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Report to Congressional Requesters

October 2003

MEDICAID NURSING HOME PAYMENTS

States' Payment Rates Largely Unaffected by Recent Fiscal Pressures

GAO-04-143

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GAO Accountability • Integrity • Reliability

Highlights

Highlights of GAO-04-143, a report to congressional requesters

Why GAO Did This Study

Almost half of all Americans over the age of 65 will rely on nursing home care at some point in their lives, and two in three nursing home residents have their care covered at least in part by Medicaid. Under Medicaid, states set nursing home payment rates and the federal government reimburses a share of state spending. According to the most recently available data, Medicaid nursing home expenditures exceed $43 billion, and total Medicaid spending for fiscal year 2003 is expected to double by 2012. Such projections of increased Medicaid spending come as most states are confronting their third consecutive year of fiscal pressure. According to the National Association of State Budget Officers (NASBO), in fiscal year 2003, 30 states collected less revenue than they budgeted for, and 37 states reduced enacted budgets by almost $14.5 billion.

In light of concerns about the adequacy of nursing home resources, GAO was asked to examine how state Medicaid programs determine nursing home payment rates and whether these payment methods or rates have changed given recent state fiscal pressures. GAO interviewed state and nursing home industry officials in 19 states and obtained documentation about nursing home payment rates and methods, including state methods to determine nursing home per diem rates for fiscal years 1998 through 2004.

www.gao.gov/cgi-bin/getrpt?GAO-04-143.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118.

What GAO Found

Recognizing the large share of Medicaid spending that is allocated to nursing homes and the importance of spending their Medicaid dollars effectively, the 19 states GAO reviewed have designed multifaceted approaches to setting nursing home payment rates. All of these states base payment rates on homes' actual costs and most develop rates specific to each home. These payment methods also generally incorporate incentives to achieve certain goals, such as promoting efficiency or encouraging homes to target spending toward resident care. States typically update payment rates regularly to reflect changes in nursing homes' costs due to factors such as inflation or residents' changing care needs.

Although each of the 19 states experienced recent fiscal pressure, states' nursing home payment rates have remained largely unaffected. Any future changes, however, remain uncertain. During fiscal years 1998 through 2004, only 4 of these states—Illinois, Massachusetts, Michigan, and Texas—cut the per diem rates paid to all nursing homes at some point, and in 2 of these states, the rate reduction was for less than 1 year. Two other states—Connecticut and Oregon—also froze nursing home per diem rates for a portion of this period. In addition, all 19 states modified the methods they use to determine nursing home payment rates during this time, such as changing ceilings on payment rates; however, irrespective of shifting fiscal pressure, the extent to which states changed specific features of their payment methods generally remained constant, with varying effects on payment rates to individual homes within states. Further, in over three-quarters of these states, nursing home per diem rates grew, on average, by an amount that exceeded the skilled nursing facility market basket index, the index used by the Centers for Medicare & Medicaid Services to measure changes in the price of nursing home goods and services for Medicare, from fiscal years 1998 through 2003. Many states were able to avoid making significant changes to nursing home payment rates by relying on existing resources, such as tobacco settlement and budget stabilization funds, and increasing revenue by imposing cigarette or nursing home provider taxes. Even with these alternative funding sources and recent temporary federal fiscal relief, however, officials in some states suggest that nursing home payment reductions are possible in the future.

GAO received comments on a draft of this report from Medicaid officials in the 19 states reviewed, who generally agreed with the characterization of their respective nursing home payment methods. GAO also received technical comments from representatives of two organizations that represent the nursing home industry.

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Abbreviations

AAHSA	American Association of Homes and Services for the Aging
AHCA	American Health Care Association
BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
CPI	Consumer Price Index
CMS	Centers for Medicare & Medicaid Services
CNA	certified nursing assistant
IOC	Inspection of Care
NASBO	National Association of State Budget Officers
NCSL	National Conference of State Legislatures
NGA	National Governors Association
OBRA	Omnibus Budget Reconciliation Act
OSCAR	Online Survey Certification and Reporting
RUG	Resource Utilization Group
SCHIP	State Children's Health Insurance Program
SFY	state fiscal year
SNF	skilled nursing facility
TILE	Texas Index for Level of Effort
UPL	upper payment limit

GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, DC 20548

October 17, 2003

The Honorable Charles E. Grassley
Chairman
The Honorable Max Baucus
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable W.J. "Billy" Tauzin
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable John Shimkus
House of Representatives

Almost half of all Americans over the age of 65 will rely on nursing home care at some point in their lives. Medicaid, a joint federal-state program that spent over $43 billion on nursing home services in fiscal year 2001, pays at least in part for the care provided to approximately two in three nursing home residents. Under Medicaid, states set their own nursing home payment rates and the federal government provides funds to match states' share of spending as determined by a federal formula.[1] Expenditures for Medicaid nursing home services have grown over the past several years and are expected to continue to grow as the baby boom generation ages, with 2001 expenditures expected to more than double by 2012. Projections of such increased Medicaid spending come as states faced their third consecutive year of fiscal pressure in 2003. According to the National Association of State Budget Officers (NASBO), 37 states reduced their fiscal year 2003 enacted budgets by almost $14.5 billion, the largest spending cut since 1979, in part due to lower than expected revenue collections.

In view of your concerns about the adequacy of nursing home resources, you asked us to examine whether recent fiscal pressures have affected

[1]The federal share of Medicaid funding varies by state and is based on a state's per capita income in relation to the national per capita income. For fiscal year 2003, the federal share of individual states' Medicaid expenditures ranged from 50 to 76.6 percent, averaging 57 percent across states.

how states determine nursing home payment rates or the rates they pay homes. Specifically, you asked us to provide information on (1) state Medicaid programs' methods to determine nursing home payment rates for services provided to Medicaid residents and (2) how these payment methods and rates have changed given recent state fiscal pressures.

To answer these questions, we interviewed officials from the state Medicaid and budget offices, as well as representatives from the local affiliates of national nursing home associations, in 19 states.[2] We selected these states based on a number of criteria, including overall population, Medicaid nursing home residents per capita, and largest decline or smallest growth in state tax revenue from 2000 through 2002. From the officials we interviewed we obtained documentation, including state laws and regulations, on how states determined nursing home payment rates (including changes) from state fiscal years 1998 through 2004, as well as the average per diem rates states paid nursing homes from state fiscal years 1998 through 2003.[3] We conducted our work from September 2002 through September 2003 in accordance with generally accepted government auditing standards. (For additional information on our scope and methodology, see app. I.)

Results in Brief

Recognizing the large share of Medicaid spending that is allocated to nursing homes and the importance of spending their Medicaid dollars effectively, states have designed multifaceted approaches to pay nursing homes for the care they provide to Medicaid-covered residents. All 19 states we reviewed base nursing home payment rates on homes' costs, and over three-quarters of these states develop rates that are specific to each home. The 19 states also incorporate various incentives in their payment methods to achieve certain goals, such as promoting efficient and economical home operations or encouraging homes to target spending

[2]We originally selected 20 states: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Iowa, Massachusetts, Michigan, New Jersey, New York, North Dakota, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, and Vermont. We subsequently excluded Arizona from our analysis because its payment method applies to only 5 percent of Medicaid nursing home residents. Costs of care provided to the remaining 95 percent of the state's nursing home residents are paid by the state's managed-care program.

[3]We examined states' methods for determining payment for nursing homes' operating costs, which include the costs of direct resident care, indirect care services (such as dietary, laundry, and medical supplies), and administration. Per diem rates for fiscal year 2004 were not available for all states.

toward direct resident care. For example, to promote efficiency, most of these states impose ceilings on the payment homes can receive. States do not, however, encourage efficiency to the same degree for all types of costs; instead, their payment methods often impose a higher ceiling for costs related to direct resident care than to other costs, thus encouraging homes to spend more on resident care. In addition, to reflect changing nursing home costs due to certain factors, such as inflation, almost all the states we reviewed update payment rates annually, often using current information on individual homes' costs. Twelve of the 19 states also adjust payment rates based on the care needs or case-mix of a home's residents. These adjustments are intended to further link payments to potential costs while encouraging homes to accept residents who require more costly care.

Despite each of the 19 states experiencing recent fiscal pressure, states' nursing home payment rates have remained largely unaffected. Any future changes, however, remain uncertain. During fiscal years 1998 through 2004, only 4 of these states—Illinois, Massachusetts, Michigan, and Texas—cut the per diem rates paid to all nursing homes at some point, and in 2 of these states the rate reduction was for less than 1 year. Two other states—Connecticut and Oregon—also froze nursing home per diem rates for a portion of this time period. In addition, all 19 states modified the methods they use to determine nursing home payment rates during this time, such as changing ceilings on payment rates; however, irrespective of shifting fiscal pressure, the extent to which states changed specific features of their payment methods generally remained constant, with varying effects on payment rates to individual homes within states. Further, in over three-quarters of these states, nursing home per diem rates grew, on average, by an amount that exceeded the skilled nursing facility (SNF) market basket index, which is used by the Centers for Medicare & Medicaid Services (CMS) to measure changes in the price of nursing home goods and services for Medicare, from fiscal years 1998 through 2003. More than three-quarters of the states indicated that they have forestalled more significant changes to their payment rates by relying on alternative funding sources to help balance their state budgets, such as tobacco settlement or budget stabilization funds, and increasing revenue by imposing cigarette or nursing home provider taxes. Even with these alternative funding sources and recent temporary federal fiscal relief, however, officials in some states suggest that nursing home payment reductions are possible in the future.

We received comments on a draft of this report from Medicaid officials in the 19 states that were included in our review, who generally agreed with our characterization of their respective nursing home payment methods, as well as from representatives of two organizations that represent the nursing home industry. State and association officials provided clarifying and technical comments regarding nursing home payment methods and rates, which we incorporated as appropriate throughout the report.

Background

Medicaid operates as a joint federal-state program to finance health care coverage for certain categories of low-income individuals, over 11 million of whom are elderly or disabled.[4] In total, Medicaid cost almost $258 billion in fiscal year 2002, and the Congressional Budget Office (CBO) projects that fiscal year 2003 spending will double by 2012. Today, Medicaid ranks as the third largest mandatory spending program in the federal budget and represents the largest source of federal funds to the states, accounting for 41 percent of all federal outlays for grants to states and local governments in fiscal year 2001. In terms of overall state expenditures, outlays for Medicaid rank second only to elementary and secondary education, accounting for an estimated 15 percent of general fund expenditures in state fiscal year 2002.[5]

Within broad federal guidelines, states have considerable flexibility in how they administer their Medicaid programs. The federal statute requires state programs to cover certain services and populations, such as nursing home services for qualifying elderly and for disabled individuals aged 21 and over.[6] Each state determines what medical services to cover, establishes eligibility requirements, sets provider payment rates, and develops its own administrative structure. As a result, Medicaid essentially operates as 56 separate programs: 1 in each of the 50 states, the District of Columbia, Puerto Rico, and each of the U.S. territories. Nursing homes care for people with a wide range of clinical conditions and provide a variety of

[4]This figure represents 27 percent of total Medicaid enrollment in fiscal year 2000, the most recent year for which data are available by type of beneficiary.

