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Modeling the Impact of Declining Occupancy on Nursing Home Reimbursement

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Summary

The states and the Centers for Medicare & Medicaid Services (CMS) have undertaken significant efforts in the development of home and community based services (HCBS) to assure that services are provided in the most appropriate setting and that the institutional emphasis of Medicaid is reduced. These efforts have been supported, in part, by transition or diversion grants, of which the latest and the largest is the Money Follows the Person (MFP) demonstration.

As the states begin their MFP demonstrations, there has been concern expressed about "the amount of money that does not follow the person." Given the cost-based nature of state reimbursement systems, certain costs will be "left" and incorporated into the rates for the remaining nursing home residents.

The purpose of this paper was to examine the effect of occupancy rates on nursing home reimbursement in the context of these state and federal efforts to change the institutional emphasis of Medicaid long-term care. The examination first looked, in general, at reimbursement policies in use across the nation.

Six states were then selected to respond to a survey and follow-up interviews to collect information concerning their transition and diversion efforts and their reimbursement methodologies. From the six, California, Indiana, and Pennsylvania were selected to model the impact of three different occupancy rate assumptions, each on a hypothetical facility's rate calculation resulting in nine models.

In summary, the analysis of these nine models indicate that given the effect of existing rate-setting parameters, much of "the fixed costs" and "the fixed component of variable costs" would not get calculated back into the rates paid for on-going nursing home services. The costs that do would be evenly allocated across all resident days used

in rate setting regardless of payer source, including Medicare and private pay days also limiting the impact to Medicaid.

Background

Institutional Bias

Medicaid was enacted in 1965 as a companion program to Medicare. Provisions of Section 1905 (a) of the Social Security Act, implemented in 42 CFR 440 Subpart A, defined the mandatory and optional services to be provided if a state opted to participate in the program. Medicaid initially paid for services provided mainly in institutions such as intermediate care facilities for persons with mental retardation (ICF/MR) or nursing homes (NH). Nursing home stays were included in the list of Medicaid services, but home and community services were not. This original institutional emphasis has lead to an "institutional bias."

Section 2176 of the Omnibus Budget Reconciliation Act (OBRA) 1981 amended the Social Security Act by creating section 1915 authorizing Medicaid paid home and community based (HCB) services for persons who would otherwise receive services in an institution.[1] However, there is still regulatory language, both federal and state, that reflects the institutional emphasis of Medicaid and affects an individual's relative preference for institutional services. The following two examples help clarify the potentially vague concept of "institutional bias."

First, to be eligible for HCB services, an individual must meet nursing home or other institutional level of care and must have his/her level of care reassessed every year to determine continued eligibility [2]. There is no comparable requirement in the Code of

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[1] For a description of the 1915c waiver requirements see LeBlanc, Tonner, & Harrington. (2000, Winter) http://findarticles.com/p/articles/mi_m0795/is_2_22/ai_74798219

[2] The requirement for annual assessments as a condition of receiving HCBS is found in the Technical Guidance for item B-6-g "Re-evaluation Schedule" of the CMS Instructions, Technical Guide and Review Criteria for HCBS waiver applications. For a copy of this document see https://www.hcbswaivers.net/CMS/faces/portal.jsp

Federal Regulations (CFR) for a person in a nursing home. Consider an individual receiving Medicaid benefits who has resided in a nursing home for several years. In states that do not elect to complete annual re-determinations in nursing homes, there is the possibility that this person will lose Medicaid eligibility if he/she leaves the nursing home. This may happen if the individual seeks to obtain home and community services and is given the required level of care assessment. If the screening determines the person to be ineligible for nursing home services, Medicaid eligibility can be lost.

A second bias relates to the medically needy programs in use in conjunction with nursing home services in about 30 states, according to the Center for Medicare & Medicaid Services (CMS) records. These medically needy programs permit individuals who are over income to "spend down" to Medicaid limits if their medical bills are sufficiently large. A person with an income of $6,500 a month and a nursing home cost of $6,000 a month can become eligible for Medicaid through the medically needy option. If the state does not have a medically needy program for HCB services, the same person in the community will have to pay out of pocket for services. Again consider the individual who has resided in a nursing home for several years. The person can lose their Medicaid eligibility when transitioning to HCB services if his/her income level is too high and the state does not have a HCBS medically needy program. A variant on this bias is the state's use of a medically needy program for HCB services with a lower income level than the medically needy program for nursing facility services.

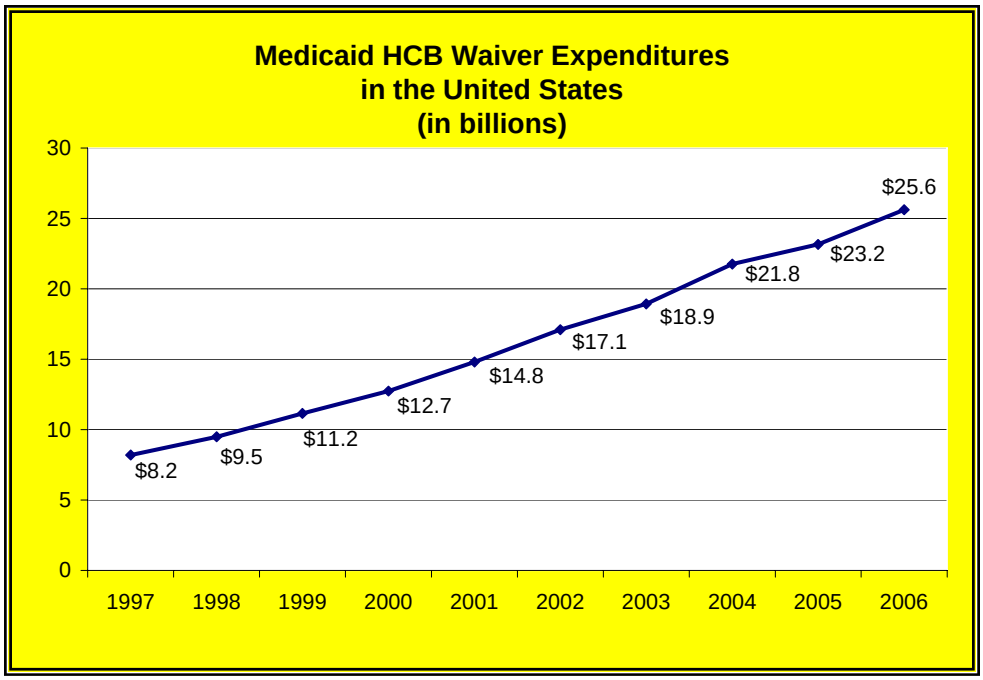
Growth in Home and Community Based Services

Federal authority began to balance the institutional emphasis by changing the Medicaid program to allow it to provide more home and community related services. The growth of the HCBS program has been steady throughout its history, with more pronounced recent growth due to legal pressure, activities of disabilities advocates and the federal emphasis on expanding HCB service options[3].

[3] As of 3-1-08 the Waivers and Demonstration Website of the Centers for Medicare & Medicaid Services showed 458 waivers and demonstrations.

The services authorized by Section 1915 are called waiver programs. Under the waiver authority, states can wave the requirements of "state wideness" and "comparability" and provide specific services to specific target groups, established through the waiver approval process and place limits on the number of people who receive services. Using waivers, states can provide services not usually covered by the Medicaid program, as long as these services are required to prevent a person from being institutionalized. Services covered under waiver programs include case management, homemaker, health aide, personal care, adult day health, habilitation and respite care to name a few.[4] Chart 1 shows the growth in the HCBS program from $8.2 billion in 1997 to $25.6 billion in 2006.

Chart 1: Growth in the HCBS Waiver Programs in the United States



Source: HCBS Clearing House for the Community Living Exchange Collaborative, Medicaid HCBS Waiver Expenditures www.hcbs.org. Data source CMS 64 data, Center for Medicaid and State Operations, Division of Financial Operations.

[4] Personal care and home health services are mandatory Medicaid state plan services that may be covered by some states' Medicaid home and community based programs or programs that are state-funded.

The New Freedom Initiative (NFI), introduced by the Bush administration on February 1, 2001 and followed by Executive Order 13217 on June 18, 2001, was a nationwide effort to remove barriers to community living for people of all ages with disabilities and long-term illnesses. This unprecedented initiative supported states' efforts to modernize their programs and infrastructure to meet the goals of the *Olmstead v L.C.*, a Supreme Court decision that requires states to administer services, programs and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[5]

CMS provided funding opportunities to assist states in implementing change. One such opportunity is the impressive Real Choice Systems Change grant program. Since 2001, 332 grants have been issued awarding approximately $270 million to the 50 states, the District of Columbia and two U.S. territories. [6]

States have been rebalancing the way Medicaid long-term care services are delivered and financed, but still vary greatly in the proportion of Medicaid long-term care funds expended on HCB services.[7] For example, according to the American Association of Retired Persons (AARP) publication "Across the States Profiles of Long Term Care and Independent Living," Oregon and New Mexico spent over two-thirds of their long-term care dollars on HCB services while Mississippi and Washington DC spent less than 20 percent in 2005.

In February 2006, Congress enacted the Deficit Reduction Act (DRA) of 2005, which created the Money Follows the Person rebalancing demonstration. The idea of "money follows the person" is to allow money to be attached to an individual's needs rather than to a particular setting. This is the largest demonstration program in the history of Medicaid, providing $1.75 billion in funding. The demonstration provides enhanced

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[5] *Olmstead,* Commissioner, Georgia Dept. of Human Resources, et al. v. L. C., by Zimring, guardian ad litem and next friend, et al. No. 98—536. Argued April 21, 1999–Decided June 22, 1999

[6] See http://www.cms.hhs.gov/RealChoice/

[7] The word "rebalancing" implies that something had been balanced previously. The concept of "balancing" was first brought to national attention by: Ladd, Kane, & Kane (1999, April). This report was an update of 1992 work and does not appear to be available on-line.

federal funding for twelve months for each person that has lived in an institution for at least six months and is transitioned to a qualified community residence.

The demonstration projects goals are to:

- Increase the use of HCB services;
- Eliminate barriers that restrict the flexible use of Medicaid funds to provide necessary services to individuals eligible for Medicaid in the setting of their choice;
- Increase the assurance that HCB services will be provided to eligible individuals; and,
- Ensure procedures are in place to provide quality and quality improvement.

CMS awarded demonstration grants to 31 states in two phases: Phase I awarded grants to 17 states proposing to transition 23,604 individuals from nursing homes or Intermediate Care Facility for the Mentally Retarded (ICF/MR) back to the community and Phase II awarded grants to 14 additional states proposing to transition 14,127 individuals. The grants assist states in their rebalancing efforts and provide information to CMS on how states reduce reliance on institutions while managing costs and quality.[8]

Reimbursement Methodologies

The waivers and demonstration grants have a cost neutrality test. The cost of care provided under these programs cannot exceed the projected cost of services provided in a nursing home or other institutional setting. A persistent concern in the discussion of rebalancing is the impact of decreasing occupancy on the nursing home per diem rates.

Although the money to pay for the services "follows the person" from the institutional setting, the question remains as to how much of the difference between the costs of care in the institution and community can be considered a savings. How much of the cost remains at the institution? In theory, when institutions are reimbursed on a cost-based system, as residents are transitioned from the nursing home the occupancy rates

[8] Mathematica Policy Research Inc. Money Follows the Person Demonstration Grants: Summary of State MFP Program Applications August 31, 2007

decrease, thereby spreading the fixed portion of costs across a smaller base and likely increasing the cost of each unit of service. These increased nursing home per diem costs, if incorporated into the rate calculation, would increase the overall cost of long-term care services to the state and potentially reduce dollars available for additional home and community based services. If not reimbursed by Medicaid or other payers, the increased nursing home per diem costs could create access issues for appropriate nursing home placement. To understand the potential impact of rebalancing on the cost of nursing home care, it is important to understand reimbursement methods employed in the states.

In addition to the discussion presented in this document, it may be useful for the reader to refer to several of the reports produced by the Rutgers Center for State Health Policy that cover the topics of cost-effectiveness and funding practices in nursing home transition. The Center has done extensive research in this area as part of its technical assistance activities for grantees of the Real Choice Systems Change grant, funded by the Centers for Medicare & Medicaid Services.[9]

To assist in reading the report, it may be helpful to establish definitions for frequently used terms.

- *Retrospective reimbursement:* Payment of an interim rate that is settled to actual costs at the end of a set period.
- *Prospective reimbursement:* Payment of rates based on historical data or budget projections with no subsequent settlement to actual costs.
- *Flat rates:* Rates established by dividing available budget dollars by case load projections or anticipated units of service.
- *Price-based:* A standard price established for all providers within the state or peer group. The price determination may be linked to the actual cost experience of the effected provider group.
- *Cost-based:* A provider-specific rate determined by using the provider's own cost experience or budget projections.

[9] See the "Product List" at Rutgers CSHP Community Living Exchange: http://www.cshp.rutgers.edu/cle/. Reports include, *Money Follows the Person: State Approaches to Cost Effectiveness; Money Follows the Person; Financing and Budgeting; Reducing Nursing Home Utilization and Expenditures and Expanding Community-Based Options;* and others.

- *Historical cost:* Actual cost experience determined from a completed fiscal period.
- *Budgeted cost:* Projected cost experience for a future fiscal period.
- *Fixed Costs:* Expenses that do not change in proportion to the activity of a business with a relevant period of production.
- *Variable Costs:* Expenses that change in relation to the activity of the business.
- *Marginal Costs:* The change in total cost attributable to the production of one additional unit of service.
- *Peer groups:* Providers with similar characteristics such as size, specialty, ownership or location (rural or urban).
- *Projected Inflation factors:* A factor used to project inflation that providers will experience during the rate period.

States have considerable latitude in the methods used to reimburse for long-term care services and may use different methods for different services. Because of the broad language of the Medicaid legislation, each state has developed its own unique payment methodology.

Provider-Independent Rates

Reimbursement systems may be provider-independent or provider-dependent. Rates that are not based on a particular provider's costs are *provider-independent rates*. Both flat rate and pricing systems are provider-independent rates. In these systems, providers are reimbursed according to a set flat rate or an established price regardless of their individual cost experience.

Flat rate systems rates are established by determining available dollars within the state budget for a particular service and dividing that amount by a projection of case load or anticipated units of service.

Prices may be established through the creation of a hypothetical provider and the determination of necessary inputs and market prices for those inputs. Prices can also be

developed based on benchmarks, such as means, medians or percentiles of the cost experience of the provider group.

Provider-Dependent Rates

A common feature of a *provider-dependent* rate system is that the reimbursement to each provider is linked in some way to its particular costs, whether projected or historical. There is considerable variability in the design of provider-dependent rates. Provider-dependent rates can either be retrospective or prospective in nature.

Retrospective systems establish an interim rate by using cost estimates, which are used to make payments during the rate period. After the rate period ends and actual cost experience is determined, there is an adjustment made from interim rates to actual cost experience. Interim rates can be established using either budget projections or historical costs of a prior period. In calculating the settlement to actual costs, upper limits or ceilings may be imposed, requiring a settlement to the lower of the actual cost experience or the calculated upper limit.

If limits are set too low, this retrospective system more closely resembles a pricing system. However, if limits are set reasonably, it should compensate providers for the provision of services beyond the industry norm. One disadvantage is that these systems lack incentives to control costs and tend to be inflationary. This decreases the state agency's ability to control expenditures and predict future costs. In recent years, both state Medicaid and federal Medicare payments have moved away from retrospective reimbursement systems.

Prospective systems typically use past costs trended forward to establish reimbursement rates. Budget projections or some combination of budgeted and historical costs can also be used. Whatever the basis for establishing rates, they are not settled to actual costs at the end of the rate period.

