NURSING HOME

MEDICAID REIMBURSEMENT PROGRAM

From The Office Of State Auditor
Claire McCaskill

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AUDIT REPORT

Office Of The
State Auditor Of Missouri
Claire McCaskill

March 2001

www.auditor.state.mo.us

YELLOW SHEET

Missouri nursing home Medicaid rates need to be rebased more frequently using more current and actual nursing home cost report data.

This audit reviewed the financial status of Missouri's nursing home industry in relation to the state's Medicaid Reimbursement Program. Our audit determined the funding increase and projected effect on the industry if Medicaid reimbursement rates are adjusted (rebased), evaluated varying reimbursement methods, reviewed possible funding sources, and studied how the industry fared nationally. The following highlights our results:

Medicaid rates based on old cost data

Missouri Medicaid rates are adjusted (rebased) using actual nursing home cost data less often then other states. Missouri uses trend factors to annually adjust nursing home Medicaid rates, but these rates are based on nearly decade-old cost report data for many homes. In 1998, only one other state's nursing home Medicaid rates were based on cost data older than the 1992 cost data used in Missouri. In addition, a national study reported 33 other states used cost report data that was no more than two years old to set 1998 rates. Rate adjustments based on more current cost report data would allow Medicaid rates to more accurately reflect actual operating costs for each nursing home. (See page 10)

Nursing home industry is overbuilt.

Missouri's average occupancy rate for its nursing homes (80 percent) is one of the lowest in the nation and continues to decline. Nursing homes with low occupancy rates receive lower reimbursements and cannot fully recover administrative and capital costs under the current rate structure. In addition, the large number of unoccupied beds indicates more nursing homes are open than what is needed, which increase the costs for the Medicaid program. (See page 12)

Rebase cost lowest if Medicaid rates are capped at costs.

The additional funding needed to rebase Medicaid rates using the most current cost data range from $57 million to $132 million depending on the specific rate computation used. This audit reviewed various methods including those using current state regulations and methods if state regulations changed. If the state rebases using current regulations, our analysis showed it would cost as much as $132 million. But it could cost less than half that amount ($57 million) if the state capped reimbursement rates at allowable costs. (See page 15)

Missouri may receive up to $436 million in additional funding in the next two calendar years through federal approval to participate in a Medicaid legislation "loophole." This money, known as the Intergovernmental Transfer Program (IGT), can be used by the state for any purpose. The current plan for the money calls for "one-time efficiency grants" to the nursing homes of up to $196 million over the next two fiscal years. These grants would replace the annual trend factor increases in each nursing home's rate. This funding would be in addition to $60 million in IGT monies already distributed to nursing homes in fiscal year 2001. These grants provide funding equally to financially-distressed and profitable nursing homes. (See page 18)

A "hold harmless" provision would cost state more.

After rebasing, the new Medicaid rate for some homes may be less than the home's current rate. The Department of Social Services in the department's initial budget request for fiscal year 2002 asked the General Assembly to institute a "hold harmless" provision. Such a provision would allow facilities whose rate might decrease as a result of rebasing to retain the higher current rate. This provision, which is currently not allowed under state regulation, would cost the state at least an additional $2 million. (See page 16)

NURSING HOME
MEDICAID REIMBURSEMENT PROGRAM

TABLE OF CONTENTS

STATE AUDITOR'S REPORT

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We have audited the State of Missouri's Nursing Home Medicaid Reimbursement Program. Using the most complete and current information available, we examined the state of the nursing home industry as of 1998. The objectives of this audit were to determine:

1. The estimated increase in Medicaid funding that would result if the Medicaid reimbursement rates are adjusted (rebased) under current state regulations using the 1998 cost report data.

2. The status of the nursing home industry in 1998 as impacted by the Medicaid reimbursement rates.

3. The projected effect upon the nursing home industry if rates are rebased.

4. If a correlation exists between 1998 Medicaid rates and overall quality of care provided by nursing homes as indicated by 1998 inspection deficiency data.

5. How Missouri nursing homes compare to national medians for selected statistics.

Our audit was conducted in accordance with generally accepted government auditing standards and included such procedures as we considered necessary in the circumstances. In this regard, we reviewed applicable state laws and regulations, interviewed applicable personnel of the Department of Social Services - Division of Medical Services (DMS), and reviewed certain records, documents, and national studies.

As part of our audit, we assessed the state's management controls to the extent we determined necessary to evaluate the specific matters described above and not to provide assurance on those controls. With respect to management controls, we obtained an

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understanding of the design and relevant polices and procedures and whether they have been placed in operation and we assessed control risk.

Our audit was limited to the specific matters described above and was based on selective tests and procedures considered appropriate in the circumstances. Had we performed additional procedures, other information might have come to our attention that would have been included in this report.

The accompanying Background Section and the information presented in the appendices is presented for informational purposes. This information was obtained from the Division of Medical Services' management or other indicated sources and was not subjected to the procedures applied to the audit of the Nursing Home Medicaid Reimbursement Program.

The Results and Overall Conclusion Section presents our findings arising from our audit of the Nursing Home Medicaid Reimbursement Program.

Claire McCaskill
State Auditor

December 12, 2000 (fieldwork completion date)

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EXECUTIVE SUMMARY

NURSING HOME
MEDICAID REIMBURSEMENT PROGRAM
EXECUTIVE SUMMARY

We have audited the state's Nursing Home Medicaid Reimbursement Program. Based upon our work, we reached the following conclusions:

- Missouri's nursing home Medicaid rates are adjusted (or rebased) using actual cost report data less frequently than many other states. A national study reported 33 other states use cost report data that is no more than two years old to make annual nursing home Medicaid rate adjustments. The current Medicaid rate for the majority of Missouri's nursing homes is based upon 1992 cost report data which has been adjusted for trend factors and other increases annually. More frequent adjustment of the base year would allow Medicaid rates to more accurately reflect actual operating costs for each nursing home.

- Current state regulations require nursing home Medicaid rates to be rebased using cost reports from at least one cost report year 1995 through 1999. The additional funding needed to rebase the 2002 Medicaid rates is dependent upon the specific methodology used. The following table indicates the expected impact under various methodologies discussed in this report. Under the $57 million estimate, most nursing home Medicaid providers would be reimbursed at allowable costs while limiting the reimbursement to costs for economically and efficiently operated homes.

Additional Funding Requirements under Various Rebasing Methodologies
(In Millions)

Methodology	Prepared By	State Funds**	Federal Funds	Total Funds
Using current regulations	SAO	$53	$79	$132
Using current regulations	DMS	$50	$76	$126
Capped * without Minimum Utilization	SAO	$29	$43	$72
Capped * without Minimum Utilization	DMS	$27	$41	$68
Capped * with Minimum Utilization	SAO	$23	$34	$57

* Revised current regulations to limit rates to no more than a home's allowable costs
** General Revenue or Intergovernmental Transfer Program funding.

- The $256 million in Intergovernmental Transfer Program funding that has been or is planned to be provided to nursing homes as one-time grants does not eliminate the need to rebase nursing home Medicaid rates. The remaining $196 million which has not been distributed is an available source to fund the state's share of the costs to rebase nursing home rates.

- The average overall occupancy rate for Missouri nursing homes (about 80%) is one of the lowest in the nation. The occupancy rate has declined from 84.9 percent in 1995 to 80.8 percent in 1999 and this trend appears to be continuing. The total number of available

bed days has remained relatively stable over the same period. Homes that have low occupancy rates cannot fully recover administrative and capital costs under the current rate structure. In addition, the large number of unoccupied beds indicates more nursing homes are open than otherwise might be needed and, as a result, increase the costs for the Medicaid program.

