Florida’s Model of Nursing Home Medicaid Reimbursement for Disaster-Related Expenses

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Purpose: This study describes Florida’s model of Medicaid nursing home (NH) reimbursement to compensate NHs for disaster-related expenses incurred as a result of 8 hurricanes within a 2-year period. This Florida model can serve as a demonstration for a national model for disaster-related reimbursement. Design and Methods: Florida reimburses NHs for approved disaster-related costs through hurricane interim rate requests (IRRs). The state developed its unique Medicaid per diem rate temporary add-on by adapting its standard rate-setting reimbursement methodology. To understand the payment mechanisms and the costs that facilities incurred as a result of natural disasters, we examined the IRRs and cost reports for facilities requesting and receiving reimbursement. Results: Cost reports and IRR applications indicated that Florida Medicaid spent close to $16 million to pay for hurricane-related costs to NHs. Implications: Without Florida’s Hurricane IRR program, many facilities would have not been reimbursed for their hurricane-related costs. Florida’s model is one that Medicare and other states should consider adopting to ensure that NHs receive adequate reimbursement for disaster-related expenses, including tornadoes, earthquakes, floods, blizzards, and other catastrophic events.

Key Words: Public policy, Organizational & Institutional issues, Long-term care, Institutional care/residential care
vision and/or hearing impairments, in addition to other conditions that necessitate high levels of direct care (Dosa et al., 2008; Fernandez et al.; Jones, 2002).

Although great strides have been made in disaster preparedness and planning among NHs since the death of 125 NH residents in Hurricane Katrina (Berger, 2008), providers face unanticipated and unavoidable operating expenses as well as facility damage after storms and other natural disasters (such as tornadoes, earthquakes, floods, and blizzards). It is therefore important to devise strategies to protect NHs financially to ensure the provision of quality care to home residents. However, a policy issue is whether or not these affected NHs should be reimbursed for disaster-related expenses—and if so, how.

**Florida’s 2004–2005 Hurricane Experience**

Between August 13, 2004 and September 25, 2004, Florida experienced four major hurricanes: Charley, Frances, Ivan, and Jeanne (Florida Office of the Inspector General, 2004), damaging an estimated 20% of Florida NHs (Polivka-West & Hyer, 2007) and causing close to $23.7 billion in insured damages (Colemont Insurance Brokers, 2006). The following year was another record-breaking Atlantic hurricane season. Florida’s most populated areas were significantly affected by four additional hurricanes—Dennis, Katrina, Rita, and Wilma (Florida Office of the Inspector General, 2005). In 2004 and 2005, many facilities were affected multiple times by the various storms that resulted in the evacuation of hundreds of residents and severe damage to many facilities (Hyer, Brown, Christensen, & Thomas, 2009; Hyer, Brown, Thomas et al., 2009).

Florida NHs were reimbursed for hurricane evacuation and property damage expenses from various sources depending on ownership of the NHs and insurance policies. For Florida proprietary NHs, the sources were limited to private insurance and the Florida Agency for Health Care Administration (AHCA) funds, regardless of whether the natural disaster had a formal federal declaration as a disaster or not. For nonprofit NHs, both private insurance and AHCA funds were available, but additional federal reimbursement was available when the federal government had designated a formal disaster area.

Specifically, the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) has guided federal support of state and local disaster response for more than 30 years and allows the President to declare federal disaster areas for specified intervals, thereby enabling entities within the designated disaster areas access to federal aid. Under the Stafford Act, nonprofit NHs derive recovery costs and financial assistance following a disaster from Federal Emergency Management Agency’s (FEMA) Public Assistance program (U.S. Congressional Research Service, 2006). However, an underlying tenet of this federal policy is that assistance should first come from insurance. Although the Stafford Act does reimburse nonprofit NHs, various requirements (Internal Revenue Service Tax Exempt status and cost-sharing) must be met and only disaster-related costs associated with the site, equipment, or facility can be reimbursed.

