STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

SA-PG-SUN CITY, LLC, d/b/a PALM GARDEN OF SUN CITY, ET AL.,

Petitioners,

vs.

AGENCY FOR HEALTH CARE ADMINISTRATION,

Respondent.

Case Nos. 06-3824 through 06-3837

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on April 14 and 15, 2008, in Tallahassee, Florida, before Lawrence P. Stevenson, a duly-designated Administrative Law Judge of the Division of Administrative Hearings ("DOAH").

APPEARANCES

For Petitioners: Peter A. Lewis, Esquire
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Tallahassee, Florida 32308

For Respondent: Brevin Brown, Esquire
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STATEMENT OF THE ISSUE

The issue in these consolidated cases is whether the Agency for Health Care Administration ("AHCA") properly disallowed

Petitioners' expense for liability insurance and accrued contingent liability costs contained in AHCA's audit of Petitioners' Medicaid cost reports.

PRELIMINARY STATEMENT

These cases involve AHCA's Medicaid audits of 14 SA-PG ("Palm Gardens") facilities' cost reports for the period of July 29, 2002, through February 28, 2003 (the "audit period"). Each of the audits contained numerous adjustments to the Palm Gardens cost reports, and Palm Gardens filed Petitions for Formal Administrative Hearing (Petitions) contesting the adjustments. Those Petitions were consolidated and form the basis of this proceeding. The parties submitted a Pre-hearing Stipulation that resolved all but two of the adjustments.

The first remaining adjustment at issue is AHCA's disallowance of Palm Gardens' accrual of expenses for contingent liability, listed in the cost reports under the category of general and professional liability ("GL/PL") insurance, where Palm Gardens did not document that it had purchased GL/PL insurance. The second adjustment at issue is ACHA's disallowance of a portion of a premium paid by Palm Gardens for a GL/PL insurance policy issued by Mature Care Insurance Company ("Mature Care policies"). The amounts still in dispute under these two adjustments are as follows, by location of the Palm Gardens facility:

Sun City (DOAH Case No. 06-3824):	$126,672.00
Port St. Lucie (DOAH Case No. 06-3825):	$126,672.00
Winter Haven (DOAH Case No. 06-3826):	$126,672.00
West Palm Beach (DOAH Case No. 06-3827):	$200,589.00
Orlando (DOAH Case No. 06-3828):	$126,672.00
Pinellas (DOAH Case No. 06-3829):	$126,672.00
Clearwater (DOAH Case No. 06-3830):	$126,672.00
Ocala (DOAH Case No. 06-3831):	$199,342.00
North Miami (DOAH Case No. 06-3832):	$126,672.00
Largo (DOAH Case No. 06-3833):	$152,818.00
Jacksonville (DOAH Case No. 06-3834):	$126,672.00
Gainesville (DOAH Case No. 06-3835):	$126,672.00
Vero Beach (DOAH Case No. 06-3836):	$199,342.00
Tampa (DOAH Case No. 06-3837):	$126,672.00
Total amount in dispute:	$ 2,018,811.00

The AHCA audits were issued between September 28, 2006, and October 4, 2006. Palm Gardens timely filed its Petitions, which AHCA forwarded to DOAH on October 5, 2006. The cases were assigned to the undersigned and consolidated for hearing. Several continuances were granted, and the case was placed in abeyance for a period of approximately two months, in order to allow the parties to conduct settlement negotiations and narrow the issues presented at the formal hearing. The formal hearing was held on April 14-15, 2008.

At the hearing, Palm Gardens presented the testimony of Stanley W. Swindling, Jr., an expert in health care accounting and Medicare/Medicaid reimbursement principles; Keith B. Parnell, an expert in insurance for the long-term care industry; and John A. Owens, an expert in health care accounting and Medicare/Medicaid reimbursement. Mr. Parnell also provided rebuttal testimony. Petitioners' Exhibits 1 through 8 were

admitted into evidence. AHCA presented the testimony of Lisa D. Milton, AHCA's administrator of audit services and an expert in certified internal auditing; Patrick M. Wester, agent relations administrator for Florida Surplus Lines Service; Steve Diaczyk, an audit evaluation and review analyst for AHCA and an expert in accounting, auditing, and Medicaid policy; and Janette Smiley, an expert in accounting and Medicaid auditing. AHCA's Exhibits 1 through 13, 20 through 22, 25, relevant portions of 26, 27 through 31, 33, 35, 41, 44, and 45 were admitted into evidence. Joint Composite Exhibit 1 (Palm Gardens' cost reports) and Joint Composite Exhibit 2 (AHCA's final audit reports) were admitted into evidence.

The three-volume Transcript of the hearing was filed at DOAH on May 1, 2008. The parties filed their proposed recommended orders on May 12, 2008. Both proposed recommended orders have been carefully considered during the preparation of this Recommended Order.

FINDINGS OF FACT

Based upon the oral and documentary evidence presented at the final hearing, and on the entire record of this proceeding, the following findings of fact are made:

1. Petitioners operate licensed nursing homes that participate in the Florida Medicaid program as institutional providers. The 14 Palm Gardens facilities are limited liability

companies operating as subsidiaries of New Rochelle Administrators, LLC, which also provides the facilities with management services under a management contract.

2. AHCA is the single state agency responsible for administering the Florida Medicaid program. One of AHCA's duties is to audit Medicaid cost reports submitted by providers participating in the Medicaid program.

3. During the audit period, Petitioners provided services to Medicaid beneficiaries pursuant to Institutional Medicaid Provider Agreements that they entered into with AHCA. The Provider Agreements contained the following relevant provision:

> (3) Compliance. The provider agrees to comply with local, state, and federal laws, as well as rules, regulations, and statements of policy applicable to the Medicaid program, including Medicaid Provider Handbooks issued by AHCA.

4. Section 409.908, Florida Statutes (2002)[1], provided in relevant part:

> Reimbursement of Medicaid providers.--Subject to specific appropriations, the agency shall reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein. These methodologies may include fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding pursuant to s. 287.057, and other mechanisms the agency considers

> efficient and effective for purchasing services or goods on behalf of recipients. . . .
>
> * * *
>
> (2)(a)1. Reimbursement to nursing homes licensed under part II of chapter 400 . . . must be made prospectively. . . .
>
> * * *
>
> (b) Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards and to ensure that individuals eligible for medical assistance have reasonable geographic access to such care. . . .

5. AHCA has adopted the Title XIX Long-Term Care Reimbursement Plan (the "Plan") by reference in Florida Administrative Code Rule 59G-6.010. The Plan incorporates the Centers for Medicare and Medicaid Services ("CMS") Publication 15-1, also called the Provider Reimbursement Manual (the "Manual" or "PRM"), which provides "guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended." CMS Pub. 15-1, Foreword, p. I.

6. The audit period in these cases spans two versions of the Plan: version XXIII, effective July 1, 2002, and version XXIV, effective January 1, 2003. It is unnecessary to distinguish between the two versions of the Plan because their language is identical as to the provisions relevant to these cases.

7. Section I of the Plan, "Cost Finding and Cost Reporting," provides as follows, in relevant part:

> C. The cost report shall be prepared by a Certified Public Accountant in accordance with chapter 409.908, Florida Statutes, on the form prescribed in section I.A. [AHCA form 5100-000, Rev. 7-1-90], and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual (CMS-PUB. 15-1)(1993) incorporated herein by reference except as modified by the Florida Title XIX Long Term Care Reimbursement Plan and State of Florida Administrative Rules. . . .

8. Section III of the Plan, "Allowable Costs," provides as follows, in relevant part:

> C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS-PUB. 15-1 (1993) and this plan, to exceed the level that a prudent buyer would incur, then

the excess costs shall not be reimbursable under the plan.

9. The Plan is a cost based prospective reimbursement plan. The Plan uses historical data from cost reports to establish provider reimbursement rates. The "prospective" feature is an upward adjustment to historical costs to establish reimbursement rates for subsequent rate semesters.[2] The Plan establishes limits on reimbursement of costs, including reimbursement ceilings and targets.

10. AHCA establishes reimbursement ceilings for nursing homes based on the size and location of the facilities. The ceilings are determined prospectively, on a semiannual basis. "Targets" limit the inflationary increase in reimbursement rates from one semester to the next and limit a provider's allowable costs for reimbursement purposes. If a provider's costs exceed the target, then those costs are not factored into the reimbursement rate and must be absorbed by the provider.

11. A nursing home is required to file cost reports. The costs identified in the cost reports are converted into per diem rates in four components: the operating component; the direct care component; the indirect care component; and the property component. GL/PL insurance costs fall under the operating component. Once the per diem rate is established for each component, the nursing home's reimbursement rate is set at the

lowest of four limitations: the facility's costs; the facility's target; the statewide cost ceiling based on the size of the facility and its region; or the statewide target, also based on the size and location of the facility.

