STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

ADVANTE AT JACKSONVILLE, Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case Nos. 07-3626 07-5155
ADVANTE AT ST. CLOUD,[1] Petitioner, vs. AGENCY FOR HEALTH CARE ADMINISTRATION, Respondent.	)	Case No. 08-0220

RECOMMENDED ORDER

Pursuant to notice, a final hearing was held in this case on February 19, 2008, in Tallahassee, Florida, before Errol H. Powell, a designated Administrative Law Judge of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Peter A. Lewis, Esquire
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For Respondent: Karen Dexter, Esquire
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STATEMENT OF THE ISSUE

The issue for determination is whether Petitioners' Interim Rate Request (IRR) for an increase should be granted.

PRELIMINARY STATEMENT

By letter dated July 16, 2007, Petitioner Avante at Jacksonville requested an IRR effective August 1, 2007, pursuant to Florida Title XIX Long-term Care Reimbursement Plan (Plan) Section IV J.2., for additional costs incurred from self-insured losses as a result of paying $350,000.00 to settle a lawsuit involving the Estate of D. P. By letter dated July 18, 2007, the Agency for Health Care Administration (AHCA) denied the IRR on the basis that the IRR failed to satisfy the requirements of "Section IV J." Petitioner Avante at Jacksonville contested the denial and timely requested a hearing. On August 10, 2007, this matter was referred to the Division of Administrative Hearings. A hearing was scheduled for November 8, 2007, on agreement of the parties. The hearing was continued and re-scheduled on agreement of the parties for December 10, 2007.

By letter dated October 22, 2007, Petitioner Avante at Jacksonville made a second request for an IRR, this time pursuant to the Plan Section IV J.3., for the additional costs

incurred from the self-insured losses as a result of paying the $350,000.00 settlement. By letter dated October 30, 2007, AHCA denied the second request for an IRR, indicating that the first request was denied based on "all sub-sections of Section IV J of the Plan"; that the second request failed to satisfy the requirements of the Plan Section IV J.3. and all sections and sub-sections of the Plan "necessary and proper for granting [the] request." Petitioner Avante at Jacksonville contested the denial and timely requested a hearing. On November 9, 2007, this matter was referred to the Division of Administrative Hearings. By Order dated November 26, 2007, consolidation was granted and the two matters (Case Nos. 07-3626 and 07-5155) were consolidated. The parties filed a joint motion for continuance, which was granted, and by Order dated December 24, 2007, these matters were re-scheduled for hearing on February 19, 2008.

By letter dated December 10, 2007, Petitioner Avante at St. Cloud requested an IRR effective November 1, 2007, pursuant to the Plan Section IV J for additional costs associated with claims paid to the Estate of G. M. in the amount of $90,000.00. By letter dated December 12, 2007, AHCA denied the IRR on the basis that the IRR failed to satisfy the requirements of "Section IV J of the Plan necessary and proper for granting [the] request." Petitioner Avante at St. Cloud contested the denial and timely requested a hearing. On January 11, 2008,

this matter was referred to the Division of Administrative Hearings. Petitioner Avante at St. Cloud filed a motion for continuance, which was granted, and by Order dated February 4, 2008, these matters (Case Nos. 07-3626, 07-5155, and 08-0220) were consolidated for the hearing scheduled on February 19, 2008.

At hearing, the parties filed a Joint Pre-Trial Stipulation regarding issues of law on which the parties agreed. Those issues of law included the following:

> Florida Title XIX Long-Term Care Reimbursement Plan, Version XXX, effective date July 1, 2006, has been adopted and incorporated by reference in Rule 59G-6.010, Florida Administrative Code.
>
> Florida Title XIX Long-Term Care Reimbursement Plan, Version XXXI, effective date August 26, 2007, has been adopted and incorporated by reference in Rule 59G-6.010, Florida Administrative Code.
>
> Florida Title XIX Long-Term Care Reimbursement Plan, Versions XXX and XXXI, incorporates by reference The Provider Reimbursement Manual (CMS Pub. 15-1).
>
> Provision 4.J.1. of the Long Term Care Reimbursement Plan is not at issue in this case and does not apply to the facts of this case.

Also, at hearing, the parties agreed that Version XXXI of the Plan is applicable to this matter.