Prospective systems can also incorporate upper limits or ceilings. For providers with costs below the upper limits, there may be efficiency incentives. Efficiency incentives involve the payment of some portion of the difference between an upper limit and actual costs below the limit. In addition to upper limits, these systems may incorporate lower limits or floors. If there is a floor, the provider is paid its cost or the floor, whichever is greater.

The rates for these systems are based on cost reports submitted by the providers. The rate calculation uses allowable costs, as defined by the state, frequently divided into cost centers or cost components. Examples of cost centers include direct service costs, indirect costs and general and administrative costs.

Inflation, Rebasing and Minimum Occupancy Limits

State reimbursement rules vary in their use of inflation, rebasing and occupancy limit requirements. Once set, rates are normally in place for a specified period of time. Following this pre-determined payment period, rates are evaluated and potentially adjusted for inflation. Widely used indices to determine the inflation adjustment include the Consumer Price Index or various "market basket" indices that are designed to measure changes in prices paid for a fixed bundle of goods and services that are cost inputs to a segment of the health care industry.

Not only are there inflationary increases that impact the cost of providing services, but methods of service delivery may also change. Periodically rates are evaluated for reasonableness and rebased as indicated. States vary in the period of time they use to rebase rates; for example, West Virginia rebases twice a year and New Jersey rebases annually.

States also vary in their use of minimum occupancy limits, the percentage levels used and in the cost centers to which the limits are applied. If applied and a nursing home's occupancy falls below the established level or limit, such as 85% of available bed days, the limit is used to calculate rate per diems rather than actual days.

All State Comparison

In Medicaid reimbursement systems, the impact that declining occupancy would have on reimbursement can be directly linked to the underlying rate formula. Factors that influence the linkage include the rate system's relationship to actual facility costs, whether provider-dependent or independent, the frequency of rebasing or incorporating new cost data into the calculation, cost or growth limits and the stability of the available bed count used to calculate occupancy.

The following matrix was developed using publicly available sources including state supported websites, the American Health Care Association OSCAR data base and the Commerce Clearing House Medicare and Medicaid Guide. With the exception of six states selected for further review, entries on the matrix have not been independently verified.

The matrix details reimbursement characteristics of the systems currently used in the fifty states. At present, all states employ prospective reimbursement in almost every case. The exceptions are Illinois and Kentucky. Illinois reimburses therapy retrospectively and Kentucky reimburses ancillary costs retrospectively. Forty-three states use a facility-dependent or cost-based payment system. The remaining seven states use a pricing system or a combination of pricing and cost known as a blended system. Sixteen states listed use of annual rebasing. The rebasing schedule for an additional seventeen states could not be determined from sources reviewed.

Table 1: State Reimbursement Matrix Rate Setting Parameters
Source: Myers and Stauffer LC, 2008.

State	Prospective or Retrospective	Cost-Based or Price	Cost Centers	Case Mix or Acuity Adjustment See note	Inflation	Rebasing	Incentives	State Occupancy 2001	State Occupancy 2007	MFP/Other
Alabama	Prospective	Cost-Based	Operating Costs Direct Care Costs Indirect Care Costs Property Costs	NH LOC	DRI, Annually	Marshall-Swift Evaluation Service, Annually	None Found	92.05%	88.00%*	
Alaska	Prospective	Cost-Based	Routine Cost Capital costs/routine cost centers Capital costs/ancillary cost centers Costs (excluding capital costs)/ ancillary services	ICF/SNH LOC	Non-Capital: CMS Nursing Home without Capital Market Basket Capital: Skilled Nursing home Total Market Basket Capital Cost component.	Not less than every 4 years Annually if actual per diem costs are ><2% above/below approved rate	None Found	85.75%	86.20%	
Arizona	Prospective	Cost-Based	Primary Care costs Indirect Care costs Capital costs	Managed Care	GDP, Adjusted Annually	None Found	None Found	83.29%	79.00%*	
Arkansas	Prospective	Cost-Based	Direct Care Cost Indirect Care/Admin/Op Cost Fair Market Rental Cost Quality Assurance Fee	Skilled or Intermediate LOC	Market Basket w/o Capital Annually	Annually	None Found	76.59%	72.40%*	MFP
California	Prospective	Cost-Based	Fixed Cost' Property Taxes Labor Cost All Other Costs	NH-A, NH-B LOC	Based on each cost center All other costs is inflated by California CPI	Annually	Not Specified	85.81%	85.80%*	MFP
Colorado	Prospective	Cost-Based	Property Room and Board, except food costs	MDS/RUG	CPI, Annually	None Found	Quality of Care Administrative Cost Incentive	85.80%	83.40%*	
Connecticut	Prospective	Cost-Based	Direct Cost Indirect Cost Fair Rent Capital- Related Administrative & General	Chronic/Convalescent Hospital, Rest Home with Nursing Supervision, Home For the Aged, ICF LOC	CPI (all urban) Annually	No more often than every 2 years, no less often than every 4 years	Incentive to Reserve Beds for Respite Care	93.68%	92.40%*	MFP

State	Prospective or Retrospective	Cost-Based or Price	Cost Centers	Case Mix or Acuity Adjustment See note	Inflation	Rebasing	Incentives	State Occupancy 2001	State Occupancy 2007	MFP/Other
Delaware	Prospective	Cost-Based	Primary Patient Care Secondary Patient Care Support Services Administration Capital	Skilled or Intermediate LOC	CPI, Annually	Primary Patient Care Component – Annually Basic Rate- Every 4 Years	None Found	92.44%	86.50%*	MFP
District of Columbia	Prospective	Cost-Based	Routine & Support Costs Nursing & Resident Care Costs Capital-Related Costs	Skilled or Intermediate LOC	CMS PPS SNF Input Price Index Annually	Every 4 yrs	Efficiency Incentive	93.23%	93.20%*	MFP
Florida	Prospective	Cost-Based	Direct Care Indirect Care	TBI/SCI,SNF	Factor not specified, Annually	None Found	Efficiency Incentive	85.13%	88.80%	
Georgia	Prospective	Cost-Based	Routine & Special Services Dietary Laundry/Housekeeping & Plant Operating/Maintenance Administrative & General Property & Related	MDS/RUG	Factor not specified, Annually	None Found	Efficiency Incentive	91.47%	89.20%*	MFP
Hawaii	Prospective	Price	Direct Nursing General & Administrative Capital Costs	MDS/RUG	Factor not specified, Annually	Annually	Capital Incentive Adjustment G&A Incentive Adjustment ROE Adjustment G&A Small Facility Adjustment Subtotal ´ GET Adjustment	92.70%	95.60%	MFP
Idaho	Prospective	Cost-Based	Property & Utility Costs Non-Property & Non-Utility Costs Efficiency Increments	MDS/RUG	Skilled Nursing home Market Basket +1%	Annually	Efficiency Incentive Quality Incentive	72.53%	74.30%	
Illinois	All But Therapy - Prospective Therapy Costs - Retrospective	Cost-Based	Support Costs Nursing Costs Capital Costs	MDS/NON-RUG	CPI, Annually	None Found	Quality Incentive	82.08%	79.20%*	MFP

State	Prospective or Retrospective	Cost-Based or Price	Cost Centers	Case Mix or Acuity Adjustment See note	Inflation	Rebasing	Incentives	State Occupancy 2001	State Occupancy 2007	MFP/Other
Indiana	Prospective	Cost-Based	Direct Care Indirect Care Therapy Administrative & Capital Costs	MDS/RUG	Nursing Home without Capital Market Basket Index, Annually	None Found	Potential Profit Add-on Payment	76.98%	80.70%	MFP
Iowa	Prospective	Cost-Based	Direct Patient Care Support Costs	MDS/RUG	CMS/SNF Index, every two years	Every two years	Cost Containment Incentive	83.79%	81.70%*	MFP
Kansas	Prospective	Cost-Based	Administration Property Costs Room & Board Health Care Costs	MDS/RUG	Not Specified	At least every 7 years	Efficiency Incentive	87.05%	85.20%*	MFP
Kentucky	All But Ancillary - Prospective Ancillary - Retrospective	Price	Nursing Costs Other Costs	MDS/RUG	Price-Based-Annually	Price-Based SNF-Annually	None Found	91.81%	91.50%*	MFP
Louisiana	Prospective	Cost-Based	Direct Care Administrative & Operating Capital Pass-thru	MDS/RUG	Skilled Nursing Home without Capital Market Basket Index, Annually	In 2008	Direct Care Incentive Quality of Care Incentive	79.80%	74.40%*	MFP
Maine	Prospective	Cost-Based	Direct Care Routine Costs Fixed Costs	MDS/RUG	DRI, Annually	Periodically as determined by the Commissioner of the Department of Health and Human Services	Quality of Care Incentive	89.81%	91.00%	
Maryland	Prospective	Cost-Based	Routine & Administrative Other Patient Care Capital Costs Nursing Services & Therapy	LOC-Light, Moderate, Heavy, Heavy Special/ Ancillary Nursing Services, Therapy	Skilled Nursing home Market Basket	None Found	Efficiency Incentive	85.91%	87.80%	MFP
Massachusetts	Prospective	Cost-Based	Nursing Costs Other Operating Capital Costs Transition Payments Total Payment Adjustments	Level I,II,III, & IV LOC	DRI, Annually	Annually	Efficiency Incentive Outstanding Compliance Incentive Acceptable Compliance Incentive	91.13%	90.70%*	
Michigan	Prospective	Cost-Based	Plant Cost Variable Cost Add-ons	NH LOC Plus Add-On	Nursing Home Market Basket, Annually	Annually	Quality of Care Incentive	87.31%	87.90%	MFP
Minnesota	Prospective	Cost-Based	Care-Related Costs Other Operating Costs	MDS/RUG	CPI-U, Annually	Annually	Efficiency Incentive	93.64%	92.00%*	
Mississippi	Prospective	Cost-Based	Capital-Related Costs Administration & Operating Costs Fair Rental Value	MDS/RUG	Trend Factors to be determined, Annually	Rate calculated each quarter	Direct Care Access Incentive Quality Incentive	89.95%	89.60%*	
Missouri	Prospective	Cost-Based	Patient Care Ancillary Capital Administration	SNF, ICF	1994 and 1995 HCFA Market Basket Index of 3.4% and 3.3% respectively for a total of 6.7%	At Least Annually	Patient Care Incentive Ancillary Care Incentive Multi-Component Incentive Quality Assurance Incentive	76.31%	74.60%*	MFP
Montana	Prospective	Price	Operating Cost Direct Resident Care Cost	MDS/RUG	Not required	None Found	None Found	78.53%	72.50%*	

State	Prospective or Retrospective	Cost-Based or Price	Cost Centers	Case Mix or Acuity Adjustment See note	Inflation	Rebasing	Incentives	State Occupancy 2001	State Occupancy 2007	MFP/Other
Nebraska	Prospective	Cost-Based	Direct Nursing Support Services Fixed Cost	MDS/RUG	7/1/06-6/30/07 = 6%	None Found	Special Needs Incentive	87.34%	83.10%*	MFP
Nevada	Prospective	Price	Operating Direct Health Care Capital	MDS/RUG	None Found	None Found	None Found	79.94%	84.50%	
New Hampshire	Prospective	Cost-Based	Administration Other Support Costs Plant Maintenance Capital-Related Patient Care	MDS/RUG	CMS prospective payment system (PPS) skilled nursing home input price, At Least Annually	At least every five years	Quality Incentive	91.69%	89.40%*	MFP
New Jersey	Prospective	Cost-Based	Patient Care Raw Food General Services Expense Property-Operating Property-Capital	Level I & II LOC, Track I, II, & III	Inflation factor added to base year, Annually	None Found	None Found	88.32%	88.50%	MFP
New Mexico	Prospective	Cost-Based	Cost of meeting certification standards Costs of routine services Facility costs	High & Low Rate Based on Resident Care Needs	Regional Direct Input Price Adj., Factor, Annually	Every 3 years	High Quality NH Care Incentive	90.18%	86.70%*	
New York	Prospective	Cost-Based	Direct Cost Indirect Cost Non-comparable Cost Capital Cost	PRI/RUG	Annually	At least every six years	Improved Performance/Patient Care	94.04%	92.40%*	MFP
North Carolina	Prospective	Cost-Based	Direct Patient Care Administration Maintenance Other Costs	MDS/RUG	Yes	Annually	Quality of Care Incentive	90.84%	88.50%*	MFP
North Dakota	Prospective	Cost-Based	Direct Care Cost Other Direct Care Indirect Care Property cost	MDS/RUG	Annually	At least every four years	Efficiency Incentive	92.74%	91.70%*	MFP
Ohio	Prospective	Cost-Based	Capital Costs Other Protected Costs Direct Care Costs Indirect Care Costs	MDS/RUG	CPI-U, Annually	No more than every three years	Efficiency Incentive Quality Incentive	86.86%	88.10%	MFP
Oklahoma	Prospective	Cost-Based	Direct Care Costs Other Costs	Level I & II, SNF	CPI, Annually	At least annually	Not Specified	70.60%	66.20%*	MFP
Oregon	Prospective	Cost-Based	Not Specified	LOC, Complex Medical Needs Add-On	OR-WA CPI-U, Annually	None Found	Quality of Care Incentive	74.26%	64.50%*	MFP
Pennsylvania	Prospective	Blended	Resident Care Cost Other Resident-Related Cost Administrative Cost Capital Cost	MDS/RUG	CMS Nursing Home Without Capital Market Basket Index, Annually	Annually	Occupancy Incentive on the Administrative and Capital Component Profit limitation Incentive	87.76%	91.50%	MFP
Rhode Island	Prospective	Cost-Based	Pass Thru Items Direct Labor Fair Rental Value Other Operating Cost Center	Skilled, Intermediate I & II LOC	NNHIPI, Annually	None Found	Quality of Care Incentive Cost Incentive	89.74%	93.90%	
South Carolina	Prospective	Cost-Based	General Service & Dietary Cost Laundry/Housekeeping & Maintenance Costs	Skilled, Intermediate I, Intermediate/MR LOC	Federal Market Basket, Annually	None Found	Efficiency Incentive	92.78%	93.10%	MFP

State	Prospective or Retrospective	Cost-Based or Price	Cost Centers	Case Mix or Acuity Adjustment See note	Inflation	Rebasing	Incentives	State Occupancy 2001	State Occupancy 2007	MFP/Other
South Dakota	Prospective	Cost-Based	Direct Care Costs Non-direct Care Costs Plant/Operational Administration Costs Capital Costs	MDS/RUG	Annually, Index not specified	None Found	Cost-Containment Incentive	91.51%	99.90%	
Tennessee	Prospective	Cost-Based	Not Specified	Level I & II LOC	Skilled Nursing home Market Basket Index	Annually	Cost-Containment Incentive	90.10%	88.60%*	
Texas	Prospective	Cost-Based	Fixed Capital Costs Patient Care Costs Dietary Costs Facility Costs Administration Costs	CARE/TILES	CPI-U, Annually	At least annually	Quality Incentive	77.57%	74.40%*	MFP
Utah	Prospective	Yes-Exclusive of NHs that admit high-cost pts that have contract rates	Case Mix Factor General & Administrative Costs Property Costs	MDS/RUG	CMS Market Basket	Yes	Efficiency Incentive	73.85%	71.00%*	
Vermont	Prospective	Cost-Based	Direct Costs Indirect Costs Property-Related Costs	MDS/RUG	NHMB, When specific Cost Center is Rebased	At least every 3 years for Nursing Costs At least every 4 years for Other Costs	Quality Incentive	90.92%	92.00%	
Virginia	Prospective	Cost-Based	Plant/Capital Costs Operating Costs Nurse Aide Training & Competency	MDS/RUG	DRI, Annually	Every two years	Efficiency Incentive	90.33%	90.90%	MFP
Washington	Prospective	Cost-Based	Direct Care Costs Therapy Costs Support Services Variable Return Financing Allowance	MDS/RUG	Factor defined in the biennial appropriations act, Annually	Every three years except Property which is rebased every year	Efficiency Incentive	87.20%	86.70%*	MFP
West Virginia	Prospective	Cost-Based	Standard Services Mandated Services Nursing Services Cost of Capital	MDS/RUG	CPI, Every six months	None Found	Efficiency Incentive	90.85%	88.20%*	
Wisconsin	Prospective	Cost-Based & price based (for support services costs)	Direct Care Costs Support Services Costs Property Tax/Municipal Services Costs Capital Costs	MDS/RUG	Yes	None Found Rebase Annually	Quality of Care Incentive - under development	84.18%	87.70%	MFP
Wyoming	Prospective	Cost-Based	Health Care Costs Capital Costs Operating Costs	Skilled, Intermediate LOC	DRI SNF Market basket	None Found	Incentive Adjustment	82.50%	81.60%*	

Note: Relative Resource Case Mix Systems: MDS/RUG states using the Minimum Data State 2.0 assessment form and the Resource Utilization Group classification system
PRI/RUG New York using the Patient Review Instrument and RUG-II an earlier version of the grouper
CARE/TILE Texas using the Client Assessment Review and Evaluation and the TILE grouper an iteration of RUG-II

* Decrease in occupancy from December 2001 to June 2007

Simplified Rate Example

States that use provider-dependent cost-based rate setting methods and rebase annually should be impacted most by declining occupancy rates. To illustrate this refer to Table 2 for a simple rate example. Data on costs in this example are hypothetical but are based on rate experience in states that includes rate levels and the percent of costs included in each cost center.