12. The facility's target is based on the initial cost report submitted by that facility. The initial per diem established pursuant to the initial cost report becomes the "base rate." Once the base rate is established, AHCA sets the target by inflating the base rate forward to subsequent six-month rate semesters according to a pre-established inflation factor. Reimbursement for cost increases experienced in subsequent rate semesters is limited by the target drawn from the base rate. Thus, the facility's reimbursement for costs in future rate semesters is affected by the target limits established in the initial period cost report. Expenses that are disallowed during the establishment of the base rate cannot be reclaimed in later reimbursement periods.

13. Petitioners entered the Medicaid program on June 29, 2002. They filed cost reports for the nine-month period from their entry into the program through February 28, 2003. These reports included all costs claimed by Petitioners under the accrual basis of accounting in rendering services to eligible Medicaid beneficiaries.

14. In preparing their cost reports, Petitioners used the standard Medicaid Cost Report "Chart of Accounts and Description," which contains the account numbers to be used for each ledger entry, and explains the meaning of each account number. Under the general category of "Administration" are set forth several subcategories of account numbers, including "Insurance Expense." Insurance Expense is broken into five account numbers, including number 730810, "General and Professional Liability -- Third Party," which is described as "[c]osts of insurance purchased from a commercial carrier or a non-profit service corporation."[3] Petitioners' cost report stated the following expenses under account number 730810:

Facility	Amount
Palm Garden of Clearwater	$145,042.00
Palm Garden of Gainesville	$145,042.00
Palm Garden of Jacksonville	$145,042.00
Palm Garden of Largo	$171,188.00
Palm Garden of North Miami	$145,042.00
Palm Garden of Ocala	$217,712.00
Palm Garden of Orlando	$145,042.00
Palm Garden of Pinellas	$145,042.00
Palm Garden of Port St. Lucie	$145,042.00
Palm Garden of Sun City	$145,042.00
Palm Garden of Tampa	$145,042.00
Palm Garden of Vero Beach	$217,712.00
Palm Garden of West Palm Beach	$231,151.00
Palm Garden of Winter Haven	$145,042.00

15. AHCA requires that the cost reports of first-year providers undergo an audit. AHCA's contract auditing firm, Smiley & Smiley, conducted an examination[4] of the cost reports of

the 14 Palm Gardens nursing homes to determine whether the included costs were allowable.

16. The American Institute of Certified Public Accountants ("AICPA") has promulgated a series of "attestation standards" to provide guidance and establish a framework for the attestation services provided by the accounting profession in various contexts. Attestation Standards 101 and 601 set out the standard an accountant relies upon in examining for governmental compliance. Smiley & Smiley examined the Palm Gardens cost reports pursuant to these standards.

17. During the course of the audit, Smiley & Smiley made numerous requests for documentation and other information pursuant to the Medicaid provider agreement and the Plan. Petitioners provided the auditors with their general ledger, invoices, audited financial statements, bank statements, and other documentation in support of their cost reports.

18. The examinations were finalized during the period between September 28, 2006, and October 4, 2006. The audit report issued by AHCA contained more than 2,000 individual adjustments to Petitioners' costs, which the parties to these consolidated proceedings have negotiated and narrowed to two adjustments per Palm Gardens facility.[5]

19. As noted in the Preliminary Statement above, the first adjustment at issue is AHCA's disallowance of Palm Gardens'

accrual of expenses for contingent liability under the category of GL/PL insurance, where Palm Gardens could not document that it had purchased GL/PL insurance. The second adjustment at issue is ACHA's disallowance of a portion of the premium paid by Palm Gardens for the Mature Care Policies.

20. The total amount of the adjustment at issue for each facility is set forth in the Preliminary Statement above. Of that total for each facility, $18,849.00 constituted the disallowance for the Mature Care Policies. The remainder constituted the disallowance for the accrual of GL/PL related contingent liabilities.

21. Janette Smiley, senior partner at Smiley & Smiley and expert in Medicaid auditing, testified that Petitioners provided no documentation other than the Mature Care Policies to support the GL/PL entry in the cost reports. Ms. Smiley testified that, during much of the examination process, she understood Petitioners to be self-insured.

22. Ms. Smiley's understanding was based in part on statements contained in Petitioners' audited financial statements. In the audited financial statement covering the period from June 28, 2002, through December 31, 2002, Note six explains Petitioners' operating leases and states as follows, in relevant part:

> The lease agreement requires that the Company maintain general and professional liability in specified minimum amounts. As an alternative to maintaining these levels of insurance, the lease agreement allows the Company to fund a self-insurance reserve at a per bed minimum amount. The Company chose to self-insure, and has recorded litigation reserves of approximately $1,735,000 that are included in other accrued expenses (see Note 9). As of December 31, 2002, these reserves have not been funded by the Company. . . .

23. The referenced Note nine, titled "Commitments and Contingencies," provides as follows in relevant part:

> Due to the current legal environment, providers of long-term care services are experiencing significant increases in liability insurance premiums or cancellations of liability insurance coverage. Most, if not all, insurance carriers in Florida have ceased offering liability coverage altogether. The Company's Florida facilities have minimal levels of insurance coverage and are essentially self-insured. The Company has established reserves (see Note 6) that estimate its exposure to uninsured claims. Management is not currently aware of any claims that could exceed these reserves. However, the ultimate outcome of these uninsured claims cannot be determined with certainty, and could therefore have a material adverse impact on the financial position of the Company.

24. The relevant notes in Petitioner's audited financial statement for the year ending December 31, 2003, are identical to those quoted above, except that the recorded litigation reserves were increased to $4 million. The notes provide that,

as of December 31, 2003, these reserves had not been funded by Petitioners.

25. Ms. Smiley observed that the quoted notes, while referencing "self-insurance" and the recording of litigation reserves, stated that the litigation reserves had not been funded.

26. By e-mail dated April 21, 2005, Ms. Smiley corresponded with Stanley Swindling, the shareholder in the accounting firm Moore Stephens Lovelace, P.A., who had primary responsibility for preparing Petitioners' cost reports. Ms. Smiley noted that Petitioners' audited financial statements stated that the company "chose to self-insure" and "recorded litigation reserves," then wrote (verbatim):

> By definition from PRM CMS Pub 15-1 Sections 2162.5 and 2162.7 the Company does in fact have self-insurance as there is no shifting of risk. You will have to support your positioning a letter addressing the regs for self-insurance. As clearly the financial statement auditors believe this is self-insurance and have disclosed such to the financial statement users. If you cannot support the funding as required by the regs, the provider will have to support expense as "pay as you go" in accordance with [2162.6] for PL/GL.
>
> * * *
>
> Please review 2161 and 2162 and provide support based on the required compliance. If support is not complete within the regulations, amounts for IBNR [incurred but not reported] will be disallowed and we will

> need to have the claims paid reports from the TPA [third party administrator] (assuming there is a TPA handling the claims processing), in order to allow any expense.

27. Section 2160 of the Manual establishes the basic insurance requirement:

> A. General.-- A provider participating in the Medicare program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. Where a provider chooses not to maintain adequate insurance protection against such losses, through the purchase of insurance, the maintenance of a self-insurance program described in §2161B, or other alternative programs described in §2162, it cannot expect the Medicare program to indemnify it for its failure to do so. . . .
>
> . . . If a provider is unable to obtain malpractice coverage, it must select one of the self-insurance alternatives in §2162 to protect itself against such risks. If one of these alternatives is not selected and the provider incurs losses, the cost of such losses and related expenses are not allowable.

28. Section 2161.A of the Manual sets forth the general rule as to the reimbursement of insurance costs. It provides that the reasonable costs of insurance purchased from a commercial carrier or nonprofit service corporation are allowable to the extent they are "consistent with sound management practice." Reimbursement for insurance premiums is

limited to the "amount of aggregate coverage offered in the insurance policy."

29. Section 2162 of the Manual provides as follows, in relevant part:

> PROVIDER COSTS FOR MALPRACTICE AND COMPREHENSIVE GENERAL LIABILITY PROTECTION, UNEMPLOYMENT COMPENSATION, WORKERS' COMPENSATION, AND EMPLOYEE HEALTH CARE INSURANCE
>
> A. General.-- Where provider costs incurred for protection against malpractice and comprehensive general liability . . . do not meet the requirements of §2161.A, costs incurred for that protection under other arrangements will be allowable under the conditions stated below. . . .
>
> * * *
>
> The following illustrates alternatives to full insurance coverage from commercial sources which providers, acting individually or as part of a group or a pool, can adopt to obtain malpractice, and comprehensive general liability, unemployment compensation, workers' compensation, and employee health care insurance protection:
>
> 1. Insurance purchased from a commercial insurance company which provides coverage after a deductible or coinsurance provision has been met;
>
> 2. Insurance purchased from a limited purpose insurance company (captive);
>
> 3. Total self-insurance; or
>
> 4. A combination of purchased insurance and self-insurance. . . .