In Florida, some damaged NHs were reimbursed by their property and casualty insurance. For both proprietary and nonprofit facilities, property and casualty insurance paid the costs associated with repairing damage to the buildings and grounds (American Insurance Association, 2006). Yet, the payout of these claims led to a hike in subsequent premiums, increased deductibles for NHs, and resulted in fewer carriers agreeing to write this class of business insurance. For those who did continue to write this type of insurance, they reduced coverage in critical areas such as removal of sublimits for evacuation and peril of wind (AON Association Services, 2004). As a result, many businesses (including NHs) could no longer afford the premiums for wind damage and possible evacuation. Therefore, they either were forced to entirely exclude wind from their property policy or to purchase a small “loss limit” policy to cover wind damage. Notably, NHs that did not have mortgages were not required to have property insurance, so many opted either to go without coverage, to pay high deductibles, or to underinsure their business simply to survive economically (Revkin, 2006).

Florida, widely hailed as “state-of-the-art in hurricane response” (Gross, 2007), recognized (a) the extraordinary costs that NHs incurred during hurricanes and (b) that many NHs would not receive reimbursement for their disaster-related costs. For these reasons, in 2004, Florida created a system that allows for the disaster-related expenses of all eligible NHs to be reimbursed by Medicaid. Medicaid is the primary payer for Florida’s long-stay resident population (60% in 2005; Harrington, Carrillo, & LaCava, 2006). Florida’s AHCA reimburses NHs.
for approved disaster-related costs through hurricane interim rate requests (IRRs)—a unique model that uses the existing reimbursement methodology and documentation system to provide a temporary add-on to the current Medicaid rates in order to compensate NHs for the additional costs as a result of the hurricanes (AHCA, 2004a).

In this article, we describe the development and implementation of Florida Medicaid’s Hurricane IRR system as an example of how Medicaid might reimburse long-term care providers for extraordinary care following disasters. Specifically, we report the amount and types of hurricane-related expenses that were incurred and reimbursed during the eight hurricanes between 2004 and 2005. Because natural disasters do not occur solely in Florida and are not restricted to hurricanes, it is important to develop a model for disaster-related reimbursement that could be implemented nationally.

Reimbursement Through Florida Medicaid Hurricane IRRs

The Florida Medicaid’s Hurricane IRR procedures use the current, well-developed, and convenient Medicaid cost-reporting system. Eligible providers request a temporary add-on within 60 days of the end of a specific “hurricane-related period.” (This period varies depending on when storms impact the state, but for Florida’s AHCA, the hurricane-related period typically ends September 30, even though the meteorological hurricane season is from June 1 to November 30.) The IRR application must be received within 60 days after the end of this period (usually November 30). Complete documentation of costs can be submitted later as long as the IRR is filed on time. Because the state plan requires the agency to make appropriate ceiling adjustments when new state or federal requirements are imposed, the temporary rates granted for the hurricane-related costs are added on to the Medicaid per diem rate (AHCA, 2005). These new cost ceilings are not permanent; Medicaid allows a 1-month interim adjustment. In order to warrant an interim or temporary rate adjustment, allowable costs must change the rate by at least 1% and represent a minimum of $5,000 of additional costs.

To receive a temporary add-on Medicaid rate, facilities must provide proof of insurance reimbursement from existing insurance policies before the state will reimburse uncovered expenses. For nonprofit facilities eligible for reimbursement through the Stafford Act, damaged facilities must first apply for reimbursement from FEMA, which is typically a very involved and exacting process. Facilities with property and casualty insurance must also submit their insurance claims to FEMA before requesting reimbursement. Documentation of insurance claims and FEMA’s decision (for nonprofit NHs) must be provided to AHCA before the IRR can be processed for review. Appropriately, AHCA will not reimburse costs already paid by insurance companies or FEMA. In addition, all the costs that are being claimed during the hurricane-reported period must be deemed as the direct result of a hurricane in order to be reimbursed.