Further, at hearing, Petitioners presented the testimony of three witnesses and entered 12 exhibits (Petitioners' Exhibits

numbered 1 through 12) into evidence. AHCA presented the testimony of one witness and entered two exhibits (Respondent's Exhibits numbered 2 and 3) into evidence. The parties entered two joint exhibits (Joint Exhibits numbered 1 and 2) into evidence.[2] Official Recognition was taken of Brookwood-Walton County Convalescent Center v. AHCA, 845 So. 2d 223 (Fla. 1st DCA 2003).

A transcript of the hearing was ordered. At the request of the parties, the time for filing post-hearing submissions was set for more than ten days following the filing of the transcript. The Transcript, consisting of one volume, was filed on March 5, 2008. Respondent requested an extension of time for the parties to file post-hearing submissions, and the request was granted. The parties timely filed their post-hearing submissions, which were considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. AHCA is the agency of state government responsible for the implementation and administration of the Medicaid Program in the State of Florida.

2. AHCA is authorized to audit Medicaid Cost Reports submitted by Medicaid Providers participating in the Medicaid Program.

3. Avante at Jacksonville and Avante at St. Cloud are licensed nursing homes in Florida that participate in the Medicaid Program as institutional Medicaid Providers.

4. On May 23, 2007, Avante at Jacksonville entered into a settlement agreement with the representative of the estate of one of its former residents, D. P. The settlement agreement provided, among other things, that Avante at Jacksonville would pay $350,000.00 as settlement for all claims. Avante at Jacksonville paid the personal representative the sum of $350,000.00.

5. By letter dated July 16, 2007, Avante at Jacksonville requested an IRR effective August 1, 2007, pursuant to the Plan Section IV J.2., for additional costs incurred from self-insured losses as a result of paying the $350,000.00 to settle the lawsuit. Avante at Jacksonville submitted supporting documentation, including a copy of the settlement agreement, and indicated, among other things, that the costs exceeded $5,000.00 and that the increase in cost was projected at $2.77/day, exceeding one percent of the current Medicaid per diem rate.

6. At all times pertinent hereto, the policy held by Avante at Jacksonville was a commercial general and professional liability insurance policy. The policy had $10,000.00 per occurrence and $50,627.00 general aggregate liability limits.

7. The policy was a typical insurance policy representative of what other facilities in the nursing home industry purchased in Florida.

8. The policy limits were typical limits in the nursing home industry in Florida.

9. By letter dated July 18, 2007, AHCA denied the IRR on the basis that the IRR failed to satisfy the requirements of Section IV J. of the Plan, necessary and proper for granting the request. Avante at Jacksonville contested the denial and timely requested a hearing.

10. Subsequently, Avante at Jacksonville became concerned that, perhaps, the incorrect provision of the Plan had been cited in its IRR. As a result, a second IRR was submitted for the same costs.

11. By letter dated October 22, 2007, Avante at Jacksonville made a second request for an IRR, this time pursuant to the Plan Section IV J.3., for the same additional costs incurred from the self-insured losses as a result of paying the $350,000.00 settlement. The same supporting documentation was included. Avante at Jacksonville was of the opinion that the Plan Section IV J.3. specifically dealt with the costs of general and professional liability insurance.

12. By letter dated October 30, 2007, AHCA denied the second request for an IRR, indicating that the first request was

denied based on “all sub-sections of Section IV J of the Plan”; that the second request failed to satisfy the requirements of the Plan Section IV J.3. and all sections and sub-sections of the Plan “necessary and proper for granting [the] request.”

13. Avante at Jacksonville contested the denial and timely requested a hearing.

14. On October 19, 2007, Avante at St. Cloud entered a settlement agreement with the personal representative of the estate of one of its former residents, G. M. The settlement agreement provided, among other things, that Avante at St. Cloud would pay $90,000.00 as settlement for all claims. Avante at St. Cloud paid the personal representative the sum of $90,000.00.

15. By letter dated December 10, 2007, Avante at St. Cloud requested an IRR effective November 1, 2007, pursuant to the Plan Section IV J, for additional costs incurred as a result of paying the $90,000.00 to settle the lawsuit. Avante at St. Cloud submitted supporting documentation, including a copy of the settlement agreement, and indicated, among other things, that the increase in cost was projected at $2.02/day, exceeding one percent of the current Medicaid per diem rate.