Table 2: Hypothetical Rate Example Demonstrating the Potential Impact of Reduced Occupancy on Nursing Home Per Diem Rates

Facility Assumptions:	94 bed facility 34310 bed days available All property costs are fixed The greater the reduction in occupancy the larger the variable portion of direct care costs Three different occupancy levels 97% 84% 64%			
Rate Setting Parameters:	Mean per diem plus a percentage add-on for all cost centers Cost centers	Percentage Add-on		
	Direct Care including therapy	15%		
	Indirect Care	10%		
	Administration	5%		
	Property	0%		
	No cost center limits No minimum occupancy requirement			
Rate Setting Scenarios				
Occupancy Rates:		97%	84%	64%
Resident Days:		33,281	28,981	21,960
Allowable Costs Plus Inflation:	Direct Care cost	$1,982,532	$1,791,311	$1,479,087
	Indirect Care cost	$869,543	$798,765	$683,199
	Administration	$410,434	$401,963	$388,132
	Property cost	$521,493	$521,493	$521,493
Rate Calculation:	Direct Care per diem	$68.50	$71.08	$77.46
	Indirect Care per diem	$28.74	$30.32	$34.22
	Administration per diem	$12.95	$14.56	$18.56
	Property per diem	$15.67	$17.99	$23.75
	Total rate	**$125.86**	**$133.96**	**$153.98**

Consider a nursing home that maintains an average staffing ratio over all shifts of six residents to one direct care aide. Staffing and other direct care costs are usually viewed as variable. If the nursing home's occupancy was reduced by only one resident, there would probably not be a reduction in direct care staff. A small reduction in occupancy or bed days might not reduce direct costs at all. However, if the occupancy was reduced by eight residents, there most probably would be reduction in staff and related costs.

In theory, if the marginal cost of providing an additional unit of service is not elastic or consistent for all additional units of service, there is a fixed nature for a portion of the variable costs. When determining the new per diem rates, this fixed portion of variable costs would be redistributed across the remaining residents in the same manner as any other fixed cost. A review of the literature shows no information about the elasticity of changes in direct costs due to changes in occupancy.

In the example above, indirect care and property costs are assumed to be fixed, regardless of occupancy, while direct care costs drop, but at a slower rate than occupancy. An assumed percentage drop in occupancy from 97% to 84% and a reduction in direct care cost of 9.7% cause the per diem reimbursement rate increases by over 6%. While a reduction in direct care costs from $1,982,532 to $1,479,087, a drop of over 25%, and a reduction in occupancy from 97% to 64%, increases the per diem rate by over 22%.

In practice the larger the reduction in occupancy rates, the larger the portion of costs that are variable.[10] If the occupancy percentage was reduced to 0%, the nursing home would most likely close and all costs would then be variable.

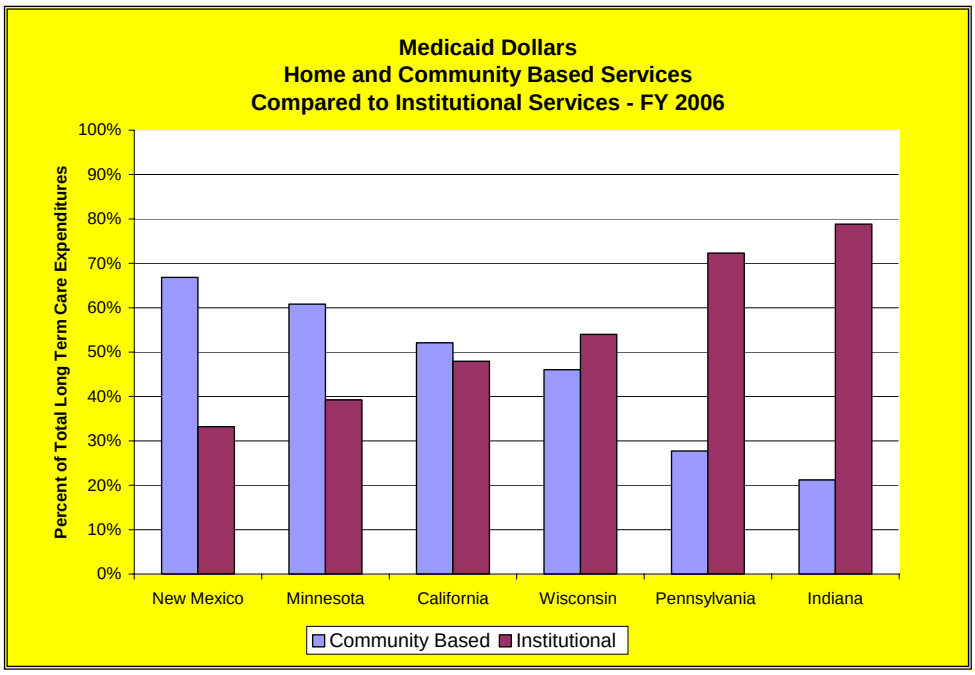
[10] For discussion purposes, costs are frequently distinguished as either "fixed" or "variable." The point of view in this paper is the larger the reduction in occupancy rates, the larger the portion of total costs that function as variable. To illustrate, substantial reduction in occupancy could cause closure of wings, units or potentially entire facilities causing the associated "fixed costs" to decline.

This is a simple example; actual rate setting systems are more complex. To examine reimbursement methodologies in more detail, different occupancy levels will be modeled using selected states' rate setting algorithms. Including parameters such as cost center limits and minimum occupancy requirements in the rate setting methodology can mitigate or control per diem rate increases due only to declining occupancy. Also, states are actively involved in closing, "re-positioning," or "re-purposing" nursing home beds.

Selected State Reviews – Rate Setting Specifics

For this analysis, six states, California, Indiana, Minnesota, New Mexico, Pennsylvania and Wisconsin, were selected for review based on changes in the number of nursing homes, bed capacity and occupancy levels, plus the use of policy initiatives such as "money follows the person", transition and diversion projects that use in-home services, assisted living and adult foster homes. These states, as illustrated in Chart 2 below, have different spending levels on home and community based care versus institutional services. Comparisons are based on the percent of total dollars, due to the large variation in budgets among selected states.

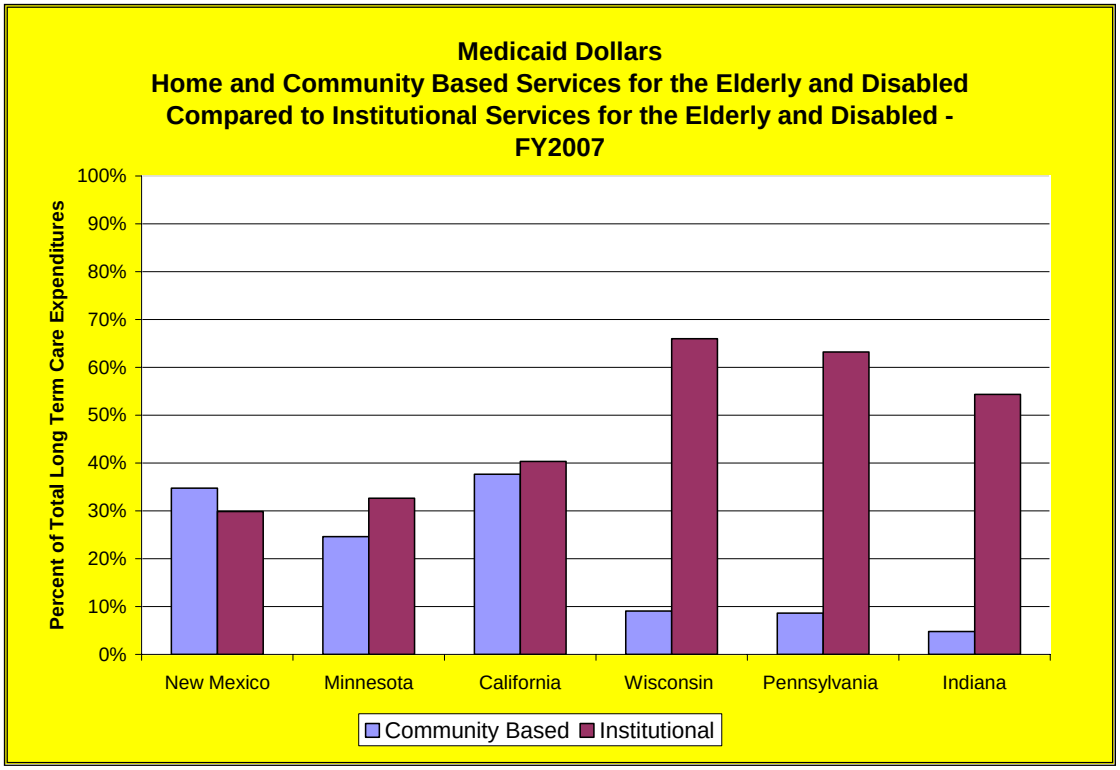
Chart 2: Distribution of Medicaid Long-Term Care Expenditures



Source: CMS 64 data, Centers for Medicare & Medicaid and State Operations Division of Financial Operations

When expenditures for MR/DD services are removed from the analysis represented in Chart 3, there is a significant change in the picture. The wider variance between institutional and home and community services for the aged and disabled is not surprising given the early motivation for the rebalancing efforts began with MR/DD services.[11]

Chart 3: Distribution of Medicaid Long-term Care Expenditures for Older Adults and People with Disabilities (excluding MR/DD)

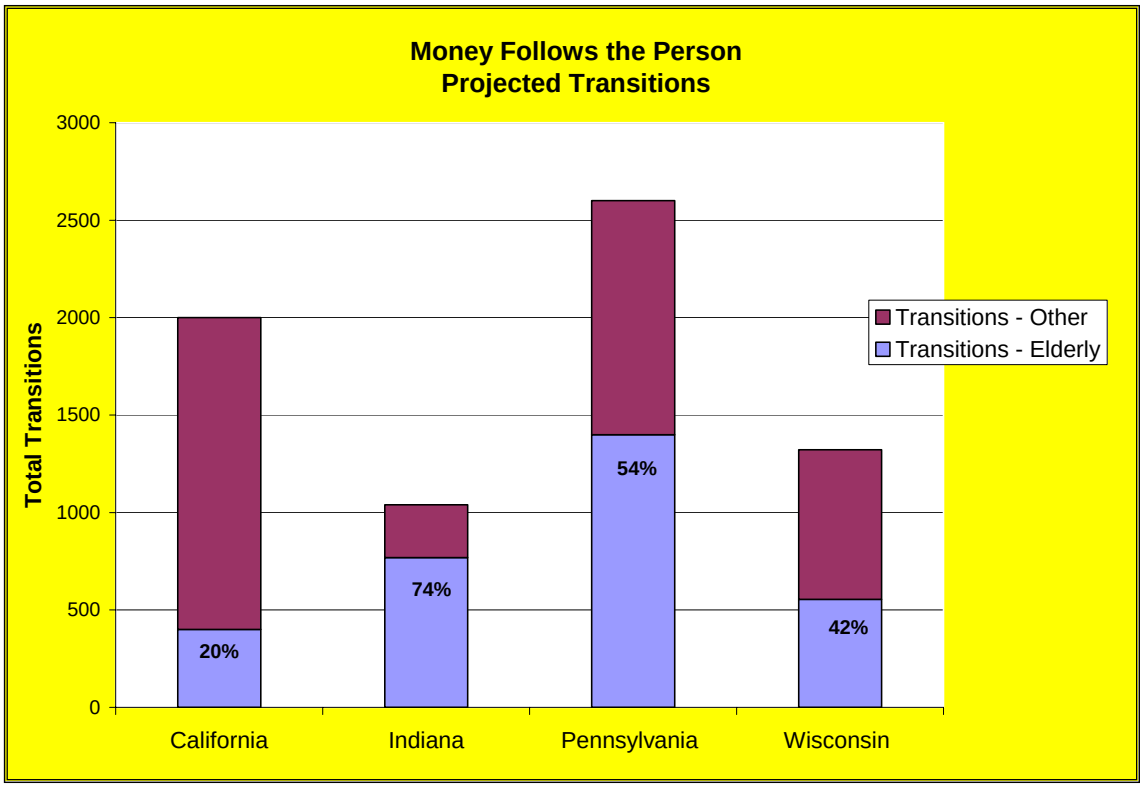


Source: CMS 64 data, Center for Medicaid and State Operations Division of Financial Operations

[11] The growth of home and community based services took place against a backdrop of lawsuits circumscribing states' ability to limit community services for people with developmental disabilities. As of May 2007, such suits had been filed in 25 states: 16 were settled, six were dismissed including the Pennsylvania case of *Sabree vs. Richmond*, and three were pending. While the *Olmstead* decision is widely known, other influential decisions contributed to the cumulative impact of this litigation effort. For example, the 1998 11th U.S. Circuit Court of Appeals decision in the *Doe v. Chiles* lawsuit held that the state of Florida could not limit access to entitled ICF/MR services. The end result of these lawsuits is that on a percentage basis more money is spent on home and community bases services for persons with developmental disabilities than is spend for the elderly and physically disabled

Of the six states selected, California, Indiana, Pennsylvania and Wisconsin have current federal Money Follows the Person demonstration grants and are working on transition or diversion initiatives. Chart 4 shows the projected number of transitions for these four states that are expected to occur during the five-year project, highlighting the percent of those transitions expected to be elderly persons from nursing homes.