The Florida disaster reimbursement process is designed to be administratively simple for the requestors and the state agency. This contrasts starkly with FEMA’s documentation demands. In order to apply for an interim rate add-on, disaster-affected NHs must submit the same items required of all facilities under the current Florida Medicaid cost-reporting system: (a) detailed summary schedule (which includes subtotals for direct patient care [DPC], indirect patient care [IPC], and operating), (b) payroll summary, (c) dietary summary, and (d) other expenses summary. DPC covers all salaries and benefits of staff providing nursing care directly to the residents (AHCA, 2005). IPC includes salaries and benefits for individuals providing indirect care to residents (indirect nursing, social service or activities, and dietary) as well as supplies and materials associated with activities for residents or dietary needs (e.g., nursing supplies for evacuees, video for evacuees, canned food, or bottled water). The operating cost center included salaries and benefits for individuals who deal with operation of the NH (e.g., administrative, housekeeping, maintenance) as well as other supplies and materials necessary to conduct day-to-day operation of the NH (e.g., diesel for generators, repair of water damage, postage for document shipping regarding the hurricane, hand towels for evacuees). The “other expenses” summary worksheet in the IRR application covers numerous nonfood items, such as activities for evacuated residents, additional housekeeping expenses, nursing supplies, diesel for generators, and repairs, invoices for all these expenses must be included as well.

The payroll summary schedule must contain the wages (including all the overtime for the hurricane-related period) and benefits for all three types of staff: DPC, IPC, and operating. The dietary expense summary schedule must contain all food-related...

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costs for the hurricane-related period. Furthermore, the payroll and dietary expense summary worksheets must include invoices for the wages and the dietary expenses incurred during the hurricane interval. In addition to these two worksheets, providers must submit the invoices documenting the expenses paid during the three payroll periods prior to the designated hurricane-related period and 3 months prior invoices for dietary. In order to reimburse the legitimate costs associated with the hurricane, the average of the three payroll period and 3 months prior costs are subtracted from the designated hurricane-related period expenses to detail what expenses were over and above the usual cost of providing care.

For the IRR application, in addition to the detailed summary schedule, payroll summary, dietary summary, and other expenses summary, the facility must specify the total number of Medicaid patient days affected, that is, the total number of Medicaid residents during the total number of days that the facility incurred hurricane-related increased expenses. After receiving complete documentation and rationales, AHCA reviews all costs before granting IRRs. The final add-on rate consists of three components: operating, DPC, and IPC. The reported costs within each cost center are divided by the total Medicaid days within the adjusted rate period (generally 1 month) to determine a per diem rate add-on for each component. Processed as a retroactive rate adjustment, the hurricane reimbursement is paid as an add-on to the facilities’ Medicaid per diem for 1 month (AHCA, 2004b).

Reimbursement Case Study

In an effort to understand the monetary costs of this system to the state, as well as the costs that facilities incurred as a result of natural disasters, the Florida Medicaid Nursing Home IRR summary data set was used to provide information about the number of facilities that applied for reimbursement and the average per diem add-on each facility received. In 2004, 259 NHs (223 were proprietary facilities and 36 were nonprofit facilities) submitted an IRR. Of these, 220 (85%) facilities received reimbursement totaling $12,837,677, with an average of $52,830 per home and with an average per diem add-on of $17 for 30 days (an 11% increase in the average Medicaid per diem rate for 2004). In 2004, 195 of the facilities receiving add-on rates were proprietary facilities, whereas 25 were nonprofit. In 2005, 72 IRRs were submitted to ACHA (62 were submitted by proprietary NHs and the other 10 were nonprofit). Of these, 47 (65%) received a total amount of $3,362,406, an average of $71,541 per home and an average per diem add-on of $34 (a 22% increase in the average Medicaid per diem rate for 2005). Thirty-eight proprietary facilities and only five nonprofit facilities received an interim rate add-on in 2005. Between the 2 years, Florida Medicaid spent close to $16 million to pay for hurricane-related costs.

To gain a greater understanding of why the 19% of facilities that submitted IRRs in 2004 and 2005 were denied, interviews were conducted with two senior staff members of the Florida AHCA. They reported that the three primary reasons for facilities to be denied reimbursement was their failure to return requested information before the stated deadline, lack of receipts or other proof of expenses, or receipt of FEMA dollars or insurance proceeds after filing an IRR that negated the need for a Medicaid rate adjustment.