16. At all times pertinent hereto, the policy held by Avante at St. Cloud was a commercial general and professional

liability insurance policy. The policy had $10,000.00 per occurrence and $50,000.00 general aggregate liability limits.

17. The policy was a typical insurance policy representative of what other facilities in the nursing home industry purchased in Florida.

18. The policy limits were typical limits in the nursing home industry in Florida.

19. By letter dated December 12, 2007, AHCA denied the IRR on the basis that the IRR failed to satisfy the requirements of "Section IV J of the Plan necessary and proper for granting [the] request."

20. Avante at St. Cloud contested the denial and timely requested a hearing.

Insurance Policies and the Nursing Home Industry in Florida

21. Typically, nursing homes in Florida carry low limit general and professional liability insurance policies.

22. The premiums of the policies exceed the policy limits. For example, the premium for a policy of Avante at Jacksonville to cover the $350,000.00 settlement would have been approximately $425,000.00 and for a policy of Avante at St. Cloud to cover the $90,000.00 settlement would have been approximately $200,000.00.

23. Also, the policies have a funded reserve feature wherein, if the reserve is depleted through the payment of a

claim, the nursing home is required to recapitalize the reserve or purchase a new policy. That is, if a policy paid a settlement up to the policy limits, the nursing home would have to recapitalize the policy for the amount of the claim paid under the policy and would have to fund the loss, which is the amount in excess of the policy limits, out-of-pocket.

Florida's Medicaid Reimbursement Plan for Nursing Homes

24. The applicable version of the Plan is Version XXXI.

25. AHCA has incorporated the Plan in Florida Administrative Code Rule 59G-6.010.

26. AHCA uses the Plan in conjunction with the Provider Reimbursement Manual (CMS-PUB.15-1)[3] to calculate reimbursement rates of nursing homes and long-term care facilities.

27. The calculation of reimbursement rates uses a cost-based, prospective methodology, using the prior year's costs to establish the current period per diem rates. Inflation factors, target ceilings, and limitations are applied to reach a per patient, per day per diem rate that is specific to each nursing home.

28. Reimbursement rates for nursing homes and long-term care facilities are typically set semi-annually, effective on January 1 and July 1 of each year.

29. The most recent Medicaid cost report is used to calculate a facility's reimbursement rate and consists of

various components, including operating costs, the direct patient care costs, the indirect patient care costs, and property costs.

30. The Plan allows for the immediate inclusion of costs in the per diem rate to Medicaid Providers under very limited circumstances through the IRR process. The interim rate's purpose is to compensate for the shortfalls of a prospective reimbursement system and to allow a Medicaid Provider to increase its rate for sudden, unforeseen, dramatic costs beyond the Provider's control that are of an on-going nature. Importantly, the interim rate change adjusts the Medicaid Provider's individual target rate ceiling to allow those costs to flow ultimately through to the per diem paid, which increases the amount of the Provider's overall reimbursement.

31. In order for a cost to qualify under an interim rate request, the cost must be an allowable cost and meet the criteria of Section IV J of the Plan.

32. The Plan provides in pertinent part:

> IV. Standards
>
> * * *
>
> J. The following provisions apply to interim changes in component reimbursement rates, other than through the routine semi-annual rate setting process.
>
> * * *

2. Interim rate changes reflecting increased costs occurring as a result of patient or operating changes shall be considered only if such changes were made to comply with existing State or Federal rules, laws, or standards, and if the change in cost to the provider is at least $5000 and would cause a change of 1 percent or more in the provider's current total per diem rate.
a. If new State or Federal laws, rules, regulations, licensure and certification requirements, or new interpretations of existing laws, rules, regulations, or licensure and certification requirements require providers to make changes that result in increased or decreased patient care, operating, or capital costs, requests for component interim rates shall be considered for each provider based on the budget submitted by the provider. All providers' budgets submitted shall be reviewed by the Agency [AHCA] and shall be the basis for establishing reasonable cost parameters.
b. In cases where new State or Federal requirements are imposed that affect all providers, appropriate adjustments shall be made to the class ceilings to account for changes in costs caused by the new requirements effective as of the date of the new requirements or implementation of the new requirements, whichever is later.

