

Medicaid Nursing Facility Reimbursement Workgroup Report

November 2009



Medicaid Nursing Facility Reimbursement Workgroup Report

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Executive Summary

The 2008 Legislature amended Section 409.908, Florida Statutes, relating to Reimbursement of Medicaid Providers, to create subparagraph 409.908 (23)(c), which specified the creation of Workgroups to focus on the methodology in which Medicaid reimbursement is determined for certain provider types. With the creation of this language, the Agency for Health Care Administration (Agency) established 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 requested nominations for Nursing Home Workgroup members, and appointed four members to the workgroup, two association representatives, one from each association, and two provider representatives. The provider representatives are directly related to operating and participating facilities within the Florida Medicaid program. The Agency, as facilitator and staff for the Workgroup, created and submitted a charter to the Workgroup at the first meeting. The Workgroup adopted the charter, which specified purpose and scope, as the basis and direction of the Workgroup. (See Appendix A).

During the initial meetings of the Workgroup, the Agency provided an overview of the Medicaid program and specific information related to the nursing facilities' budget and current reimbursement plan and methodology. 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 have an average daily Medicaid census of approximately 42,550 individuals. Statewide, the average occupancy rate for a Medicaid participating nursing home is 89.25 percent.

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).

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

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

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Issues of Concern Related to the Current Reimbursement Methodology

The members of the Workgroup identified issues of concern related to the continuation of the current methodology. Inadequate resolution of the main issues of concern could create negative potential outcomes for the future for the nursing facilities and the Medicaid program. The following issues were among the issues raised and discussed by the Workgroup during the course of its deliberations.

- Whether the use of two rate setting periods introduces a degree of budget unpredictability for the providers.
- Cost report filing and timely audit completion requirements and their potential to delay timely setting of interim rates.
- Need for revisions to update the Fair Rental Value System (FRVS) methodology to reflect the systematic changes that the state has experienced over time related to construction methods, building code changes, and property and building value and expenses.
- Feasibility of a modified approach to establishing peer groups and calculating ceilings.
- Need for a revised supplemental payments policy.

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.

The workgroup reached a general consensus on potential solutions for these issues.

- Establishment of a single rate setting period per year was supported; however, establishment of a uniform cost reporting fiscal year end was not supported.
- The reimbursement plan should be amended to establish reasonable timeframes for cost report submissions and for the conducting of audits and desk reviews. AHCA should be given legislative authority to enforce the initial cost reporting requirements which will lead to a more timely audit process.
- 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 L) should be considered as the model for the new system. (Please note that the preliminary 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 the previous workgroup from 2000.)
- 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 greater statistical ability to explain variance in costs 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.
- Eliminate the supplemental payment for AIDS patients and re-calculate the Medicaid per diem rate for affected facilities. Create an outlier payment methodology (supplemental payment and/or equipment fee schedule) for ventilator-dependent and other medically complex, technology-dependent residents.

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Closing Comments:

The workgroup achieved a consensus that the current methodology is still a valid one. However, modifications to specific areas would improve the Medicaid reimbursement methodology. To achieve an ideal methodology, each of the identified issues of concern would need to be adopted at the same time and not pieced together or phased-in over a period of years.

In addition, the modifications identified above are consistent with processes used in other states. Members of the Workgroup are familiar with and some have actual experience in other states.

Additional details relating to the issues and alternatives are discussed later in this report.

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Workgroup Overview

The Agency for Health Care Administration (AHCA or the Agency) Workgroup on Medicaid 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 the deliberations of the Workgroup, the Agency developed this report, to be submitted to the “relevant committees of the Senate and House of Representatives by November 1, 2009.” The Workgroup 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 discussed only those nursing home related issues that are funded by the Florida Medicaid program.

The Workgroup consisted of four members appointed by the Deputy Secretary for Medicaid. Agency staff served as facilitators and a resource 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. Evaluation of alternative Medicaid reimbursement and payment methodologies for nursing facilities including prospective payment methodologies.
- b. Report findings to the Director of Medicaid as to the outcome of its fact finding.

