system recognizes.

Recommendations

The purpose of this report is to recommend options that would ensure adequate reimbursement to meet the costs of providing nursing home care services for Medicaid residents served by a majority of nursing home providers. For purposes of this report, "majority of nursing home providers" has been defined as 51% of all nursing homes participating in the Medicaid program. "Costs" have been defined as each provider's actual, inflated Operating, Direct Patient Care, Indirect Patient Care, and Property costs as reported in their most recently filed cost report. In order to ensure reimbursement that is adequate to meet the costs of a majority of nursing home providers, the following options are considered:

1. Using the current reimbursement methodology, and assuming the restoration of the $66 million rate reduction that went into effect beginning July 1, 2004, minor changes could be applied to the current methodology to reimburse 51% of all providers 100% of total costs. The first step would be to eliminate all target limitations for the Operating and Indirect Patient Care components, which would cost an estimated $77 million and $33 million, respectively. Additionally, revise all providers' Property component rates by making changes to both the Fair Rental Value System and the Cost methodology until 51% of all providers are reimbursed 100% of total facility cost, an additional cost of approximately $46 million. The annualized total cost during the first year of implementation is approximately $156 million, assuming the $66 million rate reduction is restored separately, or approximately $222 million in total.

2. Another option would include more significant changes to the current methodology, but would continue to employ its basic elements. These changes may include:
    a. Revising what is considered Medicaid allowable costs.
    b. Fixing one or more of the reimbursement components at a fixed level of reimbursement.
    c. Applying a factor to the total rate until a majority of providers are reimbursed their full costs.

Item (a) may alter the current measurements of cost and payments for services, therefore the exact funding required to implement this change cannot be determined, but is not expected to exceed the $156 million described in Option 1, assuming the $66 million rate reduction is restored separately. Item (c) would cost approximately $100 million in the first year of implementation, and also assumes the $66 million rate reduction is restored separately. A methodology for continuing item (c) after the initial year of implementation would have to be developed as it is inconsistent with the current system of reimbursement.

3. Implement a new Acuity-Based Reimbursement System. The cost/savings to the State is unknown at this time as further analysis is required to quantify the details of such a system. If it is assumed that a majority of providers should be reimbursed 100% of their costs at any given time, then the overall cost of this system is anticipated to be in line with the costs described in Option 1.

BACKGROUND

Legal Authority

Legal authority for nursing services is governed by Title 42, Code of Federal Regulations (C.F.R.) Parts 405, 442, 456, and 483. State authority for participation in the Title XIX Medicaid Program is Chapters 409.919 and 409.908 Florida Statutes (F.S.). Reimbursement requirements are contained in Chapter 409.908, F.S., and Chapter 59G – 6.010 Florida Administrative Code (F.A.C.), Payment Methodology for Nursing Home Services. The Title XIX Long Term Care Reimbursement Plan (Plan) is incorporated by Chapter 59G – 6.010 F.A.C. The Plan contains the specific guidelines and methodologies used in determining each nursing provider's specific reimbursement rate. The methodologies included in the Plan will be the focus of this study.

General

At the July 2004 Medicaid cost reimbursement rate setting there were a total of 643 facilities participating in the Medicaid program. Current reimbursement rates range from $113.89 per day to $190.50 per day, with the average Medicaid reimbursement rate being $150.69. Among the 643 facilities, 526 facilities are prospective and 117 facilities are on budget. A facility that is prospective is using actual costs while a facility that is on budget is using estimated costs until such time that actual cost have been incurred and submitted for reconciliation with the estimated costs. The facilities range in bed size from 20 to 462 beds. The average bed size for a facility is 125 beds. The Medicaid program pays a single payment rate unique to each facility for all levels of nursing home care. During state fiscal year 2004 – 05 nursing homes will account for approximately $2.3 billion of the total Medicaid budget.

Medicaid reimbursement for nursing homes is a cost-based, prospective system. Each provider is required by the Plan to submit a complete cost report that details all of their costs for their entire reporting period, making appropriate adjustments for determination of allowable costs. The cost report is based on financial and statistical records maintained by the provider. All the costs of a provider fall into one of four components that comprise the final reimbursement rate. The components of the rate are Operating, Direct Patient Care, Indirect Patient Care, and Property. The costs incurred during each reporting period are inflated by a cost inflation factor to bring the prior period costs to current period values. Due to the prospective reimbursement methodology, the most current reimbursement rates are often based on costs that the providers incurred twelve to eighteen months prior.

The reported costs are adjusted down to Medicaid allowable costs. These costs are then segregated by cost component and each component is divided by total Medicaid days of the reporting period to determine a rate on a per diem basis, meaning a per

patient per day amount. The sum of the individual components results in the final Medicaid per diem rate reimbursed to each provider for each day that a Medicaid recipient is in the facility.

Costs

Each provider's cost report contains costs incurred in providing nursing home services as defined by both State and Federal law. These costs include all expenses necessary in providing routine services, such as room and board, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities. Also included are costs associated with maintaining statutory standards and regulations, such as required nursing staffing minimums and required insurances. The facilities also report costs required for the continuing operational side of the facility, such as housekeeping, maintenance, and property related additions and replacements.

Medicaid Adjustment Rate (MAR)

Prior to July 1, 1996, an incentive factor was available to providers whose Operating and Patient Care component per diems were under the effective class ceiling and who had provided a specified quality of care. Those providers who had been granted either a standard or superior quality of care licensure rating were also eligible to receive additional incentives. Incentives were paid to encourage high-quality care while containing costs. Beginning with the July 1, 1996 rate semester, incentive factor payments were no longer allowed and were replaced with a Medicaid Adjustment Rate (MAR) for Patient Care only. For a provider to be eligible for the MAR add-on they must be receiving a prospective rate unless they are a new provider associated with a non-related party change of ownership or operator whose application was received by Medicaid on or after September 1, 2001.

The calculation of the MAR add-on, also referred to as an incentive, takes factors into consideration. Facilities with 90% or greater Medicaid Utilization shall have their MAR equal their weighted base rate. The weighted base rate is determined by multiplying their base rate by the Medicaid adjustment weight, which is set at .045, then multiplying by the percentage of standard and superior (without differentiation) licensure rating days to total licensure rating days. Facilities with 50% or less Medicaid utilization shall receive no MAR. Facilities between 50% and 90% Medicaid utilization shall have their MAR determined by multiplying their weighted base rate by the Medicaid adjustment. The MAR is to be included in both the Direct Patient Care component and Indirect Patient Care component of the provider's total reimbursement rate.

Facilities that have a base rate equal to their cost will be reimbursed more than their cost because the incentives will take them above cost. This explains how a facility can be reimbursed greater than 100% of their cost.

New providers with no cost history resulting in a change of ownership or operator filed before September 1, 2001, where the previous provider participated in the Medicaid program will not receive MAR until the provider goes prospective. New providers with no cost history resulting in a change of ownership or operator filed on or after September 1, 2001, where the prior provider participated in Medicaid, shall be eligible for the MAR. The MAR will be equivalent to the prior providers' MAR until the new provider goes prospective.

Cost Inflation

Allowable costs are the basis of the reimbursement rate. Being a cost-based, prospective system, each providers' costs for a given reporting period must be inflated forward by a "cost inflation" factor. This brings each facility's reported, prior period costs up to today's dollars. This cost inflation factor is calculated by using the Skilled Nursing Facility Market Basket of Routine Service Costs inflation indices for the following three components:

- Salaries and Benefits – includes Wages and Salaries combined with Employee Benefits
- Dietary – Food
- All Others – includes Fuel and Utilities, combined with Other Expenses

The indices are combined by summing the products of each index times the ratio of the respective budget share to total budget share represented by the combined indices. A weighted quarterly index is then constructed by summing the products of the weights and quarterly component indices. This quarterly composite index is utilized to obtain monthly indices called the Florida Nursing Home Cost Inflation Index by averaging pairs of quarterly indices and interpolating between these averages. In determining each facility's cost inflation factor, Medicaid takes the monthly Florida Nursing Home Cost Inflation Index that corresponds to the midpoint of the rate semester for which Medicaid is setting the reimbursement rates divided by the monthly Florida Nursing Home Cost Inflation Index that corresponds to the midpoint of each facility's cost reporting period. This gives Medicaid the cost inflation factor that is multiplied times each facility's most recently reported Operating, Direct Patient Care, and Indirect Patient Care costs to bring these prior period costs to current period dollars.

Target Inflation

The purpose of a target rate of inflation is to measure efficiency against cost increases. The target rate of inflation principle is that a provider's cost should not increase from one fiscal period to the next by a percentage amount which exceeds 1.4 times the average percentage of increase in the Florida Nursing Home Cost Inflation Index for the same period. The target inflation factor is calculated by dividing the monthly Florida Nursing Home Cost Inflation Index that corresponds to the midpoint of the current rate semester for which Medicaid is setting rates divided by the monthly Florida Nursing Home Cost Inflation Index that corresponds to the midpoint of the previous rate semester. The product of this calculation is multiplied by 1.4 to determine the target inflation factor. This target inflation factor is used in determining provider specific limitations to each cost component of the reimbursement rate. See page 13 for a description of changes that have resulted in limitations to the target inflation.

Provider Target Limitations

Before establishing the final rate for each component, limitations are placed on each component. These limitations are the Provider Target, the New Provider Target, the Cost-based Class Ceiling, and the Target-based Class Ceiling. Each of these limitations is calculated differently and is unique to the individual provider or provider grouping, also known as the provider's class.

The Provider Target is unique to each provider. It is based on each provider's first semester of actual, inflated cost. Each subsequent rate semester, the prior semester's Provider Target is inflated forward by multiplying the prior semester's Provider Target by the current rate semester's target inflation factor (as described above) to become the current rate semester's Provider Target.

