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Analysis of Selected Nursing Facilities' Use of Medicaid Reimbursement for Direct Care Compensation

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

HHS OIG Data Brief • A-07-23-04134

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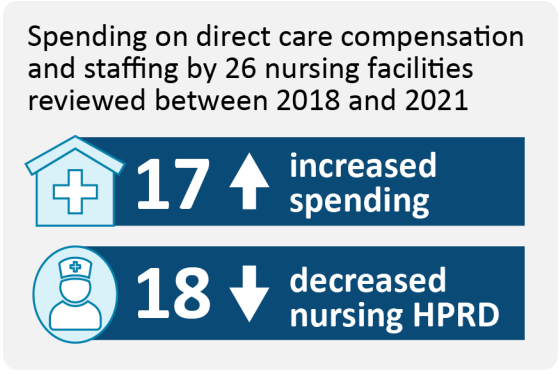
Purpose of This Data Brief

Key Takeaways:

Although spending on direct care compensation increased for 17 of the 26 nursing facilities we reviewed, facility staffing—as measured by nursing hours per resident day (HPRD)—decreased for 18 of these nursing facilities between the two time periods (2018 and 2021) we reviewed.

Nursing facility spending on direct patient care, and the quality of that care, are of critical importance for residents of these facilities, their family members, and the Medicaid program itself. Improving nursing facilities is a top priority for the Office of Inspector General (OIG).

Our objectives were to analyze spending for selected nursing facilities in 2018 and in 2021[1] to determine: (1) the percentage of funds received through Medicaid reimbursement that the facilities spent on direct care compensation, (2) whether the percentage used for direct care compensation at each facility changed between the 2018 and 2021 data snapshots, and (3) whether that change was a result of new ownership.



Federal requirements require nursing facilities to provide services and activities that attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. To determine how nursing facilities spent the funds they received through Medicaid reimbursement and to ensure that we took different types of nursing facilities into account, we selected 26 nursing facilities across 9 States (see Appendix A, which describes our audit scope and methodology).[2] We used Medicaid cost reports and

[1] The 2021 spending we analyzed occurred during the COVID-19 public health emergency. Associated impacts are reflected in the results that this data brief conveys.

[2] There are approximately 15,000 nursing facilities nationwide. We selected 26 nursing facilities that were either Medicare- or Medicaid-certified, or both, for our audit.

supporting documentation to determine the percentage of Medicaid reimbursement that these facilities spent on direct patient care. Specifically, we calculated the Medicaid portion of direct care compensation and compared it to the total Medicaid reimbursement that these facilities received. We use the term "direct care compensation" to refer to nursing facilities' compensation for their direct care workers and for their support staff.[3]

In May 2024, the Centers for Medicare & Medicaid Services (CMS) finalized Federal requirements pertaining to staffing of long-term care facilities, which would direct States to collect and report information on compensation for direct care workers as a percentage of Medicaid reimbursement for those working in nursing facilities.[4] Although these requirements have not yet been implemented, they spell out certain definitions with respect to nursing facility staffing that are relevant to the analysis we summarize in this data brief.

We provide this data brief to CMS for its information and review. Information in this data brief may also be of interest to other stakeholders, including other policymakers, State Medicaid agencies, and nursing facilities.

BACKGROUND

Medicare and Medicaid Coverage of Nursing Facilities

The Medicare and Medicaid programs cover care in nursing facilities for eligible enrollees. Sections 1819 and 1919 of the Social Security Act (the Act) establish requirements for skilled nursing facilities (Medicare) and nursing facilities (Medicaid) to meet certain specified requirements to participate in Medicare and Medicaid; these requirements are implemented in Federal regulations at 42 CFR part 483, subpart B.[5]

States are required to make payments to Medicaid providers for care and services described under the benefits generally discussed under section 1905 of the Act. Related requirements appear in sections 1902(a)(30)(A) and 1903 of the Act and implementing Federal regulations at 42 CFR §§ 433 and 447. Although there are no Federal requirements that address how nursing facilities are to spend the funds they receive through Medicaid reimbursement—including the

[3] See also "Definitions Related to Nursing Facility Reporting and Staffing That We Use for This Data Brief" below for CMS's definition of "direct care workers," "support staff," and "compensation," which we used to develop the term "direct care compensation."