[5]National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States* (Washington D.C.: June 2003), http://www.nasbo.org (downloaded June 27, 2003).

[6]In addition to the mandatory services states are required to include in their Medicaid programs, states may choose to cover certain optional services, including personal care services and physical and occupational therapies.

services, including basic custodial care, medical social services, skilled nursing care, and rehabilitative therapies. Medicaid is the single largest funding source for nursing home services, providing about one-half of total expenditures for these services in 2003.[7] Medicaid supports the care of an even larger share of nursing home residents, paying at least in part for the services provided to approximately two in three residents nationwide.[8]

Federal requirements regarding states' methods for reimbursing nursing homes for the services they provide to Medicaid residents have changed over time. A 1972 amendment to the Social Security Act required that states reimburse nursing homes on a reasonable cost-related basis.[9] Under this requirement, states developed methods to identify nursing homes' reasonable costs as well as set rates based on these costs, both of which were subject to federal verification and approval. Nursing home providers filed a number of federal lawsuits contesting the adequacy of states' payment rates.

In 1980, Congress passed legislation, commonly referred to as the Boren Amendment, which provided that Medicaid payment rates for nursing homes had to be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities."[10] The Boren Amendment also transferred responsibility for verifying that rates complied with these standards from the federal government to states; however, it did not grant states unlimited discretion in developing payment rates. The 1980 Conference Report that accompanied the Boren Amendment stated that rates should not be developed "solely on the basis

[7]According to CMS's actuarial estimates, national nursing home spending will total more than $108 billion in 2003. Medicaid and Medicare will cover about 50 percent and 11 percent of these costs, respectively, and about 37 percent of these costs will be covered by out-of-pocket payments, private health insurance, and other private funds. (These percentages do not add to 100 because of rounding.)

[8]Certain Medicaid enrollees, including nursing home residents, are required to contribute shares of their incomes to the costs of their care, which in part explains why the share of nursing home residents supported in some measure by Medicaid is greater than Medicaid's share of total nursing home revenues.

[9]Social Security Amendments of 1972, Pub. L. No. 92-603, § 249, 1972 U.S.C.A.A.N. 1548, 1667. Prior to this amendment, there were no substantive federal standards governing state payment for nursing home services.

[10]Ominbus Budget Reconciliation Act (OBRA) of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650. The Boren Amendment was extended to payments for inpatient hospital services as part of OBRA 1981 (Pub. L. No. 97-35 § 2173, 95 Stat. 808 (1981)).

of budgetary appropriations" and required states to submit annual assurances to the Secretary of Health and Human Services that rates complied with Boren regulations.[11] The Conference Report also clarified that while the Boren Amendment was intended to give states discretion to develop the methods and standards on which payment rates would be based, the federal government retained final authority in approving states' rates.[12]

During the roughly 17 years following the enactment of the Boren Amendment, providers in many states filed suits alleging that Medicaid payment rates were not sufficient and therefore violated federal requirements that rates be reasonable and adequate to cover the costs of efficiently and economically operated nursing homes. In 1990, the Supreme Court found that the amendment imposed a binding obligation on states to adopt reasonable and adequate payment rates and held that providers could sue to enforce this obligation and challenge Medicaid payment rates in federal court.[13] After this decision, nursing home providers continued to rely on the courts to review payment rates they considered insufficient and verify that these rates complied with federal payment standards.

The Balanced Budget Act of 1997 (BBA) repealed the Boren Amendment, providing states with increased flexibility to develop approaches to pay nursing homes that participate in Medicaid.[14] States are no longer required to submit annual rate findings to the federal government but instead must develop and implement a public process for determining rates, which requires that states publish all proposed and final rates—including their methodologies and justifications—and ensure that providers, beneficiaries, and their representatives are given reasonable opportunity to review and comment on rates.[15] Additionally, states must continue to

[11]H.R. Conf. Rep. No. 96-1479 at 154 (1980), *reprinted in* 1980 U.S.C.A.A.N. 5903, 5945.

[12]H.R. Conf. Rep. No. 96-1479 at 154 (1980).

[13]*Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990).

[14]Pub. L. No. 105-33, § 4712, 111 Stat. 509 (1997).

[15]States may fulfill public process requirements in a number of ways, including holding public hearings to disclose proposed rates and payment methods; using an open commission or similar process to set rates; or publishing changes to payment methods in newspapers of general circulation and making copies of proposed and final rates, payment methods, and justifications underlying changes available to the public.

ensure that payments are consistent with efficiency, economy, and quality of care standards.[16]

State Fiscal Pressures

In 2003, states faced their third consecutive year of fiscal pressure, with revenue collections again falling short of planned expenditures. A June 2003 survey conducted by NASBO and the National Governors Association (NGA) found that 30 states collected less revenue in fiscal year 2003 than they planned for in their budgets, with sales tax collections 2.5 percent lower than originally budgeted and personal and corporate income tax collections 8.6 percent and 8.3 percent lower than expected, respectively.[17] According to an April 2003 survey conducted by the National Conference of State Legislatures (NCSL), 39 states and the District of Columbia faced budget shortfalls at some point during fiscal year 2003, totaling over $29 billion.[18]

At the same time states have experienced shortfalls in their expected revenue collections, they have also experienced significant growth in Medicaid expenditures. According to CMS, the state and local share of Medicaid spending grew almost 14 percent in fiscal year 2002 and is projected to grow almost 10 percent in 2003.[19] In their June 2003 survey, NASBO and NGA reported that 25 states experienced Medicaid budget shortfalls in state fiscal year 2002, and 28 states reported these shortfalls in 2003.

[16]42 U.S.C. §1396a(a).

[17]NGA and NASBO.

[18]National Conference of State Legislatures (NCSL), *State Budget Update: April 2003* (Washington, D.C.: April 2003).

[19]The 2002 spending growth is based on Medicaid expenditure data from CMS. Projections of increased spending for 2003 are based on calendar year actuarial estimates published by CMS staff in *Health Affairs*. See S. Heffler et al., "Health Spending Projections For 2002-2012", *Health Affairs*, vol. 22, no. 2 (Bethesda, Md.: Project Hope, 2003); http://www.healthaffairs.org/WebExclusives/Heffler_Web_Excl_020703.htm (downloaded June 13, 2003). The projected increase in states' 2003 Medicaid spending includes spending for the State Children's Health Insurance Program (SCHIP), which was created under BBA to provide health care coverage to children of low-income families with incomes that exceed the eligibility limits for Medicaid.

Fiscal pressures have compelled states to confront difficult choices, especially because 49 states and the District of Columbia are required to balance their budgets.[20] Recognizing that the Medicaid program represents a large component of many states' budgets, virtually all states have implemented or planned new cost-containment measures in order to control Medicaid spending growth in 2003, according to another recent state survey.[21] For example, 45 states reported that they planned to reduce spending on prescription drugs, which is an optional benefit, during fiscal year 2003. In addition, benefit reductions, such as limits for vision care and dental services, and changes to eligibility requirements, such as a lowered income threshold for Medicaid program eligibility, were additional cost-containment measures used or proposed by states.

In May 2003, Congress passed the Jobs and Growth Tax Relief Reconciliation Act, which included $20 billion in fiscal relief to state and local governments.[22] Of these funds, $10 billion is earmarked for Medicaid, providing temporary enhancements to the federal share of Medicaid funding through June 2004 to help states maintain Medicaid services and eligibility.[23] The remaining $10 billion in fiscal relief is divided among the states based on population and can be used to assist states in providing government services.

[20]Vermont is the only state that is not required to balance its budget each year. See Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Budgets* (Washington, D.C.: October 2001).

[21]See Victoria Wachino et al., *Medicaid Spending Growth: a 50-State Update for Fiscal Year 2003* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, January 2003).

[22]Pub. L. No. 108-27, 117 Stat. 752, 764 (2003).

[23]Temporary enhancements to the federal share of Medicaid funding involve both a "hold-harmless" provision that prevents each state's federal matching rate from decreasing below certain levels and an across-the-board increase to federal matching rates for all states. Under the hold-harmless provision, states receive the higher of their fiscal year 2002 or fiscal year 2003 federal matching rates for the period April 1 through September 30, 2003, and the higher of their fiscal year 2003 or fiscal year 2004 federal matching rates for the period October 1, 2003, through June 30, 2004. In addition, an across-the-board increase of 2.95 percentage points is applied to each state's matching rate as determined under the hold-harmless provision for the period April 1, 2003, through June 30, 2004, provided the state does not restrict Medicaid eligibility below the levels specified in its state plan as of September 2, 2003.

State Nursing Home Payment Methods Link Rates to Costs, Encourage Efficiency, and Typically Target Funds to Direct Resident Care

Recognizing the importance of spending Medicaid dollars effectively, the 19 states we reviewed have designed methods to develop nursing home payment rates that include incentives for homes to deliver care efficiently, operate economically, and concentrate resources on direct resident care. While nursing home payment rates in most of these states are related to individual homes' costs of delivering needed services, most states also limit payment for certain types of costs and many provide additional payments for direct resident care. Most of these states also regularly adjust rates to reflect changes in homes' costs or in the care needs of the residents that homes serve.

Table 1 provides an overview of various payment features used by the 19 states we reviewed as of September 2003. These features will be discussed below in greater detail. Because states pursue different strategies to meet their various objectives, methods to determine rates differ considerably among states. However, over half of the states we reviewed include at least five such features in their payment methods, with states most commonly using payment ceilings and annual rate updates.

Table 1: Features Found in Medicaid Nursing Home Payment Methods in 19 States, September 2003

State	Home-specific rates	Efficiency incentive	Ceilings or flat rate	Peer groups	Add-on payment for direct resident care	Rate updates		Case-mix system
						Rates rebased annually	Rates consistently inflated in non-rebase years	
Alabama	X	X	X	X	X	X		
Arkansas	X		X				X	
California			X	X	X	X		
Colorado	X	X	X			X		X
Connecticut	X	X	X	X			X	
Florida	X		X	X	X	X		
Illinois	X	X	X	X	X			X
Iowa	X	X	X	X	X	[a]		X
Massachusetts			X		X		X	X
Michigan	X		X	X		X		
New Jersey	X		X	X		X		X
New York	X		X	X	X		X	X
North Dakota	X	X	X			X		X
Oregon			X				X	X
Pennsylvania	X	X	X	X		X		X
Rhode Island	X		X				X	
South Dakota	X		X		X	X		X
Texas			X		X		X[b]	X
Vermont	X		X		[c]		X	X
Total	**15**	**7**	**19**	**10**	**9**	**9**	**8**	**12**

Source: States' Medicaid programs.

[a]In Iowa, nursing home payment rates were rebased annually until July 1, 2001, when the state began to phase in its new payment method.

[b]Until September 1, 2001, Texas rebased rates annually. Since this time, the state rebases rates biennially in conjunction with developing its budget and inflates rates to the midpoint of the 2-year period.