The New Provider Target is also unique to each provider. For a provider new to Medicaid, it is initially calculated as the average per diem for the district in which the facility is located plus 50% of the difference between the average district per diem and the facility class ceiling. The class ceiling is defined as the lower of the Cost-based Class Ceiling and the Target-based Class ceiling. For a provider that underwent a non-related change of ownership or operator prior to September 1, 2001, the New Provider Target was initially calculated as the prior provider's component per diem excluding incentives plus 50% of the difference between the prior provider's component per diem excluding incentives and the class ceiling. For a provider that undergoes a non-related change of ownership or operator after September 1, 2001, the New Provider Target is equivalent to the previous provider's reimbursement rate excluding incentives. Each rate semester after the initial calculation, the prior rate semester's New Provider Target is inflated by multiplying this amount by the target inflation factor to become the current rate semester's New Provider Target. As the

New Provider Target was effective at the July 1991 rate semester, not all providers will have this limitation. A provider will have a New Provider Target only if, after July 1, 1991, the provider entered the Medicaid program or had a non-related party change of ownership or operator. It is also possible for a provider to have a New Provider Target in one component, but not in another component. This will be explained in greater detail in the next section.

Class Ceiling Limitations

The Target-based Class Ceiling and the Cost-based Class Ceiling are unique to the provider grouping, or class. Each class is a division of providers based upon their geographic region in the state (North, South, and Central) and the provider size based upon number of total Medicaid beds (Small - less than 100 beds and Large - greater than 100 beds). The six classes are identified as: North Small, North Large, South Small, South Large, Central Small, and Central Large.

The Target-based Class Ceiling for each class was initially established at the January 1993 rate setting by inflating forward the July 1992 Cost-based Class Ceiling to become the January 1993 Target-based Class Ceiling. Each rate semester after the initial calculation, the prior rate semester's Target-based Class Ceiling is inflated forward using the target inflation factor to become the current rate semester's Target-based Class Ceiling. The Target-based Class Ceiling is always inflated from period to period by the target inflation rate. Therefore, this represents the theory that the average costs of providers within a particular class should not increase more than 1.4 times the average increase in the Florida Nursing Home Cost Inflation Index from period to period.

The Cost-based Class Ceiling for the Operating Cost component is based on the median operating costs, plus one standard deviation, of all prospective costs for providers within the same class. The Cost-based Class Ceiling for the Direct Patient Care and Indirect Patient Care components is based on the median costs, plus 1.75 standard deviations, of all prospective costs for providers within the same class. These median costs are then multiplied by the ratio of each class median to the state median. Therefore, the Cost-based Class Ceilings are based on each provider's reported, actual, inflated costs by class. Cost-based Class Ceilings are recalculated every six months. Unlike the target limitations, these ceilings consist of costs inflated by the cost inflation factor, as opposed to the target inflation factor.

Each cost component will not necessarily have all of these limitations placed upon it. The Operating component will receive the lower of its actual inflated cost, the Provider Target, Cost-based Class Ceiling, Target-based Class Ceiling, or the New Provider Target, if applicable. As of January 1, 2002, the Direct Patient Care component has only one limitation. It receives the lower of actual inflated cost or the Cost-based Class

Ceiling. The Indirect Patient Care component will receive the lower of its actual inflated cost, the Provider Target, Cost-based Class Ceiling, Target-based Class Ceiling, or the New Provider Target, if applicable.

Prior to January 2002, the Direct Patient Care component and Indirect Patient Care component were combined into just one Patient Care component. The Patient Care component would receive the lower of its actual inflated cost, the Provider Target, Cost-based Class Ceiling, Target-based Class Ceiling, or the New Provider Target, if applicable. When the Patient Care component was split at January 2002, a complete re-basing of the targets for the Indirect Patient Care component occurred. A re-basing for the Direct Patient Care component could not occur because there would be no targets for this component, only the Cost-based Class Ceiling. The re-basing of the Indirect Patient Care component meant that at the January 2002 rate setting, the Provider Target, Target-based Class Ceiling, and New Provider Target would drop off and that the Indirect Patient Care component per diem would be the lower of actual inflated cost and the Cost-based Class Ceiling. Then, at the July 2002 rate setting, the January 2002 actual inflated cost would be inflated forward to become the July 2002 Provider Target. Also, at the July 2002 rate setting, the January 2002 Cost-based Class Ceiling would be inflated forward to become the July 2002 Target-based class Ceiling. If a provider had the New Provider Target before January 2002, it would not return unless the provider underwent a non-related party change of owner or operator after July 1, 2002. For the rate semesters subsequent, the targets would continue to track as normal.

Property costs are reimbursed through the per diem in one of two ways. First, for providers who are on the Fair Rental Value System or “FRVS”, reimbursement is calculated using the cost of assets, property taxes, insurance, and any applicable home office costs. Also taken into consideration is the facility’s mortgage amount and interest rate. The Property component under FRVS has no target limitations or ceilings, as described above, but instead applies a per-bed standard limitation. The per-bed standard limitation sets a maximum amount that each facility’s property asset indexing can grow. Approximately 90% of the providers in the Medicaid Nursing Home program are reimbursed under the FRVS methodology. The second way a nursing home is reimbursed for property costs is under the “Cost” method. For these providers, reimbursement is based upon depreciation costs, interest costs, and return on equity. Again, there are no target limitations applied, but rather a statewide ceiling that applies to all providers reimbursed under this methodology. Approximately 10% of the providers in the Medicaid Nursing Home program are reimbursed under this methodology.

Changes in Reimbursement Methodology

Over the years, there have been both policy changes as well as reimbursement methodology changes that have had an effect on the reimbursement rates. For instance, the current target inflation factor is calculated as 1.4 times the Florida Nursing Home Inflation Index. Originally, the target inflation factor was calculated by using a multiplier of 2 times the Florida Nursing Home Inflation Index. In July 1990, the multiplier was reduced from 2 to 1.786. In August 1992, the multiplier was further reduced from 1.786 to 1.5. Then in July 1996, the multiplier was reduced to its current level of 1.4. Since the target inflation factor has a "carry forward" effect, these reductions resulted in lower provider target limitations than would have resulted if the multipliers had not been reduced. Therefore, assuming a provider's costs increased from one period to the next at the same rate as the previous target inflation, the variance between the provider's costs and the provider's target limitations would be greater due only to the decrease in the multiplier. In July 1993, for the Operating component, approximately 259 of 564 (45.92%) active providers' rates were reimbursed 100% of their costs. Approximately 180 of 564 (31.91%) of providers' rates were limited to provider targets. During this time the target inflation multiplier was 1.5 times the Florida Nursing Home Inflation Index. By July 1998, with the multiplier at this time being 1.4, approximately 198 of 638 (31.03%) of active providers' rates were reimbursed 100% of their costs. Approximately 440 of 638 (68.97%) of providers' rates were limited to provider targets. At the July 2004, rate setting the Operating component, had 112 of 648 (17.28%) active providers were receiving their costs prior to the mandated budget reduction. The remaining 536 (82.72%) providers were limited to a provider target.

The reduction in the inflation multiplier is not the only factor affecting the widening gap between cost and provider target limitations. Another notable policy change affecting reimbursement includes the statutory regulations requiring General Liability and Professional Liability Insurance (GLPL), effective July 1, 2000. GLPL is reported as an administrative expense within the Operating component of the Medicaid cost report. Prior to July 2000, both the State and the nursing home industry recognized that the availability and affordability of GLPL would become increasingly beyond the providers' reach. During state fiscal year 2000-01, the State allowed for interim rate requests to address the increased costs of GLPL. In meeting the requirements of the interim rate provisions for GLPL, those nursing homes to which interim rates were granted were allowed to have their provider target limitations increased up to their Cost-based Class Ceilings. While this provided some relief to the providers, most providers did not receive an interim and therefore did not benefit from any relief. This was another cost that over time increased the gap between provider costs, provider targets, and ceiling limitations. Temporary relief was provided again in July 2002 when a partial re-basing of the target limitations went into effect. Again, this relief was short lived, as the re-basing was non-recurring and target limitations returned to their previous levels at July 2003.

The requirements set forth in Section 49 of Senate Bill 1202, passed by the 2001 Florida Legislature, required that Medicaid amend the Plan and cost reporting system to create Direct Patient Care and Indirect Patient Care components of the Patient Care component from the per diem rate. In order to obtain the information necessary to divide the Patient Care component into these two components, the AHCA required all prospectively reimbursed providers to submit a supplemental schedule, containing all Direct Patient Care costs of the facility, as part of their cost reports. The Direct Patient Care component includes salaries and benefits of Direct Patient Care staff providing nursing services, including registered nurses, licensed practical nurses, and certified nursing assistants who deliver care directly to the residents in the nursing facility. This excludes nursing administration, minimum data set (MDS) coordinators, care plan coordinators, staff development, and the staffing coordinator. All other Patient Care costs are included in the Indirect Patient Care cost component of the Patient Care per diem rate.

A second provision of Senate Bill 1202 required the nursing facilities to comply with new nursing staffing ratios effective January 1, 2002. For the January 1, 2002, rate setting and after, Medicaid used the reported hours information from the supplemental schedule to calculate a “gross up factor” included in facility rates for the increased staffing requirements. The “gross up factor” was added to each facility’s Direct Patient Care costs to account for the additional reimbursement needed to bring each facility from its current staffing levels to the required new minimum staffing levels effective January 1, 2002, of 1.0 hours per patient day for registered nurses and 2.3 hours per patient day for certified nursing assistants. The required minimum staffing levels increased at January 1, 2003, from 2.3 hours per patient day to 2.6 for certified nursing assistants. The minimum staffing requirement for registered nurses remained at 1.0 hours per patient day. The required minimum staffing levels for certified nursing assistants was scheduled to increase from 2.6 hours per patient day to 2.9 for certified nursing assistants on January 1, 2004, but was delayed by the 2003 Florida Legislature until May 1, 2004. The staffing increase for certified nursing assistants rescheduled for May 1, 2004, was again delayed until July 1, 2005, by the 2004 Florida Legislature.

