Background

CHAPTER 1

As the United States population ages, an increasing number of Americans will need some type of long-term care services. While more attention is being focused on the development of alternatives to nursing home care, most public and private spending still pays for institutional care in nursing homes. Federal and state governments provide most of the funding for nursing home care. Medicaid is the largest government payer for nursing home care, and in some states nursing home costs are the largest single category of Medicaid spending. For this reason, policy makers have shown growing concern about the cost of nursing home services.

Our report compares 1995 nursing home rates in five states in the Upper Midwest: Minnesota, Iowa, North and South Dakota, and Wisconsin. This chapter presents an overview of the nursing home industry in each of those states, and describes each state's Medicaid reimbursement system. We asked:

- **What are the main features of the nursing home industry in each state?**
- **What key features characterize the Medicaid nursing home reimbursement system in each state?**

To answer these questions, we analyzed federal government Medicaid data; reviewed statutes, rules, and procedures related to each state's Medicaid reimbursement system; and interviewed state Medicaid officials.

The nursing home industry in each state differs in size and nature of ownership.

The nursing home industry in each state examined share some characteristics, such as more nursing home beds per capita and higher rates of nursing home use than the national average. But they differ in size, nature of ownership, and how they distinguish between different levels of care. In addition, there is wide variation in nursing home reimbursement systems among the states examined, because the federal government gives each state flexibility to establish its own Medicaid reimbursement methods and payment rates. In most states the Medicaid reimbursement systems are complex and comparisons are difficult.

NURSING HOME INDUSTRY IN FIVE MIDWESTERN STATES

This study focuses on Medicaid-certified nursing facilities subject to the payment rates established in Minnesota, Iowa, North Dakota, South Dakota, and Wisconsin.[1] A nursing facility is:

> an institution which is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for injured, disabled, or sick persons; or on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services which can be made available to them only through institutional facilities.[2]

Medicaid is an entitlement program in which the federal and state governments share the costs of medical care for the poor, elderly, and disabled. In 1994, Medicaid spending for nursing homes totaled $28 billion nationally and represented 21 percent of all Medicaid expenditures, topped only by the amount spent for hospital services. However,

- **Nursing home payments constituted the *largest* category of Medicaid spending in Minnesota, North and South Dakota, and Wisconsin.**

In Minnesota, nursing home care accounted for 35 percent of all Medicaid spending in 1994.

In Minnesota, total Medicaid spending for all types of care by federal, state, and county governments was approximately $2.5 billion in 1994. Nursing home care accounted for 35 percent of all Medicaid expenditures, well above the national average. Table 1.1 shows that Wisconsin, North Dakota, and South Dakota spent similar portions of their Medicaid budgets on nursing home care. Iowa, on the other hand, looked more like the national average, spending more on hospital care and only 22 percent of its Medicaid budget on nursing home services.

Nationally, Medicaid financed care for nearly 69 percent of nursing home residents in 1993.[3] As Table 1.1 shows, Wisconsin was close to but below the national average, followed by Minnesota, North and South Dakota, and Iowa. One factor that might account for these differences is that some nursing homes may prefer private residents because facilities can charge higher rates to private residents compared with Medicaid patients.[4]

---

1 This report uses the terms "nursing facility" and "nursing home" interchangeably. Because every state in our evaluation uses different procedures to finance state-owned facilities, we did not include these facilities in our evaluation.

2 Omnibus Budget Reconciliation Act of 1987 (OBRA), Laws of 100th Congress First Session, Public Law 100-203, Subtitle C: Nursing Home Reform, Part 2 Medicaid Program, Section 1919(a).

3 American Health Care Association, *Facts and Trends: The Nursing Facility Sourcebook* (AHCA: Washington, D.C., 1994), 12-13. In 1995, Medicaid paid for the services of 66 percent of Minnesota's nursing home resident days and 56 percent of South Dakota's resident days. The lack of comparable data prevents a more up-to-date comparison with other states.

4 Richard DuNah and others, "Variations and Trends in Licensed Nursing Home Capacity in the States, 1978-1993," *Health Care Financing Review* 17, no. 1 (Fall 1995): 185.

