PAYING MORE, BUT NOT GETTING BETTER CARE

THE CASE FOR A NEW PAYMENT SYSTEM FOR NURSING HOMES IN NEW YORK'S MEDICAID PROGRAM

Founded in 1932, the Citizens Budget Commission is a nonpartisan, nonprofit civic organization devoted to influencing constructive change in the finances and services of New York City and New York State governments.

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New York State can provide its needy residents with better nursing home care and save about $1.2 billion annually by changing the way its Medicaid program pays nursing homes. The current payment method perpetuates inefficiencies and inequities without assuring high quality care.

New York State has an opportunity to become a national leader in nursing home standards by modernizing its payment system to reward homes that do a better job at lower cost. This paper explains why the current system is wasteful, and how a better payment system might work.

THE CASE FOR A NEW PAYMENT SYSTEM

New York's Medicaid program is the most expensive in the nation, projected to cost $45 billion in fiscal year 2008-09 and to consume nearly one-third of the New York State budget while covering 4.7 million state residents.[1] Spending per beneficiary in New York of $7,910 annually is also the highest in the nation, and it is 69 percent above the national average based on the most recent comparable data.[2]

Nursing homes play a significant role in the costs of New York's Medicaid program. The $6.5 billion spent for nursing homes in 2004 represented over 17 percent of the State's total Medicaid spending, and spending per nursing home beneficiary, $32,441, exceeded the national average by 32 percent.[3]

In New York, the Medicaid program pays nursing homes an average of $187 per day, 44 percent above the average of $130 per day for the rest of the nation.[4] If allowance is made for New York's higher cost of living – estimated to be about 13 percent above the national average – the premium paid by New York taxpayers is still 27 percent.[5] This differential has been narrowing as other states have increased their lower rates more rapidly than New York, but the premium paid in New York remains substantial and costly.

New York's relatively higher rates cannot be attributed to two factors sometimes used to justify them - differences in the ancillary services included in the rates and differences in the severity of illness (called case-mix) among the patients served. Some states, like New York, include physical therapy and other ancillary care services in addition to basic room, board, and nursing care in the daily Medicaid nursing home payment rate; other states pay for these services separately or not at all. But this is not the reason for New York's higher rates. An analysis performed for the federal government shows that after adjusting Medicaid rates for the different ancillary services included in rates, New York's Medicaid nursing home rates were still 57 percent higher than the national mean.[6]

Similarly, case-mix differences do not explain the higher rates. New York's nursing home rates exceed those of the other 34 states with the same type of case-mix adjusted payment system by an even greater amount than for states with a "flat rate" system. New York's average daily rate is 44 percent higher than the average for the 34 states with a case-mix system, and 42 percent higher than the average for the 13 states with a flat rate system.[7]

Higher rates are not buying better care

The major items driving New York's high per diem costs are not those associated with better care for residents. One of the most important factors in nursing home quality is the ratio of nursing staff to patients.[8] Despite much higher spending, nursing homes in New York do no better than homes nationally on this critical indicator. In 2005 New York ranked 30th among all states for direct care nursing hours per patient day, providing 3.6 hours versus the national average of 3.7 hours.[9] A more recent survey of homes shows New York staffing at the national average (3.7 hours).[10] New York nursing homes spend an estimated 45 percent of the average daily rate on direct nursing care wages and benefits--about $85 of the $187

daily rate--compared to an estimated national average of 54 percent.[11]

Another significant quality indicator is how well nursing homes avoid having their residents admitted to hospitals for chronic conditions and other avoidable reasons. These hospital admissions unnecessarily put nursing home residents at risk for hospital-acquired infections and for mental status changes including disorientation. Unfortunately, New York homes rely heavily on hospitalizations for the elderly for conditions that could be managed on an outpatient basis.[12] Nearly one-third of all nursing home patients' hospital admissions in New York between 1999 and 2004 were for "ambulatory-care-sensitive conditions" such as diabetes and were judged to be avoidable. These avoidable hospitalizations are not just dangerous for nursing home patients; they are expensive with the costs for these admissions totaling about $1.2 billion annually.[13]