In addition to these changes, effective July 1, 2004, the Legislature mandated a $66,689,094 reduction to the nursing home reimbursement budget. This was a direct cut to each component of the rate, except for the Direct Patient Care component. The average final per diem reduction to all facilities was $3.92, which resulted in an average annualized facility reimbursement reduction of $103,716.

ANALYSIS

One of the objectives of this report is to determine the adequacy of the current payment rates in meeting the costs of providing care to Florida's Medicaid residents. In order to properly analyze this information, it is necessary to review the historical trends of the providers' costs versus their reimbursement.

As discussed earlier in this report, each facility's final Medicaid per diem rate is the lower of each component's actual inflated cost, target, or ceiling limitation. The components consist of Operating costs, Direct Patient Care costs, Indirect Patient Care costs, and Property costs. The base year for the analysis is July 1993. This rate semester has been selected as the base year for this analysis because this is the last rate semester that reflects a full re-basing in the Operating and Patient Care components of the final per diem. Therefore, each provider's Operating and Patient Care components had newly re-based target limitations that equal their cost multiplied by the target inflation rate. In addition, the target-based class ceilings had been re-based as well. Therefore, the July 1993 Operating and Patient Care component per diems are as close to cost as can be determined based on re-basing.

Chart 1 (next page) shows what percentage of providers are receiving 100% of their costs in their total reimbursement rate. During the rate semesters following the July 1993 rate semester, costs began growing at a rate of inflation greater than the target rate of inflation. As you move farther away from July 1993, the percentage of providers receiving 100% of their costs decreased. Initially at January 1994, there is a sharp decline of providers who receive 100% of their costs. This is due to new cost reports being used for the first time, as compared to their new targets. This shows that almost immediately, costs have grown at a rate greater than the target inflation rate. The percent of providers receiving 100% of their costs continues to decline until July 1999 when the State implemented a case-mix add-on to each provider's rate. This add-on was to the final rate and with the additional reimbursement, more providers were reimbursed a higher percentage of their costs. Another sharp decrease occurs at July 2003 when the non-recurring funds for a partial re-base to the Operating component ends. The decline at July 2004 represents the legislatively mandated rate reduction. After the July 2004 reduction, approximately 613 of 643 (95.33%) of providers were not being reimbursed 100% of their total costs.

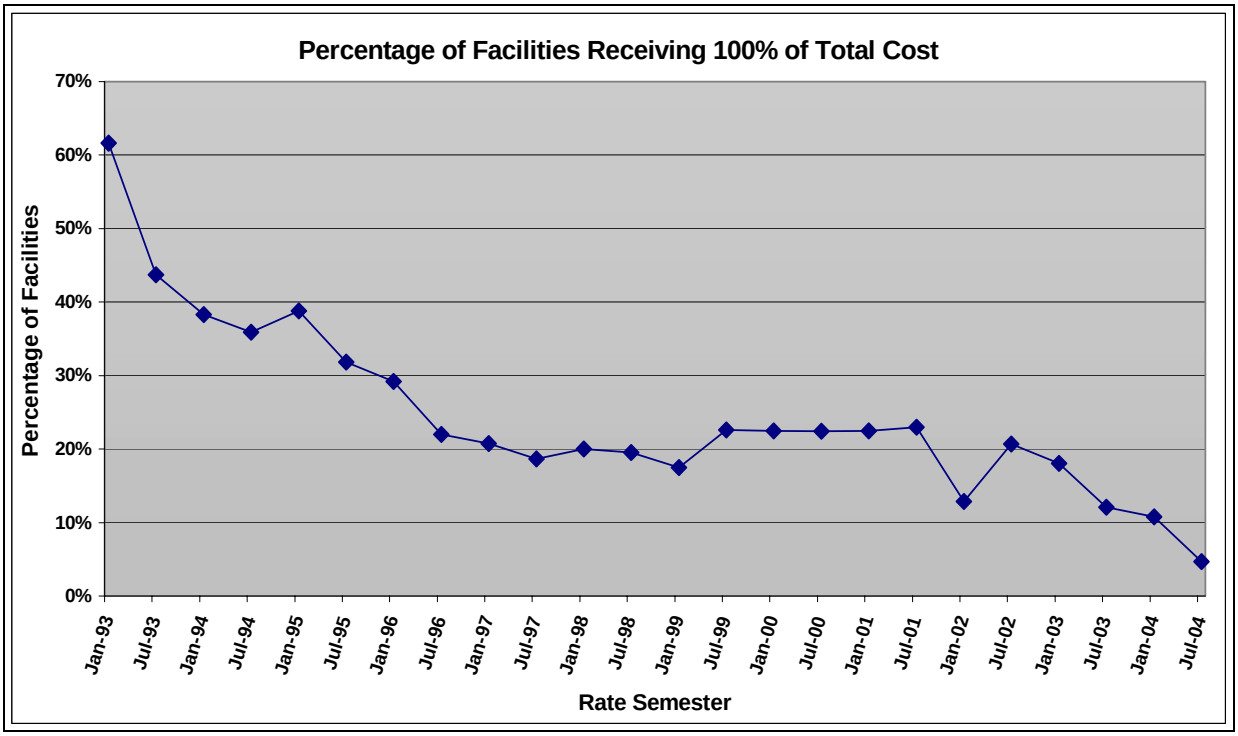

Chart 1: Percentage of Facilities Receiving 100% of Total Cost

Chart 2 (shown below) shows the same information as above, but for those providers receiving 95%, 90%, and 85% of costs.

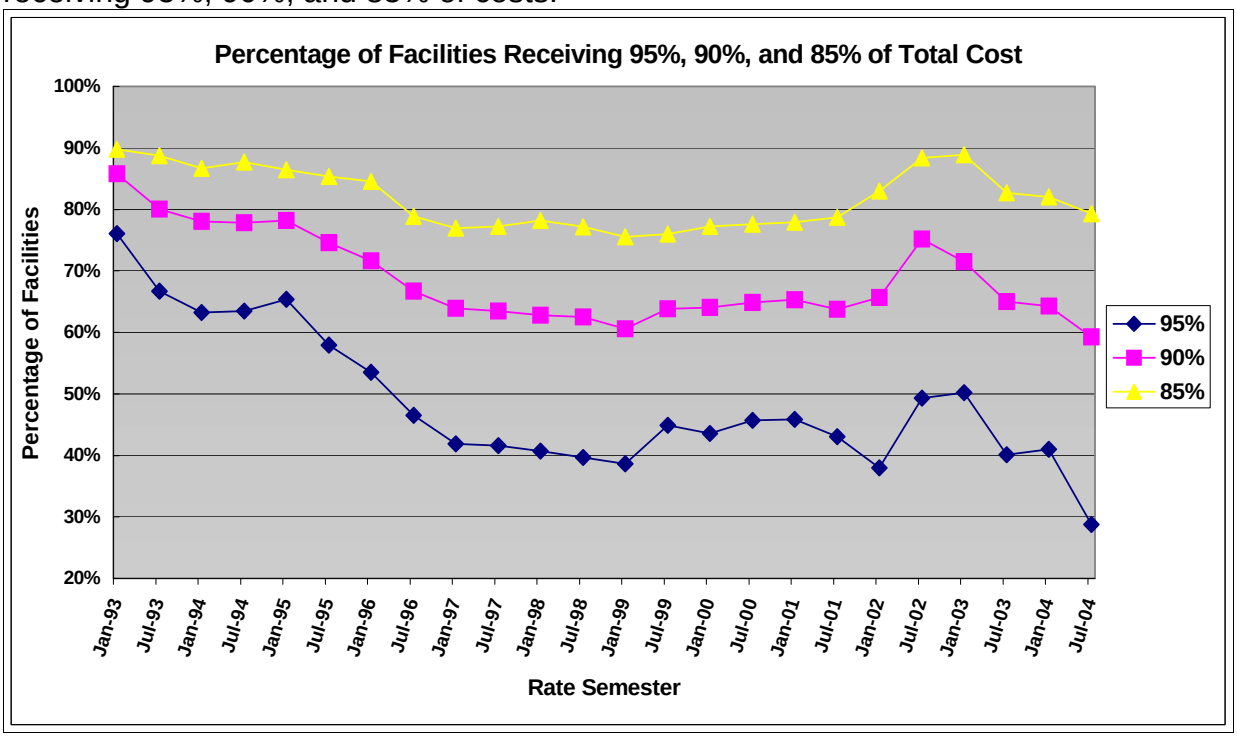

Chart 2

In analyzing the trends in costs versus reimbursement, it is necessary to review the individual component trends as well. This allows for the analysis of individual factors that influence a single cost component and its relation to the total. As evidenced in Chart 3, a historical review of the Operating component shows that in July 1995, approximately 52.13% of the providers were receiving 100% of their Operating costs within their Operating component per diem. Approximately 65.93% received 95% of their Operating costs in that same rate semester. Between July 1995 and January 2004, there was an overall decline in the number of providers receiving 100%, 95%, 90%, and 85% of their costs, respectively. More noticeable declines were observed at July 1996, July 2000, and July 2003. Beginning in July 1996, incentives were removed from the Operating component. Since incentives were an add-on to the final Operating component per diem, removal of the incentives would explain the decrease in the number of providers who received a higher percentage of their costs within their component per diem. In addition, in July 1996, the target inflation multiplier was reduced from 1.5 to 1.4. This further increased the difference between provider costs and provider target limitations. Effective July 2000, the General and Professional Liability Insurance issue intensified and the high cost of obtaining the insurance contributed to more providers being limited by a target or ceiling limitation and thereby receiving a lower percentage of cost. The July 2003 decline is caused by the reversal of the partial re-base, as it was funded with non-recurring funds.