Reimbursement by Cost-Reporting Category

Table 1 displays the mean reimbursement to each facility for each of these cost-reporting categories during 2004 and 2005. A facility that received an add-on reimbursement in one area (e.g., operating costs) may not have had increased costs in another area (e.g., direct care) and therefore was not reimbursed for those expenses. Therefore, the number of facilities varies for each cost center.

<table>
<thead>
<tr>
<th>Cost center</th>
<th>2004</th>
<th>2005</th>
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<tbody>
<tr>
<td></td>
<td>Mean reimbursement</td>
<td>SD</td>
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<tr>
<td>Direct</td>
<td>$23,352</td>
<td>$22,211</td>
</tr>
<tr>
<td>Indirect</td>
<td>$12,682</td>
<td>$13,522</td>
</tr>
<tr>
<td>Operating</td>
<td>$27,553</td>
<td>$47,424</td>
</tr>
<tr>
<td>Total</td>
<td>$52,830</td>
<td>$62,582</td>
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Table 1. Cost Center by Year

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The category providing additional reimbursement to the largest number of facilities was operating costs, with 213 (97%) facilities receiving reimbursements in 2004 and 46 (98%) in 2005. The extremely large standard deviations reported in Table 1 reflect the fact that some facilities requested reimbursements at the minimum amount of $5,000, whereas others requested as much as $483,801. The large variation in these reimbursed costs resembles other financial and economic data (Briggs & Gray, 1999). Although the distribution was skewed with a long tail to the right, 90% of the cases were within double the mean value in both 2004 and 2005.

In an effort to determine if reimbursed costs differed by ownership status, we conducted a series of independent samples t tests. Results indicated that in both 2004 and 2005, there were no significant differences in reimbursement for operating, direct, or indirect costs between the proprietary and nonprofit NHs.

Next, we inspected all the IRR cost reports that were submitted in 2004 and 2005. For most facilities, we were able to obtain more detailed information prepared by their accountants that allowed us to allocate costs into specific accounting categories to reflect expenses associated with utilities, repairs, replacement of damaged items, extra supplies, meals, travel, lodging, transportation costs, contracted services, and capital replacement. Staff salaries and benefits were allocated into either DPC salaries (for RNs, LPNs, and CNAs), IPC salaries (for Indirect Nursing [nonpatient care activities such as discharge planning and Minimum Data Set record keeping], Activities, and Dietary), or operating salaries (Plant, Housekeeping, and Administration).

Table 2 presents the detailed breakdown of NHs’ additional reimbursement requests by specific cost categories. Costs associated with payroll, extra supplies, and repairs were the most requested reimbursement categories. The Stafford Act provides reimbursement to nonprofit NHs for debris removal, protective preparation of the building and equipment, repair or replacement of its buildings or equipment, and for the use of temporary buildings or equipment. Because the Stafford Act does not allow for reimbursements of salaries or operating expenses (FEMA, 2001), nonprofit facilities that were affected by a hurricane were eligible for Florida’s AHCA reimbursements and submitted IRRs to cover these costs. All the nonprofit facilities receiving reimbursements for which we were able to break down costs received reimbursement for salary costs (in 2004, 19 of the 25 nonprofit facilities that received reimbursement could be broken down further into specific cost centers; in 2005, all four of the nonprofit facilities that received reimbursement that could be broken down into specific cost centers received money for salary costs). In addition, in 2004, over half of the nonprofit facilities requested reimbursement for meals, travel, and lodging (n = 10) and extra supplies (n = 16). In 2005, all four of the nonprofit facilities of which costs could be broken down received reimbursement for extra supplies.