New York's high spending for nursing homes is not explained by other non-staffing quality indicators. According to data compiled by the AARP, New York does just better than the national average for the percent of nursing homes (15 percent) with deficiencies leading to harm or jeopardy to residents. New York ranked sixth worst for the high number of formal complaints per nursing facility filed with the State.[14] The federal government has begun reporting on 19 non-staffing quality outcome measures for nursing homes nationally. These data show New York homes do significantly better than national norms at providing flu and pneumococcal vaccinations, perform at or just above the national norm for most other indicators, but do worse at preventing pressure sores.[15]

The current system is inefficient

If higher payment rates are not buying higher quality, what accounts for New York's high spending? The high rates in New York are based on an outdated payment system that the State has relied upon since 1986. When the current system was developed over 20 years ago, many of the elements built into it (and added to it over the years) provided financial incentives for nursing home operators to meet State health policy goals. Now many of these elements are outdated, rendering them counterproductive in terms of meeting New Yorkers' current long-term care needs.

In the New York system, payment rates are specific to each of the 658 nursing homes in the state and are based on the costs incurred by each nursing home in 1983; homes sold after 1983 have updated base years.[16] Those costs are divided into four categories - direct, indirect, capital, and non-comparable. The 1983 costs have been updated annually based on inflation with some limits. Direct costs include wages and benefits for workers providing health care services such as nursing and physical therapy. Direct costs are subject to a ceiling based on the severity of residents' illnesses, a measure referred to as case-mix. The indirect costs are expenses for room and board, administration and other overhead. The indirect costs are subject to a ceiling based on the nursing home's "peer group" - free-standing versus hospital-based, and less than 300 beds versus more than 300 beds - with hospital-based and larger homes having higher ceilings. Nursing homes must receive approval from the State Department of Health prior to undertaking major capital investments,

Table 1
Skilled Nursing Facilities Per Diem Costs
Fiscal Year 2006

	Average Per Diem Costs		Difference		NY as %
	U.S.	New York	Amount	Percent	of U.S.
Nursing Care	$61.50	$80.46	$18.96	27.6%	131%
Other General Services	76.14	103.68	$27.54	40.1%	136%
Employee Benefits	17.97	37.45	$19.48	28.4%	208%
Capital	17.41	20.14	$2.73	4.0%	116%
Subtotal	**$173.02**	**$241.73**	**$68.71**	**100.0%**	**140%**
Ancillary Services	$18.63	$13.00	-$5.63	NA	70%
Total SNF Services	**$191.65**	**$254.73**	**$63.08**	NA	**133%**

Notes: The "Other General Services" category includes Administrative and General, Plant Operation, Maintenance and Repairs, Laundry and Linen Service, Housekeeping, Dietary, and Nursing Administration cost centers. The "Ancillary Services" category includes Radiology, Laboratory, Intravenous Therapy Oxygen Therapy, Physical Therapy, Occupational Therapy, Speech Pathology, Electrocardiology, Medical Supplies Charged to Patients, Drugs Charged to Patients, Some Dental Care, Support Services and Other Ancillary Service cost centers. The analysis excludes the highest and lowest one percent of records in distribution on total costs per day.
NA = Not applicable.

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Cost Reports, Skilled Nursing Facility, "SNF FY 2006 (WINZipped.csv.76 MB)" http://www.cms.hhs.gov/CostReports/Downloads/SNF2008_06_30FY2006zip> (Accessed: September 8, 2008).

and then Medicaid reimburses these capital costs by dividing interest and depreciation expenses by the facility's number of patient days and adding this amount to the daily rate. Non-comparable costs include specialty services, such as on-staff physicians, that not all homes provide. These costs are reimbursed in the Medicaid daily rate without a ceiling.