30. Section 2162.3 of the Manual provides:

> Self-Insurance.-- You may believe that it is more prudent to maintain a total self-insurance program (i.e., the assumption by you of the risk of loss) independently or as part of a group or pool rather than to obtain protection through purchased insurance coverage. If such a program meets the conditions specified in §2162.7, payments into such funds are allowable costs.

31. Section 2162.7 of the Manual provides, in relevant part:

> Conditions Applicable to Self-Insurance.--
>
> A. Definition of Self-Insurance.-- Self-insurance is a means whereby a provider(s), whether proprietary or nonproprietary, undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. . . .
>
> * * *
>
> B. Self-Insurance Fund.-- The provider or pool establishes a fund with a recognized independent fiduciary such as a bank, a trust company, or a private benefit administrator. In the case of a State or local governmental provider or pool, the State in which the provider or pool is located may act as a fiduciary. The provider or pool and fiduciary must enter into a written agreement which includes all of the following elements:
>
> 1. General Legal Responsibility.-- The fiduciary agreement must include the appropriate legal responsibilities and obligations required by State laws.
>
> 2. Control of Fund.-- The fiduciary must have legal title to the fund and be

> responsible for proper administration and control. The fiduciary cannot be related to the provider either through ownership or control as defined in Chapter 10, except where a State acts as a fiduciary for a State or local governmental provider or pool. Thus, the home office of a chain organization or a religious order of which the provider is an affiliate cannot be the fiduciary. In addition, investments which may be made by the fiduciary from the fund are limited to those approved under State law governing the use of such fund; notwithstanding this, loans by the fiduciary from the fund to the provider or persons related to the provider are not permitted. Where the State acts as fiduciary for itself or local governments, the fund cannot make loans to the State or local governments. . . .

32. The quoted Manual provisions clarify that Ms. Smiley's message to Mr. Swindling was that Petitioners had yet to submit documentation to bring their "self-insurance" expenses within the reimbursable ambit of Sections 2161 and 2162 of the Manual. There was no indication that Petitioners had established a fund in an amount sufficient to liquidate its anticipated liabilities, or that any such funds had been placed under the control of a fiduciary. Petitioners had simply booked the reserved expenses without setting aside any cash to cover the expenses.

33. AHCA provided extensive testimony regarding the correspondence that continued among Ms. Smiley, Mr. Swindling, and AHCA employees regarding this "self-insurance" issue. It is

not necessary to set forth detailed findings as to these matters, because Petitioners ultimately conceded to Ms. Smiley that, aside from the Mutual Care policies, they did not purchase commercial insurance as described in Section 2161.A, nor did they avail themselves of the alternatives to commercial insurance described in Section 2162.A. Petitioners did not purchase commercial insurance with a deductible, did not self-insure, did not purchase insurance from a limited purpose or "captive" insurance company, or employ a combination of purchased insurance and self-insurance.

34. Ms. Smiley eventually concluded that Petitioners had no coverage for general and professional liability losses in excess of the $25,000 value of the Mutual Care Policies. Under the cited provisions of the Manual, Petitioners' unfunded self-insurance expense was not considered allowable under the principles of reimbursement. Petitioners were uninsured, which led Ms. Smiley to further conclude that Section 2162.13 of the Manual would apply:

> Absence of Coverage.-- Where a provider, other than a governmental (Federal, State, or local) provider, has no insurance protection against malpractice or comprehensive general liability in conjunction with malpractice, either in the form of a limited purpose or commercial insurance policy or a self-insurance fund as described in §2162.7, any losses and related expenses incurred are not allowable.

35. In response to this disallowance pursuant to the strict terms of the Manual, Petitioners contend that AHCA should not have limited its examination of the claimed costs to the availability of documentation that would support those costs as allowable under the Manual. Under the unique circumstances presented by their situation, Petitioners assert that AHCA should have examined the state of the nursing home industry in Florida, particularly the market for GL/PL liability insurance during the audit period, and further examined whether Petitioners had the ability to meet the insurance requirements set forth in the Manual. Petitioners assert that, in light of such an examination, AHCA should have concluded that generally accepted accounting principles ("GAAP") may properly be invoked to render the accrued contingent liabilities an allowable expense.

36. Keith Parnell is an expert in insurance for the long-term care industry. He is a licensed insurance broker working for Hamilton Insurance Agency, which provides insurance and risk management services to about 40 percent of the Florida nursing home market. Mr. Parnell testified that during the audit period, it was impossible for nursing homes to obtain insurance in Florida. In his opinion, Petitioners could not have purchased commercial insurance during the audit period.

37. To support this testimony, Petitioners offered a study conducted by the Florida Department of Insurance ("DOI") in 2000 that attempted to determine the status of the Florida long-term care liability insurance market for nursing homes, assisted living facilities, and continuing care retirement communities. Of the 79 companies that responded to DOI's data call, 23 reported that they had provided GL/PL coverage during the previous three years but were no longer writing policies, and only 17 reported that they were currently writing GL/PL policies. Six of the 17 reported writing no policies in 2000, and five of the 17 reported writing only one policy. The responding insurers reported writing a total of 43 policies for the year 2000, though there were approximately 677 skilled nursing facilities in Florida.

38. On March 1, 2004, the Florida Legislature's Joint Select Committee on Nursing Homes issued a report on its study of "issues regarding the continuing liability insurance and lawsuit crisis facing Florida's long-term care facilities and to assess the impact of the reforms contained in CS/CS/CS/SB 1202 (2001)."[6] The study employed data compiled from 1999 through 2003. Among the Joint Select Committee's findings was the following:

> In order to find out about current availability of long-term care liability insurance in Florida, the Committee

> solicited information from [the Office of Insurance Regulation, or] OIR within the Department of Financial Services, which is responsible for regulating insurance in Florida. At the Committee's request, OIR re-evaluated the liability insurance market and reported that there has been no appreciable change in the availability of private liability insurance over the past year. Twenty-one admitted insurance entities that once offered, or now offer, professional liability coverage for nursing homes were surveyed by OIR. Six of those entities currently offer coverage. Nine surplus lines carriers have provided 54 professional liability policies in the past year. Representatives of insurance carriers that stopped providing coverage in Florida told OIR that they are waiting until there are more reliable indicators of risk nationwide to re-enter the market.

39. Among the Joint Select Committee's conclusions was the following:

> In the testimony the Committee received, there was general agreement that the quality of care in Florida nursing homes is improving, in large part due to the minimum staffing standards the Legislature adopted in SB 1202 during the 2001 Session. There was not, however, general agreement about whether or not lawsuits are abating due to the tort system changes contained in SB 1202. There was general agreement that the long-term care liability insurance market has not yet improved.
>
> After hearing the testimony, there is general agreement among the members of the Joint Select Committee that:
>
> * * *
>
> General and professional liability insurance, with actual transfer-of-risk, is

virtually unavailable in Florida. "Bare-bones" policies designed to provide minimal compliance with the statutory insurance requirement are available; however, the cost often exceeds the face value of the coverage offered in the policy. This situation is a crisis which threatens the continued existence of long-term care facilities in Florida.

40. To further support Mr. Parnell's testimony, Petitioners offered actuarial analyses of general and professional liability in long-term care performed by AON Risk Consultants, Inc. (AON) on behalf of the American Health Care Association. The AON studies analyzed nationwide trends in GL/PL for long-term care, and also examined state-specific issues for eight states identified as leading the trends in claim activity, including Florida. They provided an historical perspective of GL/PL claims in Florida during the audit period.

41. The 2002 AON study for Florida was based on participation by entities representing 52 percent of all Florida nursing home beds. The study provided a "Loss Cost per Occupied Bed" showing GL/PL liability claims losses on a per bed basis. The 2002 study placed the loss cost for nursing homes in Florida at $10,800 per bed for the year 2001. The 2003 AON study, based on participation by entities representing 54 percent of Florida nursing home beds, placed the loss cost for nursing homes in Florida at $11,810 per bed for the year 2002.

42. The studies showed that the cost per bed of GL/PL losses is materially higher in Florida than the rest of the United States. The nationwide loss per bed was $2,360 for the year 2001 and $2,880 for the year 2002. The GL/PL loss costs for Texas were the second-highest in the country, yet were far lower than the per bed loss for Florida ($5,460 for the year 2001 and $6,310 for the year 2002).

43. Finally, Petitioners point to the Mature Care Policies as evidence of the crisis in GL/PL insurance availability. The aforementioned SB 1202 instituted a requirement that nursing homes maintain liability insurance coverage as a condition of licensure. See Section 22, Chapter 2001-45, Laws of Florida, codified at Subsection 400.141(20), Florida Statutes. To satisfy this requirement, Petitioners entered the commercial insurance market and purchased insurance policies for each of the 14 Palm Gardens facilities from a carrier named Mature Care Insurance Company. The policies carried a $25,000 policy limit, with a policy premium of $34,000. These were the kind of "bare bones" policies referenced by the Joint Select Committee's 2004 report.