[4] The final rule was published on May 10, 2024 (89 Fed. Reg. 40876). In April 2025, a Federal district court vacated the provisions of the May 2024 final rule at 42 CFR §§ 483.35(b)(1) and (c) that had imposed a minimum nurse staffing standard and a 24/7 registered nurse requirement. *Am. Health Care Ass'n v. Kennedy*, 2025 U.S. Dist. LEXIS 242020 (N.D. Tex. April 7, 2025).

[5] A skilled nursing facility is a nursing facility that has the staff and equipment to provide skilled nursing care and, in most cases, skilled rehabilitative services and other related health services to people with and without Medicare (the Act § 1819(1)(a)).

amount of the Medicaid reimbursement that must be spent on direct care compensation—States are obligated, as part of their program operations, to monitor and oversee Medicaid program expenditures to ensure that these funds are used according to the statutory and regulatory requirements.

Nursing Facilities Reporting Requirements

Federal regulations at 42 CFR § 447.253(f) require nursing facilities to submit annual cost reports. Cost reports capture the nursing facilities' characteristics (i.e., information on the type of facility, the number of resident days, and the percent occupancy, among other attributes), Medicaid utilization,[6] cost and charges by cost center, and financial statement data. In addition, nursing facilities are required to submit electronically, in a uniform format, to CMS direct care staffing information based on payroll and other verifiable and auditable data through the Payroll-Based Journal (PBJ) system (42 CFR § 483.70(p)).

Furthermore, nursing facilities are required to submit to CMS information on changes of ownership (42 CFR § 455.104(c)(1)(iv)).[7]

Payroll-Based Journal System

Nursing facilities are required to electronically submit direct care staffing information, based on payroll data, to CMS. The electronic system that the nursing facilities use is called the PBJ system. Guidance for use of this system appears in the *CMS PBJ Policy Manual* (June 2022). Among other things, these data include staff hours for registered nurses, licensed practical nurses, and certified nursing assistants (CNAs).

Definitions Related to Nursing Facility Reporting and Staffing That We Use for This Data Brief

In May 2024, CMS finalized a rule (May 2024 final rule; footnote 4) that would, among other things, require States to report the percentage of Medicaid payments for certain Medicaid-covered institutional services spent on direct care compensation (89 Fed. Reg. 40876 (May 10, 2024)). Although this final rule has not yet been implemented, it spells out certain definitions with respect to nursing facility staffing that are relevant to the analysis we summarize in this data brief.

[6] Medicaid utilization is a measure of the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given time period. For this data brief, we obtained the Medicaid utilization directly from the cost reports or calculated the Medicaid utilization for each selected nursing facility by dividing the Medicaid enrollee bed days by the total enrollee bed days.

[7] Notwithstanding this requirement, a Government Accountability Office (GAO) report, *Nursing Homes: Limitations of Using CMS Data To Identify Private Equity and Other Ownership* (GAO-23-106163), Sept. 22, 2023, identified limitations in the ownership information that nursing facilities enrolled in Medicare reported to CMS. We cite this GAO report to demonstrate the increased attention being paid to efforts to identify ownership structures in nursing facilities.

Accordingly, we follow CMS in defining "direct care workers" to include the following categories of staff who provide services to Medicaid-eligible individuals receiving services in nursing facilities: nurses (registered nurses, licensed practical nurses, nurse practitioners, and clinical nurse specialists); CNAs who provide such services under the supervision of one of the foregoing types of nurses; licensed physical therapists, occupational therapists, speech language pathologists, and respiratory therapists, and their assistants; and social workers; among others (89 Fed. Reg. 40876, 40995 (May 10, 2024)).

In addition, we follow CMS in defining "support staff" to include individuals who are not direct care workers and who maintain the physical environment of the nursing facility or who support other services (such as cooking or housekeeping) for residents. Examples of support staff include housekeepers, janitors, environmental service workers, groundskeepers, food service workers, dietary workers, and drivers (89 Fed. Reg. 40876, 40995 (May 10, 2024)).

We also follow CMS in defining "compensation" to include salary, wages, and other benefits such as health and dental benefits, sick leave, and tuition reimbursement. CMS's definition of "compensation" also includes the employer share of payroll taxes for direct care workers and support staff who deliver Medicaid-covered nursing facility services. This definition does not, however, include training costs (89 Fed. Reg. 40876, 40995, and 40918–40919 (May 10, 2024)).

