1997 STATE DATA BOOK ON LONG TERM CARE PROGRAM AND MARKET CHARACTERISTICS

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INTRODUCTION

This is a summary of findings from a project on state long term care (LTC) program and market characteristics conducted by researchers at the University of California, San Francisco, and Wichita State University under a cooperative agreement with the U.S. Health Care Financing Administration and the U.S. Department of Housing and Urban Development. Descriptive data for 1997 were collected from a survey of state officials in 1998. The data collection effort was designed to build upon a cross-sectional longitudinal data set on long term care program characteristics in the states for the 1978 through 1997 period. Primary data were collected by telephone using structured questionnaires that requested specific data from each state.

STATE DATA BOOK

A state data book has been prepared which has a state by state presentation of statistical data for 1997. Data were collected from three different surveys of: (1) state LTC providers; (2) state certificate-of-need and moratorium programs; and (3) Medicaid reimbursement agencies.

Each part includes data on five types of long term care services: (1) nursing home facilities (NF); (2) intermediate care facilities for the mentally retarded (ICF-MR); (3) residential care (or board and care); (4) adult day care; and (5) home health agencies.

In addition, analytic papers have-been prepared which describe special studies that were conducted. These papers include special analyses of data from the 50 states regarding the change in nursing home beds and the predictors of reimbursement rates. The following is a summary of the most important findings from the 1997 descriptive data and from trends over the 1978-1997 period.

DEMOGRAPHIC TRENDS IN THE STATES

The demand for long term care services is growing with the increasing numbers of individuals who are aged and chronically ill. In 1997, there were 34.1 million Americans who were age 65 and older. As the population ages and develops chronic illnesses, the need for long term care services, including nursing home services increases. The average aged population in the U.S. has been increasing rapidly. The aged population (65 and over) was 11 percent of the total population in 1978 but grew to 12.7 percent in 1997. The percentage aged 85 and over increased from 1.0 in 1978 to 1.4 percent in 1997 in the

total U.S. population. States show a wide range of ratios of aged population. Alaska has the lowest ratio of aged (5.3 percent aged 65 and over in 1997) while Florida had 18.5 percent aged 65 and over. States with the lowest ratios tended to be in the west and states with the highest ratios of aged were in the northeast or central regions. The data on the population came from the U.S. Bureau of the Census.

NURSING HOME PROVIDERS

Nursing home services were estimated to be $87.5 billion, or 8.7 percent of the total health care expenditures in the United States in 1996 (Levit et al 1998). The increase in nursing home expenditures was estimated to be 4.3 percent between 1995 and 1996. The large state and federal expenditures for nursing homes has drawn the attention of policy makers and researchers to understand the market for nursing home services. As the need for nursing home care grows, the nation's capacity to provide such nursing home care is the subject of concern.

The number of facilities in the nation increased from 14,264 in 1978 to 17,628 in 1997. This represents a 24 percent increase in the 19-year period of 1978-1997 for the U.S. The total number of combined skilled nursing and nursing facility beds in the states increased from 1.31 million to 1.81 million between 1978 and 1997, a 38 percent increase during the 19-year period. Thus, the growth in the number of beds exceeded the growth in the total number of facilities. The U.S. average number of beds per facility increased from 91.8 beds in 1978 to 102.7 beds in 1997 (a 12 percent increase).

There were 53.4 beds per 1,000 population aged 65 and over in the U.S. in 1978 compared with 53.1 in 1997. The average number of beds per 1,000 aged 85 and over declined from 610.3 to 468.1 per 1,000 aged 85 and over between 1978 and 1997 (a 23.3 percent decline). Between 1996 and 1997, 28 states showed declines in the ratio of nursing home beds per 1,000 population aged 65 and over. Many of the states with declines were from the west.

Data on nursing home occupancy rates across states are increasingly difficult to obtain from the state agencies. In 1978, the average nursing home occupancy rate for 25 reporting states was 90.3 percent. The average occupancy rates for the U.S. increased gradually to a high of 92.8 percent in 1984 (46 states reporting), and then gradually declined again to 86.0 percent in 1997 (25 states reporting). Because many states have not collected occupancy data during the last four years, the lower rates may simply be an artifact of these states reporting. Occupancy rates varied from a low of 73.5 percent in Texas to a high of 95.9 percent in Connecticut in 1997.

COMMUNITY-BASED PROVIDERS

Considerable growth in home care and other community-based long term care services occurred during the 1990s. Thus, those who need long term care services have greater choices and expanded opportunities for public funding for such programs. Although the demand for long term care services is growing, little is known about the availability of community-based long term care providers.

Intermediate Care Facilities for the Mentally Retarded

In 1997, 6,480 licensed ICF-MR facilities were identified in the states. This was a decrease of 135 facilities over the total reported in 1996. The largest number was reported in California (953 facilities). Texas and New York also had large numbers of facilities relative to those reported by other states.

There were 128,430 licensed ICF-MR beds in the states in 1997. This was a decrease of 0.2 percent over the total beds in 1996. Texas also had the largest number of beds, but its beds declined by 1.5 percent over its numbers in 1996.

The average number of beds per facility was 19.8 beds in 1997. Although there was a slight increase in the US average number of beds per facility in 1997, the average varied considerably across the states. As with nursing homes, ICF-MR beds per population varied by state. The highest ratio of ICF-MR beds per 1000 population was in the District of Columbia with 1.58. The lowest ratios were in Alaska (0.00), New Hampshire (0.02) and Vermont (0.02). Generally, states were unable to report occupancy rates for ICF-MR facilities. For those states reporting (9 states), the average occupancy rate, was 94.3 percent in 1997.

Residential Care

There were 49,913 licensed residential care facilities reported for adults and/or the aged in 1997. This was a 42 percent increase over the 35,171 licensed board and care homes serving the elderly in 1990. The state with the largest number of facilities was California (10,539) and the state with the smallest number of facilities was Indiana (31).

The total number of licensed residential care beds for adults and/or the aged in the U.S. was 827,584 in 1997. This was a 60.8 percent increase over the 514,749 licensed board and care beds serving the elderly reported in 1990. The increase is, in part, related to more complete reporting on residential care from the states. Some states have residential care reporting and monitoring located in as many as three agencies, making data collection difficult. California reported 162,489 beds, over twice as many as Florida, 4 times as many as New York, and nearly 7 times as many as Texas. The average number of licensed residential care beds per facility was 16.6 beds in 1997.

The ratio of licensed residential care beds serving adults was 24.3 residential care beds per 1000 population age 65 and over in 1997. These ratios also varied widely across states, from 49.7 beds per population in Oregon to 3.4 beds per 1,000 in Indiana. The data also show that the ratio of licensed residential care beds per aged population may have increased over the 1989-1997 period, although many states were unable to report historical data.

In 1997, there were 11,724 'other residential care' facilities in the U.S., an increase of 25 percent since 1996. The number of 'other residential care' beds was 99,198 in 1997, an increase of 47 percent since 1996.

Home Health Care Agencies

There were a total of 14,062 licensed home care agencies in the U.S. in 1997. The number increased by 343 percent over the 3,175 in 1989. Texas, Florida, California, and New York report large numbers of agencies. The average ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.5 in 1997. Texas had the largest ratios of agencies per aged population (1.65), Pennsylvania had the smallest (0.05). Many states were unable to report on the number of agencies licensed in earlier years. Eleven states do not license agencies but rather use certification of agencies for participation in Medicare and Medicaid. The number of certified home health care agencies increased from 2,905 agencies in 1989 to 10,489 agencies in 1997. This was a 261 percent increase in certified agencies over the 1989-1997 period.

Day Care Centers

Twenty-seven states reported 3,435 licensed adult day care centers in 1997 in the U.S. Pennsylvania and California reported the largest numbers of day care centers in 1997 (620 and 598, respectively). When the number of centers was compared with population aged 65 and over, the national average ratio per 1,000 aged population was 0.16 in 1997. Louisiana had the highest ratio of day care centers per population (0.55).

In summary, the total number of ICF-MR, residential care, home care and adult day care programs have been increasing in the recent time period. The large number of available providers shows these providers are important components of the long term care delivery system. It is expected that these programs provide alternatives to nursing home services, and may reduce the demand for nursing home care. The wide variations of all types of LTC programs reflect the many historic differences in state programs and utilization patterns.

CERTIFICATE-OF-NEED AND MORATORIA

State certificate of need policies are designed to limit or plan provider supply. Congress passed the National Health Planning and Resources Development Act

of 1974 (P.L. 93-641) to establish the certificate-of-need program (CON), which required approval for new beds and services. After the federal requirements for health planning and certificate of need were removed in 1986, there was greater variation in state CON activities.

By 1980, all states had adopted CON programs. In 1982, 44 states had CON only, 6 had CON and moratorium, and only one had no CON. Between 1996 and 1997, 44 states (including the District of Columbia) continued their CON programs and/or moratorium for nursing homes.

Some states began adopting moratoria on all nursing bed growth in the early 1980s. Eight states that retained their CON programs also added a moratorium on nursing home beds and services during the 1980s. In 1997, 12 states had both a CON and moratorium, seven states had only a nursing home moratorium (with no CON), and 25 states had CON only. This left only 7 states with neither a CON nor a moratorium.

In summary, during 1997, 44 states regulated the growth of new nursing home beds and/or facilities through either a CON and/or a moratorium. Of the total states, 40 also had a CON and/or moratorium requirement for regulating the conversion of hospital beds to nursing home beds.

Many states that had CON and/or moratorium programs for nursing homes also used them for other long term care programs. Intermediate care facilities for the mentally retarded (ICF-MR) were regulated under CON and/or moratorium requirements by a majority of states (32 states in 1997). Of these states, 12 had both a CON and moratorium and 4 had a moratorium only on ICF-MR beds and facilities. Surprisingly, 10 states included residential care facilities under their CON and/or moratorium requirements in 1997.

Between 1979 and 1981, 28 states had CON programs for home health agencies. Once a state developed CON for home health care, they generally retained the program (only seven states dropped CON during the 1978-1992 period). In 1997, 17 states used a CON only for home health and 1 state had both a CON and moratorium. .

The total number of nursing home CON applications in the US declined from 1,194 applications in 1986 to 821 in 1997. Florida had a consistently higher number of applications than other states. The U.S. average denial rate was 36 percent in 1986, and in 1997 had increased to 53 percent of total dollars. The total dollar amount of applications was $2.4 billion in 1986, and then declined to $0.92 billion in 1990. In 1997, the value of applications was $1.52 billion, a decline from $2.52 billion in 1996. CON application data were missing from eight states in 1997, compared to 3 missing in the previous year. The decline in CON applications appears related to the number of states reporting.

In summary, in spite of the federal withdrawal of support for the CON program, the majority of states and the District of Columbia retained their CON and/or moratoria for nursing homes and ICF-MR. A number of states also used CON and/moratorium for other long term care programs. The number and dollar value of applications submitted and approved has fluctuated over time. In 1997 the dollar value of CON applications was still high, $1.52 billion, with approvals totaling $0.70 billion.

MEDICAID REIMBURSEMENT RATES

State Medicaid provider rates can have a critical impact on stimulating or reducing supply and demand for nursing home services. State Medicaid programs have been making major efforts to control the growth in nursing home reimbursement rates. States are given a great amount of flexibility in their reimbursement methods and the variation across states is substantial.

NURSING HOME REIMBURSEMENT

Reimbursement Methods

Primary data were collected on state Medicaid nursing home reimbursement rates and methods for the 1978-1997 time period. Rates were categorized into five groups: (1) retrospective, (2) prospective class, (3) prospective facility specific, (4) prospective adjusted, and (5) combination of prospective and retrospective. Retrospective reimbursements traditionally have set rates based on the costs of providing care. Prospective methods set rates in advance, by setting a flat rate for groups of facilities (class method) or by setting rates for each facility based on historical costs and other factors (facility-specific). Adjusted methods allow upward adjustments during a period, generally based upon cost information that becomes available. Combinations systems use different approaches, and sometimes these are set for different cost centers. In addition, some states have been adjusting their rates based upon the characteristics of residents (casemix reimbursement). Such methods can be applied to any of the five general rate-setting methods.

Pennsylvania was the only state that changed their general nursing home reimbursement methods between 1996 and 1997. The number of states using retrospective reimbursement methods declined from 13 in 1979 to only 1 state (Nebraska) in 1997. The number of states using prospective facility-specific methods was 20 in 1997. The states using prospective class methods (4 in 1978 and 3 in 1997) remained relatively stable over the period. Twenty-four states used prospective adjusted methods in 1997 compared with only 13 in 1979. Combination methods were used in 3 states in 1979 and in 3 states again in 1997. These trends in methods show more complex but flexible rate setting methods.

Casemix Reimbursement

The most striking trend has been the increase in the number of states using casemix reimbursement methods, which pay on the basis of patient care needs, to account for differences in the costs of providing for those needs. By 1997, there were 26 states using casemix reimbursement, an increase over the 19 that used this method in 1992. No changes were made in the use of casemix between 1996 and 1997. The use of casemix reimbursement methods may improve access for heavy care patients, enhance quality of care, increase facility efficiency, and more fairly treat facilities on the basis of patients admitted. Casemix systems, however, can create incentives to increase patient dependence and could have negative effects on quality of care depending upon how the systems are designed and monitored.

Ancillaries

One critical feature of rates is whether or not ancillaries are included and which ones are included. In 1997, 33 states included durable medical equipment, 35 included physical therapy, 32 included occupational therapy, 31 included respiratory therapy, and 10 included physician services. Forty-seven states included non-legend drugs and only 3 states included prescription drugs. Where an ancillary is included in a daily nursing home rate, the rate should be higher, but ancillary costs may be less. There was a greater tendency to include ancillaries in rates by 1997 than there had been in previous years.

Cost Reporting Years

States use cost reports from previous years to set their prospective rates. In 1994, all states except 2 were using cost report data from the 1990s to set current reimbursement rates. In 1997, 30 states used cost reports from 1995, 1996 or 1997 in setting rates.

Capital Component

The methods of reimbursing capital are of special interest. States have different methods of valuating capital. Historic cost and market value approaches may allow less control of changes in rates, by allowing greater inflation in valuation of capital. There was a slight shift away from pure historic cost valuation of capital between the 1984 (33 states) and the 1987-1989 period (30 states). In 1997, 25 states used historic costs methods, while 7 used combination systems, 9 used rental value, and the others used different systems.

Reimbursement Rates

Each state can be characterized by one overall average reimbursement rate for nursing homes. Depending on payment and rate setting methods, estimating

average reimbursement rates by state is variably complex and imprecise. State Medicaid reimbursement rates have increased substantially overtime. In 1980, the weighted average nursing home per them rate across the states was $30.36. This increased to $46.92 in 1985 and by 1992, it was $76.72. In 1997, the average reimbursement increased to $91.45 in 1997 from $88.39 in 1996. When inflation was taken into account, the rates increased from $36.84 in 1980 to $56.98 in 1997. Thus, the average inflation adjusted rate increase for the 17-year period was 55 percent, an average of 3.2 percent annually. The inflation-adjusted rates increased only about 1.1 percent between 1996 and 1997.

In summary, the variations in nursing facility rates and methods create major differences in revenues by state and regions. Such variations can have a direct impact on the financial viability of LTC facilities and the public and private investments made in LTC facilities.

OTHER MEDICAID LONG TERM CARE REIMBURSEMENT

Intermediate Care for the Mentally Retarded

State ICF-MR reimbursement is established by the Medicaid program. The methodologies vary considerably across states but tend to be similar to the methods for nursing facilities. In 1997, 18 states used prospective facility specific methods, 13 used retrospective reimbursement, 12 used adjusted rates, 3 states used prospective class reimbursement, and 5 used combination methods. The Medicaid reimbursement rates varied from $70.36 per day in Oklahoma to $510.78 per day in Oregon in 1997.

Home Health Care

States have a variety of ways to reimburse Medicaid home health agencies. States may opt to simply apply Medicare principles, which was used by 12 states out of 51 reporting in 1997 (including Washington DC). Another 9 states used Medicare principles, with some state modifications. Nineteen states used a fee schedule for payment to home health agencies. One state used retrospective reimbursement methods, 5 states used prospective agency-specific reimbursement rates, and 5 used other methods. The average reimbursement rate for Medicaid home health care was $69.81 per visit in 1997 for those 44 states reporting rates. Rates ranged for registered nursing care from $ 26.92 in Indiana to $164.96 in Alaska.

Residential Care

Sixteen states provide Medicaid services to persons in residential care under the Medicaid waiver program. Some rates are tied to specific types of clients while other payment rates are allocated for different types of services or facilities.

Adult Day Care

Forty-one state Medicaid programs provide reimbursement for adult day care services. Reimbursement rates vary by types of day care and by clients. The client groups may include the aged, developmentally disabled, mentally ill, persons with HIV/AIDS, and other groups depending upon the state program.

Subacute Care

Fifteen states have Medicaid reimbursement rates for subacute care facilities. Reimbursement rates may vary by the types of clients and services approved. These types may include residents receiving ventilator services, complex respirator services, special rehabilitation services, head trauma care, and AIDS/ARC services that are more intense than the traditional nursing facility services but less costly than general hospital services and rates.

Summary

States have wide discretion in setting reimbursement rates for long term care services. As the number of types of services expand, states are developing more complex reimbursement methods and the variation in rates appears to be increasing.

DEFINITIONS

Add-on Reimbursement Costs:	The procedure of incorporating additional costs that are beyond the normal rate setting methodology. These costs may be included in the rate calculation or be added to the calculated rate so that they actually affect the rate.
Adjusted Reimbursement Method:	A change in a rate upward during the rate year. For our purposes this can include more than one rate period during a year, even if the rates are not adjusted during those periods or an Interim rate. An actual change in the rate is required, not just policy or provision that would allow it to be adjusted. The change in the rate does not always include all facilities with a given state.
ADL:	Activities of Daily Living are those activities for which individuals may require assistance from others, such as bathing, dressing, eating, toileting, and transferring. These activities needs are frequently used by states or programs in determining eligibility for long term care services.
Adult Day Care Facility:	A state-licensed adult facility that provides services for individuals on a part time and/or intermittent basis. Programs generally include health, social, personal care, and related supportive service in a protective setting to meet the needs of functionally or mentally impaired adults.
Adult Foster Care:	Residential care homes providing 24 hour supervision, protection and personal care as well as room and board in a home-like and family-like environment. Adult foster care serves a small number of persons, often from one to six individuals, and often with the primary caregiver residing in the home.
Ancillary Services:	A usually consistent (across states) set of services provided in the course of care in a nursing facility. They can be included in the rate under the appropriate cost center, billed separately, or paid by another program.

Appraisal/Reappraisal:	Formal estimation of the value of an asset in a nursing facility.
Assisted Living Facility:	Residential care facilities (not including licensed nursing home care) that provide 24 hour care to older people who on a continuing basis need personal care in order to compensate for ADL limitations.
Beds:	The total number of licensed beds in a facility at the end of the calendar year. This is used as a capacity measure of a facility.
Boren Amendment:	This legislation was passed in l980 to require states to reimburse Medicaid providers using rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." A number of nursing homes and their associations have filed lawsuits against states under the Boren Amendment.
Case-Mix Reimbursement:	Systems that require a method for assigning scores or "weights" to different residents, reflecting the relative costliness of caring for different residents, based on measurable characteristics (e.g., dependencies in activities of daily living). These weights are incorporated if rate setting is at the facility or patient level. Systems that pay different rates for different levels of care are classified here as having case-mix reimbursement.
Certificate-of-Need (CON):	State requirement that particular categories of health care providers must meet in order to receive approval to build new facilities and beds or to remodel or convert existing facilities, to add new programs or services, or to purchase new equipment. Each state may establish its own criteria for CON as well as monitoring and/or penalty procedures.
Class or Flat Reimbursement Method:	State designation of reimbursement method based on a uniform reimbursement amount and may be established for peer groups such as size or geographical region (class) or be uniform (flat) across

	a state. The system is categorized as a class method only if the rate is the same for all facilities in the class.
Combination Reimbursement Method:	Combination of rates set in advance (prospective) for some cost components and/or set afterward for others based on actual costs (retrospective).
Capital Costs:	The portion of the per diem rate that includes costs associated with construction, acquisition or lease of land, buildings or equipment used for resident care in a nursing home.
COBRA:	Consolidated Omnibus Budget Reconciliation Act of 1985. This legislation "Added new capital provision allowing state Medicaid programs the latitude to grant a more generous step-up upon a change of ownership if they so desired. Under COBRA, for transfers on or after October 1, 1985, the valuation of the facility can increase over that allowed under DEFRA by one-half the percentage increase in the Dodge Construction Index or Consumer Price Index, which is lower, measured from the date of acquisition by the seller to the date of the change in ownership. COBRA allowed an inflation adjustment of asset basis upon a change of ownership. COBRA is not mandatory. Programs can continue to impose the DEFRA limitations." (Lubarsky 1993)
Cost Centers:	Categories (set individually by state) of costs usually used for rate delineation such as in case-mix as well as for cost finding and rate calculations. Specific cost center categories may be set for nursing care, administration, or others areas, or may be a more inclusive category cost center such as for direct or indirect care. These are generally used to apply a limit or cap to an area of expenditure, but approaches vary. Some systems apply limits differently to components within what are considered the same cost center.
Cost Report:	Facility specific cost reports which are used to calculate and set policy for reimbursement. Usually includes allowable costs, non allowable costs, and aggregate patient information.

Cost Report Year:	Fiscal year of cost report used in setting a reimbursement rate.
DEFRA:	Section 2314 of the Deficit Reduction Act of 1984 which "added provisions that limited adjustments upon a change of ownership to the historical cost of the owner of record of a facility as of July 18, 1984. Medicaid will pay for the use of an asset only once. Many state Medicaid programs do not have depreciation recapture provisions. As such, some of these state have utilized DEFRA to impose a more stringent limitation upon an ownership change by not allowing any step-up whatever, not even to the seller's historical cost. In this case, the buyer's basis for depreciation and interest would be the seller's net book value. DEFRA does not preclude states from utilizing alternative methods of capital payment, such as fair rental approaches." (Lubarsky 1993)
Domicillary Care:	May be considered a type of residential care facility.
DRGs:	Diagnosis Related Groups are used as the basis for the Medicare prospective payment system for hospital reimbursement.
Equity:	The difference between appraisal value and property debt. (Lubarsky 1993).
Fair Rental System:	An equitable system for calculating a capital per diem rate, irrespective of cost. It is based on a gross, net or modified method of facility value which can increase with inflation and building upkeep.
Facility-Specific Reimbursement Method:	State designation of reimbursement method based on facility characteristics, costs, or patient characteristics. This method may be for only a portion of the total reimbursement rate.
Free-Standing Facility:	A nursing home facility not attached physically to a hospital.
Historic Cost:	Method for acquiring an asset such as a nursing facility less discounts plus all normal incidental costs

	necessary to bring the facility into existing use and location.
Hospital-Based Facility:	A nursing home facility that is attached to a hospital.
Home Health Care Agencies:	Agency which may be licensed by the state to provide nursing, therapy, personal care, and/or other services in an individual's home or in the community. States may develop their own criteria for licensing which may be different from the federal criteria for certification to provide Medicare and/or Medicaid services. Some states do not require licensure but certify agencies to provide Medicare/Medicaid services under the federal guidelines.
ICF:	Intermediate care facility. Under the implementation of OBRA in 1990, these facilities became "nursing facilities" or "Nfs." The designation of ICF is used by some states to indicate the level of care needed for residents as opposed to the classification of the facility.
Interim Rate:	A temporary prospectively set per diem rate paid during a rate period that is then retroactively adjusted when final cost and other needed data are available. If an interim rate is fully adjusted to costs, the system is classified as retrospective; if the rate is not fully adjusted to costs, it is classified here as prospective.
ICF-MR:	Intermediate care facilities for the mentally retarded (ICF-MR) are state licensed facilities that provide 24-hour care and supervision to persons who can benefit from active treatment. Generally health, social, personal care, and related supportive services are provided in a protective setting to meet the needs of functionally and/or mentally impaired individuals.
Imputed Value:	Cost that is implied. In the case of nursing home reimbursement it is a value reached by a mathematical formula and is generally a composite of different costing methods or calculations.
Limit/Cap:	Method of constraining costs, usually of a particular Cost center. It can be a percentile of a median, fixed

	rate such as found in capital cost, an occupancy rate, etc.
Market Value:	Typically, the price at which an item could be sold.
Medicaid:	Title XIX of the Social Security Act, commonly known as the Medicaid Act, 42 USCA 1396-1396, creates a cooperative relationship between the federal government and states that elect to share the medical expenses of persons who have limited financial resources.
Medicaid Resident Days in Percent:	The total number of Medicaid resident days in a nursing home divided by all resident days in the nursing home, expressed as a percentage.
NNHIPI:	National nursing home input price index.
Nursing Home Facility (NF):	A state licensed facility providing skilled nursing and/or intermediate care services to individual residents on a 24 hour basis. This category was created by OBRA l987 Nursing Home Reform legislation.
OBRA, 1987:	Omnibus Reconciliation Act of 1987. This legislation included Nursing Home Reform legislation. Provisions were made that "Facilities must meet certain requirements, or conditions of participation, for professional staffing, provision of services, facility standards, administrative management and other health and safety standards that may be prescribed by the Secretary. These requirements include the maintenance of policies governing the administrative and medical procedures of the nursing facility and safeguards to assure quality of care and protect residents' rights." "The OBRA '87 requirements revise the conditions of participation for nursing homes, the process for monitoring compliance with the law, and the remedies available to Federal and State agencies in the event of noncompliance. The provisions require nursing facilities to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This outcome is to be achieved through a

	resident assessment coordinated with an individualized plan of care reviewed annually. These vehicles for achieving and assessing quality of care replace the existing Inspection of Care process." The legislation also required that "Survey agencies monitor the performance of facilities by determining whether they comply with the Federal conditions of participation." Procedures for states in the overall operation of the survey and certification program are contained in regulations and administrative guidelines were developed and implemented at various points after the legislation was adopted.
Occupancy Rate:	The average daily census of facility residents compared to the total number of licensed beds, expressed as a percentage.
Pass-through:	Costs that are outside the structure of the rate calculating procedure and will remain outside, thus will have no direct effect on the per diem rate.
Personal Care:	May be considered a type of residential care facility.
Prospective Payment:	Rates set in advance of payment.
Peer Groupings:	Groupings of cohorts used in the rate setting process of nursing facilities. Groups types may be by size of facilities, ownership, geographic location (Urban/Rural, County, Region, etc.) or other categories which can be a ceiling or combination of groupings defined within a state system.
Rate Year:	Specific time period for an established rate, which may: be a calendar year for states or facilities; coincide with the federal fiscal year (starts October 1); be a state fiscal year (usually starts in July or September); or be a facility fiscal year (starting and clustering at more than one month with in a year).
Rate Period:	Length of time a rate is in effect. This can be an annual, semi-annual, or a state-specific period (e.g., a quarter).
Rebase:	Updates or changes to the basic data on which the calculations are made for arriving at reimbursement rates.

Rental Value:	Cost to lease an item of property.
Replacement Costs:	Current cost to replace property in a particular geographic area.
Replacement Value:	Current cost to replace the service potential of an existing asset. The emphasis is placed on obtaining an asset with identical future service capabilities, which is also another definition of replacement costs.
Resident-Specific Reimbursement Method:	State designation of reimbursement method using calculations based on individual resident characteristics/costs, as in a case-mix system. This approach may be used for all or for only a portion of the total reimbursement rate.
Residential Care Facility – Aged/Disabled:	A facility that provides services to individuals not requiring skilled nursing care. Services are provided on a 24 hour basis and generally include supportive care services and supervision for those who are physically impaired, most often either the elderly or physically disabled persons. These may include board and care, foster care, family homes, group homes, domicillary care, or other types of facilities. States develop their own criteria for licensure or non-licensure for different types of facilities and the states have their own definitions and names for facility categories.
Residential Care Facility – Other:	A facility that provides 24 hour residential care services to mentally retarded and developmentally disabled persons as well as other special population groups. As with residential care for Aged/Disabled, 'Residential Care Other' does not provide skilled nursing care.
Retrospective Reimbursement Methods:	Payment is determined after services are rendered, based on actual costs. Interim rates are used and then the final rates are adjusted to cover actual costs when cost data are available.

RUGs:	Resource utilization groups are categories developed to classify residents based upon the amount of personnel resources used to provide care for those residents.
Sheltered Care:	May be considered a type of residential care facility.
SNF:	Skilled nursing facility. Under the implementation of OBRA in 1990, these facilities became "nursing facilities" or "Nfs." This designation is retained by some states to characterize the level of care needs of residents rather than the classification of the facility.
Subacute Care:	Nursing home services offered 24 hours either in hospitals at a level less intensive than acute inpatient services, but more intensive than Medicaid nursing facility care. These services may be offered in special care units or integrated within general units. They may focus on short-term, intermediate, or long term care nursing services, and may be licensed as general hospital beds, swing beds, or nursing home beds. Hospital subacute care not provided in licensed nursing facility beds are not included in this report.
Swing Beds:	Acute care hospital beds that may be used to provide skilled nursing care to patients on a temporary or part-time basis. Facilities are generally paid a Medicaid reimbursement rate below that paid for acute hospital care.
Traditional Capital Reimbursement Method:	A system for calculating capital per diem rate based on cost which is usually subject to controls.
Waiver Services:	Medicaid legislation allows states to provide special services under specific waiver provisions. Section 2176 of P.L. 97-35 (OBRA 1981) added Section 1915 to the Social Security Act to allow for home and community-based waiver services. COBRA (l985), OBRA (1986), OBRA (l987), and OBRA (1990) all added new sections for waivers.

STATE PROFILES

ALABAMA

Nursing Homes

The number of nursing homes in Alabama increased slightly since 1996 (233 in 1997 compared to 232). The number of beds also has shown an increase, from 24,968 in 1996 to 25,754 in 1997. From 1987 to 1997 Alabama experienced a total bed growth rate of 13.48 percent compared to the U.S. average of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over was 45.9 in 1997, lower than the U.S. ratio of 53.1.

Intermediate Care for Mentally Retarded

In 1996, the number of ICF/MR facilities decreased for the first time in Alabama since 1989 from 8 down to 7 facilities. There was no further decrease in ICF/MR facilities in 1997. The number of beds has been steadily decreasing from 1,350 in 1989 to 1,176 in 1994 to 879 in 1997. This decrease in both facilities and beds is largely due to a court order to move residents out of ICF/MRs.

Residential Care for Adults/Aged

Alabama licenses residential care for the aged and other groups in assisted living/family homes, assisted living/group homes, congregate living facilities, and one home for special services which specializes in elderly patients with behavioral problems. The total number of facilities and beds has been slowly increasing, from 163 facilities and 3,464 beds in 1989 to 192 facilities and 4,462 beds in 1994 to 257 facilities with 6,186 beds in 1997. This growth has continued to raise the ratio of licensed beds per 1000 population aged 65 and over, but the state ratio has remained far lower than the national ratio (11.0 in 1997 compared to 24.3 US average).[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Alabama in 1997. State owned adult day care facilities must meet certain requirements as part of the contract with the state and must subsequently be "approved" by the Department of Adult Services. Home health care was not licensed in 1997. Certified home care agencies had continued to grow steadily from 118 in 1989 to 182 in 1996. 1997 showed a decline to 181 certified home health agencies.

CON/Moratorium

Alabama had a CON for nursing homes from 1979 through 1997, adding a moratorium to it from 1984 through 1989 and then again in 1994 and 1995. Only the CON remained in effect by 1996. A CON was required in 1997 for hospital bed conversions, ICF/MRs,[2] and home health care. There was neither a CON nor moratorium on residential care, hospice or adult day care.

[1] 'Other Residential Care' in Alabama includes therapeutic group homes, long term residential care homes, residential care homes/special services, crisis residential programs, adult foster homes, semi-independent living, and supported housing.

[2] State owned ICF/MRs are exempt from CON review. Currently ICF/MRs are operated only by the state.

ALABAMA

Demographics

Percentage Population 65 and Over	13.0 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	233
Total Beds	25,754
Beds Per Nursing Facility	110.5 (US 102.7)
Average Occupancy Rate	94.4
Beds Per 1000 Population:	
Age 65 and Over	45.9 (US 53.1)
Age 85 and Over	422.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.23 (US 6.01)
Expenditures Per 1000 Pop, 1996	$103,037 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care For The Mentally Retarded

Total Facilities	7
Total Beds	879
Beds Per 1000 Population	0.20 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	257
Total Beds for Adult/Aged	6,186
Beds Per 1000 Pop, Age 65 and Over	11.0 (US 24.3)
Total Facilities, Other	463
Total Beds, Other	1,863

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	10.50 (US 6.51)
Expenditures Per 1000 Pop, 1996	$24,187 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

ALABAMA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid facility-specific nursing facility rates.[1] The method employs peer groupings and ceilings broken down within cost center categories. The basic reimbursement method was adopted in 1991. Rates were based on a facility fiscal year beginning July 1. The cost report ending June 30, 1995 was used to calculate an interim FY97 rate. Inflation was based the DRI (market basket index of operating costs-skilled nursing facility). Rate setting and a mid-year weighted adjustment are made based on the FY96 cost report. No minimum standard for occupancy was used to set the reimbursement rate in Alabama.

Adjustments

No significant adjustment was made other than the annual rate setting adjustments of the rate for FY97.

Cost Centers

Alabama uses four cost centers: 1. operating, ceiling 105% of the median; 2. direct care, ceiling 118% of the median, then capped at an additional 10%; 3. indirect care, ceiling 110% of the median[2]; and 4. property.

Ancillary Services

Non-prescription drugs, medical supplies, patient transportation, dental consultant, and oxygen machines were included in the rate. Ancillary services were cost based and rolled into the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Alabama. They employed two levels of care in a combined dual facility.

Capital Costs

The value of capital was determined by a fair rental system. Gross asset value of land, buildings, and equipment, reduced by outstanding mortgage debt as well as interest expense, property taxes, and insurance are included in the valuation. The fair rental systems maximum for new beds was $28,477. This amount was re-based by 3.8 percent. Gross rental factor was 2.5%.

Reimbursement Rate

The FY97 average reimbursement rate for Alabama was $94.73.

Other Long-Term Care

Alabama used the same system for hospital-based as for free-standing nursing facilities. ICF-MR facilities were reimbursed on a prospective facility specific average rate of $252.64.[3] Home health agencies were reimbursed using Medicare principles, but with state alterations, including flat rates for RN and for home health aide services that were set at the same $27.00 per visit in I997. Alabama Medicaid reimbursed under waiver for other residential care for the aged and for adult day care. Rates were based on a prospective method.

[1] Includes NF/IMD (mental disease) and NF/IDD (developmentally disabled) institutions, which are exempt from all ceilings.

[2] Actual allowable reported cost plus 50% difference of reported cost and ceiling is used to set rates.

[3] Large institutionally based facility over 15 beds.