This payment system leads New York to pay for costs that are well above national norms but are not related to the quality of care residents receive. As shown in Table 1, in 2006 the average per diem cost for all patients (not just Medicaid patients) in nursing homes in New York State was $242, or 40 percent above the national figure of $173 (excluding ancillary costs).[17] Of the $69 difference, fully $28 was in administrative and related expenses, $19 was for fringe benefits, and $3 for capital costs. Only about $19 of the total difference was related to nursing care provided to patients.

Inequities are piled on top of inefficiencies

Because New York's payment rates are based on facility-specific historic costs, homes of the same ownership type (for-profit and nonprofit) and in the same geographic region are paid very differently for the same types of patients. As shown in Table 2, in the Northern Metro area

Table 2
Maximum Medicaid Nursing Home Reimbursement Rate
by Region and Ownership Type, 2007

	Average Maximum Medicaid Rate (a)			Highest Rate
Region	Proprietary	Voluntary	Public	as Precent of Lowest
Central	$146	$168	$160	
Range	123-177	131-225	137-177	183%
% Variation	44%	72%	29%	
Long Island	$228	$252	$247	
Range	170-287	202-294	232-267	173%
% Variation	69%	46%	15%	
New York City	$224	$251	$251	
Range	154-314	176-330	218-283	214%
% Variation	104%	88%	30%	
Northeastern	$153	$173	$154	
Range	132-200	125-285	136-192	228%
% Variation	52%	128%	41%	
Northern/Metro	$192	$200	$221	
Range	138-241	147-270	153-362	262%
% Variation	75%	84%	137%	
Rochester	$152	$172	$199	
Range	126-196	129-206	150-261	207%
% Variation	56%	60%	74%	
Utica	$141	$157	$167	
Range	126-158	115-192	141-202	176%
% Variation	25%	67%	43%	
Western	$148	$169	$164	
Range	121-179	130-220	136-212	182%
% Variation	48%	69%	56%	

Source: Data supplied by the New York State Department of Health.
Note:(a)Maximum rates are case-mix adjusted for patients ineligible for Medicare Parts B&D and are for non-specialty units only.

daily rates adjusted for case-mix vary by 162 percent, ranging from a low of $138 at a for-profit home to a high of $362 at a government owned facility. Rates vary just as starkly even for homes of the same ownership type. In New York City, the case-mix standardized average daily rate for for-profit homes ranges from a low of $154 to a high of $314; in the Northeastern region, the variation is 128 percent among not-for-profits.

New legislative action is needed for improvements

New York's outdated system remains in place largely because New York State legislators ultimately determine the method for setting--and dollars appropriated to--Medicaid nursing home rates. New York State Health Department officials cannot change the system as part of their administrative discretion. It is now necessary to seek legislative changes in order to revise the payment system.

The difficulties of achieving reform through legislative action are evident in the "rebasing" legislation passed in 2006 and becoming effective on January 1, 2009. Intended as an improvement, these changes do little or nothing to alter the inefficiencies and inequities.

The 2006 legislation updates the base year using 2002 costs. Costs will, therefore, be seven years old when re-basing is implemented. In addition, the legislation maintains the facility-specific payment rates creating inequities among homes without providing any incentive to improve quality or efficiency. Payment rate inequities among homes will be exacerbated because the new rates will not be applied uniformly. Homes that have a higher rate under their existing base year (and homes with base years after 2002) are held harmless; specialty units for AIDS and other service intensive diagnoses have a permanent hold harmless protection.

The re-basing methodology also effectively maintains Wage Equalization Factor (WEF) provisions that are supposed to account for variations in wages and benefit costs among regions. However, old harmless provisions within the WEF adjustment allowed individual homes to choose the most beneficial for them from among four different WEF calculations based on 1983, 1987, 1993, or 2001 costs. Homes in New York City, for example, have benefited from a relatively generous labor contract in 1982 that has been perpetuated in the 1983 WEF calculations. The re-basing legislation calls for only one WEF calculation based on 2002 costs. Hold harmless provisions negate the new WEF calculation by allowing homes to maintain existing higher rates. The re-basing legislation also requires a redistribution of costs above ceilings within the system.