- After rebasing, the new Medicaid rate for some nursing homes may be less than the homes' current rate. Granting a hold harmless provision allowing such facilities to retain the higher current rate following rebasing would cost the Medicaid program at least an additional $2 million. Such a provision is currently not allowed under state regulations, but was proposed in the fiscal year 2002 initial budget request made by the Department of Social Services – Division of Medical Services (DMS).

- Within the nursing home Medicaid rate structure, cost component ceilings are used to limit payments to homes at levels considered to be appropriate for those that are economically and efficiently operated. The ability of homes to maintain allowable reimbursable costs below these ceilings impacts the homes' profitability in relationship to their Medicaid rates.

- There appeared to be no definitive correlation between the overall quality of care provided by nursing homes and the home's Medicaid rate, allowable costs per day, rate versus cost differential, or direct care cost per day.

- For 1997, Missouri's nursing homes ranked below national medians for direct care expenses, average wages for full-time employees, net revenues per day, and operating expenses per resident; while the overall median profit margin for these homes exceeded the national median.

SCOPE AND METHODOLOGY

NURSING HOME
MEDICAID REIMBURSEMENT PROGRAM
SCOPE AND METHODOLOGY

Scope

We reviewed nursing home Medicaid cost report data for the 1998 cost report year. We compared facility specific cost data to the 1998 Medicaid rates. We obtained deficiency data arising from inspections of nursing homes performed by the Department of Social Services - Division of Aging. We reviewed applicable state laws and regulations, interviewed applicable personnel of the Department of Social Services, and reviewed department records and procedures related to determination of nursing home Medicaid rates.

Methodology

We performed the following procedures as part of our audit work:

- Reviewed 13 CSR 70-10.015 which describes current nursing home Medicaid rate setting methodology.

- Obtained an understanding of the internal controls and procedures used by the Department of Social Services - Division of Medical Services (DMS) to determine the Medicaid reimbursement rates for nursing homes.

- Obtained the 1998 cost report data submitted by nursing homes and desk audited by the DMS.

- Prepared a projection of the additional funding required to adjust the Medicaid rates based upon the 1998 cost reports and examined possible rebasing alternatives and funding sources.

- Analyzed cost report and rate setting data to identify the relationships between costs and rates and examined the impact upon the nursing home industry if rebasing is adopted.

- Obtained the deficiency data as recorded in the Online Survey and Certification Reporting System (OSCAR) arising from inspections performed by the Department of Social Services - Division of Aging for the last four inspection cycles.

- Developed a scale of quality of care based upon the OSCAR deficiency data to evaluate the correlation between a nursing home's Medicaid rate and client quality of care.

- Analyzed various national nursing home statistics cited in studies, *The Guide to the Nursing Home Industry, 2000* and *1998 State Data Book on Long Term Care Program and Market Characteristics.*

- Analyzed nursing home occupancy data.

RESULTS AND OVERALL CONCLUSIONS

Frequency of Rebasing

Missouri's 1998 and current Medicaid rates for the majority of nursing homes are based on cost report data for the base year of 1992. The *1998 State Data Book on Long Term Care Program and Market Characteristics*[1] reported thirty-three states used cost data that was no more than two years old to set the 1998 Medicaid rates.

Most nursing home rates are based upon 1992 cost data.

Under 13 Code of State Regulations (CSR) 70-10.015, nursing home Medicaid rates shall be adjusted (rebased) using the nursing home cost report data from one or more cost report years from the period 1995 to 1999. The Department of Social Services - Division of Medical Services (DMS) proposed in the department's initial fiscal year 2002 budget request using the 1998 cost reports to adjust the Medicaid rates.

The current rate methodology was implemented in 1995. As discussed in the Background Section of this report, nursing home rates are adjusted annually based on industry trend factors and other items. In Missouri, the base year for the majority of homes is nearly a decade old. More frequent adjustment of the base year would allow Medicaid rates to more accurately reflect actual and current operating costs for each facility.

Analysis of 1998 Cost Report Data

We reviewed the state of the nursing home industry using statistics generated from the cost report data as well as other nationally compiled information. We compared the 1998 cost data and 1998 rates for the following 489 nursing homes which currently remain in the Medicaid program:

In 1998, most rates were significantly below allowable costs.

Nursing Home Rate Type	Number of Homes
Prospective Rate	450
Interim Rate	27
Hospital - Based	10
State run	2
Total	489

We compared the total patient related revenues as reported on the cost reports to the total allowable costs per patient day as well as Medicaid rates to those costs for each of the 489 homes:

[1] *1998 State Data Book on Long Term Care Program and Market Characteristics, Harrington, C., Ph.D., et al, Nov 1999, page 7.*

Revenues versus Allowable Costs

Relationship	Number of Homes	Percentage of Total
Patient related revenue exceeded costs	331	68%
Costs exceeded patient related revenues	158	32%

Medicaid Rate versus Allowable Costs

Relationship	Number of Homes	Percentage of Total
Medicaid rate exceeded costs	202	41%
Costs exceeded Medicaid rate	287	59%

For these facilities the overall average:

- revenue per day was $97.23,
- allowable costs per day were $97.46, and
- Medicaid rate was $87.66.

We also analyzed the cost data by facility location, overall occupancy, Medicaid share of occupancy, facility type, and component ceiling impact:

Location

Type	Number of Homes	Number of Homes with Costs > Rates	Percentage of Homes with Costs > Rates
Metropolitan[2]	150	104	69%
Non-metropolitan	339	183	54%

Nursing homes costs may be rising faster in metropolitan areas than in rural areas.

Occupancy

Type	Number of Homes	Number of Homes with Costs > Rates	Percentage of Homes with Costs > Rates
Above 85%	219	117	53%
Below 85%	270	170	63%

Under the current rate methodology, the administrative and fair rental value components of the rate include a minimum utilization factor set at 85 percent occupancy. As a result, homes with lower occupancy are reimbursed for a lower proportion of their administrative and fair rental value costs than higher occupancy homes.

[2] Facilities located in the cities of St. Louis, Kansas City and Springfield and the counties of St. Louis, St. Charles, Jefferson, Jackson, and Clay.

The Guide to the Nursing Home Industry, 2000[3] reported Missouri's 1997 nursing homes occupancy rate (84.07 percent) ranked 45th lowest among all states. The *1998 State Data Book on Long Term Care Program and Market Characteristics*[4] reported the Missouri's average 1998 occupancy rate ranked 21st of 22 states reported in this study. We obtained a report from the state's Certificate of Need Program indicating the following occupancy rates from 1995 through June 30, 2000. That report is based upon the results of quarterly surveys of occupancy in Intermediate Care Facilities and Skilled Nursing Facilities (ICF/SNF) conducted by the Department of Social Services - Division of Aging.

Missouri's occupancy rate is among the lowest in the nation.

ICF/SNF Licensed and Available Beds

Year	Available Days	Occupied Days	Occupancy %
1995	20,615,477	17,495,421	84.9
1996	20,663,774	17,371,774	84.1
1997	20,743,505	17,196,411	82.9
1998	20,749,679	16,920,556	81.5
1999	20,537,127	16,591,034	80.8
2000 (6 mo.)	10,134,424	8,084,665	79.8

The total number of available bed days decreased very little from 1995 through 1999; however, overall occupancy rates fell by 4 percent over the same period. Department of Social Services officials indicted this trend appears to be due to expanded in-home and community-based services available to individuals who previously only had the option of going to a nursing home.

As noted above administrative and capital costs must be allocated using the 85 percent minimum utilization factor. Homes with low occupancy receive proportionately lower Medicaid rates. In 1998, 114 of 270 (42 percent) homes with occupancy rates below 85 percent had per day costs that were greater than per day revenues. However, only 43 of 219 homes (20 percent) with occupancy rates above 85 percent had costs greater than revenues.