ALABAMA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$94.73
Percentage Rate Change From Previous Year	10.70%
Peer Groupings	Number of Beds and Ceilings
Year of Cost Report to Set Rate	1996[1]
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None (one level of care)
Capital Reimbursement Determination	Fair Rental System
Ancillary Services Included in Rate	Medical Supplies, Patient Transport, Dental Consultant, Oxygen Machines, Non-Prescription Drug

Hospital-Based Nursing Facilities

Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility Specific
Average Reimbursement Rate	$252.64
Capital Reimbursement Determination	Use Allowance[2]
Ancillary Services Included in Rate	Covers All Ancillary Services

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$27.00 (flat rate)
Average Reimbursement Rate, HH Aide Visit	$27.00 (flat rate)

Other Residential Care For Aged[3]

Method	Prospective Flat Rate
Reimbursement Program	1915c Waiver
Average Reimbursement Rate by Service	
Case Management	$33.02 per hour
Personal Care	$9.39 per hour
Respite-Skilled/Unskilled	$16.60 per hour/$8.98 per hour
Home Maker	$10.29 per hour

Adult Day Care[3]

Method	Prospective Flat Rate[4]
Reimbursement Program	1915c Waiver
Average Reimbursement Rate-Day Health	$13.62 per day
Facility Type	Day Health
Clients Covered	Aged & Disabled

Sub-Acute Care

No Separate Program

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[1] Year ending June 30, 1996.

[2] 2% of the acquisition cost of buildings, improvements, and depreciation on the remaining fixed assets.

[3] Waiver for Elderly and Disabled

[4] October 1996 through September 1997

ALASKA

Nursing Homes
Nursing homes in Alaska dropped from 22 in 1995 to 16 in 1996[1]. The number of nursing home beds dropped from 1,051 in 1995 to 733 in 1996. Nursing home facilities and beds remained constant in 1997. Alaska had the fewest nursing homes and beds in the country. Although the proportion of Alaska's total population aged 65 and over increased from 4.0 in 1990 to 5.3 in 1997, it was still well below the US average of 12.7 and represents the lowest proportion of all the states. The ratio of beds per 1000 population aged 65 and over continued to be below the national average in 1997 (22.9 compared to 53.1).

Intermediate Care for Mentally Retarded
ICF/MR facilities have been phased out in Alaska. The last facility was closed as of July 1, 1997.

Residential Care for Adults/Aged
In 1996 'Pioneer Homes,' formerly licensed as nursing homes, converted licensure to assisted living facilities. In 1996, all categories of residential care for the aged were condensed down to one category, 'assisted living.' There were 83 assisted living facilities in 1997 with a total of 1,075 beds. The number of residential care beds per 1000 population aged 65 and over jumped from 13.8 in 1995 to 33.6 in 1997. This rate is higher than the U.S. average of 24.3.[2]

Adult Day Care and Home Health Care
Although adult day care was not licensed in Alaska in 1997, state owned agencies are required to meet standards set by the Older Alaskan Commission. Alaska had 26 home health care agencies in 1997. While there was no change in the number of agencies since 1995, this represents an increase of 5 agencies since 1994. Alaska's ratio of agencies per 1,000 population aged 65 and over (0.81 in 1997), was substantially greater than the national ratio of 0.50.

CON/Moratorium
Alaska had a CON for nursing homes from 1979 through 1997. In 1996 a moratorium for nursing homes was implemented and continued through 1997[3]. ICFMRs[4] were subject to both CON and moratorium in 1997. There were also CON reviews required for hospital bed conversions, and home health care[5] in 1997. There was neither a CON nor moratorium on residential care, assisted living, hospice or adult day care.

[1] Six of these facilities were 'Pioneer Homes' which transferred from nursing facility licensure to 'assisted living.'
[2] 'Other Residential Care' in Alaska includes 123 assisted living facilities with 513 beds designated for non-aged populations.
[3] The Moratorium on construction of new nursing homes will end May, 1998.
[4] All ICF-MRs were decertified in 1997, the moratorium will end May, 1998.
[5] Home Health Agencies rarely surpass the $1 million threshold to trigger a CON review.

ALASKA

Demographics

Percentage Population 65 and Over	5.3 % (US 12.7 %)
Percentage Population 85 and Over	0.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	16
Total Beds	733
Beds Per Nursing Facility	45.8 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	22.9 (US 53.1)
Age 85 and Over	366.5 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	1.61 (US 6.01)
Expenditures Per 1000 Pop, 1996	$77,525 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	0
Total Beds	0
Beds Per 1000 Population	0.00 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	83
Total Beds for Adult/Aged	1,075
Beds Per 1000 Pop, Age 65 and Over	33.6 (US 24.3)
Total Facilities, Other	123
Total Beds, Other	513

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	26
Agencies Per 1000 Pop, Age 65 and Over	0.81 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.76 (US 6.51)
Expenditures Per 1000 Pop, 1996	$24,610 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

ALASKA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer grouping within free-standing facilities. The basic reimbursement method was adopted July 1, 1989. Rates were set and rebased annually by facility year-end, clustering in June and December. The 1994 cost report was used to determine rates for the routine portion of FY97 rate. Inflation based on the DRI, influenced by state data, was used to trend rates for the base year operating expenses less capital. A minimum occupancy standard was not used in setting the reimbursement rate for FY97.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Three inclusive cost centers were used for reimbursement in Alaska: routine, ancillary, and capital. No limits were applied for FY97.

Ancillary Services

Ancillary Services were a separate cost center. Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, and patient transportation were included in the rate. The ancillary cost center rate was built into the rate, calculated from the base year costs.

Case-Mix Adjusters

No case-mix adjusters were used in Alaska. Their system provided for a single level of care. Case-mix was planned for the future. However, an implementation date was not available.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expenses, nursing facilities used the actual interest, subject to a ceiling. The maximum allowable interest was not capped for FY97. Capital costs include interest, depreciation, insurance on property, plant and equipment, leases and rentals for real property exclusive of equipment, amortization of capitalized loan improvements and amortization of startup organization and abandoned planning costs amortized over a period of 60 months. Alaska uses straight-line depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Alaska was $237.47, calculated by days of care.

Other Long-Term Care

Alaska used the same system for hospital-based as for free-standing nursing facilities. Although it also reimbursed ICF-MR using this same system, its averaged reimbursement was over 50% higher than that for nursing facilities. Home health agencies were paid 80% of their submitted charges with an average reimbursement rate of $164.96 for a RN visit and $90.16 for a HH Aide visit.

ALASKA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$237.47
Percentage Rate Change From Previous Year	5.3%
Peer Groupings	None
Year of Cost Report to Set Rate	1994
Inflation Adjustment	DRI, Influenced by State Data
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

IFC-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$414.84

Home Health

Method	Pay 80% of Submitted Charges
Average Reimbursement Rate, RN Visit	$164.96
Average Reimbursement Rate, HH Aide Visit	$90.16

Other Residential Care for Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

ARIZONA

Nursing Homes

The number of nursing homes in Arizona increased from 164 facilities in 1996 to 167 in 1997, as did the number of beds from 17,521 in 1996 to 17,579 in 1997. In Arizona there was a total bed growth rate of 20.85 percent between the years 1987 and 1997, compared to the national average of 15.06. However, despite this growth, the 1997 ratio of beds per 1000 population aged 65 and over remained low at 29.2 compared to the U.S. average of 53.1.

Intermediate Care for Mentally Retarded

From 1992 through 1996, the number of ICF/MR facilities and beds had remained constant, maintaining at 12 facilities and 271 beds. In 1997, decreasing to 11 facilities and 223 beds. The ratio of ICF/MR facilities per 1,000 total population is lower than the national average (0.05 compared to the U.S. average of 0.48).

Residential Care for Adults/Aged

Licensed residential care in Arizona is divided into 4 categories - 'Residential Care', 'Supervisory Care', 'Supportive Residential Living'[1] and 'Adult Care'[2]. The total number of residential care facilities in Arizona increased from 843 in 1996 to 1,122 in 1997. The total number of beds increased from 11,842 in 1996 to 17,507 in 1997. These totals reflect increases in 'Residential Care Institutions' and 'Adult Care Homes'. 'Supervisory Care Homes' showed a decrease from 80 facilities in 1996 to 75 facilities in 1997, and a decrease from 2935 beds in 1996 to 2742 in 1997. The ratio of licensed beds per 1000 population aged 65 and over was higher than the national average in 1997 (29.1 compared to the US average of 24.3).

Adult Day Care and Home Health Care

Adult day care in Arizona is provided in adult day health care facilities. The number of these facilities increased from 13 in 1989 to 30 in 1994 before dropping to 25 in 1996. Adult day care remained at 25 in 1997. In 1997 there were 146 home health care agencies, a decrease of 10 since 1996. Arizona's ratio of home health care agencies per 1,000 population aged 65 and over remains half the national average (0.24 as compared to the U.S. average of 0.50).

CON/Moratorium

Arizona had a CON for nursing homes between 1979 and 1981, eliminated it in 1982 and had neither a CON nor moratorium through 1997. In 1997 there was neither a CON nor moratorium on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] Supportive Residential Living was a newly separated category in 1997. It had previously been included in the Residential Care Institutions

[2] There were 43 certified but unlicensed 'Adult Foster Care Homes' that have approximately 4 beds each and are subject to fewer regulations than the licensed facilities. Data on this category had never been collected prior to 1997.

ARIZONA

Demographics

Percentage Population 65 and Over	13.2 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	167
Total Beds	17,579
Beds Per Nursing Facility	105.3 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	29.2 (US 53.1)
Age 85 and Over	297.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.61 (US 6.01)
Expenditures Per 1000 Pop, 1996	$2,539 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	11
Total Beds	223
Beds Per 1000 Population	0.05 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,122
Total Beds for Adult/Aged	17,507
Beds Per 1000 Pop, Age 65 and Over	29.1 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	25
Facilities Per 1000 Pop, Age 65 and Over	0.04 (US 0.16)

Licensed Home Health Care

Total Agencies	146
Agencies Per 1000 Pop, Age 65 and Over	0.24 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.22 (US 6.51)
Expenditures Per 1000 Pop, 1996	$110 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

ARIZONA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on facility-specific data[1]. The method employs the peer grouping of geographic location (by county): metro and rural (overall rural, and special rural). The basic reimbursement method was adopted in 1989. Annual rates were set by an October to September facility fiscal year for the primary care component. Most facilities were on a calendar year. The 1996 cost report was used for FY97. The DRI was used to trend rates as well as regional wage indexes through a nursing facility market basket. The indirect and capital components of the rate were adjusted to reflect a minimum occupancy adjustment of 90%.

Adjustments

No adjustment was made other than the annual rate setting adjustment of the initial rates.

Cost Centers

Cost centers consist of primary care (nursing costs only), indirect care (non-nursing and non-capital), and capital.

Ancillary Services

Respiratory therapy, non-prescription drugs, medical supplies, and durable medical equipment were included in the rate. These ancillaries were included in the calculation of the rate under the appropriate cost center.

Case-Mix Adjusters

Case-mix adjusters were used in Arizona. Four levels-of-care classes were employed, including ventilator and sub-acute patients (Class 4). Class 4 was based on negotiated rates and didn't exceed an aggregate monthly limit unless prior authorization was obtained. Three levels of "care only" classes were used in the Primary cost component. It used the PAS, the Maryland time and motion study, and salary information based on Arizona's nursing facility industry. Rates were set on an overall basis. The primary care portion was accounted for in case-mix.

Capital Costs

Arizona used historic cost to determine the value of capital. Depreciation, interest, and rent from facility rate filings were used as the basis of the capital cost component which becomes a fixed statewide rate. For capital-interest expenses, nursing facilities used the actual interest expense. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 weighted average reimbursement rate for Arizona was $88.23.

Other Long-Term Care

Arizona used the same system for hospital-based as for free-standing nursing facilities but employed a combination system to pay for ICF-MR with average rates well over three-times that for nursing facilities. Home health agencies were reimbursed using a capped fee schedule that paid over twice as much ($45.76) for a RN visit as for a home health aide visit ($21.82). Arizona Medicaid reimbursed under waiver for adult day care and used a prospective fee for service method.

[1] The rates themselves were categorized both as class and facility specific

ARIZONA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$88.23
Percentage Rate Change From Previous Year	4.25%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1996
Inflation Adjustment	DRI Market Basket & Regional Wage Indices
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	Acuity Measure, Primary Care is Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Respiratory Therapy Durable Med. Equip. Non-Prescription Drug Medical Supplies

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Combination Class
Average Reimbursement Rate	$252.56 by day of care
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Included All Ancillary Services

Home Health

Method	Capped Fee Schedule
Average Reimbursement Rate, RN Intermittent Visit	$61.10
Average Reimbursement Rate, HH Aide Visit	$24.44
Home Delivered Meals, Per Meal	$5.94
Homemaker, Per Hour	$13.94
Personal Care, Per Hour	$14.37
Attendant Care, Per Hour	$ 8.92
Short-Term Respite care, Per Hour	$ 5.83

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Capped Fee Schedule
Reimbursement Program	1115 HCBS Waiver
Average Reimbursement Rate	$4.94 per hour
Facility Type	Social, Day Health, Dementia/Alzheimer's Disease
Clients Covered	Aged, Physically Disabled

Sub-Acute Care

No Separate Program

ARKANSAS

Nursing Homes

The number of nursing homes in Arkansas has fluctuated mildly in the past 20 years. There was an overall increase from 211 in 1980 to 241 in 1995, remaining at 241 in 1996 and 1997. The number of beds has been increasing, from 22,533 in 1990 to 25,373 through 1997. From 1987 to 1997 Arkansas' bed growth rate was 15.2 percent compared to the national average of 15.06 percent. The ratio of nursing home beds per 1000 population aged 65 and over was 70.5 in 1997, substantially greater than the U.S. ratio of 53.1.

Intermediate Care for Mentally Retarded

In 1997, Arkansas continued to have 40 ICF/MR facilities with a total of 1,802 beds. These totals have remained unchanged since 1992. The ratio of ICF/MR beds per 1,000 total population, 0.71 in 1997 remains higher than the US national average of 0.48.

Residential Care for Adults/Aged

The number of residential care facilities in Arkansas increased from 98 in 1989 to 130 in 1997. The number of beds steadily increased from 2,609 in 1989 to 4,506 in 1997. There was an increase of 9 facilities and of 133 beds since 1996. The ratio of licensed residential care beds per 1000 population aged 65 and over was 12.5 in 1997, nearly half the national ratio (24.3).[1]

Adult Day Care and Home Health Care

Arkansas had 35 licensed adult day care facilities and 7 licensed adult day health care facilities in 1997. This is a total increase of 11 facilities since 1996 and a tripling of the number since 1989. Despite this increase, Arkansas' ratio of adult day care facilities per 1000 population 65 and over is still slightly lower than the national average (0.12 compared to 0.16 US average). The number of licensed home health care agencies has increased steadily from 215 in 1993 to 257 in 1997 (with an increase of 2 facilities since 1996). Arkansas ratio of home health care agencies per 1000 population 65 and over is higher than the national average (0.71 compared to 0.50 US average).

CON/Moratorium

Arkansas had a CON (called a 'permit of approval') for nursing homes from 1979 through 1997. In 1987 and 1988, and again in 1992 and 1993, a moratorium was added to the CON. In 1997 a CON was also required for hospital bed conversions, residential care, and home health care. ICF/MRs were subject to both a CON and moratorium in 1997. In 1997, there were 26 CON applications from nursing facilities, 2 of which were denied.
In 1997 hospice was subject to a moratorium only, while adult day care had neither CON nor moratorium requirements.

[1] 'Other Residential Care' in Arkansas includes one residential care facility with 60 beds which provides care to persons of all ages with head injuries.

ARKANSAS

Demographics

Percentage Population 65 and Over	14.3 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	241
Total Beds	25,373
Beds Per Nursing Facility	105.3 (US 102.7)
Average Occupancy Rate	83.1
Beds Per 1000 Population:	
Age 65 and Over	70.5 (US 53.1)
Age 85 and Over	604.1 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.62 (US 6.01)
Expenditures Per 1000 Pop, 1996	$117,137 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	40
Total Beds	1,802
Beds Per 1000 Population	0.71 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	130
Total Beds for Adult/Aged	4,506
Beds Per 1000 Pop, Age 65 and Over	12.5 (US 24.3)
Total Facilities, Other	1
Total Beds, Other	60

Licensed Adult Day Care

Total Facilities	42
Facilities Per 1000 Pop, Age 65 and Over	0.12 (US 0.16)

Licensed Home Health Care

Total Agencies	257
Agencies Per 1000 Pop, Age 65 and Over	0.71 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.87 (US 6.51)
Expenditures Per 1000 Pop, 1996	$26,689 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

ARKANSAS

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific[1] rate. The method employed level of care as a peer group. The basic reimbursement method was adopted in 1981. Annual rates were set using a state fiscal year beginning July 1. 1979 cost reports were used for FY97. Inflation based on the HCFA Market Basket for nursing facilities plus other state factors were used to trend rates. The minimum occupancy standard was set at 85%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Arkansas separates expense into five cost centers: direct care, therapy, care related, administrative and operating, property and equipment. No limits were applied.

Ancillary Services

Physical therapy, occupational therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation and oxygen were included in the rate.

Case-Mix Adjusters

Case-mix adjusters were used in Arkansas. They had four levels of care. Patients were measured by an acuity measurement. Rates were on an individual basis. The entire rate was case-mix adjusted.

Capital Costs

Arkansas determined the value of capital based on historic cost[2]. For capital-interest expenses, nursing facilities used the actual interest, subject to a ceiling[2]. Construction or renovation costs exceeding $100,000 must have had prior approval to be allowed. Rental costs or lease expense was allowed. Depreciation was allowed. The shortest depreciation period allowed was based on straight-line depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Arkansas was $61.98.

Other Long-Term Care

Arkansas used the same system for hospital-based as for free-standing nursing facilities. It employed a retrospective method to set ICF-MR rates. Home health services were reimbursed using a fee schedule with a flat rate. RN visits were paid over twice as much ($67.59) as were home health aide visits ($33.06). Adult day care was reimbursed through elder choice waiver, using a prospective class methodology on a per hour basis.

[1] Arkansas considered their rate a Class/Flat rate, but because the rate was entirely Case-Mix adjusted based on the individual it was re-categorized.

[2] Subject to DEFRA and COBRA requirements.

ARKANSAS

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$61.98
Percentage Rate Change From Previous Year	3.2%
Peer Groupings	Level of Care
Year of Cost Report to Set Rate	1979
Inflation Adjustment	HCFA Market Basket
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	Acuity Measurement Entire Rate Case-Mix Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective
Average Reimbursement Rate	
State Facilities	$181.87
Private Facilities	$184.52
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Includes All Ancillary Services

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$70.87 (Medicaid maximum cap)
Average Reimbursement Rate, HH Aide Visit	$27.74
Average Reimbursement Rate, PT Visit	$70.95
Average Reimbursement Rate, LPN Visit	$59.20

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Class
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Service	
Social	$5.03 per hour
Day Health	$6.69 per hour
Facility Type	Social, Day Health
Clients Covered	Elderly

Sub-Acute Care

No Separate Program

CALIFORNIA

Nursing Homes

The number of nursing homes in California fluctuated between 1980 and 1984. In 1996 California had 1,464 nursing facilities with 133,127 nursing beds. In 1997 the number of nursing homes dropped to 1,443 with a decrease in beds to 130,051. Between the years 1987 and 1997 California had a growth rate of 10.85 percent compared to the national rate of 15.06 percent. California's ratio of licensed beds per 1000 population aged 65 and over (36.4 in 1997), is considerably less than the national ratio of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in California, including the large ICF/DDs and the smaller ICF/DDHs and ICF/DDNs, has increased steadily since 1989, from 386 to 953 in 1997. The number of beds, increased from 10,036 in 1989 to 11,352 in 1994 and then decreasing in 1995 and 1996 to 7088 beds. ICF/MR beds increased to 7,400 in 1997.

Residential Care for Adults/Aged

California has two primary categories of residential care: adult residential care for persons ages 18 to 59, and residential care for the elderly aged 60 and over. The total number of residential care facilities increased from 8,336 in 1989, to 10,076 in 1996 and to 10,539 in 1997. California had 162,489 residential care beds in 1997, an increase of 4,854 beds since 1996 and the most residential care beds in the country. The ratio of licensed residential care beds per 1000 population aged 65 and over was 45.5 in 1997, compared to the national ratio of 24.3[1]

Adult Day Care and Home Health Care

California licenses adult day care and adult day support. In 1997, California had a total of 598 facilities, the second highest number of facilities in the country. Home health care had been growing rapidly in California, increasing from 456 licensed agencies in 1989 to 1,230 in 1996. In 1997 there was a decrease to 1,058 licensed home health agencies. The ratio of licensed home health care agencies per 1,000 population aged 65 and over, however remains lower than the national average (0.3 compared to 0.50).

CON/Moratorium

California had a CON for nursing homes from 1979 to 1986, eliminated it in 1987 and had neither a CON nor a moratorium through 1997. In 1997 there was neither a CON nor a moratorium on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] 'Other Residential Care' in California includes residential facilities for chronically ill (mostly for persons with HIV), and social rehabilitation facilities which provide care in a group setting to adults recovering from mental illness.

CALIFORNIA

Demographics

Percentage Population 65 and Over	11.1 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	1,443
Total Beds	130,051
Beds Per Nursing Facility	90.1 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	36.4 (US 53.1)
Age 85 and Over	334.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.75 (US 6.01)
Expenditures Per 1000 Pop, 1996	$65,188 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	953
Total Beds	7,400
Beds Per 1000 Population	0.23 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	10,539
Total Beds for Adult/Aged	162,489
Beds Per 1000 Pop, Age 65 and Over	45.5 (US 24.3)
Total Facilities, Other	101
Total Beds, Other	1,256

Licensed Adult Day Care

Total Facilities	598
Facilities Per 1000 Pop, Age 65 and Over	0.17 (US 0.16)

Licensed Home Health Care

Total Agencies	1,058
Agencies Per 1000 Pop, Age 65 and Over	0.3 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.45 (US 6.51)
Expenditures Per 1000 Pop, 1996	$29,552 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

CALIFORNIA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on class rates. The method employed two peer groupings for level B (SNF) only: geographic location and number of beds (related to level of care). The basic reimbursement method was adopted in 1978. Rates were set based on a Medi-Cal period August to July. California rebased annually. The earliest possible cost report used was fiscal year ending July 1994. Inflation, based on the California CPI, labor index, with property allowed two percent, was used to trend rates. No minimum occupancy standard was used.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY 97.

Cost Centers

Four cost centers were used in California: capital; property tax; salaries, wages, and benefits; and all other. No limits were applied.

Ancillary Services

Ancillary services included in the rate for FY97 were non-prescription drugs, medical supplies, and oxygen.

Case-Mix Adjusters

No case-mix adjusters were used in California. Two levels of care [facility types A (ICF) and B (SNF)] are available in California.

Capital Costs

Historic cost was used to determine the value of capital in California. For capital-interest expenses, nursing facilities used the Medicare System. Refinancing and renovation, as well as, rental costs and leases were allowed as costs. Capital costs included depreciation and interest. The American Hospital Association guidelines were applied to depreciation. Straight-line depreciation was used.

Reimbursement Rate

The average FY97 reimbursement rate for California was $81.54, calculated by average days of care.

Other Long-Term Care

California paid for hospital-based nursing facility care prospectively, which averaged nearly two and a half times the average rate for free-standing nursing facilities. State ICF-MR facilities were reimbursed using retrospective methods. Non-state ICF-MR facilities were reimbursed by the same method as free-standing nursing facilities, paying $92.88 per diem. Home health payment was prospective, cost-based. Adult day care was reimbursed under optional service in their state plan using a prospective flat rate. Sub-acute care was paid a facility-specific rate up to the class median. Pediatric sub-acute was paid using a model.

CALIFORNIA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$81.54
Percentage Rate Change From Previous Year	2.2%
Peer Groupings	Geographic Location and Number of Beds
Year of Cost Report to Set Rate	94/95
Inflation Adjustment	California CPI, Labor Index, Property
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Oxygen Medical Supplies

Hospital-Based Nursing Facilities

Method	Facility Specific Capped
Average Reimbursement Rate	$187.29

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities, Interim	Not available, paid at cost
Private Facilities	$92.88
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport

Home Health

Method	Prospective Cost-Based
Average Reimbursement Rate, RN Visit	$68.05 (1 hour visit)
Average Reimbursement Rate, HH Aide Visit	$41.59 (2 hour minimum visit)

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	Under state plan, optional service
Average Reimbursement Rate	$55.18 per day
Facility Type	Adult Day Centers
Clients Covered	Aged, Physically Disabled, Mentally Ill, AIDS/HIV, Developmentally Disabled

Adult Sub-Acute Care

Method	Facility-Specific up to class median
Ventilator/Non-Ventilator	$267.84/$245.26

Pediatric Sub-Acute Care

Method	Model
Ventilator-Bay Area	$440.17
Ventilator-All Others	$415.51
Non-Ventilator-Bay Area	$395.92
Non-Ventilator-All Others	$371.26

COLORADO

Nursing Homes

The number of nursing homes in Colorado has grown slowly, increasing from 229 in 1996 to 233 in 1997. The number of beds increased from 20,293 in 1996 to 20,500 in 1997. The growth rate between 1987 and 1997 was 9.6 percent compared to the national rate of 15.06 percent. The state's ratio of licensed nursing home beds per 1000 population age 65 and over, has remained close to the national ratio (52.0 compared to the U.S ratio of 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MR beds has been steadily decreasing in Colorado as facilities downsize. The number of facilities decreased from 9 in 1989 to 4 in 1997. The number of beds has steadily decreased from 1,187 in 1989 to 284 in 1997. Colorado had a ratio of ICF/MR beds per 1000 total population of 0.07, substantially lower that the U.S. average of 0.48.

Residential Care for Adults/Aged

Residential care in Colorado is provided in personal care boarding homes and alternate care facilities.[1] In 1997 there were 365 total facilities with 7,772 beds. This represents an increase of 24 facilities and 491 beds since 1996. In 1997, Colorado had a ratio of licensed residential care beds per 1000 population aged 65 and over of 19.7, under the national ratio (24.3).[2]

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Colorado in 1997. The number of certified home health agencies increased from 200 in 1996 to 207 in 1997.

CON/Moratorium

Colorado had a CON for nursing homes from 1979 to 1983 but eliminated it in 1984. In 1990 the state instituted a nursing home moratorium, which remained in effect through 1997[3]. Beginning in1996 and continuing through 1997 there was also a moratorium on hospital bed conversions. There was neither a CON nor moratorium on residential care, ICF/MRs, home health care, hospice or adult day care in 1997.

[1] This category also includes personal care boarding homes/residential treatment facilities.

[2] 'Other Residential Care' in Colorado includes residential care facilities for developmental disabilities.

[3] The moratorium for nursing facilities applies only to Medicaid beds and Medicaid bed conversions.

COLORADO

Demographics

Percentage Population 65 and Over	10.1 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	233
Total Beds	20,500
Beds Per Nursing Facility	88.0 (US 102.7)
Average Occupancy Rate	84.9
Beds Per 1000 Population:	
Age 65 and Over	52.0 (US 53.1)
Age 85 and Over	465.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.55 (US 6.01)
Expenditures Per 1000 Pop, 1996	$65,816 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	4
Total Beds	284
Beds Per 1000 Population	0.07 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	365
Total Beds for Adult/Aged	7,772
Beds Per 1000 Pop, Age 65 and Over	19.7 (US 24.3)
Total Facilities, Other	277
Total Beds, Other	1,899

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.00 (US 6.51)
Expenditures Per 1000 Pop, 1996	$47,830 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	Moratorium Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

COLORADO

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing home care in the state of Colorado. This method was based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1982. Fair rental allowance was added in 1985. A facility fiscal year was used to set rates. The year endings tended to cluster December 31 (50%) and June 30 (30%). Rates were set and rebased annually. The earliest cost report used was from 1995. Inflation based on the CPIU was used to trend rates. Occupancy was imputed to 85% for urban facilities (except Class V) or actual if higher than 85%. Fair Rental allowance is the greater of 90% imputed occupancy or actual for all facilities.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Colorado separated reimbursement into three cost centers: 1. administration and general, ceiling is actual cost limited to the 85th percentile of Medicaid patient; 2. health care and raw food, limited to the 90th percentile of Medicaid patient; and 3. fair rental allowance.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and physician services were included in the rate. Ancillaries were entered on the cost report, then when audited the cost was compared to the ceiling before the rate was set.

Case-Mix Adjusters

No case-mix adjusters were used in Colorado. They provided four levels of care. There were no plans for implementing case-mix.

Capital Costs

Appraisal/reappraisal and a rental value (fair rental allowance) was used to determine the value of capital. Per bed appraisals were capped at $33,741.00. Nursing home capital-interest expenses were valued for working capital at actual interest expense, subject to a ceiling. Depreciation or interest connected to capital related asset is already reimbursed through the fair rental allowance rate. Depreciation was based on the straight-line method. Payments were based on a gross versus a net fair rental system. The rental factor was 9.375%.

Reimbursement Rate

The FY97 average reimbursement rate for Colorado was $90.31, weighted by days of care.

Other Long-Term Care

Colorado used the same system for hospital-based as for free-standing nursing facilities. A prospective facility-specific method without adjustments was used for ICF-MR. Home health agencies were reimbursed using a fee schedule with flat rates, paying almost twice as much ($61.04) for a RN visit as for a home health aide visit ($32.35). Other residential care was paid under waiver using a prospective class method; and adult day care was reimbursed under waiver using a prospective facility-specific approach averaging $35.94, by facility. Head trauma care[1] was more than three and a half times that of the free-standing facility rate.

[1] Colorado did not consider Head trauma treatment sub-acute. These were individuals who could be rehabilitated.

COLORADO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$90.31
Percentage Rate Change From Previous Year	18.94%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
Inflation Adjustment	CPI-Urban
Minimum Occupancy in Rate-Setting	85% Urban (except class V)
90% Fair Rental Allowance for All	
Case-Mix Adjusters	None
Capital Reimbursement Determination	Combination
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Physician Services

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method-State Facilities	Retrospective Facility-Specific
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate-State Facilities	$286.40
Private Facilities	$138.32
Capital Reimbursement Determination	
State Facilities	Historic Cost
Private Facilities	Appraisal/Rental Value
Ancillary Services Included in Rate (all facilities)	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$61.04
Average Reimbursement Rate, HH Aide Visit	$32.35

Other Residential Care For Aged

Method	Prospective Class
Reimbursement Program	1915C Waiver
Average Reimbursement Rate	$27.65 per day (maximum)
Facility Type	Group home, Foster home, Residential care

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	1915C Waiver
Average Reimbursement Rate-Day Care	$33.86 (per two unit day by facility)
Average Reimbursement Rate-Alternate Care	$27.65 (flat rate)
Facility Type	Social (restorative model)
Clients Covered	Must meet LTC criteria

Sub-Acute Care

No separate program[1]

[1] Colorado did not consider sub-acute Care a separate unit. Individuals who could be rehabilitated for Head Trauma were reimbursed at a per diem of $266.64 based on a prospective facility-specific method.

CONNECTICUT

Nursing Homes

Nursing care in Connecticut is provided through chronic/convalescent nursing homes and rest homes. In 1997 there were 325 licensed nursing homes with 32,012 beds, a drop of 20 facilities and 30 beds since 1996. From 1987 to 1997 the growth rate of nursing home beds was 15.59 percent compared to the national average of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over was 68.1 in 1997, greater than the national ratio of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MRs facilities decreased from 150 in 1996 to 117 in 1997. Beds decreased from 1,388 in 1996 to 1,198 in 1997.[1] The ratio of ICF/MR beds per 1000 total population was 0.37 in 1997, under the national ratio of 0.48.

Residential Care for Adults/Aged

Residential care for the elderly in Connecticut is provided in homes for the aged. The number of these facilities decreased steadily from 128 in 1989 to 112 in 1996. The number of beds also decreased steadily from 3,248 in 1989 to 3,000 in 1996. In 1997 a small increase to 113 facilities and 3,077 beds occurred.[2] The ratio of licensed beds per 1000-population aged 65 and over was 6.5 in 1997, substantially lower than the U.S. ratio of 24.3.

Adult Day Care and Home Health Care

Adult day care was not licensed in Connecticut in 1997. The number of licensed home health care agencies increased from 119 in 1996 to 124 in 1997.[3] The ratio of agencies per 1000 population 65 and over was 0.26 in 1997, nearly half the national ratio of 0.50.

CON/Moratorium

Connecticut had a CON for nursing homes from 1979 through 1990, adding a moratorium to it in 1991. Both remained in effect through 1997. In 1997 there was also a CON and moratorium on hospital bed conversions and ICF/MRs[4], while a CON alone covered residential care. There was neither a CON nor moratorium on home health care, hospice or adult day care. There were 27 CON applications for nursing homes in 1997, none of which were denied.

[1] State run facilities left the ICF/MR program in 1997. These facilities joined the community-based waiver program.

[2] Other Residential Care facilities in Connecticut are: Mental Health Community Residences, Mental Health Residential Living Centers and Substance Abuse & Dependence Facilities. There were a total of 77 facilities and 1738 beds in 1997.

[3] There were also 18 Assisted Living Service Agencies that provide housekeeping and ADL assistance to chronic but stable persons who reside in a managed residential community.

[4] The moratorium on ICF/MRs is defacto in that a new ICF/MR would have to be budgeted into the state plan; otherwise a new ICF/MR would be prohibited.

CONNECTICUT

Demographics

Percentage Population 65 and Over	14.4 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	325
Total Beds	32,012
Beds Per Nursing Facility	98.5 (US 102.7)
Average Occupancy Rate	95.9
Beds Per 1000 Population:	
Age 65 and Over	68.1 (US 53.1)
Age 85 and Over	542.6 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	12.67 (US 6.01)
Expenditures Per 1000 Pop, 1996	$256,573 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	117
Total Beds	1,198
Beds Per 1000 Population	0.37 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	113
Total Beds for Adult/Aged	3,077
Beds Per 1000 Pop, Age 65 and Over	6.6 (US 24.3)
Total Facilities, Other	77
Total Beds, Other	1,738

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	124
Agencies Per 1000 Pop, Age 65 and Over	0.26 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.85 (US 6.51)
Expenditures Per 1000 Pop, 1996	$88,578 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	CON Only
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

CONNECTICUT

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed two peer groupings: geographic location and licensure levels of ICF and SNF. The basic reimbursement method was adopted in 1990. A state fiscal year was used to set annual rates beginning July 1. 1992 cost reports were used for FY97. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Connecticut separates reimbursement into four cost centers: administration and general, limited to 105% of the median; direct, limited to 135% of the median; indirect, limited to 115% of the median; and fair rental.

Ancillary Services

Physical therapy (maintenance only), respiratory therapy, non-prescription drugs, medical supplies, and durable medical equipment were included in the Indirect cost center portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Connecticut. Two levels of care were provided. There were no plans for implementing a case-mix system.

Capital Costs

The value of capital was determined by a combination of historic cost and a fair rental system. The systems delineated between profit and non profit nursing facilities. For capital-interest expense, facilities used the actual interest expense. Renovation was allowed as an add-on. Rental costs and leases were limited to the lower of cost or historical cost. Non-profit facilities used the lower of interest and depreciation or the fair rental value. The rental factor was set at a minimum of $4.73. The American Hospital Association guidelines were applied to depreciation. Straight line was used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Connecticut was $126.28, weighted by days of care.

Other Long-Term Care

Connecticut did not have hospital-based nursing facilities. It used the same method for ICF-MR as for nursing facilities but paid slightly more than two and a half times as much on average for ICF-MR. Home health rates were set using Medicare principles with state alterations. A prospective facility- specific method was used to set rates for adult day care.