44. The fact that the policies cost more than they could ever pay out led Mr. Swindling, Petitioners' health care accounting and Medicaid reimbursement expert, to opine that a

prudent nursing home operator in Florida at that time would not have purchased insurance, but for the statutory requirement.[7]

45. The Mature Care Policies were "bare bones" policies designed to provide minimal compliance with the statutory liability insurance coverage requirement. The policies cost Petitioners more than $37,000 in premium payments, taxes, and fees, in exchange for policy limits of $25,000. In its examination, AHCA disallowed the difference between the cost of the policy and the policy limits, then prorated the allowable costs because the audit period was nine months long and the premium paid for the Mature Care Policies was for 12 months.

46. AHCA based its disallowance on Section 2161.A of the Manual, particularly the language which states: "Insurance premiums reimbursement is limited to the amount of aggregate coverage offered in the insurance policy." Petitioners responded that they did not enter the market and voluntarily pay a premium in excess of the policy limits. They were statutorily required to purchase this minimal amount of insurance; they were required to purchase a 12-month policy; they paid the market price[8]; and they should not be penalized for complying with the statute. Petitioners contend they should be reimbursed the full amount of the premiums for the Mature Care Policies, as their cost of statutory compliance.

47. Returning to the issue of the contingent liabilities, Petitioners contend that, in light of the state of the market for GL/PL liability insurance during the audit period, AHCA should have gone beyond the strictures of the Manual to conclude that GAAP principles render the accrued contingent liabilities an allowable expense.

48. Under GAAP, a contingent loss is a loss that is probable and can be reasonably estimated. An estimated loss from a loss contingency may be accrued by a charge to income. Statement of Financial Accounting Standards No. 5 ("FAS No. 5"), Accounting for Contingencies, provides several examples of loss contingencies, including "pending or threatened litigation" and "actual or possible claims and assessments."

49. Petitioners assert that the contingent losses reported in their cost reports were actual costs incurred by Petitioners. The AICPA Audit and Accounting Guide for Health Care Organizations, Section 8.05, provides:

> The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, are accrued when the incidents that give rise to the claims occur. Estimated losses from asserted and unasserted claims are accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims and the relationship of past reported incidents to eventual claims payments. All relevant information, including industry experience, the entity's own historical experience, the entity's

> existing asserted claims, and reported incidents, is used in estimating the expected amount of claims. The accrual includes an estimate of the losses that will result from unreported incidents, which are probable of having occurred before the end of the reporting period.

50. Section 8.10 of AICPA Guide provides:

> Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle (generally within one year of the date of the financial statements) are classified as current liabilities. All other accrued unpaid claims and expenses are classified as non-current liabilities.

51. As noted above, Petitioners' audited financial statements for the fiscal years ending December 31, 2002, and December 31, 2003, showed that the accrual was incurred and recorded by Petitioners during the audit period. Mr. Swindling prepared Petitioners' cost reports, based on information provided by Petitioners, including trial balances reflecting their costs, statistics on patient days, cost data related to square footage, and revenue information.

52. Mr. Swindling advised Petitioners to include the accrued losses. He believed that the loss contingency was probable and could be reasonably estimated. The losses were probable because it was "a given in the state of Florida at that time period that nursing homes are going to get sued."

53. Mr. Swindling testified that the accrual reflected a per bed loss amount of $1,750, which he believed to be a

reasonable estimate of the contingent liabilities faced by Petitioners during the audit period. This amount was much less than the per bed loss indicated by the AON studies for Florida.

54. Mr. Swindling used the criteria set forth in Section 8.05 of the AICPA Guide to establish the estimate. He determined that the lesser amount was adequate based on his discussions with Petitioners' management, who indicated that they had a substantial risk management program. Management also disclosed to Mr. Swindling that Petitioners' leases required $1,750 per bed in liability coverage. See Finding of Fact 22, supra.

55. Mr. Swindling believed that the estimated loss per bed was reasonable based on the AON studies and his knowledge and experience of the state of the industry in Florida during the audit period, as further reflected in the DOI and Joint Committee on Nursing Homes materials discussed above.

56. Mr. Swindling's opinion was that the provisions of the Manual relating to GL/PL insurance costs do not apply under these circumstances. The costs at issue in this proceeding are not general and professional liability insurance costs subject to CMS Pub. 15-1; rather, they are loss contingencies related to general and professional liability, including defense costs, litigation costs, and settlement costs. Mr. Swindling placed the loss contingency under number 730810, "General and

Professional Liability -- Third Party" because, in the finite chart of accounts provided by Medicaid, that was the most appropriate place to record the cost.[9] Despite the initial confusion it caused the agency's auditors, the placement of the loss contingency under number 730810 was not intended to deceive the auditors.

57. Mr. Swindling opined that, under these circumstances, Sections 2160 through 2162 are in conflict with other provisions in the Manual relating to the "prudent buyer" concept, and further conflict with the Plan to the extent that the cited regulations "relate to a retrospective system as opposed to prospective target rate-based system."

58. Mr. Swindling agreed that the application of Sections 2160 through 2162 to the situation presented by Petitioners would result in the disallowance of the loss contingencies. Mr. Swindling observed, however, that Sections 2160 through 2162 are Medicare regulations. Mr. Swindling testified that Medicare reimbursements are made on a retrospective basis.[10] Were this situation to occur in Medicare -- in which the provider did not obtain commercial insurance, self-insurance, or establish a captive insurer -- the provider would be deemed to be operating on a pay-as-you-go basis. Though its costs might be disallowed in the current period, the provider would receive reimbursements

in subsequent periods when it could prove actual payment for its losses.

59. Mr. Swindling found a conflict in attempting to apply these Medicare rules to the prospective payment system employed by Florida Medicaid, at least under the circumstances presented by Petitioners' case. Under the prospective system, once the contingent loss is disallowed for the base period, there is no way for Petitioners ever to recover that loss in a subsequent period, even when the contingency is liquidated.

60. During his cross-examination, Mr. Swindling explained his position as follows:

> . . . Medicare allows for that payment in a subsequent period. Medicaid rules would not allow that payment in the subsequent period; therefore you have conflict in the rules. When you have conflict in the rules, you revert to generally accepted accounting principles. Generally accepted accounting principles are what we did.
>
> Q. Where did you find that if there's a conflict in the rules, which I disagree with, but if there is a conflict in the rules, that you follow GAAP? Where did you get that from? I mean, we've talked about it and it's clear on the record that if there is no provision that GAAP applies, but where did you get that if there's a conflict? Just point it out, that would be the easiest way to do it.
>
> A. The hierarchy, if you will, requires providers to file costs on the accrual basis of accounting in accordance with generally accepted accounting principles. If there's no rules, in absence of rules -- and I

forget what the other terms were, we read it
into the record before, against public
policy, those kind of things -- or in my
professional opinion, if there is a conflict
within the rules where the provider can't
follow two separate rules at the same time,
they're in conflict, then [GAAP] rules what
should be recorded and what should be
reimbursed.

*   *   *

Q. [T]he company accrued a liability of
$2 million for the cost reporting period of
2002-2003, is that correct?

A. Yes.

*   *   *

Q. Do you have any documentation supporting claims
paid, actually paid, in 2002-2003 beyond the mature
care policy for which that $2 million reserve was set
up?

A. No.

Q. So what did Medicaid pay for?

A. Medicaid paid the cost of contingent
liabilities that were incurred by the
providers and were estimated at $1,750 per
bed. Generally accepted accounting
principles will adjust that going forward
every cost reporting period. If that
liability in total goes up or down, the
differential under [GAAP] goes through the
income statement, and expenses either go up
or they go down. It's self-correcting,
which is similar to what Medicare is doing,
only they're doing it on a cash basis.

61. Mr. Swindling explained the "hierarchy" by which allowable costs are determined. The highest governing law is the Federal statutory law, Title XIX of the Social Security Act,

42 U.S.C. Subsection. 1396-1396v. Below the statute come the federal regulations for implementing Title XIX, 42 C.F.R. parts 400-426. Then follow in order Florida statutory law, the relevant Florida Administrative Code provisions, the Plan, the Manual, and, at the bottom of the hierarchy, GAAP.

62. Mr. Swindling testified that in reality, a cost report is not prepared from the top of the hierarchy down; rather, GAAP is the starting point for the preparation of any cost report. The statutes, rules, the Plan and the Manual are then consulted to exclude specific cost items otherwise allowable under GAAP. In the absence of an applicable rule, or in a situation in which there is a conflict between rules in the hierarchy such that the provider is unable to comply with both rules, the provider should fall back on GAAP principles as to recording of costs and reimbursement.