The target limitations within the Operating component have not been re-based since January 1993. As described earlier in this report, a target re-basing simply resets the provider target limitations based on each provider's most recent costs multiplied by the inflation target factor. Without periodic re-basing to the target limitations, the difference between the growth rate of the costs versus the growth rate of the target inflation will continually increase, thereby creating a situation where eventually all providers will be limited by target limitations.

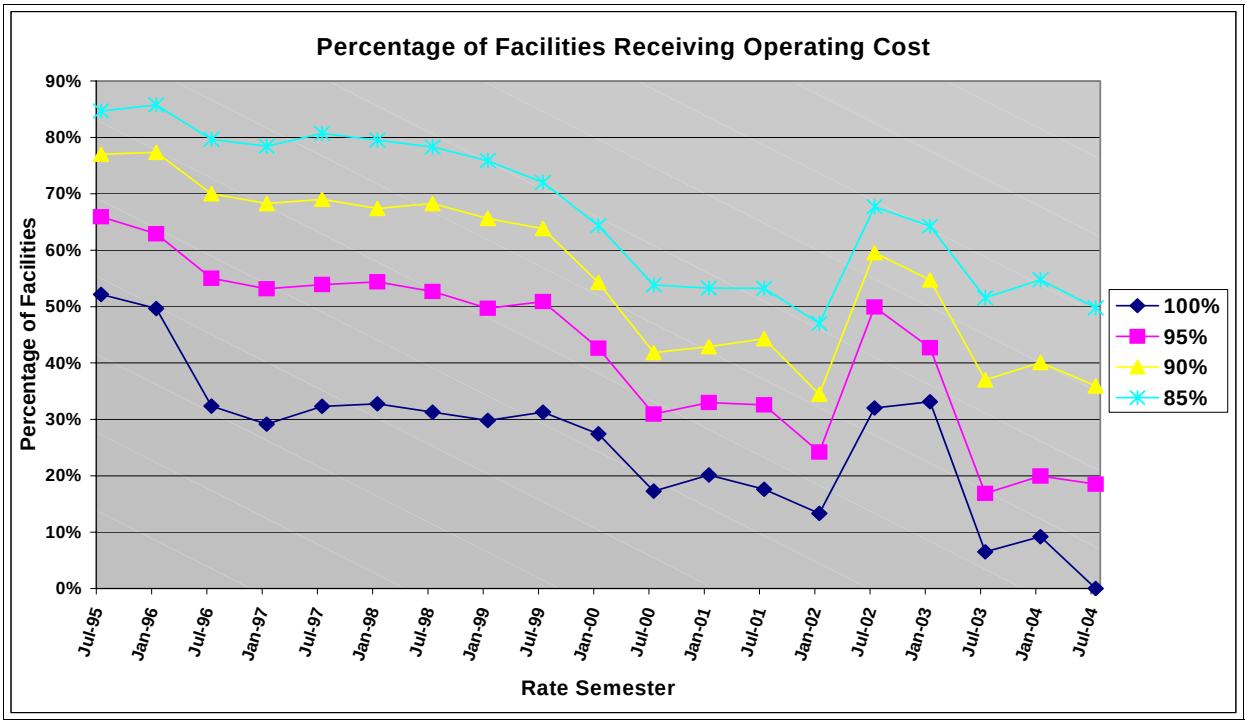

Chart 3

A review of the Patient Care component from January 1993 through July 2004, shows that beginning in January 1993 through January 1999, there was a gradual decrease of the percentage of providers who received their cost within their Patient Care component reimbursement per diem (see Chart 4). At July 1999, there was sharp decline in the number of providers receiving cost. The reaction to this decline came in January 2000, when there was a legislatively mandated partial re-basing of the Patient Care target limitations. Then in January 2002, there was a dramatic increase in the percentage of providers receiving cost. This is due to the Senate Bill 1202, passed by the Florida Legislature, which divided the Patient Care component into the Direct and Indirect Patient Care components and eliminated the target limitations. With each rate semester after January 2002, there is a decline in the percentage of providers receiving cost. This is mostly due to the return of the Indirect Patient Care component target limitations. Finally, at July 2004, another sharp decrease is seen due to the rate reduction.

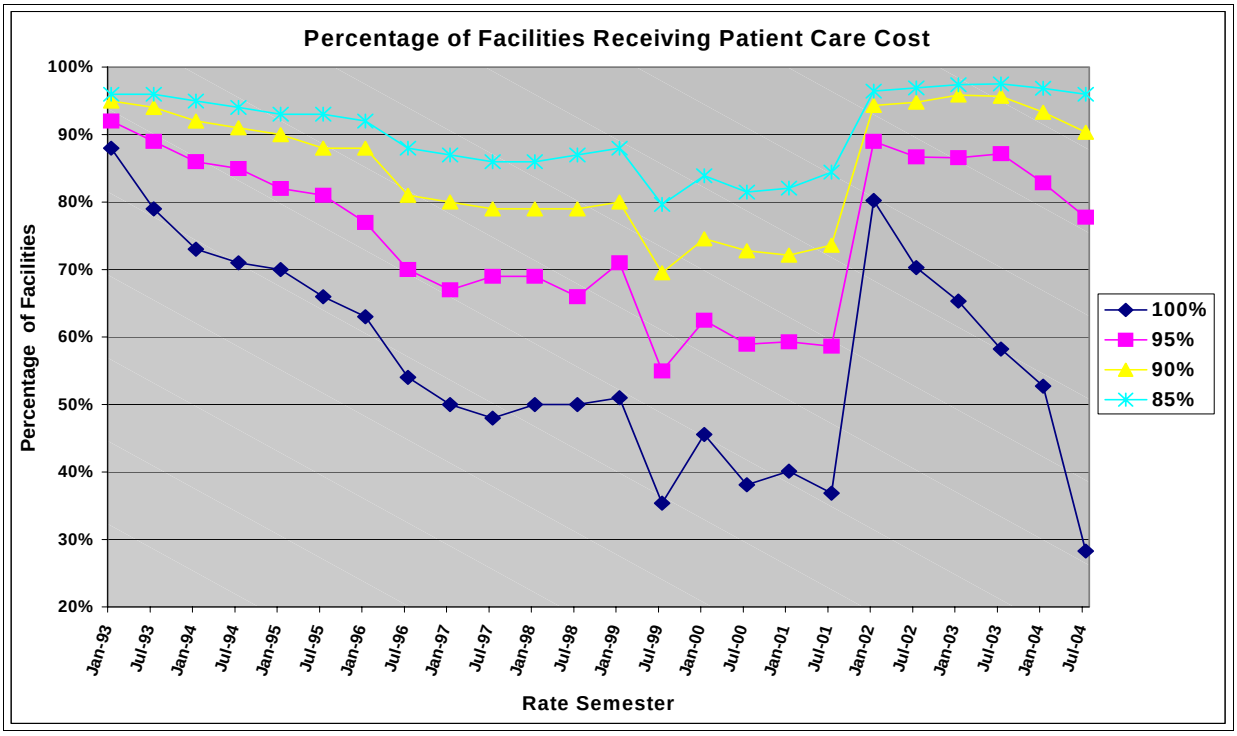

Chart 4

Effective January 2002, the Patient Care component was divided into the Direct and Indirect Patient Care components. During the January 2002 rate semester, each of these components had their target limitations removed. Therefore, both of these component per diems were based on the lower of cost or cost-based class ceiling. Prior to January 2002, most of the providers who were receiving reimbursement less than cost were limited to a target limitation. Upon removal of the target limitations, approximately 85.6% of all providers were reimbursed 100% of their costs in the Direct Patient Care component.

Chart 5 shows that for the rate semesters from January 2002 through July 2004, more than 80% of the providers received 100% of their cost within their Direct Patient Care component per diem. This is explained by the removal of the target limitations and the class-based target ceiling.