OIG Definition
"Direct Care Compensation"

Nursing facilities' compensation for:

- direct care workers
- support staff

To address our second objective later in this data brief, we use CMS's definition of hours per resident day (HPRD) for a Medicaid-covered nursing facility as the total number of hours worked by each type of staff divided by the total number of residents as calculated by CMS.

Data Used To Develop This Data Brief

Our primary sources of data for this data brief were the Medicaid cost reports, PBJ data, and responses to questionnaires that we sent to the Medicaid State agencies and the 26 selected nursing facilities. We reviewed the selected nursing facilities' Medicaid cost reports to identify statistical data and information on revenues and expenses, thereby to calculate the Medicaid portion of direct care compensation, which we examined in the context of the facilities' Medicaid reimbursement. We obtained nurse staffing hours directly from the nursing facilities and from the PBJ data, and we used the questionnaire responses to supplement and clarify the Medicaid cost report and PBJ data.

Each of the 26 selected nursing facilities represented 1 of 3 different types of nursing facility in 2021: State- or local-government owned (government-owned) (9 facilities), nonprofit (10

facilities), or for-profit (7 facilities).[8] In 2021, the Medicaid utilization (footnote 6) exceeded 50 percent for 18 of the 26 nursing facilities.

To address our objectives, we analyzed data from 2 years: 2018 and 2021.[9] We treated the data for each year as snapshots, which we examined to identify differences between the 2 years in the percentages of funds received through Medicaid reimbursement that the selected nursing facilities spent on direct care compensation; whether the percentage used for direct care compensation at each facility changed between the 2018 and 2021 data snapshots; and whether that change was a result of new ownership. We did not analyze these data continuously across this 4-year timeframe. Therefore, this report uses the term "between 2018 and 2021" to point to these differences (in the percentages of funds spent on direct care compensation, whether these percentages changed, and whether that change was a result of new ownership) between the 2018 and 2021 data snapshots.

The nursing facilities we selected had different reporting periods. When a nursing facility used a calendar year for its reporting period, we selected the periods January 1, 2018, through December 31, 2018, and January 1, 2021, through December 31, 2021. When a nursing facility used a fiscal year for its reporting period, we selected the years beginning during 2018, and during 2021, respectively. For example, when a nursing facility's fiscal year began on July 1, we selected the periods July 1, 2018, through June 30, 2019, and July 1, 2021, through June 30, 2022.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A describes our audit scope and methodology.

[8] Two nursing facilities that had been classified as nonprofit according to our 2018 data snapshot subsequently underwent ownership changes. As a result, the 2021 data snapshot classified these two facilities as for-profit. We discuss ownership changes later in this data brief, in the discussion that relates to our third objective.

[9] Data from 2021 were the most current available data as of the start of our audit.

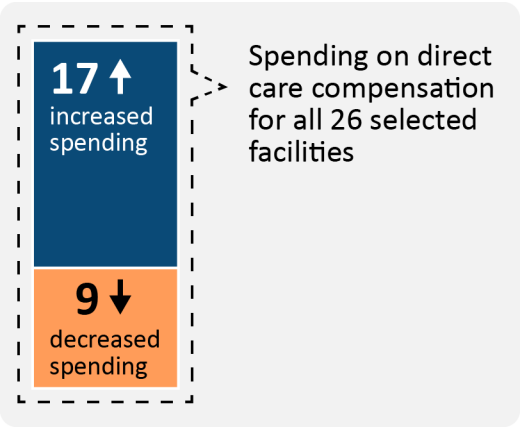
RESULTS OF ANALYSIS

PERCENTAGES OF FUNDS RECEIVED THROUGH MEDICAID REIMBURSEMENT THAT THE SELECTED NURSING FACILITIES SPENT ON DIRECT CARE COMPENSATION

For our first objective, we analyzed nursing facility spending to determine the percentage of Medicaid reimbursement that the 26 selected nursing facilities spent on direct care compensation in 2018 and in 2021. Specifically, we made the following determinations for the 26 nursing facilities we reviewed:

- 17 nursing facilities (5 government-owned, 9 nonprofit, and 3 for-profit) increased the percentage of funds received through Medicaid reimbursement that they spent on direct care compensation between 2018 and 2021, and

- 9 nursing facilities (4 government-owned, 1 nonprofit, and 4 for-profit) decreased the percentage of funds received through Medicaid reimbursement that they spent on direct care compensation between 2018 and 2021.