The Workgroup met seven times between January and September of 2009. Agency staff worked with members to develop supporting documentation of agenda items for each meeting. During the meetings, the Workgroup discussed the purpose and goals of the Workgroup and agreed to adopt guiding principles to use in identifying any potential changes to the Medicaid reimbursement system. Documentation and minutes of each meeting are posted online at:

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

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

Medicaid Nursing Facility Reimbursement Workgroup Report

Guiding Principles

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.

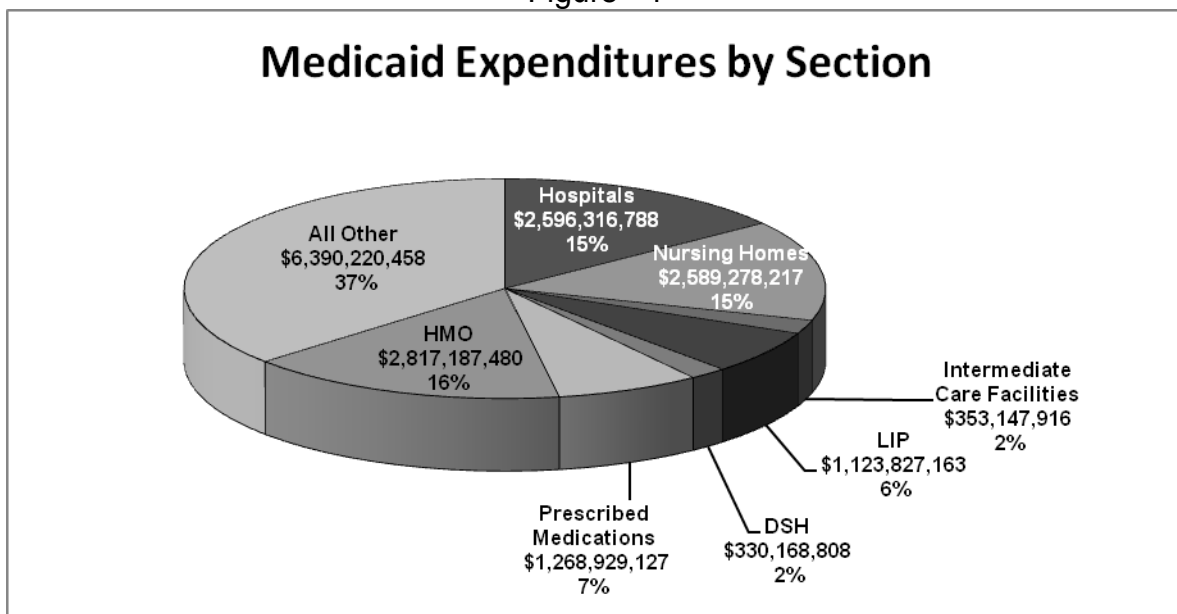
- Ease of administration (rate setting, billing, audit process)
- Budget predictability and stability for both the Agency and nursing home providers
- Elimination or reduction of artificial barriers that contribute to variations in provider costs and quality of care delivered
- Viability of potential solutions

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Florida Medicaid Overview

The Medicaid program is a state administered program that is funded by both the Federal Government and the state of Florida. There are federal requirements that must be met, and those are specified in the Florida State Plan as approved by the Centers for Medicare and Medicaid Services (CMS). There are mandatory and optional eligibility groups and service categories. In State Fiscal Year 2009-10, Florida Medicaid was appropriated \$17.5 billion in funds. The federal share of funding is 67.64%, while the state share is 32.36%. Forty-five percent of all Medicaid expenditures cover hospitals, nursing homes, Intermediate Care Facilities for the Developmentally Disabled, Low Income Pool and Disproportionate Share Payments. About 7% 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 59% of current year expenditures. The Federal Medical Assistance Percentage (FMAP) is used in determining the amount of federal matching funds for state's expenditures under the Medicaid program. Over time, Florida's FMAP has generally been declining, except that 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 Medicaid Assistance Percentage (FMAP).