CONNECTICUT

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$126.62
Percentage Rate Change From Previous Year	2.6%
Peer Groupings	Geographic Location and Level of Care
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost/Fair Rental
Ancillary Services Included in Rate	Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Physical Therapy

Hospital-Based Nursing Facilities

None

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$343.02 (median)
Ancillary Services Included in Rate	Medical Supplies, Patient Transport, Non-Prescription Drug

Home Health

Method	Fee with possible add-ons
Fee Per Visit, RN or LPN	$79.00 per visit
Fee for Quarter Hour, HH Aide Visit	$4.95 per quarter-hour
Fee Per Visit, Occupational Therapy	$71.00
Fee Per Visit, Physical Therapy	$69.00

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Upper Limit Cap
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Facility Type	
Social	$46.00 per day
Medical[1]	$48.00 per day
Clients covered	Aged

Sub-Acute Care — No Separate Program

[1] Prior to 1994 only the medical model existed and the rate was a max. Cap of $46.30 by contract negotiation.

DELAWARE

Nursing Homes[1]

The total number of nursing homes in Delaware grew from 47 in 1987 to 57 through 1996[2], decreasing to 53 in 1997. The number of beds grew from 3,948 in 1987 to 5,758 in 1996, decreasing to 5,492 in 1997. Between 1987 and 1997, Delaware had a bed growth rate of 39.11 compared to the national rate of 15.06. There were 58.4 beds per 1000 population aged 65 and over in Delaware in 1997, greater than the national ratio of 53.1.

Intermediate Care for Mentally Retarded[1]

The number of ICF/MR facilities in Delaware declined from a high of 13 in 1990 to 5 in 1996 and 1997. The number of licensed beds has declined from 460 in 1989 to 361 in 1997 (a decline of 22 beds since 1996). Nevertheless, Delaware's 1997 ratio of ICF/MR beds per 1000 total population remains just higher than the national ratio (0.49 compared to 0.48).

Residential Care for Adults/Aged[1]

In 1997 Delaware had 'family care' and 'assisted living'[3] as categories of residential care. There were 125 licensed residential care facilities with 770 beds in 1997, a decrease of 1 facility and 427 beds since 1996. The ratio of licensed beds per 1000 population age 65 and over was 8.2 in 1997 compared to the U.S. ratio of 24.3[4].

Adult Day Care and Home Health Care[1]

Adult day care was not licensed in Delaware in 1997. There were 39 licensed home health care agencies in Delaware in 1997, a decrease of 1 agency since 1996. The ratio of home health agencies per 1000 population aged 65 and over in Delaware was slightly lower than the national ratio (0.41 compared to 0.50).

CON/Moratorium

Delaware had a CON for nursing homes from 1979 through 1997. In 1997, a CON was also required for hospital bed conversions and ICF/MRs[5]. There was neither a CON nor moratorium on residential care, home health care, hospice or adult day care. There was 1 nursing home CON application submitted in 1997, it was not denied.

[1] 1997 data was not available. These data are an average of 1996 and 1998 data.

[2] 1993 through 1996 totals for nursing homes include 'rest (residential) homes licensed as nursing facilities.

[3] Assisted living was a new residential care category in 1997, with 8 facilities and 448 beds.

[4] 'Other Residential Care' in Delaware includes: neighborhood homes, group homes for people with AIDS, and group homes for mentally ill.

[5] Although there is a CON required for ICF/MRs there has not been a CON application since 1988.

DELAWARE

Demographics

Percentage Population 65 and Over	12.9 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	53
Total Beds	5,492
Beds Per Nursing Facility	103.6 (US 102.7)
Average Occupancy Rate	87.1
Beds Per 1000 Population:	
Age 65 and Over	58.4 (US 53.1)
Age 85 and Over	610.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.00 (US 6.01)
Expenditures Per 1000 Pop, 1996	$100,141 (US $111,686)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	5
Total Beds	361
Beds Per 1000 Population	0.49 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	125
Total Beds for Adult/Aged	770
Beds Per 1000 Pop, Age 65 and Over	8.2 (US 24.3)
Total Facilities, Other	61
Total Beds, Other	310

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	39
Agencies Per 1000 Pop, Age 65 and Over	0.41 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.34 (US 6.51)
Expenditures Per 1000 Pop, 1996	$16,776 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

DELAWARE

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific rate. The method employed was a peer grouping by geographic location. The basic reimbursement method was adopted in 1988. A federal fiscal year was used to set annual rates. Rates were rebased in 1992. The 1996 cost report was used to set the FY97 rates. Inflation was based on the CPI and the MCPI. Occupancy was set at 90% for existing homes and 75% for new homes.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Delaware separated reimbursement into six cost centers: 1. administration, limited at 105% of the median; 2. primary, limited per group mean; 3. secondary, limited at 115% of the median; 4. support, limited at 110% of the median; 5. capital and 6. Ancillary (public[1] only).

Ancillary Services

For private facilities, non-prescription drugs, medical supplies, and physician services (only if on staff), were included in the rate under the associated cost component. For public[1] facilities, physical therapy, respiratory therapy, durable medical equipment, prescription drugs, and oxygen were also included in the rate.

Case-Mix Adjusters

Case-Mix Adjusters were used in Delaware. In April of 1993 the system changed from five levels of care to eight levels of care based on an acuity measurement. Rates were set on an individual-patient basis. The rate was adjusted proportionally by certain cost centers. Service categories that were accounted for in the rate included direct nursing care, Indirect nursing care, and other patient care.

Capital Costs

The value of Capital was determined by historic cost. Nursing facility capital-interest expenses were valued by actual interest expense. Refinancing, renovation, as well as rental costs, and leases were allowed as costs. Depreciation charges were allowed. The American Hospital Association guidelines were used for depreciation. Depreciation was based on straight line.

Reimbursement Rate

The FY97 average reimbursement rate for Delaware was $104.15 calculated by days of care.

Other Long-Term Care

Delaware used the same system for hospital-based as for free-standing nursing facilities, but reimbursed ICF-MR using a prospective facility-specific system, with an average rate about 50% higher than for nursing facilities. Home health agencies were reimbursed using Medicare principles, but with state alterations, with a cap for RN payment nearly three and a half times higher than for home health aide. Delaware Medicaid paid under waiver for adult day care, using prospective facility-specific methods.

[1] 35 of Delaware's facilities were Private while three were Public.

DELAWARE

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$104.15
Percentage Rate Change From Previous Year	4.81%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1996
Inflation Adjustment	CPI & MCPI
Minimum Occupancy in Rate-Setting	90% (existing homes) & 75% (new homes)
Case-Mix Adjusted	Direct Nursing, Indirect Nursing, & Other Patient
CM Measurement, Acuity Measure	
Capital Reimbursement Determination	Historic Cost
Ancillary Services[1] Included in Rate	Physical Therapy[2], Respiratory Therapy[2], Non-Prescription Drug, Oxygen[2], Speech Therapy[2], Durable Med. Equip.[2], Occupational Therapy[2], Physician Services[2] [3], Medical Supplies, Prescription Drug[2], Patient Transport (non-emergency)

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific with No Peer Groupings and No Cost Center Caps
Average Reimbursement Rate	$187.95
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit/HH Aide Visit	$96.83/$30.68

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915c Waiver
Average Reimbursement Rate	$46.89 (Social)
Facility Type	Social, Day health, Alzheimer's
Clients Covered	Aged, Phys., Ment., & Develop. Disabled and AIDS/HIV

Sub-Acute Care

No Separate Program

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[1] Ninety percent of Delaware's facilities were private and ten percent were public. All ancillaries were included in the public facilities.
[2] Not included in the rate for Private facilities.
[3] Only if on staff.

DISTRICT OF COLUMBIA

Nursing Homes

The number of nursing homes in Washington, D.C. grew from 11 in 1980 to 22 in 1996 and to 23 in 1997. There were 3,096 licensed nursing home beds in D.C. in 1996, a decrease of 184 beds since 1995. 1997 brought the bed count up to 3,124. The bed growth rate between 1987 and 1997 was 4.38 percent compared to the national rate of 15.06 percent. The District of Columbia had 42.8 beds per 1000 population aged 65 and over in 1997, less than the national average of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in the District has increased steadily from 113 in 1992 to 129 in 1997 (an increase of 4 facilities since 1996). ICF/MR beds have also increased from 748 in 1992 to 837 in 1997 (an increase of 25 licensed beds since 1996). This represents a 1997 ratio of 1.58 licensed beds per 1000 total population, significantly greater than the national ratio of 0.48.

Residential Care for Adults/Aged

Residential care in D.C. is provided in community residential facilities. The number of these facilities increased from 203 in 1996 to 208 in 1997. The number of licensed beds also increased from 1,632 in 1996 to 1,674 in 1997. D.C. had a ratio of 22.9 residential care beds per 1000 population age 65 and over in 1997, less than the national ratio of 24.3.

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Washington, D.C. in 1997. There were 19 certified home health care agencies in 1997, a decrease of 10 since 1996.[1]

CON/Moratorium

Washington, D.C. had a CON for nursing homes from 1979 through 1997, with a brief moratorium added to it from October 1988 to February 1989. In 1997 a CON was also required for hospital bed conversions, residential treatment facilities, adult day care and home health care, while there was neither a CON nor moratorium on ICF/MRs. In 1997 there was one CON application for 148 new nursing beds, 124 of these beds were denied.

[1] Fraud and abuse account for some of the decrease in certified home health care agencies.

DISTRICT OF COLUMBIA

Demographics

Percentage Population 65 and Over	13.9 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	23
Total Beds	3,124
Beds Per Nursing Facility	135.8 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	42.8 (US 53.1)
Age 85 and Over	347.1 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	9.62 (US 6.01)
Expenditures Per 1000 Pop, 1996	$272,213 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	129
Total Beds	837
Beds Per 1000 Population	1.58 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	208
Total Beds for Adult/Aged	1,674
Beds Per 1000 Pop, Age 65 and Over	22.9 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.43 (US 6.51)
Expenditures Per 1000 Pop, 1996	$24,795 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	CON Only
Adult Day Care	CON Only

* Opinion of State Health Planning Officials.

DISTRICT OF COLUMBIA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The basic reimbursement method was adopted in 1996 with a maximum rates limited to the fees group median for routine plus support costs, nursing and patients care costs. The 1995 cost reports were used to develop the base for FY97. Inflation based on the Medicare Market Basket Index was used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

A new system was in place for FY97. There has been no significant change since then.

Cost Centers

The District of Columbia separates reimbursement into three cost centers: 1. nursing and patient care, limited to 100% of the median; 2. routine and support, limited to 100% of the median; and 3. capital with no median limit.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, physician services, and speech are included in the rate. Ancillaries are under the patient care portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used FY96. Planning for case-mix is in progress. A single level of care is provided.

Capital Costs

Capital costs are used on FY95 cost reports trended forward by Medicare Market Basket Index.

Reimbursement Rate

The FY97 average reimbursement rate for DC was $148.86 weighted by facilities.

Other Long-Term Care

The District of Columbia hospital-based nursing facilities[1] methods were the same as the free-standing nursing facilities. ICF-MR is reimbursed based on a prospective median based system derived from cost reports from 993. It pays for homehealth using a fee schedule with a flat rate, paying five times as much for a RN visit ($65.00) as for an hour of home health aid services ($12.50). Adult Day Care is provided under the State Plan on a fixed fee basis.

[1] There were only three hospital based facilities.

DISTRICT OF COLUMBIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$148.86
Percentage Rate Change From Previous Year	1.13%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
Inflation Adjustment	Medicare Market Basket
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusters	None (Planning in progress)
Capital Reimbursement Determination	Market Value
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Speech Therapy, Patient Transport, Durable Med. Equip., Medical Supplies, Physician Services

Hospital-Based Nursing Facilities

Method	Same as Free-standing Nursing Facilities

ICF-MR

Method	Similar to Free-standing Nursing Facilities
Average Reimbursement Rate	$241.54

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$65.00 per visit
Average Reimbursement Rate, HH Aide Visit	$45.30 per hour

Other Residential Care For Aged

Method	Fee schedule with Flat Rate Average
Reimbursement Rate, RN Visit	$65.00 per visit
Average Reimbursement Rate, HH Aide Visit	$12.50 per hour

Adult Day Care

Method	Prospective Upper Limit
Reimbursement Program	Covered under state regulations
Average Reimbursement Rate by Facility Type	$87.83
Facility Type	Day Health
Clients Covered	Not available

Sub-Acute Care

Method	Prospective Patient-Specific
Ventilator	Not available

FLORIDA

Nursing Homes

Florida's Nursing home facilities increased from 515 in 1987 to 681 in 1997. The number of beds increased from 58,620 in 1987 to 79,918 in1997, an increase of 21,298 beds. The bed growth rate for 1987 through 1997 was 36.33 percent, the fourth highest growth rate in the country (high compared to the U.S. average rate of 15.06 percent). The ratio of licensed nursing home beds per 1000 population age 65 and over continued to be substantially lower than the U.S. ratio (29.5 compared to 53.1) in 1997.

Intermediate Care for Mentally Retarded

Florida had 112 ICF/MRs with a total of 3,538 beds in 1996[1]. In 1997, ICF/MR facilities and beds dropped to 21[2] and 3508 respectively. The ratio of ICF/MR beds per 1000 total population remains well below the national average (0.24 compared with 0.48).

Residential Care for Adults/Aged

Florida licenses two categories of residential care for the elderly - assisted living facilities[3] and adult family care homes[4]. The total number of these facilities grew from 1,914 in 1989 to 2,278 in 1997 (a decrease of 51 facilities since 1996). The total number of beds increased from 59,180 in 1989 to 65,465 in 1997 (a decrease of 1,952 beds since 1996). The ratio of licensed beds per 1,000 population aged 65 and over was 24.2 in 1997, greater than the U.S. average ratio of 24.3.[5]

Adult Day Care and Home Health Care

The number of licensed adult day care facilities in Florida increased from 143 in 1996 to 148 in 1997. The number of licensed home health care agencies decreased from 1,696 in 1996 to 1,448 in 1997. Florida had a ratio of licensed home health care agencies per 1000 population aged 65 and over that was slightly higher than the national ratio in 1997 (0.53 compared to 0.50).

CON/Moratorium

Florida had a CON for nursing homes from 1979 through 1997. In 1997 a CON was also required for hospital bed conversions, ICF/MRs, home health care[6], and hospice, while there was neither a CON nor moratorium on residential care or adult day care. There were 133 CON applications submitted for nursing homes in 1997, of these 71 were denied.

[1] The total number of ICF/MRs represents both facilities licensed as ICF/MRs and facilities that have been converted to Homes for Special Services which will remain with that designation pending litigation.

[2] Florida stopped licensing private facilities in 1997. The 21 ICF/MRs represent large state owned facilities only.

[3] Formerly known as adult congregate living facilities.

[4] Formerly known as adult foster homes.

[5] 'Other residential care' in Florida includes foster homes (for mentally retarded and developmentally disabled), large as well as small group homes and residential habilitation centers with a total of 854 facilities and 5,990 beds.

[6] The CON for home health care is required only for Medicare certified home health agencies.

FLORIDA

Demographics

Percentage Population 65 and Over	18.5 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	681
Total Beds	79,918
Beds Per Nursing Facility	117.4 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	29.5 (US 53.1)
Age 85 and Over	272.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.69 (US 6.01)
Expenditures Per 1000 Pop, 1996	$76,018 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	21
Total Beds	3,508
Beds Per 1000 Population	0.24 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,278
Total Beds for Adult/Aged	65,465
Beds Per 1000 Pop, Age 65 and Over	24.2 (US 24.3)
Total Facilities, Other	854
Total Beds, Other	5,990

Licensed Adult Day Care

Total Facilities	148
Facilities Per 1000 Pop, Age 65 and Over	0.05 (US 0.16)

Licensed Home Health Care

Total Agencies	1,448
Agencies Per 1000 Pop, Age 65 and Over	0.53 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.38 (US 6.51)
Expenditures Per 1000 Pop, 1996	$19,999 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

FLORIDA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing home care in the state of Florida, based on a class/flat rate. The method employed two peer groupings: geographic location (north, central, and south counties) and number of beds (two groups). The two peer groupings were used to create six classes with specific ceilings. The basic reimbursement method was adopted in 1983 with some amendments. Semi-annual rates are set in January and July. The most current cost report data available was used to set rates for FY97. Florida used a target rate system which controlled and limited the rate. The target rate included costs for operating and patient care. Inflation based on the DRI was used to trend rates. Occupancy (low occupancy adjustment) was set by changes in standard deviations of the total state average.

Adjustments

Other than the annual rate setting adjustment for FY97, adjustments are made as needed based on field audits, desk audits, and other appropriate information received.

Cost Centers

Florida separated reimbursement into four cost centers: 1. operating costs, limited by the target rate system and a class ceiling; 2. patient care cost, limited by the target rate system and a class ceiling; 3. property; and 4. return-on-equity.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation and oxygen were included in the rate under the patient care component. For Medicaid clients not eligible for Medicare Part B , the state only pays the co-insurance and deductibles through the crossover.

Case-Mix Adjusters

It is anticipated that an add-on to the patient care component based on a facility's average case-mix rate will be implemented April 1, 1998.

Capital Costs

Two systems were used in Florida. For those using the historic system, refinancing, renovation, and rental costs and leases were allowed with a cap of $13.65. The American Hospital Association guidelines were used with the straight line method for depreciation. Equity was provided on cost based only. Depreciation and interest expense was an allowable cost. The fair rental value system began on October 1, 1985. FRVS based on historical acquisition costs was indexed forward. The fair rental system allowed construction cost and indexing. The rental system was applied to an appreciating property base. For capital-interest expenses, nursing facilities used the actual interest, subject to a ceiling or Chase Manhattan Prime.

Reimbursement Rate

The FY97 average reimbursement rate for Florida was $95.95, weighted by number of facilities and months.

Other Long-Term Care

Florida used the same system for hospital-based as for free-standing nursing facilities, and the same for ICF-MR, but with a rate at well over half of that for nursing facilities. Home health agencies were reimbursed using a fee schedule with a flat rate, paying ($31.04) for an RN visit as for a home health aide visit ($17.46). Florida Medicaid paid under waiver for adult day care, using negotiated contract fees.

FLORIDA

Free-Standing Nursing Facilities

Method	Prospective Class, Adjusted
Average Reimbursement Rate	$95.95
Percentage Rate Change From Previous Year	2.6%
Peer Groupings	Number of Beds & Geographic Location
Year of Cost Report to Set Rate	Most Current Available
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Low Occupancy Rate
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost or Fair Rental
Ancillary Services Included in Rate	Physical Therapy, Respiratory Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	Non-Ambulatory $242.42 Residential/Institutionalized $199.56
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$31.04
Average Reimbursement Rate, HH Aide Visit	$17.46
Average Reimbursement Rate, LPN Visit	$26.19

Other Residential Care For Aged

Method	Fee Schedule with Flat Rate
Reimbursement Program	1915c Waiver Singular
Average Reimbursement Rate by Service Type	
Assisted Living	$25.00 Maximum per. day
Average Reimbursement Rate by Clients	
Aged & Disabled age 60 and above	$25.00 Maximum per. day

Adult Day Care

Method	Fee Schedule with Flat Rate
Reimbursement Program	1915c Waivers home and community based services.
Average Reimbursement Rate by Facility Type	
Day Health	$10.00 per. hour, 4 hr. minimum
Average Reimbursement Rate by Clients Covered	Not available
Aged & Physically Disabled	$10.00 per. hour 4 hr. minimum
AIDS / ARC	$10.00 per. hour 4 hr. minimum

Sub-Acute Care

No Separate Program

GEORGIA

Nursing Homes

The number of nursing home facilities in Georgia has fluctuated since 1980. In 1997, there were 373 facilities, a total increase of 7 facilities since 1996. The number of beds rose to from 40,025 in 1996 to 40,047 in 1997. Between 1987 and 1997 Georgia experienced a total growth rate of 14.62 percent compared to the national rate of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over was 54.3 in 1997, just greater than the national ratio of 53.1.

Intermediate Care for Mentally Retarded

Georgia had 10 ICF/MR facilities with 1,835 beds in 1997 - a decrease of 1 facility and 363 beds since 1996. The ratio of beds per 1000 total population was 0.24 in 1997, half that of the national ratio (0.48).

Residential Care for Adults/Aged

All residential care in Georgia is now licensed as personal care homes. These homes provide care for both aged and non-aged individuals. In 1997, Georgia had 1,902 personal care homes with 18,540 beds. This is a total increase of 93 facilities and 1,943 beds since 1996. In 1997, the ratio of beds per 1000 population aged 65 and over is above the national ratio (25.1 compared to 24.3 U.S. average).

Adult Day Care and Home Health Care

Adult day care was not licensed in Georgia in 1997. The number of licensed home health care agencies has gradually increased, from 76 in 1990 to 106 in 1997 despite this increase, Georgia's ratio of agencies per 1000 population aged 65 and over remained much lower than the national average (0.14 compared to 0.50).

CON/Moratorium

Georgia had a CON for nursing homes from 1979 through 1997.[1] In 1997, a CON was also required for hospital bed conversions, ICF/MRs and home health care. There was neither a CON nor moratorium on residential care, assisted living, hospice or adult day care. There were 17 nursing home CON applications submitted in Georgia in 1997, 3 of which were denied.

[1] Although there was no official moratorium for nursing homes, in 1995 and 1996 the state sent out statements indicating that they would not accept CON applications for nursing homes.

GEORGIA

Demographics

Percentage Population 65 and Over	9.9 % (US 12.7 %)
Percentage Population 85 and Over	1.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	373
Total Beds	40,047
Beds Per Nursing Facility	107.4 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	54.3 (US 53.1)
Age 85 and Over	520.1 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.46 (US 6.01)
Expenditures Per 1000 Pop, 1996	$85,891 (US $111,686)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	10
Total Beds	1,835
Beds Per 1000 Population	0.24 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,902
Total Beds for Adult/Aged	18,540
Beds Per 1000 Pop, Age 65 and Over	25.1 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	106
Agencies Per 1000 Pop, Age 65 and Over	0.14 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.88 (US 6.51)
Expenditures Per 1000 Pop, 1996	$14,761 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

GEORGIA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employs peer groupings by category of service and bed size. The basic reimbursement method was adopted in 1978. A state fiscal year was used to set and rebase the rates annually beginning July 1. The FY95 cost report was used for FY97. Inflation based on the DRI was used to trend rates. A minimum occupancy standard of 85% was used for the property portion of the rate.

Adjustments

The rates are adjusted by audit, periodic intensity level (patient mix ratio) changes, and appeals.

Cost Centers

Five cost centers were used for setting reimbursement rates in Georgia: 1. routine and special services, limited to the 90th percentile; 2. dietary, limited to the 90th percentile; 3. Laundry, housekeeping, operation and maintenance of plant limited to the 85th percentile; 4. administrative and general, limited to the 70th percentile; and 5. property and related, limited to the 90th percentile.

Ancillary Services

Physical therapy, occupational therapy, intravenous therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, physician services, oxygen, speech, recreational therapy, and tube feeding were included in the rates net charges.

Case-Mix Adjusters

No case-mix adjusters were used in Georgia. Georgia incorporated four levels of care.

Capital Costs

Well over 90% of all nursing facilities are under a fair rental system based on the Dodge construction cost index. A small percentage are reimbursed their actual cost of depreciation and amortization, lease expenses, and capital related interest expense.

Reimbursement Rate

The FY97 average reimbursement rate for Georgia was $75.46 it is a weighted average of hospital based free standing nursing facilities. Averaged by the number of facilities between free-standing and hospital based.

Other Long-Term Care

Georgia used the same system for hospital-based as free-standing nursing facilities, averaging a 25% higher per diem rate. It used the same method for ICF-MR rates, which average almost three-times higher than for free-standing nursing facilities. Home health rates were set using a prospective agency-specific system that paid the same average rate ($54.00) for a RN visit as for a home health aide visit. Other residential care and adult day care[1] was paid under waiver, using a prospective flat rate.

[1] Georgia's Adult Day Care waiver has been in place since 1979.

GEORGIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$75.46
Percentage Rate Change From Previous Year	-2.0%
Peer Groupings	By Category of Service and Bed Size
Year of Cost Report to Set Rate	1995
Inflation Adjustment	6.6%
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Fair Rental
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Intravenous Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Physician Services, Oxygen, Recreational Therapy, Speech Therapy, Tube Feeding, Dietary Supplemental Feeding

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$91.56

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$210.91
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Prospective Agency Specific
Average Reimbursement Rate, RN Visit	$54.00
Average Reimbursement Rate, HH Aide Visit	$54.00

Other Residential Care For Aged

Method	Prospective Flat Rate
Reimbursement Program	1915c Waiver
Average Reimbursement Rate by Facility	
Family Model Agency	$23.49 per day
Group Home	$23.49 per day

Adult Day Care

Method	Prospective Patient-specific Rate
Reimbursement Program	1915c Waiver[1]
Facility Type	Combination of Activities
Average Reimbursement Rate by Clients Covered	
Aged, Physically Disabled	
Level I	$42.00 minimum 5 hours
Level 2	$52.50 minimum 5 hours

Sub-Acute Care — No Separate Program

[1] Georgia's Adult Day Care waiver has been in place since 1979.

HAWAII

Nursing Homes

There was no change in number of nursing homes in Hawaii between 1996 and 1997 (44 facilities). In 1997 there were 3,948 licensed beds, a decrease of 2 beds since 1996. Between 1987 and 1997 the total bed growth in Hawaii was 33.83 percent, more than twice the national average of 15.06 percent for the same period. Although Hawaii's ratio of licensed nursing home beds per 1000 population aged 65 and over has increased since 1995, the 1997 ratio (25.1) was less than half the national average of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Hawaii increased from 21 facilities in 1996 to 23 facilities in 1997. The number of beds has decreased, however, from 142 in 1996 to 137 in 1997. Hawaii's ratio of licensed ICF/MR beds per 1000 total population was 0.11 in 1997, much lower than the national average of 0.48.

Residential Care for Adults/Aged

There were 547 residential care facilities with 2,795 beds[1] in Hawaii in 1997, an increase of 1 facility and a decrease of 23 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over was 17.8 in 1997, below the national ratio (24.3).[2]

Adult Day Care and Home Health Care

Hawaii licenses adult day care and adult day health centers. In 1997 there were 18 of the former and 9 of the latter, a total increase of 2 facilities since 1996. Hawaii's ratio of adult day care facilities per 1000 population aged 65 and over was 0.17 in 1997, only slightly higher than the national average of 0.16. There were 27 licensed home health care agencies in Hawaii in 1997, a decrease of 1 since 1996. This is the second fewest in the country (Alaska had the fewest with 26 agencies). Hawaii's ratio of licensed agencies per 1000 population aged 65 and over was 0.17 in 1997, well below the national ratio of 0.50.

CON/Moratorium

Hawaii had a CON for nursing homes from 1979 through 1997[3]. In 1997, a CON was also required for hospital bed conversions, ICF/MRs, home health care and hospice. There was neither a CON nor moratorium on residential care or adult day care. There were 3 nursing home CON applications submitted in 1997, none were denied[4].

[1] The total number of 'Residential Care for Adults/Aged' beds includes 36 beds which are part of the Maluhia wait list project. These beds exist within Arch Home type 1 facilities. They are reserved for people who qualify for nursing home care but have not been placed in a nursing home due to unavailable space.

[2] 'Other Residential Care' in Hawaii includes 41 domicilliary care homes for the developmentally disabled with 184 beds and 18 special treatment facilities with 534 beds.

[3] Hawaii strongly discourages nursing home applications. The probability of disapproval is 99%. Hawaii is one step away from having a moratorium.

[4] These were existing beds proposed for conversion from ICF to SNF/ICF

HAWAII

Demographics

Percentage Population 65 and Over	13.2 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	44
Total Beds	3,948
Beds Per Nursing Facility	89.7 (US 102.7)
Average Occupancy Rate	90.7
Beds Per 1000 Population:	
Age 65 and Over	25.1 (US 53.1)
Age 85 and Over	263.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.54 (US 6.01)
Expenditures Per 1000 Pop, 1996	$122,211 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	23
Total Beds	137
Beds Per 1000 Population	0.11 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	547
Total Beds for Adult/Aged	2,795
Beds Per 1000 Pop, Age 65 and Over	17.8 (US 24.3)
Total Facilities, Other	59
Total Beds, Other	718

Licensed Adult Day Care

Total Facilities	27
Facilities Per 1000 Pop, Age 65 and Over	0.17 (US 0.16)

Licensed Home Health Care

Total Agencies	27
Agencies Per 1000 Pop, Age 65 and Over	0.17 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	0.52 (US 6.51)
Expenditures Per 1000 Pop, 1996	$1,530 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

HAWAII

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed peer groupings by facility type in two ways: Free-standing versus hospital based and ICF versus SNF. The basic reimbursement method was adopted in 1985. A state fiscal year was used to set annual rates beginning July 1. The 1992 cost report was used for FY97. Inflation based on the DRI was used to trend rates. Facilities in Hawaii had a high occupancy making use of a minimum occupancy standard irrelevant.

Adjustments

No adjustments were made outside the regular rate setting procedures.

Cost Centers

Three cost centers were used for setting reimbursement rates in Hawaii: 1. nursing, limited to 115% of state-wide average per peer group; 2. general & administration, limited to 110% of state-wide average per peer group; and 3. capital, limited to 110% of state-wide average.

Ancillary Services

Maintenance therapy and medical supplies were included in the rate, as part of the nursing component.

Case-Mix Adjusters

No case-mix adjusters were used in Hawaii. They offer three levels of care. There were no plans to implement a case-mix system.

Capital Costs

The value of capital was determined by historic cost. Capital-interest expenses were inflated forward from the 1992 base year cost report, limited by a cap component. Refinancing, renovations, and rental costs and leases were allowed as costs. The rental costs and leases cost was limited to the owner's cost. Depreciation was based on straight line. The American Hospital Association guidelines were used for depreciation. A return on net equity was provided using the Medicare formula to for-profit facilities only, based on 1992 figures.

Reimbursement Rate

The FY97 average reimbursement rate for Hawaii was $132.59, weighted by total medicaid days.

Other Long-Term Care

Hawaii's hospital-based nursing and ICF-MR facilities used the same methodology as for free-standing nursing facilities, however the rates for both types of facilities were higher. Other residential care set rates by a prospective method based on a class/flat rate. Home health rates were set using Medicare principles. A prospective facility-specific method was used to set rates for adult day care.

HAWAII

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$132.59
Percentage Rate Change From Previous Year	2.3%
Peer Groupings	Free-Standing vs. Hospital, Levels of Care
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Not relevant
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Maintenance Therapy Medical Supplies

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$199.64

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$256.91
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

Method	Prospective Flat Rate
Reimbursement Programs	2176 Waiver
Average Reimbursement Rate by Facility Type	
Foster Home	Rate not available

Adult Day Care

Method	Prospective Facility-specific
Reimbursement Program	2176 Waiver
Average Reimbursement Rate (all services)	Rate not available
Facility Type	Social, Day Health, Dementia/Alzheimer's Disease
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill, Substance Abusing, AIDS/HIV, and Pediatric

Sub-Acute Care — No Separate Program

IDAHO

Nursing Homes

The number of nursing homes in Idaho increased from 86 facilities in 1996 to 90 in 1997. The number of beds increased from 6,352 in 1996 to 6,638 in 1997. From 1987 to 1997, the total bed growth rate was 34.84 percent, substantially higher than the national rate (15.06 percent). The ratio of licensed nursing home beds per 1,000 population aged 65 and over continued to be below the national ratio (48.5 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Idaho increased from 56 in 1996 to 57 in 1997. The number of beds decreased from 567 in 1996 to 555 in 1997. The ratio of ICF/MR beds per 1,000 total population was 0.46, slightly less than the national ratio of 0.48.

Residential Care for Adults/Aged

Idaho had three categories of residential care for adults/aged in 1997. There were 151 residential care facilities for the elderly with 3,552 beds, 35 "combined" facilities with 843 beds providing care to the elderly as well as to developmentally disabled and mentally retarded clients, and 13 Adult foster homes with 51 beds. This is an increase of 41 facilities and 1,357 beds since 1996, bringing the ratio of licensed beds per 1,000 population aged 65 and over up to 32.5, higher than the national ratio of 23.1.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Idaho in 1997. There were 92 licensed home health care agencies in Idaho in 1997, a decrease of 3 agencies since 1996, but an increase of 17 agencies since 1994. There were 0.67 home health care agencies per 1000 population aged 65 and over in 1997, above the national ratio of 0.50.

CON/Moratorium

Idaho had a CON for nursing homes between 1979 and 1982 but eliminated it in 1983 and has had neither a CON nor moratorium through 1997. In 1997, there was neither a CON nor moratorium on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] 'Other Residential Care' in Idaho includes: residential care for developmentally disabled, mentally ill, physically disabled and traumatic brain injury.

IDAHO

Demographics

Percentage Population 65 and Over	11.3 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	90
Total Beds	6,638
Beds Per Nursing Facility	73.8 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	48.5 (US 53.1)
Age 85 and Over	414.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.46 (US 6.01)
Expenditures Per 1000 Pop, 1996	$75,174 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	57
Total Beds	555
Beds Per 1000 Population	0.46 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	199
Total Beds for Adult/Aged	4,446
Beds Per 1000 Pop, Age 65 and Over	32.5 (US 24.3)
Total Facilities, Other	41
Total Beds, Other	507

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	92
Agencies Per 1000 Pop, Age 65 and Over	0.67 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.94 (US 6.51)
Expenditures Per 1000 Pop, 1996	$20,026 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

IDAHO

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer grouping. Hospital based facilities were separated for determining the prospective percentile caps. The basic reimbursement method was adopted in 1982. Facility year cost reports were used to set annual rates at the beginning of each facility fiscal year. The 1995 cost reports were used for FY97. Inflation of costs was based on DRI indexes. The higher of Marshall Swift Construction, or CPI cost was used to inflate the property rental component. A minimum occupancy standard of 80% applied only to cost based property reimbursement.

Adjustments

Aside from the annual rate setting adjustment, the rates for individual facilities may be adjusted upward twice per year to accommodate cost increases that was unforeseen, beyond facility control, and not compensated for by DRI indexes.

Cost Centers

Two cost centers were used for setting reimbursement rates: 1. property, incentive, exempt cost, and utilities (non-capped/retrospective adjustment); 2. capped costs including dietary, housekeeping, laundry, administration, therapy services, maintenance, supplies, nursing services, employee benefits, social, activities, and nursing capped at the 75th percentile[2].

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, speech therapy and oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Idaho. One level of care was provided. There were no plans to implement a case-mix system.

Capital Costs

The value of capital was determined by a rental value based on a property rental formula. The rental factor was $13.19 for a new facility in 1996. The rental rate currently ranges from $3.40 to $13.59 depending on facility age, type facility, and major capital improvements.

Reimbursement Rate

The estimated FY97 average reimbursement rate for Idaho was $86.39, weighted by number of facilities for free-standing nursing facilities.