Chart 4: Projected Number of Total Transitions for Selected MFP Project States



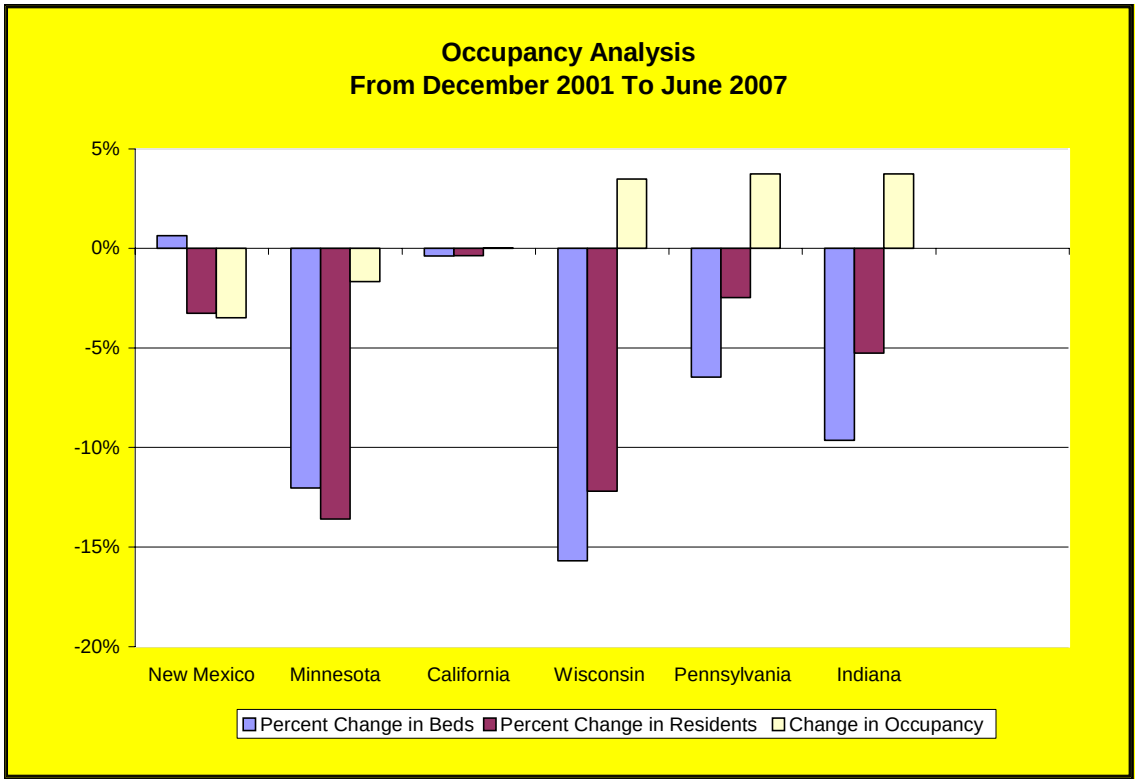
Source: Money Follows the Person Demonstration Grant Program Applications

To better understand the current environments and the transition efforts, each state was sent a survey and asked staffs to provide information on transition and diversion efforts. The questionnaire and a summary of the responses are included in the appendix.

The six states selected for review are at various stages in their transition and diversion efforts. As illustrated in Chart 5, in four of the states the occupancy rates actually increased. By looking at their data, we see five of the six states show a reduction of beds from December 2001 to December 2007, ranging from a 469 bed reduction in

California to a 7,067 bed reduction in Wisconsin. In the six states there was a net reduction of 23,578 beds and 14,487 residents. However, in Wisconsin, Pennsylvania and Indiana the number of beds available decreased faster than the number of residents resulting in an increase in the occupancy percentage.

Chart 5: Analysis of Changes in Occupancy



Source: Myers and Stauffer, 2008

These six states represent both cost-based and blended cost/price reimbursement methodologies. They have different rate parameters, including varying rebasing schedules, minimum occupancy requirements for all or various categories of cost, cost center limits and budget or rate increase caps. They also use different incentives to encourage certain behaviors in the provider community, such as cost containment and closing or repurposing beds.

The following discussion takes a closer look at specifics of their reimbursement methodologies.

California

California's current reimbursement methodology provides for a prospective cost-based system with facilities divided into categories by licensure, and then, with the exception of distinct-part level B facilities, organized into peer groups by level of care, geographic area and/or bed-size. Rates for each category and peer group are based on a facility's annual or fiscal period closing audited cost report.

Adjusted costs are divided into four cost categories that are projected forward to the upcoming rate year using the following update factors:

- Fixed Costs, which typically represent approximately 10.5% of the total costs, are not updated given that these costs are relatively constant from year to year.
- Property Taxes, which represent only about .5% of the total costs, are updated by 2% annually.
- Labor Costs, which include salaries, wages and benefits, typically represent 65 to 70% of the total costs and are updated using a factor developed by the Rate Development Branch staff using labor costs reported by the facilities.
- All Other Costs, which are usually approximately 24% of the total costs, are updated using the California Consumer Price Index.

Any costs that are attributable to federal or state mandates are added to the updated costs to arrive at final projected costs.

Free-standing nursing facilities are categorized as being either level A or B. Level A facilities are peer-grouped by location only. Level B facilities are peer-grouped by both bed size and location. Reimbursement rates are established for each peer group using the median projected costs.

Facilities that are distinct parts of acute care hospitals are not divided by peer group. All facilities comprising this category are paid a rate set at the lower of the individual facility's projected cost or the median projected cost for the category. Facilities

with less than 20% Medi-Cal utilization are excluded from the establishment of the median projected costs.

Indiana

Indiana Medicaid reimburses nursing home providers using facility-specific payment rates based on average per resident day costs and adjusted by case mix. A rate sheet illustrating the Indiana calculation is included in the appendix. There are five rate components: direct care, indirect care, administrative, therapy and capital.

All rate components are adjusted for inflation using the CMS Nursing Home without Market Basket Inflation Index. This is applied to all costs except for certain fixed costs, such as working capital interest. Beginning July 1, 2002 the inflation factor was reduced by 3.3% but not less than zero.

The state employs a minimum occupancy requirement for direct care, indirect care, and administration at 85% for fixed costs with some exception for recent increases. To determine what amount of total costs for each of the above rate components represent fixed costs, analyses were preformed on the types and average amounts of costs within each of these three components. The following fixed cost percentages are applied to the total costs:

- Direct care – 25%
- Indirect care – 37%
- Administrative 84%

There is a provision to recognize and adjust for providers that de-license unused beds. A provider may request an additional rate review before the next annual rate setting to adjust for a revised number of licensed beds.

Therapy costs include the costs of providing therapy (i.e., physical, occupational, speech and respiratory) services to nursing home residents. The therapy component is

equal to the provider's allowable per resident day direct therapy costs. The indirect costs associated with therapy services reimbursed by other payers (primarily Medicare) and non-allowable ancillary services are removed.

The costs for indirect care services are calculated on a per resident day basis. The provider is allowed to receive a profit add-on or 52% of the difference between the indirect care per resident day cost and 100% of the indirect care median. The overall indirect care component limit is 100% of the indirect care median.

The direct care component consists of nursing and nursing aide services, nurse consulting services, pharmacy consultants, medical director services, nurse aide training, medical supplies, oxygen and medical records costs. The costs are calculated on a per resident day basis and adjusted by the facility average case mix index for all residents to arrive at the provider's normalized costs. The normalized cost is then adjusted by the facility's average case mix index for Medicaid residents. The overall direct care rate component is limited to 110% of the direct care median multiplied times the facility average case mix index for Medicaid residents.

The provider is allowed to receive a profit add-on of 60% of the difference between the administrative per resident day costs and 100% of the administrative cost median. The overall administrative component is limited to 100% of the administrative cost median. Capital costs are reimbursed by means of a fair rental value allowance calculated on a per bed basis.

After all the ceilings and limiters are applied, rates are held to an overall Maximum Allowable Increase (MAI), which is 1 + the per annum percentage increase of the previous Annual Medicaid Rate Components, including the MAI.

There is currently a state plan amendment awaiting CMS approval that would add a quality assessment fee to be paid by all nursing home providers with Medicaid utilization greater than or equal to 25% or with revenues greater than or equal to

$700,000. Attached to this state plan are rate parameter changes that would eliminate the inflation factor reduction, increase overall rate limits and increase profit ceilings.

Pennsylvania

Net operating prices for Pennsylvania are established based upon audited nursing facility costs for the three most recent years available in the state's information database, adjusted for inflation. All available data, both audited and un-audited with adjustments, are used for a provider with fewer than three audited cost reports.

Prior to price setting, cost report information is indexed forward to the 6th month of the 12-month period for which the prices are set. The index used is the 1st Quarter issue of the CMS Nursing Home without Capital Market Basket Inflation Index.

Total facility and Medical Assistance (MA) CMI averages from the quarterly CMI reports are used to determine case-mix adjustments for each price-setting and rate-setting period.
The nursing facility's capital rate are based upon the fair rental value of the nursing facility's property, fixed and movable, with a real estate tax component based upon the nursing facility's actual audited real estate tax costs.

The Pennsylvania system uses three CMI calculations: an individual resident's CMI, the facility MA CMI and the total facility CMI, developed using the RUG-III 44-classification grouper to adjust payment for resident care services based.

To set net operating prices, nursing facilities are divided into 14 mutually exclusive peer groups. A peer group with fewer than seven nursing facilities is collapsed into the adjacent peer group with the same bed size.

Prices are set prospectively on an annual basis during the second quarter of each calendar year and are in effect for the subsequent July 1 through June 30 period. Peer

group prices are established for resident care costs, other resident related costs and administrative costs.

Rates are set prospectively each quarter of the calendar year and are in effect for one full quarter. Net operating rates are based on peer group prices, as limited by a price established using adjusted average per-diem costs. A 90% minimum occupancy is required in the calculation of the administration and capital rate per diem. Resident care peer group prices are adjusted for the MA CMI of the nursing facility each quarter and are effective on the first day of the following calendar quarter.

Wisconsin

Wisconsin Medicaid is a national leader noted for innovation, oversight and community involvement in the use of managed care. The Division of Disability and Elder Services operates the Pace and Partnership program and the Family Care program.

Family Care is a voluntary long-term managed-care program where Care Management Organizations (CMO) provide or arrange for services in the Family Care benefit. Each CMO develops a provider network to provide services to Family Care recipients who live in their own homes, nursing facilities, or other group living situations. Family Care will foster recipients' independence and quality of life, while recognizing the need for support to remain independent. The nursing home benefit includes all stays in a facility, including Intermediate Care Facility for People with Mental Retardation (ICF/MR) and people under age 21 or 65 and over who are living in Institution for Mental Disease (IMD). Rates paid for nursing home benefits under Family Care are included in Table 3.

Table 3: Nursing Facility Capitation Rates Wisconsin Family Care

CMO County	Nursing Home	Non-Nursing Home
Fond du Lac	$ 2,324.17	$ 691.71
La Crosse	$ 2,238.09	$ 656.11
Milwaukee	$ 2,220.56	$ 724.55
Portage	$ 2,496.02	$ 666.28
Richland	$ 2,355.28	$ 713.47
Community Care, Inc. (Serves Kenosha and Racine Counties)	$ 2,957.33	$ 689.33

Source: www.dhfs.state.wi.us/LTCare/StateFedRegs/CapitationRates.htm**:**

These rates were developed based on a regression model of functional status developed from CMO-reported experience for calendar year 2006. The functional measures that were used include county, Skilled Nursing Facility (SNF) level of care for the elderly, type of developmental disability for the disabled, number of IADL, ADL and their level of support, interaction among various ADL, behavioral indicators and medication management.

The fee for service nursing home final rates are determined by comparing a facilities base rate, a calculated or "Methods" rate or the inflated projected expenses for direct care, property tax and support services.

Minnesota

The 1995 Minnesota Legislature authorized the Commissioner of the Department of Human Services to establish a contractual alternative payment system. To implement this legislation, the Department established the Alternate Payment System (APS) Contract Project. The purpose of the project is to explore a contract-based reimbursement system

as an alternative to the current cost-based (Rule 50) system. APS facilities are exempt from several of the requirements of the cost-based system for reimbursement, including the filing of cost reports and auditing, the nursing home moratorium process, equalization for short-stay private pay residents and Medicare certification requirements.

Currently 304 of 434 MN Nursing Facilities participate in APS. The Department continues to issue a request for proposals from nursing homes to provide services on a contract basis. The APS Project is viewed as a transitional step toward implementation of performance-based contracting.

In Minnesota there are 36 Case Mix Classifications; the 34 RUG groups, plus two state specific categories, which are the DDF (default) group and the BC1 (lowest in the facility). The DDF group is used when a facility elects to take the rate for a CMI of 1.0 rather than completing a full assessment on a resident staying less than 14 days. The BC1 rate is applied for late assessments, and stays in effect until the 1st of the month following submission of the late assessment.

State law requires nursing homes to charge both private pay and Medicaid residents the same rate for the same services. Nursing homes may charge more for private rooms or other services that are not required to provide. The Minnesota Case Mix Classification system applies to all residents of Medicaid certified nursing homes or boarding care homes.

New Mexico

New Mexico's nursing home rates are prospective, cost-based and rebased every three years. A facility is reimbursed the lower of a rate calculated from audited reported costs or a payment ceiling. An inflation factor, based on the CMS Market Basket Index, may be added to reported costs based on budget availability and department discretion. Rebased costs can not be in excess of 110% of the previous year's audited costs that are adjusted by using the appropriately determined inflation factor. The reimbursement rate is

segregated between operating expense and facility expense, and these rates are calculated separately for reimbursement purposes.

Since rebasing occurs only once every three years, certain circumstances, such as additional costs to meet enhanced requirements or additional costs as a result of uninsurable losses, may warrant an adjustment to the base year. A rate incentive is added to the rate to reduce costs in the operating cost center. It is calculated at half the difference between the operating cost ceiling and the facility's allowable operating costs up to a limit of $2.00 per diem.

To accommodate the federal elimination of the skilled nursing facility/intermediate care facility (SNF/ICF) distinction, two levels of NH services exist representing the care needs of the respective recipients. A high NH rate and a low NH rate are established for each provider. Development of these rates was linked to the provider's SNF/ICF status on September 30, 1990.

In order to insure that the Medicaid program does not pay for costs associated with unnecessary beds, defined by utilization, allowable facility costs are calculated by imputing a 90% occupancy rate for new facilities, replacement facilities or existing facilities that increased beds on or after January 1, 1988.

Rate Modeling

To examine the potential impact of changes in occupancy, we modeled a rate calculation at three different occupancy levels replicating the methodologies in use in California, Indiana and Pennsylvania. These models are included in the appendix.

There are many possible rate-setting methods that can be used in a rate system. We tried to select states for the modeling that incorporate many of the potential rate methods and parameters in their systems. California and Indiana have cost-based prospective systems and Pennsylvania uses a blend of cost and price. Parameters used include cost screens; minimum occupancy requirements applied to specific cost centers

and to an assumed fixed percentage of all costs; case mix adjustments to direct care; profit ceilings and incentives; a pass through of costs such as taxes and insurance and add-ons for quality or provider assessment; fair rental value capital rates, limits applied to individual cost centers or to overall rates; and maximum percentage increases calculated on aggregate state costs.

In an effort to develop rates that could be compared across the states and occupancy levels, we used the same beginning total costs, beds and resident days in the modeling for each state. This was a challenge, given the different cost categories and inflation methodologies. The data for each of the following occupancy levels was used in the state modeling and the same data was also used in the earlier simple example. The reported costs in the table are un-inflated. The Indiana and California examples begin with an assumed inflation calculation, while the Pennsylvania model begins with reported costs that are inflated in the rate calculation. Any component of the rate that was assumed rather than calculated is identified in the description of the model.

Table 4: Data Used in State Rate Modeling

Occupancy Level	Reported Costs	Beds	Bed – Days Available	Medicare Days	Medicaid Days	Total Days
97%	$3,614,417	94	34,310	4,493	20,801	33,281
84%	$3,357,006	94	34,310	3,912	18,113	28,981
64%	$2,938,181	94	34,310	2,965	13,725	21,960

Source: Myers and Stauffer, 2008.