Figure - 1



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For State Fiscal Year 2009-10, the budget for Nursing Homes is \$2.6 billion. Over the past few years, there have been multiple legislatively mandated modifications to nursing facility reimbursement, including rate reductions and increased staffing requirements. Most recently, nursing homes received a \$75.2 million 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 million reduction effective 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 back reductions to Medicaid reimbursement. See Appendix B for more detail.

The increase to the FMAP due to the ARRA enabled a larger buy back of rate cuts through use of the Quality Assessment. Accordingly, an additional reduction of \$123.7 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 C through E for information of how Florida Medicaid compares to other states on a variety of indicators.

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Current Methodology of Medicaid 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 a Medicaid daily census of approximately 42,550 individuals. The number of beds per facility 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 State Fiscal Year 2009-10 budget for Medicaid Nursing Home care is \$2,589,278,217 and the latest projection of total Medicaid expenditures for Nursing Homes during the same time period is \$2,705,963,699. A history of Florida Medicaid nursing home expenditures since the inception of the program is provided in Appendix F.

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 utilizes historical data from cost reports to establish reimbursement rates. The Plan 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 rates are established for each facility every January 1 and July 1, based on the latest cost reports received by October 31 and April 30, respectively. The January 1 – June 30 and July 1 – December 31 periods are referred 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.

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

- Operating,
- Direct Patient Care,
- Indirect Patient Care,
- Property, and
- Return on equity (ROE).

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The Operating component includes administration, laundry and linen, plant operations, and housekeeping expenses. It may also include Medicaid bad debt expenses. The Direct Patient Care component includes wage 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 services. The Property component includes either: interest and depreciation or a fair rental value. In either case, the property component also includes the costs of property insurance, property taxes and home office property. The Return on Equity component is a 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, Direct and Indirect Patient Care, and cost-based Property components are subject to limits on the maximum amount a provider can receive for the component, regardless of actual cost. These limits are called reimbursement ceilings.

Nursing homes are divided into six ceiling classes. The classes are based upon size (1-100 beds = small, or over 100 beds = large), and location (North, South, or Central) of the facility within the state. The distribution of the facilities throughout the state at July 1, 2009 is as follows:

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

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

Rate Adjustments

The Medicaid Adjustment Rate (MAR) is an add-on to the Direct and Indirect Patient Care component for qualifying facilities. This add-on is not subject to class ceilings, targets or new provider limitations and is added to the per diem components after any limitations have been applied.

To qualify for the MAR, a provider must have ratings other than conditional for one year prior to the rate semester and have Medicaid utilization greater than 50 %. The MAR is 4.5 % of the Direct and Indirect Patient Care per diem multiplied by the ratio of non-conditional days divided

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by total days. The MAR is then prorated for facilities with between 50 and 90 % Medicaid utilization. Providers with 90 % or greater Medicaid utilization receive the full MAR, facilities with less than 50 % Medicaid utilization receive no MAR.

Targets

On January 1, 1988, a nursing home target rate system that limits the rate of increase in Operating and Indirect Patient Care per diem rates from one rate semester to the next was implemented. Target rates are set for class ceilings and the Operating and 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 2.0 times the rate of 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. 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 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 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 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 rate of inflation each semester.

Staffing

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)

A grossing up of a provider's Direct Care component was implemented prior to each of these periods to assist Nursing Homes in recruiting and retaining Direct Care staff (RNs, LPNs, and CNAs) to meet the change in staffing requirement.

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Per Diem Paid

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

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

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

- Facility specific inflated cost
- Cost based class ceiling

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

Property Reimbursement

There are two different methods for property reimbursement: the “cost method” (cost) and the Fair Rental Value System (FRVS). The cost 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, home office property, and taxes on property) divided by total patient days to 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 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 value 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 type of ownership or rental arrangements. The value of the facility is used in the calculation of the per

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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 % component, the Return on Equity (ROE) or 20 % 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.

The calculation of the capital component or 80 % 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 resulting quotient is the 80 % capital component. The adjustment factor assumes that a stabilized facility should operate at 90 % of patient capacity.

The ROE or 20 % component uses a similar calculation. First, 20 % 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 % capital component. The resulting quotient is the ROE or 20 % 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 was less under the FRVS method than the cost method, the facility 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 under FRVS was greater than cost based reimbursement at October 1, 1985, 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.