Other Long-Term Care

Idaho used a similar system for hospital-based as for free-standing nursing facilities, but with different rates, paying about third-higher per diem rates on average. ICF-MR was reimbursed on the same basis as nursing facilities, but at a rate over twice as high. Home health agencies were reimbursed using Medicare principles with state alterations that included a cap for RN payment over two and a half times that for home health aide visits. Sub-acute care was paid using a negotiated average patient-specific rate of $155.20[3].

[1] Idaho had a retrospective system with prospective caps ands interim rates, adjusted to cost at audit settlement. Retrospective systems with interim rates were re-categorized as Prospective.

[2] Retrospective adjustment subject to cap.

[3] For Nursing Facility patients with needs beyond scope of normal services

IDAHO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$86.39
Percentage Rate Change From Previous Year	-1.8%
Peer Groupings	None[1]
Year of Cost Report to Set Rate	1995
Inflation Adjustment	DRI & for Property Higher of MSC[2] or CPI-Renters Cost
Minimum Occupancy in Rate-Setting	80% for cost based property
Case-Mix Adjusters	None
Capital Reimbursement Determination	Rental Value
Ancillary Services Included in Rate[3]	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Speech Therapy, Oxygen

Hospital-Based Nursing Facilities

Method	Similar[4] to Free-Standing Nursing Facilities
Average Reimbursement Rate	$115.74

ICF-MR

Method	Prospective Effective 10/1/96
Average Reimbursement Rate	$183.61
Capital Reimbursement Determination	Rental rate similar to Nursing Facilities but not more than Medicare aggregate.
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen, Non-Prescription Drug, Active Treatment

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$103.26 (cap)
Average Reimbursement Rate, HH Aide Visit	$36.41 (cap)

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

Method	Patient/Facility-Specific
Average Rate[5]	$152.74

[1] Hospital Based facilities were separated for determining the prospective percentile caps.

[2] Marshall Swift Construction

[3] When not covered by medicare. Ancillary costs covered by medicare are removed.

[4] Property cost based on audit. Caps differ. No Rental value.

[5] For Nursing Facility patients with needs beyond scope of normal services.

ILLINOIS

Nursing Homes

The number of nursing homes in Illinois increased from 805 in 1996 to 810 in 1997. The number of beds also increased from 102,632 in 1996 to 107,072 in 1997. The bed growth rate between 1987 and 1997 was 12.36 percent compared to the national rate of 15.06 percent. Illinois' ratio of beds per 1,000 population aged 65 and over was well above the national ratio in 1997 (72.3 compared to 53.1).

Intermediate Care for Mentally Retarded

In 1996 Illinois had 325 ICF/MR facilities with 8,174 beds, a decrease of 36 facilities and an increase of 36 beds since 1994[1]. In 1997 facilities decreased to 317 with beds increasing to 10,529. The ratio of ICF/MR beds per 1000 total population was 0.88, well above the national ratio of 0.48 in 1997.

Residential Care for Adults/Aged

Illinois had 46 sheltered care facilities with a total of 7,442 beds in 1997. This is an increase of 1 facility and 9 beds since 1996. The ratio of licensed residential care beds per 1000 population aged 65 and over remained far lower than the national ratio (5.0 compared to 24.3) in 1997.

Adult Day Care and Home Health Care

Adult day care was not licensed in Illinois in 1997. There were 492 licensed home health care agencies in 1997, an increase of 23 since 1996. The ratio of agencies per 1000 population aged 65 and over in Illinois was still lower than the national ratio (0.33 compared to 0.50).

CON/Moratorium

Illinois had a CON for nursing homes from 1979 through 1997. In 1997 a CON was also required for hospital bed conversions, ICF/MRs and on skilled and sheltered residential care. There was neither a CON nor moratorium on home health, hospice or adult day care. There were 23 nursing home CON applications in 1997, 7 of which were denied.

[1] The figures for ICF/MRs include ICF/DD and DMHDD facilities and beds.

ILLINOIS

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	810
Total Beds	107,072
Beds Per Nursing Facility	132.2 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	72.3 (US 53.1)
Age 85 and Over	604.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.90 (US 6.01)
Expenditures Per 1000 Pop, 1996	$102,547 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	317
Total Beds	10,529
Beds Per 1000 Population	0.88 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	46
Total Beds for Adult/Aged	7,442
Beds Per 1000 Pop, Age 65 and Over	5.0 (US 24.3)
Total Facilities, Other	42
Total Beds, Other	1,639

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	492
Agencies Per 1000 Pop, Age 65 and Over	0.33 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.07 (US 6.51)
Expenditures Per 1000 Pop, 1996	$16,952 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

ILLINOIS

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of geographic location by region. The basic reimbursement method was adopted in the early 1980's. The FY94 frozen reimbursement rates were increased by a flat 6.8% in mid fiscal year 1997.

Adjustments

No adjustments were made to the initial prospective rates for the rate period. Some rates were adjusted downward during and retroactively to the rate period due to cost report audit but these adjustments are merely corrections in the cost data upon which prospective rates are based. These are not adjustments based on actual service delivery.

Cost Centers

Three cost centers were used for setting reimbursement rates in 1994: 1. administration and general services, limited to the 75th percentile; 2. capital, limited by uniform building cost; 3. direct care and nursing, limited by average geographic wage and staff times for each of the specific services covered.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs[1] medical supplies, durable medical equipment, and oxygen were included in the nursing and direct care component of the rate.

Case-Mix Adjusters

Case-mix was adopted in the early 1980's. A patient acuity or needs level measure was used in the case-mix system and direct care rates were based on the particular facility's resident case-mix (the average per patient need-service level).

Capital Costs

Reimbursement for capital cost was based on a Fair Rental Value system. The rates were determined on the basis of the facility's specific building costs combined with uniform building costs, equipment costs and other capital costs. Renovations and improvements were allowable costs. A return on investment of eleven percent was made.

Reimbursement Rate

The FY97 average per patient reimbursement rate for Illinois was $70.28.

Other Long-Term Care

Illinois used the same method for hospital-based as for free-standing nursing facilities and a similar method for ICF-MR. Home health was paid using Medicare principles, with the same average rate for RN as for home health aide visits ($41.55). Adult day care was paid under waiver, using a flat rate. Sub-acute care was paid under a prospective patient-specific system. The average rate in FY97 was $180.42.

[1] This includes general use stock drugs only.

ILLINOIS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$70.28[1]
Percentage Rate Change From Previous Year	6.8%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1992
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	Yes
Case-Mix Adjusters	Acuity Measure, Direct Care is CM Adjusted
Capital Reimbursement Determination	Fair Rental Value System
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Oxygen, Durable Med. Equip.

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Reimbursement Rate	$100.19
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities, plus Patient Transport

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$41.55
Average Reimbursement Rate, HH Aide Visit	$41.55
Speech, Occupational, and Physical Therapist	$41.55

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Once A Week
Reimbursement Program	1115c Wavier
Flat Reimbursement Rate	$23.18 plus transportation add on $3.00
Facility Type	Social and Day Health
Clients Covered	Dementia/Alzheimers Disease

Sub-Acute Care

Method by program/client	Prospective Patient-Specific
Average Rates (per diem)	
AIDS	$123.15-$192.91
Ventilator	$300.11
Multiple, Complex Diagnosis	$137.77-$184.37

[1] Frozen January 1, 1994, rates were increased by 6.8% midyear FY 97.

INDIANA

Nursing Homes

The number of nursing homes in Indiana decreased from 592 in 1996 to 590 in 1997. The number of beds also decreased from 68,602 in 1996 to 64,509 in 1997. Between 1987 and 1997 the bed growth rate was 18.16 percent compared to the national growth rate of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over in 1997 was 87.9 compared to the national ratio of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Indiana increased from 13 in 1990 to 18 in 1994 where it remained through 1997. The number of beds also increased gradually from 997 in 1990 to 1,767 in 1996 and 1997. The ratio of ICF/MR beds per 1000 total population was 0.30 in 1997, compared to the national average of 0.48.

Residential Care for Adults/Aged

There were 31 residential care facilities with 2,475 beds in Indiana in 1997, an increase in 8 facilities and 489 beds since 1996. This is a ratio of 3.4 licensed beds per 1000 total population aged 65 and over, compared to the national average of 24.3[1].

Adult Day Care and Home Health Care

Adult day care was not licensed in Indiana in 1997. There were 435 licensed home health care agencies in 1997, an increase of 32 since 1996 and a ratio of agencies per 1000 population aged 65 and over that continued to be slightly greater than the national ratio (0.59 compared to 0.50).

CON/Moratorium

Indiana had a CON for nursing homes from 1979 through 1995.[2] In January, 1997 the Indiana General Assembly voted to override the veto, making CON in effect again July 1997. In 1997 there was a CON requirement for hospital conversion. There was both CON and moratorium on ICF/MRs. There was neither a CON nor moratorium on residential care, home health, hospice or adult day care. There were no nursing home Con applications submitted in 1997.

[1] 'Other Residential Care' in Indiana includes an estimated 550 group homes with 4,527 beds for persons with mental retardation.

[2] In July 1996 the Governor vetoed a renewal of the CON program and it was terminated.

INDIANA

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	590
Total Beds	64,509
Beds Per Nursing Facility	109.3 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	87.9 (US 53.1)
Age 85 and Over	768.0 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.22 (US 6.01)
Expenditures Per 1000 Pop, 1996	$126,421 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	18
Total Beds	1,767
Beds Per 1000 Population	0.30 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	31
Total Beds for Adult/Aged	2,475
Beds Per 1000 Pop, Age 65 and Over	3.4 (US 24.3)
Total Facilities, Other	550
Total Beds, Other	4,527

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	435
Agencies Per 1000 Pop, Age 65 and Over	0.59 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	1.70 (US 6.51)
Expenditures Per 1000 Pop, 1996	$7,658 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

INDIANA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. A facility fiscal year cost report was used to set and rebase rates annually. The earliest possible cost reports applied to FY97 were from 1995. Historical costs were trended forward using the HCFA/SNF inflation index. A minimum occupancy standard was set at 90% effective 6/1/95.

Adjustments

Staffing costs were limited to 5 1/2 hrs. per pt.-day for skilled care and 4 1/4 per pt. day for intermediate care[1].

Cost Centers

Indiana separated reported costs into nine cost centers: 1. nursing- 2. dietary; 3. housekeeping and laundry; 4. plant operations; 5. ownership; 6. general and administration, 7. total employee benefits; 8. social services and 9. therapy services.

Ancillary Services

Non-prescription drugs, medical supplies, and Speech, Respiratory, Occupational, Physical therapies were included in the rate under the appropriate cost center.

Case-Mix Adjusters

No case-mix adjusters were used to set rates in Indiana. Two levels of care were provided.

Capital Costs

Historic cost was used in determining the value of capital for nursing facilities in Indiana. Depreciation or revaluation of property was subject to ceilings for existing providers. A return-on-equity based on net equity was provided. A use fee was included to reimburse for debt service on property financing

Reimbursement Rate

The average nursing facility reimbursement rate for Indiana was $80.32 for FY97.

Other Long-Term Care

Indiana used the same system for hospital-based as for free-standing nursing facilities and a similar method for ICF-MR. Home health agencies were reimbursed using a fee schedule with a flat rate. RN services were reimbursed at a rate of $26.92 per hr. plus $26.72 per visit for overhead. Home Health aide services were reimbursed at a rate of $11.78 per hour plus $26.72 overhead per visit. Adult day care was paid using a retrospective flat rate. Sub-acute care was reimbursed using a prospective facility-specific method.

[1] Costs have been adjusted to reflect allowable costs based on the rate setting criteria. Examples include adjustments for excessive owners' compensation, staffing costs, working capital interest and capital.

INDIANA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$80.32
Percentage Rate Change From Previous Year	-1.78%
Peer Groupings	Statewide
Year of Cost Report to Set Rate	1995
Inflation Adjustment	HCFA SNF Market Basket
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies OT, PT, Speech, and Respiratory Therapies

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Rate	
State Facilities	$215.88
Private Facilities	Small: $128.96 Large: $133.43
Ancillary Services (all facilities)	All Ancillary Services Except Prescription Drug & Physician Services
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Hour	$26.92
Average Reimbursement Rate, HH Hour	$11.78
Overhead Reimbursement per Visit	$26.72

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Retrospective Flat Rate
Program	1915c Waiver
Average Rate	$5.50/Hour
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate	
AIDS/HIV	$185.01
Ventilator Care	$234.68

Cost have been adjusted to reflect allowable costs based on the rate setting criteria. Examples include adjustments for excessive owners' compensation, staffing costs, working capital interest and capital.

IOWA

Nursing Homes

The number of nursing homes in Iowa increased steadily from 407 in 1980 to 481 in 1997. The number of beds has fluctuated but has grown from 30,449 in 1980 to 35,198 in 1997. This was an increase of 2 facilities and 265 beds since 1996. Between 1987 and 1997 the total growth rate was 4.11 percent, small compared to the national rate of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over, however, remained high in 1997 – 82.0, compared to the national average of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities has increased from 119 in 1996 to 122 in 1997. The number of beds has also increased from 3,038 in 1996 to 3,026 in 1997. This represents a ratio of 1.06 ICF/MR beds per 1000 total population in Iowa, two times higher than the national average of 0.48.

Residential Care for Adults/Aged

The number of residential care facilities has continued to decrease in Iowa, from 175 in 1996 to 167 in 1997. The number of beds has continued to decrease as well, from 6,659 in 1996 to 6,284 in 1997. The ratio of licensed beds per 1000 population 65 and over was 14.6 in 1997, lower than the national ratio of 24.3.[1]

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Iowa in 1997. There were approximately 206 certified home health care agencies in Iowa in 1997, a decrease of 2 agencies since 1996.

CON/Moratorium

Iowa had a CON for nursing homes from 1979 through 1997. In 1997 a CON was also required for hospital bed conversions, and a CON and moratorium was required for ICF/MRs. There was neither a CON nor moratorium on residential care, home health care, hospice or adult day care in 1997. There were 7 nursing home CON applications submitted in Iowa in 1997, 1 of which was denied.[2]

[1] 'Other Residential Care' in Iowa includes: residential care facilities for mentally retarded, residential care facilities for persons with mental illness, and residential care facilities for the developmentally disabled. There has been a steady decrease in 'Other Residential Care in Iowa. In 1995 the total number of facilities was 277 and the number of beds was 2582. In 1997 the facilities and beds decreased to 190 and to 2159 respectively.

[2] 120 beds were proposed, 14 were denied initially. (76 of the 120 were replacement beds) The applicant that was denied the 14 beds returned with a new proposal and received approval on 12 beds.

IOWA

Demographics

Percentage Population 65 and Over	15.0 % (US 12.7 %)
Percentage Population 85 and Over	2.1 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	481
Total Beds	35,198
Beds Per Nursing Facility	73.2 (US 102.7)
Average Occupancy Rate	91.5
Beds Per 1000 Population:	
Age 65 and Over	82.0 (US 53.1)
Age 85 and Over	577.0 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.64 (US 6.01)
Expenditures Per 1000 Pop, 1996	$95,117 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	122
Total Beds	3,026
Beds Per 1000 Population	1.06 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	167
Total Beds for Adult/Aged	6,284
Beds Per 1000 Pop, Age 65 and Over	14.7 (US 24.3)
Total Facilities, Other	190
Total Beds, Other	2,159

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.86 (US 6.51)
Expenditures Per 1000 Pop, 1996	$28,189 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

IOWA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1975. A facility fiscal year was used to set rates semi-annually (only once per facility) and a maximum rate cap annually. Facilities clustered with the state fiscal year that began in July or the calendar year. The 1997 cost report or previous six months was used for FY97. Inflation based on CPI and an incentive were used to trend rates. Occupancy was set at minimum of 80%.

Adjustments

A January 1997 adjustment was made in May 1997, retro-active to January.

Cost Centers

Cost centers were not used for setting reimbursement rates in Iowa.

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, patient transportation and oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Iowa. Two levels of care were provided. There were no plans to implement a case-mix system.

Capital Costs

The value of capital was determined by historic cost. Appraisals were used to establish expense for rent/lease arrangement or when the historic value was unknown. Actual interest expense valued capital-interest expenses. Refinancing, renovation, and rental costs and leases were allowed as costs. The rental costs and leases cost was limited to the owner's cost. Depreciation charges were allowed. Straight line was used for depreciation. Depreciation was based on a useful life of forty years.

Reimbursement Rate

The FY97 average reimbursement rate for Iowa was $71.70.

Other Long-Term Care

Iowa used the same system for hospital-based as for free-standing nursing facilities. It used the same method to set ICF-MR rates, which average for free-standing nursing facilities. Home health services are reimbursed under Medicare principles. Adult day care is covered under waivers, using a prospective method.

IOWA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$71.70
Percentage Rate Change From Previous Year	5.2%
Peer Groupings	None
Year of Cost Report to Set Rate	1996 or Previous Six Months
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Combination
Ancillary Services Included in Rate	Non-Prescription Drug, Durable Med. Equip., Medical Supplies, Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities No Maximum Rate Amount
Average Reimbursement Rate	$256.63
Capital Reimbursement Determination	Historic Cost, Market Value, Rental Value
Ancillary Services Included in Rate	Non-Prescription Drug, Durable Med. Equip., Medical Supplies, Patient Transport, Physical Therapy, Occupational Therapy, Respiratory Therapy, Oxygen

Home Health

Method	Medicaid Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915c Waivers
Average Reimbursement Rate by Service	$60.00 per day cap for 8-12 hours
Facility Type	Day Health
Clients Covered	Aged, Elderly, Brain Injury, AIDS, Ill and Disabled waiver clients

Sub-Acute Care

No Separate Program

KANSAS

Nursing Homes

There was an increase in 45 nursing homes and 2,684 beds in Kansas since 1996. The bed growth rate, between 1987 and 1997, was 13.85 percent compared to the national rate of 15.06 percent. The 1997 ratio of licensed nursing home beds per 1000 population aged 65 and over remained much higher than the national ratio (89.9 compared to the U.S. ratio of 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Kansas reached 48 in 1991 then decreased steadily to 43 in 1996 and then to 42 in 1997. The number of beds was 988 in 1991 and decreased steadily to 905 in 1996 and then to 888 in 1997. The ratio of ICF/MR beds per 1000 total population was 0.34 in 1997, lower than the national ratio of 0.48.

Residential Care for Adults/Aged

Kansas has had some recent changes in its licensure of residential care – in 1997 assisted living and residential health care replaced intermediate personal care facilities.[1] In total, there were 218 residential care facilities with 5,707 beds, in 1997 - an increase of 109 facilities and 1,728 beds since 1996 but a ratio of licensed beds per 1000 population aged 65 and over that was still below the national ratio (16.2 compared to 24.3).[2]

Adult Day Care and Home Health Care

Adult day care became licensed in Kansas on July 1, 1995. By 1997 there were 20 licensed facilities, an increase of 12 since 1996. There were 412 licensed home health care agencies in Kansas in 1997, an increase of 38 since 1996 and a ratio of agencies per 1000 population aged 65 and over more than double that of the national ratio (1.17 compared to 0.50).

CON/Moratorium

Kansas had a CON for nursing homes between 1979 and 1984 but eliminated it in 1985 and has had neither a CON nor moratorium through 1997. In 1997 there was neither a CON nor moratorium on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] In 1996 2 licensed personal care facilities with 79 beds remained. In 1997 no personal care facilities existed. The beds moved to assisted living and residential health care facilities.

[2] 'Other Residential Care' in Kansas includes 14 mental health facilities with 891 beds.

KANSAS

Demographics

Percentage Population 65 and Over	13.5 % (US 12.7 %)
Percentage Population 85 and Over	1.9 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	490
Total Beds	31,639
Beds Per Nursing Facility	64.6 (US 102.7)
Average Occupancy Rate	86.1
Beds Per 1000 Population:	
Age 65 and Over	89.9 (US 53.1)
Age 85 and Over	645.7 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.28 (US 6.01)
Expenditures Per 1000 Pop, 1996	$90,652 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	42
Total Beds	888
Beds Per 1000 Population	0.34 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	218
Total Beds for Adult/Aged	5,707
Beds Per 1000 Pop, Age 65 and Over	16.2 (US 24.3)
Total Facilities, Other	14
Total Beds, Other	891

Licensed Adult Day Care

Total Facilities	20
Facilities Per 1000 Pop, Age 65 and Over	0.06 (US 0.16)

Licensed Home Health Care

Total Agencies	412
Agencies Per 1000 Pop, Age 65 and Over	1.17 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.80 (US 6.51)
Expenditures Per 1000 Pop, 1996	$44,760 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

KANSAS

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in the mid 1970s. The calendar year 1996 cost reports were used to set rates. The rate was set on the following July 1st, and was rebased yearly. Inflation based on DRI was used to trend rates. The minimum standard for occupancy was set at 85%. There is an incentive factor based on keeping administrative and plant operating costs lower than peer facilities.

Adjustments

There was an adjustment provision implemented on October 1, 1996 for the federal increase in the minimum wage. A second minimum wage adjustment was planned for September 1, 1997. It is facility specific and based on a request and documentation. Property fee rebasing of capital expenditure thresholds are met and for audit adjustments. The 24 hour nursing factor adjustment expired 12-31-95.

Cost Centers

Four cost centers are used for reimbursement in Kansas. 1. room and board (laundry, housekeeping, and dietary) limited to 130% of median; 2. administration limited to 115% of median; 3. property consisting of the real and personal property fee and the plant operating costs, limited to 130% of median; 4. health care limited to 125% of median for a case mix index of one.

Ancillary Services

Ancillary services are included in the health care cost center. Physical , occupational , respiratory and speech therapies, non-prescription drugs, non-prescription drugs, and non emergent resident transportation were included in the rate.

Case-Mix Adjusters

Case-Mix was fully implemented July1, 1994. RUGs III factors were used in the case-mix. Case-mix was set on an overall facility basis. Direct nursing care was accounted for in the case mix system.

Capital Costs

The value of capital was based on an imputed value. Kansas had a facility specific property fee, implemented in 1985. The fee was based on 1984 ownership costs (depreciation, mortgage interest, lease and amortization of lease expense). When the property fee was higher than ownership costs, the difference could have been considered a return on equity.

Reimbursement Rate

The FY97 average reimbursement rate for Kansas was $67.11, based on days of care.

Other Long-Term Care

Kansas used the same system for hospital-based as for free-standing nursing facilities. A retrospective facility-specific method was employed for public ICF-MRs while a prospective facility-specific method was used for private facilities. Home health was reimbursed using a fee schedule with flat rates, nearly 50% higher for RN visits ($60) as for home health aide visits ($40). Other residential care for the aged was covered under waiver, as was adult day care, using a prospective facility-specific method.

KANSAS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Weighted Average Reimbursement Rate	$67.11
Percentage Rate Change From Previous Year	5.5%
Peer Groupings	None
Year of Cost Report to Set Rate	1996 (calendar year)
Inflation Adjustment	DRI (prospective)
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	RUGs III, Direct Nursing Care is adjusted
Capital Reimbursement Determination	Property Fee
Ancillary Services Included in Rate	Physical Therapy, Speech Therapy, Non-Prescription Drug, Durable Med. Equip.

Hospital-Based Nursing Facilities

Same as Free-Standing Nursing Facilities

ICF-MR

Method	
Public	Retrospective Facility-specific
Private	Prospective Facility-specific
Average Reimbursement Rate	
Public Facilities	$286.00[1]
Private Facilities	$161.97[2]
Capital Reimbursement Determination	
Public Facilities	Actual Costs
Private Facilities	Historic
Ancillary Services in Rate (all facilities)	All ancillary services were included

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$60.00
Average Reimbursement Rate, HH Aide Visit	$40.00

Other Residential Care For Aged[3]

Method	Fee for service
Reimbursement Program	1915c Waiver
Average Reimbursement Rate by Service	
Health Care Attendant I and II	$12.00 to $13.25 per hour
Personal Care	$12.10
Care and Training	$23.00
Facility Type	Group, Family, and Residential Homes

Adult Day Care

Method	Fee for service
Reimbursement Program	1915c Waiver
Average Reimbursement Rate by Service	
Social	$20.00/day
Day Health	$23.00/day
Clients Covered	Aged and Physically Disabled

Sub-Acute Care

No Separate Program

[1] Three state facilities. July 1996 through June 1997.

[2] Averaged by number of facilities. Rate on 10/1/97.

[3] Includes combination of aged & physically disabled clients, which could not be disaggregated.

KENTUCKY

Nursing Homes

The number of nursing homes and beds in Kentucky fluctuated but increased between 1980 and 1995. Since then, the number of facilities has increased from 324 facilities in 1996 to 326 in 1997. The number of beds has also increased from 26,229 in 1996 to 26,950 in 1997. The bed growth rate for 1987 through 1997 was 26.42 percent (well above the national rate of 15.06 percent). The ratio of licensed nursing home beds per 1,000 population aged 65 and over was higher than the national ratio in 1997 (55.1 compared to 53.1).

Intermediate Care for Mentally Retarded

There were 9 ICF/MRs in Kentucky from 1990 to 1994. In 1996 ICF/MR facilities increased to 12, then increased to 13 facilities in 1997. The total number of ICF/MR beds remained constant at 1,203 from 1990 to 1994, increasing with some fluctuation to 1214 in 1997. The ratio of licensed ICF/MR beds per 1000 total population was 0.31 in 1997 (below the national ratio of 0.48.)

Residential Care for Adults/Aged

Kentucky licenses two categories of residential care - personal care homes and family care homes. In 1997 there were 199 of the former with 7,089 beds and 358 of the latter with approximately 984 beds - a total decrease of 13 facilities and 200 beds since 1996. Kentucky's ratio of licensed beds per 1000 population aged 65 and over, 16.5, remained below the national ratio (24.3) in 1997.[1]

Adult Day Care and Home Health Care

There were 67 licensed adult day care facilities in Kentucky in 1997, an increase of 16 since 1996. There were 120 licensed home health care agencies in 1997, an increase of 5 since 1996. The ratio of licensed home health care agencies per 1000 population aged 65 and over (0.25) remained at just half the national ratio (0.50) in 1997.

CON/Moratorium

Kentucky had a CON for nursing homes in 1979, added a moratorium to it between 1980 and 1990, eliminated the moratorium but kept the CON in 1991, and reinstated the moratorium (with the CON) through 1992, 1993, and 1994. In 1995 the moratorium was dropped again, and there was only a CON for nursing homes through 1997. In 1997, a CON was also required for hospital bed conversions, ICF/MRs,[2] residential care, home health care, hospice and adult day care. There were 108 nursing home CON applications submitted in 1997, 102 of which were denied.

[1] 'Other Residential Care' in Kentucky includes: 37 group homes with 296 beds for mental retardation and 12 psychiatric treatment facilities with 96 beds.

[2] ICF/MRs require a CON but there is a mandate in the state health plan, which indicates that none will be approved.

KENTUCKY

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	326
Total Beds	26,950
Beds Per Nursing Facility	82.7 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	55.1 (US 53.1)
Age 85 and Over	490.0 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.60 (US 6.01)
Expenditures Per 1000 Pop, 1996	$102,777 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	13
Total Beds	1,214
Beds Per 1000 Population	0.31 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	557
Total Beds for Adult/Aged	8,073
Beds Per 1000 Pop, Age 65 and Over	16.5 (US 24.3)
Total Facilities, Other	49
Total Beds, Other	392

Licensed Adult Day Care

Total Facilities	67
Facilities Per 1000 Pop, Age 65 and Over	0.14 (US 0.16)

Licensed Home Health Care

Total Agencies	120
Agencies Per 1000 Pop, Age 65 and Over	0.25 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	16.41 (US 6.51)
Expenditures Per 1000 Pop, 1996	$35,546 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	CON Only
Adult Day Care	CON Only

* Opinion of State Health Planning Officials.

KENTUCKY

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of geographic location (urban/rural). The basic reimbursement method was adopted in 1977. In September of 1990 Kentucky added case-mix. A state fiscal year was used to set and rebase rates annually beginning July 1, with quarterly adjustments. The 1996 cost report were used for FY97. Inflation based on the DRI and Case-mix was used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

The reimbursement rate was adjusted with quarterly case-mix adjustments only.

Cost Centers

Two cost centers were used for setting reimbursement rates in Kentucky: 1. nursing, limited to 115% of median by urban/rural; and 2. all other, limited by 115% of median by urban/rural.

Ancillary Services

Include x-ray, physical therapy, speech therapy, occupational therapy, respiratory therapy, oxygen, non-prescription drugs, lab procedures and other related supplies. Pharmacy and physician services are billed to these programs. These services are not included in the per diem rate.

Case-Mix Adjusters

Case-mix was adopted October 1, 1990. Kentucky used Minnesota's case-mix system, based on overall-facility set rates. The direct nursing care was case-mix adjusted. Kentucky's quality assurance team conducted paper reviews (200+ per year) for accuracy of resident data assessments.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expenses, nursing facilities used actual interest expense. Refinancing (interest and depreciation), renovation, and rental costs and leases were allowable costs. The rental costs and lease costs were limited to the cost of ownership. Straight line was used for depreciation. Escalating capital cost as a result of a change of ownership is limited.

Reimbursement Rate

The FY97 reimbursement rate for Kentucky was $83.00, calculated by days of care and weighted by three-month rate periods.

Other Long-Term Care

Kentucky used the same system for hospital-based as for free-standing nursing facilities. ICF-MR are full cost facilities. Home health services are reimbursed using retrospective facility-specific methods, with an average payment for RN visits ($76.94) three times that for home health aides ($28.49).

KENTUCKY

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$83.00
Percentage Rate Change From Previous Year	8.43%
Peer Groupings	Geographic Location by Urban/Rural
Year of Cost Report to Set Rate	1996
Inflation Adjustment	DRI and Case-Mix
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	Used Minnesota CM System, Direct Nursing Portion was Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drugs, Medical Supplies, Oxygen, Speech Therapy

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Reimbursement Rate	$202.31/day (not weighted, includes state facilities) ICFMR - full cost facility

Home Health

Method	Retrospective Facility-Specific
Average Reimbursement Rate, RN Visit	$76.94
Average Reimbursement Rate, HH Aide Visit	$28.77

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility Specific
Program	Health Care Model
Adult Day Health Rate	$31.11per half unit

Sub-Acute Care — No Separate Program

LOUISIANA

Nursing Homes

The number of nursing homes in Louisiana has fluctuated but has shown an overall increase from 316 in 1987 to 347 in 1997. The number of beds has steadily increased, from 35,873 in 1987 to 41,628 in 1997. Between 1996 and 1997 there was a decrease of 2 facilities, and an increase of 724 beds. For the period 1987 through 1997 there was a total bed growth rate of 16.04 percent, compared to the national rate of 15.06 percent. Louisiana's ratio of licensed beds per 1000 population aged 65 and over was steadily above the national ratio throughout this period (in 1997, 83.8 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs increased from 465 in 1996 to 466 in 1997. The number of ICF/MR beds increased from 6,751 in 1996 to 6,780 in 1997. In 1997, the ratio of beds per 1000 population was more than triple the national ratio with 1.56 compared to 0.48.

Residential Care for Adults/Aged

There were 128 adult residential care facilities with 2,115 beds in Louisiana in 1997. This is an increase of 16 facilities and no change in beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over was 4.3 in 1997 compared to the national ratio of 24.3.

Adult Day Care and Home Health Care

In 1997, there were a total of 258 adult day care facilities, an increase of 74 facilities since 1996. Also in 1997, there were 14 adult day health centers, an increase of 2 centers since 1996[1]. Louisiana had a ratio of agencies per 1000 population aged 65 and over that was much higher than the national ratio in 1997 (0.55 compared to 0.16). There were 543 licensed home health care agencies in 1997, a decrease of 9 agencies since 1996. The ratio of home health agencies per 1000 population aged 65 and over was 1.09 in 1997, compared to the national ratio of 0.50.

CON/Moratorium

Louisiana had a CON (called a 'facility need review' program)[2] for nursing homes from 1979 to 1996. There was also a moratorium in 1984 (dropped in 1985). In 1997 there was no CON requirement but there was a moratorium on nursing homes. In 1997 there was a CON required for ICF/MRs. There was neither a CON nor moratorium on hospital bed conversions, residential care, assisted living, home health care, hospice or adult day care.

[1] Louisiana discontinued the 2-year wait for licensure of adult day health care facilities in 1999. Previously each provider was required to have 2 years experience as a Louisiana licensed health care provider before obtaining adult day health care licensure. Louisiana State officials expect an increase in licensure in mid 1999.

[2] The "facility need review program" monitors the occupancy rates and bed inventories of all the parishes. If there is a high occupancy rate, the parish is studied and an advertisement for applications is placed in the newspaper. Agencies apply to build a new facility or add on to an existing facility. A 3-person committee then reviews the proposals, evaluates them and awards contracts.

LOUISIANA

Demographics

Percentage Population 65 and Over	11.4 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	347
Total Beds	41,628
Beds Per Nursing Facility	120.0 (US 102.7)
Average Occupancy Rate	82.0
Beds Per 1000 Population:	
Age 65 and Over	83.8 (US 53.1)
Age 85 and Over	785.4 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	9.44 (US 6.01)
Expenditures Per 1000 Pop, 1996	$117,088 (US $111,686)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	466
Total Beds	6,780
Beds Per 1000 Population	1.56 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	128
Total Beds for Adult/Aged	2,115
Beds Per 1000 Pop, Age 65 and Over	4.3 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	272
Facilities Per 1000 Pop, Age 65 and Over	0.55 (US 0.16)

Licensed Home Health Care

Total Agencies	543
Agencies Per 1000 Pop, Age 65 and Over	1.09 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.67 (US 6.51)
Expenditures Per 1000 Pop, 1996	$6,235 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	CON Only
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

LOUISIANA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on class rates. The method employed peer groupings by level of facility (IC1, IC2, and SN). The basic reimbursement method was adopted in 1982. A state fiscal year was used to set rates annually beginning July 1. The cost report year used for FY97 was 1993. Inflation based on the CPI (all items, food, medical care, and wage) for December of preceding and second preceding year was used to trend rates. No minimum occupancy standard was used.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

Louisiana separated reimbursement into five cost centers at the 60th percentile; 1. Food costs 2. Other routine costs 3. Aides and attendants salaries 4. Nursing Services 5. Fixed cost.

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, and oxygen were ancillary services included in the rate. Non emergency medical transportation. Physical therapy is included in the skilled nursing rate.

Case-Mix Adjusters

No case-mix adjusters were used in Louisiana. Three levels of care facilities were provided: IC1, IC2, and SN. There were no plans to implement a case-mix system.

Capital Costs

The value of capital was determined by historical costs. Rental costs and leases were allowable costs. Louisiana allowed for depreciation charges. Depreciation was based on straight line. The American Hospital Association guidelines were used for depreciation periods. A return-on-equity of five percent of the base flat rate was allowed for all nursing facilities.

Reimbursement Rate

The FY97 weighted average reimbursement rate for Louisiana was $61.12.

Other Long-Term Care

Louisiana used the same system for hospital-based as for free-standing nursing facilities. It employed a prospective patient-specific method for state and a prospective facility level of care for non-state ICF-MRs, averaging nearly twice the rate paid to nursing facilities. Home health agencies were paid using prospective Medicare principles. Adult day care was covered under a 1915c waiver. It employed a prospective facility-specific method.