Among the selected nursing facilities, we identified the following additional data points with respect to the percentage of funds received through Medicaid reimbursement that was spent on direct care compensation between 2018 and 2021:

- The largest increase was 58.88 percent, by a government-owned nursing facility. The government-owned nursing facility stated that the increased costs were caused by having to contract for nursing staff at a higher cost.

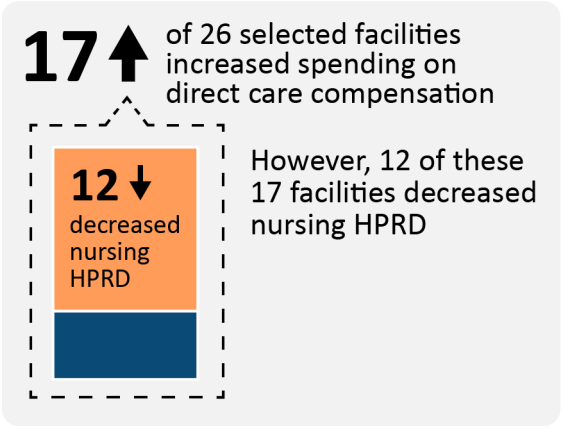
- The largest decrease was 17.11 percent, by a for-profit nursing facility. The for-profit nursing facility stated that it had to reduce direct care costs to stay financially viable.

(See Appendix B for data on the percentages of Medicaid reimbursement that the 26 selected nursing facilities spent on direct care workers and on support staff.)

CHANGES IN NURSING FACILITIES' DIRECT CARE COMPENSATION BETWEEN 2018 AND 2021

For our second objective, we identified changes, between the 2018 and 2021 data snapshots, in the percentages of funds received through Medicaid reimbursement that the 26 selected nursing facilities spent on direct care compensation.

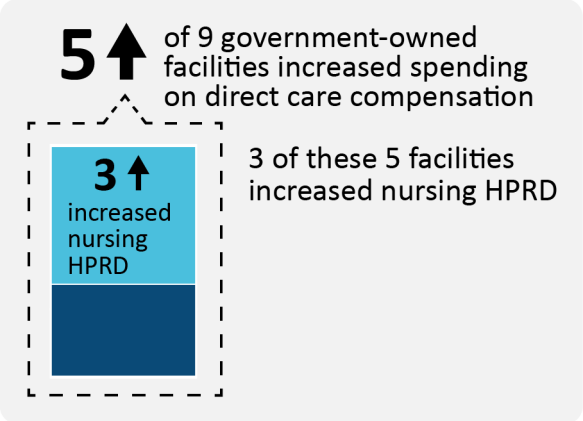
Between 2018 and 2021, the percentage of Medicaid reimbursement spent on direct care compensation increased for 17 of the 26 selected nursing facilities. Of these 17 nursing facilities, 12 had decreases in their nursing HPRD.



We asked these 12 nursing facilities to explain why their direct care compensation had increased but their nursing HPRD had decreased. Most of these nursing facilities attributed the increase in direct care compensation to an increase in labor costs because of the difficulties in hiring and retaining staff during the COVID-19 public health emergency (the facilities generally reported using higher wages and retention bonuses to overcome these difficulties). In addition, nursing facilities had to contract for nursing staff, which also contributed to higher labor costs despite the decreases in HPRD at some of the selected facilities.[10]

Changes in Government-Owned Nursing Facilities' Direct Care Compensation in the Context of Nursing Hours Per Resident Day