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Findings and Issue Identification

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:

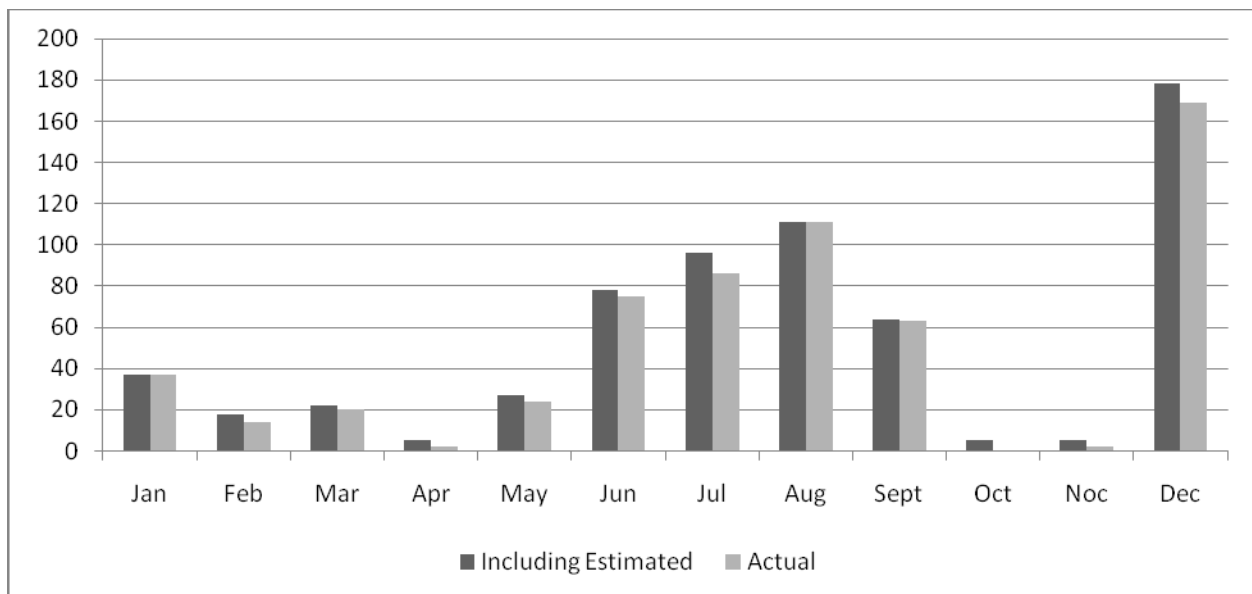
- Revised cost reporting, rate setting and auditing time frames
 - One rate setting period per year
 - Uniform cost report time frame
 - Cost report filing requirements
 - Audit completion timeline requirements
- Payment limits
 - Targets
 - Ceilings
- Acuity based payment
- Revised Fair Rental Value System (FRVS)
- Revised supplemental payment 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 two rate setting periods introduces a degree of budget unpredictability. 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.

Figure - 2 shows the current distribution of providers by fiscal year end. December is the most prevalent fiscal year end for nursing homes.

Figure - 2



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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 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 always had a single rate setting period for managed care organizations. The single rate setting 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. The Florida Association of Homes and Services for the Aging (FAHSA) and the Florida Health Care Association (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 would be supported, but that having a single 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 G- FYE Cost Report Months Used for the January 2009 Rate Semester and Appendix H – Medicaid Cost Survey Results for further detail.

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.

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. A valid cost report must be filed and cost settlement for the initial budget period. All initial cost reports are audited since there is a high risk of misstatements with new Medicaid providers.

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The Workgroup determined that providers not submitting an initial cost report in a timely manner (or not at all) delays the cost settlement and audit process. This leads to increases in the amounts of overpayments and delays in subsequent changes of ownerships.

The only enforceable time requirement to file an initial cost report in the State Long Term Care 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.

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 cost settlement/audit process results in larger overpayment balances and causes providers to realize larger current liability all at once.