LOUISIANA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$61.12
Percentage Rate Change From Previous Year	-3.78%
Peer Groupings	Level of Care
Year of Cost Report to Set Rate	1993
Inflation Adjustment	CPI (by cost component)
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Oxygen Medical Supplies Durable Med. Equip. Non Emergency Transportation

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Patient-Specific
Non-State Facilities	Prospective Level of Care
Average Reimbursement Rate	Public: $130.92[1] State: $193.52[2]
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	
State Facilities	All Ancillary Services
Private Facilities	None

Home Health

Method	Prospective by Type
Average Reimbursement Rate, RN Visit	$68.65
Average Reimbursement Rate, HH Aide Visit	$24.38
Physical Therapy Rate	$70.46

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915c Waiver
Average Reimbursement Per Diem[3]	$30.85
Day Health	(Limited to 80% of Nursing, IC facility level 2)
Clients Covered	Aged

Sub-Acute Care — No Separate Program

[1] Includes provider tax.

[2] SSDI included without provider tax of $8.74. Weighted by facility capacity.

[3] Weighted by patient-days.

MAINE

Nursing Homes

The number of nursing homes in Maine has fluctuated but overall has shown a decrease from 142 facilities in 1987 to 135 in 1996 to 134 in 1997. The number of beds also has fluctuated, decreasing from 9,477 in 1987 to 9,432 in 1996 to 9,174 in 1997. Despite the reduction in beds, and a negative growth rate over the 1987-1997 period (-3.2 percent compared to 15.06 percent), Maine has maintained a ratio of licensed nursing home beds per 1000 population aged 65 and over just under that of the national ratio. In 1997 the ratio was 53.0, compared to 53.1 nationally.

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Maine has decreased from 41 in 1996 to 33 in 1997. The number of ICF/MR beds has also decreased from 406 in 1996 to 334 in 1997. The ratio of ICF/MR beds per 1,000 total population in Maine was 0.27 in 1997, below the U.S. ratio of 0.48.

Residential Care for Adults/Aged

There are three categories of residential care in Maine - boarding homes, adult foster homes, and adult family care homes. The total number of facilities grew from 657 in 1996 to 739 in 1997. The total number of beds increased from 5,636 in 1996 to 6,153 in 1997. The ratio of licensed beds per 1000 population aged 65 and over, 35.6, continued to be greater than the national ratio in 1997 (24.3).[1]

Adult Day Care and Home Health Care

There were 55 licensed adult day care facilities in Maine in 1997, an increase of 17 since 1996. There were 90 licensed home health care agencies in 1997, an increase of 2 since 1996 and a ratio of agencies per 1000 population aged 65 and over of 0.52 just greater than the national ratio of 0.50.

CON/Moratorium

Maine had a CON for nursing homes from 1979 to 1980, adding a moratorium in 1981 that remained in effect through 1997. In 1997 there was both a CON and moratorium on hospital bed conversions and ICF/MRs. There was neither a CON nor moratorium on residential care, home health care, hospice or adult day care. There were 5 nursing facility CON applications in 1997, 2 of which were denied[2]

[1] 'Other Residential Care' in Maine includes 4 psychiatric facilities with 513 beds.

[2] 2 CON application approvals were ownership transfers, the other approval was a conversion to nursing home beds.

MAINE

Demographics

Percentage Population 65 and Over	13.9 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	134
Total Beds	9,174
Beds Per Nursing Facility	68.5 (US 102.7)
Average Occupancy Rate	87.0
Beds Per 1000 Population:	
Age 65 and Over	53.0 (US 53.1)
Age 85 and Over	436.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.43 (US 6.01)
Expenditures Per 1000 Pop, 1996	$145,911 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	33
Total Beds	334
Beds Per 1000 Population	0.27 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	739
Total Beds for Adult/Aged	6,153
Beds Per 1000 Pop, Age 65 and Over	35.6 (US 24.3)
Total Facilities, Other	4
Total Beds, Other	513

Licensed Adult Day Care

Total Facilities	55
Facilities Per 1000 Pop, Age 65 and Over	0.32 (US 0.16)

Licensed Home Health Care

Total Agencies	90
Agencies Per 1000 Pop, Age 65 and Over	0.52 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.66 (US 6.51)
Expenditures Per 1000 Pop, 1996	$43,189 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MAINE

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care. This method was based on a facility-specific rate. Free-standing facilities were separated from hospital based facilities. The basic prospective reimbursement method was adopted in 1982. A facility fiscal year was used to set per diem rates. Sixty percent of the facilities begin their fiscal year January 1. The FY97 rates were determined using the facility costs during the operating years beginning in 1993 inflated forward. Inflation was based on the DRI and Maine's wage market basket for hospitals which were used to trend rates. There was no minimum occupancy standard used in FY97[2].

Adjustments

Adjustments during the rate period were made quarterly.

Cost Centers

Four cost centers were used for setting reimbursement rates in Maine: 1. nursing, limited to 112% of the median; 2. indirect, limited at 110% of the median; 3. routine, limited to 108% of the median; and 4. fixed cost. Operating costs were limited by the Medicare upper limit.

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and oxygen were included in the rate.

Case-Mix Adjusters

Case-mix was implemented October 1993. Residents were evaluated by an acuity measurement based on an overall-facility basis. The Direct nursing care was case-mix adjusted. A possible 44 levels were available using the MDS+.

Capital Costs

The value of capital is determined by historic cost. Actual interest expense was an allowable cost limited to the historical cost of a facility. Rental Costs and Leases was an allowable cost. The Rental costs and leases was limited to the cost of ownership. Depreciation was based on the straight line method. The American Hospital Association guidelines were used for depreciation periods. Maine paid eight percent on a net return on equity.

Reimbursement Rate

The FY97 average reimbursement rate for Maine was $113.41, calculated by facility quarterly reports.

Other Long-Term Care

Maine used the same system for hospital-based as for free-standing nursing facilities. Retrospective actual cost or a prospective variable rate inflated forward annually is used to set ICF-MR rates. Home health rates were set using a prospective agency- specific system. The rate for an RN visit ($75.71) was more than twice that of the HH Aide visit ($35.79). Adult day care was paid under waiver, using a prospective contract negotiated rate. Other residential care was provided under the state plan on a retrospective facility-specific basis. Sub-acute care was provided on a prospective facility-specific basis.

[1] Capital is retrospective with an interim rate. Because of the interim rate the method is considered to be prospective.

[2] 90% minimum occupancy has been established for all facilities with fiscal years beginning on or after 7/ 1/ 95.

MAINE

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$113.41[1]
Percentage Rate Change From Previous Year	-0.6[1]%
Peer Groupings	Free-Standing Nursing Facilities Separated from Hospital-Based Nursing Facilities
Year of Cost Report to Set Rate	1993
Inflation Adjustment	DRI & ME Wage Market Basket for Hospitals
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	Acuity Measure Direct Nursing Portion of Rate Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$178.91

ICF-MR

Method	Actual cost or variable rate inflated forward
Average Reimbursement Rate	$260.00
Ancillary Services Included in Rate	
State Facilities	Same as Free-Standing Nursing Facilities including Active Habilitative Treatment
Private Facilities	Non-Prescription Drug Medical Supplies Durable Med. Equip.

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$75.71
Average Reimbursement Rate, HH Aide Visit	$35.79

Other Residential Care For Aged

No Medicaid Program[2]

Adult Day Care

Method	Prospective Contract Negotiation
Reimbursement Program	Covered under State Plan
Average Reimbursement Rate by Client	
Aged and Physically Disabled	$6.00 per hour
Facility Type	Day Health

Sub-Acute Care

Method	Prospective Patient/Facility-Specific
Average Rate	
Head Injury	$359.89- $456.02

[1] Maine has a seven percent gross receipts tax, which was implemented in FY94.
[2] Maine has an MRDD Program for Developmentally Disabled, which was not specifically for the aged.

MARYLAND

Nursing Homes

Nursing homes in Maryland increased from 253 facilities and 30,011 beds in 1996 to 260 facilities and 30,703 beds in 1997. Between 1987 and 1997 Maryland had a total bed growth rate of 23.10 percent, well above the national rate of 15.06 percent. The ratio of licensed nursing home beds per 1,000 population aged 65 and over was just less than the national ratio in 1997 (52.6 compared to 53.1).

Intermediate Care for Mentally Retarded

Maryland is in the process of downsizing and closing ICF/MRs resulting in a decrease in facilities from 11 in 1989 to 4 in 1996 and 1997. Beds decreased from 1,819 in 1989 to 1,143 in 1997 (with a decrease of 182 beds since 1996). The ratio of ICF/MR beds per 1000 total population was 0.22 in 1997, well below the U.S. ratio of 0.48.

Residential Care for Adults/Aged

Maryland licenses four categories of residential care - domicillary care[1] (located in freestanding facilities and nursing homes), senior (group) assisted living, congregate housing facilities and continuing care retirement facilities[2]. In 1997 there were 2,193 total facilities with 20,231 beds, an increase of 247 facilities and 1,957 beds since 1996. The substantial growth in the number of beds has increased the ratio of licensed beds per 1000 population aged 65 and over from 16.4 in 1995 to 34.6 in 1997 - well above the 1997 national ratio of 24.3.[3]

Adult Day Care and Home Health Care

There were 120 licensed adult day care facilities in Maryland in 1997, a growth of 1 since 1996. There were 88 licensed home health care agencies in Maryland in 1997, a decrease of 19 agencies since 1996. The 1997 ratio of home health care agencies per 1000 population aged 65 and over was 0.15, less than half the national ratio of 0.50.

CON/Moratorium

Maryland required a CON for nursing homes from 1979 through 1997. In 1997 a CON was also required for hospital bed conversions, ICF/MRs, home health care, and hospice. There was neither a CON nor moratorium on other residential care or adult day care. There were 9 nursing home CON applications submitted in 1997, only 2 of which were approved.

[1] Domicillary care figures include both licensed and certified facilities.

[2] Congregate housing and continuing care retirement facilities (CCRC) were a new category in 1996. There were 28 CCRC facilities with 9,997 residential care beds in 1996. The inclusion of this category accounts for the large increase in residential care beds in Maryland in 1996.

[3] 'Other Residential Care' in Maryland includes 28 substance abuse facilities with 610 beds.

MARYLAND

Demographics

Percentage Population 65 and Over	11.5 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	260
Total Beds	30,703
Beds Per Nursing Facility	118.1 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	52.6 (US 53.1)
Age 85 and Over	503.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.60 (US 6.01)
Expenditures Per 1000 Pop, 1996	$81,711 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	4
Total Beds	1,143
Beds Per 1000 Population	0.22 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,193
Total Beds for Adult/Aged	20,231
Beds Per 1000 Pop, Age 65 and Over	34.6 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	120
Facilities Per 1000 Pop, Age 65 and Over	0.21 (US 0.16)

Licensed Home Health Care

Total Agencies	88
Agencies Per 1000 Pop, Age 65 and Over	0.15 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.42 (US 6.51)
Expenditures Per 1000 Pop, 1996	$41,305 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MARYLAND

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on both facility-specific and patient-specific rates. The method employed the peer grouping of patients by regions. The basic reimbursement method was adopted in 1983 when case-mix was adopted. A state fiscal year was used to set and re-base rates annually beginning July 1. The provider's FY 1995 cost reports were used to set rates for FY97. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. nursing service; 2. administrative/routine, limited to a ceiling of 111%[2] of the median by region and bed size; 3. other patient care limited to a ceiling of 116%[1] of the median by region; and 4. capital.

Ancillary Services

Physical therapy, occupational therapy, non-prescription drugs, and medical supplies were included in the rate as allowable costs.

Case-Mix Adjusters

Case-mix was adopted in 1983. The nursing services portion of the rate was based on patient ADL dependencies. The four levels of care reimbursed were light, moderate, heavy, and heavy special.

Capital Costs

The value of capital was determined by appraisal/reappraisal as a fair rental system. One third of the homes were appraised every four years or upon renovation. The maximum allowed appraised value is $36,662.14 per bed. A return-on-equity was provided at 6.82% multiplied by allowable net equity.

Reimbursement Rate

The FY97 reimbursement rate for Maryland was $98.88.

Other Long-Term Care

Maryland used the same system to pay hospital-based nursing facilities as free-standing nursing facilities, but used retrospective patient- or facility-specific rates for ICF-MRs, which were paid almost three times as much on average per diem as are nursing facilities. Home health payment used Medicare principles with state alterations. Adult day care was paid using prospective flat rates.

[1] Adjusted by an interim rate then settled at cost.
[2] Mid year adjustment.

MARYLAND

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific, Adjusted
Average Reimbursement Rate	$98.88
Percentage Rate Change From Previous Year	4.98%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1995
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusters	Patient ADL dependencies Direct Nursing Portion of Rate Adjusted
Capital Reimbursement Determination	Appraisal as Fair Rental
Ancillary Services Included in Rate	Physical Therapy — Non-Prescription Drug Occupational Therapy — Durable Med. Equip. Medical Supplies

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Patient/Facility-Specific
Average Reimbursement Rate	$265.00
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy — Occupational Therapy Respiratory Therapy — Non-Prescription Drug Medical Supplies — Durable Med. Equip. Physician Services

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$95-105.00
Average Reimbursement Rate, HH Aide Visit	$55.00

Other Residential Care For Aged[1]

Method	Prospective Facility-Specific
Reimbursement Program	1915c Waiver
Average Rate by Facility Type	
Group Home	Not Available

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	MD State Program
Average Reimbursement Rate by Service	$57.59 /day
Facility Type	Combination of Social & Day Health
Clients Covered	Aged, Physically Disabled, & Mentally Disabled
Sub-Acute Care	No Separate Program

[1] Includes combination of aged & physically disabled clients, which could not be disaggregated.

MASSACHUSETTS

Nursing Homes

Although there was a decrease in 1997 (with a loss of 9 facilities and 520 beds), nursing homes and beds in Massachusetts fluctuated but showed overall growth between the years 1987 and 1997, increasing from 564 facilities with 46,778 beds in 1987 to 599 facilities with 58,333 beds in 1997. A total growth rate for the period of 24.70 percent, above the national rate of 15.06 percent. The ratio of licensed nursing home beds per 1000 population aged 65 and over has been well over the national ratio since at least 1980 (in 1997, 67.7 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs dropped from 83 in 1992 to 7 in 1993. This drop was due to a change in licensure which converted the smaller ICF/MRs to "home and community based waiver facilities." The number of facilities fluctuated since 1993, returning to a total count of 7 facilities in 1995 and remaining so through 1997. Beds decreased from 1,857 in 1996 to 1,703 in 1997.[1] Massachusetts is currently downsizing ICF/MRs by decertifying beds as they become empty. The ratio of beds per 1000 total population was 0.28 in 1997, well below the national ratio of 0.48.

Residential Care for Adults/Aged

Massachusetts provides residential care through rest homes and assisted living facilities. In 1997 there were 159 rest homes with 5,341 beds and 85 assisted living facilities with 4,876 rooms[2]. The ratio of licensed beds per 1000 population aged 65 and over was 11.9 in 1997. This is still well below the 1997 national ratio of 24.3.

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Massachusetts in 1997. However, in 1997 there were 205 certified home health agencies, up from 178 in 1996.

CON/Moratorium

Massachusetts had a CON for nursing homes from 1979 through 1994, with a moratorium added to it in 1991 that remained in effect through 1997. In 1997 there was also a CON/moratorium on hospital bed conversions, ICF/MRs, and level 4 residential care facilities. There was neither a CON nor moratorium on assisted living, home health care, hospice or adult day care. In 1997 there were 2 nursing home CON applications, neither of these were denied.

[1] The total number of ICF/MRs represents the number of certified facilities as ICF/MRs are state run and are not licensed in Massachusetts.

[2] The method of counting assisted living in Massachusetts is by units (rooms), rather than bed count. Each room has 1-2 residents.

MASSACHUSETTS

Demographics

Percentage Population 65 and Over	14.1 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	599
Total Beds	58,333
Beds Per Nursing Facility	97.4 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	67.7 (US 53.1)
Age 85 and Over	535.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.76 (US 6.01)
Expenditures Per 1000 Pop, 1996	$193,699 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	7
Total Beds	1,703
Beds Per 1000 Population	0.28 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	244
Total Beds for Adult/Aged	10,217
Beds Per 1000 Pop, Age 65 and Over	11.9 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.18 (US 6.51)
Expenditures Per 1000 Pop, 1996	$83,026 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	CON & Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MASSACHUSETTS

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used to set Medicaid reimbursement for nursing facilities. This method was based on a facility-specific rate. The method employed peer groupings of level of care by region and case-mix. The basic reimbursement method was adopted in 1990. A calendar year was used to set rates annually. The 1993 cost report were used for FY97. An inflation factor based on MACPI and DRI-SNF was used to trend rates to FY97. The FY93 to FY97 inflation factor of 11.2% was applied to non-capital costs. The minimum occupancy standard was set at 96%.

Adjustments

No adjustments were made outside the regular rate setting procedures.

Cost Centers

Eight cost centers were used for setting reimbursement rates in Massachusetts: 1. nursing, limited to 110% of median by geographic location; 2. administrative and general allowance of $9.72 per day 3. working capital; 4. director of nursing, limited to $75,000.00 annual salary; 5. variable, limited to 108% of the median; 6. motor vehicle, allowance set at $1,500.00; 7. fixed costs and 8. equity allowance.

Ancillary Services

Non-prescription drugs, in house medical supplies, and in house physician services were included in the rate. They are combined under the variable cost center.

Case-Mix Adjusters

Case-mix was adopted in 1990. They used a Constant Minute focusing on ADL's as of July 1, 1991. Ten individual resident-based rates (from direct nursing cost center) were added to an average overall-facility rate.

Capital Costs

Historic cost and an imputed value determined the value of existing capital. Refinancing and renovation were allowable costs. Depreciation charges were allowed. Straight line was used for depreciation set on a forty-year period for buildings. A return on net equity for profit facilities on fixed assets was allowed. The maximum rate of return allowable was 7.875%. For new capital projects payments were a blend of per diem allowance and historical cost.

Reimbursement Rate

The FY97 average reimbursement rate for Massachusetts was $111.92, calculated by days of care.

Other Long-Term Care

Massachusetts used the same system for hospital-based as for free-standing nursing facilities. A prospective facility-specific method was used for ICF-MR. Home health agencies were paid on a fee schedule with a flat rate nearly three times higher ($55.76) for RN visits as for home health aide visits ($18.70). Adult day care was paid using a class method.

MASSACHUSETTS

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific
Average Reimbursement Rate	$111.92
Percentage Rate Change From Previous Year	2.86%
Peer Groupings	Geographic Location (level of care by region)
Year of Cost Report to Set Rate	1993
Inflation Adjustment	MACPI & DRI-SNF
Minimum Occupancy in Rate-Setting	96%
Case-Mix Adjusters	Acuity Measurement Direct Nursing Portion was Adjusted
Capital Reimbursement Determination	Historic Cost and Imputed Value
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Physician Services (in-house)

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method[1]	Prospective Facility-Specific
Average Reimbursement Rate	$418.14
Ancillary Services Included in Rate	Physical Therapy Occupational Therapy
Respiratory Therapy	Non-Prescription Drug
Medical Supplies	Patient Transport
Physician Services	

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$56.94
Average Reimbursement Rate, HH Aide Visit	$19.60

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Combination Class
Reimbursement Program	MA State Program
Average Rate by Facility Type	
Day Health Facility	$33.61 per day
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care — No Separate Program

[1] Private facilities were eliminated. There were seven State facilities.

MICHIGAN

Nursing Homes

The number of nursing homes in Michigan decreased from 459 in 1996 to 458 in 1997. The number of beds increased from 51,640 in 1996 to 51,866 in 1997. In the 10-year period between 1987 and 1997 Michigan had an overall bed growth rate of 2.68 percent, less than one-fifth the national rate (15.06 percent). The ratio of nursing home beds per 1,000 population aged 65 and over continued to be below the national ratio in 1997, (42.7 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Michigan increased steadily between 1989 and 1996 from 308 to 504. Facilities decreased to 407 in 1997.[1] The number of ICF/MR beds increased from 3,052 in 1989 to 3,554 in 1994. In 1996 beds dropped to 3,494 and by 1997 had decreased to 2,787. The ratio of ICF/MR beds per 1000 population was well below the national ratio, (0.28 compared to 0.48)

Residential Care for Adults/Aged

Michigan licenses two categories of residential care: homes for the aged, and adult foster care (a category that includes family homes, group homes, a few congregate care facilities, and 4 county infirmaries). In 1997 there were 4,698 total facilities, a drop of 9 since 1996. The number of beds increased by 395 beds between 1996 and 1997 (from 44,791 to 45,186) and the ratio of licensed beds per 1000 population aged 65 and over remained high, 37.2 compared to 24.3 nationally.

Adult Day Care and Home Health Care

Adult day care was not licensed in Michigan in 1997. Home health care was not licensed in 1997, but there were 250 certified home health care agencies, an increase of 15 since 1996.

CON/Moratorium

Michigan required a CON for nursing homes from 1979 through 1997. In 1996 a moratorium was instituted for Medicaid reimbursed beds in nursing homes that continued through 1997. In 1997 a CON was also required for hospital bed conversions, while there was neither a CON nor moratorium on residential care, ICF/MRs, home health care, hospice or adult day care. There were 62 nursing home CON applications submitted in 1997, none were denied.

[1] Michigan closed 97 ICF/MRs in 1997.

MICHIGAN

Demographics

Percentage Population 65 and Over	12.4 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	458
Total Beds	51,866
Beds Per Nursing Facility	113.2 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	42.7 (US 53.1)
Age 85 and Over	392.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.57 (US 6.01)
Expenditures Per 1000 Pop, 1996	$80,629 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	407
Total Beds	2,787
Beds Per 1000 Population	0.28 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	4,698
Total Beds for Adult/Aged	45,186
Beds Per 1000 Pop, Age 65 and Over	37.2 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.99 (US 6.51)
Expenditures Per 1000 Pop, 1996	$22,339 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MICHIGAN

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of number of beds with ceiling limits for administrative costs. The basic reimbursement method was adopted in 1985. A facility fiscal year was used to set annual rates. The 1995 Cost report was used for FY97. Inflation based on the DRI plus one percent for nursing facilities. The minimum occupancy standard was set at 85% of available beds.

Adjustments

The rates were adjusted upward during the rate period for all facilities. Adjustment for wage increases was outside of the rate limit. Wage increases were limited to $.50 per employee hour.

Cost Centers

Two cost components containing various cost centers are used for setting reimbursement rates in Michigan: 1. The Variable Base was limited to the 80th percentile, and contained: nursing, dietary, nursing administration, utilities; and laundry; and 2. support, contained: plant operation, administration and general, housekeeping, and so on, limited by peer group and bed size to 80th percentile within peer group. A general limit on operating costs was set at the 80th percentile of Medicaid day utilization in industry (Support plus Base Cost).

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and oxygen were included in the rate on an average per diem basis.

Case-Mix Adjusters

No case-mix adjusters were used in Michigan. One level of care was provided. A case-mix system was under consideration.

Capital Costs

The value of capital was determined by historic cost and a modified rental value, with appraisals. For capital-interest expensed nursing facilities used the actual interest expense, subject to a ceiling. Refinancing and refurbishing were allowable costs. Depreciation charges were allowed for twelve percent of the facilities. The straight line method was used for depreciation. The American Hospital Association guidelines were used for depreciation. Reimbursement was limited to total capital cost of $32,500 per bed.

Reimbursement Rate

The FY97 average reimbursement rate for Michigan was $88.85, calculated by days of care.

Other Long-Term Care

Michigan used a similar method for hospital-based as for free-standing nursing facilities. It used retrospective facility-specific payment for ICF-MRs, paying almost three-times as much per diem as for nursing facilities. Home health was paid under a fee schedule with flat rates, paying about 20% more for RN visits ($71.85) as for home health aide visits ($45.90). Sub-acute care was reimbursed using a prospective facility-specific method.

MICHIGAN

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$84.17
Percentage Rate Change From Previous Year	5.9%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1995
Inflation Adjustment	DRI and 1% for Nursing Facilities
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost, Modified Rental Value and Appraisals
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport Oxygen

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities, Limited to 80th percentile of Hospital-based NFs.
Average Reimbursement Rate	$114.79
Capital Reimbursement Determination	Historic Cost, Depreciation Costs

ICF-MR

Method[1]	Retrospective Facility-Specific
Average Reimbursement Rate	$229.52
Peer Groupings	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy Occupational Therapy Oxygen Durable Med. Equip.

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$71.85
Average Reimbursement Rate, HH Aide Visit	$45.90

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate: Ventilator	$347.23[2]

[1] A single small private facility was still in existence in FY94.

[2] Estimate.

MINNESOTA

Nursing Homes

The number of nursing homes in Minnesota has remained fairly constant, showing a decrease from 445 in 1987 to 438 in 1997 (a decrease of 2 facilities since 1996). The number of beds has remained constant as well, with 44,972 beds in 1985 and 44,303 beds in 1997 (a decrease of 366 beds since 1996). The ratio of licensed nursing home beds per 1,000 population aged 65 and over has been consistently far greater than the national ratio (in 1997, 76.6 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Minnesota decreased from 293 in 1996 to 283 in 1997. The number of beds also decreased from 4,040 in 1996 to 3,804 in 1997. The ratio of ICF/MR beds per 1,000 total population in Minnesota was almost double the U.S. ratio (0.81 compared to 0.48).

Residential Care for Adults/Aged

Minnesota has three categories of residential care - board and care, adult foster care and board and lodging. There were 3,392 total facilities with 17,721 beds in 1997, an increase of 294 facilities and 2,769 beds since 1996. In 1997 the ratio of beds per 1,000 population aged 65 and over was above the national ratio (30.7 compared to 24.3)[1].

Adult Day Care and Home Health Care

There were 99 licensed adult day care facilities in Minnesota in 1997, an increase of 7 from 1996. There were 715 licensed home health care agencies in 1997, no change since 1996 but an increase of 56 since 1995. The ratio of agencies per 1000 population aged 65 and over was 1.24, the second highest ratio in the country (Texas had the highest ratio with 1.65). The national average in 1997 was 0.50.

CON/Moratorium

Minnesota had a CON for nursing homes between 1979 and 1982. In 1983, a moratorium was added and in 1984, the CON was removed. The moratorium on nursing homes remained in effect through 1997. In 1997 there was also a moratorium on hospital bed conversions and residential care (boarding care). There was neither a CON nor moratorium on ICF/MRs, home health care, hospice or adult day care.

[1] 'Other Residential Care' in Minnesota includes performance-based facilities for mentally retarded and supervised living for developmentally disabled as well as substance abuse with a total of 451 facilities and 7,299 beds.

MINNESOTA

Demographics

Percentage Population 65 and Over	12.3 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	438
Total Beds	44,303
Beds Per Nursing Facility	101.1 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	76.6 (US 53.1)
Age 85 and Over	560.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.38 (US 6.01)
Expenditures Per 1000 Pop, 1996	$179,774 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	283
Total Beds	3,804
Beds Per 1000 Population	0.81 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	3,392
Total Beds for Adult/Aged	17,721
Beds Per 1000 Pop, Age 65 and Over	30.7 (US 24.3)
Total Facilities, Other	451
Total Beds, Other	7,299

Licensed Adult Day Care

Total Facilities	99
Facilities Per 1000 Pop, Age 65 and Over	0.17 (US 0.16)

Licensed Home Health Care

Total Agencies	715
Agencies Per 1000 Pop, Age 65 and Over	1.24 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	22.72 (US 6.51)
Expenditures Per 1000 Pop, 1996	$92,873 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	Moratorium Only
Residential Care	Moratorium Only
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MINNESOTA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on patient-specific and facility-specific rates. Geographic location by region was used as a peer grouping. The basic reimbursement method was adopted in 1985 when Minnesota added case-mix. A state fiscal year was used to set annual rates beginning July 1. The 1996 cost reports were used for FY97. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was 85% for operating costs and 95% for property.

Adjustments

Not adjusted.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. care related costs, limited to 115% of the median; 2. other operating costs, limited to 105% of the median; 3. administration costs, limits were variable, dependent on size of facility; 4. property costs.

Ancillary Services

Non-prescription drugs, some medical supplies, and durable medical equipment were included in the rate. These ancillary services were included under the appropriate cost center. Therapies may be included based on provider's option.

Case-Mix Adjusters

Case-mix was adopted in 1985. Minnesota used resident classes and class weights, rates set based on overall facility. Only the direct nursing care component was case-mix adjusted.

Capital Costs

The value of capital was determined by a combination of historic cost, appraisal and a rental value. For capital-interest expense nursing facilities used the actual interest expense, subject to a ceiling. Refinancing, renovation, rental costs and leases were allowable costs. Interest was capped. A limit was set on the maximum appraised value. The rental factor was 5.66, applied to an appreciating property base, based on a real rate of return. Property rates are adjusted for sale and major capital improvements. Capital repair allowance equity incentive and re-financing incentive add-ons exist.

Reimbursement Rate

The FY97 weighted reimbursement rate for Minnesota was $101.79, weighted by days of care and case-mix.

Other Long-Term Care

Minnesota used the same system for hospital-based as for free-standing nursing facilities. It used Medicare principles for state ICF-MR regional treatment centers and prospective facility-specific payment for private ICF-MRs. Home health agencies were paid using Medicare principles with state alterations, about one-third more ($50.28) for an RN visit as for a home health aide visit ($38.57). Other residential care for the aged was paid under waiver using a prospective patient-specific method. Sub-acute care was reimbursed using a retrospective facility-specific method.

MINNESOTA

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific
Average Reimbursement Rate	$101.79
Percentage Rate Change From Previous Year	2.4%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1996
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85% Operating & 95% Property
Case-Mix Adjusters	Resource-Based Measure; Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost of improvement plus 1992 Appraisal (with inflation), Rental Value, and Sale.
Ancillary Services Included in Rate	Non-Prescription Drug; Medical Supplies; Durable Med. Equip.; PT, OT, RT, ST (provider's option)

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Reimbursement Rate	Included in Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Regional Treatment Centers Medicare Principles
Private Facilities	Prospective Facility-Specific Adjusted by Geographical Groupings, Cost Settled
Statewide Weighted Average Reimbursement Rate	$145.45
Capital Reimbursement Determination (private facilities)	Historic Cost

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$50.28
Average Reimbursement Rate, HH Aide Visit	$38.57

Other Residential Care For Aged[1]

Method	Prospective Patient-Specific
Reimbursement Program	2176 Waiver
Facility Type	Residential
Average Reimbursement Rate	Not available

Adult Day Care

No Medicaid Program

Sub-Acute Care

Method	Retrospective Facility-Specific
Average Rate:Ventilator	$262.86[2] per day

[1] Includes combination of aged & physically disabled clients, which could not be disaggregated.

[2] Single facility.

MISSISSIPPI

Nursing Homes

The number of nursing homes has remained fairly constant in Mississippi, increasing only from 171 in 1987 to 179 in 1996 and 1997. The number of beds has fluctuated but has shown an overall increase from 14,763 in 1987 to 17,208 in 1996 and to 17,335 in 1997. The total bed growth rate for this 10-year period was 17.42 percent, higher than the national rate of 15.06 percent. The ratio of nursing home beds per 1,000 population aged 65 and over, however, remained just below the national ratio in 1997 (52.1 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in Mississippi increased to 13 in 1997, after having remained at 12 since 1989. The number of ICF/MR beds increased slightly during this period from 1,622 beds in 1989 to 2,225 in 1996 and to 2,293 in 1997. The ratio of ICF/MR beds per 1,000 total population was 0.84 in 1997, much higher than the national ratio of 0.48.

Residential Care for Adults/Aged

Residential care in Mississippi is provided in personal care homes. There were 159 homes in 1997 with 3,392 beds, an increase of 6 homes and 536 beds since 1996. Despite the increase, the ratio of licensed beds per 1,000 population aged 65 and over remained well below the national ratio in 1997 (10.2 compared to 24.3).[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Mississippi in 1997. There were 70 licensed home health care agencies in 1997, a drop of 3 since 1996 and a ratio of licensed agencies per 1000 population aged 65 and over of 0.21 (less than half the national ratio of 0.50).

CON/Moratorium

Mississippi had a CON for nursing homes in 1980 and added a moratorium to it in 1981. Both remained in effect through 1997. In 1997 the CON/moratorium also covered hospital bed conversions, ICF/MRs, and home health care. There was neither a CON nor moratorium for residential care homes, hospice or adult day care. There were no nursing home CON applications submitted in 1997.

[1] 'Other Residential Care' in Mississippi included 5 psychiatric treatment facilities with 177 beds.

MISSISSIPPI

Demographics

Percentage Population 65 and Over	12.2 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	179
Total Beds	17,335
Beds Per Nursing Facility	96.8 (US 102.7)
Average Occupancy Rate	94.3
Beds Per 1000 Population:	
Age 65 and Over	52.1 (US 53.1)
Age 85 and Over	444.5 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.73 (US 6.01)
Expenditures Per 1000 Pop, 1996	$105,106 (US $111,686)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	13
Total Beds	2,293
Beds Per 1000 Population	0.84 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	159
Total Beds for Adult/Aged	3,392
Beds Per 1000 Pop, Age 65 and Over	10.2 (US 24.3)
Total Facilities, Other	5
Total Beds, Other	177

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	70
Agencies Per 1000 Pop, Age 65 and Over	0.21 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.32 (US 6.51)
Expenditures Per 1000 Pop, 1996	$4,612 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	CON & Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MISSISSIPPI

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed a bed peer grouping. The basic reimbursement method was adopted in 1993. A state fiscal year was used to set annual rates beginning July 1. The 1995 cost reports were used for FY97. Inflation based on a Mississippi Market basket was used to trend rates. A minimum occupancy standard was set at 80%. Rates are set each year based on the annual cost reports.

Adjustments

Rates were adjusted upward retroactively one time for ten to fifteen percent of facilities due to a change of ownership or a class change. The rate was adjusted upward during the rate period one time for all facilities due to a change in federal minimum wage.

Cost Centers

Cost centers used for setting reimbursement rates were: 1. direct care, 2. therapy, 3. care related, 4. administration and operating, 5. property and equipment, and 6. not allowable.

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, oxygen, and patient transportation were included in the rate.

Case-Mix Adjusters

Case-mix adjusters based on RUGs III were used in Mississippi. Case-mix was implemented July 1 1993. A possible 35 levels of care were provided.

Capital Costs

The value of capital is determined by a fair rental system using the age of the facility. The straight-line method was used for depreciation. A return on non-property equity of 9.5% was paid.

Reimbursement Rate

The FY97 average reimbursement rate for Mississippi was $76.77.

Other Long-Term Care

Mississippi used the same system for hospital-based as for free-standing nursing facilities and for ICF-MRs. Home health care was reimbursed under Medicare principles.

MISSISSIPPI

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$76.77
Percentage Rate Change From Previous Year	5.32%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1995
Inflation Adjustment	MS Market Basket
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusters	Case-Mix adjusted, RUGs III[1]
Capital Reimbursement Determination	Fair Rental
Ancillary Services Included in Rate	Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Oxygen, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$139.11
Ancillary Services Included in Rate	Non-Prescription Drug, Oxygen, Medical Supplies, Patient Transport

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$71.41
Average Reimbursement Rate, HH Aide Visit	$27.06
Average Reimbursement Rate, PT Visit	$65.00
Average Reimbursement Rate, Speech Therapist	$65.00

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

[1] Collapsed to 35 groups.