63. John A. Owens, currently a consultant in health care finance specializing in Medicaid, worked for AHCA for several years up to 2002, in positions including administrator of the audit services section and bureau chief of the Office of Medicaid Program Analysis. Mr. Owens is a CPA and expert in health care accounting and Medicare/Medicaid reimbursement.

64. Mr. Owens agreed with Mr. Swindling that AHCA's disallowance of the accrued costs for GL/PL liability was improper. Mr. Owens noted that Section 2160 of the Manual

requires providers to purchase commercial insurance. If commercial insurance is unavailable, then the Manual gives the provider two choices: self-insure, or establish a captive program.

65. Mr. Owens testified that insurers were fleeing the state during the period in question, and providers were operating without insurance coverage. Based on the state of the market, Petitioners' only options would have been to self-insure or establish a captive.

66. As to self-insurance, Petitioners' problem was that they had taken over the leases on their facilities from a bankrupt predecessor, Integrated Health Services ("IHS"). Petitioners were not in privity with their predecessor. Petitioners had no access to the facilities' loss histories, without which they could not perform an actuarial study or engage a fiduciary to set up a self-insurance plan.[11]

67. Similarly, setting up a captive would require finding an administrator and understanding the risk exposure. Mr. Owens testified that a provider would not be allowed to set up a captive without determining actuarial soundness, which was not possible at the time Petitioners took over the 14 IHS facilities.

68. Thus, Petitioners were simply unable to meet the standards established by the Manual. The options provided by

the Manual did not contemplate the unique market situation existing in Florida during the audit period, and certainly did not contemplate that situation compounded by the problems faced by a new provider taking over 14 nursing homes from a bankrupt predecessor.

69. Mr. Owens agreed with Mr. Swindling that, under these circumstances, where the requirements of the Manual could not be met, Petitioners were entitled to seek relief under GAAP, FAS No. 5 in particular. In situations where a loss is probable and can be measured, then an accounting entry may be performed to accrue and report that cost. Mr. Owens concluded that Petitioners' accrual was an allowable cost for Medicaid purposes, and explained his rationale as follows:

> My opinion is, in essence, that since they could not meet -- technically, they just could not meet those requirements laid out by [the Manual], they had to look somewhere to determine some rational basis for developing a cost to put into the cost report, because if they had chosen to do nothing and just moved forward, those rates would be set and there would be nothing in their base year which then establishes their target moving forward.
>
> So by at least looking at a rational methodology to accrue the cost, they were able to build something into their base year and have it worked into their target system as they move forward.

70. Steve Diaczyk, an audit evaluation and review analyst for AHCA, testified for the agency as an expert in accounting,

auditing, and Medicaid policy. Mr. Diaczyk was the AHCA auditor who reviewed the work of Smiley & Smiley for compliance with Medicaid rules and regulations, and to verify the accuracy of the independent CPA's determinations.

71. Mr. Diaczyk agreed with Mr. Swindling's description of the "hierarchy" by which allowable costs are determined.
Mr. Diaczyk affirmed that Petitioners employed GAAP rather than Medicaid regulations in preparing their cost reports.

72. Mr. Diaczyk testified regarding the Notes to Petitioners' audited financial statements, set forth at Findings of Fact 22-24, supra, which left AHCA's auditors with the understanding that Petitioners were self-insuring. Mr. Diaczyk pointed out that Section 2162.7 of the Manual requires a self-insurer to contract with an independent fiduciary to maintain a self-insurance fund, and that the fund must contain monies sufficient to cover anticipated losses. The fiduciary takes title to the funds, the amount of which is determined actuarially.

73. Mr. Diaczyk explained that, in reimbursing a provider for self-insurance, Medicaid wants to make sure that the provider has actually put money into the fund, and has not just set up a fund on its books and called it "self-insurance" for reimbursement purposes. AHCA's position is that it would be a windfall for a provider to obtain reimbursement for an accrued

liability when it has not actually set the money aside and funded the risk. Medicaid wants the risk transferred off of the provider's books and on to the self-insurance fund.

74. Mr. Diaczyk testified as to the differing objectives of Medicaid and GAAP. Medicaid is concerned with reimbursing costs, and is therefore especially sensitive regarding the overstatement of costs. Medicaid wants to reimburse a provider for only those costs that have actually been paid. GAAP, on the other hand, is about report presentation for a business entity and is concerned chiefly with avoiding the understatement of expenses and overstatement of revenue. Under GAAP, an entity may accrue a cost and not pay it for years. In the case of a contingent liability, the entity may book the cost and never actually pay it.

75. Mr. Diaczyk described the self-insurance and liquidation provisions of 42 C.F.R. Section 413.100, "Special treatment of certain accrued costs." The federal rule essentially allows accrued costs to be claimed for reimbursement, but only if they are "liquidated timely." Subsection (c)(2)(viii) of the rule provides that accrued liability related to contributions to a self-insurance program must be liquidated within 75 days after the close of the cost reporting period. To obtain reimbursement, Petitioners would

have had to liquidate their accrued liability for GL/PL insurance within 75 days of the end of the audit period.

76. Mr. Diaczyk also noted that, even if the 75-day requirement were not applicable, the general requirement of Section 2305.2 of the Manual would apply. Section 2305.2 requires that all short-term liabilities must be liquidated within one year after the end of the cost reporting period in which the liability is incurred, with some exceptions not applicable in this case. Petitioners' accrued liability for general and professional liability insurance was not funded or liquidated for more than one year after the cost reporting period. It was a contingent liability that might never be paid. Therefore, Mr. Diaczyk stated, reimbursement was not in keeping with Medicaid's goal to reimburse providers for actual paid costs, not for potential costs that may never be paid.

77. Petitioners responded that their accrued liabilities constituted non-current liabilities, items that under normal circumstances will not be liquidated within one year.
Mr. Parnell testified that there is great variation in how long it takes for a general and professional liability claim against a nursing home to mature to the point of payment to the claimant. He testified that a "short" timeline would be from two to four years, and that some claims may take from eight to eleven years to mature. From these facts, Petitioners urge that

42 C.F.R. Section 413.100 and Section 2305.2 of the Manual are inapplicable to their situation.

78. As to Section 2305.2 in particular, Petitioners point to Section 2305.A, the general liquidation of liabilities provision to which Section 2305.2 provides the exceptions discussed above. The last sentence of Section 2305.A provides that, where the liability is not liquidated within one year, or does not qualify under the exceptions set forth in Sections 2305.1 and 2305.2, then "the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, <u>but is allowable in the cost reporting period when the liquidation of the liability occurs</u>." (Emphasis added.)

79. Petitioners argue that the underscored language supports the Medicare/Medicaid distinction urged by Mr. Swindling. In its usual Medicare retroactive reimbursement context, Section 2305.2 would operate merely to postpone reimbursement until the cost period in which the liability is liquidated. Applied to this Medicaid prospective reimbursement situation, Section 2305.2 would unfairly deny Petitioners any reimbursement at all by excluding the liability from the base rate.

80. Mr. Diaczyk explained that, where the Medicaid rules address a category of costs, the allowable costs in a provider's

cost report are limited to those defined as allowable by the applicable rules. He stated that if there is a policy in the Manual that addresses an item of cost, the provider must use the Manual provision; the provider cannot use GAAP to determine that cost item. In this case, Mr. Diaczyk agreed with Ms. Smiley as to the applicable rules and the disallowance of Petitioners' contingent liability costs.

81. According to Mr. Diaczyk, GAAP may be used only if no provisions farther up the chain of the "hierarchy" are applicable. In this case, the Medicaid rules specifically addressed the categories of cost in question, meaning that GAAP did not apply.

82. Under cross-examination, Mr. Diaczyk testified that the accrual made by Petitioners in their cost reports would be considered actual costs under GAAP, "[a]ssuming that they had an actuarial study done to come up with the $1.7 million that they accrued." Mr. Diaczyk acknowledged that AICPA Audit and Accounting Guide for Health Care Organizations, Section 8.05, does not limit the provider to an actuarial study in estimating losses from asserted and unasserted claims. See Finding of Fact 49, supra, for text of Section 8.05. Mr. Diaczyk pointed out that the problem in this case was that Petitioners gave AHCA no documentation to support their estimate of the accrual, despite

the auditor's request that Petitioners provide documentation to support their costs.

83. Mr. Diaczyk's testimony raised a parallel issue to Mr. Swindling's concern that Medicaid's prospective targeting system permanently excludes any item of cost not included in the base rate. Mr. Swindling solved the apparent contradiction in employing Medicare rules in the Medicaid scenario by applying GAAP principles. Responding to the criticism that GAAP could provide a windfall to Petitioners by reimbursing them for accrued costs that might never actually result in payment, Mr. Swindling responded that GAAP principles would adjust the cost for contingent liabilities going forward, "truing up" the financial statements in subsequent reporting periods. This truing up process would have the added advantage of obviating the agency's requirement for firm documentation of the initial accrual.