[c]Vermont provides an add-on payment to reimburse wages and other expenses for all nursing home staff except the nursing home administrator.

States Typically Develop an Individual Rate for Each Home

All 19 states we reviewed base the per diem, or daily, rate they pay to nursing homes on costs, as reported in cost reports. While 4 states—California, Massachusetts, Oregon, and Texas—use the average or median costs of all homes to pay the same, flat rate, with some adjustments, to all homes or homes within a specified group, the remaining 15 states compute a rate for each home based on the individual home's costs.[24] States that pay home-specific rates attempt to make more effective use of their resources for nursing homes. They avoid paying lower-cost homes rates significantly in excess of their costs, which can occur when rates are based on the average or median costs across homes. In addition, by not making such excess payments to lower-cost homes, states with home-specific rates can use the same overall budget to pay more higher-cost homes rates that are closer to their costs.

States Design Payment Methods to Encourage Efficient Nursing Home Operations

States design their payment methods to encourage nursing homes to deliver care efficiently and economically. For example, all 19 states develop their payment rates prospectively, or prior to the time during which the rates apply, using historical cost reports. Prospective rates encourage nursing homes to operate efficiently and incur only necessary costs.[25] Homes that deliver care for less than the payment amount profit; conversely, providers experience losses if costs are higher than the payment rate.

Seven of the states we reviewed use explicit efficiency incentives to further encourage homes to minimize spending by providing them with additional payment if they keep their spending below a certain amount. For example, Connecticut nursing homes with indirect care or

[24]In Massachusetts, Oregon, and Texas, payment rates to individual homes are adjusted to reflect variation in resident care needs, while California pays groups of similar homes the same rate. In addition, Massachusetts pays a small portion of capital costs on a home-specific basis, and from state fiscal years 2000 through 2003, Texas imposed a staff compensation accountability requirement for homes to spend 85 percent of their direct resident care rate on staffing wages and benefits. Homes that did not spend this limit had to pay the state the difference between what they spent and 85 percent of the flat, direct resident care rate.

[25]Under the alternative, retrospective payment systems, the actual costs incurred during the year are paid after the submission and review of a home's cost report at the end of the year. Retrospective systems are recognized as inflationary; consequently, all states we reviewed set rates prospectively. However, Michigan performs limited retrospective adjustments to the payment rate for individual homes to cover changes in certain costs, such as qualifying renovations.

administrative costs below the median of all homes' costs in these categories have up to 25 percent of this difference incorporated into their per diem rates.[26] (See app. II for more detail on how states develop nursing home payment rates.)

To further encourage homes to operate efficiently, the 15 of the 19 states that pay home-specific rates place ceilings, or limits, on the costs that are reflected in their nursing home payment rates.[27, 28] These ceilings encourage homes to control spending as they will not be reimbursed for costs that exceed these ceilings. Since the majority of homes have demonstrated that they can provide care at costs below the ceiling, states may regard costs above the ceiling as excessive.

In addition to imposing ceilings, many states use other mechanisms to limit the costs that they recognize when determining homes' per diem rates. While in some cases these mechanisms may also encourage efficiency, in other cases they may result in fewer homes receiving their full costs than what the ceiling levels indicate. For example, regardless of increasing nursing home costs, Colorado limits the annual increase in administrative costs it recognizes to 6 percent, while South Dakota allows no more than an 8 percent annual increase in overall payment rates. In addition, although Rhode Island and North Dakota rebase their per diem rates regularly, they do not rebase cost-center ceilings as frequently. For example, Rhode Island inflates cost-center ceilings annually instead of rebasing them, and North Dakota rebases ceilings every 3 years on average, inflating them during the interim years. (See app. II for descriptions of additional limits states place on nursing home payments.)

To avoid penalizing homes for costs beyond their control, 10 of the states we reviewed categorize homes into peer groups and then set ceilings for each peer group rather than having a single statewide ceiling for all homes. States often establish peer groups for homes in the geographic areas that

[26]Seventeen of the 19 states we reviewed also incorporate occupancy standards, which reduce the per diem rate for nursing homes with resident occupancy that is below an established level. App. II addresses occupancy standards in more detail.

[27]The ceiling is typically based on a percentage of the median costs, or a certain percentile of costs, for all homes in the state or within a category of homes. Individual homes' rates are typically determined by the lower of their own costs or the ceiling.

[28]In the four states that generally pay a flat rate to all homes or to all homes in a group, the flat rate also promotes efficiency since homes with costs below the rate are able to retain the difference.

have similar labor markets and associated wage costs or homes of comparable size (i.e., homes with a large or small number of beds) that should operate at similar levels of efficiency. For example, since costs per day may vary by geographic location—such as urban versus rural areas—establishing peer groups by location allows states to set higher ceilings for homes in the more costly areas. Peer groups may be unnecessary in states with ceilings that are set well above the median costs and where most homes have costs below the ceilings or in states where wages vary little across areas.

Despite the various ways states encourage nursing home efficiency, industry representatives and industry-sponsored studies nonetheless raise concerns that Medicaid payments do not cover the full costs of all nursing homes. For example, a 2002 industry-sponsored study reported that nursing home costs for Medicaid-covered residents in 2000 exceeded Medicaid payment rates an average of $10 per resident day in the 37 states included in the study.[29] In addition, industry representatives in 7 of the states we reviewed expressed concern that state payment methods do not adequately account for increases in certain costs, such as liability insurance or direct resident care staff wages and benefits.[30,31] However, by incorporating certain features, such as ceilings, into their nursing home payment methods, states have intentionally designed their payment methods so that not all homes receive their full costs and so that lower-cost homes, which are more likely to be efficient and economical, have payment rates nearer to their costs.

[29]BDO Seidman, LLP, *A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care* (July 2002).

[30]For example, Texas Medicaid officials examined Texas nursing home cost report data from fiscal years 1998 through 2001 and found that average liability insurance costs per nursing home bed increased almost threefold, from $207 to $592. Nonetheless, these costs represented less than 1 percent of total costs for the typical Texas nursing home in 1998 and less than 2 percent of the typical home's costs in 2001.

[31]Additionally, industry representatives in six states expressed concern regarding payment methods for homes' capital costs, noting that capital payment may be insufficient for a variety of reasons, including states' use of nursing homes' historic values, which do not reflect homes' current capital values, when determining payment rates and low ceilings in the capital cost center. A detailed analysis of payment methods for nursing homes' capital costs was beyond the scope of this report.

Nursing Home Payment Methods Encourage Spending in Areas Specifically Related to Direct Resident Care

Through the design of their payment methods, states generally seek to encourage nursing home spending on direct resident care. All 19 states we reviewed divide nursing home costs into categories, or cost centers, with common categories being direct resident care, indirect care, administrative, and capital (see table 2). By varying their payment policies for each category, most states seek to target more of their funds to direct resident care.[32]

Table 2: Types of Cost Centers and Related Costs Commonly Found in 19 States' Medicaid Nursing Home Payment Methods

Cost center	Type of included costs
Direct resident care	Nursing staff salaries, wages, and benefits
Indirect care	Dietary, medical supplies, laundry, social services and activities, and maintenance
Administrative	Administrative salaries and expenses and office supplies
Capital	Building and equipment expenses including depreciation, taxes, interest, and rent

Source: State Medicaid programs.

Note: Indirect care and administrative costs are combined into a single cost center in 8 states and separated into two centers in 11 states.

How states establish ceilings or efficiency incentives for each cost center may encourage nursing homes to spend more money on direct resident care than other areas. In nine of the states we reviewed that pay home-specific rates, the direct resident care ceiling is higher than the administrative ceiling, thus allowing a higher proportion of homes to have their payments based on their total direct resident care costs than is the case for their administrative costs. For example, for all homes within each peer group in Connecticut, the direct resident care ceiling is set at 135 percent of the median direct resident care costs while the administrative ceiling is set at 100 percent of the median administrative costs. In addition, five of the seven states with efficiency incentives that reward homes for spending less do not apply them to direct resident care costs, thereby minimizing the incentive for homes to restrict spending in this area.[33]

[32]The states we reviewed categorize nursing home costs into two to seven centers.

[33]In addition, 9 of the 17 states with occupancy standards do not apply these standards to the direct resident care cost center, and consequently payment for these costs is not limited in homes with low occupancy (see app. II).

Further, nine of the states we reviewed used add-on payments to reimburse wages or other expenses for staff who provide direct resident care or to promote the provision of high-quality direct resident care. For example, in 2000, Massachusetts began providing an add-on payment to nursing homes for certified nursing assistants (CNA), who assist residents with activities such as bathing and eating. This add-on is based on CNA salaries and Medicaid nursing home utilization. Because homes often use add-on payments to increase their spending on direct resident care, these payments may lead to higher costs on homes' cost reports and therefore could result in higher future per diem rates.[34]

States Update Payment Rates to Reflect Changing Costs

To reflect changes in nursing homes' costs, 17 of the 19 states we reviewed regularly calculate new payment rates or adjust existing rates for inflation. To rebase, or calculate new rates, states generally use costs as reported in nursing homes' most recent cost reports that reflect inflation or other cost changes such as those due to more expensive technologies, a different staff mix, or changing direct resident care needs.[35] Nine of the 19 states we reviewed rebase rates annually, and 8 states rebase homes' rates every 2 to 4 years.[36] The 2 remaining states, however, rebase infrequently, if ever; Illinois has only rebased rates once in the past 9 years, and New York has not fully rebased homes' rates since 1986.[37]

[34]Texas allows homes to qualify for additional direct resident care payments through its staff enhancement program, in which 92 percent of nursing homes participate. The state's staff compensation accountability provision, which was in effect from fiscal years 2000 through 2003, provided homes with an incentive to target funds toward direct resident care. This provision was eliminated in state fiscal year 2004, which began on September 1, 2003.

[35]Frequent rebasing could have mixed effects on nursing homes' spending. Since homes that limit expenditures could receive a lower payment rate when states rebase rates, frequent rebasing may reduce the incentive for homes that are paid prospective rates to limit overall spending. However, frequent rebasing may also prevent homes from making excessive cost reductions that could adversely affect resident care.

[36]Arkansas rebases its payment rate using two different schedules: Costs related to direct resident care staff and food are rebased every year, whereas costs associated with services not directly related to residents, such as administrative costs, are rebased at least once every 3 years.

[37]New York does, however, rebase the payment for homes' capital costs annually. According to a state official, the effect of rebasing capital costs on nursing home rates varies by home; however, in recent years, the capital portion of many homes' rates has declined.

Most states we reviewed also apply a standard inflation factor, such as the Consumer Price Index (CPI) or the SNF market basket index, to adjust rates during years they do not rebase or to reflect inflation between the midpoint of the cost report year and the midpoint of the year when the rates will be paid, a period that generally ranges from 18 to 36 months.[38] However, Illinois has not consistently updated rates for inflation during non-rebase years since 1994, and Iowa's new nursing home payment method, which was fully implemented on July 1, 2003, does not have a provision for adjusting rates during non-rebase years.[39] In addition, rather than using a standard inflation factor, Connecticut and Illinois use legislatively determined amounts to update rates when they do not rebase.[40] These amounts vary from year to year and are influenced by budget availability.