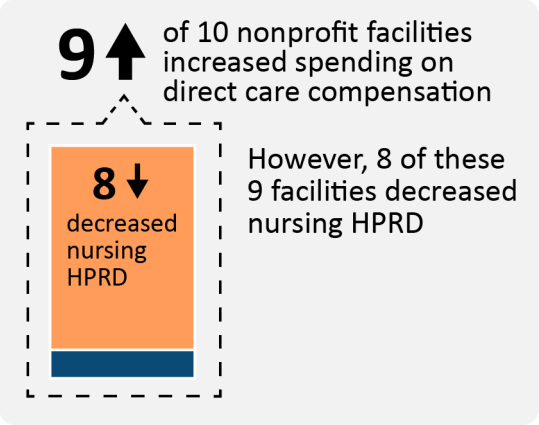
Between 2018 and 2021, five of the nine government-owned nursing facilities increased their percentages of Medicaid reimbursement spent on direct care compensation, and three of these five nursing facilities also had increases in their nursing HPRD. One of the five government-owned nursing facilities increased its percentage of Medicaid reimbursement spent on direct care compensation in 2021 in relation to 2018, but this facility had less staffing (i.e., a decrease in its HPRD) in 2021 than it had in 2018. When asked,



[10] Nursing facilities also responded that their costs for goods, such as additional personal protective equipment, increased from 2018 to 2021. However, because these costs were excluded from the calculation of the percentage of Medicaid payments spent on compensation for direct care workers and support staff in the May 2024 final rule, we excluded them from our calculation of direct care compensation.

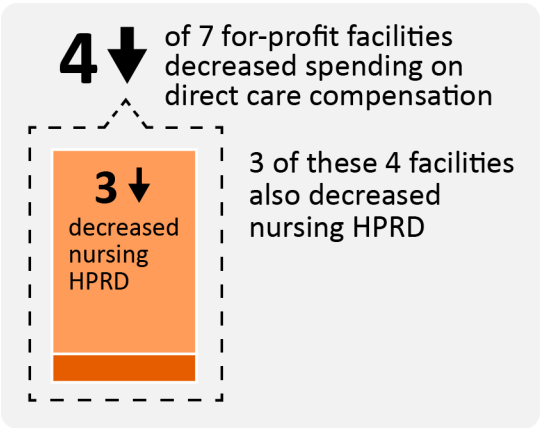
this nursing facility attributed the increase in direct care compensation to the COVID-19 public health emergency. The facility added that it increased its contract nursing staff, and the contract rates increased, because of pressures on the economy and demand (see Facility 26 in Appendix C, which provides a summary of our analysis for the 26 nursing facilities we reviewed).

Changes in Nonprofit Nursing Facilities' Direct Care Compensation in the Context of Nursing Hours Per Resident Day



Between 2018 and 2021, the percentage of Medicaid reimbursement spent on direct care compensation increased for 9 of the 10 nonprofit nursing facilities, but the nursing HPRD for 8 of these 9 facilities decreased. For example, one of the nonprofit nursing facilities had an increase in Medicaid reimbursement spent on direct care compensation of nearly 19 percent between 2018 and 2021, but its nursing HPRD between those same 2 years decreased by 0.36 HPRD. The 2021 Medicaid cost report for this nursing facility showed a notable increase in other nursing expenses. When we inquired about this increase in direct care compensation and decrease in nursing HPRD, the nursing facility explained that it had to contract for nursing staff at a higher cost.[11] This facility also stated that many of its in-house nurses and staff had become infected with COVID-19 during the public health emergency, which forced the facility to hire contracted nurses (see Facility 16 in Appendix C).

Changes in For-Profit Nursing Facilities' Direct Care Compensation in the Context of Nursing Hours Per Resident Day



Between 2018 and 2021, four of the seven for-profit nursing facilities decreased their percentages of Medicaid reimbursement spent on direct care compensation, and three of these four facilities had decreases in their nursing HPRD. For instance, one for-profit nursing facility decreased its Medicaid reimbursement spent on direct care compensation by 15.50 percent between 2018 and 2021, and its nursing HPRD between those same 2 years decreased by 0.97 HPRD. Officials from this nursing facility did not explain why direct care compensation had decreased, but they did describe the challenges they had experienced in obtaining staff

[11] The increase in this nursing facility's other nursing expenses generally reflected a greater use of contracted licensed practical nurses and nurses' aides.

after the declaration of the COVID-19 public health emergency and the need as a result to use contract nursing staff, which increased costs. Officials from this facility also referred to increases in general, overtime, and bonus pay. Despite the decrease in nursing HPRD, the nursing facility stated that it maintained sufficient staff to appropriately care for the enrollees in its resident population (see Facility 12 in Appendix C).