84. Mr. Swindling's "truing up" scenario under GAAP would undoubtedly correct Petitioners' financial statements. However, Mr. Swindling did not explain how the truing up of the financial statements would translate into a correction of Petitioners' reimbursement rate.[12] If costs excluded from the base rate cannot be added to future rate adjustments, then costs incorrectly included in the base rate would also presumably remain in the facility's rate going forward.[13] Thus,

Mr. Swindling's point regarding the self-correcting nature of the GAAP reporting procedures did not really respond to AHCA's concerns about Petitioners' receiving a windfall in their base rate by including the accrual for contingent liabilities.

85. On April 19, 2005, Petitioners entered into a captive insurance program. Petitioners' captive is a claims-made GL/PL policy with limits of $1 million per occurrence and $3 million in the aggregate. Under the terms of the policy, "claims-made" refers to a claim made by Petitioners to the insurance company, not a claim made by a nursing home resident alleging damages. The effective date of the policy is from April 21, 2005, through April 21, 2006, with a retroactive feature that covers any claims for incidents back to June 29, 2002, a date that corresponds to Petitioners' first day of operation and participation in the Medicaid program. The Petitioners' paid $3,376,906 for this policy on April 22, 2005.

86. Mr. Parnell testified that April 2005 was the earliest time that the 14 Palm Gardens facilities could have established this form of insurance program.

87. In summary, the evidence presented at the hearing regarding the contingent liabilities established that Petitioners took over the 14 Palm Gardens facilities after the bankruptcy of the previous owner. Petitioners were faced with the virtual certainty of substantial GL/PL expenses in operating

the facilities, and also faced with a Florida nursing home environment market in which commercial professional liability insurance was virtually unavailable. Lacking loss history information from their bankrupt predecessor, Petitioners were unable to self-insure or establish a captive program until 2005.

88. Petitioners understood that if they did not include their GL/PL expenses in their initial cost report, those expenses would be excluded from the base rate and could never be recovered. Petitioners' leases for the facilities required them to fund a self-insurance reserve at a per bed minimum amount of $1,750. Based on the AON studies and the general state of the industry at the time, Petitioners' accountant concluded that, under GAAP principles, $1,750 per bed was a reasonable, conservative estimate of Petitioners' GL/PL loss contingency exposure for the audit period.[14] Based on all the evidence, it is found that Petitioners' cost estimate was reasonable and should be accepted by the agency.

89. Petitioners included their GL/PL loss contingency expenses in their initial Medicaid cost report, placing those expenses under a heading indicating the purchase of insurance from a third party. The notes to Petitioners' audited financial statements stated that the facilities were "essentially self-insured." These factors led AHCA to request documentation of Petitioners' self-insurance. Petitioners conceded that they

were not self-insured and carried no liability insurance aside from the Mature Care policies.

90. The parties had little dispute as to the facts summarized above. The parties also agreed as to the applicability of the "hierarchy" by which allowable costs are determined. Their disagreement rests solely on the manner in which the principles of the hierarchy should be applied to the unique situation presented by Petitioners in these cases.

CONCLUSIONS OF LAW

91. The DOAH has jurisdiction over the parties to and the subject matter of this proceeding pursuant to Section 120.569 and Subsection 120.57(1), Florida Statutes.

92. In Courts v. Agency for Health Care Administration, 965 So. 2d 154, 155-156 (Fla. 1st DCA 2007), the court drew on various sources to provide a concise, useful description of the Medicaid program:

> "The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396, is a cooperative federal-state program designed to allow states to receive matching funds from the federal government to finance necessary services to qualified low-income individuals." Esteban v. Cook, 77 F. Supp. 2d 1256, 1259 (S.D. Fla. 1999); see also Russell v. Agency for Persons with Disabilities, 929 So. 2d 601, 602 (Fla. 1st DCA 2006); Harris v. McRae, 448 U.S. 297, 308-09, 100 S. Ct. 2671, 65 L. Ed. 2d 784 (1980). "[T]he purpose of Congress in enacting Title XIX was to provide federal assistance for all legitimate state

> expenditures under an approved Medicaid plan." Harris, 448 U.S. at 308-09 (citations omitted). The guidelines for the Medicaid program are set forth in the federal statutes and regulations and are adopted into specific state laws and rules in each state. 42 U.S.C. § 1302. In each state, a "single state agency" is responsible for administering the Medicaid program. 42 C.F.R. § 431.10. In Florida, AHCA is designated as the Florida state agency authorized to make payments to qualified providers for medical assistance and related services on behalf of eligible individuals. See § 409.902, Fla. Stat. (2005); see generally, Russell, 929 So. 2d at 602-03.

93. AHCA is charged by statute with the responsibility to "reimburse Medicaid providers, in accordance with state and federal law, according to methodologies set forth in the rules of the agency and in policy manuals and handbooks incorporated by reference therein." § 409.908, Fla. Stat.

94. Subsection 409.908(2)(a)1., Florida Statutes, provides:

> Reimbursement to nursing homes licensed under part II of chapter 400 and state-owned-and-operated intermediate care facilities for the developmentally disabled licensed under part VIII of chapter 400 must be made prospectively.

95. Subsection 409.908(2)(b), Florida Statutes, provides, in relevant part:

> Subject to any limitations or directions provided for in the General Appropriations Act, the agency shall establish and implement a Florida Title XIX Long-Term Care

> Reimbursement Plan (Medicaid) for nursing home care in order to provide care and services in conformance with the applicable state and federal laws, rules, regulations, and quality and safety standards. . . .

96. An agency's interpretation of its own rule is entitled to deference, unless the interpretation is clearly erroneous. Pan American World Airways, Inc. v. Florida Public Services Commission, 427 So. 2d 716, 719 (Fla. 1983); Miles v. Florida A&M University, 813 So. 2d 242, 245 (Fla. 1st DCA 2002). More specifically, the court in Pan American, 427 So. 2d at 719, stated:

> We have long recognized that the administrative construction of a statute by an agency or body responsible for the statute's administration is entitled to great weight and should not be overturned unless clearly erroneous. The same deference has been accorded to rules which have been in effect over an extended period and to the meaning assigned to them by officials charged with their administration. (Citations omitted.)

97. AHCA asserts that Petitioners failed to comply with the Plan's and the Manual's provisions regarding insurance, and that this failure should result in the disallowance of Petitioners' accrued expenses for GL/PL liability. Petitioners assert that their situation was not contemplated by the Plan and the Manual, which assume the availability of commercial insurance, self-insurance, and/or captive insurance programs, and therefore presume that a provider's failure to obtain

coverage under one or more of these three options must be voluntary. Petitioners argue that the provisions relied upon by AHCA to disallow their accrued expenses do not contemplate a situation where insurance of any kind is simply unavailable.

98. The underlying facts in these consolidated cases were largely undisputed. At issue is the parties' disagreement as to the manner in which the established state and federal law hierarchy applies to the unique circumstances presented by those facts. In Brookwood-Walton County Convalescent Center v. Agency for Health Care Administration, 845 So. 2d 223, 225 (Fla. 1st DCA 2003), the court set forth the hierarchy in the following language:

> In determining allowable reimbursable costs, AHCA utilizes the Florida Title XIX Long-Term Care Reimbursement Plan (Plan), the Federal Medicare Program's Health Insurance Manual (HIM-15)[now CMS Pub. 15-1], and generally accepted accounting principles (GAAP). The Plan has been adopted and incorporated by reference in Rule 59G-6.040, Florida Administrative Code. Through incorporation, AHCA has adopted the HIM-15 as a rule. See Rules 59G-1.010(102) and -6.010, Fla. Admin. Code. In assessing what is an allowable cost, AHCA looks, first, to the Plan; second, to the HIM-15; and third, to GAAP.

99. As set forth in the above excerpts from Section 409.908, Florida Statutes, state law requires AHCA to develop and implement a reimbursement plan. AHCA has developed the Plan, which is incorporated by reference in Florida

Administrative Code Rule 59G-6.010. As required by statute, the Plan provides for prospective payment and calls for participating nursing homes to provide care and services in conformance with applicable state and federal laws, rules, regulations, and quality and safety standards.

100. CMS Pub. 15-1, or the Manual, was designed to determine allowable costs for the retrospective payment system of the federal Medicare program.

101. The experts testifying for both parties agreed that reimbursement and cost findings may be determined using GAAP if no provisions farther up the chain of the hierarchy are "applicable." As to the accrual for GL/PL related contingent liability costs, the parties disagree as to the "applicability" of the Manual provisions establishing reimbursement requirements relating to insurance.