By Adjusting Rates for Case-Mix, States Link Payment to Resident Needs

Instead of paying rates that are based on the costs required to care for a nursing home's residents during the cost reporting period, 12 of the 19 states we reviewed use case-mix systems to tie payment to the costs associated with a home's current resident care needs. Using a variety of methods, states classify homes' residents by the level of care they require and adjust payment rates to reflect the costs associated with treating current residents with different levels of need.[41] While the rate adjustment occurs with varying frequency, most states adjust rates for case-mix two to four times a year.

Adjusting rates for case-mix may encourage homes to accept residents who require more expensive care, and it also provides states with a tool to compare more appropriately homes' costs and to not penalize homes that have higher costs due to a more costly mix of residents. In addition, case-

[38]The SNF market basket index, which is the CMS index of prices for nursing home inputs (e.g., wages, food, and drugs), is used to adjust nursing home payments for Medicare. Some states use the CPI for a specific geographic area to adjust rates; for example, Vermont uses the CPI for New England.

[39]Nursing home payment rates in Iowa were rebased annually under the prior payment system, which was in effect until July 1, 2001.

[40]Connecticut uses its legislatively determined inflation factor to update rates annually.

[41]Seven of the 12 states rely on a variation of the Resource Utilization Group (RUG) Patient Classification System—the case-mix classification system used for Medicare—to classify nursing home residents, while the remaining 5 states have developed their own classification systems. The RUG system classifies nursing home residents into groups depending on their therapy, nursing, and special care needs.

mix adjusted rates particularly help target payments in states that otherwise pay the same, flat rate. Three of the four flat-rate states we reviewed make case-mix adjustments to the rates so payments more closely approximate the costs likely incurred by individual homes for treating residents.

State Fiscal Pressures Generally Have Not Affected Medicaid Payment Rates to Nursing Homes, but Future Changes Remain Uncertain

Recent state fiscal pressures have not resulted in widespread reductions in Medicaid payment rates to nursing homes in most states we reviewed, although all of these states modified how they pay nursing homes from fiscal years 1998 through 2004. While in some cases modifications to payment methods have clearly increased or decreased payment rates, in other instances the effect of these modifications on payment rates for individual homes is mixed. Further, in nearly three-quarters of the states we reviewed, nursing home per diem rates grew, on average, by an amount that exceeded the SNF market basket index for state fiscal years 2001 through 2003, similar to the years immediately following the repeal of the Boren Amendment. To avoid making significant changes to nursing homes' payment rates, many states reported that they relied on existing resources, such as budget stabilization funds and tax increases, to generate additional funding. Other factors have also influenced the nature and extent of states' changes to nursing home payment rates. Even with recent temporary federal fiscal relief, however, officials in some states suggest that nursing home payment reductions are possible in the future.

State Fiscal Pressure Has Not Led to Major Changes in Medicaid Nursing Home Payment Methods or Rates

Over the past several years, the states we reviewed have faced increasing budget pressures, and all reported experiencing fiscal pressure in fiscal year 2003. These budget pressures followed consecutive years of significant economic growth in many states. For example, through state fiscal year 2000, Connecticut experienced 10 years of budget surpluses; however, in state fiscal year 2001 the surpluses ended, and the state's deficit was over $800 million. Also, in 2001, Massachusetts began experiencing increased fiscal pressures mainly because of decreased tax revenues and lower capital gains.

Irrespective of shifting fiscal pressures experienced by these states, their modifications to nursing home payment methods have not resulted in widespread payment reductions to nursing homes from fiscal years 1998 through 2004. During this time, all 19 states we reviewed either modified

components of their payment methods, such as changing cost-center ceilings or implementing case-mix systems, or created new payment methods, as was the case in Arkansas and Iowa.[42] However, the extent to which states changed specific features of their payment methods generally remained constant during this time, with varying effects on payment rates to individual homes within states. (See app. III for a list of selected state changes.)

In addition, despite each of the 19 states experiencing recent fiscal pressure, only 4 states—Illinois, Massachusetts, Michigan, and Texas—explicitly cut the per diem rates paid to all nursing homes at some point during state fiscal years 1998 through 2004, and the rate reduction was for less than 1 year in 2 of these states. For example, for the 3-month period of March through May 2003, Massachusetts reduced payment rates to nursing homes by approximately 2.5 percent, but increased payment rates in June 2003 by about 6.3 percent.[43] Similarly, Michigan reduced nursing home rates from January through September 2002 by approximately 1 percent.[44] With the start of Michigan's fiscal year 2003 (October 1, 2002), this reduction was lifted; however, facing budgetary constraints, the state again reduced nursing home payment rates from March 2003 through September 2003 by roughly 1.85 percent.[45] While reductions in per diem rates were temporary in these 2 states, the reduction in per diem rates in Illinois and Texas were for longer periods of time. Illinois, for example, implemented an across-the-board 5.9 percent cut to existing rates to all Medicaid providers, including nursing homes, in July 2002, and froze

[42]Some states we reviewed also noted limited changes made to Medicaid services and eligibility, such as Florida's elimination of denture coverage for all adults in 2002, which could affect nursing home residents.

[43]The June 2003 increase in per diem rates was due to provider tax revenues. In addition, according to a state official, the state has proposed eliminating the March 2003 cut of 2.5 percent as part of a plan to increase per diem rates by an additional 3.1 percent. If approved, the new per diem rates will be retroactive to September 1, 2003, and will be in effect for the remainder of fiscal year 2004, which began on July 1, 2003. Increases in per diem rates for the first 2 months of state fiscal year 2004—July and August 2003—will be spread over the remaining months of the fiscal year.

[44]For Michigan nursing homes, this reduction applied to payment for direct resident care, indirect care, and administrative costs, but was not applied to payment for capital costs. While this reduction was in effect, the state implemented a provider tax on all nursing home beds, and revenue from this tax was used to provide an increase to Medicaid per diem rates beginning July 1, 2002.

[45]The reduction was only applied to payment for homes' direct resident care, indirect care, and administrative costs.

payment rates at this reduced level for fiscal year 2004, which began on July 1, 2003. Similarly, in its 2004/2005 biennial budget, which began September 1, 2003, Texas reduced payment rates to Medicaid providers, with nursing home per diem rates being reduced by 1.75 percent from their fiscal year 2003 levels.

In addition to these four states, Oregon froze Medicaid payment rates to nursing homes in fiscal year 2003 at fiscal year 2002 rates and extended this freeze at the beginning of fiscal year 2004. Beginning on July 1, 2003, Connecticut froze Medicaid payment rates to nursing homes at January 2003 levels and also reduced the level of payment increases granted to other Medicaid long-term care providers.[46]

The effect of states' other modifications on payment methods varies. While some changes have obvious positive or negative effects on payment rates, the effect of other changes on payments to individual nursing homes is mixed. For example, New Jersey's decreased ceiling for administrative and indirect care costs—from 105 to 100 percent of the median costs for all homes—and Michigan's elimination of add-on payments for quality incentives and direct resident care staff wages likely lowered payment rates to some extent for some nursing homes. Conversely, payment to some nursing homes in New York and Vermont increased because of recently implemented add-on payments for direct resident care staff wages. Effects of other changes on nursing home payments, such as Colorado's implementation of a case-mix system in 2000 or the addition of two counties to California's Bay Area peer group in 2002, could either increase or decrease payment rates depending on the home.

Although the effect that changes to payment methods have on rates for individual nursing homes may be mixed, average per diem rates in the states we reviewed generally have kept pace with increasing nursing home costs as measured by the SNF market basket index from state fiscal years 1998 through 2003. As figure 1 shows, from state fiscal years 2001 through 2003—a period during which all 19 states we reviewed were experiencing increased fiscal pressures—the average annual percentage change in states' average per diem rates in 14 of the 19 states exceeded the SNF

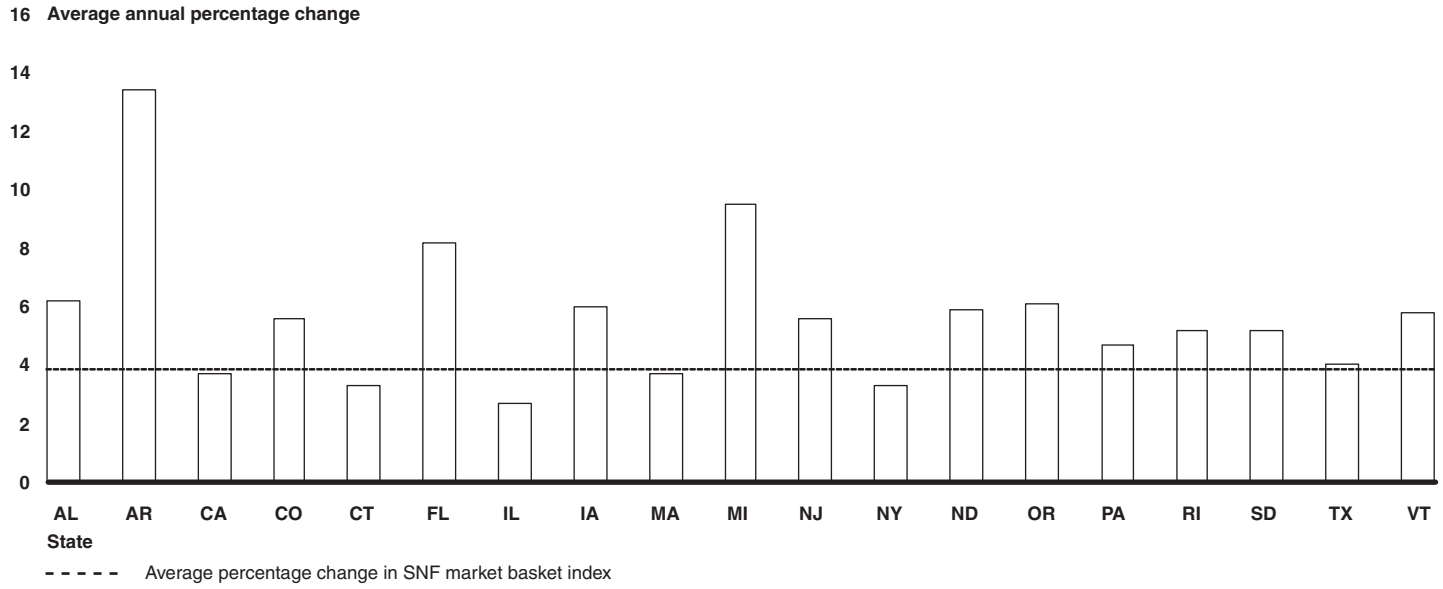
[46]Oregon's rate freeze will continue, pending CMS approval of a waiver pertaining to the state's new provider tax legislation. Under Connecticut's rate freeze, nursing homes will continue to receive their January 2003 rates through the end of calendar year 2004.

market basket index.[47] This trend is similar to what occurred to rates during the years immediately following the repeal of the Boren Amendment—1998 through 2000—when states' fiscal conditions were generally much more positive. In that earlier period, the average annual percentage change in states' average per diem rates met or exceeded the SNF market basket index in 14 of these states, although the states that fell below the SNF market basket index differed somewhat between the two periods.[48]

[47]The SNF market basket index measures changes in the costs of the resources nursing homes use, such as wages for staff or prices of supplies and equipment. It does not reflect necessary changes in the quantities of resources nursing homes must use, such as increased staff time when residents' needs become more complex over time. However, changes in residents' needs from year to year, on average, are modest. The SNF market basket index overstates the costs that Medicaid per diem nursing home rates are intended to reimburse since it includes prescription drug costs, which Medicaid programs typically pay separately. The index may not reflect certain cost changes in individual states. For example, in recent years, significant increases in malpractice insurance costs, which likely exceed the national average cost increase reflected in the index, have been reported in several states. Also, some states have instituted or increased provider taxes nursing homes must pay—a cost change not immediately reflected in the index. Four states we reviewed —Arkansas, Massachusetts, Michigan, and New York—implemented such a tax during the time period reflected in figure 1. For example, New York imposed a provider tax of 6 percent of nursing homes' adjusted gross revenues in state fiscal year 2003; as a result, the SNF market basket index understates cost increases experienced by the state's nursing homes during the time period of our analysis by 1.6 percentage points. Based on discussions with payment experts, we believe that the SNF market basket index is the best proxy measurement available to determine how Medicaid nursing home per diem rates have kept pace with nursing homes' changing costs. In addition, states capture changes in costs not fully reflected in the SNF market basket index when they rebase rates, which 17 of the states we reviewed do regularly.