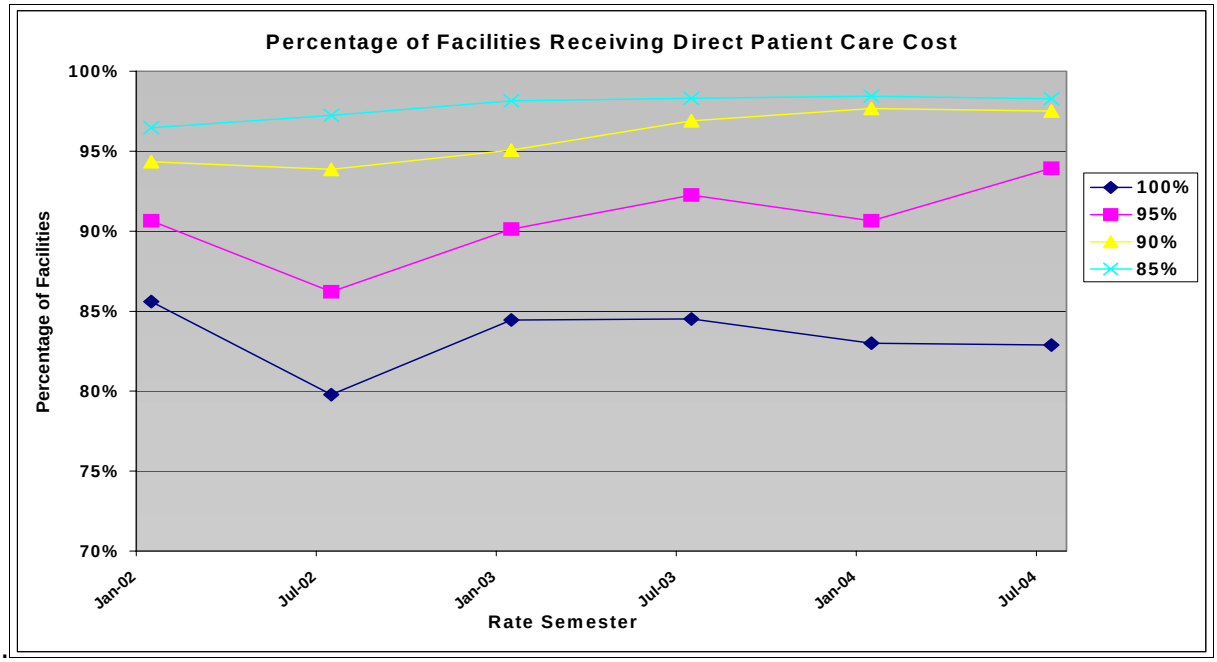

Chart 5

The information in Chart 5 is contrasted by the quick decline in the percentage of providers receiving cost in the Indirect Patient Care component for the same timeframe as shown in Chart 6. The decline that begins in July 2002 is due to the return of the provider target limitation and the target-based class ceiling. This shows that the growth in costs from semester to semester is greater than the growth in the target inflation rate during the same semesters.

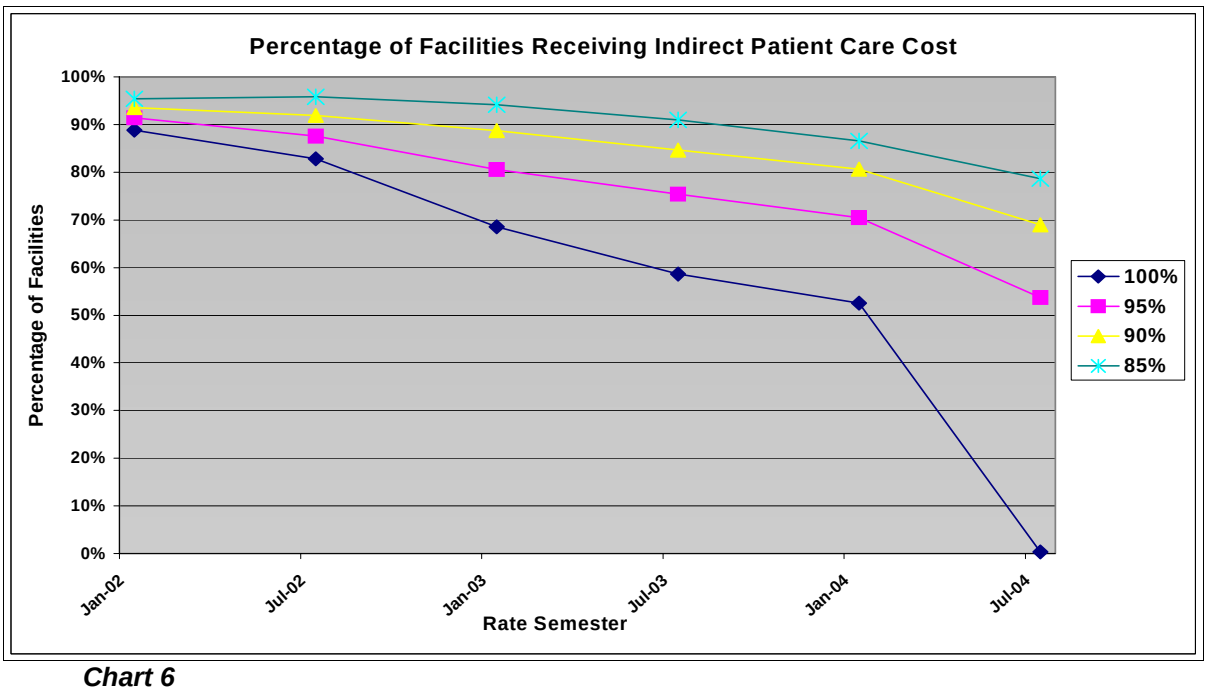

Chart 6

The analysis of costs versus reimbursement on a historical basis reveals that over time the difference between cost and reimbursement is becoming greater. Beginning at January 1993, approximately 61.6% of the providers received 100% of their costs within their final per diem rate. By July 2004, only 4.67% of providers received 100% of their costs.

In order to determine the adequacy of the Medicaid reimbursement rate, a comparison was made of the most recent provider-reported inflated Medicaid costs for the July 2004 rate setting and actual Medicaid reimbursement for the July 2004 rate setting. All providers were grouped according to their respective Medicaid utilization percentage. As the accompanying five charts show, the Medicaid providers did not have their most recent reported Medicaid costs used to set the July 2004 rates covered by their actual Medicaid reimbursement for the July 2004 rate semester, irrespective of their Medicaid utilization or component.