102. AHCA's analysis begins with Section I.F. of the Plan, which requires that the cost information submitted by a provider must be "current, accurate, and in sufficient detail to support costs set forth in the report." Section 2304 of the Manual provides:

> Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers,

> requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

103. AHCA accurately states that Petitioners failed to provide any invoice supporting GL/PL insurance in excess of the Mature Care policies. AHCA asserts that "Petitioners claimed over 2 million dollars of professional and general liability insurance for which no documentary support was provided." The facts of the case do not entirely support AHCA's assertion. Petitioners did record their accrual for GL/PL contingent liability under an "insurance" heading on their cost report, but Petitioners informed Ms. Smiley at the time of the audit that they had purchased no form of commercial insurance, were not self-insured, and had not established a captive program during the audit period.[15]

104. AHCA found this lack of insurance coverage to be dispositive. Section 2162 of the Manual requires self-insurance to be funded within 75 days of the end of the cost reporting period. Section 2305 of the Manual provides that only those expenses paid within one year of the cost reporting period may be included in the report. Petitioners did not meet the requirements of either section.

105. AHCA notes that Petitioners did not meet the criteria for self-insurance set forth in 42 C.F.R. Subsection

413.100(c)(2), which allows accrued costs to be claimed for reimbursement only if they are liquidated timely. Under Subsection (c)(2)(viii), such timely liquidation of accrued liability for contributions to a self-insurance program must occur within 75 days after the close of the cost reporting period. Petitioners did not meet the requirements of this section.

106. AHCA notes that Section 2162.A of the Manual, see Finding of Fact 29, supra, provides for four alternatives to full insurance coverage from commercial sources: commercial insurance with deductible or coinsurance provisions; insurance from a captive company; total self-insurance; or a combination of purchased insurance and self-insurance. Petitioners did not meet the requirements of this section.

107. Section 2162.7 of the Manual requires, as a condition of self-insurance, that a provider establish a fund with an independent fiduciary who must have control of the fund. Petitioners did not meet this requirement.

108. Section 2162.2 of the Manual sets forth the standards for captive insurance programs. Petitioners did not establish a captive program during the audit period.

109. Finally, Section 2162.13 of the Manual, see Finding of Fact 34, supra, states that a provider's losses are not allowable if the provider has no insurance protection against

malpractice or comprehensive general liability in conjunction with malpractice, either in the form of commercial insurance, captive insurance, or self-insurance. AHCA accurately states that Petitioners did not meet any of these requirements. Petitioners are therefore to be considered "uninsured" for purposes of Section 2162.13 and their accrued costs for GL/PL contingent liability costs should be disallowed.

110. In response, Petitioners return to Subsection 409.908(2)(b), Florida Statutes, and the Plan, both of which reference applicable state and federal laws, rules and regulations. The Manual provisions cited by AHCA in disallowing the contingent expenses are not applicable.

111. Petitioners argue that the Manual provisions create a standard for reimbursement of these costs that was impossible for Petitioners to meet under all the circumstances presented. The evidence established that Florida nursing homes faced a liability insurance crisis during the audit period. Commercial insurance was virtually nonexistent in any form that made economic sense. Petitioners purchased the "bare bones" Mature Care policies to meet the statutory insurance requirement, but at a premium well in excess of the policy limits.

112. From all of the evidence, it is reasonable to infer that any larger GL/PL policy that Petitioners might have purchased during the audit period would have carried terms

similar to those of the Mature Care policies. From this inference, Petitioners argue that the cost of such insurance would not have been reimbursable because Section 2161 of the Manual limits reimbursement to the amount of aggregate coverage offered in the insurance policy. The cost of such insurance would also violate the "prudent buyer" provisions of Section 2103 of the Manual, see Finding of Fact 44 and accompanying Endnote seven, supra, and violate the definition of "allowable costs" set forth in Section III.C. of the Plan, see Finding of Fact eight, supra.

113. Petitioners thus contend that the insurance crisis created a conflict within the Manual between the requirements to obtain insurance and the prudent buyer principles, and that this conflict requires the application of GAAP with respect to Petitioners' accrued GL/PL liability.

114. It could also be reasonably argued that the commercial insurance requirements of the Manual were simply inapplicable during the Florida nursing home insurance crisis, because the products then available on the market did not constitute "insurance" as that term is contemplated in the Manual or in any rational course of business. A contract which calls for a premium payment far in excess of the policy limits does not include any transfer of risk and therefore is not what a prudent buyer would call "insurance" at all.

115. Petitioners further point to the disadvantage under which they operated during the audit period. Petitioners entered the Medicaid program having taken over the operations of IHS, a bankrupt predecessor. Petitioners had no contractual privity with IHS, and commenced operations without any loss or claims history available. Mr. Owens' testimony credibly established that there was no way Petitioners could have established either a captive insurer or funded a self-insurance program that would have met the requirements of Section 2162.7 of the Manual without access to these histories.

116. Thus, Petitioners were in a position in which commercial insurance was unavailable (except, perhaps, at a premium in excess of the coverage offered), self-insurance was unavailable, and a captive program could not be established during the audit period. Petitioners' situation is not contemplated by the Manual. Section 2160 of the Manual provides in relevant part:

> A. General.-- A provider participating in the Medicare program is expected to follow sound and prudent management practices, including the maintenance of an adequate insurance program to protect itself against likely losses, particularly losses so great that the provider's financial stability would be threatened. Where a provider chooses not to maintain adequate insurance protection against such losses, through the purchase of insurance, the maintenance of a self-insurance program described in §2161B, or other alternative programs described in

§2162, it cannot expect the Medicare program to indemnify it for its failure to do so. . . .

. . . If a provider is unable to obtain malpractice coverage, it must select one of the self-insurance alternatives in §2162 to protect itself against such risks. If one of these alternatives is not selected and the provider incurs losses, the cost of such losses and related expenses are not allowable. (Emphasis added.)

117. The underscored language is couched in terms of the provider "choosing" not to maintain adequate insurance protection, and failing to "select" an option from the menu supplied by Section 2162. In requiring the purchase of commercial insurance or the "selection" of one of the listed alternatives, the Manual presumes that one of those options would be available to cover the GL/PL losses incurred by a provider.

118. However, during the audit period, Petitioners were unable to "select" any of the offered alternatives. The evidence at hearing established that Petitioners entered a captive insurance program on April 19, 2005. Mr. Parnell, who developed the program for Petitioners, credibly testified that this was earliest date on which such a program could have been established.

119. Petitioners reasonably conclude that the Manual simply does not address situations in which none of the listed

alternatives is available to a provider. Because neither the Plan nor the Manual addresses these situations, Petitioners assert that the principle of the hierarchy dictates that allowable costs in this case should be determined by GAAP.

120. Petitioners also argue that AHCA's reliance on the Manual does not take into account the statutory requirement for a prospective payment system or the Plan's targeted rate structure. The initial cost reporting period establishes the provider's base rate. The target limitations established by the Plan limit the growth of a provider's reimbursement rate from one rate semester to the next, regardless of the provider's actual costs after the base period. Petitioners claim they would suffer irreparable harm if their accrued contingent liabilities are disallowed under AHCA's interpretation of the Manual, because Petitioners would in all likelihood never recover those costs even after they are eventually liquidated.

121. The evidence established that the costs at issue were non-current liabilities, meaning that they will not under usual circumstances be liquidated within one year. One of the reasons AHCA gave for disallowing these costs was a lack of documentation to establish that Petitioners liquidated the liability within one year as required by Section 2305 of the Manual, or within 75 days of the close of the cost reporting

period for self-insurance payments as required by Section 2162.9 of the Manual.

122. AHCA's reasoning is inconsistent with the established fact that these accrued costs are not capable of being liquidated within the timeframes set forth in the cited Manual provisions. Section 2305 of the Manual deals only with short term liabilities; the Manual is apparently silent as to the liquidation of non-current liabilities. Petitioners reasonably argue that the absence of a Manual provision dealing with these costs leads to the conclusion that these costs should be governed by GAAP.

123. Petitioners note that the last sentence of Section 2305.A provides:

> Where the liability (1) is not liquidated within the 1-year time limit, or (2) does not qualify under the exceptions specified in §§2305.1 and 2305.2, the cost incurred for the related goods and services is not allowable in the cost reporting period when the liability is incurred, <u>but is allowable in the cost reporting period when the liquidation of the liability occurs</u>. (Emphasis added.)

124. Petitioners also point to Section 2162.9, which provides in relevant part:

> Accruals of payments to be made into the fund are allowable costs in the year of accrual if paid within 75 days after the end of a provider's cost reporting period. <u>Payments made after the 75th day will be deemed allowable in the reporting period</u>

> paid, provided the total contributions made in that period do not exceed the amount prescribed by the actuary as necessary for the adequacy of the fund. (Emphasis added.)