Medicaid Share of Occupancy

Type	Number of Homes	Number of Homes with Costs > Rates	Percentage of Homes with Costs > Rates
Above 75%	127	70	55%
Below 75%	362	217	60%

As the Medicaid share of occupancy increases homes must more closely align costs to rates since their ability to fund additional costs from other sources is reduced. In addition, homes qualifying for the first part of multiple component incentive will also receive an additional incentive if the

[3] *The Guide to the Nursing Home Industry, 2000, HCIA Inc., Baltimore, MD, © 1999. Reprinted with Permission. For more information, please call (800) 568-3282*

[4] *Harrington, C., Ph.D., et al, page 11*

Medicaid share is above 75 percent. The total number of nursing home days covered by Medicaid has declined at about the same rate as overall occupancy.

Entity Type

Type	Number of Homes	Number of Homes with Costs > Rates	Percentage of Homes with Costs > Rates
Profit Homes	344	197	57%
Non - profit Homes	145	90	62%

Nothing significant was noted in the entity type analysis.

Component Ceilings

A key factor affecting whether allowable costs are greater than rates or rates are greater than costs appears to be the ability of nursing homes to operate at or below the various cost component ceilings. These component ceilings are discussed in more detail in the Background Section of this report. The following tables reflect the number of homes exceeding certain cost ceilings or component limits and the percentage of those homes with reimbursable allowable costs exceeding rates:

Analysis by Individual Ceiling or Component Limit

Ceiling/Component Limit	Number of Homes	Percentage of These Homes with Costs > Rates
Patient care	187	81%
Ancillary	377	70%
Administrative	271	75%
Capital Costs > highest rental value component of $16.98	113	95%

Analysis by Number of Limits Exceeded

Number of Ceiling/ Component Limits Exceeded	Number of Homes	Percentage of These Homes with Costs > Rates
0	50	6%
1	127	28%
2	153	63%
3	121	94%
4	38	100%

For the 1998 cost-reporting year, 66 percent of all nursing homes participating in the Medicaid program exceeded 2 or more of the rate component ceilings or limits.

Key issues from these statistics:

- The state's nursing home rate methodology is designed to limit the amounts of reimbursable costs through the imposition of cost component ceilings and minimum utilization factors so that homes are reimbursed at rates that would cover the costs of economically and efficiently operated nursing homes. Nursing homes that cannot keep costs below the ceiling component limits or have low occupancy will be more likely to have overall costs that exceed their Medicaid rate.

- The longer the interval between rebasing costs the greater the number of homes for which actual growth or change in costs will vary from the granted trend factors. As a result, nursing homes whose actual cost increases each year exceeded industry trends may gradually fall behind financially. Conversely nursing homes that have been able to reduce costs or whose actual cost increases each year were less than industry trends should benefit financially.

- The current trend of decreasing nursing home occupancy with a relatively stable number of available beds seems to reflect an over capacity in the industry which ultimately causes the need for more Medicaid funding. The minimum utilization factor helps limit the impact of low occupancy rates on Medicaid per diems.

(See Appendices B - E in this report for various tables or charts with more detailed results of this analysis.)

Profit Margin

The *Guide to the Nursing Home Industry, 2000*[5] reported the following 1997 median values for Missouri and nationally for various statistics:

Comparison of Median Statistics, U.S. vs. MO, 1997

Statistical Category	Average National Statistics	Missouri's Reported Statistics	Missouri's Rank
Revenue per Day	$109.70	$101.05	32
Operating Expense per Day	$107.94	$98.74	34
Profit Margin	4.61%	5.06%	18
Direct Care Cost per Day	$36.18	$25.75	44
Annual Salary per Full Time Employee	$25,182	$18,230	44

This data reflects that Missouri nursing homes had expenditures, especially direct care costs, during that year below national median statistics and profit margins that exceeded national median statistics.

[5] *The Guide to the Nursing Home Industry, 2000, HCIA Inc., Baltimore, MD, © 1999. Reprinted with Permission. For more information, please call (800) 568-3282*

The cost report data used in our analysis did not include total revenues and expenses for nursing homes, only patient related revenue and allowable costs. We were therefore unable to calculate a true profit margin for nursing homes, however, in order to estimate industry profitability we netted patient related revenues per day against the allowable costs per day and divided this amount by the total revenues. The average ratio of the netted computation to total revenues was 1.87 percent and the median was 5.44 percent. Nursing home profitability appeared to be as follows:

	Percentage
Percentage of homes losing money	32%
Percentage of homes marginally profitable	36%
Percentage of homes with 10 % + profit margins	32%

Future Costs of Medicaid Nursing Home Funding Under Current Proposals

The DMS has estimated annual state and federal funding for nursing homes will increase by $126 million (state share $50 million) after rebasing. Using the 1998 cost data and current Medicaid rate setting methodology set forth in state regulations, we determined that state and federal funding requirements could increase by as much as $132 million (state share $53 million).

The primary reasons for the differences in the two calculations are:

- The DMS used a trend factor rate for the period 1999 to 2002 of 14.9 percent while we used 15.75 percent. Our calculation used the same annual and estimated rates; however, we compounded them annually while the DMS did not.

- We used September 2000 interest rates in our calculation while DMS used the September 1998 rates.

- We took the 1998 costs and ran them through the rate methodology as set forth in 13 CSR 70-10.015 to determine what the rate would have been in 1998 and then trended the rate forward while DMS had trended the 1998 costs to 2002 and then ran them through the rate methodology to calculate the 2002 rate.

- The DMS calculation included a hold harmless provision (discussed below) while ours did not.

After rebasing our estimates indicate 73 percent of nursing homes will have Medicaid rates greater than allowable costs. The increased funding for the industry would result from:

- Differences over the numerous years since rebasing last took place, between the trend factors granted and changes in actual costs.

- Higher computed component ceiling limits that would allow homes to recover some allowable costs they otherwise would not have under prior ceiling limits. Part of the reason for this is that costs related to approximately 100 homes that have entered the Medicaid program since 1992 are not included in the current ceiling component limit total calculations.

Hold Harmless Provision

State regulation clearly indicates the rates are to be adjusted upward or downward when rebasing is done. The DMS's rate calculation and fiscal 2002 initial budget request for nursing home Medicaid funding allowed homes with a current rate that is higher than the rate that would result from rebasing to retain the higher rates, that is be "held harmless." The estimated impact of this provision would be:

Source	Number of Homes	Estimate Additional State and Federal Funding
DMS estimate	25	$2.6 million
State Auditor estimate	19	$2.2 million

While the additional cost is minimal, the majority of these homes will have rates greater than allowable costs and as a result there does not appear to be any need for such a provision. If Medicaid rates were rebased with rates capped at allowable costs as discussed below, the estimated additional state and federal funding to cover a hold harmless provision could be as much as $24 million.

Other Rate Setting Methodologies

The *1998 State Data Book on Long Term Care Program and Market Characteristics*[6] reported that states use the following general rate-setting Medicaid reimbursement methodologies:

Method	Number of States[7] Using the Method
Prospective adjusted (rates may increase during the rate year)	24
Prospective facility-specific	20
Prospective class	3
Combination prospective and retrospective	3
Retrospective	1
	51

Missouri uses a prospective facility-specific methodology. Retrospective methodologies set rates based on the cost of providing care while prospective methods set rates in advance for each facility based on historical costs (facility-specific) or set a flat rate for groups of facilities (class method). Adjusted methods allow rate increases during a period over which rates have already

[6] *Harrington, C., Ph.D., et al, page 6*
[7] Includes Washington D.C.

been established. In recent years this method has increased in usage by many states. The study also noted 26 states enhance the general rate-setting methodology used with a case-mix reimbursement approach which uses patient care needs as a basis to set at least some portion of the overall rate. This approach has also increased in popularity over the last several years. Missouri does not include any case-mix analysis in the rate setting process.