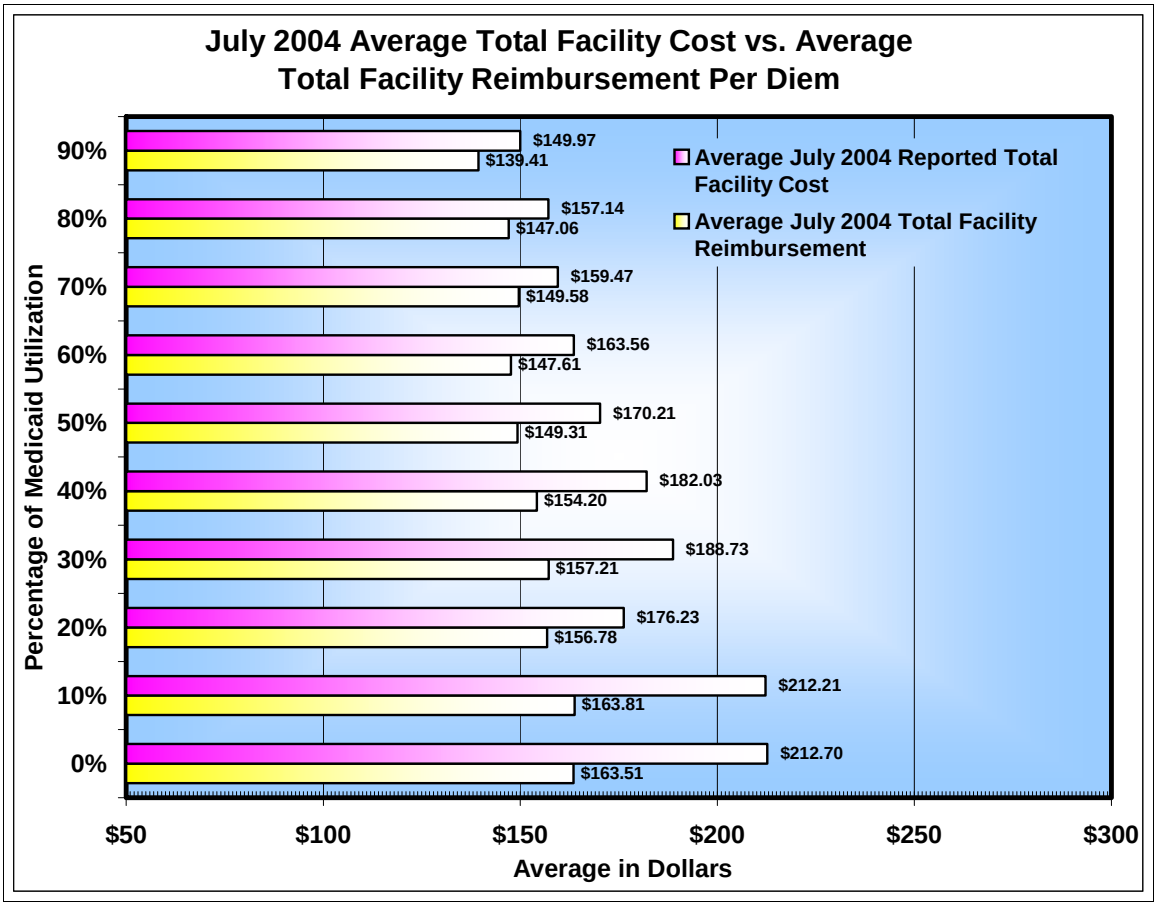

Chart 7

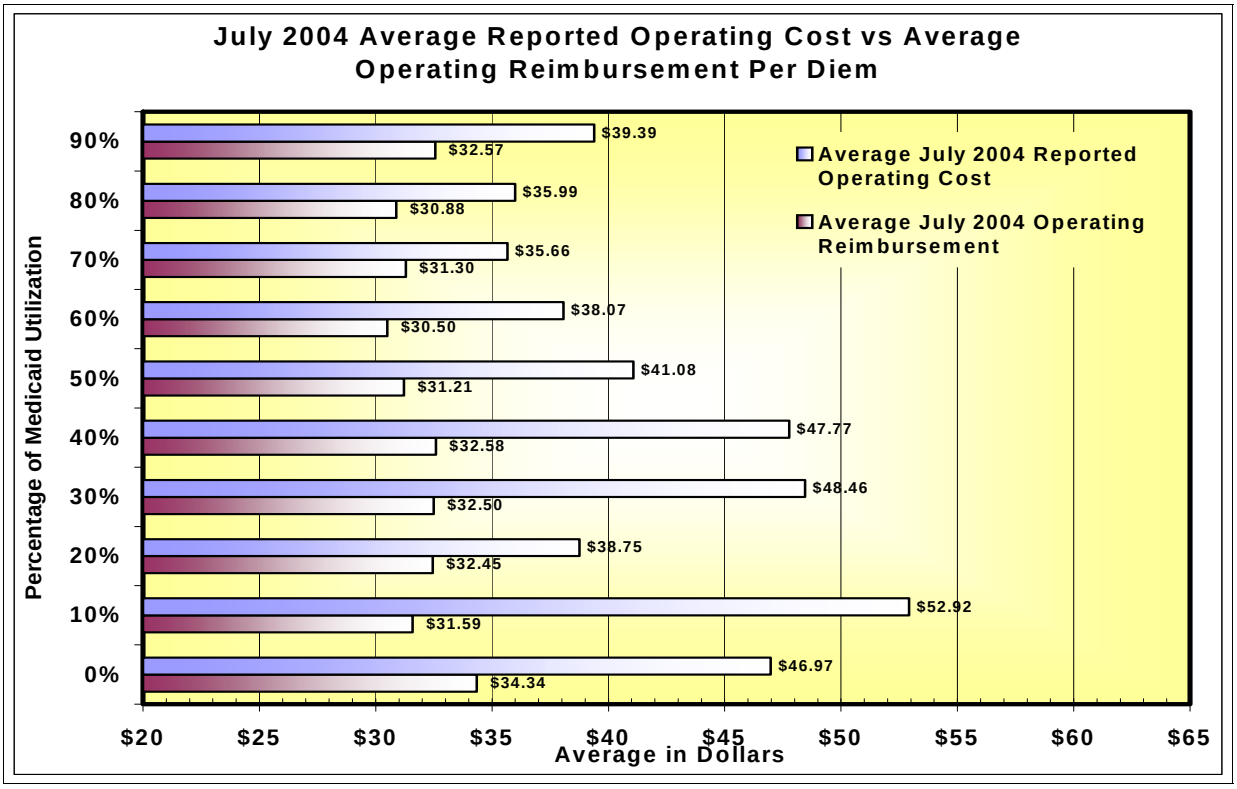

Chart 8

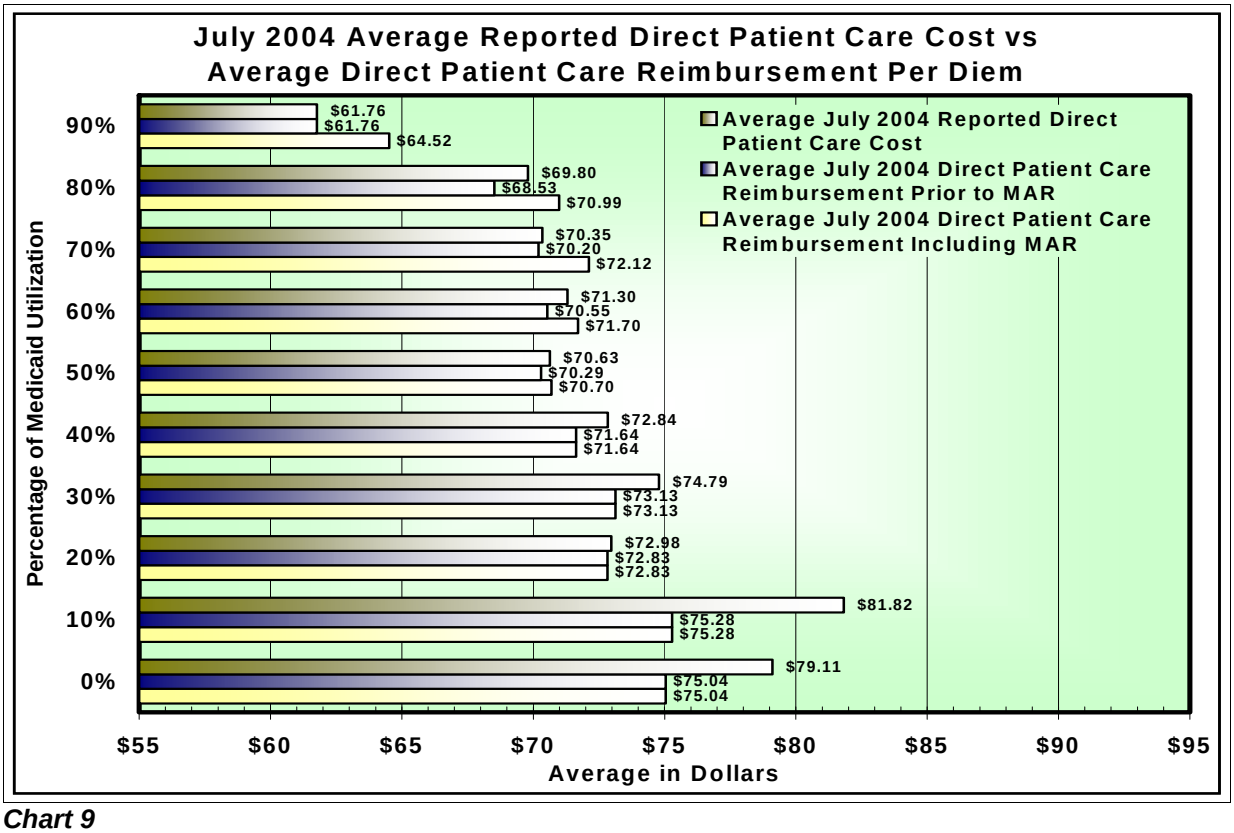

Chart 9

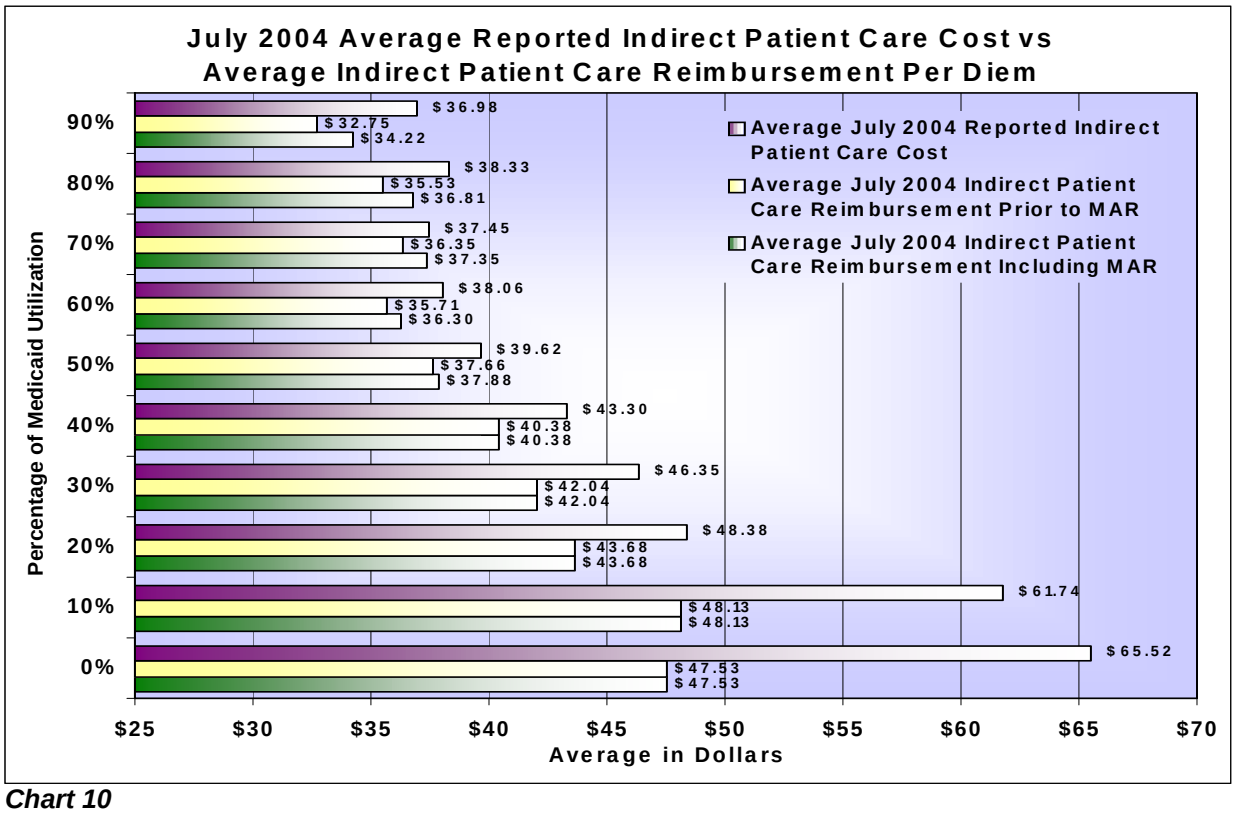

Chart 10

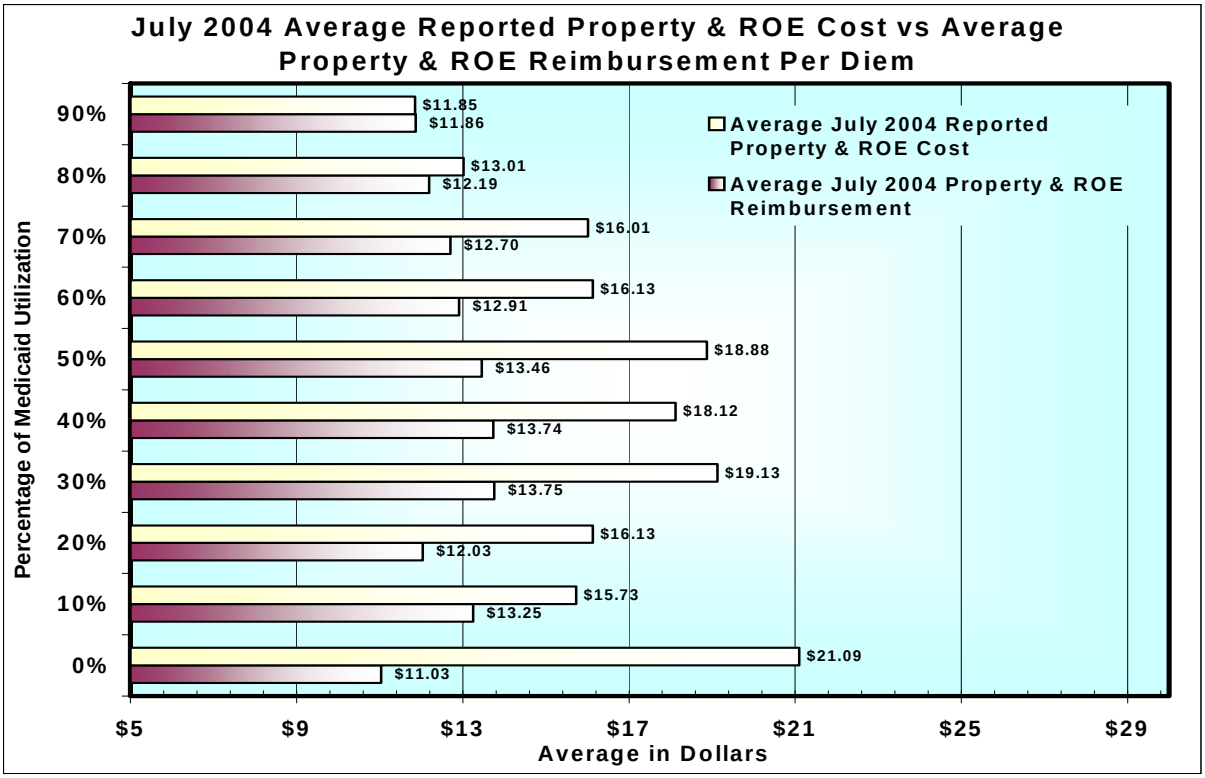

Chart 11

The Total Reported Cost (chart 7) comparison shows the total facility Medicaid cost is clearly not reimbursed by the total facility Medicaid reimbursement. The Operating, Indirect Care, and Property component comparisons all show that costs are not covered by reimbursements. The Direct Care component reported cost is covered in the higher Medicaid utilization percentage groupings and the gap between reported costs and actual component reimbursement is much narrower. This is because the only limitation placed on reimbursement is the Cost-based Class Ceiling that is recalculated each rate setting with the most recent reported costs and the MAR, which can narrow the gap and allow a provider to receive greater than reported cost in the component. Though the Direct Care component is reimbursed its reported cost and more in some cases, the Total Reported Cost comparison shows that this is not enough to make up the deficit from the remaining components.

In general, there is less variance between cost and reimbursement in those facilities that have Medicaid utilization percentages higher than fifty percent (see charts 8-11). Notably, the greater the Medicaid utilization percentage facilities receive a greater percentage of the reported costs, while the lower Medicaid utilization percentage facilities receive a lower percentage of the reported costs. This is most likely explained by the fact that the low Medicaid utilization percentage facilities are mostly private pay facilities or continuing care retirement centers and make up the difference with their private pay residents or through other sources of revenue.

RECOMMENDATIONS

The second objective of this report is to make recommendations for changes in the current payment methodology or for development of a new payment methodology necessary to ensure a stable financial environment in which reimbursement is adequate to meet the costs of providing nursing home care for Florida's Medicaid residents served by a majority of nursing home providers.

The following recommendations address the requirements of this report. However, it should be noted that additional issues warrant consideration within the framework of long-term care reimbursement, but are beyond the scope of this report. Such issues would include the connection between reimbursement and quality of care, consideration of reasonable payment of services for providers with less than a minimum percentage of Medicaid utilization, an understanding of the overall objective of providing services to the frail and elderly, and alternative payment methodologies incorporating market driven principles and consumer choice.

Listed below are the options to ensure reimbursement for 100% of costs for a majority of nursing home providers. All options assume the restoration of the $66,689,094 reduction applied in SFY 2004-05.

1. Changes based upon the current reimbursement methodology:

    a. Eliminate the target limitations within the Operating and Indirect Patient Care components. This option would allow for these component per diems to be the lesser of cost or cost-based class ceiling, thereby creating a higher reimbursement rate and allow for reimbursement at a greater percentage of costs each year. This is identical to the methodology currently in place for the Direct Patient Care component. Eliminating the target limitations would require additional Medicaid funding during the first year of implementation of approximately $76,921,068 million in the Operating component and additional funding of approximately $32,907,065 million in the Indirect Patient Care component. These two changes alone would not achieve the goal of this report.

    b. Make revisions to both the FRVS formula and Cost methodology that would allow for higher reimbursement in the Property component. These changes would cost approximately $45,678,367 during the first year of implementation. Listed below are possible methodology changes for implementing this provision.

        - Increase the ceiling for the Property component for providers receiving property reimbursement under the Cost methodology. The current ceiling is $13.65 per day. Providers within this category would receive the lower of the revised ceiling or actual cost.

        - Decrease the occupancy factor in the calculation of the Capital and ROE portions of the FRVS per diem. In the Capital and ROE formulas, the occupancy factor is the denominator; so reducing this factor would increase the result of the formula. The current occupancy factor assumes 90% occupancy.

        - Increase the per bed standards that apply to the asset indexing portion of the FRVS per diem. Currently, the per bed standard is a limitation to asset indexing. This increase would allow for higher asset indexing based on building costs, capital additions, and improvements made to the facilities.