Additionally, not filing an initial cost report causes delays in any subsequent Change of Ownership (CHOW) process. Licensure of the new operator may be held up indefinitely if the seller has not filed an initial cost report. This delay can disrupt the CHOW process because both parties are unable to determine Medicaid liability.

Since an initial Medicaid cost reporting period can be between six and eighteen months, setting the deadline five months after the 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 be a component of any enforceable mandate.

Consensus: The reimbursement plan should be amended to establish reasonable timeframes for all cost report submissions and for the conducting of audits and desk reviews. AHCA should be given legislative authority to enforce the cost reporting requirements.

C. Payment Limits

Targets

The Workgroup studied targets to see if they represent artificial barriers that cause significant differences in how providers operate. Targets were implemented in 1988, as a means to limit the rate of increase in Operating and Patient Care per diem rates from one rate semester to the next. Targets were created to limit the overall growth in the peer group ceilings and to limit the rate of growth of individual nursing home provider's costs. Since July 1, 2001 target limits are not imposed on the Direct Care Cost Component of Patient Care.

Targets are rebased, that is temporarily removed as payment limits, only when the Legislature authorizes additional funds for a rebasing. Generally speaking, target limits increase at a steadier rate than the actual cost increases experienced by nursing homes. Thus, periodic rebasing is needed to ensure that payment rates adequately reflect actual costs. Significant savings accrue to the state while the targets are in effect. These savings, however, come at the

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expense of the nursing home provider's financial strength and, in most cases, are subsidized to a large extent by increases in the nursing home private pay rates.

The last time rebasing occurred was on July 1, 2007. The average change in total nursing home rates from the prior rate semester was 4.25% of which a substantial portion was due to rebasing. This was a 239% increase over the three year average rate of increase 1.78%. The target limits were applied again at their rebased level on January 1, 2008. Refer to Figure - 3 (It is important to note that the larger increase in the January 2007 per diem rate is due to an increase in the rates to reflect the increased staffing standard effective on that date).

Figure - 3

Change in Average Per Diem 07/04 to 01/08		
Rate Semester	Weighted Average Per Diem	Change from Prior Rate Setting
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%

The Workgroup found that target limits, particularly provider-specific target limits, cause differences in facility operations. 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 Florida State Plan to establish specific timeframes for the rebasing of global targets that artificially limit rate growth.

Ceilings

Ceilings were created as a 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 facility size and are grouped into six classes.

The Work group evaluated the current ceilings method to determine if better 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.

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Because the Central Class ceilings are calculated by using the simple average of the North and South cost based ceilings, a more accurate, alternate method of separately calculating the Central Class ceilings was 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, which in turn would have significantly impacted nursing home payment rates, immediate implementation of this alternate method was rejected by the Workgroup noting that additional analysis was necessary. Refer to Figure - 4

Figure - 4

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

Minor modification of the method for calculating ceilings was discussed. When the ceiling methodology was developed in the early 1980s, 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".

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Currently, a normalized rate from every provider is used for calculating the standard deviations and medians of the 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 determine how ceilings would be affected by these two alternatives. (See appendix K – Ceilings Comparison Chart).

Additionally, the Workgroup 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 analysis of variance). Based upon the results of the models the following observations can be made:

1. Different 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.

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 geographic classes for ceiling calculations although additional analysis will be required to refine the classes. In particular, data for the subcomponents of 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 is 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 was 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 are paid.

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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.

D. Acuity Based Payment

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.

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, 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.

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 I. 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”.

Please refer to Appendices I and J for more detail.

Consensus: The Workgroup agreed that since Florida has the nation’s 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.

E. 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 the perpetuation of an antiquated cost based property payment system, creates inequities in the Florida payment system. The current Florida FRV system also creates inappropriate incentives that encourage debt financing and discourage investment in renovation or replacement of aging buildings.

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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 and North Carolina. 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 nursing home 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 renovation of existing 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.

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

The Workgroup discussed three alternative fair rental methods:

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

Ultimately, the Workgroup focused on a gross fair rental method and suggested that 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 and cost methods.

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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 L and M for more information on the Georgia FRVS method.

To demonstrate how the calculations would work under the gross fair rental method, two models were constructed. These models were created by mimicking the current Georgia gross fair rental method. The first model was calculated 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.