[48]The average annual percentage change in states' average per diem rates fell below the SNF market basket index from 1998 through 2000 in Arkansas and South Dakota; from 2001 through 2003 in Connecticut and Massachusetts; and for both periods in California, Illinois, and New York.

Figure 1: Average Annual Percentage Change in Average Per Diem Rates, by State, Compared to the SNF Market Basket Index, State Fiscal Years 2001-2003



Source: State Medicaid programs.

Notes: Each bar represents the compounded average of the annual percentage change in statewide average per diem rates from 2001 through 2003, and is based on GAO analyses of Medicaid nursing home per diem rates from 2000 through 2003. For each of these fiscal years, states provided the most readily available per diem rates, which were most commonly those rates in effect at the beginning of the fiscal year. All states provided homes' average rates weighted by resident days except Arkansas and Pennsylvania, which provided projected rates for state fiscal year 2003. Per diem rates were unavailable for 2003 in Michigan.

From state fiscal years 2001 through 2003, the average annual change in per diem rates fell below the SNF market basket index in five states—California, Connecticut, Illinois, Massachusetts, and New York. The factors that contributed to per diem rates falling below this index varied among these states.[49] For example, Illinois' rate reduction in fiscal year 2003 of almost 6 percent contributed to the average rate change falling below the SNF market basket index. In addition, the lack of regular rebasing likely contributed to lower per diem rates in Illinois and New

[49]For other reasons, some states' annual average percentage change in the per diem rates fluctuated above or below the SNF market basket index. For example, Arkansas implemented a new nursing home payment system in January 2001, and as a result rate increases were significantly higher than the SNF market basket index.

York. Illinois rebased rates only once from fiscal years 1994 through 2001, and as previously noted, New York has not fully rebased rates since 1986.

In addition, industry officials in some states told us that the inflation factor used to update rates in non-rebase years is insufficient to meet nursing homes' changing costs. For example, industry officials in New York said that the inflation factor the state uses to update homes' rates annually, the CPI, does not reflect increasing health care costs. In addition, Connecticut—which rebases rates at least once every 2 to 4 years—uses a legislatively set inflation factor to increase rates in non-rebase years, which for the past several years has been limited to approximately 2 percent. Industry and Medicaid officials contend that this legislated amount, which has consistently fallen below the SNF market basket index, does not correspond with increases in actual nursing home costs.

States Averted More Significant Payment and Programmatic Changes to Nursing Homes through Several Means

To help balance their budgets, states we reviewed have relied on alternative funding sources—including budget stabilization and tobacco settlement funds— and have enhanced revenue by increasing taxes (see table 3).[50]

[50]Some states have also enhanced their revenue through the use of upper payment limit (UPL) schemes in nursing homes. We have noted problems with some state UPL programs in the past; however, independently reviewing the validity of these programs was beyond the scope of this report. See U.S. General Accounting Office, *Medicaid: HCFA Reversed Its Position and Approved Additional State Financing Schemes*, GAO-02-147 (Washington, D.C.: Oct. 30, 2001), and *Medicaid: State Financing Schemes Again Drive Up Federal Payments*, GAO/T-HEHS-00-193 (Washington, D.C.: Sept. 6, 2000). Also see related GAO products at the end of this report.

Table 3: Examples of Funding Sources States Reported Using to Respond to Fiscal Pressures, 1998-2003

State	Tobacco settlement fund	Budget stabilization fund	Cigarette tax increase	Medicaid trust fund
Alabama				
Arkansas				
California	X			
Colorado	X			
Connecticut		X		
Florida	X			
Illinois	X		X	
Iowa	X	X		
Massachusetts	X	X		
Michigan	X	X	X	X
New Jersey	X	X	X	
New York	X	X	X	
North Dakota		X		
Oregon	X		X	
Pennsylvania	X	X		
Rhode Island	X			
South Dakota				X
Texas				
Vermont		X	X	
Total	**12**	**9**	**6**	**2**

Source: State Medicaid programs.

Sixteen of the 19 states we reviewed reported using alternative funding sources, such as tobacco settlement, budget stabilization, cigarette tax increases, and Medicaid trust funds to deal with their states' budgetary pressures. Most commonly, states relied on tobacco settlement funds to ease fiscal pressures. While many of the states we reviewed have employed alternative funding sources or cigarette tax increases, not all the states relied on these funds to cope with their budget situations. For

instance, all 19 states received tobacco settlement funds, yet only 12 used these funds from 1998 through 2003 to respond to fiscal pressures.[51]

To help fund Medicaid nursing home payments in particular, several states rely on nursing home provider taxes, and in light of recent fiscal pressures, an increasing number of states have recently adopted or proposed these taxes in an effort to fund nursing home payments or to avert service reductions.[52] Of the 19 states we reviewed, 8 currently have provider taxes for nursing homes, with at least 4 of these states implementing the tax since 2001, when fiscal pressures began increasing in many states. In addition, 5 of the states reviewed currently have pending for CMS's approval a proposal to adopt a provider tax on nursing homes (see table 4). Of all types of providers, nursing homes were most commonly subject to new provider taxes in state fiscal years 2003 and 2004, according to a recent survey of all 50 states and the District of Columbia.[53]

[51]Tobacco settlement funds are received by all 50 states, the District of Columbia, and the 5 U.S. territories. Annually, tobacco companies pay 46 states for past health care costs related to tobacco use as required by the Master Settlement Agreement of 1998. The remaining 4 states—Florida, Minnesota, Mississippi, and Texas—receive payments from tobacco companies per the requirements of individual settlement agreements. See U.S. General Accounting Office, *States' Allocations of Fiscal Years 2002 and 2003 Master Settlement Agreement Payments*, GAO-03-407 (Washington, D.C.: Feb. 28, 2003).

[52]As a general rule, states may impose a health-care related nursing home provider tax for up to 6 percent of nursing homes' gross revenues if the tax is broad-based and uniformly applied to all health care providers in a provider class—for example, to all nonpublic nursing homes as either a dollar amount per bed or a percent of individual homes' revenues. See 42 U.S.C. § 1396b (w)(3)(B) and (C); 42 C.F.R. § 433.68 (f). In a state with a nursing home provider tax, a nursing home may claim, as an allowable Medicaid cost, the portion of the provider tax paid that relates to providing services to Medicaid beneficiaries. Upon paying the home's claim for reimbursement, the state subsequently receives federal matching funds for these paid claims, including the provider tax.

[53]See Vernon Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004, Results from a 50-State Survey* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, September 2003).

Table 4: Existing or Pending Nursing Home Provider Taxes in 13 of 19 Reviewed States, September 2003

Status	State
Existing	Alabama
	Arkansas
	Illinois
	Massachusetts
	Michigan
	New York
	Rhode Island
	Vermont
Pending	Colorado
	Iowa
	New Jersey
	Oregon
	Pennsylvania

Source: State Medicaid programs.

Officials in some states told us that they have avoided making substantial reductions to nursing home payment rates because of other factors. For example, state legislative or regulatory action is typically required to change nursing home payment methods, and garnering sufficient support for such changes—especially for rate reductions—is often difficult. In addition, the nursing home industry has actively worked to avoid decreases in payment rates in several states. For example, industry officials in Alabama, Iowa, and Texas cited campaigns that they considered successful in various ways, such as preventing rate reductions or encouraging rate increases. Specifically, nursing home industry officials in Iowa said that two proposed nursing home rate cuts were defeated in part because of their opposition. Also, industry officials in Texas said that through their efforts, nursing homes were able to obtain rate increases for fiscal year 2002.

Future Options for Dealing with Fiscal Pressures May Be More Uncertain

Although the extent of states' continued fiscal pressure is unknown, states expect their poor fiscal situations to continue through fiscal year 2004. According to an April 2003 NCSL study, 28 states and the District of Columbia expected budget shortfalls totaling over $53 billion in fiscal year 2004.[54] These budget gaps may be difficult to fill as many states reported that they have depleted or nearly depleted their alternative funding sources. Over half of the states we reviewed that used budget stabilization funds, and 3 of the 12 states that used tobacco settlement funds, reported having depleted or nearly depleted these sources.

Some states we reviewed reported their plans to confront continuing budget pressures in fiscal year 2004. As previously noted, at least six of these states reduced or froze their nursing home payment rates at some point during the past 2 fiscal years. In addition, these and other states have recently undertaken or are currently considering actions to reduce future nursing home payment rates. For example, California rebased nursing home rates for the 2004 rate year, which began on August 1, 2003, but has already frozen 2005 payment rates at current levels. Similarly, in August 2003, Connecticut froze per diem rates at their January 2003 levels through December 2004. Even with recent temporary federal fiscal relief, officials in some states suggest that nursing home payment reductions are possible in the future. For example, a Michigan state official indicated that reductions in 2004 per diem rates are probable because the legislative appropriation is likely insufficient to rebase rates.

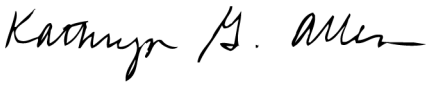
External Comments

We provided a draft of this report to the Medicaid Director in each of the 19 study states for technical review. All states generally agreed with our characterization of their respective nursing home payment methods and, when necessary, provided clarifying or technical comments, which we incorporated as appropriate. In addition, we obtained oral comments on a draft of this report from representatives of two nursing home associations, the American Health Care Association (AHCA) and the American Association of Homes and Services for the Aging (AAHSA). We have modified the report, as appropriate, in response to their technical comments.