        - Make adjustments to the calculation of the Florida Construction Cost Inflation Index (FCCI). The FCCI is based on regional forecasts of the Consumer Price Index (All Urban) and is used in the asset indexing calculation as an inflationary factor. An adjustment to the FCCI would allow for higher asset indexing, as well as higher per bed standards.

- All of the above changes to the FRVS system assume that none of the changes would reimburse providers benefiting from the methodology changes any more than reported property cost. Providers currently receiving more than cost under FRVS would continue to do so.

These changes to the current methodology would require revisions to the Title XIX Long-Term Care Reimbursement Plan. No statutory changes are necessary. The time frame for implementation, beginning with legislative approval, could take up to 180 days for proper public notice, federal approval, and rate implementation. The total cost in the initial year of implementation of all the above changes required to reimbursement 51% of all providers 100% of costs is approximately $155,506,500. Costs in future years would increase due to inflationary pressures on provider costs and average spending by providers, and reimbursement ceilings would be the only limiting factor for all components other than the property component.

2. Significant changes to the current methodology:

   a. Make revisions to what costs are considered “allowable” Medicaid costs. This could include, but not be limited to the following:

      - Limit salaries and benefits at the Home Office level.
      - More limits on allowable benefits for employees.
      - Limit allowable management fees.
      - Removal of Medicare costs prior to the calculation of Medicaid costs. The effects of this option would have to be thoroughly evaluated, as heavily utilized ancillaries (e.g. therapies) are included in Medicaid costs only to the extent used by Medicaid residents, and changing cost reporting methodologies should be considered only if the benefits are material.

      This option alone would not ensure reimbursement to 51% of providers at 100% of their cost.

   Implementation of this option would require changes to the Long-Term Care Plan, the Medicaid Cost Reporting Instructions, and possibly the Medicaid Cost Report Chart of Accounts. The time frame for implementation, including analysis and determination of allowable Medicaid costs could take up to 270 days for proper public notice, federal approval, and rate implementation.

   b. Fix one or more components at a fixed price level of reimbursement. For example, with the minimum staffing standards in place, the state could set a per day reimbursement for direct care staffing. Although multiple methodologies could set the rate, it could also be determined as the rate for which 51% of providers were reimbursed 100% of their cost for that component. Depending upon which component of the per diem rate was

fixed, implementation of this option may require statutory changes, and would definitely require amendments to the Long-Term Care Plan. The time-frame for implementation could take up to 180 days for public notice, federal approval, and rate implementation.

c. Increase each nursing home provider's final reimbursement by an amount that ensures that 51% of the providers are reimbursed 100% of their costs. Each provider's rate would be increased by a factor or add-on until 51% of providers received 100% of their costs, but each provider's rate would not exceed total reported cost unless its per diem exceeded cost before the application of this factor or add-on. This option would cost approximately $99,551,242 during the initial year of implementation. Since the factor or add-on is to the final rate, no provider would have their add-on amount limited by target or ceiling limitations. This would ensure that all providers receive a benefit from this increase, as well as meeting the goal of reimbursing 51% of all providers 100% of their costs.

   No statutory changes would be required to implement this option, but the Long-Term Care Plan would need to be amended. The timeframe for implementation, beginning with legislative approval, could take up to 180 days for proper public notice, federal approval, and rate implementation.

   There are several assumptions that must be noted in analyzing the $100 million. First, any provider who was receiving reimbursement less than cost received a benefit of bringing all providers' reimbursement rates to cost until 51% of the providers were receiving 100% of their costs. Therefore, a provider may have received additional funds, but may still be receiving reimbursement that is less than 100% of cost. Also, providers already receiving their costs or greater would receive no benefit under this scenario. Providers may receive reimbursement greater than their costs due to the MAR add-on or their FRVS rate being greater than actual property costs. If current payments greater than costs were reduced to costs, the $100 million would be reduced by approximately $9.8 million.