By controlling the cost and bed data for each occupancy level, the variation in calculated rates among the states is a function of the different rate methods. Care has been taken to as accurately as possible replicate the states' rate methods. The standardized costs and days accommodate comparisons, but may impact the level of the resulting rates. This impact would be in total dollars and should not impact the functioning of the rate parameters.

Although cost center limits, profit limits and maximum allowable rate increase limits would most probably change when rates are rebased, the impact of rebasing the state's database was not considered in the models. Changes in rate parameters, calculated on the entire nursing home database, could not be calculated and were held constant in all occupancy level models. Any changes to limits and maximums would impact the findings.

California

California's system is the least complex of the three state methods. Audited costs that have been inflated are divided into cost categories or cost centers. Four of these categories, direct care labor, indirect care labor, direct and indirect care non-labor and administration are limited by benchmark per diem caps developed for each peer group using percentile arrays. The inflation calculation and the assigned peer group were assumed in the California models. Other costs are passed through the rate and not exposed to benchmark caps. These include property tax, liability insurance, license fees and caregiver training. A fair rental value system (FRV) is used in California to reimburse for capital costs. The FRV rate was also assumed in the models.

Add-ons to the rate calculation include a quality assurance fee and a minimum wage adjustment. The add-on rates and the benchmark caps were obtained from the final 2007/2008 rate calculations posted on the California website.[12]

California rates are held to a maximum annual increase of 5.5% of the weighted average Medi-Cal rate for the previous year, adjusted for changes in the cost to comply with new state and federal mandates. The limit was not imposed in the final 2007/2008 rates for California. The potential impact of this limit to final rates, should occupancy levels be reduced statewide, could not be estimated in the modeling.

[12] These are found at www.dhcs.ca.gov/services/medi-cal/pages/LTCAB1629.aspx in download files 2007.08 AB169 Final Rates and 2007.08 Benchmarks

The following table summarizes the results of the California models, assuming the reduction from 97% occupancy to 84% occupancy and then from 84% to 64%. The calculation of savings in this table does not reflect potential changes that would occur in the benchmark caps and the maximum annual increase and is presented to assist in comparing the impact of the rate parameters. It reflects the nursing home costs to the state and does not consider the cost of the alternative HCB services that would be provided.

Table 5: Summary of Modeling for California

California	Fewer Medicaid days	Cost per day at previous level	Saving due to fewer days	Remaining days	Difference in cost	Increased cost of remaining days	Net Savings	% Net Savings
at .84 level	2,688	$ 128.41	$ 345,166	18,113	$ 7.62	$ 138,021	$ 207,145	60.01%
at .64 level	4,388	$ 136.03	$ 596,900	13,725	$ 18.73	$ 257,069	$ 339,830	56.93%

Source: Myers and Stauffer, 2008. See Appendix for California models.

The California table demonstrates the potential impact of occupancy for one nursing home reducing from 97% to 84% occupancy with no reduction in available beds and then again from the 84% to 64%. The simplistic approach in estimating savings would be to multiply the number of fewer Medicaid days times the rate that was then being paid or, at the 84% level in this summary, 2,688 days times $128.41 or $345,166.

Knowing that the simplistic approach overstates the savings by any increase in rate for the remaining Medicaid recipients, we would need to reduce the savings by that amount. In this example, at the 84% occupancy level, the recalculated rate went for $128.41 to $136.03, or a difference of $7.62 per day. Multiplying that increase times the remaining Medicaid days would reduce the potential savings by $138,021.

The net savings for each level of occupancy reduction is 60.01% and 56.93% respectively. Although not 100% of rate times the reduced days, the potential savings to Medicaid is significant. This potential savings reflects the nursing home costs to the state and does not consider the cost of the alternative HCB services that would be provided.

When modeling the rate parameters at the individual provider level, we were unable to estimate the impact of California's Maximum Annual Increase Limit of 5.5%. If aggregate state rates increased at a sufficient rate to invoke this limit, the impact would increase potential net savings.

Indiana

Indiana's system uses several different rate parameters to control costs and create incentives to impact provider behavior. The system uses an 85% minimum occupancy requirement for fixed costs and imposes set percentages to determine the fixed portion of direct care, indirect care and administration. Capital costs are exposed to a 95% minimum occupancy requirement. Rates are adjusted for acuity using the RUG-III classification system. There are two rate add-ons. One is based on a quality report care, which we assumed in the example. The other is based on the amount of the provider assessment divided by the number of total resident days. Profit ceilings are set to encourage efficiency and overall rate limits are used to control costs.

Indiana also imposes a rate maximum limit of 5.5%, but it is applied to a comparison of each individual facility's cost increases rather than a weighted statewide calculation.

Table 6: Summary of Modeling for Indiana

Indiana	Fewer Medicaid days	Cost per day at previous level	Saving due to fewer days	Remaining days	Difference in cost	Increased cost of remaining days	Net Savings	% Net Savings
at .84 level	2,688	$ 128.50	$ 345,408	18,113	$ 3.23	$ 58,505	$ 286,903	83.06%
at .64 level	4,388	$ 131.73	$ 578,031	13,725	$ 1.77	$ 24,293	$ 553,738	95.80%

Source: Myers and Stauffer, 2008. See Appendix for Indiana models

The table summarizes the results of the Indiana models, assuming the reduction from 97% occupancy to 84% occupancy and then from 84% to 64%. The calculation of savings would be the same as that used in the California summary. It does not reflect potential changes that would occur in either the profit ceiling or overall rate limits that are

established from statewide information. It also does not include any adjustment of the maximum annual rate increase requirement. In this example the potential net savings are 83.06% and 95.80%. The increase in savings from the 84% level to the 64% illustrates the effectiveness of the minimum occupancy requirement and the manner in which it is applied.

Pennsylvania

Pennsylvania's system is a blend of cost-based and price. Rates are constructed from the lower of a price established for each peer group or a limited price established using the provider's adjusted per diem costs. In this system, the prices basically act as an upper limit. The per diem costs used in the rate calculation are adjusted for acuity using a RUG-III classification groups and the resulting rates are also case mix adjusted.

One rate parameter that can potentially contain costs, or at least delay recognition of the costs in the rate calculation, is the procedure of averaging the three most recent cost reports to determine the per diems. A minimum occupancy requirement is used in determining per diem costs for administration and capital, which is reimbursed using a fair rental value.

Table 7: Summary of Modeling for Pennsylvania

Pennsylvania	Fewer Medicaid days	Cost per day at previous level	Saving due to fewer days	Remaining days	Difference in cost	Increased cost of remaining days	Net Savings	% Net Savings
at .84 level	2,688	$ 131.94	$ 354,655	18,113	$ 1.72	$ 31,154	$ 323,500	91.22%
at .64 level	4,388	$ 133.66	$ 586,500	13,725	$ 5.19	$ 71,233	$ 515,267	87.85%

Source: Myers and Stauffer, 2008. See Appendix for Pennsylvania models

The table summarizes the results of the Pennsylvania models, assuming the reduction from 97% occupancy to 84% occupancy and then from 84% to 64%. Potential net savings in this example are 91.22% and 87.85% respectively. Pennsylvania's three-year average calculation impacts the savings from year to year, as it would take three

years to fully recognize the impact. We see this reflected as higher savings in the first year.

The calculation of savings does not reflect potential changes that would occur when the prices are re-established from new statewide data. Pennsylvania, unlike the two other states, does not have an overall maximum rate of increase limit. The calculation reflects the nursing home costs to the state and does not consider the cost of the alternative HCB services that would be provided.

Conclusion

Understanding, and if possible, controlling the financial effect of policy and program changes is important to the successful implementation of those changes. A concern over the impact of decreasing occupancy on nursing home per diem rates is appropriate but should not be overstated or allowed to unduly impact policy decisions. Instead, concerned state staffs could conduct analysis of the reimbursement system to estimate the impact of changes given the state's nursing home reimbursement regulations.

Ideally rate parameters should be structured in such a way as to assist the states in attaining its goals. As states work to rebalance their long-term care systems, modeling changes can assist in understanding the impact the rates can have on the achievement of those goals and the impact potential changes may have on the resulting rates.

For comparative and illustrative purposes, this paper focused on a single provider and used hypothetical data that was modeled against actual rate parameters. States attempting to evaluate the impact of reducing occupancy on their rate parameters could apply the methodology from this paper using their state specific rate-setting regulations to gain a quick understanding of the potential. To understand the fiscal implication to a state of a significant policy change, such as Money Follows the Person, would require the use of sound cost projections based on historical cost and occupancy data for all nursing homes in the state. States may also benefit from studies that examine multi-year data on reported costs of nursing homes with changing occupancy rates.

From this limited review, it has been shown that rate setting parameters currently used or available for use in the states' systems can control the impact of decreasing occupancy on the nursing home per diem rates. It also appears that certain parameters may be more effective than others in affecting these desired results.

Minimum occupancy limits are most typically applied to fixed costs. The Indiana minimum occupancy requirement is also applied to a portion of the variable costs by using an established percentage. This method of imposing minimum occupancy appeared to be the most effective in controlling the impact of reduced occupancy, particularly at the extreme level of 64%.

A balanced system of long-term care should improve choice, access, quality of care and quality of life while also containing costs. It should maximize consumer preferences while slowing future budget growth. At a minimum, the reimbursement system in use in the states should be neutral to policy and program goals and should not conflict or work against those goals. Financing or reimbursement systems alone cannot shape policy, they can, however, impact its successful implementation.

Appendices

Rate Models

California Modeling - 97% Occupancy

Occupancy Statistics		Current Cost Report			
	Beds Available	94			
	Total Bed Days Available	34,310			
	Skilled Nursing Medi-Cal Days	20,801			
	Medicare Days	4,493			
	Total Skilled Nursing Resident Days	33,281			
	Occupancy Percentage	97.00%			
	Pier Group based on county	1			
Cost Category		Costs	Per Diem	Per Group Cap	Final Per Diem
	Direct Care Labor	$ 1,982,532	$ 59.57	$ 77.89	$ 59.57
	Indirect Care Labor	$ 627,457	$ 18.85	$ 21.69	$ 18.85
	Direct/Indirect Care Non-Labor	$ 406,035	$ 12.20	$ 19.77	$ 12.20
	Administration	$ 410,434	$ 12.33	$ 15.65	$ 12.33
Pass-Through		Costs	Per Diem		Final Per Diem
	Property Tax	$ 53,250	$ 1.60		$ 1.60
	Liability Insurance	$ 62,901	$ 1.89		$ 1.89
	License Fees	$ 22,964	$ 0.69		$ 0.69
	Caregiver Training	$ 9,651	$ 0.29		$ 0.29
	Fair Rental Value System		$ 6.30		$ 6.30
Add-Ons					
	Quality Assurance Fee		$ 8.27		$ 8.27
	Minimum Wage		$ 0.30		$ 0.30
Reimbursement Rate to Calculate Caps					$122.30
			Uncapped Per Diem	Per Diem Cap	Final Per Diem
Labor-Driven Operating Allocation		$ 208,799	$ 6.27	$ 6.11	$ 6.11
Total Rate Before Maximum Annual Increase Limit *			**$ 128.41**		

* The maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medical rate for the previous year adjusted for the change in the cost to facilities to comply with new state of federal mandates. No limit was applied in the current year.

California Modeling – 84% Occupancy

Occupancy Statistics		Current Cost Report			
	Beds Available	94			
	Total Bed Days Available	34,310			
	Skilled Nursing Medi-Cal Days	18,113			
	Medicare Days	3,912			
	Total Skilled Nursing Resident Days	28,981			
	Occupancy Percentage	84.47%			
	Pier Group based on county	1			
Cost Category		Costs	Per Diem	Per Group Cap	Final Per Diem
	Direct Care Labor	1,791,311	61.81	77.89	61.81
	Indirect Care Labor	582,605	20.10	21.69	20.10
	Direct/Indirect Care Non-Labor	393,108	13.56	19.77	13.56
	Administration	407,829	14.07	15.65	14.07
Pass-Through		Costs	Per Diem		Final Per Diem
	Property Tax	53,250	1.84		1.84
	Liability Insurance	62,901	2.17		2.17
	License Fees	22,964	0.79		0.79
	Caregiver Training	9,651	0.33		0.33
	Fair Rental Value System		6.30		6.30
Add-Ons					
	Quality Assurance Fee		8.27		8.27
	Minimum Wage		0.30		0.30
Reimbursement Rate to Calculate Caps					$129.55
			Uncapped Per Diem	Per Diem Cap	Final Per Diem
Labor-Driven Operating Allocation		189,913	6.55	6.48	6.48
Total Rate Before Maximum Annual Increase Limit *			**$ 136.03**		

* The maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medical rate for the previous year adjusted for the change in the cost to facilities to comply with new state of federal mandates. No limit was applied in the current year.

California Modeling - 64% Occupancy

Occupancy Statistics		Current Cost Report			
	Beds Available	94			
	Total Bed Days Available	34,310			
	Skilled Nursing Medi-Cal Days	13,725			
	Medicare Days	2,965			
	Total Skilled Nursing Resident Days	21,960			
	Occupancy Percentage	64.00%			
	Pier Group based on county	1			
Cost Category		Costs	Per Diem	Per Group Cap	Final Per Diem
	Direct Care Labor	1,479,087	67.35	77.89	67.35
	Indirect Care Labor	509,376	23.20	21.69	21.69
	Direct/Indirect Care Non-Labor	386,017	17.58	19.77	17.58
	Administration	389,588	17.74	15.65	15.65
Pass-Through		Costs	Per Diem		Final Per Diem
	Property Tax	53,250	2.42		2.42
	Liability Insurance	62,901	2.86		2.86
	License Fees	22,964	1.05		1.05
	Caregiver Training	9,651	0.44		0.44
	Fair Rental Value System		6.30		6.30
Add-Ons					
	Quality Assurance Fee		8.27		8.27
	Minimum Wage		0.30		0.30
Reimbursement Rate to Calculate Caps					$147.51
			Uncapped Per Diem	Per Diem Cap	Final Per Diem
Labor-Driven Operating Allocation		159,077	7.24	7.38	7.24
Total Rate Before Maximum Annual Increase Limit *			**$ 154.76**		

* The maximum annual increase in the weighted average Medi-Cal reimbursement rate will not exceed 5.5 percent of the weighted average Medical rate for the previous year adjusted for the change in the cost to facilities to comply with new state of federal mandates. No limit was applied in the current year.