Use of a case mix component adds more subjectivity to the rate setting process since the level of patient care needs which is determined by the nursing home could be exaggerated for the patient's initial and annual assessment to increase funding. Expected higher state administrative costs along with patient rating subjectivity appear to limit the usefulness of this approach. More frequent rebasing should allow the Medicaid rates to reflect changes in the overall acuity level of a nursing home's residents while avoiding the administrative complexity associated with case-mix methodologies.

Consider capping rates at no more than allowable costs.

Besides the estimate used in the budget proposal noted above, the DMS also considered a proposal under which nursing home Medicaid rates would be rebased using the 1998 cost reports as the base year but the resultant Medicaid rates would be capped at no more than the allowable facility specific costs per day. The DMS estimated the additional funding required to implement this proposal to be $68 million (state share $27 million.) Under this scenario, the rates would be determined under the current methodology including component ceilings based upon the 1998 cost report data. Some facilities would receive some benefit from the patient care, ancillary and multiple component incentives. However, the Medicaid rate would be capped at the allowable costs per day. The DMS estimate did not include the 85 percent minimum utilization factor. We prepared an estimate using a methodology similar to that used by the DMS but based it upon the compounded trend factor and current interest rates as well as another estimate which incorporated the minimum utilization factor:

Estimate	Amount
Without Minimum Utilization	$72 million (state share $29 million)
With Minimum Utilization	$57 million (state share $23 million)

Under the $57 million estimate, most nursing home Medicaid providers would be reimbursed at allowable costs while limiting the reimbursement to costs for economically and efficiently operated homes. No provider would be paid more than allowable costs. If this rate methodology were adopted, 173 facilities would have their Medicaid rate reduced from state fiscal year 2001 levels while 316 facilities would receive rate increases.

New Funding Source

The IGT program may provide up to $436 million in funding to the state in the next 2 years.

For fiscal year 2001, the state received approval based on an amendment in the Medicaid State Plan to participate in a "loophole" in federal Medicaid legislation that allows states to receive additional federal matching funds based on enhanced payments to some government operated health care providers as allowed under Medicare's "upper payment limit" rules. Under the state's Intergovernmental Transfer (IGT) Program, after the state claims the federal matching funds, the enhanced payments to these providers are returned to the state. Based on the funding derived from this process, in November 2000, each nursing home participating in the Medicaid program was distributed a share of $60 million (approximately $6.30 per Medicaid day) in funding based on the number of Medicaid days of service provided in fiscal year 2000. According to the DMS, the state may receive up to $117 million in additional funding under this program during the fiscal year. IGT program funding can be spent by the state for any purpose.

Effective March 2001, the federal government implemented changes to modify the existing rules to significantly limit the upper payment limit funding states can receive. Under the federal legislative changes, Missouri will only be able to participate under previous upper payment limit rules one more federal fiscal year. The DMS has estimated an additional $256 million will be made available during state fiscal year 2002. The current estimate for state fiscal year 2003 is $63 million. The actual amount available in 2003 will depend upon future changes in Medicare rates and actual funding provided to nursing homes in 2002.

The DMS has developed an IGT spending plan. Under this plan nursing homes would receive "one time efficiency" grants of $196 million over state fiscal years 2002 and 2003 in addition to the $60 million already received in fiscal year 2001. The remainder of the Intergovernmental Transfer revenues ($180 million) would be used to supplement other Medicaid programs. The DMS has not developed eligibility criteria or other "efficiency" grant requirements at this time.

If the "efficiency" grants are distributed under the same methodology as the $60 million distribution in November 2000, nursing homes would receive an estimated $13.52 per day in fiscal year 2002 and $6.41 per day in fiscal year 2003. In fiscal year 2002, 69 percent of nursing homes would have a combined rate plus grant per diem that exceeds their fully trended allowable costs. Those homes would be paid $87 million more than allowable costs. In fiscal year 2003, 42 percent of homes would have a combined rate plus grant per diem that is greater than the estimated fiscal year 2003 allowable costs per day. Those homes would be paid $35 million more than costs. See the following tables:

POTENTIAL IMPACT OF IGT GRANTS

	Fiscal Year 2002		Fiscal Year 2003	
	Rate + IGT Grant >Cost	Cost >Rate + IGT grant	Rate + IGT Grant >Cost	Cost >Rate + IGT grant
# of Homes	337	152	205	284
% of Homes	69%	31%	42%	58%
Compensation in Excess of Allowable Costs	$87 million	---	$35 million	---
Compensation Less Than Allowable Costs	---	$58 million	---	$108 million

RATE + IGT grant versus Allowable Costs

Fiscal Year 2002	Rate + IGT grant	Allowable Costs	Difference
Average	$109.25	$107.77	$1.48
Median	$109.46	$100.32	$7.55
Fiscal Year 2003			
Average	$102.13	$111.21	$(9.08)
Median	$102.35	$103.53	$(2.71)

It appears that simply using the funds designated for the nursing home program arising from the IGT program to make "efficiency" grants to nursing homes in 2002 and 2003 would provide significant funding to the industry, but not address long-term funding needs or the need to rebase rates. The Department of Social Services does not want to include the IGT funding in the nursing home rate structure since there will be no identified funding source when the revised upper payment limit rules reduce the state's IGT funding. The department indicated that there would be significantly less industry resistance to the ending of the IGT grant payments if the program is terminated by the federal government than to cutting established rates in the future. Under the proposed usage of the IGT monies as one-time efficiency grants, Missouri is only delaying by no more than two years an inevitable increase in General Revenue funding that will be necessary for the Medicaid nursing home program once rates are rebased.

The IGT monies are a currently available source to fund the costs of rebasing nursing home Medicaid rates. Rebasing rates would more closely align Medicaid rates and provider costs and could be tailored to limit rates to costs of economically and efficiently operated homes. Regular rebasing would help to ensure the highest number of providers practically and reasonably possible would be reimbursed for the cost of providing Medicaid services. The legislature should consider use of the IGT monies as a transitional source to fund the cost of rebasing nursing home Medicaid rates.

Medicaid Rates and Quality of Care

To examine the relationship between a nursing home's quality of care and Medicaid rate we performed the following procedures:

- Obtained the inspection deficiency data for the 489 homes in our analysis from the Department of Social Services - Division of Aging. The data is maintained in the federal Online Survey and Certification Reporting (OSCAR) system.

- Identified the inspection survey falling within or most closely following the facility's 1998 cost report year.

- Sorted the 489 homes by the difference between their Medicaid rate and their 1998 allowable costs per day.

- Chose three groups of nursing homes for our study:

  - 50 with patient day costs that significantly exceeded the home's Medicaid rate,
  - 50 with Medicaid rates and costs that were approximately equal,
  - 50 with Medicaid rates that significantly exceeded the patient day costs.