Maintaining the inefficient mechanisms in the current system increases costs, does not target funding to quality or to patient needs, and does little to ease the inequities. More fundamental reform is needed.

THE ELEMENTS OF A BETTER SYSTEM

A new payment strategy should address the problems in current rates by changing from a facility-specific to a standardized base rate system that varies primarily by differences in patient-specific characteristics and in geographic labor costs. A new system should also improve

quality of care by adequately funding nurse staffing levels, enforcing the staffing standards, and rewarding homes that have exceptionally good outcomes.

The starting point for a better system should be a standard base rate that is comparable to national norms, but increased to provide sufficient resources for adequate nursing care. As noted earlier, the average per diem nursing home payment under Medicaid outside New York State was $130 in 2004. Like homes in New York, those in the rest of the nation do not provide adequate nursing care. A panel of experts reported to the federal Centers for Medicare and Medicaid Services in 2001 that the minimum staffing requirement to ensure nursing home patient safety is 1.3 hours of registered nurse (RN) and licensed practical nurse (LPN) care per patient day and 2.8 hours of non-skilled care per patient day for a total of 4.1 hours of care per day.[18] Among New York nursing homes, 98 percent do not meet these federally recommended levels compared to 97 percent of homes nationally.[19]

Meeting the federally recommended level of 4.1 hours of total nursing care per patient per day requires an additional 30 minutes of nursing assistant care per patient per day, and substituting 15 minutes of LPN care with an additional 9 minutes of RN care. Based on national wage rates, the additional nursing assistant care adds about $7.14 for wages and benefits per patient per day on average, and the skilled care substitution is actually less expensive than current staffing ratios. In total, meeting federally recommended levels would require additional wage and benefit costs equal to about $6.10 per day, raising the national base rate to $136.10.

This national base rate should be adjusted in New York for two factors – regional variation in wage rates and differences in patient illness severity or case-mix. As noted earlier, New York already has a case-mix weight for adjusting rates. This system could be applied to the new standardized rate, or a more refined case-mix system building on the Resource Utilization Groups (RUGs) used by the Medicare program could be developed and applied.

In order to adjust for regional wage differences, the approach used by the Medicare program could be adapted. Medicare nursing home base rates are standardized nationally for urban and rural locations. In addition to case-mix adjustments, Medicare adjusts the standardized rate for variations in regional labor costs. The regional wage index is applied to 70 percent of the Medicare base rate, reflecting the proportion of cost estimated to be related to labor costs. Based on the cost-of-living differential identified earlier, this would likely increase the base rate in New York by an average of 13 percent.

Because Medicare pays only for nursing home care immediately following a hospital discharge, Medicare nursing home patients tend to have short stays for highly intensive nursing or physical rehabilitative therapies that are assigned high weights within the RUG system. New York's Medicaid nursing home patients are more like Medicare patients in lower weighted RUG categories that require nursing care to maintain a current level of functioning rather than intensive rehabilitative therapies. Average Medicare payments, reflecting the intensity of services provided, are generally higher than average Medicaid rates. Therefore,

applying a method similar to Medicare's to New York State's Medicaid nursing home population with less intensive rehabilitative care needs would not yield similarly high rates. In fact, under Medicare's payment system, the average Medicare nursing home payment in New York--$294--is only 11 percent above the average Medicare rate nationally--$264;[20] this compares favorably to the 27 percent difference in Medicaid rates noted earlier and is somewhat less than the 13 percent cost-of-living differential identified above.