Table 1.1: Medicaid and Demographic Statistics Related to Nursing Home Services

	Minnesota	Iowa	North Dakota	South Dakota	Wisconsin	U.S. Total
Medicaid Spending, 1994						
Total (in millions)	$2,469.7	$1,089.1	$278.9	$290.6	$2,255.9	$136,886.4
Nursing Facilities (in millions)	863.9	240.5	94.6	86.8	687.4	28,127.0
Percent of Total State Medicaid Spending	35%	22%	34%	30%	30%	21%
Percent of Nursing Home Residents Financed by Medicaid, 1993	63.1%	51.3%	57.5%	56.5%	67.4%	68.8%
Percent of State Population Over the Age of 65, 1994	12.5%	15.4%	14.7%	14.7%	13.4%	12.7%
Nursing Home Beds Per 1,000 Aged 65 and Over, 1994	78.3	82.0	75.8	71.8	69.7	53.3

Sources: Health Care Financing Administration , *Medicaid Statistics: Program and Financial Statistics Fiscal Year 1994*; American Health Care Association, *Facts and Trends*, 1994; Current Population Reports, Bureau of the Census; C. Harrington, *1994 Data Book*.

Historically,

- **States in the Upper Midwest, including Minnesota, have more nursing home beds per capita and a higher rate of nursing home use than the national average.**

Midwestern states had a higher rate of nursing home use than the national average.

In 1994, Minnesota had approximately 78 nursing home beds per 1,000 people age 65 and over, compared with a national average of 53 beds per 1,000.[5] As shown in Table 1.1, each of the neighboring states was also above the national average. In addition, Minnesota also had a higher proportion of its elderly citizens living in nursing homes than the national average. In 1994, 7.1 percent of Minnesota residents aged 65 and over lived in nursing homes, compared with 5 percent nationally. Over time, however, Minnesota has moved closer to the national average: the percent of Minnesotans aged 65 and over living in nursing homes has declined from 8.8 percent in 1980 to 7.1 percent in 1994.[6]

The number, type, ownership, and size of nursing homes in each state is summarized in Table 1.2. In 1995, Minnesota had 444 Medicaid-certified nursing homes with over 44,000 beds, for an average of 100 beds per facility. In total size,

5 Charlene Harrington, James H. Swan, and others, *1994 State Data Book on Long-Term Care Program and Market Characteristics* (San Francisco: University of California and Wichita: Wichita State University, October 1995).

6 Minnesota Departments of Health and Human Services, *Profile of Minnesota Nursing Homes and Long-Term Care Alternatives: 1996* (St. Paul, Feb. 1996), 1-2. The number of nursing home beds compared to the elderly population also has declined in neighboring states. Moratoriums on the licensing and/or construction of new beds has helped regulate the supply of nursing home beds. Minnesota has had a moratorium since 1983. North Dakota, South Dakota, and Wisconsin also have moratoriums, and Iowa has a certificate of need program.

Table 1.2: Comparison of Nursing Homes and Beds, 1995

Type of Facility	Minnesota		North Dakota		South Dakota [1]		Wisconsin [2]		Iowa [3]	
	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds	Number of Facilities	Number of Beds
All	444	44,827	83	7,060	107	7,871	366	41,446	427	32,245
Freestanding	355	37,998	60	5,202	83	6,327	340	39,608	406	30,985
Hospital-Attached	89	6,829	23	1,858	24	1,544	26	1,839	21	1,260
Public	67	5,286	1	38	3	167	40	5,711	18	999
For-profit	145	14,675	9	758	38	2,801	191	21,178	249	18,319
Non-profit	232	24,884	73	6,264	66	4,903	135	14,557	160	12,927
Number of Beds:										
1-49	53	1,881	16	597	19	775	28	1,015	70	2,676
50-99	212	15,328	41	2,804	72	4,902	166	12,198	267	18,190
100-199	154	20,742	24	3,142	15	1,972	131	17,233	86	10,461
200 and Over	25	6,876	2	517	1	222	41	11,001	4	918

Source: Program Evaluation Division analysis of state nursing home cost report data.

[1]South Dakota data represent 107 of 112 nursing homes.