- Developed a scale under which increasing values were assigned to increasingly severe deficiencies. The quality score was determined by adding together the values of all the deficiencies in the survey. Homes with higher scores were considered to have a lower overall quality of care. We then analyzed the quality scores for the three groups by cost/rate differential, location, overall occupancy, Medicaid share of occupancy, and direct patient care costs:

Cost Rate Differential Analysis

Cost Rate Differential	Average $ Difference	Average Quality Score	Average # of Deficiencies	# of Homes with No Deficiencies
Cost > Rate	(49.25)	25.90	4.96	15
Cost ≅ Rate	(.17)	33.84	6.52	7
Rate > Cost	16.39	30.22	6.14	10

Location, Occupancy and Medicaid Share of Occupancy Analysis

	Number in Group	Average Quality Score	Average # of Deficiencies	Homes with No Deficiencies
Metropolitan	51	32.39	6.41	11
Non-Metropolitan	99	28.75	5.60	21
High Occupancy	62	22.16	4.61	14
Lower Occupancy	88	35.50	6.76	18
High Medicaid Share	42	37.31	7.14	8
Lower Medicaid Share	108	27.14	5.38	24

Direct Patient Care Costs per Day and Quality Score

Patient Care Cost Range	Average $/day	Average Quality Score	Average # of Deficiencies	Homes with No Deficiencies
High 50	64.91	20.44	3.98	15
Middle 50	45.78	35.86	6.96	12
Low 50	38.68	33.66	6.68	5

There was no definitive correlation between the quality score and the rate cost relationship. There were similar numbers of nursing homes with high and low quality scores in each of the three groups. Also, nursing homes with the highest direct patient care costs as well as those with higher overall occupancy and lower Medicaid occupancy had slightly, but not significantly so, better quality scores but the correlation factor for this data was not significant.

No statistical correlation between rates and quality of care was found.

Overall Conclusions

Missouri's nursing homes are being impacted by overall trends of decreased occupancy and Medicaid patient days along with trended rates based on actual cost report data that are nearly 10 years old for many homes. National statistics compiled for 1997 indicated Missouri's nursing homes ranked below national medians for several expenditure categories while the overall median profit margin for these homes exceeded the national median. In addition, 1998 nursing home cost reports indicated 59 percent of the state's nursing homes had allowable costs that exceeded the home's Medicaid rate while 68 percent of the state's nursing homes were profitable.

Missouri's nursing home Medicaid rates are rebased less frequently than in most other states. More frequent and timely rebasing would better align the Medicaid rates and the costs of economically and efficiently operated nursing homes.

Current state regulations require nursing home Medicaid rates to be adjusted or rebased using cost reports from at least one cost report year 1995 through 1999. Rebasing Medicaid rates for Missouri nursing homes using 1998 cost data will require additional state and federal funding in fiscal year 2002 of amounts ranging between $57 million and $132 million based on the specific rate computation methodology used. The additional costs would be required for all future years, Any desired change in the rate methodology would require revision to existing state regulations covering the computation of nursing home Medicaid rates.

The $256 million in Intergovernmental Transfer Program funding that has been or is planned to be provided to nursing homes as one-time grants does not eliminate the need to rebase nursing home Medicaid rates. The remaining $196 million which has not been distributed is an available source to fund the state's share of the costs to rebase nursing home rates.

Revising Missouri's laws to allow a hold harmless provision for nursing homes whose rebased rate is less than the current rate received will require state and federal funding of at least an additional $2 million.

There appeared to be no definitive correlation between the overall quality of care provided by nursing homes and the home's Medicaid rate, costs per day, rate versus cost differential or direct care cost per day.

Recommendations

We Recommend the General Assembly:

1.1 Adjust state law to ensure nursing home Medicaid rates are rebased annually using cost reports that are no more than 2 years old like the majority of other states.

1.2 Consider a rate structure that limits nursing homes rates to no more than allowable costs using established minimum utilization factors. If incentives are still considered necessary to provide additional funding to the industry, the eligibility criteria for those incentives should consider the home's quality of care as well as direct patient care costs.

1.3 Consider using the funding generated through the Intergovernmental Transfer Program to pay for the state's share of the costs to rebase nursing home Medicaid rates.

1.4 Consider declining nursing home occupancy and Medicaid patient day trends when determining the funding needs for Missouri's nursing homes.

1.5 Not adjust state law to allow a hold harmless provision when nursing home rates are rebased.

The Department of Social Services Comments:

1.1 This recommendation would be difficult, if not impossible, for the department to implement due to the timing of submission of nursing home cost reports. Costs reports are required to be filed with the department five months following the facilities fiscal year end. The department would not have audited cost report information to develop a budget decision item for General Assembly consideration until the following budget cycle. Thus, the earliest the department would be able to comply with the proposed statutory provision would be for cost reports that are three years rather than two years old.

1.3 Moneys gained through the intergovernmental transfer (IGT) program should be treated as one-time add-on payments and not be used to support on-going per diem increases. Facilities rely on consistent per diem rates for future planning. If the state were unable to replace the IGT monies when this funding ends, per diems would have to be reduced and the nursing facilities would be forced to make unanticipated reductions.

The department did not comment on the other recommendations.

This report is intended for the information of the management of the state of Missouri, the Department of Social Services, and the General Assembly. However, this report is a matter of public record and its distribution is not limited.

BACKGROUND

NURSING HOME
MEDICAID REIMBURSEMENT PROGRAM
BACKGROUND

The current Medicaid rate determination methodology is set forth in 13 CSR 70-10.015. Under this methodology, the reimbursement rate is based upon allowable costs as reported on an individual nursing home cost report for a base year. When the current methodology was developed in 1995 the base year chosen was 1992. If nursing homes entered the program after 1992, the base year cost report for that facility will generally be the one covering the second full business year for that home. Only the base year cost data is used to determine the prospective Medicaid rate for each facility. In subsequent years, the rates are adjusted for all homes with prospective rates through trended percentages or specific dollar amount increases in the per diem as determined from appropriations by the state legislature. In 1998, the highest Medicaid rate per-diem rate paid to a nursing home was $100.68 and the lowest rate paid was $64.34.

(See Appendix F for the average 1998 Medicaid rate for each state.)

The Department of Social Services - Division of Medical Services, Institutional Reimbursements (DMS-IR) section performs a desk audit of each cost report to identify unallowable costs or misclassified costs. If DMS-IR audit staff question particular expenditures, the nursing home may be required to submit additional detailed documentation. Nearly all 1998 cost reports had been desk audited as of January 2001. The DMS-IR may conduct onsite field audits of nursing home records if the cost report covers the rate setting base year and a significant number of questions arising during the desk review have not been resolved.

Sources of Funding

Monthly nursing homes funding for a Medicaid eligible resident is computed in the following manner:

Daily Medicaid Patient Rate	x	Number of Days Patient in the Home	=	Amount Due Nursing Home
Amount Due Nursing Home	-	Resident's Share[8]	=	Medicaid Program Share

The Medicaid program share is paid from:

- Federal funding (approximately 60 percent)

[8] Any monies (social security, pension, etc.) received that would cause the assets of a nursing home resident to exceed the $1,000 retention limit.

- State funding along with redistribution of Nursing Facility Reimbursement Allowance (NFRA) tax assessments (approximately 40 percent). NFRA taxes are further discussed below.

Nursing homes also may receive funding under the federal Medicare program or private payments either from individuals or insurance companies.

(See Appendix A for actual and estimated nursing home Medicaid funding sources for the five fiscal years ending June 30, 2002.)

Rate Increases

Missouri has generally granted nursing homes annual rate adjustments based on a trend factor or adjustment for inflation. The DMS annual budget request increase for nursing home Medicaid funding is based on the Health Care Financing Administration (HCFA) Market Basket Index for Nursing Homes, a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one year. The legislature generally appropriates a fixed amount of funding for the nursing home Medicaid program. The following table indicates the actual HCFA trend factors and the granted rate adjustments for the years 1995 through 2001. In addition, to the trend factor, the per-diem rates were increased in two steps by a total of $4.43 in 1996 and 1997 for increases in the minimum wage. The minimum wage increases approximated a 6 percent increase in the rates.