While a modified Medicare methodology would provide a sound basis for setting payment rates in New York, it would not guarantee that nursing homes will actually use the money as intended. Owners may spend less on needed nursing care and apply more to profit or overhead. The Inspector General of the United States Department of Health and Human Services recently reported on health and safety deficiencies at nursing homes nationally.[21] New York did no better than homes nationally, with the percentage of New York homes cited rising from 90.4 percent in 2005 to 92 percent in 2007. The Inspector General noted that Medicare and Medicaid were being billed by some homes for services that "were not provided or were so wholly deficient that they amounted to no care at all." He also noted that because Medicare pays a higher rate for more severely ill patients, some homes improperly classified patients or overstated the severity of their illnesses to increase their reimbursement rate. [22]

Any new nursing home payment system should, therefore, be accompanied by adequate standards for direct care staffing levels, a robust accountability system to ensure that the level of care paid for in the rates is actually provided, and financial incentives for homes to meet quality outcome goals. First, New York homes should be staffed at the federally recommended level of 4.1 hours of care per patient per day; *New York should be the national leader in nursing home quality—instead of just nursing home spending.*

Next an accountability system to ensure that the new staffing standards are met needs to be enforced. The nursing home industry should be held to the same accounting standards required of other industries that contract with government payers; an auditing system should be developed to detail whether the level of staffing assigned to a patient meets the criteria required according to the patient's RUG category. Ideally, direct care employees providing care to a given patient (whose RUG category essentially defines the contract) should be verifiable with payroll records. Minimally, homes should provide payroll and employment tax filings electronically to State and federal auditors on an annual basis, so they can target audits to homes with staffing levels that do not correlate with their case-mix index.

Finally, financial incentives to provide measurable quality outcomes should be built into the system. Some states have implemented "pay-for-performance" initiatives to reward homes that meet quality measures. For example, Minnesota, Iowa, and Kansas reward homes with additional payments depending on how well they score on outcome surveys. In Minnesota's program a third-party surveys homes to determine how well they meet five quality indicators worth a total of 100 points—a home's reliance on in-house as opposed to "agency or pool" staff, for example, is worth 10 points; homes meeting the maximum quality level are

Table 3
Estimated Savings from New Nursing Home Payment System, State Fiscal Year 2008-09
(dollars in millions)

	Estimated Savings			
	Total	Federal	State	Local
Reduce Spending to Regionally Adjusted National Average	$1,584	$792	$661	$131
Staffing Improvements (3.3%)	($238)	($119)	($99)	($20)
Quality Outcomes Bonus Payments (3%)	($108)	($54)	($45)	($9)
Adjusted Savings	$1,238	$619	$516	$103

Source: CBC staff calculations. See text for methodology.

eligible for a bonus payment equal to 3 percent of their base rate.[23] In Iowa, homes can receive up to 3 percent of median costs depending on the number of points earned toward meeting 10 outcome standards. Homes scoring 0-2 points are not eligible for a bonus; homes scoring 3-4 points receive 1 percent additional; those scoring 5-6 points earn 2 percent, and those scoring 7-10 points earn 3 percent. In Kansas, homes are eligible for an added dollar value, rather than percent of rate, up to $3.00 per day according to quality scores.

New York State should develop a set of quality indicators such as those being used in other states and being tested by Medicare to assess patient outcomes. Homes should not receive their full daily rate if they fail to meet minimum quality standards; homes exceeding quality standards should be eligible for bonus payments.

THE POTENTIAL SAVINGS

The new payment system outlined above would yield significant savings for New Yorkers, while promoting higher quality care. Bringing New York's Medicaid payments in line with national Medicaid norms, after adjusting for cost-of-living, requires a 21 percent reduction in nursing home rates. Similarly, bringing New York Medicaid rates to within 11 percent of the national Medicaid norm - the same differential between New York's and the national average Medicare rate - requires a 23 percent rate reduction.[24] Reducing New York State's projected Medicaid nursing home spending of $7.2 billion in fiscal year 2008-09 an average of 22 percent produces $1.6 billion in savings.[25] (See Table 3.)