CHANGES IN NURSING FACILITIES' DIRECT CARE COMPENSATION WHEN THERE WAS AN OWNERSHIP CHANGE BETWEEN 2018 AND 2021

For our third objective, we identified 2 nursing facilities (of the 26 that we selected) that changed ownership between our 2018 and 2021 data snapshots. Specifically, we determined that these two nursing facilities had nonprofit ownership according to the 2018 data snapshot and had acquired for-profit ownership by the time of our 2021 data snapshot.

One nursing facility that changed to for-profit ownership between 2018 and 2021 slightly increased (by 0.84 percent) its direct care compensation between those 2 years. Despite this slight increase in spending on direct care compensation, this nursing facility saw a decrease in nursing HPRD of 0.18 HPRD (see Facility 1 in Appendix C).

The other nursing facility that changed to for-profit ownership had the largest decrease in direct care compensation of all the 26 nursing facilities we selected (17.11 percent), but its nursing HPRD decreased by only 0.02 HPRD (see Facility 25 in Appendix C). This nursing facility stated that it was able to reduce direct care compensation by converting contract nursing staff to in-house labor.

For the other 24 nursing facilities in our nonstatistical sample, we did not identify any changes in ownership. We note, though, that as CMS has pointed out, complex ownership structures make it difficult to identify nursing facilities' owners. Also, our data illustrate the challenges that may exist in identifying the individuals and entities responsible for quality of care in nursing facilities.[12] For example, 1 nursing facility that we reviewed listed 6 organizations and 10 individuals with ownership interests, managing control, or both. Despite disclosure requirements (in effect during both our 2018 and 2021 data snapshots) for nursing facilities to submit to CMS information on changes of ownership (footnote 7), it could be difficult for CMS, as well as enrollees or their family members via CMS's Care Compare website, to identify the

[12] CMS remarked upon this difficulty in a final rule issued in November 2023, after we initiated our audit work for this data brief. This final rule expanded disclosure requirements, including ownership information, for Medicaid nursing facilities. The rule also outlines CMS's concerns about the quality of care and operations of nursing facilities, including (though by no means exclusively) those owned by private equity and other types of investment firms (88 Fed. Reg. 80141, 80142–80244 (Nov. 17, 2023)).

owners, investors, operators, or other individuals or entities that have responsibility for nursing facility operations.[13]

Awareness of these difficulties is relevant to OIG and other stakeholders that have taken an interest in attempting to identify the ownership structures of nursing facilities. At this point, though, we are unable to draw conclusions about the extent to which changes in ownership may affect changes in the percentage of funds received through Medicaid reimbursement that nursing facilities spend on direct care compensation.

CONCLUSIONS

We are providing this data brief to CMS for its information and review. Information in this data brief may also be of interest to other stakeholders, including other policymakers, State Medicaid agencies, and nursing facilities.

Before starting our audit work and on the basis of our preliminary research, we anticipated finding that nursing facilities that spent higher-than-average percentages of their Medicaid reimbursement on direct care compensation would also have had higher-than-average nursing HPRD. Our analysis of the 26 nursing facilities we reviewed did not, however, identify a positive correlation of this nature. We did note that higher direct care compensation for the nursing facilities reviewed was usually attributed to increases in salary compensation, from having either to contract nursing staff or to offer bonuses to nursing staff.

We note as well that the lack of a clear, strong correlation between higher direct care compensation and higher nursing HPRD suggests that other factors—such as ownership structures—may play an outsized role in enhancing, or detracting from, quality of care provided by nursing facilities. Further work and analysis are needed to draw conclusions about possible correlations between these and other factors as they relate to the quality of care in nursing facilities, which serve such a critical role in America's health care system.

We issued a draft of this data brief to CMS. CMS furnished technical comments, which we addressed as appropriate.

[13] The publicly available Care Compare website allows consumers, their family members and caregivers, and other stakeholders to research quality-of-care metrics, health inspection reports, and CMS quality ratings for nursing facilities.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

To determine how the 26 nursing facilities that we selected for this audit spent the funds they received through Medicaid reimbursement in 2018 and in 2021, we calculated the Medicaid portion spent on direct care compensation and examined that portion in relation to each nursing facility's Medicaid reimbursement for that year. We used Medicaid cost reports and other supporting documentation provided by the selected nursing facilities to identify the Medicaid reimbursement (base and supplemental, excluding COVID-19-related supplemental reimbursements) they had received each year. To determine how the changes in direct care compensation affected staffing levels, we used CMS's PBJ data to determine registered nurse hours, licensed practical nurse hours, and CNAs' hours. (We calculated the HPRD by dividing nursing hours by Medicaid enrollee days.)