MISSOURI

Nursing Homes

Between 1996 and 1997, an increase of 1 facility and 424 beds occurred in Missouri. The number of nursing homes in Missouri has fluctuated but has shown an increase over a ten-year period, increasing from 568 in 1987 to 628 in 1997. The number of beds has also fluctuated but increased overall from 50,230 in 1987 to 59,407 in 1997. The total bed growth rate for this period was 18.27 percent, greater than the national rate (15.06 percent). The ratio of licensed beds per 1,000 population aged 65 and over was greater than the national ratio throughout the period (in 1997, 80.2 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Missouri has decreased from 26 facilities and 1,578 beds in 1996 to 22 facilities and 1,551 beds in 1997. The ratio of ICF/MR beds per 1,000 total population was 0.29 in 1997 - substantially lower than the U.S. ratio of 0.48.

Residential Care for Adults/Aged

Missouri provides residential care in type 1 and type 2 residential facilities. In 1997, there were 693 total facilities with 22,310 beds, a decrease of 30 facilities and 746 beds since 1996. Despite the decrease Missouri maintained a ratio of licensed beds per 1,000 population aged 65 and over greater than that of the national ratio (in 1997, 30.1 compared to 24.3).[1]

Adult Day Care and Home Health Care

Missouri licenses medical model adult day care and social model adult day care. In 1997, there were 48 of the former and 6 of the latter, a total increase of 7 facilities since 1996. There were 286 licensed home health care agencies in Missouri in 1997, no change since 1996 but an increase of 32 since 1995. Missouri continues to have a ratio of licensed home health care agencies per 1,000 population aged 65 and over below the national ratio (in 1997, 0.39 compared to 0.50).

CON/Moratorium

Missouri had a CON for nursing homes between 1980 and 1982 and added a moratorium to it in 1983. Both the CON and moratorium remained in effect through 1997. In 1997, the CON/moratorium also covered hospital bed conversions[2] and residential care. ICF/MRs were covered by a CON only, though applications have been officially discouraged for many years. There was neither a CON nor moratorium on home health care, hospice or adult day care. There were 10 nursing home CON applications submitted in 1997, 1 of which was denied.

[1] 'Other Residential Care' in Missouri includes residential care for persons with mental retardation or developmental disabilities, congregate living and individualized living, for a total of 1,753 facilities and 15,981 beds.

[2] CON is in effect for hospital bed conversions only for more than 10 beds or 10%.

MISSOURI

Demographics

Percentage Population 65 and Over	13.7 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	628
Total Beds	59,407
Beds Per Nursing Facility	94.6 (US 102.7)
Average Occupancy Rate	78.8
Beds Per 1000 Population:	
Age 65 and Over	80.2 (US 53.1)
Age 85 and Over	625.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.71 (US 6.01)
Expenditures Per 1000 Pop, 1996	$101,856 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	22
Total Beds	1,551
Beds Per 1000 Population	0.29 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	693
Total Beds for Adult/Aged	22,310
Beds Per 1000 Pop, Age 65 and Over	30.1 (US 24.3)
Total Facilities, Other	1,753
Total Beds, Other	15,981

Licensed Adult Day Care

Total Facilities	54
Facilities Per 1000 Pop, Age 65 and Over	0.07 (US 0.16)

Licensed Home Health Care

Total Agencies	286
Agencies Per 1000 Pop, Age 65 and Over	0.39 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.23 (US 6.51)
Expenditures Per 1000 Pop, 1996	$17,513 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON Only
Hospital Bed Conversion	CON & Moratorium
Residential Care	CON & Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MISSOURI

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in January of 1995. A federal fiscal year is used to set annual rates beginning October 1. Costs from 1992 cost reports were used for setting the FY97 rate. Inflation based on HCFA market basket index was used to trend rates. The minimum occupancy standard was set at 85%.

Adjustments

The rates can be adjusted for additional beds or construction of a replacement facility.

Cost Centers

Four cost centers were used for setting reimbursement rates in Missouri.
Patient Care - 120% of median
Ancillary - 120% of median
Administrative - 110% of median
Capital - Fair Rental Value

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, and oxygen were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Missouri. One level of care was provided. There were no plans to implement a case-mix system.

Capital Costs

The value of capital was determined by fair rental value. Capital interest was based on outstanding loan amount multiplied by the prime rate + 2% as of September 1st. A rate of return is paid at 2.5% based on fair value of the facility
less outstanding loan.

Reimbursement Rate

The FY97 average reimbursement rate for Missouri was $83.35, weighted by number of facilities.

Other Long-Term Care

Missouri used the same system for hospital-based as for free-standing nursing facilities, and a retrospective method for ICF-MR. Home health was reimbursed using Medicare principles with state alterations, paying the same average rate for an RN visit as for a home health aide visit ($59.87). Adult day care and other residential care were paid using a prospective flat rate methodology.

MISSOURI

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$83.35
Percentage Rate Change From Previous Year	13.9%
Peer Groupings	None
Year of Cost Report to Set Rate	1992
Inflation Adjustment	HCFA Market Basket Index
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Fair Rental Value
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Average Reimbursement Rate	$219.08
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate	$142.75
Ancillary Services Included in Rate (all facilities)	Same as Free-Standing Nursing Facilities

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$59.87
Average Reimbursement Rate, HH Aide Visit	$59.87

Other Residential Care For Aged

Method	Prospective Flat Rate
Reimbursement Program	Covered under state plan
Average Reimbursement Rate	Not available

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	Not Available
Average Reimbursement Rate	$32.00 per diem
Facility Type	Day Health
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care — No Separate Program

MONTANA

Nursing Homes

In 1997 the number of nursing facilities remained constant at 106 but there was an increase from 7,602 beds in 1996 to 7,653. Since 1987 the number of nursing homes in Montana has fluctuated but overall there has been an increase from 98 in 1987 to 106 in 1997. The number of beds has also fluctuated, but increased from 6,662 in 1987 to 7,653 in 1997. This represents a total growth rate of 14.88 percent for the period, slightly less than the national rate of 15.06 percent. Montana has been consistently above the national ratio in nursing home beds per 1,000 population aged 65 and over (in 1997, 66.0 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Montana has remained fairly constant at 3 facilities since 1990. The ICF/MR beds have fluctuated with 188 beds in 1990, decreasing to 170 in 1996 and remaining so in 1997. The ratio of licensed beds per 1,000 total population well below the national ratio (0.19 compared to 0.48).

Residential Care for Adults/Aged

Residential care in Montana is provided in personal care homes, adult foster care homes, and retirement homes. In 1997 there were a total of 228 facilities and 3,955 beds, an increase of 49 facilities and 652 beds since 1996. The ratio of licensed beds per 1,000-population aged 65 and over increased from 13.1 in 1996 to 34.1 in 1997, much higher than the national ratio of 24.3[1].

Adult Day Care and Home Health Care

There were 45 licensed adult day care facilities in Montana in 1997, an increase of 4 since 1996. There were 62 licensed home health care agencies in 1997, an increase of 2 since 1996. The ratio of home health care agencies per 1,000 population aged 65 and over was slightly higher than the national ratio in 1997 (0.53 compared to 0.50).

CON/Moratorium

Montana has required a CON for nursing homes since 1980. In 1997 a CON was also required for hospital bed conversions and home health care. Both a CON and moratorium were in effect on ICF/MRs in 1997. Neither a CON nor moratorium was required on residential care, hospice or adult day care. There were 2 nursing home CON applications submitted in 1997, only 1 of which was denied.

[1] 'Other residential care' in Montana includes residential treatment, specialty mental health and chemical dependency with a total of 11 facilities and 439 beds.

MONTANA

Demographics

Percentage Population 65 and Over	13.2 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	106
Total Beds	7,653
Beds Per Nursing Facility	72.2 (US 102.7)
Average Occupancy Rate	81.8
Beds Per 1000 Population:	
Age 65 and Over	66.0 (US 53.1)
Age 85 and Over	546.6 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.52 (US 6.01)
Expenditures Per 1000 Pop, 1996	$113,315 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	3
Total Beds	170
Beds Per 1000 Population	0.19 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	228
Total Beds for Adult/Aged	3,955
Beds Per 1000 Pop, Age 65 and Over	34.1 (US 24.3)
Total Facilities, Other	11
Total Beds, Other	439

Licensed Adult Day Care

Total Facilities	45
Facilities Per 1000 Pop, Age 65 and Over	0.39 (US 0.16)

Licensed Home Health Care

Total Agencies	62
Agencies Per 1000 Pop, Age 65 and Over	0.53 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	0.00 (US 6.51)
Expenditures Per 1000 Pop, 1996	$43 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

MONTANA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employs no peer groupings. The basic reimbursement method was adopted in 1991. A state fiscal year was used to set annual rates beginning July 1. The 1994 cost reports were used for FY97. Inflation based on the DRI-SNF was used to trend rates. A minimum occupancy standard was not used to set rates.

Adjustments

No significant adjustments outside of the normal rate setting procedure were made to the FY97 rate.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. direct nursing, limited to 117% of median; 2. property, limited to $11.50; 3. operating, limited to 106% of the median; and 4. operating incentive equal to the lesser of ten percent of median operating cost or 33% of the difference between the cap and facility operating cost per day.

Ancillary Services

Non-prescription drugs, medical supplies, and patient transportation were included in the operating portion of the rate.

Case-Mix Adjusters

Case-mix[1] was adopted in 1985. The Tennessee National Health Corporation Abstract System, based on an ADL formula converted to minutes is used in their acuity-based system. Individual based rate formulas are aggregated into an overall-facility basis for reimbursement. A single level of care was provided.

Capital Costs

Historic cost and an imputed rental value determined the value of capital. For capital interest expenses, nursing facilities used actual interest. Financing, renovation and rental costs and leases were allowable costs. American Hospital Association guidelines were used for depreciation and the straight-line method was used.

Reimbursement Rate

The FY97 average reimbursement rate for Montana was $85.89, weighted by days of care. On average, the operating rate was $41.42 and capital was $7.29.

Other Long-Term Care

Montana used the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates, which averaged over three-times as high as for free-standing nursing facilities. Home health services were paid at an interim rate of $59.54 for a RN visit and $26.60 for a home health aide visit. Adult day care was covered under waiver, using a prospective patient-specific method. Sub-acute care also used a prospective patient-specific method.

[1] Montana does not call their system case-mix. They are considering implementing a system during case-mix in FY99 for rate setting in year 2000.

MONTANA

Free-Standing Nursing Facilities

Method	Prospective Patient/Facility-Specific
Average Reimbursement Rate	$101.79
Percentage Rate Change From Previous Year	2.4%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1996
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85% Operating & 95% Property
Case-Mix Adjusters	Resource-Based Measure; Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost of improvement plus 1992 Appraisal (with inflation), Rental Value, and Sale.
Ancillary Services Included in Rate	Non-Prescription Drug; Medical Supplies; Durable Med. Equip.; PT, OT, RT, ST (provider's option)

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Reimbursement Rate	Included in Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Regional Treatment Centers Medicare Principles
Private Facilities	Prospective Facility-Specific Adjusted by Geographical Groupings, Cost Settled
Statewide Weighted Average Reimbursement Rate	$145.45
Capital Reimbursement Determination (private facilities)	Historic Cost

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$50.28
Average Reimbursement Rate, HH Aide Visit	$38.57

Other Residential Care For Aged[1]

Method	Prospective Patient-Specific
Reimbursement Program	2176 Waiver
Facility Type	Residential
Average Reimbursement Rate	Not available

Adult Day Care

No Medicaid Program

Sub-Acute Care

Method	Retrospective Facility-Specific
Average Rate:Ventilator	$262.86[2] per day

[1] Includes combination of aged & physically disabled clients, which could not be disaggregated.

[2] Single facility.

NEBRASKA

Nursing Homes

The number of nursing homes in Nebraska has grown slowly, increasing from 232 in 1987 to 245 in 1996 and then to 247 in 1997. The number of nursing home beds has been essentially constant, increasing from 18,342 in 1987 to 19,419 in 1996 and then decreasing to 18,226 in 1997. The total bed growth rate for this 10-year period was -0.63 percent, compared to the national growth rate of 15.06 percent. The state's ratio of nursing home beds per 1000 population aged 65 and over, however was very high (in 1997, 79.9, compared to the national ratio of 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Nebraska fluctuated between 4 and 5 since 1989. There were 4 ICF/MR facilities in 1996 and 1997. The number of beds decreased from 798 in 1989 to752 in 1996 and to 733 in 1997. Nebraska's ratio of ICF/MR beds per 1000 total population was below the national ratio in 1997 (0.44 compared to 0.48).

Residential Care for Adults/Aged

Nebraska provides residential care in assisted living[1] and boarding homes. In 1997 there were 148 total facilities with 6,074 beds, an increase of 22 facilities and 950 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over was 26.6 - greater than the national ratio of 24.3 in 1997[2].

Adult Day Care and Home Health Care

Adult day care facilities were not licensed in Nebraska in 1997. There were 125 licensed home health care agencies in 1997, a decrease of 29 agencies since 1996 and a ratio of agencies per 1000 population aged 65 and over of 0.55 - higher than the national ratio of 0.50.

CON/Moratorium

Nebraska had a CON for nursing homes from 1980 though 1997. There was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, residential care, home health care, hospice or adult day care. There were 3 nursing home CON applications submitted in 1997, none of which were denied.

[1] 'Assisted living' was a new category in 1997, combining two categories formerly known as 'residential care' and 'domicillary facilities'.

[2] 'Other residential care' includes: centers for developmental disability, substance abuse treatment centers and mental health centers, with a total of 233 facilities and 2,094 beds.

NEBRASKA

Demographics

Percentage Population 65 and Over	13.7 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	247
Total Beds	18,226
Beds Per Nursing Facility	73.8 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	79.9 (US 53.1)
Age 85 and Over	552.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.14 (US 6.01)
Expenditures Per 1000 Pop, 1996	$126,212 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	4
Total Beds	733
Beds Per 1000 Population	0.44 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	148
Total Beds for Adult/Aged	6,074
Beds Per 1000 Pop, Age 65 and Over	26.6 (US 24.3)
Total Facilities, Other	233
Total Beds, Other	2,094

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	125
Agencies Per 1000 Pop, Age 65 and Over	0.55 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.07 (US 6.51)
Expenditures Per 1000 Pop, 1996	$9,751 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NEBRASKA

Reimbursement

Free-Standing Nursing Facilities

Methods

A retrospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of geographic location (urban/rural) and by OBRA 87 staffing standards. The basic reimbursement method was adopted July 1, 1992, when Nebraska added case-mix. A state fiscal year is used to set annual rates beginning January 1. The 1996 cost reports were used for setting the interim CY97 rates. The 1997 cost report were used to set the final FY1997 rate. The CPI was used to trend rates. The minimum occupancy standard was set at 85.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Four cost centers were used for setting reimbursement rates in Nebraska: 1. direct nursing of which salaries and benefits were limited to 125% of median for facility's peer grouping; 2. direct support, other nursing (supplies, etc.) limited to 115% of the median for facility's peer grouping; 3. other support, limited to 115% of the median for facility's peer grouping; and 4. fixed cost.

Ancillary Services

The Nebraska method does not include ancillary in the nursing facility rate. All items are either considered routine or are billed by service. Respiratory therapy, medical supplies, oxygen, and patient transportation are included in the routine care costs.

Case-Mix Adjusters

Case-mix was adopted in 1992 based on RUGs III. The rates were based on facility cost but set at the individual level. Only the direct nursing care was case-mixed. Nineteen levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used actual interest expense. Refinancing (subject to Medicare), renovation, and rental costs and leases[1] were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Nebraska was $76.70[2], weighted by number of facilities by peer group.

Other Long-Term Care

Nebraska used the same system for hospital-based as for free-standing nursing facilities. A prospective facility-specific method was used to set state and private ICF-MR rates. Home health services were paid under a fee schedule with flat rates, paying $78.00 for a RN visit and $46.78 for a home health aide visit. Adult day care was paid under waiver, using a prospective flat rate. Sub-acute care was reimbursed using prospective facility specific contract rates.

[1] Payments for leases entered into after 1984 were paid at the lower of actual lease cost or the actual fixed costs of the lessor.
[2] January 1, 1996 interim rate.

NEBRASKA

Free-Standing Nursing Facilities

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$76.70
Percentage Rate Change From Previous Year	7.44%
Peer Groupings	Geographic & OBRA 87 nursing waivers
Year of Cost Report to Set Rate	1996, 1997[11]
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	RUGS III; Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary (routine) Services Included in Rate	Respiratory Therapy, Oxygen, Medical Supplies, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method (all facilities)	Prospective Facility-Specific (no peer group)
Average Reimbursement Rate	
State Facilities	$203.67
Private Facilities	$158.60
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Patient Transport

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$78.00
Average Reimbursement Rate, HH Aide Visit	$46.78

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	2176 Waiver
Flat Reimbursement Rate	$19.50 per diem
Facility Type	Day Health and Dementia/Alzheimer's Disease
Clients Covered	Aged & Physically Disabled and AIDS/HIV[2]

Sub-Acute Care

Method	Prospective Facility-Specific Contracts
Average Rates	
Ventilator	$469.44 Based on CY 1997 Contract
Medically Complex Sub-acute	$428.05 Based on CY 1997 Contract

[1] 1996 cost report used to set CY96 interim rate. 1996 cost report used to set FY97 final rate.

[2] AIDS clients covered not by diagnosis but by nursing facility eligibility.

NEVADA

Nursing Homes

The number of nursing homes in Nevada had been growing slowly but steadily, increasing from 31 in 1987 to 43 in 1997. The number of beds also showed an overall increase from 2,743 in 1987 to 4,191 in 1997. Between 1996 and 1997 there was a decrease of 1 facility and an increase of 56 beds. The total bed growth rate for the ten-year period was 52.79 percent, over 3 times the national rate of 15.06 percent, but, despite this growth, the ratio of nursing home beds per 1,000-population aged 65 and over (21.7) was less than half the national ratio (53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs increased from 16 in 1996 to 17 in 1997. The number of beds decreased from 254 in 1996 to 242 in 1997. The ratio of ICF/MR beds per 1,000 total population in 1997 was 0.14, substantially less than the national ratio of 0.48.

Residential Care for Adults/Aged

Residential care in Nevada is provided in adult group care facilities and adult group care facilities[1] for Alzheimer's patients. In 1997 there were 253 of the former with 2,901 beds and 31 of the latter with 208 beds, a total growth of 8 facilities and 528 beds since 1996. Despite this increase, the ratio of licensed beds per 1,000 population aged 65 and over remained lower than the national ratio in 1997 (16.1 compared to 24.3).[2]

Adult Day Care and Home Health Care

Nevada had 10 licensed adult day care facilities in 1997, no change since 1996. There were 73 licensed home health care agencies in Nevada in 1997, a decrease of 39 since 1996. Nevada's 1997 ratio of agencies per 1,000 population aged 65 and over (0.38) is below the national ratio (0.50).

CON/Moratorium

Nevada had a CON for nursing homes from 1980 through 1996; however, in 1991, the law changed to exempt Clark County (Las Vegas) and Washoe County (Reno) from the CON[3]. In 1997 there was no longer a CON for nursing facilities or ICF/MRs. There was neither a CON nor moratorium on hospital bed conversions, residential care, home health care, hospice or adult day care. There were no nursing home CON applications submitted in 1997.

[1] Adult group care includes care for mentally retarded. This category was reported in the 1996 State Data Book as a separate 'other residential care' category.

[2] 'Other Residential Care' in Nevada includes treatment facilities for alcohol and drug abuse with 16 facilities and 456 beds in 1997.

[3] The CON for nursing homes excludes counties with a population over 100,000.

NEVADA

Demographics

Percentage Population 65 and Over	11.5 % (US 12.7 %)
Percentage Population 85 and Over	0.8 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	43
Total Beds	4191
Beds Per Nursing Facility	97.5 (US 102.7)
Average Occupancy Rate	87.9
Beds Per 1000 Population:	
Age 65 and Over	21.7 (US 53.1)
Age 85 and Over	299.4 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.30 (US 6.01)
Expenditures Per 1000 Pop, 1996	$39,935 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	17
Total Beds	242
Beds Per 1000 Population	0.14 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	284
Total Beds for Adult/Aged	3,109
Beds Per 1000 Pop, Age 65 and Over	16.1 (US 24.3)
Total Facilities, Other	16
Total Beds, Other	456

Licensed Adult Day Care

Total Facilities	10
Facilities Per 1000 Pop, Age 65 and Over	0.05 (US 0.16)

Licensed Home Health Care

Total Agencies	73
Agencies Per 1000 Pop, Age 65 and Over	0.38 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	1.87 (US 6.51)
Expenditures Per 1000 Pop, 1996	$10,494 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NEVADA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted January 1, 1988. A state fiscal year was used to set annual rates beginning July 1. The 1994 cost reports were used for setting the FY97 rates. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 92% on the property portion of the rate only.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Five cost centers were used for setting the prospective portion of the reimbursement rate in Nevada: 1. housekeeping; 2. administration; 3. raw foods; 4. health care; and 5. employee benefits. Within particular cost centers there may be limitations on consultant costs and administrator salary.

Ancillary Services

Non-prescription drugs and medical supplies were included in the rate.

Case-Mix Adjusters

Case-mix[1] was adopted in the early 1980s. There were six levels of care based on skill need and minimum and maximum nursing care time. Only the direct nursing care[2] portion of the rate was case-mixed.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used the actual interest, subject to a ceiling. Financing, renovation, and rental cost and leases were allowable costs.

Reimbursement Rate

The FY97 average reimbursement rate for Nevada was $85.71.

Other Long-Term Care

Nevada used a retrospective method to pay hospital-based nursing facilities, as it also does to pay large private and public ICF-MRs. Small six bed ICF-MRs are paid prospectively. The average rate is $194.94. Home health payment used a fee schedule with flat rates, much higher for RN visits ($56.51) than for home health aide visits ($24.05). Adult day care was paid using prospective flat rates.

[1] Nevada did not refer to their system as a traditional case-mix system, however it is very similar to other case-mix systems.
[2] Health care and Healthcare employee benefits.

NEVADA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$85.71
Percentage Rate Change From Previous Year	3.8%
Peer Groupings	None
Year of Cost Report to Set Rate	1994
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	92% (property)
Case-Mix Adjusters	Acuity Measure Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies

Hospital-Based Nursing Facilities

Method	Retrospective
Average Reimbursement Rate	Not Available

ICF-MR

Method	Prospective (6-bed) and Retrospective Facility-Specific[1]
Average Reimbursement Rate	$194.94
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$56.51
Average Reimbursement Rate, HH Aide Visit	$24.05

Other Residential Care For Aged

No Medicaid Program[2]

Adult Day Care

Method Prospective Flat Rate	
Reimbursement Program	2176 Waiver
Average Reimbursement Rate	$31.78 per day (6 hours)
Facility Type	Social and Day Health
Clients Covered	Aged, Physically & Developmentally Disabled, and Mentally Ill

Sub-Acute Care — Retrospective - average rate not available

[1] Interim rate was adjusted by audit.

[2] Residential Care was for the Mentally Retarded.

NEW HAMPSHIRE

Nursing Homes

The number of nursing homes in New Hampshire slowly increased from 69 in 1987 to 93 in 1996 and 1997. The number of nursing home beds has steadily increased from 6,538 in 1987 to 8,169 in 1996 and then decreased to 8,102 in 1997. The total bed growth rate, over 10 years, was 23.92 percent, higher than the national rate of 15.06 percent. The ratio of licensed beds per 1000 population aged 65 and over remained greater than the national ratio in 1997 (57.5 compared to 53.1).

Intermediate Care for Mentally Retarded

New Hampshire's ICF/MR facilities decreased from 8 in 1989 to 1 in 1997. Within the same time range the beds also decreased from 84 to 26. There was no change in the number of ICF/MR facilities or beds between 1996 and 1997. New Hampshire's ratio of ICF/MR beds per 1000 total population was 0.02 in 1997, compared to the national ratio of 0.48.

Residential Care for Adults/Aged

New Hampshire provides residential care in residential care home facilities and supported residential care facilities. In 1997 there were 76 of the former with 940 beds and 60 of the latter with 2,010 beds[1], a total decrease of 3 facilities and an increase of 214 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over drew closer to the national ratio (20.9 compared to 24.3).

Adult Day Care and Home Health Care

There were an estimated 16 licensed adult day care facilities in New Hampshire in 1997, a decrease of 5 facilities since 1996. There were 116 licensed home health care agencies in 1997, a decrease of 3 since 1996. In 1997 New Hampshire's ratio of licensed agencies per 1000 population aged 65 and over was 0.82 - greater than the national ratio of 0.50.

CON/Moratorium

New Hampshire required a CON for nursing homes from 1980 through 1997. In 1995 a moratorium was added to the CON which remained through 1997. In 1997 a CON was also required for hospital bed conversions, while there was neither a CON nor moratorium on ICF/MRs, residential care, home health care, hospice or adult day care. One nursing home CON application was submitted in 1997, which was approved.

[1] A decrease in both facilities and beds in 'residential care home' along with an increase in 'supported residential care' represents a shift from the former category into the latter.

NEW HAMPSHIRE

Demographics

Percentage Population 65 and Over	12.1 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	93
Total Beds	8,102
Beds Per Nursing Facility	87.1 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	57.5 (US 53.1)
Age 85 and Over	476.6 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.42 (US 6.01)
Expenditures Per 1000 Pop, 1996	$161,776 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	1
Total Beds	26
Beds Per 1000 Population	0.02 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	136
Total Beds for Adult/Aged	2,950
Beds Per 1000 Pop, Age 65 and Over	20.9 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	16
Facilities Per 1000 Pop, Age 65 and Over	0.11 (US 0.16)

Licensed Home Health Care

Total Agencies	116
Agencies Per 1000 Pop, Age 65 and Over	0.82 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.16 (US 6.51)
Expenditures Per 1000 Pop, 1996	$92,564 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NEW HAMPSHIRE

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed is county operated and non-county operated peer groupings. The basic reimbursement method was adopted in 1987. May 1996 cost reports were used to set annual rates for a facility fiscal year beginning October 1, 1996. Inflation based on the CPI, all items, was used to trend rates. The minimum occupancy standard was 85%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Four cost centers were used for setting reimbursement rates in New Hampshire: 1. patient care; 2. administration; and 3. support costs; 4. capital. 1, 2, and 3 had an upper limit of 75% established within peer groups for six categories.

Ancillary Services

Physical therapy, occupational therapy, medical supplies, durable medical equipment, patient transportation, and oxygen were included in the rate. Ancillaries were part of patient care.

Case-Mix Adjusters

No case-mix adjusters were used in New Hampshire. One level of care was provided. Implementation of case-mix is planned for 1\1\99.

Capital Costs

The value of capital was determined by historic cost. For capital interest expenses, nursing facilities used the actual interest expense. Refinancing, renovation, and rental cost and leases were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for New Hampshire was $108.47, weighted by days of care.

Other Long-Term Care

New Hampshire used the same system for hospital-based as for free-standing nursing facilities, but a retrospective method for ICF-MRs, which averaged almost three-times as much per diem as did nursing facilities. Home health agencies were paid using Medicare principles. Adult day care was reimbursed using a retrospective system. Sub-acute payment employed a prospective facility-specific method.

NEW HAMPSHIRE

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$108.47
Percentage Rate Change From Previous Year	4.1%
Peer Groupings	County Operated & Non County Operated
Year of Cost Report to Set Rate	1996
Inflation Adjustment	CPI (all items)
Minimum Occupancy in Rate-Setting	85%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$215.94
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Durable Med. Equip., Patient Transport, Prescription Drug, Oxygen, Physician Services

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Retrospective Facility-Specific
Reimbursement Program	Not Available
Average Reimbursement Rate	$16.50 per diem (5 hours)
Facility Type	Day Health and Dementia/Alzheimer's Disease
Clients Covered	Aged; Physically & Developmentally Disabled; Mentally Ill; Pediatric

Sub-Acute Care

Method	Prospective Facility-Specific
Average Reimbursement Rate	$269.48[1]

[1] Includes Head Trauma, Ventilator, & Behavior related units.

NEW JERSEY

Nursing Homes

The number of nursing homes increased slowly from 344 in 1987 to 365 in 1996, decreasing to 357 in 1997. The number of nursing home beds showed an overall increase (with some fluctuation) from 43,054 in 1987 to 50,857 in 1996 and to 49,688 in 1997. The total growth rate over the 10-year period was 15.41 compared to the national average of 15.06. In 1997 the ratio of licensed nursing home beds per 1000 population aged 65 and over in New Jersey remained lower than the national ratio (44.9 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in New Jersey has fluctuated between 8 and 11 since 1989, remaining at 10 since 1995. The number of ICF/MR beds also fluctuated, but overall there was an increase from 3,789 in 1989 to 4,130 in 1997. New Jersey's ratio of ICF/MR beds per 1000 total population was 0.51 in 1997, just above the national ratio of 0.48.

Residential Care for Adults/Aged

New Jersey provides residential care in residential health care facilities, boarding homes, comprehensive personal care and assisted living facilities. In 1997, there were 454 total facilities and 16,728 total beds, a decrease of 30 facilities, but an increase of 394 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over remains lower than the national ratio in 1997 (15.1 compared to 24.3).

Adult Day Care and Home Health Care

New Jersey licenses freestanding adult day health care facilities and adult day programs. In 1997 there were 43 of the former and 38 of the latter, and increase of 2 total facilities since 1996. New Jersey had 80 licensed home health care agencies in 1997, a decrease of 3 facilities since 1996 and a ratio of agencies per 1000 population 65 and over of 0.07 - much lower than the national ratio of 0.50.

CON/Moratorium

New Jersey had a CON for nursing homes from 1980 through 1997 (there was a brief moratorium added in 1991 which was taken away in 1992). In 1997 a CON was also required for hospital bed conversions, residential care, assisted living, and home health care. There was neither a CON nor moratorium for ICF/MRs, hospice or adult day care in 1997. There were 13 nursing home CON applications submitted in 1997, 8 of which were denied.

NEW JERSEY

Demographics

Percentage Population 65 and Over	13.7 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	357
Total Beds	49,688
Beds Per Nursing Facility	139.2 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	44.9 (US 53.1)
Age 85 and Over	400.7 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.27 (US 6.01)
Expenditures Per 1000 Pop, 1996	$131,916 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	10
Total Beds	4,130
Beds Per 1000 Population	0.51 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	454
Total Beds for Adult/Aged	16,728
Beds Per 1000 Pop, Age 65 and Over	15.1 (US 24.3)
Total Facilities, Other	4
Total Beds, Other	327

Licensed Adult Day Care

Total Facilities	81
Facilities Per 1000 Pop, Age 65 and Over	0.07 (US 0.16)

Licensed Home Health Care

Total Agencies	80
Agencies Per 1000 Pop, Age 65 and Over	0.07 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.70 (US 6.51)
Expenditures Per 1000 Pop, 1996	$51,633 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NEW JERSEY

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. Rates and cost limits were rebased annually. The method employed a peer grouping by type of ownership governmental/non-governmental). The basic reimbursement method was adopted in 1978. A facility fiscal year was used to set annual rates with 70% of the facilities beginning in January. Cost reports were used to set rates for the 12-month period beginning six months after the end of each facility's fiscal year. Rates were trended using inflation, based on the CPI and average hourly earnings of factory workers published by NJ Dept. of Labor, severity, and case-mix.

Adjustments

The rate period had a semi-annual adjustment of the nursing component for case-mix. This was made effective April 1, 1995.

Cost Centers

Five rate components were used for setting rates. The rate components were: 1. raw foods, limited to 120% of median; 2. general service: a. assistant administrator (limited to 105% for 99+ beds), b. administration (limited by imputed formula), c. other general service (limited to 105% of the median); 3. property-operating: a. tax (140% of county median by land size), b. utilities (limited to 125% of statewide median); 4. patient care (case-mix): a. nursing (limited to 115% of minimum licensed staffing hours by median salary levels), special patient services, b. medical director (110% of median) c. patient activities (150% of median), d. pharm. consult. (110% of median) e. non-legend drugs (limited to 110% of median), f. medical supplies (limited to 150% of median), g. social services (limited to 110% of median), and h. oxygen (limited to 110% of median); and 5. property-capital (including return on Investment): a. maintenance and replacement (110%) of median, b. property insurance (110% of median), and c. appraised value. construction cost in 1977 inflated forward for new construction.

Ancillary Services

Non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and oxygen were included.

Case-Mix Adjusters

Case-mix was implemented in October 1990. Incidence of patients with seven specific types of conditions (acuities) was used in case-mix. Rates were set on an overall-facility basis and were case-mix adjusted**.**

Capital Costs

The value of capital was determined by an Appraisal system. A square foot value limit was placed on the appraised value based upon year of construction. A size limit was placed on 367 square foot per bed. Capital-interest expenses were not directly valued. An appraisal based on the Capital Facilities Allowance (CFA) amount covers all property capital expenses (depreciation, interest, rental). A return on equity was paid to a facility if costs were less than the CFA. Beginning April 1, 1995, capital reimbursement was limited to the lower of per diem based on fair value or actual cost of depreciation, rentals and interest.

Reimbursement Rate

The FY97 average rate was $112.01, weighted by patient days, excluding specialty care and county facilities.

Other Long-Term Care

New Jersey had similar methods for hospital-based and free-standing nursing facilities. ICF-MR rates were retrospective averaging about three times those of nursing facilities. Home health used Medicare principles. Adult day care and sub-acute care methods were prospective facility-specific.

NEW JERSEY

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$112.01
Percentage Rate Change From Previous Year	4.4%
Peer Groupings	By Type of Ownership
Year of Cost Report to Set Rate	1994 (70% of facilities)
Inflation Adjustment	CPI and NJ Dept. of Labor Market Basket
Minimum Occupancy in Rate-Setting	95% and 85%
Case-Mix Adjusters	Acuity Measure, Entire Rate was Adjusted
Capital Reimbursement Determination	Appraisal; fair value or actual cost after 4/1/95
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Durable Med. Equip. Patient Transport Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	State: $255.88 Private: $317.54
Capital Reimbursement Determination	Actual Depreciation and Interest
Ancillary Services Included in Rate	Oxygen Non-Prescription Drug
Medical Supplies	Durable Med. Equip.
Physician Services	Art/Music Therapy
Occupational Therapy Physical Therapy	Respiratory Therapy Rehabilitation Therapy Lab

Home Health

Method	Medicare Principles[1]
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	Covered under state plan or 2176 Waiver
Average Reimbursement Rate by Facility Type	
Social	$30.00 per diem
Day Health	$50.00 per diem
Average Reimbursement Rate by Clients Covered	
AIDS/ARC	$64.80 per diem (2176 Waiver)
Pediatric	$86.00[2] per diem medically unstable child $140.00 technology dependent child

Sub-Acute Care

Method	Prospective Facility-Specific
Average Rate	
AIDS/ARC	$289.88 per day

[1] Retroactive settlement based on lower of reasonable covered costs, covered charges or Medicare State Limit.

[2] Technology dependent children were paid $140.00 per diem.

NEW MEXICO

Nursing Homes

The number of nursing homes in New Mexico decreased from 90 facilities in 1996 to 85 in 1997. The number of beds also decreased from 7,415 in 1996 to 7,305 in 1997. The total bed growth rate for the ten-year period from 1987 to 1997 was 18.82, compared to the national rate of 15.06. The 1997 ratio of nursing home beds per 1000 population aged 65 and over remained lower than the national ratio despite the growth (37.8 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in New Mexico decreased from 54 in 1996 to 35 in 1997. The number of beds decreased as well, from 547 in 1996 to 276 in 1997[1]. The ratio of ICF/MR beds per 1000 total population was 0.16 in 1997 - below the national ratio of 0.48.