[54]National Conference of State Legislatures (NCSL), *State Budget Update: April 2003* (Washington, D.C.: April 2003).

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Administrator of CMS and appropriate congressional committees. We will also make copies available to others upon request. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staffs have any questions, please contact me at (202) 512-7118. An additional contact and other staff members who made contributions to this report are listed in appendix IV.



Kathryn G. Allen
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Appendix I: Scope and Methodology

To examine Medicaid nursing home payment methods and rates, we selected 20 states for our review. The 20 states included the following:

- 10 states (1 from each of the 10 Centers for Medicare & Medicaid Services (CMS) regions) with the largest decline or smallest growth in revenue from 2000 through 2002 within their regions, based on data in the November 2002 fiscal survey of states conducted by the National Association of State Budget Officers (NASBO) and the National Governors Association (NGA);
- 5 states with the largest population based on 2000 Census data; and
- 5 states with the highest number of Medicaid nursing home residents per capita, as indicated by the most recent data in CMS's Online Survey Certification and Reporting (OSCAR) database (see table 5).

Nationwide, these 20 states represented approximately 62 percent of Medicaid nursing home expenditures in fiscal year 2001 and 59 percent of Medicaid nursing home residents in fiscal year 2000, according to the most recently available CMS data.

Table 5: Study States Categorized by Selection Factors

States selected for sample		
Largest decline or smallest growth in revenue from 2000 through 2002 (CMS region)	**Largest population**	**Highest number of Medicaid nursing home residents per capita**
Alabama (IV)	California	Connecticut
Arizona (IX)	Florida	Massachusetts
Arkansas (VI)	Illinois	Rhode Island
Colorado (VIII)	New York	North Dakota
Iowa (VII)	Texas	South Dakota
Michigan (V)		
New Jersey (II)		
Oregon (X)		
Pennsylvania (III)		
Vermont (I)		

Source: National Governors Association and National Association of State Budget Officers, The Fiscal Survey of States (Washington, D.C.: November 2002), http://www.nasbo.org (downloaded Dec. 6, 2002); The U.S. Census Bureau; and CMS's OSCAR.

In each of the 20 states, we interviewed officials from the Medicaid and budget offices. From these officials, we obtained information about nursing home payment methods (including changes) for state fiscal years 1998 through 2004 and per diem rates for state fiscal years 1998 through 2003. In addition, to gain a broader understanding of Medicaid nursing

home payments, we interviewed representatives from the offices of the American Health Care Association (AHCA) and/or the American Association of Homes and Services for the Aging (AAHSA) in each of the 20 states. We also interviewed national representatives of AHCA and AAHSA and consultants and experts in the field of Medicaid nursing home payment. Because Arizona's Medicaid program is predominantly a managed care system, the state determines payment rates for only 5 percent of the nursing home population. Therefore, this report excludes Arizona and presents our findings from analyses of the other 19 states.

To examine the extent to which states base nursing home payment rates on homes' costs, we reviewed documentation, including some state laws and regulations.[1] Relying on these documents as well as our interviews with state officials, we also identified key features of payment methods, such as whether rates are home-specific and how frequently states update or rebase the rates they pay nursing homes. In addition, we summarized the extent to which states' payment methods incorporate features such as peer grouping, cost-center ceilings, and case-mix adjustment systems.

To determine how state fiscal pressures have affected Medicaid programs with regard to nursing home payment rates and methods, we collected per diem rates from state fiscal years 1998 through 2003, fiscal year 2003 being the most current year for which per diem rates were available, and information about changes made to nursing home payment methods from state fiscal years 1998 through 2004. We used the per diem rate data to compare the average annual percentage change in states' average nursing home payment rates from state fiscal years 1998 through 2003 to the corresponding years' change in the skilled nursing facility (SNF) market basket index.[2] The SNF market basket index, which is developed and updated annually by Global Insights, Inc., is used by CMS to reflect changes in the prices of goods and services included in the Medicare SNF

[1]We did not perform a comprehensive review of state laws and regulations related to nursing home payment methods.

[2]To conduct this analysis, we obtained the most readily available data from the states. Depending on the state, the data provided were typically for the respective state's fiscal year, although some states provided data by calendar year. We converted calendar year rates provided by Iowa to fiscal year rates for the last 6 months of state fiscal year 1998 and for state fiscal years 1999 through 2001. For state fiscal years 2002 and 2003, Iowa provided per diem rates and resident days for each nursing home, which we used to calculate the statewide average per diem rate.

prospective payment system.[3] States typically provided us with their average Medicaid nursing home per diem rates weighted by resident days; however, in a few instances we had to use a state's home-specific rates and resident days to calculate the weighted average per diem rate. For 2003, an average per diem rate was not available in Michigan, and projected per diem rates were provided by Arkansas and Pennsylvania.

We encountered limitations with data provided by two other states. For example, North Dakota law generally prohibits nursing homes from charging private-pay residents more than the Medicaid rate;[4] however, rates provided to us by the state were based on total resident days, which include payments for 3 to 5 percent of residents whose care is paid at typically higher Medicare rates. Therefore, the rates provided to us may be slightly higher than the average Medicaid rate. Conversely, the rates provided by Pennsylvania may be slightly lower than the actual average nursing home Medicaid rate because they include nursing homes residents' temporary hospital stays, which account for approximately 1 percent of total resident days and for which homes only receive one-third of the per diem rate. Finally, we reviewed information compiled by NASBO, NGA, and NCSL related to states' fiscal outlook and possible future reductions in the Medicaid program, including reductions affecting nursing homes.

[3]Global Insights, Inc., is an economic and financial information company.

[4]N.D. Cent. Code § 50-24.4-19.1 (1999).

Appendix II: Summary of Certain Payment Characteristics Used in Selected States

States use many of the same features within their payment methods. We describe below certain features of the payment methods used in the states we reviewed: peer groups, cost-center ceilings, efficiency incentives, case-mix systems, and occupancy standards.

Peer Groups

Ten states we reviewed classify homes into peer groups, or categories based on characteristics such as size or location, and typically set separate cost-center ceilings for each peer group.[1] The states we reviewed most commonly categorize nursing homes by geographic region or home type.[2] However, how states use peer groups varies (see table 6). For example, some states, such as New Jersey, use peer groups within all cost centers, while other states, such as Alabama, only group homes in one cost center. Further, states differ in the number and type of peer grouping categories they use. For example, Illinois's peer grouping uses seven geographic regions in all cost centers; Connecticut bases its peer grouping on two geographic regions and two home types in the direct resident care cost center; and Florida's peer grouping is based on three geographic regions and two home sizes in both the direct resident care and administrative cost centers.

[1]The nine states reviewed that did not classify homes into peer groups were Arkansas, Colorado, Massachusetts, North Dakota, Oregon, Rhode Island, South Dakota, Texas, and Vermont.

[2]Home type includes categories such as home ownership (e.g., proprietary, nonprofit, or governmental); resident care need (e.g., skilled nursing homes, low-intensity homes for those with mental retardation, or chronic convalescent nursing homes); and whether the home is hospital-based or freestanding.

Table 6: Peer Grouping Techniques Used in Reviewed States, as of June 2003

State	Peer groups
Alabama	Two home sizes in the administrative cost center
California	Eight home types based on resident care need in all cost centers: five of the eight home types further grouped by three geographic regions and/or two home sizes; two of the eight home types further grouped by each resident's ventilator need; and one of the eight home types does not use additional peer groups
Connecticut	Two geographic regions and two home types based on resident care need in the direct resident care cost center
Florida	Three geographic regions and two home sizes in the direct resident care and administrative cost centers
Illinois	Seven geographic regions in all cost centers
Iowa	Two home types based on whether the home is Medicare-certified and hospital-based or freestanding
Michigan	Two home types based on ownership or whether the home is hospital-based or freestanding
New Jersey	Three home types based on ownership or resident care need in all cost centers
New York	Two home sizes, two levels of care, and whether home is hospital-based or freestanding in the indirect care cost center; 16 geographic regions for wage adjustment in the indirect care and direct resident care cost centers; two home types based on ownership and further grouped by lease type and date or financing method in the capital cost center
Pennsylvania	Four geographic regions and three home sizes in the direct resident care, indirect care, and administrative cost centers

Source: State Medicaid programs.

Cost-Center Ceilings

To limit the maximum amount states pay for costs within a given cost center, ceilings are typically set at a percentage of median costs, or a certain percentile of costs, for all nursing homes in a state or a subset of nursing homes with similar characteristics in states that pay home-specific rates.[3] Homes in these states generally receive rates based on the lower of their actual costs or the ceiling.[4] While most states we reviewed divide their operating costs into three centers—direct resident care, indirect care, and administration—plus a center for capital costs—the number of cost centers in the states we reviewed ranges from two in Oregon to seven in Rhode Island. In addition, states differ in how they categorize costs. For example, 8 states combine indirect care and administrative costs into a single cost center. Similarly, states may differ in how they categorize certain costs. For instance, Pennsylvania's direct resident care center includes medical supplies, which are considered indirect costs in Connecticut and Rhode Island. Table 7 describes ceilings for operating costs in the 15 states that pay individual/home-specific rates, and table 8 describes how the remaining 4 states—California, Massachusetts, Oregon, and Texas—develop their flat rates, which serve as a type of ceiling, to pay for all nursing homes in the state.

[3]In addition to imposing ceilings, many states use other mechanisms to limit the costs they will recognize when determining homes' rates.

[4]In states that use efficiency incentives, homes are also eligible to receive an additional payment included in their per diem rate.

Table 7: Direct Resident Care, Indirect Care, and Administrative Cost-Center Ceilings in Reviewed States with Individual Home Rates, as of June 2003

State	Cost-center ceilings		
	Direct resident care	Indirect care	Administrative
Alabama	110 percent of median costs for all homes[a]	110 percent of median costs for all homes	105 percent of median costs for all homes within each peer group
Arkansas	105 percent of 90th percentile for all homes[b]	Flat rate set at 110 percent of median costs for all homes[c]	
Colorado	125 percent of average costs weighted by total resident days for all homes within each peer group	120 percent of average costs weighted by total resident days for all homes within each peer group for room and board costs; 125 percent of weighted average costs for all homes within each peer group for other indirect costs	120 percent of average costs weighted by total resident days for all homes within each peer group[d]
Connecticut	135 percent of median costs for all homes within each peer group	115 percent of median costs for all homes	100 percent of median costs for all homes
Florida	1.75 standard deviations above median costs for all homes within each peer group	1.75 standard deviations above median costs for all homes within each peer group[e]	One standard deviation above median costs for all homes within each peer group[e]
Illinois	None	75th percentile of costs for all homes within each peer group	
Iowa	120 percent of median costs for all homes[f]	110 percent of median costs for all homes	
Michigan	80th percentile of costs for all homes within each peer group	80th percentile of costs for all homes within each peer group[g]	
New Jersey	120 percent of median costs for all homes within each peer group	110 percent through 150 percent of median costs, depending on specific type of costs, for all homes within each peer group	100 percent of median costs for all homes within each peer group
New York[h]	Ceiling based on updated 1983 prices for each level of resident care need	105 percent of average costs for all homes within each peer group	
North Dakota	99th percentile of costs for all homes[i, j]	85th percentile of costs for all homes[i]	75th percentile of costs for all homes
Pennsylvania	117 percent of median costs for all homes within each peer group	112 percent of median costs for all homes within each peer group	104 percent of median costs for all homes within each peer group[k]
Rhode Island	80th percentile of costs for all homes	80th percentile of costs for all homes	80th percentile of costs for all homes
South Dakota[l]	115 percent of median costs[m] for all homes, and 80 percent of costs that fall from 115 percent through 125 percent of the median	105 percent of median costs[m] for all homes, and 80 percent of costs that fall from 105 percent through 110 percent of the median	105 percent of median costs[n] for all homes, and 80 percent of costs that fall from 105 percent through 110 percent of the median
Vermont	115 percent of median costs for all homes	105 percent of median costs for all homes	Median costs for all homes except special hospital-based homes, which are capped at 137 percent of the median for all homes[o]

Source: State Medicaid programs.