Trend Factors 1995 – 2001

	1995	1996	1997	1998	1999	2000	2001	Compounded
ACTUAL	4.6	3.7	3.4	3.5	3.1	4.5	3.9*	29.95
GRANTED	4.6	7.0**	6.1**	3.4	2.1	1.9	3.0***	31.63

* estimated

** includes additional minimum wage adjustment

*** estimated - rate was adjusted $3.20 per day (quality assurance incentive)

Nursing Facility Reimbursement Allowance

The Nursing Facility Reimbursement Allowance (NFRA) tax was established in 1995. These monies are placed in the state's NFRA Fund. Each nursing facility, except those operated by the Department of Mental Health, is assessed a per-diem provider tax based upon the annualized total patient days as determined from the applicable ICF/SNF Certificate of Need Quarterly Survey compiled by the Department of Social Services - Division of Aging. The tax is assessed on all nursing facilities regardless of whether they participate in the Medicaid program. The DMS determines the NFRA per-diem rate each year based upon the estimated funding requirements of the NFRA Fund. The total amount collected by the tax cannot exceed 6 percent of total nursing home revenue. The DMS has estimated that for fiscal year 2001 the NFRA assessments equal about 5.75 percent of total nursing home revenue. Each facility that participates in the Medicaid program receives as part of the facility's per-diem rate an amount equal to the assessed per-diem tax for each Medicaid day.

The NFRA per-diems in 1995 through 2001 were:

	1995	1996	1997	1998	1999	2000	2001
NFRA	$2.76	$3.55	$5.30	$5.88	$5.88	$7.04	$7.50

In addition to funding the NFRA portion of the per-diem, the NFRA Fund is a source of funding for the patient care, ancillary, multiple component and quality assurance incentives. Up to $1.5 million annually from the NFRA fund is transferred to the Nursing Facility Quality of Care Fund. This provider tax is matched at the federal financial participation rate (about 60 percent).

Cost Component Ceilings

Within the rate structure, cost component ceilings are used to limit reimbursement to the costs that would be incurred by economically and efficiently operated nursing homes. There are three components (patient care, ancillary, and administrative) for which the per-diem rate is limited by a ceiling. The ceilings were set in 1995 based upon a percentage of the median value for each component within the 1992 cost report data. In subsequent years the ceilings have been increased for the granted trend factors except in fiscal year 2001. The following table lists how the ceiling for each component is derived and the ceiling in place at October 1, 1998.

Cost Component Ceilings

Component	Percent of Median	1998 Ceiling
Patient Care	120%	$ 48.56
Ancillary	120%	$ 7.76
Administrative	110%	$ 14.15

For facilities with occupancy rates below 85 percent of the total available number of bed days, the administrative costs must be allocated over an 85 percent minimum utilization factor. This requirement reduces the allowable administrative cost per-diem for low occupancy homes.

Reimbursement for Capital Costs

Missouri uses a fair rental value system to reimburse nursing homes for capital costs. There is no ceiling for the fair rental value component, however, the highest fair rental value per diem in 1998 was $16.98. The primary factors for determining the fair rental value are:

- the asset value assigned to a nursing home bed,
- the age of the bed,
- the 85 percent minimum utilization factor, and
- the interest rate used to determine the allowable return on equity and computed interest.

The current bed value was set at $32,330 per bed in 1994 and has remained constant. The asset value is reduced for the age of the beds at 1 percent per year up to 40 years. Both the return on equity and computed interest factors are limited by the aged asset value. The interest rate for return on equity is set at the 30-year Treasury Bond rate at September 2, 1994 plus 2 percent

(9.48 percent). The interest rate for the computed interest factor is set at the prime interest rate plus 2 percent at September 2, 1994 (9.75 percent).

Working Capital Per-diem

Nursing homes are also granted a rate factor to cover the cost of working capital. The working capital per-diem was implemented to reimburse homes for the cost associated with carrying operating expenses from the time the Medicaid billings are submitted until the payments can be processed. Medicaid payment processing time averages about 4.75 weeks.

Incentives

The rate structure also includes add-on incentives. The following table describes each incentive and the number of homes receiving each incentive as well as the median incentive received for the year ended 1998:

Incentive	Description	Number of Homes	Median Incentive Received
Patient Care	Available to all facilities with a prospective rate	465	$ 4.04
Ancillary	Available to facilities with an ancillary per-diem below the ancillary ceiling for all homes	323	0.95
Multiple Component I	Available to facilities for which the sum of the patient care and ancillary per-diems is greater than or equal to 60 percent but less than or equal to 80 percent of their total per-diem	456	1.30
Multiple Component II	Available to facilities receiving the first multiple component incentive if that home's Medicaid share of occupancy was greater than or equal to 75 percent.	146	0.30

In state fiscal year 2001, facilities were granted a quality assurance incentive of $3.20 per day. Facilities are required to use the monies for direct patient care costs. The state fiscal year 2002 DMS budget proposal replaces this incentive with a 3.9 percent trend factor.

Interim Rates

The Medicaid rates for nursing homes entering the program are set on an interim basis until the base year cost report is received and desk audited. Under current regulations, interim rate homes receive:

- 100 percent of the patient care component ceiling,
- 90 percent of the ancillary and administrative component ceilings,
- 95 percent of the median capital component,
- Working capital component, applicable minimum wage adjustments, and, in fiscal year 2001, the quality assurance incentive.

Interim rate homes do not qualify for the patient care, ancillary or multiple component incentives. The interim rate homes provided 298,292 Medicaid days of service in 1998.

Hospital Based Nursing Homes

Hospital based nursing homes that submit cost reports have their rates set in the same manner as other nursing homes. Hospital based nursing homes providing less than 1,000 Medicaid days per year may submit a cost report and have their rate set in the same manner as other homes. If such homes choose not to submit cost reports, the rate received is based upon 100 percent of the patient care, ancillary, and administrative ceilings plus the capital component median along with the working capital per diem and the patient care incentive. Hospital based nursing homes generally report significantly higher direct care hours per patient day than the typical nursing home. Hospital based nursing homes provided 118,545 Medicaid days of service in 1998.

Rebasing is mandated

Under 13 CSR 70-10.015 (3) (T), the DMS is required to pick at least one cost report year from the cost report years of 1995 through 1999 and compare the costs from the selected cost report year or years to the rate in effect at the time of the comparison. Each facility's reimbursement rate shall be increased or decreased to reflect the allowable costs from the cost report selected. The process of switching base years is called rebasing. However, the regulations do not specify in which year the rebasing must occur.

The DMS has proposed adopting 1998 as the new base year. Under the department proposal:

- The 1998 costs would be trended forward to 2002 and those costs would be used to set the fiscal year 2002 rates.

- The DMS would revise the cost component ceilings to reflect the median costs as determined from the 1998 cost report data.

- The asset value assigned to a bed would rise to $35,327.

- The interest rate for calculation of the return on equity factor of the fair rental value would be 8.25 percent.

- The interest rate used to determine the computed interest and the working capital factors would be 11.5 percent.

- All incentives would be based upon the trended costs.

- The quality assurance incentive granted for fiscal year 2001 would be eliminated and replaced by a trend factor of 3.9 percent for that year.