Indiana Modeling – 97% Occupancy

Occupancy Statistics	Current Cost Report								
Beds Available	94								
Total Bed Days Available	34,310								
Medicaid Days	20,801								
Medicare Days	4,493								
Total Resident Days	33,281								
Occupancy Percentage	97.00%								
85% Minimum Occupancy - Fixed Costs	29,164								
95% Minimum Occupancy Capital Costs	32,595								
Case Mix									
Facility Average CMI	1.03								
Average CMI - Medicaid Residents	0.94								
Assessment Add-On									
Non-Medicare Days	28,788								
Assessment Rate	$ 10.00								
Total Assessment	$ 287,880								
Per Diem	$ 8.65								
Quality Add-On Per Report Card	$ 2.50								
Cost Center Per Diem Calculation	Direct Care		Therapy	Indirect Care		Administration		Capital	
Allowable Inflated Costs		$1,973,391	$9,141		$869,543		$410,434	$521,493	
	Variable	Fixed		Variable	Fixed	Variable	Fixed		
Assumed Percentage	75%	25%		63%	37%	16%	84%		
Cost Allocation	$ 1,480,043	$ 493,348	$ 9,141	$ 547,812	$ 321,731	$ 65,669	$ 344,765		
Days Used in Division	33,281	33,281	33,281	33,281	33,281	33,281	33,281	33,281	
Per Diem	$ 44.47	$ 14.82	$ 0.27	$ 16.46	$ 9.67	$ 1.97	$ 10.36	$ 15.67	
	$	59.29	$ 0.27	$	26.13	$	12.33	$ 15.67	
Case Mix Adjust Costs		$ 57.57							
Other Adjustments		$ 54.11							
Median Costs		$ 63.24			$ 31.89		$ 16.58	$ 16.88	
Profit Ceiling Percentage		110%			105%		105%	100%	
Profit Ceiling		$ 65.39			$ 33.48		$ 17.41	$ 16.88	
Profit Add-On		0.65			4.41		3.05	0.73	
Per Diem Costs		$ 54.76			$ 30.54		$ 15.38	$ 16.40	
Ceiling Percentage		120%			115%		105%	100%	
Overall Rate Component Limit		$ 71.33			$ 36.67		$ 17.41	$ 16.88	
Rate Component		$ 54.76	$ 0.27		$ 30.54		$ 15.38	$ 16.40	$ 117.35
Assessment Add-On									$ 8.65
Quality Add-On									$ 2.50
					Total Rate Before Max Limit				**$ 128.50**

Indiana Modeling – 84% Occupancy

Occupancy Statistics	Current Cost Report								
Beds Available	94								
Total Bed Days Available	34,310								
Medicaid Days	18,113								
Medicare Days	3,912								
Total Resident Days	28,981								
Occupancy Percentage	84.47%								
85% Minimum Occupancy - Fixed Costs	29,164								
95% Minimum Occupancy Capital Costs	32,595								
Case Mix									
Facility Average CMI	1.03								
Average CMI - Medicaid Residents	0.94								
Assessment Add-On									
Non-Medicare Days	25,069								
Assessment Rate	$ 10.00								
Total Assessment	$ 250,690								
Per Diem	$ 8.65								
Quality Add-On Per Report Card	$ 2.50								
Cost Center Per Diem Calculation	Direct Care		Therapy	Indirect Care		Administration		Capital	
Allowable Inflated Costs		$1,782,170	$9,141		$798,765		$401,963	$521,493	
	Variable	Fixed		Variable	Fixed	Variable	Fixed		
Assumed Percentage	75%	25%		63%	37%	16%	84%		
Cost Allocation	$ 1,336,628	$ 445,543	$ 9,141	$ 503,222	$ 295,543	$ 64,314	$ 337,649		
Days Used in Division	28,981	29,164	28,981	28,981	29,164	28,981	29,164	32,595	
Per Diem	$ 46.12	$ 15.28	$ 0.32	$ 17.36	$ 10.13	$ 2.22	$ 11.58	$ 16.00	
	$	61.40	$ 0.32	$	27.50	$	13.80	$ 16.00	
Case Mix Adjust Costs		$ 59.61							
Other Adjustments		$ 56.03							
Median Costs		$ 63.24			$ 31.89		$ 16.58	$ 16.88	
Profit Ceiling Percentage		110%			105%		105%	100%	
Profit Ceiling		$ 65.39			$ 33.48		$ 17.41	$ 16.88	
Profit Add-On		$ 0.65			$ 3.59		$ 2.17	$ 0.53	
Per Diem Costs		$ 56.68			$ 31.09		$ 15.96	$ 16.53	
Ceiling Percentage		120%			115%		105%	100%	
Overall Rate Component Limit		$ 71.33			$ 36.67		$ 17.41	$ 16.88	
Rate Component		$ 56.68	$ 0.32		$ 31.09		$ 15.96	$ 16.53	$ 120.58
Assessment Add-On									$ 8.65
Quality Add-On									$ 2.50
					Total Rate Before Max Limit				**$ 131.73**

Indiana Modeling – 64% Occupancy

Occupancy Statistics	Current Cost Report								
Beds Available	94								
Total Bed Days Available	34,310								
Medicaid Days	13,725								
Medicare Days	2,965								
Total Resident Days	21,960								
Occupancy Percentage	64.00%								
85% Minimum Occupancy - Fixed Costs	29,164								
95% Minimum Occupancy Capital Costs	32,595								
Case Mix									
Facility Average CMI	1.03								
Average CMI - Medicaid Residents	0.94								
Assessment Add-On									
Non-Medicare Days	18,995								
Assessment Rate	$ 10.00								
Total Assessment	$ 189,950								
Per Diem	$ 8.65								
Quality Add-On Per Report Card	$ 2.50								
Cost Center Per Diem Calculation	Direct Care		Therapy	Indirect Care		Administration		Capital	
Allowable Inflated Costs		$1,469,946	$9,141		$683,199		$388,132	$521,493	
	Variable	Fixed		Variable	Fixed	Variable	Fixed		
Assumed Percentage	75%	25%		63%	37%	16%	84%		
Cost Allocation	$ 1,102,460	$ 367,487	$ 9,141	$ 430,415	$ 252,784	$ 62,101	$ 326,031		
Days Used in Division	21,960	29,164	21,960	21,960	29,164	21,960	29,164	32,595	
Per Diem	$ 50.20	$ 12.60	$ 0.42	$ 19.60	$ 8.67	$ 2.83	$ 11.18	$ 16.00	
Other Adjustments	$	62.80	$ 0.42	$	28.27	$	14.01	$ 16.00	
Case Mix Adjust Costs		$ 60.97							
		$ 57.32							
Median Costs		$ 63.24			$ 31.89		$ 16.58	$ 16.88	
Profit Ceiling Percentage		110%			105%		105%	100%	
Profit Ceiling		$ 65.39			$ 33.48		$ 17.41	$ 16.88	
Profit Add-On		$ 0.65			$ 3.13		$ 2.04	$ 0.53	
Per Diem Costs		$ 57.96			$ 31.40		$ 16.05	$ 16.53	
Ceiling Percentage		120%			115%		105%	100%	
Overall Rate Component Limit		$ 71.33			$ 36.67		$ 17.41	$ 16.88	
Rate Component		$ 57.96	$ 0.42		$ 31.40		$ 16.05	$ 16.53	$ 122.35
						Assessment Add-On			$ 8.65
						Quality Add-On			$ 2.50
					Total Rate Before Max Limit				**$ 133.50**

Pennsylvania Modeling – 97% Occupancy

Occupancy Statistics		Most Recent Audited Cost	Second Most Recent Audited Cost	Third Most Recent Audit Cost	Average		
	Beds Available	94	94	94	94		
	Total Bed Days Available	34,310	34,310	34,310	34,310		
	Medicaid Days	20,801	20,801	20,801	20,801		
	Medicare Days	4,493	4,493	4,493	4,493		
	Total Resident Days	33,281	33,281	33,281	33,281		
	Occupancy Percentage	97.00%	97.00%	97.00%	97.00%		
	90% Minimum Occupancy *	30,879	30,879	30,879	30,879		
Case Mix							
	Facility Average CMI	1.03	1.03	1.03			
	Medicaid CMI	1.10	NA	NA			
Inflation Factor		1.1164	1.1164	1.1164			
Fair Rental Value Plus Real Estate Taxes		$ 521,493					
Cost Category Allowable Costs							
	Direct Resident Care	$ 1,879,480	$ 1,766,711	$ 1,653,942			
	Inflated Direct Resident Care	$ 2,098,252	$ 1,972,356	$ 1,846,461			
	CMI Normalized Costs	$ 2,037,137	$ 1,914,909	$ 1,792,681			
	Other Resident Care	$ 824,344	$ 774,884	$ 725,423			
	Inflated Other Resident Care	$ 920,298	$ 865,080	$ 809,862			
	Administration Costs	$ 389,100	$ 365,754	$ 342,408			
	Inflated Administration Costs	$ 434,391	$ 408,327	$ 382,264			
Per Diem Costs							
	CMI Normalized Direct Resident Costs	61.21	57.54	53.86			
	Other Resident Care	27.65	25.99	24.33			
	Administration (use > of actual days or 90% of available days	13.05	12.27	11.49			
			Average Per Cost Category				
	Direct Resident Care		57.54				
	Other Resident Care		25.99				
	Administration		12.27				
	Rate Calculation	Average Per Diem	Per Group Price* (a)	Limited Price (b)	Lower of (a) or (b)	MA CMI	Cost Center Rate
	Direct Resident Care	57.54	84.11	66.72	66.72	1.10	73.39
	Other Resident Care	25.99	35.65	29.44	29.44	NA	29.44
	Administration	12.27	15.33	13.45	13.45	NA	13.45
Total Cost Center Rates		116.27					
	Capital Rate (FRV/the > actual days or 90% of available days	15.67					
Total Rate		**$131.94**					

Pennsylvania Modeling – 84% Occupancy

Occupancy Statistics		Most Recent Audited Cost	Second Most Recent Audited Cost	Third Most Recent Audit Cost	Average		
	Beds Available	94	94	94	94		
	Total Bed Days Available	34,310	34,310	34,310	34,310		
	Medicaid Days	18,113	18,113	18,113	18,113		
	Medicare Days	3,912	3,912	3,912	3,912		
	Total Resident Days	28,981	28,981	33,281	30,414		
	Occupancy Percentage	84.47%	84.47%	97.00%	0.886456815		
	90% Minimum Occupancy *	30,879	30,879	30,879	30,879		
Case Mix							
	Facility Average CMI	1.03	1.03	1.03			
	Medicaid CMI	1.10	NA	NA			
Inflation Factor		1.1164	1.1164	1.1164			
Fair Rental Value Plus Real Estate Taxes		$ 521,493					
Cost Category Allowable Costs							
	Direct Resident Care	$ 1,698,199	$ 1,596,307	$ 1,494,415			
	Inflated Direct Resident Care	$ 1,895,869	$ 1,782,117	$ 1,668,365			
	CMI Normalized Costs	$ 1,840,650	$ 1,730,211	$ 1,619,772			
	Other Resident Care	$ 757,245	$ 711,810	$ 666,376			
	Inflated Other Resident Care	$ 845,388	$ 794,665	$ 743,942			
	Administration Costs	$ 380,069	$ 357,265	$ 334,461			
	Inflated Administration Costs	$ 424,309	$ 398,850	$ 373,392			
Per Diem Costs							
	CMI Normalized Direct Resident Costs	$ 63.51	$ 59.70	$ 48.67			
	Other Resident Care	$ 29.17	$ 27.42	$ 22.35			
	Administration (use > of actual days or 90% of available days	$ 13.74	$ 12.92	$ 12.09			
			Average Per Cost Category				
	Direct Resident Care		$ 57.29				
	Other Resident Care		$ 26.31				
	Administration		$ 12.92				
	Rate Calculation	Average Per Diem	Per Group Price* (a)	Limited Price (b)	Lower of (a) or (b)	MA CMI	Cost Center Rate
	Direct Resident Care	$ 57.29	$ 84.11	$ 66.54	$ 66.54	1.10	$ 73.20
	Other Resident Care	$ 26.31	$ 35.65	$ 29.67	$ 29.67	NA	$ 29.67
	Administration	$ 12.92	$ 15.33	$ 13.91	$ 13.91	NA	$ 13.91
Total Cost Center Rates		$ 116.78					
	Capital Rate (FRV/the > actual days or 90% of available days	$ 16.89					
Total Rate		**$ 133.66**					

Pennsylvania Modeling – 64% Occupancy

Occupancy Statistics		Most Recent Audited Cost	Second Most Recent Audited Cost	Third Most Recent Audit Cost	Average		
	Beds Available	94	94	94	94		
	Total Bed Days Available	34,310	34,310	34,310	34,310		
	Medicaid Days	13,725	13,725	13,725	13,725		
	Medicare Days	2,965	2,965	2,965	2,965		
	Total Resident Days	21,960	21,960	21,960	21,960		
	Occupancy Percentage	64.00%	64.00%	64.00%	64.00%		
	90% Minimum Occupancy *	30,879	30,879	30,879	30,879		
Case Mix							
	Facility Average CMI	1.03	1.03	1.03			
	Medicaid CMI	1.10	NA	NA			
Inflation Factor		1.1164	1.1164	1.1164			
Fair Rental Value Plus Real Estate Taxes		$ 521,493					
Cost Category Allowable Costs							
	Direct Resident Care	$ 1,402,204	$ 1,318,072	$ 1,233,940			
	Inflated Direct Resident Care	$ 1,565,421	$ 1,471,495	$ 1,377,570			
	CMI Normalized Costs	$ 1,519,826	$ 1,428,636	$ 1,337,447			
	Other Resident Care	$ 647,686	$ 608,825	$ 569,964			
	Inflated Other Resident Care	$ 723,077	$ 679,692	$ 636,307			
	Administration Costs	$ 366,798	$ 344,790	$ 322,782			
	Inflated Administration Costs	$ 409,493	$ 384,924	$ 360,354			
Per Diem Costs							
	CMI Normalized Direct Resident Costs	$ 63.85	$ 60.02	$ 56.19			
	Other Resident Care	$ 32.93	$ 30.95	$ 28.98			
	Administration (use > of actual days or 90% of available days	$ 13.26	$ 12.47	$ 11.67			
			Average Per Cost Category				
	Direct Resident Care		$ 60.02				
	Other Resident Care		$ 30.95				
	Administration		$ 12.47				
	Rate Calculation	Average Per Diem	Per Group Price* (a)	Limited Price (b)	Lower of (a) or (b)	MA CMI	Cost Center Rate
	Direct Resident Care	$ 60.02	$ 84.11	$ 68.51	$ 68.51	1.10	$ 75.36
	Other Resident Care	$ 30.95	$ 35.65	$ 33.01	$ 33.01	NA	$ 33.01
	Administration	$ 12.47	$ 15.33	$ 13.59	$ 13.59	NA	$ 13.59
Total Cost Center Rates		$ 121.96					
	Capital Rate (FRV/the > actual days or 90% of available days	$ 16.89					
Total Rate		**$ 138.85**					

Questionnaire and Responses

Rutgers Center for State Health Policy
Contractors to Centers for Medicare & Medicaid Services
State Rebalancing Efforts: Affects on Nursing Home Occupancy and Budget
Myers and Stauffer, LC

Purpose of Study:
The Rutgers Center for State Health Policy has contracted with CMS to produce a publication that examines the impact of declining occupancy on nursing home reimbursement and review strategies that states can use to "right size" their nursing home and long term care capacity. Myers and Stauffer has been asked to assist in the collection of data and the analysis. The paper will explore the practical application of these concepts in states with working demonstrations, grants or full implementation, and the projected or actual financial impact of such applications.

CMS has approved the selection of six states to participate in the study. The states are: California, Indiana, Minnesota, New Mexico, Pennsylvania and Wisconsin. Four of the six states (California, Indiana, Pennsylvania and Wisconsin) have been involved in Money Follows the Person initiatives, while Minnesota and New Mexico have implemented successful transition and diversion programs.

Questions		Reponses	
1.	Does the state have a Money Follows the Person (MFP) program?	Yes	No
	If yes describe:		
	Include implementation data:		
	Does the state also have a diversion program?	Yes	No
	If yes describe:		
	If no MFP program does the state have a transition or diversion program?	Yes	No
	If yes describe program:		
2.	Is there a written evaluation or report on the program?	Yes	No
	If yes where can it be found?		
3.	Is there a process in place to take nursing home beds off-line or to repurpose nursing home beds?	Yes	No

	If yes describe process: Conversion to assisted living Convert double occupancy rooms to private rooms Bed-bank Facility closures (how many and how many beds)		
4.	According to information we have, the nursing home occupancy for 2001 was _____and for 2007 was ____ What is the current status of the HCBS programs in the state? Are occupancy rates increasing or decreasing?	% Increase	% Decrease
5.	What has been the affect of the MFP/diversion/transition program on the nursing home and HCBS budgets? What percent of the Medicaid budget is currently allocated to nursing homes and HCBS?	Nursing Home	HCBS
6.	Is there a moratorium or certificate of need process in place? Include description and implementation date.	Moratorium	Certificate Of Need
7.	Are there waiting lists for HCBS (Aged and Disabled) services in the state?	Yes	No
	If yes explain:		
8.	8 Do you use Intergovernmental transfers (IGT)?	Yes	No

	If yes explain:		
9.	We would like a copy of the current Medicaid Nursing Home cost report and instructions, where can we access them?		
	State Contact answering questions:	Date	

California

California received a FY2003 Real Choice Systems Change Grant, "California Pathways," for the period 9/30/03 through 9/30/07, and this grant is now closed. The state has no ongoing nursing home transition program. California is in the pre-implementation phase of its Money Follows the Person Rebalancing Demonstration, "California Community Transitions." As with other states, the project will be implemented following the approval by CMS of the operational protocol.