3. Interim rate adjustments shall be granted to reflect increases in the cost of general or professional liability insurance for nursing homes if the change in cost to the provider is at least $5000 and would cause change of 1 percent or more in the provider's current total per diem.

33. CMS-PUB.15-1 provides in pertinent part:

2160. Losses Arising From Other Than Sale of Assets
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. Where a provider chooses not to file a claim for losses covered by insurance, the costs incurred by the provider as a result of such losses may not be included in allowable costs.

* * *

2160.2 Liability Losses.—Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Insurance against a provider's liability for such payments to others would include, for example, automobile liability insurance; professional liability (malpractice, negligence, etc.); owners, landlord and tenants liability; and workers' compensation. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the reasonable cost of any legal assistance connected with the settlement or award are includable in allowable costs, provided the provider submits evidence to the satisfaction of the intermediary that the insurance coverage carried by the provider at the time of the loss reflected the decision of prudent management. Also, the reasonable cost of insurance protection, as well as any losses incurred because of the application of the

customary deductible feature of the policy, are includable in allowable costs.

34. As to whether a cost is allowable, the authority to which AHCA would look is first to the Plan, then to CMS-PUB.15-1, and then to generally accepted accounting principles (GAAP).

35. As to reimbursement issues, AHCA would look to the same sources in the same order for the answer.

36. The insurance liability limit levels maintained by Avante at Jacksonville and Avante at St. Cloud reflect sound and prudent management practices.

37. Claims that resulted in the settlements of Avante at Jacksonville and Avante at St. Cloud, i.e., wrongful death and/or negligence, are the type of claims covered under the general and professional liability policies carried by Avante at Jacksonville and Avante at St. Cloud.

38. Avante at Jacksonville and Avante at St. Cloud both had a general and professional liability insurance policy in full force and effect at the time the wrongful death and/or negligence claims were made that resulted in the settlement agreements.

39. Neither Avante at Jacksonville nor Avante at St. Cloud filed a claim with their insurance carrier, even though they could have, for the liability losses incurred as a result of the settlements. Avante at Jacksonville and Avante at St. Cloud both chose not to file a claim with their respective insurance

carrier for the liability losses incurred as a result of the settlements.

40. AHCA did not look beyond the Plan in making its determination that neither Avante at Jacksonville nor Avante at St. Cloud should be granted an IRR.

41. Wesley Hagler, AHCA's Regulatory Analyst Supervisor, testified as an expert in Medicaid cost reimbursement. He testified that settlement agreements are a one time cost and are not considered on-going operating costs for purposes of Section IV J.2. of the Plan. Mr. Hagler's testimony is found to be credible.

42. Mr. Hagler testified that settlement agreements and defense costs are not considered general and professional liability insurance for purposes of Section IV J.3. of the Plan. To the contrary, Stanley William Swindling, Jr., an expert in health care accounting and Medicare and Medicaid reimbursement, testified that general and professional liability insurance costs include premiums, settlements, losses, co-insurance, deductibles, and defense costs. Mr. Swindling's testimony is found to be more credible than Mr. Hagler's testimony, and, therefore, a finding of fact is made that general and professional liability insurance costs include premiums, settlements, losses, co-insurance, deductibles, and defense costs.[4]

43. Neither Avante at Jacksonville nor Avante at St. Cloud submitted any documentation with their IRRs to indicate a specific law, statute, or rule, either state or federal, with which they were required to comply, resulted in an increase in costs.

44. Neither Avante at Jacksonville nor Avante at St. Cloud experienced an increase in the premiums for the general and professional liability insurance policies.

45. Neither Avante at Jacksonville nor Avante at St. Cloud submitted documentation with its IRRs to indicate that the premiums of its general and professional liability insurance increased.

46. Avante at Jacksonville and Avante at St. Cloud could only meet the $5,000.00 threshold and the one percent increase in total per diem under the Plan, Sections IV J.2. or J.3. by basing its calculations on the settlement costs.

47. Looking to the Plan in conjunction with CMS-PUB.15-1 to determine reimbursement costs, CMS-PUB.15-1 at Section 2160A provides generally that, when a provider chooses not to file a claim for losses covered by insurance, the costs incurred by the provider, as a result of such losses, are not allowable costs; however, Section 2160.2 specifically includes settlement dollars in excess of the limits of the policy as allowable costs, provided the evidence submitted by the provider to the

intermediary (AHCA) shows to the satisfaction of the intermediary that the insurance coverage at the time of the loss reflected the decision of prudent management.