Shifting 3.3 percent of current spending to improve nurse staffing reduces the savings estimate $238 million.[26] Assuming half of all homes qualify to receive a full 3 percent bonus for meeting quality outcome measures, savings would be reduced another $108 million for total adjusted savings of $1.2 billion in fiscal year 2008-2009. While half the $1.2 billion savings would accrue to the federal government, the State would save $516 million, and localities would save $103 million.[27]

In developing a new payment system, the State should set base rates: (1) linked to competitive national standards not historic costs, (2) sufficient for adequate nursing care, (3) adjusted for case-mix and for regional labor costs, and should (4) enforce staffing and other quality

standards and provide financial incentives for high quality. Implementing changes of this magnitude requires a phased-in plan over several years with significant support from State legislators. A reformed system should include increased flexibility for the Department of Health and Division of Budget to adjust and improve payment rates and methods as needed. The surplus funding already in the system, however, provides New York State with a unique opportunity to develop a nursing home payment method that rewards providers of efficient and high quality care and makes New York a national leader in improving nursing home care.

Endnotes

[1] In fiscal year 2008-2009 the New York State Division of the Budget projects total Medicaid spending will reach $45 billion with the federal share $22.4 billion, the State share $15.4 billion, and the local share $7.2 billion. The combined federal/state share of $37.8 billion is included in the State budget and represents 31percent of the $120.8 billion total for fiscal year 2008-09. See *2008-09 New York State Executive Budget.* www.budget.state.ny.us.

[2] United States Department of Health and Human Services, Centers for Medicare and Medicaid, Fiscal Year 2004 National MSIS data; http://www.cms.hhs.gov/Medicaid/DataSourcesGenInfo/Downloads/Msistables2004.pdf. Downloaded 8-30-08.

[3] Ibid.

[4] Data are for 2004, are an un-weighted average of 47 states (rates for Alaska and Hawaii are not provided), and are from David C. Grabowski, Zhanlian Feng, Orna Intrator and Vincent Mor, "Medicaid Nursing Home Payment and the Role of Provider Taxes," *Medical Care Research and Review*, January 4, 2008.

[5] Cost of living indices for the 50 states were developed by analysts at Harvard University for the Office of Senator Daniel P. Moynihan. See Herman B. Leonard and Jay H. Walder, *The Federal Budget and the States*, 24th edition, (Taubman Center for State and Local Government of Harvard University and Office of Senator Daniel Patrick Moynihan, December 15, 2000) p. 90. Note that a 13 percent increase in the U.S. average Medicaid nursing home rate raises it to $147; the New York State rate of $187 is still 27 percent higher.

[6] James Swan, Valli Bhagavatula, Amit Algotar, Mouhammad Seirawan, Wendy Clemena and Charlene Harrington, "State Medicaid Nursing Home Reimbursement Rates: Adjusting for Ancillaries," *The Gerontologist,* October 2001. Updated findings provided to CBC by James Swan.

[7] Rates from Grabowski et. al., Ibid. Case-mix states identified from Brown University Center for Gerontology and Health Care Research, *Proposal and Rationale for a Simplified Medicaid Payment System for Nursing Homes in Washington State*, Prepared for Washington State Department of Social and Health Services, Report to the Legislature, October 1, 2007.

[8] G. S. Wunderlich and P. Kohler, eds., *Improving the Quality of Long-Term Care* (Washington, DC: National Academy of Sciences, Institute of Medicine, 2001) and Institute of Medicine, *Keeping Patients Safe: Transforming the Work Environment of Nurses.* (Washington, DC: National Academy Press, 2003).

[9] Ari Houser, Wendy Fox-Grage and Mary Jo Gibson, *Across the States: Profiles in Long-term Care and Independent Living 2006*, AARP (Washington, DC). Http://www.Assets.aarp.org/rgcenter/health/d18763_2006_ats_rankings.pdf.

[10] Data available at the Medicare Nursing Home Compare Website: http://www.medicare.gov/NHCompare/include/DataSection/ResultsSummary. Downloaded, October 15, 2008.