California has 27 Medicaid waivers.[13] The state is engaged in diversion efforts through its waivers, including those detailed on Table 3.

Table A-1: Selected 1915 (c) and IHSS 1115 Waivers in California

Title	Description	Waiver Capacity by Waiver Year (WY)	Waiver Term	Expiration Date	Is this waiver currently operating under an extension
Assisted Living Waiver Pilot Project (ALWPP)	Provides HCBS services as an alternative to long- term nursing home placement to Medi-Cal beneficiaries over the age of 21 in either of two settings: a Residential Care Facility for the Elderly; or in Publicly Subsidized Housing with a Home Health Agency providing the assisted care services.	200 – CY 2006 600 – CY 2007 1000 – CY 2008	1/1/06- 12/31/08	12/31/08	No
In-Home Operations (IHO)	The In-Home Operations Waiver is a new waiver established to serve either 1) participants previously enrolled in the NH A/B Level of Care Waiver who have continuously been enrolled in a DHCS In-Home Operations-administered HCBS Waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse; or 2) who have been receiving continuous care in a hospital for 36 months or greater and	210 – CY 2007 210 – CY 2008 210 – CY 2009	1/01/07- 12/31/09	12/31/09	No

[13] These can be found at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp The total includes 1915 (c), 1915 (b) and section 1115 waivers.

Title	Description	Waiver Capacity by Waiver Year (WY)	Waiver Term	Expiration Date	Is this waiver currently operating under an extension
	have physician-ordered direct care services that are greater than those available in the Nursing Home/Acute Hospital Waiver for the participant's assessed level of care.				
Multipurpose Senior Services Program (MSSP)	Provides HCBS, mostly case management services, to Medi-Cal beneficiaries who are 65 or over and disabled, as an alternative to nursing home placement. HCBS allow the individuals to remain in their homes.	16,335	7/01/04–6/30/06	6/30/09	No
Nursing home / Acute Hospital (NH/AH)	The Nursing home A/B waiver was renamed the Nursing home Acute Hospital waiver effective 1/1/07. This waiver combines the following three prior HCBS Waivers: (1) NH A/B Waiver; (2) Nursing Home Sub-acute (NH SA); and the In- Home Medical Care (IHMC) Waiver.	2,392 – CY 2007 2,552 – CY 2008 2,712 – CY 2009 2,872 – CY 2010 3,032 – CY 2011	1/1/07–12/31/11	12/31/11	No
In Home Supportive Services Plus	Demonstration to promote self-direction for persons receiving community supports	66,000 -	7/31/04 - 7/30/09	7/30/09	No

The California state and county funded In-Home Supportive Services (IHSS) Residual Program has been operating since 1973 and provides in-home supportive service options. [14] In 1993, building upon experience with this state funded program, California's Department of Health and Department of Social Services developed a similar program that operates as a Medi-Cal State Plan benefit program called the Medi-Cal Personal Care Services (PCS) program. The IHSS Residual and PCS programs together have provided services for hundreds of thousands of frail elderly and disabled individuals, allowing them to remain safely in their homes and workplaces and to avoid more costly care options.[15]

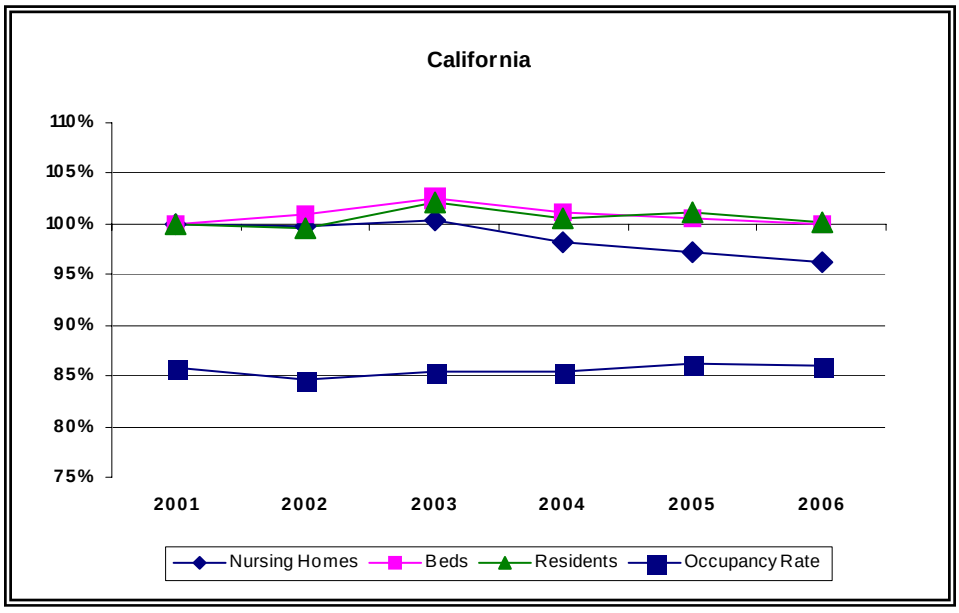
[14] In-Home Supportive Services (IHSS)Plus 1115 Demonstration Waiver Application submitted to The Centers for Medicare and Medicaid Services (CMS) State Operations by the California Department of Health Services May 2004

[15] In FY 2006, according to information provided the authors by the California Department of Social Services, the program provided services to an average 352,206 individuals monthly at an annual cost of $3,357,191,654.

Due to a state budget crisis, the IHSS Residual program was eliminated from the state's 2004 – 2005 budget. To continue these services, the state applied for and received approval for an 1115 demonstration waiver through the Independence Plus initiative. The approval allowed California to provide Medi-Cal eligible aged, blind and disabled adults and children with a program of self-directed personal care assistance and delivery options not available under the state plan PCS program.

California does not currently have a process for taking beds off-line or for repurposing the beds. They do not have a moratorium or certificate of need and intergovernmental transfers are not used in long-term care services. The number of certified nursing homes in California declined 4.65% from December 2001 to June 2007. There was a reduction of less than one per cent in beds and residents, resulting in a fairly consistent occupancy percentage level as seen. This graphic compares the numbers of homes, beds, and residents from December 2002 to December 2006 to those reported in December 2001. It also displays occupancy percentages calculated by dividing the number of residents by the number of beds.

Chart A-1: Percentage Changes in the Number of California Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 Base through December 2006



Source - OSCAR data, Centers for Medicare & Medicaid Services.

Indiana

The Money Follows the Person demonstration in Indiana was developed to transition 1,039 individuals from institutional to community based settings over the course of the next four years. The state has submitted its operational protocols and is currently awaiting final approval from CMS to begin the demonstration. The state's Division of Aging has contracted with the Indiana Association of Area Agencies on Aging (IAAAA) and its sixteen members throughout the state to conduct transitions. As planned in the grant's operational protocols, each Area Agency on Aging will employ at least one transition specialist (social worker) and one transition nurse to assist individuals seeing transition in their respective areas.

Eligibility requirements will exist for individuals wishing to participate in the program, most notably that they must indicate on their 90-day Minimum Data Set (MDS) long-term care assessment, question Q1a, that they express or indicate a preference to return to the community. Services provided to participants in their first year of transition will be the same as those provided through the Aged and Disabled Waiver, and will be paid through the enhanced FMAP match (MFP program funds). On day 366 of the participant's transition, he or she will financially switch to either the Aged & Disabled or Traumatic Brain Injury Waiver, depending upon eligibility. The services being provided will not change.

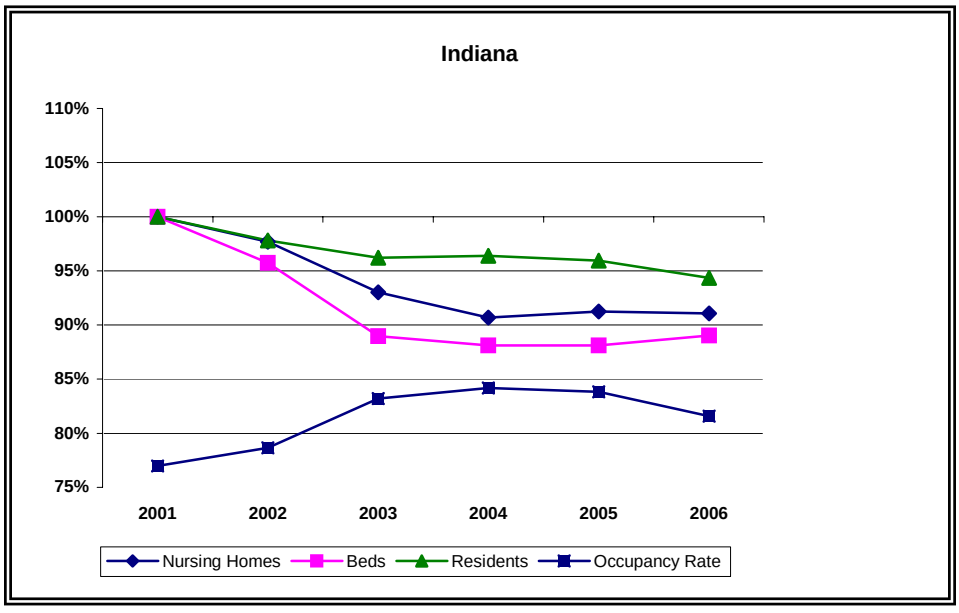
The Indiana Family and Social Services Administration, Division of Aging, through the Aged and Disabled Waiver, enrolls providers to provide Assisted Living services in lieu of nursing home placement. The Division of Aging currently has 49 assisted living providers enrolled in the Aged and Disabled Waiver. The Aged and Disabled Waiver has the capacity to serve 9,500 individuals. Currently the Division of Aging is serving approximately 6,100 individuals with a waitlist of 1,300.

Indiana is converting nursing home beds to assisted living, converting double occupancy rooms to private rooms, allowing banking of beds and facility closures. There is currently a moratorium on newly certified nursing home beds that became effective

December 15, 2005. The moratorium was set to expire in February 2008. Indiana utilizes a Supplemental Upper Payment Limit program where non-state governmental nursing facilities transfer funds to the State Medicaid agency to assist in paying for the care of their residents. In addition, the Indiana State Department of Health operates the Indiana Veterans Home, a nursing home, and transfers funds to the State Medicaid agency to assist in paying for the care of residents.

The number of nursing homes in Indiana declined 7.69% from December 2001 to June 2007. Beds and residents also declined at rates of 9.64% and 5.26% respectively. The occupancy percentage has increased when comparing changes over the same time period, caused by beds declining at a faster rate than residents. Indiana has the lowest occupancy percentage of the six states considered. The following chart uses the same methodology as that for California and shows percentage changes in homes, beds and residents.

Chart A-2: Percentage Change in the Number of Indiana Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 Base through December 2006



Source: OSCAR data, Centers for Medicare & Medicaid Services.

Pennsylvania

The Pennsylvania Money Follows the Person effort is ambitious and seeks to help approximately 2,500 persons. The effort is coordinated by the Office of Long-Term Living, which works with the mental health staff on the transition of persons 65 and older from the state mental health hospital beds.

Pennsylvania staffs have worked for about nine years to develop a nursing home transition (NHT) program. These years of work have produced an outstanding program compared to what the majority of other states have been able to accomplish. In 2006 - 2007, the state dramatically expanded its efforts with an ambitious statewide program that successfully assisted approximately 1,700 persons.

Pennsylvania also has a Nursing Facility Partnership Plan, which is intended to create a financially attractive and flexible system of incentives to motivate providers to reconfigure assets according to market realities and consumer preferences. This is being carried out on a one-to-one basis dependent on the structure of each nursing facility. For example, a provider operating older mission-driven nursing homes may want to add assisted living or independent living and reduce its nursing home beds. There is a three level incentive system:

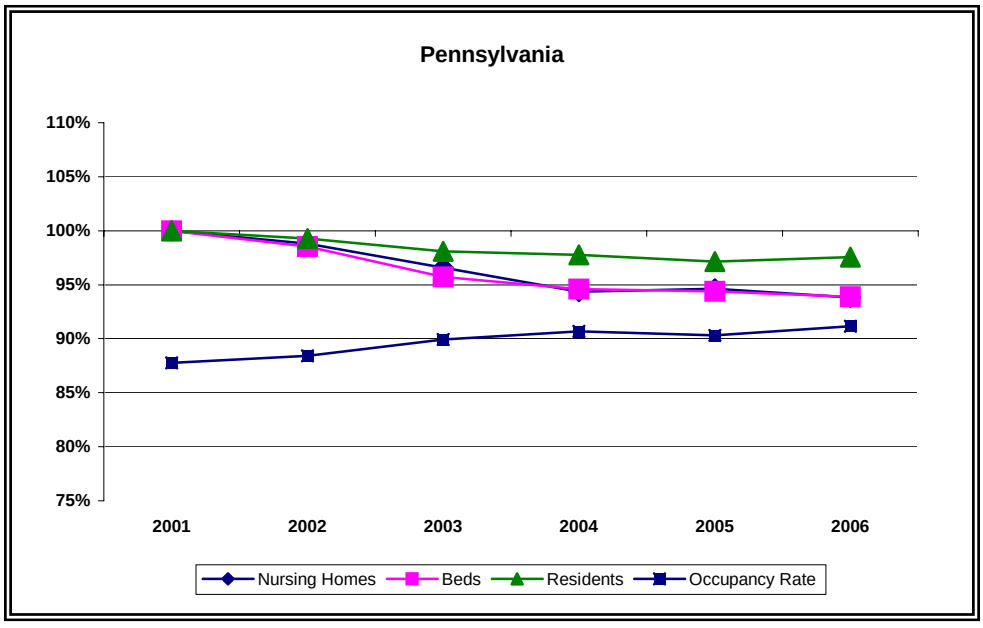
- Planned Closure Reimbursement Allowance – geared toward situations where a few beds are persistently empty and the elimination of the beds would help the owner and save Medicaid dollars.
- Amortizing Reimbursement Incentive – geared toward providers with older physical facilities that may need help with renovations in areas where the NF market exists and the facility needs reconfiguration.
- Capital Grant – geared toward facilities facing major renovations or re-builds, and the market exists but the facility needs major refreshment or replacement.

At the February 2008 Baltimore Money Follows the Person meeting, Pennsylvania staff reported that CMS was receptive to the state's efforts to reduce the number of beds by working through financial issues with providers.

There is a moratorium on the creation of new nursing home beds with an exceptions request procedure that was implemented in 1996. There are no waiting lists for the Pennsylvania Department of Aging (PDA) waiver. Intergovernmental transfers are currently used, but FY 2008-2009 will be the last year. The program is anticipated to be a little over $30 million.

In Pennsylvania from December 2001 to June 2007, nursing homes and certified beds declined at a consistent 6.43% and 6.47% respectively. The number of residents declined at a slower rate of 2.48%, causing the occupancy percentage to increase. The following graphic was developed in the same manner as that used in the discussion on California and Indiana and displays percentage changes in homes, beds, residents and occupancy.