**Discussion**

The Florida Medicaid’s Hurricane IRR model is administratively easy for NHs to request and easy for the state’s Medicaid funding agency to process because it builds on the annual cost reports that NHs must use and AHCA must review to set Medicaid per diem rates. The temporary reimbursement rate add-on is built into the current Medicaid payment system. Other states that may be considering

<table>
<thead>
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<th>Cost categories</th>
<th>2004</th>
<th>2005</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>% (n)</td>
<td>M</td>
</tr>
<tr>
<td>Salaries and benefits</td>
<td>93 (169)</td>
<td>$34,198</td>
</tr>
<tr>
<td>Utilities</td>
<td>27 (50)</td>
<td>$2,169</td>
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<tr>
<td>Contracted services</td>
<td>43 (79)</td>
<td>$7,094</td>
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<tr>
<td>Repairs</td>
<td>51 (92)</td>
<td>$13,266</td>
</tr>
<tr>
<td>Replaced damaged items</td>
<td>13 (24)</td>
<td>$5,295</td>
</tr>
<tr>
<td>Extra supplies</td>
<td>75 (137)</td>
<td>$8,220</td>
</tr>
<tr>
<td>Meals travel and lodging</td>
<td>39 (67)</td>
<td>$6,661</td>
</tr>
<tr>
<td>Transportation</td>
<td>26 (48)</td>
<td>$4,746</td>
</tr>
<tr>
<td>Capital replacement</td>
<td>18 (32)</td>
<td>$62,265</td>
</tr>
<tr>
<td>Total number of facilities</td>
<td>(182)</td>
<td>$57,807</td>
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</tbody>
</table>
similar reimbursement programs may find the Florida method attractive because of the administrative ease of this program. Florida’s model reimburses providers for extraordinary costs for providing care to vulnerable elders during disasters that are beyond the normal costs of doing business and for which no other reimbursement is available. Hence, the IRR is a familiar and feasible way to reimburse long-term care facilities for extraordinary expense incurred during a disaster. It targets only those NHs that can justify additional expenses and any approved add-on rate is for that NH only. Through a detailed documentation and justification of expenses, Florida Medicaid insures payment covers unanticipated costs due only to natural disasters. It is important to note that AHCA denied 19% of the requests in 2004 and 2005 and paid only parts of other claims. Finally, this system limits payment to Medicaid’s fair share of these extraordinary expenses.

There were large variations in the types and amounts of costs requested and reimbursed to facilities. We believe that these large variations in reimbursed costs are due to the amount of loss and the number of hurricanes that affected the facility (some facilities were struck as many as four times in 1 year). In addition, the wide range of insurance coverage, deductible payments, and type of damage sustained are potential suspects driving the differences in reimbursed costs. Some insurance companies did not cover certain costs (e.g., mold eradication and debris removal) and therefore facilities had to request reimbursement for these costs from AHCA. Another factor attributable to the difference in costs reimbursed could have been the aggressiveness of facilities claiming costs as some facilities were very detailed in documenting costs for reimbursement and therefore received larger amounts of money.

Because 72% of facilities in Florida in 2004 were proprietary and not eligible for FEMA dollars, Florida NHs’ main source of reimbursement following natural disasters was derived from insurance policies and Florida Medicaid. However, in states without a system like Florida’s, many proprietary facilities will go without reimbursement for the costs of disasters. For example, following Hurricane Katrina in 2005, Louisiana NHs who participated in a mandatory evacuation or were shelter sites submitted their costs to the Louisiana Department of Health and Hospitals (LADHH). The LADHH then requested reimbursement from FEMA to cover these costs. In 2006, Louisiana wrote this process into law and currently is still trying to receive reimbursement from FEMA for Hurricane Gustav in 2007. In Texas, for another example, where NHs operate on a flat rate Resource Utilization Group system payment, facilities do not receive any additional reimbursement for costs associated with hurricanes (except for nonprofit facilities who request money through the Stafford Act). Concerns about proprietary long-term care providers being denied access to Stafford funds and the costs of disasters resurfaced in the Texas Health Care Association after Hurricane Ike in 2008 (Culp, 2008).

This brief examination of other states’ hurricane-related reimbursement practices lends support to the uniqueness of Florida’s model for reimbursement. Florida’s mix of private, state, and federal assistance is a model that we believe needs to be adopted by other states to ensure that all NHs receive reimbursement for disaster-related expenses.