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 opportunity to fine tune these variables each time Medicaid rates are recalculated. The overall calculation stems from RS Means cost per square foot data which can be obtained each July 1 when a new RS Means cost per square foot book is released. For July 1, 2009, the cost per square foot is \$141.10. This number is multiplied by the facility's total square footage and is adjusted by a geographic location factor to calculate an RS Means value. As noted, fifty facilities provided square footage data, but the floor space of all other facilities was estimated based upon their number of beds. (Under the proposed method, providers would be required to report facility total square footage.) 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. 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 used a straight-line depreciation of 2%, while the second model used a tiered depreciation method. Also, the first model used a maximum depreciation of 1/3 the value of the RS Means plus equipment value, and the second model used a maximum facility age of 32.5 years. The current year is used for facility aging purposes. The facility age 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 determine the fair rental. See Figure - 5 for an example of a calculation from the Georgia FRVS system; refer to Appendix M for more information.

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Figure - 5

Gross Fair Rental Example	
New Bed Value	\$6,000,000.00
Equipment	\$500,000.00
Subtotal	\$6,500,000.00
Depreciation (0.375)	-\$2,437,500.00
Subtotal	\$4,062,500.00
Land	\$600,000.00
Rental Value	\$4,662,500.00
Rental Rate	9.00%
Fair Rental Patient Days	33,000
Fair Rental Rate	\$12.72

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 M) 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 previously referenced workgroup in 2000.)

F. Revised supplemental payments policy

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

AIDS Care

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 care environment (universal precautions)?” While Medicaid reimburses nursing homes at a higher rate for Medicaid recipients with AIDS, the nursing homes are required to remove the additional costs related to the AIDS days from the Medicaid cost report (usually a direct offset of the revenue collected) to ensure that the AIDS costs are not reimbursed through the regular per diem rate causing a double payment.

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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 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 if the AIDS costs had been included in their regular per diem rate. See Figure - 6

Figure - 6

AIDS OFFSETS COMPARISON FOR THE 200901 RATE SEMESTER			
Medicaid Number	Proposed Dollar Amounts	Current Total Dollar Amount	Difference Between Proposed And Total Dollar Amount
Provider A	\$4,752,502.83	\$4,813,882.89	(\$61,380.06)
Provider B	\$3,899,041.92	\$3,977,913.27	(\$78,871.35)
Provider C	\$4,877,716.23	\$5,130,188.86	(\$252,472.63)
Provider D	\$5,037,947.67	\$5,057,321.68	(\$19,374.01)
Provider E	\$3,955,650.93	\$3,952,138.21	\$3,512.72
Provider F	\$2,714,663.49	\$2,717,554.55	(\$2,891.06)
Provider G	\$5,132,609.51	\$5,142,966.42	(\$10,356.91)
Provider H	\$13,854,203.40	\$13,833,353.16	\$20,850.24
Total	\$44,224,335.98	\$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.

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 ensure 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 provided a supplemental payment for ventilator care during 1985 and 1986, but this supplement was discontinued in 1987 because of its budget impact. Many ventilator-dependent adults cannot be discharged from an acute care hospital and be placed in a nursing facility because of inadequate funding to meet the level of care needed. Nursing facilities are not able to accept these individuals at the current Medicaid per diem rate which is inadequate to cover the

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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; 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 N) 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.”

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.

Consensuses – 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.

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Closing Comments:

The workgroup achieved a consensus that the current methodology is still valid. However, modifications to specific areas would improve the Medicaid reimbursement methodology. To achieve an ideal methodology, each of the identified issues of concern would need to be adopted at the same time and not pieced together or phased-in over a period of years.

In addition, the modifications identified above are consistent with processes used in other states. Members of the Workgroup are familiar with and some have actual experience in other states.

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Glossary

Acuity based payment - A global payment rate for classes (resource groups) of residents based on the amount of care and services needed.

Fair Rental Value System (FRVS) - A property reimbursement method 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. Approximately 90% of the providers in the Florida Medicaid Nursing Home program are reimbursed under the FRVS methodology.