[2]Wisconsin data represent 366 of 411 nursing homes. Wisconsin allows nursing homes to file combined cost reports for nursing facilities (NF) and intermediate care facilities for the mentally retarded (ICF-MR), which have higher costs than nursing facilities. Facilities filing combined cost reports were excluded from this evaluation.

[3]Iowa data represent only nursing facilities that provide an intermediate level of care because detailed data on facilities that provide skilled nursing services were not available.

Minnesota and Wisconsin's nursing home industries were similar.[7] Iowa had a comparable number of facilities, but had an average of only 75 beds per facility.

While definitions vary by state, a facility is "hospital-attached" if it shares a building, specific services, and/or costs with an adjoining or nearby hospital. In some instances in Minnesota, multiple nursing homes in different locations from a hospital may also be considered attached facilities. Some hospital-attached facilities may have higher costs than freestanding homes. One reason for this is that some states, including Minnesota, use Medicare cost reporting procedures for these facilities. Twenty percent of Minnesota's nursing homes were hospital-attached, compared with 22 percent in South Dakota and 28 percent in North Dakota. In contrast, both Wisconsin and Iowa had a much smaller share of hospital-attached facilities (7 and 5 percent respectively). In addition, unlike most other states, Minnesota has 12 short-length-of-stay facilities and 4 facilities providing care for the severely physically impaired (called Rule 80 facilities), which receive special reimbursement considerations.

- **The nursing home industry in Minnesota and the surrounding states has more non-profit and fewer for-profit homes than the national average.**

7 Wisconsin has 411 nursing facilities, however, we excluded 45 facilities from our analysis These facilities filed combined cost reports for nursing facilities and intermediate care facilities for the mentally retarded (which have higher average costs than nursing homes).

Minnesota has more non-profit and publicly-owned nursing homes than the national average.

Nationally, only 16 percent of nursing homes were non-profit, compared with 52 percent in Minnesota, 62 percent in South Dakota, and 88 percent in North Dakota.[8] More than one-third of the nursing homes in Wisconsin and Iowa were non-profit enterprises. Also nationally, 73 percent of nursing home were for-profit, compared with 58 percent in Iowa, 52 percent in Wisconsin, 35 percent in South Dakota, 33 percent in Minnesota, 11 percent in North Dakota. Finally, 4 percent of nursing homes nationally were publicly-owned, compared with 15 percent in Minnesota and 11 percent in Wisconsin.[9] Iowa was at the national average with four percent, while North Dakota, and South Dakota had few public nursing homes.

Prior to 1990, nursing homes were classified as either "skilled nursing" or "intermediate care" facilities.[10] Only skilled nursing facilities could provide the highest level of nursing home care. Federal nursing home reform legislation eliminated this distinction effective October 1, 1990, and created a single class of "nursing facility," required to provide 24-hour licensed nursing care. Some states retained the skilled nursing and intermediate care designation to characterize the level of care needed by residents. Federal regulations, however, require that all nursing homes meet the same professional nurse staffing requirements. Minnesota, North Dakota, and South Dakota do not distinguish between intermediate and skilled nursing levels of care. In Wisconsin, nursing facilities provide six different levels of nursing care from intense skilled nursing to intermediate residential care.[11]

Iowa, however, differentiates between two different levels of care: nursing facilities that provide an intermediate level of care and Medicare-certified skilled nursing facilities. Unlike the other states examined, Iowa maintains a different reimbursement system for each level of care. The Iowa data we evaluated in this study represents only the nursing facilities providing an intermediate level of care, and for this reason, is not directly comparable to data for other states.[12]

---

8 Marion Merrell Dow, Inc., *Institutional Digest 1995* (Kansas City, 1995): 26.

9 A larger proportion of Wisconsin's municipal- and county-owned nursing homes than for-profit or non-profit homes were eliminated from our evaluation because of their combined nursing facility and ICF-MR cost reporting. Prior to this adjustment, publicly-owned nursing homes represented nearly 15 percent of all nursing homes in Wisconsin.

10 Prior to 1990, skilled nursing facilities provided 24-hour nursing care which was prescribed by a phycisian with a registered nurse working on the day shift seven days a week. In contrast, intermediate care facilities generally were required to have only one licensed nurse working on the day shift seven days a week. After October 1, 1990, *all* nursing facilities (including those providing and intermediate level of care) are required to provide 24-hour licensed nursing care with a registered nurse working seven days a week, eight hours a day. Additional staffing requirements for nursing facilities are discussed in Chapter 3.