Adapting the Florida Medicaid model, Medicare might reimburse providers for Medicare residents’ costs during disasters. Currently, Medicare does not reimburse disaster expenses, despite paying for an average of 13% of short-stay post-acute NH residents’ care in 2005 (Harrington et al., 2006). However, it is important to note that the Centers for Medicare and Medicaid Services did allow payment from Medicare funds for ambulance transportation during some evacuations. Even with very tight state budgets, we believe that both the federal and the state governments should bear their share of disaster-related expenses. The facilities receiving an interim rate adjustment had an average Medicaid ratio of 61% in 2004 and 67% in 2005, and received reimbursement proportional to the number of residents funded by Medicaid. Therefore, about 40% of disaster-related costs were still left unfunded.

Although federal assistance is, by law, supplemental, it should not be the sole form of assistance following a disaster. It is important that federal and state governments, along with private providers, share in the preparedness and recovery costs by necessitating property and casualty insurance for NHs and requiring Medicare to establish a system similar to the State of Florida’s Medicaid’s Hurricane IRR to reimburse Medicare residents’ extra costs due to a natural disaster.

Although Florida Medicaid’s Hurricane IRR model has proven to be effective following its first years of use, it is important to consider the
potential limitations of this type of state reimbursement system for disaster-related expenses. First, retrospective reimbursement models typically do not provide incentives for providers to be proactive. The Florida model does not encourage mitigation or hardening of existing buildings to protect residents from potential calamitous weather. Second, the Florida model allows for state reimbursements to occur after FEMA reimbursements (when applicable) and private insurance claims have been settled, but it does not require that the long-term care providers carry private insurance.

Although many facilities do obtain property insurance, the adequacy of coverage varies. One option that could be used in tandem with Florida Medicaid’s IRR model would be for states to mandate minimum insurance coverage and assure access to coverage. It is important that the state not inadvertently create a moral hazard or incentives for homes to forgo purchasing property insurance knowing the state will reimburse costs of damages and extra expenses. To prevent abuse of the Florida Medicaid’s IRR system and large costs to the state, it is important that business property insurers reinstate business interruption insurance and extra expense coverage in their umbrella property insurance coverage, specifically for health care facilities. In addition, requiring a minimum level of business property insurance coverage (with evacuation and wind sublimits) mandatory in Florida, specifically for NHs along the coasts, will ensure that NHs are able to be reimbursed for structural damage and evacuation-related expenses. This will prevent the overreliance on federal and state disaster assistance and will include use of the free market to regulate and absorb costs.

Conclusion

Examination of the amount and types of costs Florida NHs have incurred due to hurricanes, along with a review of Florida’s model of Hurricane Medicaid IRRs and rate adjustment, provides a template for providing reimbursement to long-term care facilities for expenses incurred during disasters. Florida’s experience in 2004 and 2005 clearly illustrated that disasters are expensive. States certainly have tight Medicaid budgets but NHs also operate on tight budgets and need reimbursement for extraordinary costs associated with disasters. It is important to understand that without Florida Medicaid’s Hurricane IRR model, these facilities would be left without repayment for expenses, which would adversely affect the operation of these facilities and potentially compromise the care that residents receive. Florida Medicaid’s IRR model is a promising model that should be adapted by the federal government to pay for Medicare residents, replicated by other states, and expanded to cover all disasters. With the changing health care system, it is important to readjust the reimbursement procedures to ensure that all long-term care facilities are receiving adequate reimbursements from the resident’s payer source for the funds spent to protect these residents during natural disasters. In addition, policy-makers need to examine the incentives and disincentives that Florida Medicaid’s Hurricane IRR system might be creating and need to enact policies and regulations to prevent abuse and misuse of the system. The quality of care and safety of our nation’s frailest citizens should not be jeopardized because of the economic consequences of nature’s fury. Therefore, it is important to have an effective system to reimburse for these costs, such as Florida Medicaid’s Hurricane IRR model.

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