Equipment fee schedule - A list of durable medical equipment with a standardized reimbursement fee.

Federal Medical Assistance Percentage (FMAP) - Federal government's matching share of a state's expenditures for Medicaid

Nursing Facility Quality Assessment (NFQA) - Fee assessment for all skilled nursing facility non-Medicare bed days. Fee is used to buyback budget reductions to Medicaid nursing home reimbursement.

Peer grouping - Combining nursing facilities based on factors they have in common such as size, geographic location, etc. in order to calculate reimbursement components such as ceilings.

Reimbursement ceilings - The upper rate limits for Medicaid nursing home operating and patient care reimbursement for nursing homes in a specified reimbursement class, or, the upper limit for nursing home property cost reimbursement for all nursing homes statewide. Ceilings are calculated twice a year using the most recent actual cost.

Return on equity (ROE) - A reasonable return on equity (ROE) for capital invested and used in providing patient care, excluding positive net working capital (an amount greater than zero), shall be defined for purposes of Florida title XIX Long-Term Care Reimbursement Plan as an allowable cost.

RS Means - A publication that provides accurate and up-to-date cost information to assist owners, developers, architects, engineers, contractors and others to carefully and precisely project and control the cost of new building construction and renovation projects.

Targets - Upper rate limits based on prior rate semesters upper cost limit, as adjusted by an inflation factor. Targets are provider specific and or class specific.

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Appendices

- Appendix A - [Workgroup Charter](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/nursing_home_reimbursement_workgroup_charter.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/nursing_home_reimbursement_workgroup_charter.pdf
- Appendix B - [Nursing Homes Cuts and Buybacks](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/nh_cuts_and_buy_backs_2009-02-20.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/nh_cuts_and_buy_backs_2009-02-20.pdf
- Appendix C - [Collection of State by State Comparisons of Medicaid Statistics](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/state_medicaid_comparisons.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/state_medicaid_comparisons.pdf
- Appendix D - [Pages from CMS RTI Report on OSCAR](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3c1_pages_from_cms_rti_report_on_oscar.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3c1_pages_from_cms_rti_report_on_oscar.pdf
- Appendix E - [NF Beds per 1,000 Persons Over Ages 65 and 75](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3c2_nf_beds_per_1000.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3c2_nf_beds_per_1000.pdf
- Appendix F - [History of Florida Nursing Home Reimbursement](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/4_history_fl_nf.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/4_history_fl_nf.pdf
- Appendix G - [FYE Cost Report Months Used for the January 2009 Rate Semester](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/4_distribution_of_fye_cost_reports_jan_2009.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/4_distribution_of_fye_cost_reports_jan_2009.pdf
- Appendix H - [Medicaid Cost Survey Results](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/medicaid_cost_survey_results.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/medicaid_cost_survey_results.pdf
- Appendix I - [Preliminary Analyses on Outcomes of Increased Nurse Staffing Policies in Florida Nursing Homes: Staffing Levels, Quality, and Costs \(2002-2007\), February 2009](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/10d_preliminary_nursing_home_staffing_analyses_usf_final_031109.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/10d_preliminary_nursing_home_staffing_analyses_usf_final_031109.pdf
- Appendix J - [Overview of the Nursing Home Staffing Report](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/3_overview_of_nh_staff.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/3_overview_of_nh_staff.pdf
- Appendix K - [Ceilings Comparison Chart](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3e_200901_ceilings_comparison.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3e_200901_ceilings_comparison.pdf

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- Appendix L - [Public Notice Nursing Facility Services](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3d1_public_notice_nursing_facility_services_v2.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3d1_public_notice_nursing_facility_services_v2.pdf
- Appendix M - [Nursing Facility Property Payment, April 8, 2008](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3d2_frvs_ghca_04-08-08.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/2009-07-07/3d2_frvs_ghca_04-08-08.pdf
- Appendix N - [Enhanced Medicaid Nursing Facility Reimbursement for Ventilator-Dependent Individuals in Florida](http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/ems_vent_dependent_study.pdf)
http://ahca.myflorida.com/Medicaid/quality_management/workgroups/nursing_home/ems_vent_dependent_study.pdf