[11] Nursing staff mean hourly wages are from the United States Department of Labor, Bureau of Labor Statistics, *Occupational Employment and Wages, May 2007*. Http://www.bls.gov/oes292061.htm. This wage data was adjusted to a 2004 level by annual nursing home trend factors of 3.2 percent for 2006, 3.4 percent for 2005, and 2.7 percent for 2004. The trend factor data was supplied by the New York State Department of Health. New York State hourly mean wages reduced by 10 percent for RNs and by 4 percent for CNAs, and increased by 4 percent for LPNs to reflect percent differences in the hourly mean for the nursing home industry compared to all health care industries based on national norms. Average nursing care costs for New York estimated at $16.44 for 36 minutes of RN care/day; $14.63 for 48 minutes of LPN care/day; and $28.46 for 138 minutes of nursing assistant care; this totals $59.53 per day. Average minutes of care provided in New York from the Medicare Nursing Home Compare website noted earlier. Wages assumed to reflect 70.4 percent of total compensation based on BLS, *Employer Costs per Hour Worked for All Service Producing Civilian Workers.* Http://www.bls.gov.news.release/ecec.t01.htm. This brings total nursing care compensation costs to $84.56 per day or 45 percent of the daily reimbursement rate of $187. Similar calculations for U.S. data show costs of $70.5 per day representing 54 percent of the $130 average rate.

[12] John Wennberg, Elliot Fisher, David Goodman and Jonathan S. Skinner, *Tracking the Care of Patients with Severe Chronic Illness, The Dartmouth Atlas of Health Care 2008*, The Dartmouth Institute, April 2008. http://www.dartmouthatlas.org/atlases/2008_Atlas_Exec_Summ.pdf. Downloaded September 14, 2008.

[13] David Grabowski, James O'Malley, and Nancy R. Barhydt, "The Costs and Potential Savings Associated with Nursing Home Hospitalizations," *Health Affairs*, (November/December 2007).

[14] Ari Houser et. al, op.cit.

[15] Data available at the Medicare Nursing Home Compare Website: http://www.medicare.gov/NHCompare/include/DataSection/ResultsSummary. Downloaded October 15, 2008.

[16] Number of nursing homes from U.S. Department of Health and Human Services, Centers for Medicare and Medicaid, Medicare Nursing Home Compare data; http://www.medicare.gov/NHCompare/Include/DataSection/Questions/HomeSelect.asp. Downloaded March 15, 2008.

[17] Ancillary costs include services such as radiology and laboratory tests. These services are not included in the comparison, because nursing homes vary in their inclusion of these services as operating expenses or as services provided by independent vendors and paid separately by patients or third parties.

[18] Federally recommended levels from: US Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. 2001. *Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress*: Phase II Final. Volumes I-III. Baltimore, MD.

[19] Office of the New York State Attorney General, Medicaid Fraud Control Unit, *Staffing Levels in New York Nursing Homes: Important Information for Making Choices,* January 2006.

[20] 2004 average Medicare nursing home reimbursement rates for U.S. and New York from Ari Houser et. al., op. cit.

[21] Daniel R. Levinson, Inspector General, *Memorandum Report: Trends in Nursing Home Deficiencies and Complaints,* OIE-02-08-00140, United States Department of Health and Human Services, September 18, 2008.

[22] Robert Pear, "Violations Reported at 94% of Nursing Homes," *The New York Times*, September 29, 2008.

[23] See Robert Kane, Greg Arling, Christine Mueller, Robert Held and Valerie Cook, "A Quality-Based Payment Strategy for Nursing Home Care in Minnesota," *The Gerontologist*, Vol. 47, No.1 108-115.

[24] New York State's average 2004 rate of $187.32 is 27 percent higher than the national average of $147 adjusted for New York's higher cost of living ($130 increased by 13 percent). The $39.9 difference represents 21 percent of $187.32.

[25] Projected 2008-2009 nursing home spending provided by the New York State Division of Budget.

[26] Improving staffing to the federal level would cost $6.10 in wages and benefits per patient per day, based on national wage data for 2004, representing 3.3 percent of the New York State average daily rate of $187 in 2004.

[27] New York State savings estimated at 41.6 percent of nursing home spending; counties savings estimated at 8.3 percent based on projected fiscal year 2008-2009 nursing home spending and State and local shares provided by the New York State Division of Budget.

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