Note: While the table identifies standard names for cost centers, states use a variety of names, such as nursing instead of direct resident care or operations instead of administration.

[a]In Alabama, nursing homes receive the lower of 110 percent of their direct resident care costs or 110 percent of the direct resident care ceiling.

[b]Through June 30, 2004, Arkansas imposes a floor of 90 percent of the median costs for all homes in the direct resident care center. Homes with costs below the floor retain the difference between their costs and the floor.

[c]According to an Arkansas official, the state considers its rates to be home-specific since the majority of the rate is paid on a home-specific basis through the direct resident care cost center.

[d]In Colorado, nursing homes are limited to a maximum increase in payments for administrative costs of 6 percent annually.

[e]In Florida, two additional ceilings may be applied to the indirect care and administrative cost centers. The nursing home's payment is limited to the lowest of all ceilings.

[f]In Iowa, the direct resident care ceiling for urban nursing homes is adjusted by a geographic wage index, which generally increases the ceiling for these homes by approximately 10 percent.

[g]Indirect care/administrative payment to each Michigan nursing home is limited to a percentage of the amount reimbursed in the direct resident care cost center. The exact percentage for each home depends on its size, and as of June 2003, ranged from 32.6 percent for homes with at least 150 beds to about 33.6 percent for homes with 50 or fewer beds.

[h]In the direct resident care, indirect care, and administrative cost centers, New York imposes a floor of 92.5 percent of the average costs for all nursing homes within each peer group. Homes with costs below the floor retain the difference between their costs and the floor.

[i]In North Dakota, a 3 percent operating margin is added to the payment for all nursing homes in the direct resident care and indirect care cost centers.

[j]North Dakota's direct resident care ceiling was changed to $85 at the start of state fiscal year 2004.

[k]In Pennsylvania, payment for nursing homes' administrative costs is limited to 12 percent of total payment for direct resident care, indirect care, and administrative costs.

[l]South Dakota nursing homes are limited to no more than an 8 percent annual increase in their overall payment rates.

[m]South Dakota determines median costs after excluding nursing homes in which residents have low care needs, as these homes generally have lower direct resident care and indirect care costs.

[n]When calculating the administrative cost center median, South Dakota excludes the costs of nursing homes that are part of large national chains, because according to state Medicaid officials, these homes generally operate with administrative costs that are significantly higher than independent homes.

[o]Vermont's special hospital-based homes must meet the following criteria as of June 16, 2001. They must be (1) within a hospital building, (2) part of the same corporation that governs the hospital, and (3) file Medicare cost reports jointly with the hospital.

Table 8: Direct Resident Care, Indirect Care, and Administrative Cost-Center Ceilings in Reviewed States with Flat Payment Rates, as of June 2003

	Cost-center ceilings		
State	**Direct resident care**	**Indirect care**	**Administrative**
California	Flat rate set at the median costs for all homes within certain peer groups	Flat rate set at the median costs for all homes within certain peer groups	
Massachusetts	Flat rate set at median costs for all homes[a]	Flat rate determined by adding 85 percent of median for administrative costs to median of indirect costs for all homes	
Oregon	Flat rate set at approximately 90 percent of statewide average costs for all homes[b]	Flat rate set at approximately 90 percent of statewide average costs for all homes	
Texas	Flat rate set at 107 percent of weighted average for all homes' updated 1998 costs[c]	Flat rate set at 107 percent of weighted average costs for all homes[c]	Flat rate set at 107 percent of median costs for all homes

Source: State Medicaid programs.

Note: While the table identifies standard names for cost centers, states use a variety of names, such as nursing instead of direct resident care or operations instead of administration.

[a]In Massachusetts, rates paid to all nursing homes are also adjusted based on resident care need.

[b]In Oregon, nursing homes with residents who require complex care can receive additional payments.

[c]In Texas, rates paid to all nursing homes are also adjusted based on resident care need.

Efficiency Incentives

Seven states we reviewed include efficiency incentives in their payment methods, which typically allow nursing homes with costs below a predetermined amount (generally the cost-center ceiling or the median costs) in one or more cost centers to have a portion of the difference incorporated into their per diem rates (see table 9).[5] For example, Connecticut uses efficiency incentives in both its indirect care and administrative cost centers. In the indirect care center, nursing homes with costs below the median have 25 percent of the difference between their costs and the median costs added to their per diem rates. The following hypothetical example demonstrates how this efficiency incentive generally would work. If a home's costs were $20 per day in the indirect care cost center, and the median indirect care costs for all homes were $24 per day, then the home has costs that are $4 below the median and would have 25 percent of the difference between its costs and the median, or $1, added to its rate. Each of the seven states applies efficiency incentives differently.

[5]The 12 states reviewed that did not use efficiency incentives in their payment methods are Arkansas, California, Florida, Massachusetts, Michigan, New Jersey, New York, Oregon, Rhode Island, South Dakota, Texas, and Vermont.

Table 9: Efficiency Incentives Used in Reviewed States, as of June 2003

State	Direct resident care cost center	Indirect care cost center	Administrative cost center
Alabama		If a home's costs are below the ceiling, it receives 50 percent of the difference between its costs and the ceiling	
Colorado			If a home's costs are below the ceiling, it receives 12.5 percent of the difference between its costs and the ceiling
Connecticut		If a home's costs are below the median, it receives 25 percent of the difference between its costs and median costs	If a home's costs are below the median, it receives 25 percent of the difference between its costs and median costs
Illinois		If a home's costs are below the ceiling, it receives 50 percent of the difference between the 35th and 75th percentiles of its peer group's costs	
Iowa	If a home's costs are below 95 percent of the median, it receives 100 percent of the difference between its costs and the median, up to 10 percent of the median	If a home's costs are below 96 percent of the median, it receives 65 percent of the difference between its costs and the median, up to 8 percent of the median[a]	
North Dakota			If a home's costs are below the ceiling, it receives 70 percent of the difference between its costs and the ceiling, up to $2.60 per resident day
Pennsylvania	If a home's costs are below the ceiling, it receives 3 percent of the difference between its costs and the ceiling, and up to 30 percent of the remaining difference up to ceiling	If a home's costs are below the ceiling, it receives 3 percent of the difference between its costs and the ceiling, and up to 30 percent of the remaining difference up to ceiling	

Source: State Medicaid programs.

[a]Iowa combines nursing homes' indirect care and administrative costs into a single cost center.

Case-Mix Systems

Case-mix systems categorize residents into groups based on the level of care they need and adjust payment rates to homes accordingly. Twelve of the 19 states we reviewed use case-mix systems, although the type of system and the number of case-mix categories vary widely.[6] While 5 states have designed their own systems to measure case-mix, the remaining 7 states rely on some variation of the Resource Utilization Group (RUG) Patient Classification System, which is also used to determine the acuity level of nursing home residents in the Medicare program.[7] The 7 states that use various versions of the RUG Patient Classification System place residents in 16 to 44 resident classification groups. In contrast, Oregon places residents into one of two groups, basic or complex care.[8] The case-mix classification system used by each state is shown in table 10.

[6]The seven states reviewed that did not use case-mix systems to categorize residents were Alabama, Arkansas, California, Connecticut, Florida, Michigan, and Rhode Island.

[7]CMS uses the RUG-III 44-group model to determine the case-mix of Medicare-covered nursing home residents.

[8]In Oregon, approximately 95 percent of nursing home residents are grouped in the basic care category.

Table 10: Case-Mix Classification Systems Used in Reviewed States, as of June 2003

State	Case-mix classification system
Colorado	RUG-III, 34 groups
Illinois	State-specific system, 36 groups[a, b]
Iowa	RUG-III, 34 groups
Massachusetts	State-specific system,[c] 10 groups
New Jersey	State-specific system,[d] 7 groups
New York	RUG-II, 16 groups
North Dakota	RUG-III, 34 groups
Oregon	State-specific system,[e] 2 groups
Pennsylvania	RUG-III, 44 groups
South Dakota	RUG-III, 34 groups
Texas	State-specific system,[f] 11 groups
Vermont	RUG-III, 44 groups

Source: State Medicaid programs.

[a]Illinois's case-mix system is based on its Inspection of Care (IOC) report. The IOC measures resident needs and services using 36 direct care pricing criteria to determine an average case-mix score for each nursing home. In 1994, the state stopped routinely administering comprehensive IOC reports. From 1994 through 2002, a nursing home could request an update to its IOC report if its resident turnover was at least 25 percent. However, in October 2002 the state stopped using the entire IOC system altogether and no longer prepares IOC reports. The last report for each nursing home is used to adjust payment rates for case-mix.

[b]Illinois implemented a new case-mix system based on the Minimum Data Set, also used by CMS, in state fiscal year 2004, which began on July 1, 2003. A 2-year hold harmless provision protects nursing homes from experiencing decreased rates as a result of this new system. However, since per diem rates were frozen at the beginning of state fiscal year 2004, the new case-mix system did not immediately increase payment rates to nursing homes.

[c]Massachusetts's case-mix system is based on its Management Minutes Questionnaire. Residents are grouped into 1 of 10 categories based on the level of care they require in activities of daily living and skilled nursing. On the basis of this classification, nursing homes are paid one of six different rates.

[d]New Jersey's case-mix system provides payment for additional hours of nursing for residents needing seven different services.

[e]Oregon's case-mix system provides an additional payment to nursing homes' basic rate for residents with complex care needs, for example, residents who need intravenous injections or who have open wounds requiring aggressive treatment.

[f]Texas's case-mix system is the Texas Index for Level of Effort (TILE). TILE is a state-designed, 11-group system modeled on a version of the RUG Patient Classification System. Nursing home residents are placed in 1 of the 11 groups depending on their need for various resources.