11 Intense skilled nursing care requires complex interventions and monitoring by professional nurses with specialized nursing assessment skills. In contrast, intermediate residential care is provided to disabled individuals who need social services and activity therapy. Furthermore, approximately 80 percent of Wisconsin's nursing home residents received a skilled nursing level of care in 1994.

12 Iowa Medicaid staff told us that 102 of the 427 nursing facilities providing an intermediate level of care also have units that provide skilled nursing services. We unsuccessfully attempted to obtain detailed data on current rates, costs, bed numbers, and patient days for Iowa facilities providing skilled nursing services.

DESCRIPTION OF NURSING HOME REIMBURSEMENT SYSTEMS

The federal government requires each state to pay for nursing home services through the use of rates that:

> are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.[13]

Medicaid nursing home reimbursement systems vary widely among the states we examined.

While the federal government sets general policy, it also gives each state flexibility to establish its own Medicaid reimbursement methods and payment rates for nursing home services. Consequently, there is wide variation in nursing home reimbursement systems among states, making comparisons difficult. Nursing home reimbursement policies and procedures are used to determine payment rates and can significantly affect both Medicaid nursing home rates and expenditures. For instance, a reimbursement system with lower spending limits will contain costs more than a system with higher spending limits.

We evaluated nursing home reimbursement systems and rates that were in effect for the year beginning January 1, 1995 in North Dakota, and July 1, 1995 in Minnesota, Iowa, South Dakota, and Wisconsin (called the 1995 rate year). It should also be noted that Minnesota has made changes to its reimbursement system for rates effective July 1, 1996, or the 1996 rate year. Consequently, Minnesota's current reimbursement system is different from the one examined as part of this evaluation. In 1995, the Legislature approved an alternative payment demonstration project for nursing home services.[14] The purpose of this project is to develop a purchase-of-service approach as an alternative to the current cost-based reimbursement system. As of June 1996, the Minnesota Department of Human Services has contracted with 73 nursing home providers to participate in the demonstration. Up to 40 more providers may be added to the project in early 1997.

In 1996, the Legislature modified some new reimbursement limits that had been implemented in 1995, temporarily suspended other reimbursement limits, and provided a payment increase of six cents per resident day in addition to the annual inflation adjustment for the 1996 rate year.[15] These changes apply only for the 1996 rate year. When setting nursing home reimbursement rates for the 1997 and future rate years, the law requires the Commissioner of Human Services to use the reimbursement limits adopted in 1995, and discussed in this report. (See Appendix A.)

The remainder of this chapter describes the general characteristics of nursing home reimbursement systems, particularly those used in Minnesota and each of

13 42 Code of Federal Regulations Chapter IV, Subpart C §447.250 (a).

14 *Minn. Stat.* §256B.434.

15 *Minn. Laws* (1996), Ch. 451, Art. 3, Section 11. See Appendix A.

the surrounding states during the 1995 rate year.[16] The reimbursement systems for most states are highly complex. Figures B.1 through B.5 in Appendix B summarize the key characteristics of each state's 1995 Medicaid nursing home reimbursement system. [17]

Reimbursement Payment Method

State Medicaid programs commonly base reimbursement rates paid to each nursing home on its costs. Most states use "prospective payment" methods, which use past costs to set future reimbursement rates. Reimbursement rates are set in advance based on a prior year's allowed costs (called historical costs).[18] Because prospective systems have a built-in time lag between spending and reimbursement, payments may not match current spending. Prospective methods can be further classified as:

Minnesota's reimbursement system bases payments on past costs.

1. *Facility-specific methods*, which set reimbursement rates for individual nursing homes based on allowed costs incurred by each home during a previous reporting period. Facility-specific rates may also be set based on resident census, facility type, or other conditions. Minnesota, North and South Dakota, Wisconsin, and 15 other states used prospective facility-specific payment methods in 1994.[19]

2. *Class methods*, which set a single flat payment rate for all facilities in a state or set multiple-class rates for groups of homes based on size, geographic location, resident census, or other attributes. Only California, Louisianna, and Oklahoma used this type of reimbursement method in 1994.