48. The policy coverage for Avante at Jacksonville and Avante at St. Cloud set the policy limits for each facility at $10,000.00 for each occurrence. Applying the specific section addressing settlement negotiations, the loss covered by insurance would have been $10,000.00 for each facility and the losses in excess of the policy limits--$340,000.00 for Avante at Jacksonville and $80,000.00 for Avante at St. Cloud—would have been allowable costs.

CONCLUSIONS OF LAW

49. The Division of Administrative Hearings has jurisdiction over the subject matter of this proceeding and the parties thereto pursuant to Sections 120.569 and 120.57(1), Florida Statutes (2008).

50. The standard of proof is the preponderance of evidence. § 120.57(1)(l), Fla. Stat. (2007).

51. The general rule is that "the burden of proof, apart from statute, is on the party asserting the affirmative of an issue before an administrative tribunal." Florida Department of Transportation v. J. W. C. Company, Inc., 396 So. 2d 778, 788 (Fla. 1st DCA 1981). Avante at Jacksonville and Avante at St. Cloud have the burden or proof in this matter.

52. The Plan, Version XXX, effective date July 1, 2006, has been adopted and incorporated by reference in Rule 59G-6.010, Florida Administrative Code.

53. The Plan, Version XXXI, effective date August 26, 2007, has been adopted and incorporated by reference in Rule 59G-6.010, Florida Administrative Code.

54. The Plan, Versions XXX and XXXI, incorporates by reference The Provider Reimbursement Manual (CMS PUB.15-1).

55. Version XXXI of the Plan is applicable to this matter.

56. Section IV J.1. of the Plan is not at issue in this case and does not apply to the facts of this case.

57. The Plan Section IV J does not specifically address settlement dollars. The evidence demonstrates that AHCA examined only the Plan Section IV J and determined that the IRRs should be denied. However, AHCA should have also examined CMS-PUB.15-1 since both the Plan, Section IV J and CMS-PUB.15-1 are used to determine reimbursable costs and since CMS-PUB.15-1 is a standard. CMS-PUB.15-1 provides for settlements and indicates when settlement dollars are allowable costs for reimbursement.

58. CMS-PUB.15-1, Section 2160.2 provides that settlements in excess of the policy limits of insurance are allowable costs and that the provider must satisfy the intermediary that the policy coverage at the time of the loss represented prudent management. The evidence demonstrates that the policy limits

were $10,000.00 for each facility and that the policy coverage for each facility represented prudent management. Consequently, the liability losses in excess of the policy limits were $340,000.00 for Avante at Jacksonville and $80,000.00 for Avante at St. Cloud. Hence, the liability losses for each facility were allowable costs.

59. However, the general provision in CMS-PUB.15-1 provides that, if a provider chooses not to file a loss claim with its insurance carrier for the losses covered, costs incurred as a result of such losses are not allowable. CMS-PUB.15-1, § 2160A. The evidence demonstrates that settlements are general and professional liability costs. Further, the evidence demonstrates that Avante at Jacksonville and Avante at St. Cloud chose not to file a claim with their respective insurance carrier for the losses covered by their insurance policies from the settlements, which exceeded the policy limits. Consequently, the losses incurred by Avante at Jacksonville and Avante at St. Cloud were not allowable costs. CMS-PUB.15-1, § 2160A.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Agency for Health Care Administration enter a final order denying the interim rate requests for an increase for Avante at Jacksonville and Avante at St. Cloud.

DONE AND ENTERED this 18th day of September 2008, in Tallahassee, Leon County, Florida.

ERROL H. POWELL
Administrative Law Judge
Division of Administrative Hearings
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Filed with the Clerk of the
Division of Administrative Hearings
this 18th day of September, 2008.

ENDNOTES

[1/] The corrected case-style.

[2/] Petitioners' Exhibits numbered 13 and 14 were re-numbered as Joint Exhibits numbered 1 and 2, respectively.

[3/] Health Insurance Manual No. 15, also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, Health Care Financing Administration.

[4/] AHCA agreed that Mr. Hagler was not an expert in insurance.

COPIES FURNISHED:

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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.