   The total first year cost of this option, $99,551,242, is less than the cost of Option 1, $155,506,500, due to the differences in how the rate increases were applied. This option looks only at total cost and total reimbursement, and does not incorporate how specific components of the per diem rate interact within the total rate. Should a factor or add-on affect the final per diem, to continue reimbursing a majority of providers 100% of costs would require the factor or add-on to change in future periods. The use of a factor or application of an add-on does not fit within the current methodology, but could apply directly additional funding to the stated goal of this report. Once a provider received 100% of cost, that provider's rate would not increase further during the period of implementation. By comparison, the methodology in Option 1 would allow a provider receiving less than total cost, but more than

cost in a single component, the opportunity to receive full reimbursement within another component while continuing to receive more than cost in the other component. For example, assume a provider's per diem rate is based on cost for all components except Operating and Property, and the provider is receiving $10 less than cost in the Operating Component, and $1 more than cost in the Property (FRVS) component (therefore $9 below cost in total). Using the above option, if the provider is included in the 51% receiving cost, its rate would increase by $9. Using Option 1, the $1 above cost in Property would be ignored when the Operating target was removed, and the provider's rate would increase by $10.

3. Change to an Acuity-Based Reimbursement System that would allow for an initial base rate to be set for each provider and then inflate each subsequent rate at an appropriate inflationary index based upon a skilled nursing facility market basket. This option could include, but not be limited to, different inflation multipliers based on region (urban versus rural), size of facility, different acuity levels, allowances for high Medicaid utilization, and quality of care standards.

Implementation of this option would require legislative approval, as well as extensive statutory changes to 409.908 F.S. The Long-Term Care Plan would need to be re-written to describe and implement the acuity-based reimbursement system. Implementation of this option would also require additional resources to both Medicaid and the fiscal agent, as claims billing and payment procedures would change drastically. The timeframe for implementation of this option would take place in two stages. The first stage would require up to 12 months to develop the acuity-based methodology, and would include consultation with industry associations and require contracted experts with experience in this form of payment. Medicaid would require administrative expenditure authority for the development of this methodology. The second stage could take from 12 to 24 months following finalization of the methodology, and would include public notice, federal approval, changes to the fiscal agent's claims billing and payment processes, and provider education regarding documentation and billing.

Nursing Homes Statistics - All Data Based on Original Snapshots

	7/2004 After Cuts	7/2004 Before Cuts	1/2004	7/2003	1/2003	7/2002	1/2002	7/2001	1/2001	7/2000	1/2000 - After Rebasing	7/99
Number of Facilities												
Total	643	643	641	646	649	653	653	648	646	643	645	633
Total Medicaid Days	17,219,501	17,219,501	16,432,413	16,449,348	16,589,926	16,774,328	16,795,069	16,915,299	16,802,887	16,600,648	16,749,726	16,395,852
Total Per Diem Info												
All Providers												
Minimum	113.89	116.68	112.87	109.87	105.75	84.74	83.30	94.72	87.35	86.19	77.11	78.21
Maximum	190.50	196.82	184.25	181.61	180.36	211.31	165.74	152.69	150.36	147.83	146.67	144.97
Average (Facility)	150.69	154.62	153.20	149.63	146.16	137.03	131.77	122.37	119.02	116.03	111.25	107.36
Standard Deviation Per Diem								11.12	11.40	11.20	11.57	11.44
Weighted (Days)Average	149.67	153.55	152.28	148.71	145.33	135.91	130.50	121.43	117.85	114.71	109.57	105.64
Operating Info												
Per Diem												
Minimum	16.33	17.15	16.92	16.69	17.47	17.08	15.50	11.89	14.87	14.54	14.21	13.92
Maximum	37.04	38.90	38.38	37.86	39.63	38.75	35.16	34.41	33.73	32.99	32.32	31.57
Average (Facility)	29.90	31.40	31.13	30.77	31.83	31.11	28.92	28.09	27.18	26.04	25.27	24.53
Percentage of Cost												
Average (Facility)	80.40%	84.43%	81.72%	81.17%	87.42%	88.80%	81.73%	84.81%	84.72%	84.10%	87.46%	89.52%
Weighted Average (Days)	81.83%	85.93%	83.11%	82.62%	88.39%	89.64%	82.67%	85.29%	85.44%	85.02%	88.70%	90.90%
Limitation Per Diem - (Operating)												
Facility Average	8.09	9.59	9.06	9.11	5.90	5.35	8.08	6.72	6.46	6.52	5.02	4.21
Facility Average -for those receiving a limitation	8.09	11.64	9.98	9.78	8.83	8.92	9.33	8.26	8.22	7.88	6.93	6.16
Weighted Average on Days	5.29	6.77	8.09	8.11	5.25	4.59	7.18	5.98	5.62	5.54	4.08	3.24
Weighted - those receiving	5.29	8.33	8.95	8.74	8.17	6.85	8.26	7.34	7.22	6.68	5.82	4.88
Highest	$1,296.97	1,298.44	83.31	82.05	102.56	149.23	152.34	149.67	144.76	141.69	147.34	144.60
Lowest - (non-zero)	0.01	0.01	0.01	0.03	0.04	0.01	0.03	0.01	0.07	0.01	0.01	0.02
Limitation: PerDiem X Days - (Operating)												
Total Limitation	142,095,405	116,595,815	133,012,336	133,444,517	87,294,428	77,259,062	120,636,178	101,097,701	94,475,808	92,316,021	68,297,013	53,071,501
Highest	3,594,320	3,386,641	3,257,326	3,206,085	2,882,173	2,910,942	3,268,904	3,798,752	3,644,921	2,930,675	2,840,790	2,464,036
Lowest - (non-zero)	2,080	238	183	994	648	349	955	(242,697)	(258,818)	-	-	-
Average Total Dollar Limitation	220,988	219,992	228,544	221,669	201,139	196,588	213,515	156,015	146,247	143,571	105,887	83,841
Direct Care - Patient Care Info												
Per Diem												
Minimum	45.31	45.31	45.31	45.31	43.74	33.44	37.14	-				
Maximum	82.42	82.42	81.47	78.94	76.60	68.58	68.78	-				
Average (Facility)	72.52	72.52	71.15	68.31	65.26	58.06	56.93	-				
Percentage of Cost												
Average (Facility)	100.4%	100.4%	100.3%	100.5%	99.9%	99.4%	99.9%					
Weighted Average (Days)	100.8%	100.8%	100.7%	100.9%	100.4%	100.2%	100.7%					
Limitation Per Diem (Patient Care)												
Facility Average	1.72	1.72	0.12	(0.00)	0.56	1.03	0.69	-				
Facility Average - those receiving	16.80	16.80	6.43	6.30	8.93	8.80	10.20	-				
Weighted Average on Days	0.62	0.62	0.23	0.28	(0.05)	(0.35)	0.03	-				
Weighted - those receiving	(5.07)	(5.07)	(6.55)	(6.72)	(7.71)	(7.36)	(8.64)	-				
Highest	1,286.92	1,286.92	46.21	45.90	163.67	168.61	167.90	-				
Lowest - (non-zero)	0.08	0.08	0.12	0.04	0.18	0.19	0.03	-				
Limitation PerDiem X Days (Patient Care)								0				
Total Limitation	12,684,842	12,684,842	15,469,557	14,605,585	17,350,447	21,042,136	15,425,770	-				
Highest	1,863,478	1,863,478	1,968,659	1,955,861	1,824,795	3,356,792	2,365,401	-				
Lowest - (non-zero)	1,573	1,573	775	244	646	1,299	700	-				
Average Total Dollar Limitation	116,375	116,375	143,237	146,056	171,787	159,410	164,104	-				
InDirect Care - Patient Care Info								0				

Nursing Homes Statistics - All Data Based on Original Snapshots

	7/2004 After Cuts	7/2004 Before Cuts	1/2004	7/2003	1/2003	7/2002	1/2002	7/2001	1/2001	7/2000	1/2000 - After Rebasing	7/99
Per Diem								0				
Minimum	16.80	17.65	17.18	17.26	3.89	12.89	3.38	-				
Maximum	51.44	54.02	53.58	52.70	51.67	50.82	50.17	-				
Average (Facility)	36.14	37.95	38.24	37.75	36.41	35.23	33.94	-				
Percentage of Cost								0.0%				
Average (Facility)	90.4%	95.0%	95.7%	96.9%	98.0%	99.2%	99.8%	0.0%				
Weighted Average (Days)	91.4%	96.0%	96.7%	98.0%	98.9%	100.0%	100.6%	0.0%				
Limitation Per Diem (Patient Care)								0				
Facility Average	$1.61	3.43	2.10	1.61	1.16	0.74	0.62	-				
Facility Average - those receiving	9.47	8.21	5.20	4.75	4.71	6.84	9.77	-				
Weighted Average on Days	(0.02)	(1.76)	(1.57)	(1.03)	(0.64)	(0.24)	(0.12)	-				
Weighted - those receiving	1.64	(5.33)	(4.61)	(3.98)	(3.69)	(4.88)	(7.01)	-				
Highest	$694.12	696.02	34.88	43.28	75.37	74.02	74.73	-				
Lowest - (non-zero)	0.01	0.04	0.02	0.02	0.01	0.06	0.09	-				
Limitation PerDiem X Days (Patient Care)								0				
Total Limitation	61,013,008	30,333,981	25,841,969	17,020,944	10,649,828	4,064,541	2,038,772	-				
Highest	1,525,154	1,442,161	1,102,365	1,082,952	1,183,606	1,235,020	889,763	-				
Lowest - (non-zero)	(1,241,866)	(1,304,186)	(316,800)	(110,052)	(107,917)	(92,694)	(102,597)	-				
Average Total Dollar Limitation	94,888	47,176	40,315	26,348	16,410	6,224	3,122	-				

State of Florida
Jeb Bush, Governor

Agency for Health Care Administration
Alan Levine, Secretary

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