Explanation of Terminology:

Term	Description
Administrative Costs	Costs for office, management, and maintenance personnel, utilities, maintenance and repair, vehicles, and supplies.
Allowable Costs (costs)	Costs which are allowable under state regulation as determined by the Division of Medical Services using Medicare cost criteria and principles and generally accepted accounting principles (GAAP).
Ancillary Costs	Costs for therapy, lab, x-ray, and laundry and housekeeping services.
Ancillary Incentive	An add-on per-diem if the facility's ancillary per-diem is less than the ancillary ceiling.
Available Bed Day	A day in which a licensed bed is currently staffed and capable of being occupied or is occupied.
Base Year Cost Report	The cost report for the rate setting period which is usually the second full business year after the nursing home provider enters the Medicaid program.
Capital Costs	Rent, leases, insurance, real and personal property taxes, depreciation, amortization, and interest costs.
Computed Interest Per-Diem	The capital debt (limited to facility asset value) times the applicable interest rate (currently 9.75%) divided by the total occupied days with the minimum utilization factor applied.
Cost Component	Groupings of allowable costs used to calculate the per-diem rate. The four cost components are patient care, ancillary, administrative, and capital.
Cost per Patient Day	Total costs or component costs divided by the number of days of service provided to all residents in the cost report period.
Cost Report / Data	A financial and statistical report for each nursing home with required attachments which detail the cost of providing both covered and noncovered services according to the regulations and instructions.
Desk Audit	An audit of the cost report by the DMS conducted where a field audit is not performed.
Fair Rental Value Per-Diem	The per-diem portion of the rate based upon the rental value, and rate of return, computed interest, and pass through factors.

Explanation of Terminology:

Term	Description
HCFA Market Basket Index	An index representing a statistical measure of change in costs of goods and services purchased by nursing facilities during the course of one year published quarterly by DRI/McGraw Hill.
ICF/SNF Quarterly Survey	A survey conducted by the Division of Aging and compiled by the Certificate of Need Program to determine the occupancy rates of nursing homes, both Intermediate Care and Skilled Nursing Facilities.
Medicaid Share of Occupancy	The percentage of total occupied days provided to Medicaid eligible patients.
Minimum Utilization Factor	The requirement that administrative and capital costs components be computed based upon 85 percent of the available bed days if a home's occupancy rate is below 85 percent.
Multiple Component Incentive	An add-on per-diem if the sum of the patient care and ancillary per-diems is in the range of 60% to 80% of the total per-diem. Homes qualifying for this incentive that have a Medicaid Share of Occupancy above 75% receive an additional incentive.
Occupancy Rate	The total patient days divided by the available bed days.
Pass through Expense	Costs for property insurance and real and personal property taxes.
Patient Care Costs (Direct Care)	Costs for nurses, aides, orderlies, activity, social service and dietary employees, food, medical supplies, and nonprescription drugs.
Patient Care Incentive	An add-on per-diem equal to 10% of the patient care per-diem capped at 130% of the patient care median.
Patient Day	The period of service rendered to a patient between the census-taking hour (12 A.M.) on two consecutive days and includes allowable temporary leave-of-absence and hospital leave days.
Per-Diem	The daily rate calculated under the regulations using cost components in determination of the prospective or interim rate.
Profit Margin	As used in this report, (total patient related revenues less allowable costs) divided by total patient related revenues.
Rebase/Rebasing	Adjusting the Medicaid reimbursement rates by changing the base year upon which the rates are determined.

Explanation of Terminology:

Term	Description
Reimbursable Costs	Costs that are allowable and do not exceed cost component limits and are not excluded due to the minimum utilization factor.
Trends/ Trend Factors	The annualized actual or estimated increase in costs based upon the HCFA Market Basket Index.
Working Capital Allowance	The per-diem calculated as the sum of the patient care, ancillary and administrative per-diems times 1.1 divided by 12 times the applicable interest rate (currently 9.75%). This per-diem approximates the cost of financing operating expenses from the provision of services until payment is received.

APPENDICES

APPENDIX A

SOURCES OF MEDICAID FUNDING
FIVE FISCAL YEARS ENDING JUNE 30, 2002

FISCAL YEAR	STATE FUNDS	FEDERAL FUNDS ****	NFRA TAX	RESIDENT FUNDS***	TOTAL NURSING HOME MEDICAID FUNDING
2002**	220,059,829	529,967,478	120,198,437	209,364,084	1,079,589,828
2001*	169,305,808	449,274,311	119,144,530	201,422,839	939,147,488
2000	150,336,660	440,052,450	105,700,671	192,462,192	888,551,753
1999	156,390,272	437,516,185	95,368,447	178,279,578	867,554,482
1998	149,286,641	424,787,975	93,687,417	169,874,762	837,636,795

* SFY 2001 - estimated
** SFY 2002 estimated with rebasing adopted
*** Primarily Social Security income
**** Does not include Intergovernmental Transfer Program activity

APPENDIX B

NURSING HOMES - ALLOWABLE COSTS VERSUS MEDICAID RATES BY VARIOUS CATEGORY - 1998
NUMBER OF NURSING HOMES BY CATEGORY

Line Description	Line Total	Medicaid Rate minus Allowable Costs Per Day						
		($25) or less	$(15-24)	$(5-14)	$(0-4)	$0-4	$5-14	$15 or more
# of Homes in Category	489	66	47	111	63	71	106	25
Prospective Rate	450	52	42	107	62	68	99	20
Other Rate Type	39	14	5	4	1	3	7	5
Metro Location	150	25	16	43	20	18	19	9
Rural Location	339	41	31	68	43	53	87	16
High Occupancy	219	20	16	54	27	33	53	16
Lower Occupancy	270	46	31	57	36	38	53	9
High Medicaid Share	127	13	12	29	16	19	31	7
Lower Medicaid Share	362	53	35	82	47	52	75	18
For Profit	344	38	41	75	43	52	74	21
Nonprofit	145	28	6	36	20	19	32	4
Chain Affiliated	291	38	37	75	37	35	57	12
Not Affiliated	198	28	10	36	26	36	49	13
Revenue>Expense	331	8	15	62	54	65	102	25
Revenue<Expense	158	58	32	49	9	6	4	0
# of Ceilings Exceeded:								
None	50	0	0	1	2	7	28	12
One	127	1	2	20	12	30	51	11
Two	153	13	13	38	33	28	26	2
Three	121	26	24	48	16	6	1	0
Four	38	26	8	4	0	0	0	0
Exceeded Ceiling:								
Patient Care	187	55	23	50	23	21	15	0
Ancillary	377	63	45	98	57	50	55	9
Administrative	271	48	38	83	33	27	36	6
Capital > $16.98	113	43	26	25	13	6	0	0
Medicaid Days Provided	9,502,057	979,507	1,044,400	2,421,852	1,381,423	1,369,044	1,911,202	394,629

The Medicaid business in 1998 for nursing homes on the left of the chart was not profitable while it was profitable for those on the right of the chart. The differences appear to be due to the type of nursing home, the home's overall occupancy and ability to keeps costs below the ceiling limits. Homes at each end of the chart provided a small percentage (14 percent) of the state's nursing home Medicaid services.