3. *Adjusted methods*, which allow prospective reimbursement rates, once set, to be increased during the rate year. Iowa and 23 other states used adjusted, prospective payment methods in 1994.

During the 1970s, states used retrospective reimbursement methods in which nursing homes are reimbursed for allowed costs after services are provided and costs

---

16 Charlene Harrington, James H. Swan, and others, *1994 State Data Book*; John Holahan, "State Rate-Setting and Its Effects on the Costs of Nursing Home Care", *Journal of Health Politics, Policy and Law* 9, no. 4 (Winter 1985): 647-667; Robert E. Schenkler, "Comparison of Medicaid Nursing Home Payment Systems," *Health Care Financing Review* 12, no. 1 (Fall 1991): 93-109. For more detailed information on nursing home reimbursement in Minnesota see Minnesota House of Representatives Research Department, *Nursing Home Reimbursement Information Brief* (St. Paul: October 1994) and *Nursing Home Reimbursement Information Brief: July 1996 Update* (St. Paul: July 1996); Office of the Legislative Auditor, *Nursing Homes: A Financial Review* (St. Paul, January 1991).

17 The Glossary contains definitions of many of the terms used below.

18 Allowable costs are a facility's actual costs that are eligible for reimbursement after appropriate adjustments as required by state Medicaid regulations, including the routine costs of nursing home services needed to provide quality care. Nonallowed costs include items such as gift shops and board of director expenses.

19 James H. Swan, Charlene Harrington, and others, *Medicaid Nursing Facility Reimbursement Methods Through 1994*, Draft article presented at the 121st Annual Meeting of the American Public Health Association in October 1993, June 1996 update. This article also identified three states that use combined prospective/retrospective payment methods.

are incurred. Only one state, Pennsylvania, used a retrospective reimbursement method in 1994.

Rate and Cost Reporting Years

The reimbursement systems in the states we evaluated use facility-specific cost reports from previous years to set their prospective payment rates. North Dakota uses a January 1 to December 31 rate year; Minnesota, Iowa, South Dakota, and Wisconsin have July 1 to June 30 rate years. Each state, however, uses different cost reporting periods. Figure C.1 in Appendix C compares the rate and cost reporting years for each state.[20]

Case-Mix Classification

In some states, reimbursement varies with the care needs of residents. Case mix classifies residents based on dependencies in activities of daily living, needs for special nursing care, and behavioral conditions. Higher case-mix scores are assigned to residents with higher care needs; generally, case-mix scores are used to adjust nursing or direct-care per diem rates. Nursing home residents in Minnesota, North Dakota, and South Dakota are assessed and assigned a case-mix classification. Each state, however, uses a different case-mix system: Minnesota has 11 case-mix categories, compared with 16 in North Dakota and 35 in South Dakota.

Reimbursement Limits

To contain and direct nursing home expenditures, each state limits the amount of allowed costs it will reimburse. If a facility's allowed daily costs exceed a limited reimbursement rate, then it is reimbursed at the limited rate.

States use various methods for establishing reimbursement limits. Some states, including Minnesota, North Dakota, South Dakota, and Wisconsin, set reimbursement limits for specific groups of costs (such as care-related, direct-care, other operating, and property costs).[21] Reimbursement limits can be set at a certain percent of the median daily costs for all nursing homes. Usually, the limit for nursing or direct-care services is higher than the limit for other cost categories. In 1995, Minnesota set a maximum reimbursement for "care-related costs" at 125 percent of the median per diem cost and "other operating costs" were capped at 110 percent of the median per diem cost for nursing homes in a specific geographic group. Reimbursement limits can also be set at a percentile of total per diem costs for specific cost categories. Iowa does not use cost categories to limit reimburse-

20 For rates in effect either January 1 or July 1, 1995, the states in our evaluation used nursing home costs that were incurred during different 12 month periods between July 1993 and June 1995. Minnesota and North Dakota use the same cost reporting period for all facilities; Iowa, South Dakota, and Wisconsin base cost reports on a facility's fiscal year.