Expenses reported on a nursing facility's cost report reflect costs for the entire facility. For this data brief, we calculated the Medicaid portion of costs by applying the Medicaid utilization to the total costs. To calculate the Medicaid portion of nursing hours, we applied the Medicaid utilization to total hours before calculating HPRD.

Each of the 26 selected nursing facilities represented 1 of 3 different types of nursing facility in 2021: State- or local-government owned (government-owned) (9 facilities), nonprofit (10 facilities), or for-profit (7 facilities) (footnote 8). In 2021, the Medicaid utilization exceeded 50 percent for 18 of the 26 nursing facilities.

Originally, we selected 30 nursing facilities: specifically, 1 government-owned, 1 nonprofit, and 1 for-profit nursing facility from each of 10 States to review.[14] During the survey portion of our audit, we had to eliminate one State (and its three nursing facilities) because the State agency did not require nursing facilities to submit yearly cost reports. During fieldwork, we learned that one selected for-profit nursing facility had not submitted its 2021 cost report, so we eliminated this facility from our audit. In reviewing the nursing facility cost reports, we learned that two nursing facilities, classified as for-profit on CMS's Care Compare website (footnote 13), were actually nonprofit nursing facilities. We accordingly reclassified those two facilities as nonprofit. In total, we therefore reviewed 26 nursing facilities (9 government-owned, 10 nonprofit, and 7 for-profit nursing facilities).

To identify those nursing facilities that had changes in their ownership, we reviewed documents from CMS and sent the nursing facilities a questionnaire to ask them directly about any ownership changes.

To address our objectives, we analyzed data from 2 years: 2018 and 2021. We treated the data for each year as snapshots, which we examined for the 2 years to identify differences between the 2 years in the percentages of funds received through Medicaid reimbursement that the

[14] We selected these 10 States partly to provide a mixture of both more-populous and less-populous States.

selected nursing facilities spent on direct care compensation; whether the percentage used for direct care compensation at each facility changed between the 2018 and 2021 data snapshots; and whether that change was a result of new ownership. We did not analyze these data continuously across this 4-year timeframe. Therefore, this report uses the term "between 2018 and 2021" to point to these differences (in the percentages of funds spent on direct care compensation, whether these percentages changed, and whether that change was a result of new ownership) between the 2018 and 2021 data snapshots.

The nursing facilities we selected had different reporting periods. When a nursing facility used a calendar year for its reporting period, we selected the periods January 1, 2018, through December 31, 2018, and January 1, 2021, through December 31, 2021. When a nursing facility used a fiscal year for its reporting period, we selected the years beginning during 2018, and during 2021, respectively. For example, when a nursing facility's fiscal year began on July 1, we selected the periods July 1, 2018, through June 30, 2019, and July 1, 2021, through June 30, 2022.

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APPENDIX B: PERCENTAGES SPENT ON DIRECT CARE WORKERS AND PERCENTAGES SPENT ON SUPPORT STAFF

To address our first objective, we analyzed direct care compensation to identify the percentages of Medicaid reimbursement that the 26 selected nursing facilities spent on direct care worker expense and support staff expense in 2018 and in 2021. See Table 2.

Table 2: Percentages of Direct Care Compensation Spent on Direct Care Workers and on Support Staff for the 26 Selected Nursing Facilities