Residential Care for Adults/Aged

New Mexico provides residential care in adult sheltered care homes, halfway homes, boarding homes, and adult family care homes. In 1997 there were 253 total facilities with 4,644 beds, an increase of 26 facilities and 1,503 beds since 1996. New Mexico's ratio of licensed beds per 1000 population aged 65 and over was above the national ratio in 1997 (24.1 compared to 24.3).[2]

Adult Day Care and Home Health Care

New Mexico had 15 licensed adult day care facilities in 1997, a decline of 1 since 1996. There were 168 licensed home health care agencies in New Mexico in 1997, a decrease of 4 since 1996, and a ratio of agencies per 1000 population aged 65 and over (0.87) that continued to be well above the national ratio (0.50) in 1997.

CON/Moratorium

New Mexico required a CON for nursing homes from 1979 through 1983. The CON was eliminated in 1984 and the state had neither a CON nor moratorium through 1997. In 1997 there was neither a CON nor moratorium on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] In 1997, 15 of the 50 licensed ICF/MRs were on record as still being licensed but the beds were empty. The drop in beds from 547 in 1996 to 276 in 1997 occurred because the residents of the 15 facilities were relocated to residential care.

[2] 'Other Residential Care' in New Mexico includes adult residential treatment and adult developmentally disabled facilities, with a total of 17 facilities and 163 beds.

NEW MEXICO

Demographics

Percentage Population 65 and Over	11.2 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	85
Total Beds	7,305
Beds Per Nursing Facility	85.9 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	37.8 (US 53.1)
Age 85 and Over	365.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.23 (US 6.01)
Expenditures Per 1000 Pop, 1996	$69,676 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	50
Total Beds	276
Beds Per 1000 Population	0.16 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	253
Total Beds for Adult/Aged	4,644
Beds Per 1000 Pop, Age 65 and Over	24.1 (US 24.3)
Total Facilities, Other	17
Total Beds, Other	163

Licensed Adult Day Care

Total Facilities	15
Facilities Per 1000 Pop, Age 65 and Over	0.08 (US 0.16)

Licensed Home Health Care

Total Agencies	168
Agencies Per 1000 Pop, Age 65 and Over	0.87 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.30 (US 6.51)
Expenditures Per 1000 Pop, 1996	$54,645 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NEW MEXICO

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed the peer grouping for type of ownership (state/non-state). The basic reimbursement method was adopted in 1984. A state fiscal year was used to set rates annually. The 1996 cost report were used for FY97. New Mexico was on a three year rebasing cycle with the rate inflated in the other two years and prorated for lag time. Inflation based on the HCFA market basket was used to trend rates. Minimum occupancy was set at 90%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

There were two cost centers: 1. operating, limited to 110% of median; and 2. capital, which has a ceiling that grows yearly. There was an overall ceiling applied to the rate.

Ancillary Services

Physical therapy, occupational therapy, non-prescription drugs, medical supplies, patient transportation, and nutritional supplements were included in the rate under routine operating.

Case-Mix Adjusters

No case-mix adjusters were used in New Mexico. There were two levels of care: high and low. Case-mix was not considered for implementation.

Capital Costs

The value of capital was determined by historic cost. The Medicare System valued capital-interest expenses. Refinancing (interest and depreciation), renovation, and rental costs and leases were allowed as costs. Depreciation charges were allowed. Straight line was used for depreciation. The American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for New Mexico was $111.31, calculated by number of facilities.

Other Long-Term Care

New Mexico used a prospective facility-specific system, as did hospital-based facilities, but the hospital-based facilities were case-mix with possible nine levels of care. ICF-MR facilities used a prospective rate that averaged over two times the free-standing nursing facility rate for level 1 ICF-MR facilities. Home health services were covered under Medicare principles.

NEW MEXICO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$111.31
Percentage Rate Change From Previous Year	22.0%
Peer Groupings	Type of Ownership (state/non-state)
Year of Cost Report to Set Rate	1996
Inflation Adjustment	HCFA Market Basket Indicator
Minimum Occupancy in Rate-Setting	90% (new facilities or if beds were added)
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Patient Transportation, Nutritional Supplements

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific
Average Reimbursement Rate	Case-mixed
Level One	$183.63
Level Two	$163.41
Level Three	$148.41
Capital Reimbursement System	Combination[1]
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Oxygen, Durable Med. Equip., Speech[2], Recreation[2], Psychology[2], Dietary Supplements[2]

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	Not Calculated
Average Reimbursement Rate, HH Aide Visit	Not Calculated

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

[1] Historic cost, Market Value, and Appraisal.
[2] Included in non-state facilities only.

NEW YORK

Nursing Homes

The number of nursing homes in New York has grown slowly but steadily, increasing from 610 in 1987 to 667 in 1996 and to 673 in 1997. The number of beds has been steadily increasing as well, growing from 101,077 in 1987 to 116,757 in 1996 and to 118,897 in 1997. The growth rate over this 10 year period was 17.63 compared to the national average of 15.06 Despite this growth, however, the ratio of nursing home beds per 1000 population aged 65 and over remained lower the national ratio in 1997 (49.0 compared to 53.1).

Intermediate Care for Mentally Retarded

In 1997 there were 834 ICF/MRs in New York state with approximately 12,330 beds. This total includes 19 large facilities and 815 small community based facilities with an average of 12 beds each. This was an increase of 6 facilities and a decrease of 1,378 beds since 1996. The ratio of ICF/MR beds per 1000 total population was 0.68 in 1997 - compared to the national ratio of 0.48.

Residential Care for Adults/Aged

New York provides residential care in adult homes, enriched housing facilities, family type homes, public homes, and assisted living facilities. There were 1,343 total facilities with 39,335 beds in 1997, an increase of 4 facilities and 1,593 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over remained lower than the national ratio (in 1997, 16.2 compared to 24.3)[1].

Adult Day Care and Home Health Care

Adult day care in New York is provided in three 'models' - social day care, medical model adult day care, and mental health day treatment[2]. In 1997 there were 470 total facilities, an increase of 11 facilities since 1996. There were 961 licensed home health care agencies in New York in 1997, an increase of 37 since 1996. The ratio of home health care agencies per 1000 population aged 65 and over was slightly lower than the national ratio in 1997 (0.40 compared to 0.50)

CON/Moratorium

New York required a CON for nursing homes from 1980 through 1997 (there was a brief moratorium added to it in 1986 that was dropped in 1987). In 1997 a CON was also required for hospital bed conversions, ICF/MRs, assisted living, home health, hospice and adult day care. There was neither a CON nor moratorium on residential care in 1997.

[1] 'Other residential care' in New York includes 'adult residences' which is mostly utilized by mentally ill residents. In 1997 there were 8 facilities and 440 beds.

[2] Social day care and medical model adult day health care are licensed only through an existing nursing facility and are considered part of that facility's license.

NEW YORK

Demographics

Percentage Population 65 and Over	13.4 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	673
Total Beds	118,897
Beds Per Nursing Facility	176.7 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	49.0 (US 53.1)
Age 85 and Over	410.0 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.24 (US 6.01)
Expenditures Per 1000 Pop, 1996	$270,411 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	834
Total Beds	12,330
Beds Per 1000 Population	0.68 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,343
Total Beds for Adult/Aged	39,335
Beds Per 1000 Pop, Age 65 and Over	16.2 (US 24.3)
Total Facilities, Other	9
Total Beds, Other	464

Licensed Adult Day Care

Total Facilities	470
Facilities Per 1000 Pop, Age 65 and Over	0.19 (US 0.16)

Licensed Home Health Care

Total Agencies	961
Agencies Per 1000 Pop, Age 65 and Over	0.4 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	22.79 (US 6.51)
Expenditures Per 1000 Pop, 1996	$230,837 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	CON Only

* Opinion of State Health Planning Officials.

NEW YORK

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective facility-specific method was used for setting Medicaid reimbursement for nursing facility care. Peer groupings were used for case mix intensity, type of ownership, and number of beds. The basic method was adopted January 1, 1986, based on a calendar year for case-mix adjustments. The 1983 cost report was used for operational costs. The 1995 cost report was used for FY97 capital reimbursement. Inflation based on the CWPI, a New York market basket, and a case-mix were used to trend rates. The minimum occupancy standard was 90%.

Adjustments

Quarterly adjustments to the initial rates were made upward/downward and during/after the rate period, based on case mix. Appeals also affected the rate for all facilities.

Cost Centers

A total of 36 cost centers were used including: 1. direct nursing, limited to 110% of mean below and above the statewide mean; 2. dietary, limited to 7.5% below and 5% above the mean; 3. housekeeping; 4. room and board; 5. indirect, limited to 107.5% above of the mean and 105% below the mean; 6. administration, limited to 7.5% below and 5% above the mean; 7. capital investment/rent (actual rentals only); and 8. equipment including lease hold improvements.

Ancillary Services

Physical therapy, occupational therapy, durable medical equipment, physician services, hearing, dental, podiatry, psychiatric, radiology, lab, electrocardiology and electroencephalogy was included in the rate. Some were subject to a ceiling on direct costs. Non-prescription drugs, prescription drugs, medical supplies, patient transportation and speech therapy are all part of the direct component of the rate.

Case-Mix Adjusters

Case-mix was adopted in 1986 using RUGs II factors. Case-mix was set on an overall facility basis, including direct and other patient care. A possible sixteen levels were provided. New client groups were added, such as AIDS, ventilator, brain trauma, behavior intervention, and pediatric (pediatric not case-mixed).

Capital Costs

The value of capital was determined by historic cost and appraisal/reappraisal and actual interest expense. Refinancing (interest and depreciation), refurbishing, and rental costs and leases were allowed as costs, but limited to the owner's cost. Depreciation charges were allowed with straight line and accelerated cost recovery. A sinking fund was required. A return on net equity called a "real property equity" was allowed.

Reimbursement Rate

The FY97 average reimbursement rate was $151.76, weighted by days of care.

Other Long-Term Care

Hospital-based nursing facilities used a prospective facility-specific methodology completely separated from free-standing nursing facilitates. ICF-MR facilities also used a prospective facility-specific method for setting rates which were two and a half times that of free-standing nursing facilities. Home health services used a prospective agency specific method rate with an average rate of $75.04 for a registered nurse visit and a home health aide hourly visit at $18.65 per hour. Adult day care used a prospective facility-specific rate held to 65% of the affiliated nursing home. Subacute care was tied to the case-mix system.

NEW YORK

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$151.76
Percentage Rate Change From Previous Year	-3.4%
Peer Groupings	Type of Ownership and Number of Beds
Year of Cost Report to Set Rate	1983
Inflation Adjustment	CWPI NY Market Basket & Case Mix
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	RUGS II; Direct Nursing & Other Patient Adjusted
Capital Reimbursement Determination	Historic Cost and Appraisal
Ancillary Services Included in Rate[1]	Physical Therapy, Occupational Therapy, Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Physician Services, Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	Not Available

ICF-MR

Method	Prospective Facility-Specific
Average Reimbursement Rate	$379.61
Capital Reimbursement Determination	Historic Cost and Appraisal
Ancillary Services Included in Rate	Does Not Include All Ancillary Services

Home Health

Method	Prospective Agency specific
Average Reimbursement Rate, RN Visit	$75.04 by visit
Average Reimbursement Rate, HH Aide Visit	$18.65 per hour

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific[2]
Reimbursement Program	Not Available[2]
Average Reimbursement Rate by Facility Type	
Day Health	65% of affiliated nursing facility[3]
Clients covered	Aged, Physically Disabled, Pediatrics & AIDS[2]

Sub-Acute Care

No Separate Program

[1] Also included: Electrocardiology, Electroencephalogy, Speech Therapy, Hearing, Dental Consultant, Podiatry, Psychiatry, Radiology, and Lab.

[2] AIDS Program was reimbursed by a prospective flat rate.

[3] Jan.1, 1990 rate trended to the current rate year.

NORTH CAROLINA

Nursing Homes

The number of nursing homes in North Carolina increased from 255 in 1987 to 421 in 1997. The number of beds also increased during this period, growing from 23,915 to 40,815. The total bed growth rate for this period was 70.67, over four times the national rate (15.06). The ratio of licensed beds per 1000 population aged 65 and over, however, remained lower than the national ratio in 1997 (44.0 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in North Carolina increased from 329 in 1996 to 332 in 1997. The number of ICF/MR beds also increased from 5,219 in 1996 to 5,225 in 1997. North Carolina's ratio of ICF/MR beds per 1000 total population is 0.70, well above the national ratio of 0.48 in 1997.

Residential Care for Adults/Aged

North Carolina licenses its residential care by size - family care homes have 6 residents or less, homes for the aged have 7 or more residents. There were 766 of the former with 4,209 beds and 529 of the latter with 29,969 beds in 1997, a total increase of 77 facilities and 1,508 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over continued to be greater than the national ratio in 1997 (36.8 compared to 24.3).[1]

Adult Day Care and Home Health Care

The number of adult day care facilities in North Carolina increased from 89 in 1996 to 90 in 1997. There were 838 licensed home health care agencies in North Carolina in 1997, an increase of 49 since 1996, and a ratio of licensed agencies per 1000 population aged 65 and over of 0.90 (almost double the national ratio of 0.50).

CON/Moratorium

North Carolina required a CON for nursing homes between 1980 and 1997, with a brief moratorium added to it between 1981 and 1983. In 1997 a CON was also required for hospital bed conversions, ICF/MRs, home health care and hospice. There was neither a CON nor moratorium on residential care or adult day care, while assisted living had a moratorium only in 1997. There were 130 nursing home CON applications submitted in 1997, 90 of which were denied.

[1] 'Other Residential Care' in North Carolina includes: 214 group homes for mentally disabled adults with 1,227 beds, and 1,407 mental health facilities with 8,595 beds.

NORTH CAROLINA

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	421
Total Beds	40,815
Beds Per Nursing Facility	96.9 (US 102.7)
Average Occupancy Rate	94.4
Beds Per 1000 Population:	
Age 65 and Over	44.0 (US 53.1)
Age 85 and Over	434.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.71 (US 6.01)
Expenditures Per 1000 Pop, 1996	$98,949 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	332
Total Beds	5,225
Beds Per 1000 Population	0.70 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,295
Total Beds for Adult/Aged	34,178
Beds Per 1000 Pop, Age 65 and Over	36.8 (US 24.3)
Total Facilities, Other	1,621
Total Beds, Other	9,822

Licensed Adult Day Care

Total Facilities	90
Facilities Per 1000 Pop, Age 65 and Over	0.1 (US 0.16)

Licensed Home Health Care

Total Agencies	838
Agencies Per 1000 Pop, Age 65 and Over	0.9 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.88 (US 6.51)
Expenditures Per 1000 Pop, 1996	$40,756 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NORTH CAROLINA

Reimbursement

Free-Standing Nursing Facilities

Methods

A combination method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The direct portion (nursing, dietary, house keeping, social services, patient activities, laundry/linen, and ancillaries) of the rate was set retrospectively, while the Indirect was set prospectively using a flat rate that was inflated forward. The method employed no peer groupings. The basic reimbursement method was adopted in 1977. A state fiscal year is used to set annual rates beginning October 1. The 1994 cost report was used for FY97 Inflation based on a North Carolina market basket was used to trend rates. No minimum occupancy standard was used for reimbursement.

Adjustments

Some adjustments were made but no specific information was available.

Cost Centers

Two cost centers were used for setting reimbursement rates in North Carolina: 1. direct, limited to 80th percentile (retrospective); and 2. indirect (prospective).

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and oxygen were included in the rate. Ancillary services were included in the Direct cost center.

Case-Mix Adjusters

No case-mix adjusters were used in North Carolina. Two levels of care were provided. There was also a composite rate for enhanced care[1] (ventilator and head injury).

Capital Costs

The value of capital was determined by historic cost. Appraisals were used to set rates. For capital-interest expenses, nursing facilities used actual interest expense. Refinancing, renovation, and rental costs and leases were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation. A return on net equity was provided for profit facilities. The lower of the Medicare rate or 11.875% was the maximum rate of return allowed. There is a cap on beds.

Reimbursement Rate

The FY97 average reimbursement rate for North Carolina was $92.82, weighted by days of care.

Other Long-Term Care

North Carolina used the same system for hospital-based as for free-standing nursing facilities, and a prospective[2] facility-specific method for ICF-MR. Home health used Prospective Pay Rate.

[1] Five State facilities.

[2] Interim rate with cost settlement.

NORTH CAROLINA

Free-Standing Nursing Facilities

Method	Combination Facility-Specific, Adjusted	
Average Reimbursement Rate	$92.82[1]	
Percentage Rate Change From Previous Year	6.8%	
Peer Groupings	None	
Year of Cost Report to Set Rate	1994	
Inflation Adjustment	CPI & Market Basket	
Minimum Occupancy in Rate-Setting	None	
Case-Mix Adjusted	None	
Capital Reimbursement Determination	Historic Cost	
Ancillary Services Included in Rate	Physical Therapy	Occupational Therapy
	Respiratory Therapy	Medical Supplies
	Durable Med. Equip.	Patient Transport
	Non-Prescription Drug	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective[2] Flat Rate
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate	
State Facilities	$235.00
Private Facilities	$196.38
Ancillary Services Included in Rate	
State Facilities	Includes All Ancillary Services
Private Facilities	Same as Free-Standing Nursing Facilities
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Prospective Pay Rate
Maximum Reimbursement Rate, RN Visit	$82.78
Maximum Reimbursement Rate, HH Aide Visit	$46.18

Other Residential Care For Aged[3]

Method	Prospective Patient-specific (capped)
Reimbursement Program	Waiver
Average Reimbursement Rate	$26.00 per hour
Facility Type	Group Home, Family Home, Foster Home, Boarding Home

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program[4]

[1] Fiscal year October 1, 1996 through September 30, 1997.
[2] Interim rate with cost settlement.
[3] Includes combination of aged & physically disabled clients, which could not be disaggregated.
[4] Sub-acute was not a separate program but did have Enhanced Care which included head injury and ventilator care.

NORTH DAKOTA

Nursing Homes

The number of nursing homes in North Dakota fluctuated between 1987 and 1997, dropping from 95 in 1987 to 83 in 1991 and then rising steadily to 88 in 1997. There has been a slow but relatively constant growth in nursing home beds in North Dakota. In 1987, there were 6,821; in 1997, there were 7,124. There was no change in the number of nursing facilities from 1996 to 1997, but there was a decrease in 22 beds. The total bed growth rate for the ten-year period was 4.4, low compared to the national rate of 15.06, but the ratio of licensed beds per 1000 population aged 65 and over remained well above the national ratio in 1997 (76.6 compared to 53.1).

Intermediate Care for Mentally Retarded

There were 66 ICF/MRs with 780 beds in North Dakota in 1997, no change since 1996. The ratio of ICF/MR beds per 1000 total population in North Dakota was 1.22 in 1997, compared to the national ratio of 0.48.

Residential Care for Adults/Aged

North Dakota provides residential care in adult family foster care homes of 4 beds or less and basic care facilities of 5 beds or more. In 1997 there were 93 of the former with 214 beds and 41 of the latter with 1,488 beds, a total decrease of 1 facility and an increase of 61 beds since 1996. The ratio of licensed beds per 1000 population aged 65 and over (18.3) remained less than the national ratio (24.3) in 1997[1].

Adult Day Care and Home Health Care

Adult day care was not licensed in North Dakota in 1997. There were 46 licensed home health care agencies in 1997, an increase of 3 since 1996. The ratio of licensed agencies per 1000 population aged 65 and over just about equaled the national ratio in 1997 (0.49 compared to 0.50).

CON/Moratorium

North Dakota had a CON for nursing homes from 1970 through 1994. In 1995 the CON was dropped and replaced by a moratorium. In 1997 this moratorium also covered hospital bed conversions, ICF/MRs, and residential care (basic care). There was neither a CON nor moratorium on home health care, hospice or adult day care in 1997

[1] 'Other residential care' in North Dakota includes congregate care homes, transitional community living facilities and minimally supervised living arrangements with a total of 38 facilities and 352 beds.

NORTH DAKOTA

Demographics

Percentage Population 65 and Over	14.4 % (US 12.7 %)
Percentage Population 85 and Over	2.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	88
Total Beds	7,124
Beds Per Nursing Facility	81.0 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	76.6 (US 53.1)
Age 85 and Over	508.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	9.03 (US 6.01)
Expenditures Per 1000 Pop, 1996	$167,032 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	66
Total Beds	780
Beds Per 1000 Population	1.22 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	134
Total Beds for Adult/Aged	1,702
Beds Per 1000 Pop, Age 65 and Over	18.3 (US 24.3)
Total Facilities, Other	38
Total Beds, Other	352

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	46
Agencies Per 1000 Pop, Age 65 and Over	0.49 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.74 (US 6.51)
Expenditures Per 1000 Pop, 1996	$45,085 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	Moratorium Only
Hospital Bed Conversion	Moratorium Only
Residential Care	Moratorium Only
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

NORTH DAKOTA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on both a patient specific and facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted January 1, 1990. The June 1996 cost report was used for calendar 1997 rates. Inflation based on the CPI was used to trend rates. The minimum occupancy standard of 90% was used for setting rates.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Four cost centers are used for setting reimbursement rates in North Dakota: 1. nursing and therapies (direct), limited to 99th percentile of 1992 costs trended forward; 2. other direct, limited to 85th percentile of 1992 costs trended forward; 3. property, passed through interest and depreciation; 4. indirect, limited to 75th percentile of 1992 costs trended forward.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, oxygen, and patient transportation were included in the rate.

Case-Mix Adjusters

Case-mix was adopted in 1990. North Dakota uses its own form of RUGs II to do their case-mix. Rates for case-mix reimbursement are set on an individual basis. Only the direct nursing care is accounted for in the case-mix. There were sixteen levels of payment classification.

Capital Costs

The value of capital is determined by historic cost. For capital-interest expenses, nursing facilities used actual interest expense. Renovation was an allowable cost. The state allowed for depreciation charges. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The CY97 average reimbursement rate for North Dakota was $90.86, weighted by days of care.

Other Long-Term Care

North Dakota used the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates, which averaged over two times higher than nursing facility rates. Home health services were paid under Medicare principles with state alterations. Adult day care used a prospective flat rate under a 1915c waiver.

NORTH DAKOTA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$90.86
Percentage Rate Change From Previous Year	5.9%
Peer Groupings	None
Year of Cost Report to Set Rate	June 1996
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	RUGS II; Direct Nursing Care Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Patient Transport, Durable Med. Equip., Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$186.34[1]
Minimum Occupancy in Rate-Setting	95% (may be waived in settlement process)
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Patient Transport, Non-Prescription Drug, Medical Supplies, Oxygen

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	Not Available
Average Reimbursement Rate, HH Aide Visit	Not Available

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	1915c Waiver
Client type	Aged, Physically Disabled, Cognitively Impaired

Sub-Acute Care

No Separate Program

[1] March 1997 average non-government owned $176.54; average government owned $338.29.

OHIO

Nursing Homes

The number of nursing homes in Ohio has fluctuated from 1,084 in 1987 to 1,015 in 1996 and to 982 in 1997. The number of beds increased from 85,501 in 1987 to 95,029 in 1996 and to 91,103 in 1997[1], a total bed growth rate for the period of more than half the national rate (6.55 compared to 15.06). The ratio of nursing home beds per 1000 population aged 65 and over was above the national ratio in 1997 (61.0 compared to 53.1), as it has for many years.

Intermediate Care for Mentally Retarded

In 1997 there were 447 ICF/MRs in Ohio with 8,785 beds, an increase of 66 facilities and 1,801 beds since 1996. The ratio of ICF/MR beds per 1000 total population was 0.78 in 1997, higher than the national ratio of 0.48.

Residential Care for Adults/Aged

Ohio provides residential care in adult care facilities, residential care facilities (formerly called rest homes), and homes for the aged. In 1997 there were 1,309 total facilities with 35,864 beds, an increase of 279 facilities and 15,807 beds since 1996 -a ratio of licensed beds per 1000 population aged 65 and over above the national ratio (24.0 compared to 24.3).

Adult Day Care and Home Health Care

Adult day care was not licensed in Ohio in 1997. Home health care was not licensed but in 1997, but there were 440 certified home care agencies, an increase of 8 since 1996.

CON/Moratorium

Ohio had a CON for nursing homes from 1980 through 1997, with a moratorium added in 1983 (eliminated in 1984), added again in 1987 (eliminated in 1988), and finally added again in 1993, which existed through 1997. In 1997 there was also a CON/moratorium on hospital bed conversions, while there was neither a CON nor moratorium on ICF/MRs, residential care, home health care, hospice or adult day care.

[1] The total number of nursing home beds includes both beds in nursing facilities and beds in homes for the aged, which are licensed as nursing care beds.

OHIO

Demographics

Percentage Population 65 and Over	13.4 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	982
Total Beds	91,103
Beds Per Nursing Facility	92.8 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	61.0 (US 53.1)
Age 85 and Over	552.1 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	7.42 (US 6.01)
Expenditures Per 1000 Pop, 1996	$140,242 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	447
Total Beds	8,785
Beds Per 1000 Population	0.78 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,309
Total Beds for Adult/Aged	35,864
Beds Per 1000 Pop, Age 65 and Over	24.0 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.30 (US 6.51)
Expenditures Per 1000 Pop, 1996	$23,060 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

OHIO

Reimbursement

Free-Standing Nursing Facilities

Methods

Ohio's nursing facilities (NFs) are reimbursed based on a prospective case-mix methodology. Total costs are divided by days to establish per diem in four cost centers. Per diem reimbursement is based on actual, allowable, desk-reviewed costs for the calendar year preceding the fiscal year in which the rate is paid. The CPI was used to trend Other Protected Costs, Indirect Care Costs and Capital Costs for inflation. Inflation based Employment Cost Index was used to trend Direct Care Costs. Greater of inpatient days or 85% of total bed days is the denominator to determine per diem Indirect Care Costs. Greater of inpatient days or 95% of total bed days is the denominator to determine per diem capital costs.

Adjustments

No adjustments were made to the prospective rates except for quarterly case-mix adjustments. Reconsideration of rates under extreme circumstances or extreme hardships.

Cost Centers

Payment methodology consists of four major cost centers: Direct Care Costs are limited by the peer group case-mix median day[1], Other Protected Costs are not limited by ceiling, Indirect Care Costs are limited by 112.5% of the peer group median Medicaid day[2], and Capital Costs are limited by a ceiling of $16.33. Direct care cost ceiling was rebased each fiscal year while indirect care cost ceiling is rebased in even fiscal years.

Ancillary Services

Services not included in the prospective rate for NFs include dental, laboratory, x-ray, prostheses, orthoses, oxygen, prescription drugs, physical and speech therapy, audiology, physician, ambulance and ambulette services, vision care and podiatry.

Case-Mix Adjusters

Re-introduced case-mix with the inception of new reimbursement methodology effective July 1, 1993. Payment methodology is based on (RUGs), version III case-mix system which uses federally mandated (MDS+) resident assessment instrument.

Capital Costs

Value of capital was determined by historic cost. Straight-line method and The American Hospital Association guidelines were used for depreciation. Capital costs[3] include three subcategories entitled cost of ownership, non-extensive renovations and return on net equity. Per diem capital rate for, 88.65% of actual, allowable, desk-reviewed cost of ownership expense and 85% of actual, allowable, desk-reviewed non-extensive renovation expense were divided by greater of total inpatient days. These costs were subject to maximum capital cost limitation. A capital cost efficiency incentive is paid based upon fifty per cent of the difference between desk-reviewed, actual, allowable, per diem cost of ownership and applicable efficiency incentive ceiling for each NF. Return on net equity is calculated separately based on each proprietary NF's asset/liability balance sheet subject to a ceiling of $1.00 per resident per day.

Reimbursement Rate

The estimated average proposed payment rate for NFs for FY98 was $108.96.

Other Long-Term Care

Same system for hospital-based as for free-standing nursing facilities. A similar prospective payment was used for ICFs-MR. Home health care was paid under a fee schedule with flat rates, twice as high ($41.41) for a RN as for a home health aide visit ($20.71). Adult day care, under waiver, used a prospective class method. Sub-acute care was paid under prospective facility-specific negotiated rates.

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[1] Direct Care, limited by the cost per case-mix unit (CPCMU) of the facility with the median Medicaid day of the peer group multiplied by 1.2278.

[2] Indirect Care, limited by the indirect care costs per diem of the facility with the median Medicaid day of each of the eight peer groups multiplied by 112.5%.

OHIO

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$101.72
Percentage Rate Change From Previous Year	4.4%
Year of Cost Report to Set Rate	1995 calendar year
Inflation Adjustment	CPI, Employment Cost Index
Minimum Occupancy in Rate-Setting	80% New Facilities (first three months) 85% for Indirect Care; 95% for Capital
Case-Mix Adjusters	RUGs III, Direct care case-mix adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Resp.Therapy, Non-Prescription Drugs, Medical Supplies, Ambulatory Patient Transportation, Durable Med. Equip.

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Class
Private Facilities	Similar to Free-Standing
Facilities[1]	
Average Reimbursement Rate	
State Facilities/Private Facilities	$259.26/$170.94
Ancillary Services Included in Rate	
State Facilities	Include All Ancillary Services
Private Facilities	Same as NF's and includes: Audiology, Speech, Physical and Occ. Therapy

Home Health

Method: Lesser of Medicaid Maximum or Usual and Customary Charge	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit/HH Aide Visit	$41.41/$20.71
Average Reimbursement Rate, Therapy	$31.06
Private-Duty Nursing, hourly rate	$28.04

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method: HCBS Waiver Programs Only	
Reimbursement Program	2176 Waiver
Maximum Reimbursement by Rate:	
Age 60 or above (PASSPORT)	$35.56 per day
Age 59 and below (disability)	$36.26 per day

Sub-Acute Care

Method	Prospective Facility-Specific[2]
Average Rate: Pediatric	Not Available

[1] Case-mix but not as complex; only four levels.

[2] Negotiated rates.

OKLAHOMA

Nursing Homes

The number of nursing homes in Oklahoma fluctuated but increased from 407 facilities in 1987 to 426 in 1997. Bed growth has fluctuated but overall has shown an increase from 31,136 in 1987 to 35,305 in 1997. The total bed growth rate for this 10-year period was 13.39, less than the national rate of 15.06. The ratio of licensed beds per 1000 population aged 65 and over, however, has been well above the national ratio for at least 10 years (in 1997, 79.5 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Oklahoma has increased from 36 in 1996 to 41 in 1997. The number of beds has similarly increased from 2,682 in 1996 to 2,703 in 1997. The ratio of ICF/MR beds per 1000 total population was 0.81 in 1997, much greater than the national ratio of 0.48.

Residential Care for Adults/Aged

Oklahoma had 179 licensed residential care homes with a total of 6,775 beds in 1997, an increase of 15 facilities and 567 beds since 1996. In 1997, the ratio of licensed beds per 1000 population aged 65 and over was less than the national ratio (15.3 compared to 24.3)

Adult Day Care and Home Health Care

Oklahoma had 20 licensed adult day care facilities in 1997, a decrease of 1 since 1996. Home health care licensure was implemented in November 1994; by 1997, there were 520 licensed agencies, an increase of 95 agencies since 1996. The ratio of agencies per 1000 population aged 65 and over was more than two times the national ratio (1.17 compared to 0.50).

CON/Moratorium

Oklahoma required a CON for nursing homes from 1980 through 1997. In 1997 a CON was also required for hospital bed conversions and ICF/MRs, while there was neither a CON nor moratorium on residential care, assisted living, home health care, hospice or adult day care. There were 44 nursing home CON applications submitted in 1997, none of which were denied.

OKLAHOMA

Demographics

Percentage Population 65 and Over	13.4 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	426
Total Beds	35,305
Beds Per Nursing Facility	82.9 (US 102.7)
Average Occupancy Rate	76.0
Beds Per 1000 Population:	
Age 65 and Over	79.5 (US 53.1)
Age 85 and Over	641.9 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.23 (US 6.01)
Expenditures Per 1000 Pop, 1996	$83,525 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	41
Total Beds	2,703
Beds Per 1000 Population	0.81 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	179
Total Beds for Adult/Aged	6,775
Beds Per 1000 Pop, Age 65 and Over	15.3 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	20
Facilities Per 1000 Pop, Age 65 and Over	0.05 (US 0.16)

Licensed Home Health Care

Total Agencies	520
Agencies Per 1000 Pop, Age 65 and Over	1.17 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.17 (US 6.51)
Expenditures Per 1000 Pop, 1996	$30,398 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

OKLAHOMA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a flat rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1978. A state fiscal year was used to set annual rates beginning July 1. The 1995 cost report were used for FY97. Inflation based on the DRI was used to trend rates. No minimum occupancy standard was used to set rates.

Adjustments

No additional adjustments were required for FY 1997.

Cost Centers

Three cost centers were used: 1. operating, an overall general limit, limited by the weighted mean; 2. administrative service, limited to $2.41 per patient day; and capital, limited to $6.32 per patient day.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and physician services were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Oklahoma. One level of care was provided. Changing to a case-mix system has been considered but no implementation date was set.

Capital Costs

The value of capital was determined by historic cost. A flat allowance of $6.32 for capital was paid. Depreciation charges were included if they fell within the allowance. For capital interest expenses, nursing facilities used actual interest expense, subject to a ceiling. Refinancing, renovation, and rental costs and leases were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation. A rental factor of $6.32 (same as capital allowance) was paid.

Reimbursement Rate

The FY97 averaged flat reimbursement rate for Oklahoma was $56.77.

Other Long-Term Care

Oklahoma used the same system for hospital-based as for free-standing nursing facilities. It also used the same method for private ICF-MRs, which were paid about 24% more than nursing facilities. The same method, but with retrospective adjustments, was also used for state ICF-MRs, which had rates over five-times that for nursing facility care. Home health was reimbursed using Medicare principles, paying over ten times the average rate for an RN visit ($100.00) as for a home health aide visit ($9.50).

Adult Day Care

Under the “Advancare” Waiver, Adult Day Care is provided to the aged or disabled (not including the developmentally disabled). The rate is $35.00 per day.

OKLAHOMA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$56.77
Percentage Rate Change From Previous Year	3.3%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Physician Services, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Class (retroactive adjustments)
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities	$358.07
Private Facilities	$70.36
Ancillary Services Included in Rate	
All Facilities:	Physical Therapy, Physicians Services, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Durable Med. Equip.
State Facilities Only:	Respiratory Therapy
Private Facilities Only:	Speech Therapy, Music Audiology, Recreation Therapy, Habilitative Service, Lab, X-Ray, Dental Consult, Psychology

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$100.00
Average Reimbursement Rate, HH Aide Visit	$9.50

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Waivered Services
$35.00 per day

Sub-Acute Care

No Separate Program

OREGON

Nursing Homes

The number of nursing homes in Oregon has been steadily decreasing, from 192 in 1987 to 172 in 1996 and 1997. The number of beds decreased from 15,615 in 1987 to 14,408 in 1996 and to 14,473 in 1997. The total bed growth rate for the 10-year period was -7.31 compared to the national average of 15.06. The 1997 ratio of licensed beds per 1000 population aged 65 and over remained well below the national ratio, 33.7 compared to 53.1.