APPENDIX C

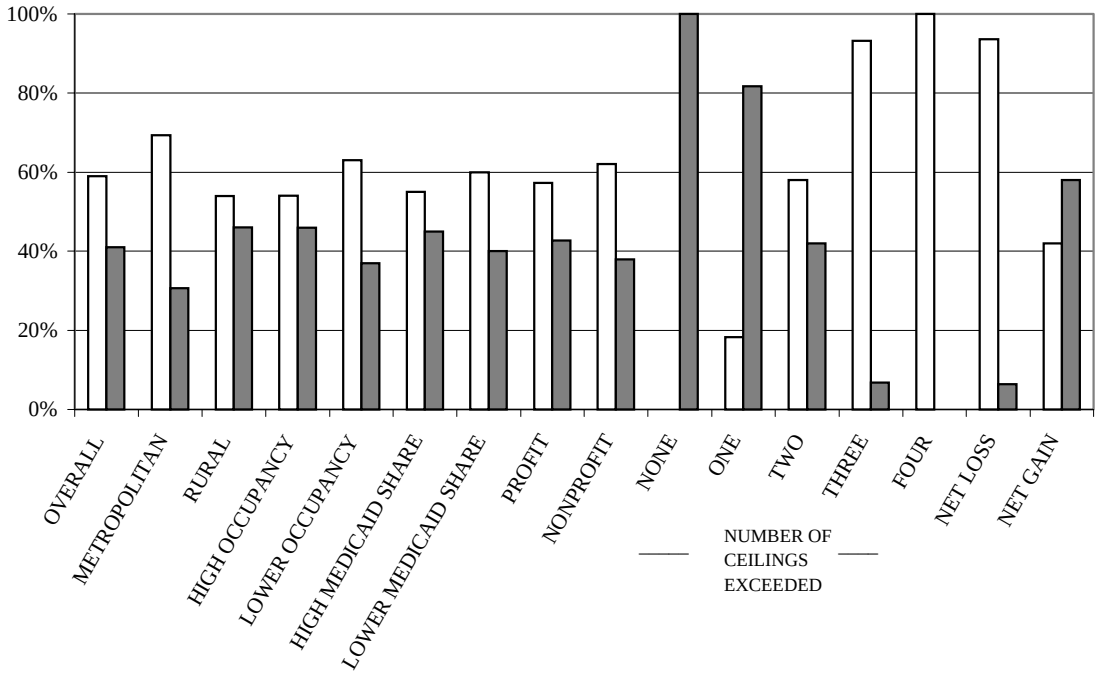
NURSING HOMES - ALLOWABLE COSTS VERSUS MEDICAID RATES BY VARIOUS CATEGORY - 1998
PERCENTAGE OF HOMES BY CATEGORY

Line Description	Line Total	Medicaid Rate minus Allowable Costs Per Day						
		($25) or less	$(15-24)	$(5-14)	$(0-4)	$0-4	$5-14	$15 or more
# of Homes in Category	489	66	47	111	63	71	106	25
Prospective Rate	92%	79%	89%	96%	98%	96%	93%	80%
Other Rate Type	8%	21%	11%	4%	2%	4%	7%	20%
Metro Location	31%	38%	34%	39%	32%	25%	18%	36%
Rural Location	69%	62%	66%	61%	68%	75%	82%	64%
High Occupancy	45%	30%	34%	49%	43%	46%	50%	64%
Lower Occupancy	55%	70%	66%	51%	57%	54%	50%	36%
High Medicaid Share	26%	20%	26%	26%	25%	27%	29%	28%
Lower Medicaid Share	74%	80%	74%	74%	75%	73%	71%	72%
For Profit	70%	58%	87%	68%	68%	73%	70%	84%
Nonprofit	30%	42%	13%	32%	32%	27%	30%	16%
Chain Affiliated	60%	58%	79%	68%	59%	49%	54%	48%
Not Affiliated	40%	42%	21%	32%	41%	51%	46%	52%
Revenue>Expense	68%	12%	32%	56%	86%	92%	96%	100%
Revenue<Expense	32%	88%	68%	44%	14%	8%	4%	0%
# of Ceilings Exceeded								
None	10%	0%	0%	1%	3%	10%	26%	48%
One	26%	2%	4%	18%	19%	42%	48%	44%
Two	31%	20%	28%	34%	52%	39%	25%	8%
Three	25%	39%	51%	43%	25%	8%	1%	0%
Four	8%	39%	17%	4%	0%	0%	0%	0%
Exceeded Ceiling								
Patient Care	38%	83%	49%	45%	37%	30%	14%	0%
Ancillary	77%	95%	96%	88%	90%	70%	52%	36%
Administrative	55%	73%	81%	75%	52%	38%	34%	24%
Capital > $16.98	23%	65%	55%	23%	21%	8%	0%	0%
Medicaid Days Provided	100%	10%	11%	25%	15%	14%	20%	4%

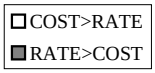
This table displays the values from Appendix B as a percentage of the homes falling into each category divided by the number of homes in that category.

APPENDIX D

STATUS OF NURSING HOME INDUSTRY 1998
COSTS vs. RATES



THIS CHART INDICATES THE PERCENTAGE OF EACH GROUP FOR WHICH THE COSTS EXCEEDED THE RATES AND THE RATES EXCEEDED THE COSTS IN 1998. IT SUMMARIZES THE DATA FOUND ON APPENDIX B AND C.



APPENDIX E

NURSING HOMES - ALLOWABLE COSTS VERSUS MEDICAID RATES
MEDIAN STATISTICS - 1998

Line Description		All Homes	Medicaid Rate minus Allowable Costs Per Day						
			($25) or less	$(15-24)	$(5-14)	$(0-4)	$0-4	$5-14	$15 or more
# of Homes in Category		489	66	47	111	63	71	106	25
MEDIAN:									
Patient Related Revenue	$	94.40	108.24	102.53	99.23	94.85	90.04	87.29	91.64
Allowable Costs	$	90.29	126.66	106.65	96.77	90.47	83.25	76.35	71.48
Net Revenue	$	4.75	(25.07)	(6.32)	2.27	4.17	7.41	11.36	20.44
Medicaid Rate	$	87.98	91.58	87.73	88.51	87.83	86.04	85.86	90.74
Rate/Cost Differential	$	(3.34)	(36.68)	(18.88)	(9.63)	(2.80)	2.47	8.61	18.55
Net Revenues/Total revenues		5.44%	(18.17%)	(5.53%)	2.43%	4.66%	8.01%	13.05%	22.16%
Direct Care Hours Per Day		2.94	3.57	2.89	2.97	2.94	2.93	2.85	2.73
Wage Per Hour	$	10.27	11.54	11.09	10.85	10.31	9.89	9.57	9.79

APPENDIX F

AVERAGE 1998 MEDICAID RATES BY STATE

STATE	AVERAGE RATE	RANKING	STATE	AVERAGE RATE	RANKING
Alabama	98.69	20	Montana	87.54	32
Alaska	253.48	1	Nebraska	81.96	37
Arizona	88.23	31	Nevada	86.17	33
Arkansas	61.98	50	New Hampshire	115.07	10
California	83.12	34	New Jersey	115.76	9
Colorado	101.55	18	New Mexico	129.04	5
Connecticut	133.83	3	New York	158.93	2
Delaware	108.56	13	North Carolina	95.12	22
Florida	97.99	21	North Dakota	94.31	23
Georgia	78.43	42	Ohio	108.96	12
Hawaii	130.42	4	Oklahoma	64.20	49
Idaho	94.26	24	Oregon	89.18	28
Illinois	74.23	44	Pennsylvania	114.23	11
Indiana	80.32	40	Rhode Island	103.97	17
Iowa *	71.70	46	South Carolina	82.75	36
Kansas	71.94	45	South Dakota	76.96	43
Kentucky	88.81	29	Tennessee	81.16	38
Louisiana	65.54	48	Texas	71.69	47
Maine	115.77	8	Utah	83.11	35
Maryland	98.88	19	Vermont	104.10	16
Massachusetts	116.63	6	Virginia	79.47	41
Michigan	91.49	27	Washington	116.00	7
Minnesota	106.47	14	West Virginia	106.27	15
Mississippi	80.60	39	Wisconsin	91.70	26
Missouri	88.34	30	Wyoming	93.78	25

*Iowa rate for nursing facilities. The rate for Skilled Nursing Facilities was $125.59.

Source: *1998 State Data Book on Long Term Care Program and Market Characteristics, Harrington, C., Ph.D., et al, Nov 1999.*