Occupancy Standards

By applying an occupancy standard, states reduce the per diem rates paid to nursing homes with occupancy below the state-established minimum levels. Of the 19 states reviewed, 17 use occupancy standards, which vary from 75 percent in Arkansas to 98 percent in Rhode Island, to determine nursing home payment rates.[9] The following hypothetical example demonstrates how a state may apply an occupancy standard. A state applies an occupancy standard of 85 percent in the indirect care cost center, but a nursing home has a 75 percent occupancy level (along with annual costs of $200,000 in the indirect care cost center and 36 beds). Using the home's actual occupancy, its payment rate for the indirect care cost center would be $20.29 (or $200,000/[.75 x 36 beds x 365 days]), whereas adjusting the home's payment in the indirect care cost center for the state's occupancy standard results in a lower rate of $17.91 ($200,000/[.85 x 36 beds x 365 days]). The extent to which states apply occupancy standards varies. Three of the states we reviewed—Alabama, Arkansas, and Iowa—apply the occupancy standard to only one cost center, and 7 others—Connecticut, Florida, Massachusetts, Michigan, New York, Rhode Island, and South Dakota—apply the occupancy standard to all cost centers (see table 11).

[9]The two states reviewed that did not incorporate occupancy standards into their nursing home payment methods were California and Oregon.

Table 11: Occupancy Standards Used in Reviewed States, as of June 2003

State	Standard	Applicable cost center(s)
Alabama	85 percent occupancy	Capital
Arkansas	75 percent occupancy	Capital
Colorado	85 percent occupancy	Administrative (rural facilities exempted)
	90 percent occupancy	Capital
Connecticut	95 percent occupancy	All
Florida	Home's total occupancy must be below the statewide average occupancy less one standard deviation and home's Medicaid occupancy must be below the statewide average Medicaid occupancy less one standard deviation[a]	All[b]
Illinois	93 percent occupancy	Indirect care/administrative and capital
Iowa	80 percent occupancy[c]	Indirect care[d]
Massachusetts	96 percent occupancy	All
Michigan	85 percent occupancy	All
New Jersey	95 percent occupancy	Capital
	90 percent occupancy	Direct resident care, indirect care, and administrative
New York	90 percent occupancy	All
North Dakota	90 percent occupancy	Administrative and capital
Pennsylvania	90 percent occupancy	Administrative and capital
Rhode Island	98 percent of statewide average occupancy	All
South Dakota	3 percent below the statewide average occupancy	All
Texas	Lower of 85 percent occupancy or statewide average occupancy	Administrative and capital
Vermont	90 percent occupancy	All except direct resident care

Source: State Medicaid programs.

Note: Unless otherwise noted, the state's occupancy standard is expressed as a minimum percentage of the number of beds occupied each day in a nursing home over a given year.

[a]In Florida, these figures are revised semiannually, based on updated census data provided by the nursing homes. The amount that a home's per diem rate is reduced depends on its actual occupancy.

[b]Florida does not apply the occupancy standard to the property component of capital in the approximately 90 percent of nursing homes that are reimbursed for capital using a fair rental value system.

[c]Iowa's occupancy standard increased to 85 percent on July 1, 2003.

[d]Within the indirect care cost center, Iowa only applies its occupancy standard to administrative and capital costs.

Appendix III: Changes to Nursing Home Payment Methods or Rates in 19 States

Officials in the states we reviewed identified changes to payment rates or to the methods their respective Medicaid programs use to determine nursing home payment rates from state fiscal years 1998 through 2004 (see table 12). While some changes have obvious positive or negative effects on payment rates, the effect of other changes can be mixed. For example, while Colorado's elimination of its quality incentive add-on payment likely lowers payment to some nursing homes, payment to some nursing homes in Vermont increased because of recently implemented add-on payments for direct resident care staff wages. The effect of other changes, such as California adding two counties to the Bay Area peer group in 2002, are likely to affect rates in both directions for different homes.

In addition to changes to how they paid nursing homes, two states—Arkansas and Iowa—designed and implemented completely new payment methodologies during this time. For example, Iowa's prior payment method did not classify homes into peer groups, did not adjust rates for the costs related to homes' resident care needs, and limited payment to the 70th percentile of all homes' total costs. Under the state's new payment method, which was phased in completely in July 2003, homes are classified into peer groups, rates are adjusted for resident care costs using the RUG-III classification system, and a ceiling of 120 percent of median costs for all homes is imposed on payment for direct resident care costs.

Table 12: State-Reported Changes to Existing Nursing Home Payment Methods or Rates, State Fiscal Years 1998-2004

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
Alabama			Moved liability insurance costs to administrative cost center instead of pass-through in 2002					
California	Added two counties to Bay Area peer group in 2002						Implemented a wage add-on for some direct resident care staff in 1999 and for other staff in 2000;[a] delayed implementation of another direct resident care wage add-on, which will apply to payments from February 2002 through July 2004, until December 2004	Froze per diem rates from August 2003 through July 2005 at August 2003 levels
Colorado		Suspended efficiency incentive in administrative cost center for 3 months in 2003	Eliminated limit on annual increase in payment for combined direct and indirect care costs in 2000	Implemented case-mix system in 2000	Eliminated occupancy standard in direct resident care and indirect care cost centers in 2000		Eliminated quality incentive add-on in 2002	Increased lag time between cost report submission and rate implementation from 2 to10 months for most homes in 2002

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
Connecticut							Implemented direct resident care and indirect care staffing wage add-on in 1999; eliminated in 2001	Delayed rate increase from July 2002 until January 2003; froze rates at January 2003 levels through December 2004
Florida		Eliminated peer group and home-specific ceilings for indirect care from January to June 2002 and for direct resident care beginning January 2002	Partially rebased administrative cost center for state fiscal year (SFY) 2003	Implemented case-mix system in 1999; eliminated in 2001			Implemented direct resident care staffing minimum add-on in 2002; delayed increase in direct resident care staffing minimum from January until May 2004	
Illinois				Eliminated routine updates to case-mix data from 1998 through 2001 and eliminated case-mix updates altogether in 2002;[b] implemented new case-mix system based on the CMS's Minimum Data Set in SFY 2004				Froze rates for SFY 1998 through 2001;[b] cut rate by 5.9 percent in SFY 2003; froze rates at SFY 2003 levels in SFY 2004

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
Iowa[c]					Increased from 80 to 85 percent in indirect care cost center in SFY 2004	Reduced cost report inflation factor by 3.4 percentage points in SFY 2004	Implemented add-on payment for quality in July 2002	
Massachusetts		Decreased ceilings for direct resident care, indirect care, and administrative cost centers in 1998					Implemented certified nursing assistant wage add-on in 2000; implemented two one-time add-on payments for nursing home performance and for nursing homes to meet Department of Mental Retardation requirements in SFY 2004	Reduced per diem rates by roughly 2.6 percent from March through June 2003[d]
Michigan						Changed inflation factor used to adjust for time between cost report submission and rate implementation from SNF market basket index to legislatively determined factor in 1999	Eliminated quality incentive add-on in 1999; eliminated direct resident care staffing wage pass-through in 2000	Reduced per diem rates by approximately 1 percent for 9 months in 2002;[e] reduced per diem rates by approximately 1.85 percent for 7 months in 2003;[e] changed beginning of rate year from start of each home's fiscal year to start of state fiscal year in SFY 2004

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
New Jersey		Increased direct resident care cost-center ceiling in SFY 2002; decreased indirect and administrative cost-center ceilings in 1999	Recategorized costs included in certain cost centers in 1999		Increased from 85 to 90 percent in direct resident care, indirect care, and administrative cost centers in 2000;[f] decreased from 90 to 85 percent in direct resident care, indirect care, and administrative cost centers in 2003			
New York							Added direct resident care staffing wage add-on in 2002	
North Dakota		Decreased direct resident care cost-center ceiling in SFY 2004		Changed the version of the RUG system used in 1999			Provided staff wage and benefit add-on from 2001 through 2003[g]	
Oregon								Froze rates at SFY 2002 level for SFY 2003; extended freeze in SFY 2004[h]

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
Pennsylvania			Changed payment of major movable property costs[i] to a pass-through instead of including in the indirect care cost center in 2001					Delayed rate adjustments pending legislative action in SFY 2004
Rhode Island							Implemented pass-through for direct resident care costs in SFY 2002	
South Dakota	Eliminated peer groups in SFY 2000	Decreased payments for certain homes in the direct resident care, indirect care, and administrative cost centers from SFY 2000 through 2002[j]					Implemented nurse's aide wage pass-through in SFY 2003	Inflated rates instead of rebasing in SFY 1999; limited annual increase in overall payment rate to 8 percent in SFY 2000; inflated rates instead of rebasing in SFY 2004

State	Peer grouping	Cost-center ceilings or efficiency incentives	Calculation of costs	Case-mix classification system	Occupancy standard	Inflation factor	Add-on payments	Payment rate
Texas							Incorporated payment for enhanced staffing program in direct resident care cost center for participating facilities in 2000	Implemented a requirement that homes spending less than 85 percent of the direct resident care rate on staffing wages and benefits refund the difference between this amount and their costs in SFY 2000; eliminated in SFY 2004; rebased biennially and inflated rates to the mid-point of the 2-year period instead of rebasing annually in SFY 2002; cut rates by 1.75 percent and eliminated rate rebasing and inflation update in SFY 2004
Vermont				Changed case-mix system to include acuity of Medicaid residents only in 1998	Eliminated 90 percent occupancy standard from direct resident care cost center in SFY 2003			

Source: State Medicaid programs.

Note: Information provided by states is current as of September 2003. Unless noted as SFY, years indicated in the table refer to the calendar years that specific changes were made or implemented.

[a]These California add-on payments are integrated into nursing home cost reports and eventually become part of the regular per diem rate calculation. The add-on payments are phased out after all homes have the add-on included in their rates.

[b]Illinois did not routinely adjust for case-mix or consistently update rates from 1994 through 2001. However, the state did adjust rates periodically for inflation based on budget availability.

[c]Iowa completed the phase-in of a new payment methodology, which included a case-mix adjustment system and peer groups, in July 2003.

[d]This reduction was implemented as a 6.5 percent cut to Massachusetts' payments for nursing homes' indirect care and administrative costs.

[e]These reductions applied to Michigan's payments for nursing homes' direct resident care, indirect care, and administrative costs but not to payments for capital costs, so the overall reduction to homes' per diem rates was somewhat less than 1 percent in 2002 and somewhat less than 1.85 percent in 2003.

[f]New Jersey did not apply the occupancy standard to nursing homes with occupancy from 85 through 90 percent if their previous year's occupancy was 90 percent or greater.

[g]North Dakota eliminated this add-on payment in 2003, when the costs of the increased staff salaries and benefits funded by the add-on became part of the regular per diem rate calculation.

[h]Oregon's rate freeze will remain in effect, pending CMS approval of a waiver proposal pertaining to the state's new provider tax.

[i]In Pennsylvania, major movable property costs include tangible items costing $500 or more that are used to provide services to nursing home residents and could include beds and office equipment.

[j]Decreased payments affect South Dakota nursing homes that have costs above 115 percent of the median in the direct resident care cost center or above 105 percent of the median in the indirect care or administrative cost centers.

Appendix IV: GAO Contact and Staff Acknowledgments

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