125. Petitioners argue that the underscored language provides further support for their argument that the Manual provisions should not be applied to their situation. AHCA employs those provisions to disallow Petitioners' accrued contingency costs for the audit period. Under the Medicare system, Petitioners could still anticipate payment in subsequent reporting periods. However, the prospective Florida Medicaid system would deny Petitioners the opportunity to use the underscored language to obtain payment in subsequent reporting periods.

126. At the hearing and in its proposed recommended order, AHCA attempted to support its position with formal opinions from the federal Department of Health and Human Services ("HHS") and the Health Care Financing Administration ("HCFA", now CMS).[16] Petitioners argue that AHCA fails to note the chief distinguishing factor: all of the cited authorities were Medicare reimbursement cases. The Medicare program as it existed when those opinions were issued was a retrospective payment system, in which each year's cost report stands alone and providers are reimbursed for actual costs incurred from period to period. Under the retrospective system, costs

incurred but not allowed in one period may be allowable in future periods.

127. Another distinction between the opinions cited by AHCA and the instant cases is that in the former, the parties could have complied with the provisions of the Manual but failed to do so. In the instant cases, the evidence established that Petitioners could not have complied with the conditions imposed by the Manual provisions. Because the Manual offered only futile options, Petitioners believed that the Manual provisions should not apply. Petitioners concluded that they were required to rely on GAAP, because GAAP was the only step in the regulatory hierarchy that specifically addressed their costs.

128. Based on all the evidence and argument presented in this proceeding, the undersigned concludes that Petitioners' position is correct as to the accrued contingent liability costs. Under the unique factual circumstances presented by these consolidated cases, it is clearly erroneous for AHCA to insist on a strict application of Manual provisions with which Petitioners could not have complied during the audit period. The Manual does not anticipate a situation in which insurance is simply not available. Subsection 409.908(2)(b), Florida Statutes, and the Plan require compliance with applicable state and federal laws, rules and regulations. It would be fundamentally unfair to apply the insurance provisions of the

Manual to Petitioners when their circumstances did not permit them to comply with those provisions during the audit period, and where they did comply by establishing a captive program at the first available opportunity.

129. The remaining question as to allowing the contingent liability costs under GAAP is the windfall issue raised by AHCA. Petitioners accrued the liability but did not fund it, and there was uncertainty whether including those accrued costs in the base rate might unjustly enrich Petitioners should those contingent liabilities never be liquidated. Mr. Swindling's "truing up" explanation established that under GAAP the financial statements would be self-correcting, but did not satisfactorily establish that the correction necessarily would be reflected in Petitioners' future Medicaid reimbursements.

130. The evidence demonstrated that, by all rational expectations, it was a certainty that these accrued liabilities would be liquidated in some amount, i.e., that there would be general and professional liability claims against these fourteen nursing homes for events occurring during the audit period. Thus, any question of a windfall had to do with the amount of the subsequent liquidated claims, not whether there would be claims at all.

131. As to the amount of the accrual, the evidence established that Petitioners employed a reasonable, conservative

estimate of their GL/PL loss contingency exposure for the audit period, an estimate that was supported to some extent by the amount of the premium Petitioners ultimately paid when they established their captive program in April 2005. Petitioners would receive no windfall through the allowance of the accrued loss contingency.

132. As to the Mature Care policies, AHCA correctly disallowed the amounts in excess of the policy limits, prorated for a nine-month period. On this issue, there was a Manual provision that directly applied to Petitioners' situation. Section 2161.A provides the following, in relevant part:

> Purchased Commercial Insurance.-- The reasonable costs of insurance purchased from a commercial carrier or a nonprofit service corporation and not from a limited purpose insurer (see §2162.2) are allowable if the type, extent, and cost of coverage are consistent with sound management practice. Insurance premiums reimbursement is limited to the amount of aggregate coverage offered in the insurance policy.

133. The evidence clearly established that Petitioners purchased these "bare bones" policies purely in order to comply with Subsection 400.141(20), Florida Statutes, and that the state of the insurance market for Florida nursing homes was such that Petitioners were forced to pay premiums in excess of the amount of aggregate coverage offered in the policies. Nonetheless, Section 2161.A expressly states that reimbursement

for insurance purchased from a commercial carrier is limited to the aggregate coverage. The regulatory hierarchy requires that a Manual provision be employed where applicable. Though it seems unfair, there is no question that Section 2161.A is applicable to the Mature Care policies and that this provision supports the agency's disallowance of the amounts in excess of the policy limits.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that AHCA enter a final order that allows Petitioners' accrual of expenses for contingent liability under the category of general and professional liability ("GL/PL") insurance, and that disallows the Mature Care policy premium amounts in excess of the policy limits, prorated for a nine-month period.

DONE AND ENTERED this 24th day of October, 2008, in Tallahassee, Leon County, Florida.

LAWRENCE P. STEVENSON
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Filed with the Clerk of the
Division of Administrative Hearings
this 24th day of October, 2008.

ENDNOTES

[1/] The quoted language was unchanged in the 2003 edition of the Florida Statutes.

[2/] In contrast, a "retrospective" system reimburses the provider's costs for the reporting period. It is a simple reimbursement system, and payments made for one reporting period have no effect on the next period.

[3/] Another Insurance Expense account number is 730820, "General and Professional Liability -- Self-Insured," which is described as "[n]ecessary contributions to a Self-Insured Fund (as described in PRM-1 2162.7) based on actuarial determination of anticipated losses and allowable administrative costs."

[4/] Janette Smiley, the lead auditor for Smiley & Smiley, testified that this was an attestation engagement that qualifies as an "examination," not a GAAP "audit." With this understanding, the parties employed the term "audit" for convenience during the hearing. See Florida Administrative Code Rule 59G-1.010(22)(a), which defines "audit" as "an examination of 'records for audit' supporting amount reported in the annual cost report or in order to determine the correctness and propriety of the report."

[5/] Petitioners prefer to call it a single adjustment for each facility, each of which contains two distinct disallowances. For accounting purposes, Petitioners' view is probably more accurate, because both disallowances were derived from Petitioners' entry for account number 730810, "General and Professional Liability" insurance coverage. For purposes of conceptual clarity in this recommended order, the undersigned has chosen to treat the disallowances as separate adjustments.

[6/] Chapter 2001-45, Laws of Florida.

[7/] Mr. Swindling specifically mentioned Section 2103 of the Manual, the "Prudent Buyer" rule, which states, "The prudent and cost conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. . . ." Petitioners also point to Section III.C. of the Plan, which states that an "implicit" criterion of any definition of allowable costs is "that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item." Any costs in excess of those that a prudent buyer would incur are not reimbursable under the Plan.

[8/] Petitioners offered no direct evidence regarding any comparative shopping they undertook prior to purchasing the policies. They rely on the reasonable inference that they would not have paid more than the value of the policies if there were other options available on the market.

[9/] Mr. Swindling testified that the provider had initially recorded some of these costs under a heading for property insurance. He believed that the GL/PL entry was more appropriate, and reclassified the cost to account number 730810.

[10/] Some evidence indicated that Medicare reimbursement is no longer made on a retrospective basis. However, AHCA did not dispute that the regulations in question were adopted at a time when the Medicare program operated as described by Mr. Swindling.

[11/] Mr. Parnell, who wrote Petitioners' current captive policy and who was the insurance agent for HIS from 1990 to 2000, testified that there was no loss history available in 2002-2003. Mr. Parnell stated that the loss history is unavailable to this day, and that he employed a team of five people to re-create the history in order to write Petitioners' captive policy in 2005.

He agreed with Mr. Owens that Petitioners could not have self-insured or established a captive during the audit period.

[12/] In Shalala v. Guernsey Memorial Hospital, 514 U.S. 87, 93-94 (1995), the United States Supreme Court emphasized the "distinction between recordkeeping practices and systems on one hand and principles of reimbursement on the other" that underlies the regulations in 42 C.F.R. part 413.

[13/] Neither party suggested that the base rate was subject to downward correction in future rate semesters. Both parties appeared to agree that that the only adjustment made to the base rate in subsequent rate semesters is the application of the pre-established inflation factor. The undersigned is aware that Section IV.J. of the Plan makes provision for interim rate adjustments. Neither party made reference to Section IV.J. at the hearing or in their post-hearing submissions.

[14/] Petitioners did not attempt directly to tie their 2005 captive insurance program to their estimate of GL/PL expenses for the audit period. However, it is found that the roughly $3.4 million premium for the captive policy is not out of line with Petitioners' estimate of GL/PL expenses for the audit period.

[15/] When directly questioned, AHCA's witnesses disclaimed any inference that Petitioners had intentionally misled the auditors as to their lack of insurance coverage. However, the tone of the agency's presentation at the hearing left the impression that AHCA believed Petitioners had been less than forthcoming during the audit.

[16/] Mt. Diablo Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, HHS Provider Reimbursement Review Board Decision 90-1202 (July 1, 1996); Los Medanos Community Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, HCFA Admin. Decision (August 3, 1992).

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.