Facility Number	Percentage of Direct Care Worker Expense (2018)	Percentage of Support Staff Expense (2018)	Percentage of Direct Care Worker Expense (2021)	Percentage of Support Staff Expense (2021)
1	85.31	14.69	84.61	15.39
2	86.19	13.81	85.40	14.60
3	74.69	25.31	68.92	31.08
4	79.09	20.91	77.41	22.59
5	71.68	28.32	76.29	23.71
6	80.36	19.64	68.46	31.54
7	85.73	14.27	91.13	8.87
8	81.31	18.69	86.19	13.81
9	84.53	15.47	80.20	19.80
10	83.68	16.32	82.09	17.91
11	88.80	11.20	84.26	15.74
12	80.37	19.63	82.12	17.88
13	71.28	28.72	77.03	22.97
14	87.07	12.93	85.88	14.12
15	95.69	4.31	95.41	4.59
16	97.89	2.11	98.62	1.38
17	66.20	33.80	57.80	42.20
18	78.47	21.53	78.42	21.58
19	87.09	12.91	81.85	18.15
20	84.09	15.91	85.08	14.92
21	80.64	19.36	76.94	23.06
22	87.06	12.94	76.03	23.97
23	76.52	23.48	75.29	24.71
24	85.76	14.24	84.18	15.82
25	83.79	16.21	81.68	18.32
26	85.29	14.71	83.85	16.15

APPENDIX C: SUMMARY OF ANALYSIS OF 26 NURSING FACILITIES REVIEWED

Facility No.	Nursing Facility Type	Percentage of Medicaid Utilization (2018)	Percentage of Medicaid Utilization (2021)	Percentage of Medicaid Reimbursement Spent on Direct Care Compensation (2018)*	Percentage of Medicaid Reimbursement Spent on Direct Care Compensation (2021)	Percentage Change	Nursing HPRD (2018)†	Nursing HPRD (2021)†	Nursing HPRD Difference
1	For-profit	73.68	78.50	74.27	75.11	0.84	3.17	2.99	-0.18
2	Nonprofit	66.27	59.56	70.39	90.93	20.53	3.47	3.42	-0.05
3	Government-owned	99.81	98.87	63.79	61.76	-2.03	6.01	4.42	-1.59
4	For-profit	69.60	64.30	64.27	77.98	13.70	3.16	3.35	0.19
5	Government-owned	64.00	73.50	106.59	117.00	10.41	3.51	4.94	1.43
6	Nonprofit	45.60	41.50	70.11	74.15	4.04	3.78	3.47	-0.31
7	Nonprofit	60.81	62.50	77.74	90.54	12.80	3.56	3.29	-0.27
8	Government-owned	27.57	14.44	62.56	121.44	58.88	5.43	5.70	0.27
9	Nonprofit	38.09	49.61	78.64	88.34	9.70	4.23	3.76	-0.47
10	Nonprofit	37.79	48.02	61.47	65.61	4.13	2.88	2.46	-0.42
11	Government-owned	34.30	37.72	85.83	80.65	-5.18	2.71	3.18	0.47
12	For-profit	69.75	65.43	69.58	54.08	-15.50	3.21	2.24	-0.97
13	Nonprofit	40.48	37.89	124.18	127.04	2.86	4.14	4.60	0.46
14	Government-owned	99.45	99.33	44.21	44.44	0.22	4.54	7.65	3.11
15	For-profit	72.92	73.06	51.58	57.64	6.06	3.11	2.92	-0.19
16	Nonprofit	76.98	72.07	55.59	74.96	19.37	3.05	2.69	-0.36
17	Government-owned	34.77	32.72	126.32	109.83	-16.49	4.87	6.78	1.91
18	Government-owned	63.49	64.94	84.72	80.58	-4.14	2.76	2.59	-0.17
19	Nonprofit	46.91	53.86	72.15	80.12	7.97	3.59	2.81	-0.78
20	For-profit	61.78	72.84	69.45	67.37	-2.08	3.02	3.13	0.11
21	For-profit	69.53	80.52	83.56	78.69	-4.87	3.85	3.24	-0.61
22	Government-owned	28.14	36.38	193.18	195.60	2.41	6.22	5.60	-0.62
23	Nonprofit	51.50	53.49	79.81	82.67	2.85	4.18	4.07	-0.11
24	Nonprofit	71.97	62.64	75.84	66.48	-9.35	3.29	3.19	-0.10
25	For-profit	60.47	56.61	78.16	61.05	-17.11	3.32	3.30	-0.02
26	Government-owned	54.47	52.80	81.06	87.47	6.41	4.39	3.69	-0.70

* Occasionally nursing facilities supplement their Medicaid reimbursement with funds from other sources (e.g., charitable contributions). When this occurs, the percentage of Medicaid reimbursement may exceed 100 percent.

† HPRD calculation includes staff hours for registered nurses, licensed practical nurses, and CNAs.

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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