21 Iowa, South Dakota, and Wisconsin updated and recalculated nursing home reimbursement limits using the most recent year of cost data. Minnesota and North Dakota recalculated reimbursement limits in 1992 and use an inflation index to adjust the limits annually.

ment rates, but sets a maximum per diem Medicaid payment rate at the 70th percentile of *total* daily costs, as determined annually by the Iowa Legislature.

A state may also set reimbursement limits for groups of nursing homes based on geographic location, number of beds, facility type, or other attributes. Minnesota, South Dakota, and Wisconsin limit reimbursement of nursing home costs based on various groupings.

Inflation Adjustments

The method a state chooses to adjust costs for inflation can cause reimbursement rates to increase at a faster pace than other states. Generally, states use either the change in a nursing home market basket or a consumer price index to inflate either reimbursement limits and/or per diem operating costs.

Services Included in Reimbursement Rates

In Minnesota, most therapy costs are not included in the reimbursement rate.

Including ancillary services (such as physical, occupational and speech therapies; and durable medical equipment) in daily payment rates can result in higher rates. North and South Dakota include ancillary services in the daily rates if the services are provided in the nursing home. In Minnesota, Iowa, and Wisconsin ancillary services can be either included in the nursing home reimbursement rate or paid by Medicaid directly to the service provider. In Minnesota, most therapy costs are billed outside of the daily payment rate.

Incentives

Most states provide various incentive payments to encourage nursing homes to reduce spending. Minnesota, North Dakota, Wisconsin, and Iowa provide various types of incentive payments applied to operating costs or total costs. Minnesota also provides refinancing and equity incentives, and Wisconsin provides a property incentive.

Property Reimbursement

North Dakota, South Dakota, Wisconsin, and Iowa base property reimbursement on historical costs allowing for depreciation and actual interest expense. Minnesota uses a fair-rental formula to calculate an imputed value for property reimbursement. Minnesota's modified rental formula is used only to determine changes to a base property rate caused by major projects or annual improvements.

Special Reimbursement Considerations

Statewide average reimbursement rates may be increased when a state provides special reimbursement considerations, usually higher reimbursement limits, to certain types of facilities. In Minnesota, hospital-attached and short-length-of-stay

facilities, and facilities serving the severely physically impaired are subject to special reimbursement considerations. South Dakota also provides special reimbursement considerations to hospital-attached nursing homes.

SUMMARY

Nursing home industries in Minnesota and the surrounding states share some characteristics, such as a higher rate of nursing home use than the national average, but they also differ in important ways. Nursing home industries were larger in Minnesota and Wisconsin than in North and South Dakota in 1995. Minnesota, North Dakota, and South Dakota had more hospital-attached nursing homes than Iowa or Wisconsin. In addition, Minnesota had more publicly-owned nursing homes than Iowa, North Dakota, and South Dakota.

Most states examined do not distinguish between "skilled nursing" and "intermediate care" after federal regulations eliminated this distinction. Minnesota, North Dakota, and South Dakota do not distinguish between intermediate and skilled nursing levels of care. Approximately 80 percent of Wisconsin's nursing home residents received a skilled nursing level of care. In contrast, Iowa continues to distinguish between these two different levels of care, and unlike other states, maintains a different reimbursement system for each level of care. Our analysis of Iowa's rates and costs focuses on nursing facilities that provide an *intermediate level of care*. For this reason, data on Iowa's nursing home reimbursement rates and costs are not directly comparable to data for the other states examined.

While the federal government regulates and sets general policy for the provision and reimbursement of nursing home care, it also gives each state flexibility to establish its own Medicaid reimbursement systems. There are more differences than similarities in the methods each state uses to establish its reimbursement rates. Each state, for instance, uses different cost reporting years, and different methods of limiting reimbursement of costs and adjusting rates to resident care needs. As a result, there is wide variation in nursing home reimbursement systems among the states examined, making comparisons difficult.

The following chapters describe the variation in Medicaid nursing home reimbursement rates in Minnesota and the surrounding states and analyze each state's nursing home cost reports to determine what specific factors account for the variation in average nursing home rates. In Chapter 5, we evaluate the impact of reimbursement limits, inflation adjustments, and incentive payments on nursing home rates and costs.