Chart A-3: Percentage Changes in the Number of Pennsylvania Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 base through December 2006



Source: OSCAR data, Centers for Medicare & Medicaid Services.

Wisconsin

For about 20 years, Wisconsin has had a mechanism for creating community program slots when nursing home beds are closed behind the relocating individual. The

mechanism is called the Community Integration Program II or CIPII. It is described in a CMS Promising Practices document.[16] The Community Relocation Initiative began on July 1, 2005 and builds on CIPII, but differs in that the bed does not have to close and the slot value is based on the cost of the person's care plan.

Wisconsin's Elderly/Physically Disabled Waiver has historically included both transitions and diversions, but has been limited by flat funding. In 2006, the legislature established additional diversion slots for persons at high risk of nursing home admission. This program has generated funding for 300 people with approved funding for another 150.

There is a small project to encourage development of assisted living units and rate incentives to create private rooms. The Wisconsin bed banking has not been used by nursing homes since the implementation of a licensed bed assessment in 2003. When Wisconsin implemented an assessment in July 2003, nursing homes immediately eliminated 2,500 beds. Most of the bed reduction resulted in double occupancy rooms converted to private rooms.

Thirty-eight nursing homes and approximately 4,000 beds have closed since 1999, primarily for financial reasons. Usually beds close, but sometimes they are transferred to another facility owned by the same corporation. About 50% of the closures and 60% of the bed loss was in Milwaukee County, Wisconsin's most populous county. The number of certified nursing home beds decreased an average of 3.1% per year from 2001 to 2006.

The state has developed an exemplary adult foster home program with 1,100 homes serving 1-2 persons and another with 1,130 homes serving more than 2 persons, which state staff refers to as the "transitional model."[17] The existence of this strong

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[16] See Centers for Medicare & Medicaid Services (2005, January) *Wisconsin – Assistance to People Who Want To Leave Nursing facilities*, retrieved on 3-7-08 from http://www.cms.hhs.gov/PromisingPractices/Downloads/wi-hcbsav.pdf

[17] Interview with Kevin Coughlin and Carrie Molke Department of Health and & Family Services, State of Wisconsin, 3-6-08.

residential program helps the state find alternatives for persons who do not wish to live in nursing homes.[18]

Wisconsin does not have a moratorium or certificate of need. It does have an absolute cap on the number of nursing home beds, but the state is well below the cap. The intergovernmental transfer program was discontinued but the state does make a claim based on Certified Public Expenditures for county losses on publicly operated nursing homes.

The number of nursing homes in Wisconsin declined 5.30% from December 2001 to June 2007. The percentage decrease in the number of certified beds is the largest percentage decline in the six states at 15.70%. The percentage decline in residents is also substantial at 12.21%. Occupancy percentages have increased, however, due to beds decreasing at a faster percentage rate than that for residents.

Percentage changes in homes, beds, residents and occupancy rates for Wisconsin using the same methods are shown below.

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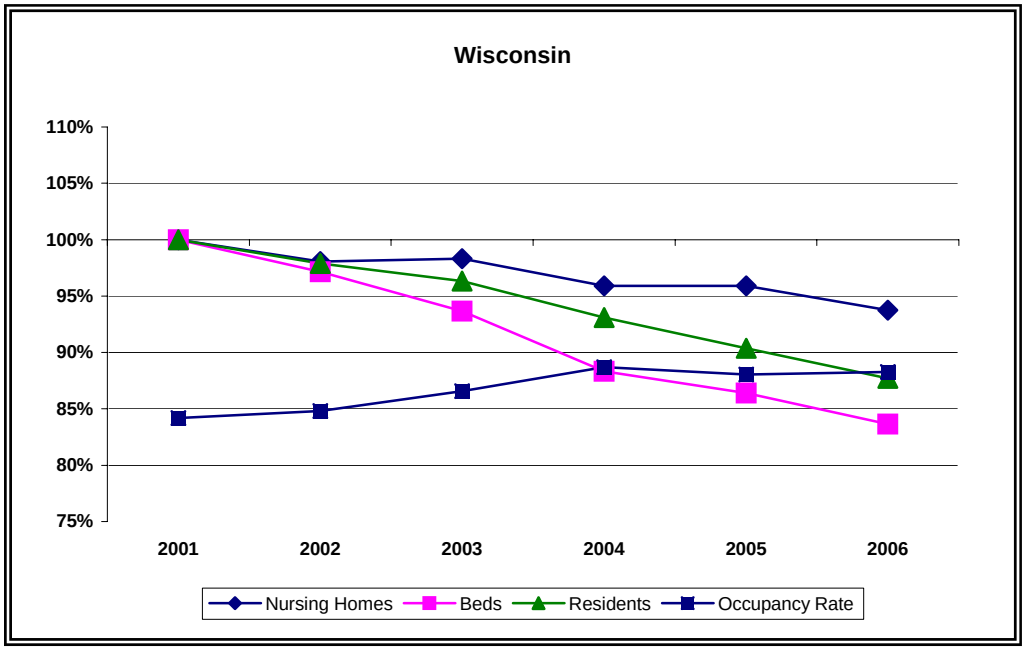
[18] States that have strong adult foster home programs such as Washington, Oregon, and Wisconsin have an easier time finding alternatives for persons who prefer not to live in nursing homes. Whereas states that have only in-home service programs and weak or non-existent assisted living and adult foster home programs encounter more severe housing problems when helping persons transition from nursing homes.

Chart A-4: Percentage Changes in the Number of Wisconsin Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 Base through December 2006



Source: OSCAR data, Centers for Medicare & Medicaid Services.

In addition to the four MFP states, we selected Minnesota and New Mexico for review. Minnesota has some interesting transition and diversion programs and New Mexico is second in the nation in the ratio of HCB services to nursing home expenditures in the Medicaid program. They responded to the same survey questions.

Minnesota

Minnesota is not part of the federal MFP demonstration project. Relocation Service Coordination is available to any person in an institutional setting who would like to relocate to the community. This Medicaid targeted case management option will pay for up to 180 days of relocation assistance.[19] Transition services are either available or will be available in all five of Minnesota's HCB programs to help cover transition costs of up to $3,000 for persons leaving institutional settings. The counties are responsible for local development of community based services for persons in nursing facilities or those

[19] The new targeted case management regulations that took effect in March 2008 will impact Minnesota's use of case management to support transition activities as it will in other states.

at risk of nursing home placement. There is a county share of nursing home costs for persons who remain in a nursing home for 90 days or longer. A special housing unit was started to work with developers. Gaps of community resources to meet the needs of nursing home residents include affordable housing, transportation and community service funding limitations. From October 2004 to September 2005, 70 individuals have been transitioned.

The Long-Term Care Consultation (LTCC) program began in 2001. A preadmission screening (PAS) is completed on all residents and a face-to-face assessment is conducted on all residents under 65 admitted to a nursing home within 45 days. If someone wants to leave an institution, LTCC staff coordinates relocation for Medicaid enrollees and assists others with assessment, planning and service referrals. Medicaid services are available for relocation coordination. LTCC services are available to all Minnesotans regardless of income or acuity. Each county board of commissioners, or two or more counties together, must establish a local LTCC team of at least one social worker and one public health nurse who are responsible for providing LTCC services to all persons who request those services, regardless of their eligibility for Minnesota health care programs. One hundred ninety individuals were diverted from nursing homes.

Minnesota's Elderly Waiver provides HCB services for people age 65 and older who are eligible for Medical Assistance (MA) and require the level of medical care provided in a nursing home, but who choose to reside in the community. Counties administer the program, which is effective through June 30, 2008.

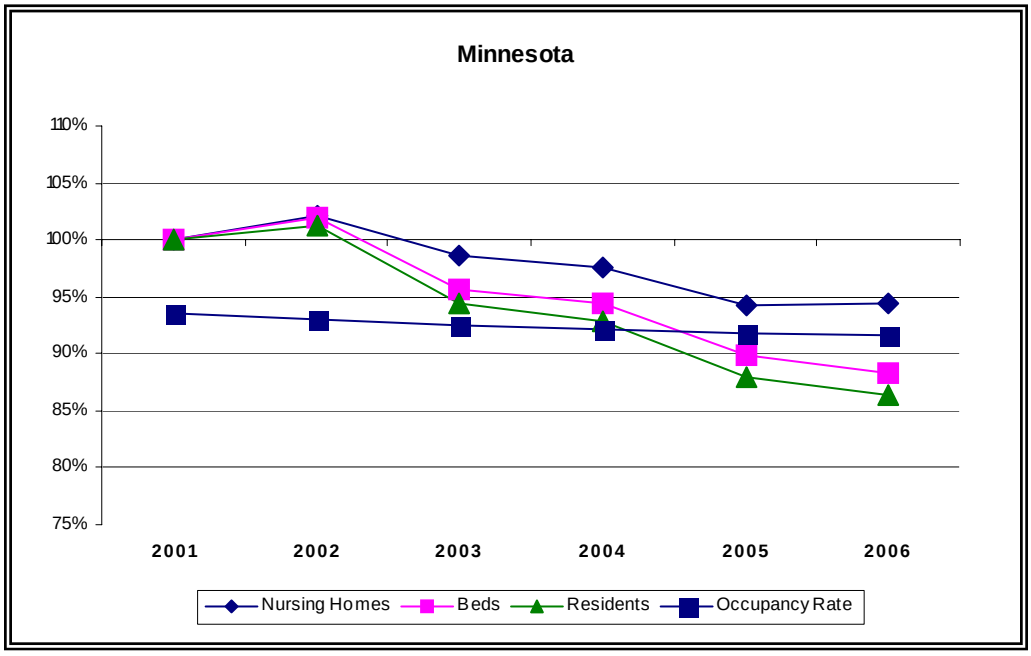
Lay-Away bed program of 2000 allows facilities to remove beds from active service without permanently losing the bed. Beds must remain in lay-away for at least one year. Beds can be laid away for up to five years. After five years, they are permanently gone. *The planned closure programs* goal is to close obsolete beds in over-bedded areas. This would be permanent de-licensure of beds or of the entire nursing home. The goal was to close 5,040 beds. The program, in place in 2001-2003, was discontinued and then reinstated in 2004. There have been 4,900 beds approved for closure. *The single bed*

incentive of 2006 adds incentives when the closure of a bed results in the creation of a new single bed room. Medicaid residents can have private rooms if medically necessary. All programs listed above are currently in place.

The current Minnesota Medicaid budget has allocated 60.8% to institutions and 39.2% to HCB services. There is a moratorium on new nursing homes and the state uses intergovernmental transfers. The number of nursing homes declined 5.53% from December 2001 to June 2007. The number of certified beds decreased 12.04%, the second largest percentage decline in beds and the number of residents decreased 13.60%, the largest percentage decrease in the six states, resulting in a 1.78% decrease in occupancy.

Using the same methodology, percentage changes in homes, beds, residents and occupancy rates for Minnesota are shown in Chart A-5.

Chart A-5: Percentage Changes in the Number of Minnesota Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 base through December 2006



Source: OSCAR data, Centers for Medicare & Medicaid Services.

New Mexico

New Mexico was not awarded a CMS Money Follows the Person grant. The state is implementing a state law requiring MFP; however, this is an initiative, not a stand-alone program. State staffs report that they have consistently discharged interested and eligible persons to the community and will fully implement a "money follows the person" philosophy through the Coordinated Long-Term Services (CLTS) Medicaid managed care waiver initiative beginning in July 2008.

The Disability and Elderly (D&E) waiver program serves persons who are eligible both medically and financially for the Medicaid institutional level of care. D&E is not an entitlement program in this state. The number of slots is limited and dependent upon state appropriations. Persons interested in applying have their names placed on a central registry until slots become available. Eligibility is determined after a registrant is offered an allocation. Services include adult day health, assisted living, case management, emergency response, environmental modifications, home maker services for adults, occupational, speech and physical therapy for adults, private duty nursing for adults and respite care.

New Mexico does not have a line-item appropriation process for Medicaid. The Medicaid budget is a global budget that gives the Human Services Department and its Medical Assistance Division (HSD/MAD) the ability to allocate the global budget where needs exist. Consequently, there is no need to "cold bed" nursing home beds in favor of home and community based services [20]. Instead, if the need for HCB services exceeds nursing home bed need, then HSD/MAD has the ability to reallocate dollars appropriately. This has been done to implement MFP in the state.

New Mexico is second in the nation in the ratio of HCB services to nursing home expenditures in the Medicaid program. Nursing home reimbursement has declined and HCBS, including state plan personal care services, has increased. The HSD/MAD has

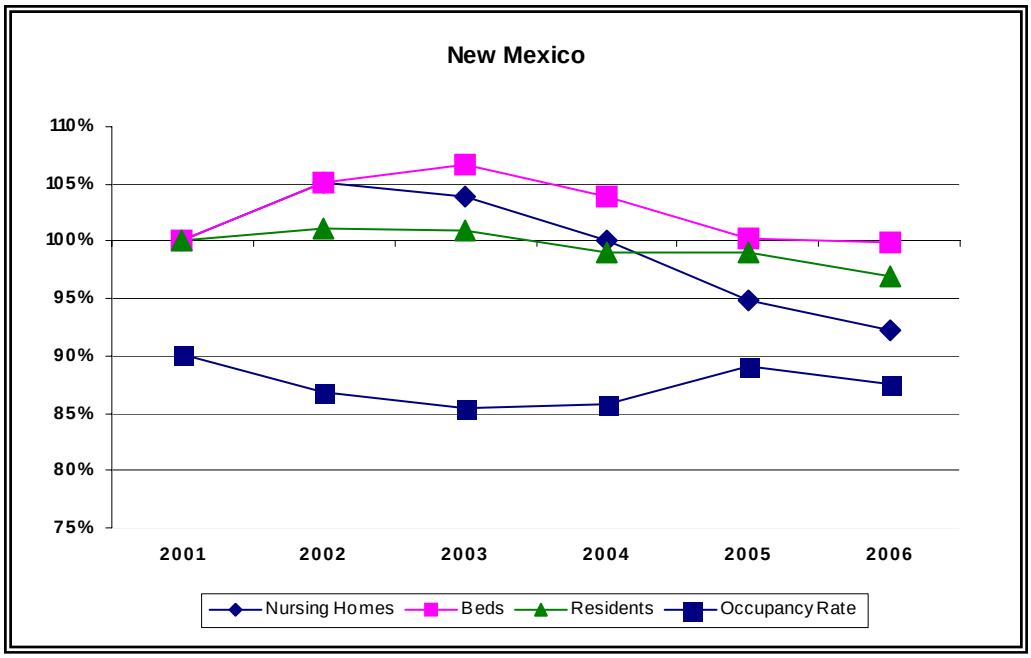
[20] "Cold bed" was the commonly used name for a federal Medicaid policy that required states to show there was an empty institutional bed for each waiver enrollee. This policy was eliminated during Clinton's first presidential term.

been studying whether there is a correlation between the decline in nursing home costs to the state and the increase in home and community based services.

New Mexico does not have a certificate of need program controlling the supply of nursing home beds. The home and community based services waiting list had approximately 6,000 persons listed in February 2008. However, there are no evaluation criteria before someone can be placed on the registry wait list. Anyone wanting to be put on the list is added to the registry.

The number of nursing homes in New Mexico declined 7.69% from December 2001 to June 2007. The number of certified beds decreased slightly or .62%. The relatively constant number of beds matched with a decrease in residents of 3.27% caused the occupancy rate to decrease by 3.87%. Chart A-6 includes the percentage changes in the homes, beds, residents and occupancy rates for New Mexico developed through the same methodology.

Chart A-6: Percentage Changes in the Number of New Mexico Nursing Homes, Beds, and Residents plus Occupancy Rates from a December 2001 Base through December 2006



Source: OSCAR data, Centers for Medicare & Medicaid Services.

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