Intermediate Care for Mentally Retarded

Oregon has been downsizing its ICF/MR program and trying to move people into group homes. From 1993 to 1996 there were only 2 facilities with 546 beds, in 1997 facilities remained at 2 while the beds decreased to 335. The ratio of ICF/MR beds per 1000 total population was 0.10, much lower than the national ratio of 0.48.

Residential Care for Adults/Aged

Oregon provides residential care in assisted living facilities, residential care facilities, commercial foster care homes, and relative foster care homes. In 1997 there were a total of 3,928 facilities with 21,381 beds, a decrease of 53 facilities and an increase of 1,181 beds since 1996. This is a ratio of licensed beds per 1000 population aged 65 and over of 49.7, compared to the national ratio of 24.3.

Adult Day Care and Home Health Care

Adult day care was not licensed in Oregon in 1997. There were 109 licensed home health care agencies in 1997, a decrease of 4 since 1996 and a ratio of licensed agencies per 1000 population 65 and over of exactly half the national ratio (0.25 compared to 0.50).

CON/Moratorium

Oregon required a CON for nursing homes from 1980 through 1997. In 1997 a CON was also required for hospital bed conversions, while there was neither a CON nor moratorium on ICF/MRs, residential care, assisted living, home health care, hospice or adult day care. There were 4 nursing home CON applications submitted in 1997, one of which was denied.

OREGON

Demographics

Percentage Population 65 and Over	13.3 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	172
Total Beds	14,473
Beds Per Nursing Facility	84.1 (US 102.7)
Average Occupancy Rate	80.0
Beds Per 1000 Population:	
Age 65 and Over	33.7 (US 53.1)
Age 85 and Over	283.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.75 (US 6.01)
Expenditures Per 1000 Pop, 1996	$50,381 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	2
Total Beds	335
Beds Per 1000 Population	0.10 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	3,928
Total Beds for Adult/Aged	21,381
Beds Per 1000 Pop, Age 65 and Over	49.7 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	109
Agencies Per 1000 Pop, Age 65 and Over	0.25 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.37 (US 6.51)
Expenditures Per 1000 Pop, 1996	$59,700 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

OREGON

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate.[1] The method employed no peer groupings. The basic reimbursement method was adopted in 1991. A state fiscal year was used to set annual rates beginning July 1. The September 1991 costs reports were used for the indirect portion of the rate, while the September 1992 cost reports were used for the direct portion. Inflation based on the DRI was used to trend rates for the direct portion of the rate and the CPI was used for the indirect portion of the rate. A minimum occupancy standard of 95% was used for the Indirect portion of the rate.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Two cost centers were used for setting reimbursement rates in Oregon: 1. indirect (prospective), limited by a flat rate; and 2. direct (retrospective), limited to the 70th percentile.

Ancillary Services

Physical therapy (if PT is on staff), occupational therapy, respiratory therapy, medical supplies, patient transportation, and oxygen[2] were included in the direct portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Oregon. Five levels of care were provided. No case-mix has been planned for Oregon.

Capital Costs

The value of capital was determined by a modified system using historic cost and rental value. For capital interest expenses, nursing facilities used the actual interest expense. Renovation and rental costs and leases were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation

Reimbursement Rate

The FY97 average reimbursement rate for Oregon was $81.88, weighted by patient days.

Other Long-Term Care

Oregon used the same system for hospital-based as for free-standing nursing facilities, and a retrospective method to set ICF-MR rates. Home health visits were paid using a fee-schedule with a flat $53.42 rate for both RN and home health aide visits. Other residential care for the aged was paid under waivers using differing methods, and adult day care was covered under waivers, using retrospective methods.

[1] Interim rates were set for the Direct Care cost center, so this component is now classified as Prospective.

[2] Only part of the cost of Oxygen.

OREGON

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$81.88
Percentage Rate Change From Previous Year	7.0%
Peer Groupings	None
Year of Cost Report to Set Rate	Sept. 1991 (indirect) or Sept. 1992 (direct)
Inflation Adjustments	DRI
Minimum Occupancy in Rate-Setting	95% Direct Care Cost
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost and Rental Value
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$510.78
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities plus Prescription Drug, Physician Services, Durable Med. Equip.

Home Health

Method	Fee-Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$50.75 per visit
Average Reimbursement Rate, HH Aide Visit	$50.75 per visit

Other Residential Care For Aged

Method	Retrospective Facility-Specific/Class
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Service	
Foster Home (Adult)	$ 578.88 per month
Residential Care	$ 560.41 per month
Assisted Living	$1021.98 per month

Adult Day Care

Method	Retrospective Contract Negotiation
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Facility Type	
Day Health	$444.31 per month
Clients Covered	Aged

Sub-Acute Care

No Separate Program

PENNSYLVANIA

Nursing Homes

The number of nursing homes in Pennsylvania steadily increased from 648 facilities in 1987 to 810 facilities in 1997. The number of beds has been steadily increasing as well, growing from 85,702 in 1987 to 97,588 in 1997. The total bed growth rate in that 10-year period was 13.87, compared to the national rate of 15.06. The ratio of licensed beds per 1000 population aged 65 and over remained less than the national ratio in 1997 (51.2 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Pennsylvania had increased steadily from 161 in 1989 to 255 in 1994, then decreased to 251 in 1996 and 1997. The number of beds also fluctuated, increasing from 7,761 in 1989 to 8,333 in 1993 and then decreasing to 6,994 in 1996 then to 7,276 in 1997. The ratio of ICF/MR beds per 1000 total population was higher than the national ratio (in 1997, 0.61 compared to 0.48).

Residential Care for Adults/Aged

There were 1,688 personal care homes with 60,070 beds providing residential care in Pennsylvania in 1997. This was an increase of 102 facilities and 4,484 beds since 1996. The additional beds raised the ratio of licensed beds per 1000 population aged 65 and over up from 29.1 in 1996 to 31.5 in 1997, greater than the national ratio of 24.3.[1]

Adult Day Care and Home Health Care

There were 235 licensed adult day care facilities, 207 licensed adult training facilities for the mentally retarded/mentally ill, and 179 vocational training day facilities for the disabled in Pennsylvania in 1997, a total increase of 8 facilities since 1996. There were 98 licensed home health care agencies in 1997, an increase of 11 since 1996. The ratio of licensed home health care agencies per 1000 population was less than the national ratio (0.05 compared to 0.50).

CON/Moratorium

Pennsylvania required a CON for nursing homes from 1980 through 1996. In 1997 there was no longer a CON for nursing facilities. In 1997, neither a CON nor moratorium was required for hospital bed conversions, ICF/MRs, residential care, assisted living, home health care, hospice or adult day care.

[1] 'Other Residential Care' in Pennsylvania includes: regular community homes for people with MR, large community homes for people with MR, family living homes for people with MR and community residential rehabilitation.

PENNSYLVANIA

Demographics

Percentage Population 65 and Over	15.8 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	810
Total Beds	97,588
Beds Per Nursing Facility	120.5 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	51.2 (US 53.1)
Age 85 and Over	458.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.29 (US 6.01)
Expenditures Per 1000 Pop, 1996	$147,246 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	251
Total Beds	7,276
Beds Per 1000 Population	0.61 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,688
Total Beds for Adult/Aged	60,070
Beds Per 1000 Pop, Age 65 and Over	31.5 (US 24.3)
Total Facilities, Other	3,130
Total Beds, Other	14,811

Licensed Adult Day Care

Total Facilities	620
Facilities Per 1000 Pop, Age 65 and Over	0.33 (US 0.16)

Licensed Home Health Care

Total Agencies	98
Agencies Per 1000 Pop, Age 65 and Over	0.05 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	1.86 (US 6.51)
Expenditures Per 1000 Pop, 1996	$3,223 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

PENNSYLVANIA

Reimbursement

Free-Standing Nursing Facilities

Methods

The basic reimbursement system was adopted in 1976, and was based on retrospective principles. Effective 1/1/96, the prospective case-mix payment system started and rates were adjusted quarterly. The new system was established with a core of 12 peer groups.

Adjustments

Effective 1/1/96, no adjustments were required since case mix rates are final rates.

Cost Centers

The case mix payment system has twenty-six cost centers. It also has two levels of care; nursing facility and residential/other.

Ancillary Services

Effective 1/1/96, physical therapy occupational therapy and respiratory therapy became allowable costs. Physician services were included if the costs were salaried or contracted. Non-prescription drugs, medical supplies, durable medical equipment, oxygen, and non-emergency patient transportation were also included in the rate. Ancillaries were part of net operating cost.

Case-Mix Adjusters

Since case mix payment system became effective 1/1/96, two types of case mix adjusters were used, case mix index (CMI) and medical assistance case- mix index (MACMI).

Capital Costs

Effective 1/1/96, a fair rental value was paid under the case mix payment system. The allowable cost established for a facility was multiplied by a factor based on the 5 year moving average of the AAA bond rating. Cost per bed limitation was raised from $22,000 to $26,000 on July 1, 1996.

Reimbursement Rate

The average of the quarterly rates for 7/1/96-6/30/97 was $109.13.

Other Long-Term Care

Pennsylvania used the same system for hospital-based as for free-standing nursing facilities. Effective 1/1/96 and forward, separate peer groups were used. Private ICF-MRs was paid using a retrospective method with full costs but some limits. Home health services are paid using a fee schedule with a flat rate nearly twice as high ($67) for RN visits as for home health aide visits ($37).

PENNSYLVANIA

Free-Standing Nursing Facilities

Method	Prospective Adjusted
Average Reimbursement Rate	$109.13
Percentage Rate Change From Previous Year	N/A prior had retrospective and case mix
Peer Groupings	14
Year of Cost Report to Set Rate	latest 3 audited
Inflation Adjustment	HCFA market basket w/o capital
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	Total CMI and MA CMI
Capital Reimbursement Determination	Appraisal Fair Rental Value
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies
Physical Therapy	Occupational Therapy
Respiratory Therapy	Durable Med. Equip.
Physician Services	Patient Transport
Oxygen	

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities (have their own peer group)

ICF-MR

Method	
State Facilities	Prospective Facility-Specific[1]
Non-state Facilities	Retrospective Facility-Specific[1]
Weighted Reimbursement Rate	
Non-State Facilities	$195.09[1]
State Facilities	$285.00
Capital Reimbursement Determination	Historic Cost (all facilities) and Rental Value (private facilities) or Cost of Ownership.
Ancillary Services Included in Rate (all facilities)	Physical Therapy Occupational Therapy
Non-Prescription Drug	Physician Services
Patient Transport	Speech/Hearing
Psychology/Counseling	

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit/HH Aide Visit	$67.00/$37.00

Other Residential Care For Aged

Method	prevailing rate by county
Reimbursement Program	2176 Waiver

Adult Day Care

Method	2176 Waiver
Average reimbursement rate	$42.89 (figure is under waiver)

Sub-Acute Care

No Separate Program

[1] State facilities method was based on full cost with some limits while non-state costs was based on allowable cost according to state regulations (restrict full cost).

[2] Averaged by number of facilities (246).

RHODE ISLAND

Nursing Homes

The number of nursing homes in Rhode Island decreased from 108 in 1987 to 100 in 1996, increasing to 104 in 1997. The number of nursing home beds has fluctuated but has shown an overall increase from 9,800 in 1987 to 10,658 in 1996 and to 10,735 in 1997. Despite this slow rate of growth (9.54 for the period, compared to 15.06 nationally), Rhode Island has steadily maintained a ratio of beds per 1000 population aged 65 and over greater than the national ratio (in 1997 68.8 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Rhode Island declined significantly between 1989 and 1997 (from 115 down to 5)[1]. The number of ICF/MR beds has similarly declined from 920 in 1989 to 47 in 1997. The ratio of ICF/MR beds per 1000 total population in Rhode Island was 0.05, much lower than the national ratio of 0.48 in 1997.

Residential Care for Adults/Aged

The number of residential care facilities in Rhode Island has increased slowly but steadily from 29 in 1989 to 59 in 1997 (an increase of 6 facilities since 1996). There were 2,126 beds in 1997, an increase of 304 since 1996. Even with the increase, the ratio of licensed beds per 1000 population aged 65 and over remained less than the national ratio in 1997 (13.6 compared to 24.3).

Adult Day Care and Home Health Care

Rhode Island provides adult day care in both 'regular' adult day care facilities and 'Alzheimer's' day care facilities. In 1997 there were 17 total adult day care facilities[2] licensed in Rhode Island, an increase of 2 facilities since 1996. There were 41 licensed home health care agencies in Rhode Island 1997, an increase of 7 since 1996. In 1997 the ratio of agencies per 1000 population aged 65 and over was 0.26 compared to the national ratio of 0.50.

CON/Moratorium

Rhode Island required a CON for nursing homes from 1980 through 1997. In 1996 a moratorium on nursing facilities was implemented and continued through 1997. In 1997 a CON and moratorium was required for hospital bed conversions and hospice. A moratorium only was in place for ICF/MRs, but there was neither a CON nor moratorium on residential care, assisted living, home health care[3], or adult day care. In 1997 there were no CON applications for nursing homes.

[1] Former ICF/MR facilities exist but have been given 'deemed status' and are no longer licensed or monitored.

[2] Rhode Island had 15 Adult day care agencies with a total of 17 separate licenses in 1997.

[3] A new type of review, not a CON, called "initial licensure review" has been implemented to review newly licensed home health agencies.

RHODE ISLAND

Demographics

Percentage Population 65 and Over	15.8 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	104
Total Beds	10,735
Beds Per Nursing Facility	103.2 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	68.8 (US 53.1)
Age 85 and Over	536.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	10.27 (US 6.01)
Expenditures Per 1000 Pop, 1996	$221,942 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	5
Total Beds	47
Beds Per 1000 Population	0.05 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	59
Total Beds for Adult/Aged	2,126
Beds Per 1000 Pop, Age 65 and Over	13.6 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	17
Facilities Per 1000 Pop, Age 65 and Over	0.11 (US 0.16)

Licensed Home Health Care

Total Agencies	41
Agencies Per 1000 Pop, Age 65 and Over	0.26 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	10.46 (US 6.51)
Expenditures Per 1000 Pop, 1996	$109,952 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	Moratorium Only
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

RHODE ISLAND

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. No peer groupings were used. The basic reimbursement method was adopted in 1978. A calendar year was used to set annual rates beginning July 1. The earliest cost report used was CY93 for FY97. Inflation based on the NNHIPI was used to trend rates. The minimum occupancy standard was set at 98% of industry average for previous year.

Adjustments

No adjustments were made to the initial rate.

Cost Centers

Seven cost centers were used for setting reimbursement rates in Rhode Island: 1. fixed property expenses, limited to 100th percentile; 2. other property related expenses, limited to 70th percentile[2]; 3. labor and payroll related expenses, limited to 80th percentile; 4. energy expenses, limited to 75th percentile; and 5. all other expenses, limited to 80th percentile; 6. management expense, limited to the 75th percentile; 7. OBRA-87 Expenses, limited to 100th percentile.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, medical supplies, laundry and patient transportation were included in the rate. Ancillary services are included in the rate based on cost report calculations.

Case-Mix Adjusters

No case-mix adjusters were used in Rhode Island. A single level of care was provided.

Capital Costs

The value of capital was determined by Historic Cost. For capital interest expense, nursing facilities used the actual interest expense. Refinancing, renovation, and equipment rental costs and leases were allowable costs subject to cost center maximum. The straight-line method and the American Hospital Association guidelines were used for depreciation (limited to cost center maximum for other property related expenses).

Reimbursement Rate

The average reimbursement rate for FY97 was $101.50.

Other Long-Term Care

Rhode Island used the same system for hospital-based as for free-standing nursing facilities and a similar system for ICF-MRs[1], which averaged almost three times the per diem rate of nursing facilities. Home health care was paid using Medicare principles with state alterations. Adult day care was covered under the state plan, using a prospective flat rate method.

[1] Reasonable Cost Related Reimbursement.
[2] For new facilities (none current).
Pre-CON facilities $18.97 (all current).

RHODE ISLAND

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$101.50
Percentage Rate Change From Previous Year	2.5%
Peer Groupings	None
Year of Cost Report to Set Rate	CY1993
Inflation Adjustment	NNHI Price Index
Minimum Occupancy in Rate-Setting	98%[1]
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historical Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific[2]
Average Reimbursement Rate	$387.00
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Laundry

Home Health

Method	Medicare Principles (Capped at $62.00)
Average Reimbursement Rate, RN visit	Range: $41.00 to $62.00
Average Reimbursement Rate, HH Aide visit	$10.23 per hour

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	Covered under state plan
Average Reimbursement Rate	$18.39 per day
Facility Type	Social
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

No Separate Program

[1] 98% of industry average for previous year.

[2] Cost related reimbursement.

SOUTH CAROLINA

Nursing Homes

The number of nursing homes in South Carolina has been steadily increasing, growing from 139 in 1987 to 193 in 1997, (an increase of 6 facilities since 1996). The number of beds increased from 12,917 in 1987 to 18,154 in 1997 (an increase of 417 beds since 1996. The total growth rate for the 10-year period was 40.54 (substantially higher than the national rate of 15.06). The ratio of nursing home beds per 1000 population aged 65 and over, however, remained below the national ratio in 1997 (40.0 compared to 53.1).

Intermediate Care for Mentally Retarded

South Carolina has been making an effort to downsize its larger ICF/MRs. In 1997, there were 158 facilities with 2,931 beds, a decrease of 6 facilities and 97 beds since 1996. Despite the decrease however, the ratio of ICF/MR beds per 1000 total population remained higher than the national ratio (0.77 compared to 0.48).

Residential Care for Adults/Aged

The number of community residential care facilities in South Carolina increased from 390 in 1990 to 479 in 1997 (an increase of 11 facilities since 1996). The number of beds also increased from 6,670 in 1990 to 11,001 beds in 1997 (an increase of 758 beds since 1996). South Carolina maintained a ratio of licensed beds per 1000 population aged 65 and over of just less than the national ratio in 1997 (24.2 compared to 24.3).

Adult Day Care and Home Health Care

There were 60 licensed adult day care facilities in South Carolina in 1997, an increase of 5 since 1996. There were 91 licensed home health care agencies in 1997, an increase of 7 since 1996. In 1997 the ratio of home health care agencies per 1000 population aged 65 and over was less than half the national ratio (0.20 compared to 0.50).

CON/Moratorium

South Carolina had a CON for nursing homes from 1980 through 1997, with a moratorium added to it between 1980 and 1988. In 1997 there was also a CON on hospital bed conversions, ICF/MRs,[1] and home health care. There was neither a CON nor moratorium on residential care, assisted living, hospice or adult day care. There were 22 nursing home CON applications submitted in 1997, none of which were denied.

[1] ICF/MRs built by the state of South Carolina are exempt from CON as long as they do not exceed the number of beds that existed in 1989.

SOUTH CAROLINA

Demographics

Percentage Population 65 and Over	12.1 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	193
Total Beds	18,154
Beds Per Nursing Facility	94.1 (US 102.7)
Average Occupancy Rate	78.9
Beds Per 1000 Population:	
Age 65 and Over	40.0 (US 53.1)
Age 85 and Over	422.2 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.25 (US 6.01)
Expenditures Per 1000 Pop, 1996	$70,779 (US $111,686)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	158
Total Beds	2,931
Beds Per 1000 Population	0.77 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	479
Total Beds for Adult/Aged	11,001
Beds Per 1000 Pop, Age 65 and Over	24.2 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	60
Facilities Per 1000 Pop, Age 65 and Over	0.13 (US 0.16)

Licensed Home Health Care

Total Agencies	91
Agencies Per 1000 Pop, Age 65 and Over	0.2 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.90 (US 6.51)
Expenditures Per 1000 Pop, 1996	$24,448 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

SOUTH CAROLINA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed peer groupings by number of beds and type of ownership. The basic reimbursement method was adopted in 1986. The federal fiscal year was used to set annual rates. The September 1995 cost report was used for FY97. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 97%.

Adjustments

Adjustments to the initial rates were made twice during the rate year for all facilities based on cost report information and case-mix[1] adjustments.

Cost Centers

Ten cost centers were used for setting reimbursement rates in South Carolina: 1. general services, limited to 105% of mean; 2. dietary, limited to 105% of mean; 3. housekeeping, laundry, & maintenance, limited to 105% of mean; 4. administration, medical records & services, limited to 105% of mean; 5. utilities; 6. medical supplies; 7. special services; 8. capital; 9. taxes, insurance: building and equipment; and 10. legal fees.

Ancillary Services

Physical therapy, speech therapy, occupational therapy, respiratory therapy, non-prescription drugs, specialty beds and medical supplies were included in the rate. However, effective 1/1/95, the following costs associated with dual eligible recipients were excluded from total allowable costs when computing the Medicaid rates. Physical therapy, speech therapy, occupational therapy, respiratory therapy, ancillary medical supplies and specialty beds.

Case-Mix Adjusters

Case-mix was adopted July 1986. Percent of Medicaid skilled to total Medicaid ("bands" or levels) by overall facility was taken into account in case-mix. General services including direct nursing care, Indirect nursing care and other patient care[2] is the only cost center subject to case mix adjustment. Two levels of care were provided.

Capital Costs

The value of capital was determined by a combination of cost based and fair rental in a modified system that uses the market value of a bed plus the mean rate of return. No capital-interest expense was paid. Renovation was an allowable cost. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for South Carolina was $78.08, weighted by days of care.

Other Long-Term Care

South Carolina used the same system for hospital-based as for free-standing nursing facilities, and a prospective[3] facility-specific method for ICF-MRs, which were paid over two times that of nursing facilities. Home health was reimbursed using Medicare principles. Adult day care was covered under waiver using a prospective flat method.

[1] Percent skilled.

[2] Social and activity cost.

[3] Retrospective with interim rate.

SOUTH CAROLINA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$78.08
Percentage Rate Change From Previous Year	4.5%
Peer Groupings	Number of Beds and Type of Ownership
Year of Cost Report to Set Rate	September 1995
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	97%
Case-Mix Adjusters	Acuity Measurement; Direct, Indirect, & Other Patient Adjusted
Capital Reimbursement Determination	Combination (see text page)
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Specialty Beds, Speech Therapy

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$173.62
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$35.00-$100.00 (Average-$73.79)
Average Reimbursement Rate, HH Aide Visit	$15.05-$55.46 (Average-$36.49)

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	2176 Waiver
Reimbursement Rate	$38.00 per day
Facility Type	Day Health
Clients Covered	Aged, Physically & Developmentally Disabled, and, Mentally Ill

Sub-Acute Care

No Separate Program

SOUTH DAKOTA

Nursing Homes

The number of nursing homes in South Dakota has remained fairly constant, ranging from 118 in 1987 to 115 in 1997 (no increase since 1996). The number of beds fluctuated with 8,001 beds in 1987 and 8,097 in 1997 (there was a decrease of 81 beds since 1996). The total bed growth rate for the period 1987 to 1997 was 1.2 percent, very much less than the national rate of 15.06 percent. The ratio of beds per 1000 population aged 65 and over remained well above the national ratio in 1997 (77.1 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities decreased from 10 in 1996 to 9 in 1997. The number of beds has similarly declined from 449 in 1996 to 437 in 1997. The ratio of ICF/MR per 1000 population has declined from being well above the national average to being just somewhat above it (in 1997, 0.59 compared to 0.48).

Residential Care for Adults/Aged

South Dakota licenses assisted living facilities and adult foster care. In 1997 there were 87 of the former and 69 of the latter. This represents an increase of 31 facilities since 1996. Assisted living beds grew from 1,045 in 1996 to 1,588 in 1997, adult foster care beds increased from 135 in 1996 to 157 in 1997, an increase of 565 total beds since 1996. Despite the additional beds, the ratio of licensed beds per 1000 population aged 65 and over is less than the national ratio (16.6 compared to 24.3).

Adult Day Care and Home Health Care

Although adult day care was not licensed in South Dakota in 1997, there were 13 certified adult day care facilities. Home health care was not licensed in 1997, but there were 56 certified home health care agencies, an increase of 2 since 1996.

CON/Moratorium

South Dakota had a CON for nursing homes from 1980 to 1987. In 1988, the state eliminated the CON and instituted a moratorium, which remained in effect through 1997. In 1997 the moratorium also covered hospital bed conversions, while there was neither a CON nor moratorium on ICF/MRs, residential care, assisted living, home health care, hospice or adult day care.

SOUTH DAKOTA

Demographics

Percentage Population 65 and Over	14.3 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	115
Total Beds	8,097
Beds Per Nursing Facility	70.4 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	77.1 (US 53.1)
Age 85 and Over	539.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.48 (US 6.01)
Expenditures Per 1000 Pop, 1996	$132,726 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	9
Total Beds	437
Beds Per 1000 Population	0.59 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	156
Total Beds for Adult/Aged	1,745
Beds Per 1000 Pop, Age 65 and Over	16.6 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.44 (US 6.51)
Expenditures Per 1000 Pop, 1996	$48,455 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	Moratorium Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

SOUTH DAKOTA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific rate. The method employed a peer grouping of geographic location by urban/rural and hospital based. The basic reimbursement method was adopted in 1975. A state fiscal year was used to set and rebase rates annually beginning July 1 of each year. The May 1994 cost reports (calendar year) were used for FY97. Inflation based on the DRI was used to trend rates. The minimum occupancy standard was set at three percent less than the annual statewide average or actual, whichever is higher.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Three cost centers were used for setting reimbursement rates in South Dakota: 1. direct care, limited to 125% of median, per group classification; 2. health subsistence, general administrative, plant/operational & other, limited to 110% of the median, per group classification; and 6. capital, limited to $9.52 per bed for level I and Level II facilities. (For hospital affiliated, capital was included as a 110% limit.)

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, prescription drugs, medical supplies, durable medical equipment, patient transportation, physician services, and oxygen were included in the rate. Ancillaries were included in the operating costs similar to other cost centers.

Case-Mix Adjusters

Case-mix was implemented in FY94. Resource utilization groups (RUGs) were used to define case-mix. Case-mix was adjusted on a patient-specific basis for direct nursing care, indirect nursing care and other patient care. A possible 35 levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. No revaluation was performed. For capital-interest expense, nursing facilities used the actual interest expense. Refinancing, renovation, and rental cost and leases were allowable costs (interest only). Depreciation charges were allowed. The straight-line method and the American Hospital Association guidelines were used for depreciation. The minimum depreciation period allowed is 33.5 years. A return on net equity was provided. The rate was 6.8%, subject to overall capital limitation.

Reimbursement Rate

The FY97 average reimbursement rate for South Dakota was $74.26, weighted by days of care.

Other Long-Term Care

South Dakota used the same system for hospital-based as for free-standing nursing facilities and a prospective facility-specific method for state[1] and private ICF-MRs. Home health visits were paid using a flat rate, with RN visits ($67.60) paid 30% more than the rate for home health aide visits ($43.70).

[1] Retrospective with interim rates.

SOUTH DAKOTA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$76.96
Percentage Rate Change From Previous Year	3.6%
Peer Groupings	Geographic Location by Rural/Urban
Year of Cost Report to Set Rate	1994 Calendar Year
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	3% Less Than the State-Wide Average
Case-Mix Adjusters	Case-Mix adjusted, RUGs adaptation
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Physician Services, Oxygen, Prescription Drugs

Hospital-Based Nursing Facilities

Method[1]	Included in Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Facility-Specific
Private Facilities	Combination Facility-Specific
Average Reimbursement Rate	
State Facilities	$195.08
Private Facilities	$167.76
Capital Reimbursement Determination	
State Facilities	Not applicable
Private Facilities	Historic Cost
Ancillary Services Included in Rate	
Private Facilities	Non-Prescription Drug, Medical Supplies, Durable Med. Equip., Patient Transport, Oxygen
State Facilities	All Ancillary Services

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$67.60
Average Reimbursement Rate, HH Aide Visit	$43.70

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

[1] No capital component in hospital facilities.

TENNESSEE

Nursing Homes

The number of nursing homes in Tennessee has been steadily increasing, growing from 284 in 1987 to 364 in 1997. The number of beds rose from 32,092 in 1987 to 40,746 in 1997. There was an increase of 2 facilities and 1,345 beds since 1996. The total bed growth rate from 1987 to 1997 was 26.97 percent compared to the national rate of 15.06 percent. The ratio of nursing home beds per 1,000 population aged 65 and over remained above the national ratio in 1997 (60.8 compared to 53.1).

Intermediate Care for Mentally Retarded

The total number of ICF/MR facilities increased from 84 in 1996 to 86 in 1997. The total number of licensed beds has been declining since 1992 when there were 2,810 beds. In 1996 the ICF/MR beds decreased to 2,100 and again to 1,762 in 1997. This decline is attributable to downsizing by several of the larger centers. The ratio of ICF/MR beds per 1,000 total population was 0.33 in 1997, below the national ratio of 0.48.

Residential Care for Adults/Aged

Tennessee provides residential care in institutional and residential homes for the aged. In 1997, there were 66 of the former with 3,175 beds and 248 of the latter with 6,382 beds, a total increase of 50 facilities and 3,181 beds since 1996. The ratio of licensed beds per 1,000 population aged 65 and over, however, remained well below the national ratio in 1997 (14.3 compared to 24.3)[1].

Adult Day Care and Home Health Care

Adult day care was not licensed in Tennessee in 1997. There were 309 licensed home health agencies in Tennessee in 1997, a decrease of 25 since 1996. The 1997 ratio of home health agencies per 1,000-population aged 65 and over was just below the national average, 0.46 compared to 0.50.

CON/Moratorium

Tennessee required a CON for nursing homes from 1980 through 1997. In 1997 a CON was also required for hospital bed conversions, ICF/MRs, home health care, and hospice. There was neither a CON nor moratorium on residential care, assisted living or adult day care. There were 14 CON applications for nursing homes in 1997, 2 of which were denied.

[1] 'Other residential care' in Tennessee includes alcohol and drug detox, alcohol and drug residential rehabilitation and alcohol and drug halfway houses with a total of 78 facilities and 1,521 beds in 1997.

TENNESSEE

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	364
Total Beds	40,746
Beds Per Nursing Facility	111.9 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	60.8 (US 53.1)
Age 85 and Over	543.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	9.05 (US 6.01)
Expenditures Per 1000 Pop, 1996	$115,392 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	86
Total Beds	1,762
Beds Per 1000 Population	0.33 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	314
Total Beds for Adult/Aged	9,557
Beds Per 1000 Pop, Age 65 and Over	14.3 (US 24.3)
Total Facilities, Other	78
Total Beds, Other	1,521

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	309
Agencies Per 1000 Pop, Age 65 and Over	0.46 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	0.18 (US 6.51)
Expenditures Per 1000 Pop, 1996	$65 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

TENNESSEE

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective[1] method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted around 1978 with some modifications in 1990 and 1996. A state fiscal year was used to set annual rates beginning July 1. The 1996[2] cost reports were used for FY97. Inflation based on the providers own three-year average limited to the 75th percentile trended forward from the midpoint of the providers cost report period. ICFMR inflation is not trended. A minimum occupancy standard was set at 80%, reduced by five percent for each five percent change down to a minimum of 60%.

Adjustments

Adjustments to the initial rates were made only for errors or audit adjustments.

Cost Centers

Cost centers were not used to determine rates in Tennessee. A comprehensive limit was set at the 65th percentile for all facilities.

Ancillary Services

Physical therapy, non-prescription drugs, and medical supplies were included in the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Tennessee. Three levels of care were provided; NFI (ICF), NFI (SNF) and ICF-MR.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expense, nursing facilities used actual interest expense. Interest, lease fees, rent, and depreciation were allowable costs. For leases the lesser amount of lease fees are actual owners cost was allowed. The straight-line method and the American Hospital Association guidelines were used for depreciation. A return on net equity was allowed at same rate that Medicare used limited to $1.50 per patient day.

Reimbursement Rate

The FY97 average reimbursement rate for Tennessee was $87.74, calculated by number of days.

Other Long-Term Care

Tennessee used the same system for hospital-based as for free-standing nursing facilities and the same method for ICF-MR, which averaged almost three times the per diem rate of ICF nursing facilities. Home health was reimbursed under a managed care system.

[1] The ICF facilities were set prospectively, and SNF facilities were set prospectively beginning 10/1/96. The state is overall prospective.

[2] The most recently filed and reviewed cost report as of June 1, were used for rate determination in 1997.

TENNESSEE

Free-Standing Nursing Facilities

Method	Combination Facility-Specific
Average Reimbursement Rate	$87.74
Percentage Rate Change From Previous Year	12.6%
Peer Groupings	None
Year of Cost Report to Set Rate	1996
Inflation Adjustment	Providers 3yr.avg. (max 75th percentile)
Minimum Occupancy in Rate-Setting	80%
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Medical Supplies, Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$371.96
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Medical Supplies, Physician Services, Psychiatric Services, Psychological Services

Home Health

Method	Managed Care System

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

TEXAS

Nursing Homes

The number of nursing homes in Texas increased from 1,078 in 1987 increasing to 1,344 facilities in 1997. The number of beds has followed a similar pattern growing from 109,729 in 1987 to 129,708 in 1997. The total bed growth rate for this period was 18.21 percent, above the national rate (15.06 percent). The ratio of beds per 1,000 population aged 65 and over remained greater than the national ratio in 1997 (66.2 compared to 53.1).

Intermediate Care for Mentally Retarded

Texas provides ICF/MR care in state schools, community mental health/mental retardation centers and freestanding ICF/MRs. The total number of ICF/MRs increased slightly from 891 in 1996 to 896 in 1997. The number of beds decreased from 14,609 in 1996 to 14,384 in 1997. The ratio of ICF/MR beds per 1,000 total population was well above the national ratio (in 1997, 0.74 compared to 0.48).

Residential Care for Adults/Aged

Texas provides residential care in personal care homes. In 1997, there were 884 facilities with 24,409 beds, an increase of 78 facilities and 5,656 beds since 1996. Despite the increases, however, the ratio of licensed beds per 1,000 population aged 65 and over remained well below the national ratio in 1997 (12.5 compared to 24.3)[1].

Adult Day Care and Home Health Care

The number of licensed adult day care facilities in Texas increased from 216 in 1996 to 249 in 1997. The number of licensed home health care agencies increased from 2,981 in 1996 to 3,237 in 1997 yielding a total number of licensed home health care agencies greater than that of any other state. As a result, the ratio of agencies per 1,000-population aged 65 and over in Texas was 1.65, over three times the national ratio of 0.50.

CON/Moratorium

Texas had a CON for nursing homes between 1980 and 1984. In 1985, the state eliminated the CON and instituted a moratorium, which remained in effect through 1997. In 1997 there was also a moratorium on hospital bed conversions and ICF/MRs, while there was neither a CON nor moratorium on residential care, assisted living, home health care, hospice or adult day care.

[1] 'Other residential care' facilities in Texas include special care facilities, crisis stabilization units, substance abuse residential care and private psychiatric hospitals, with a total 876 facilities and 18,185 beds.

TEXAS

Demographics

Percentage Population 65 and Over	10.1 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	1,344
Total Beds	129,708
Beds Per Nursing Facility	96.5 (US 102.7)
Average Occupancy Rate	73.5
Beds Per 1000 Population:	
Age 65 and Over	66.2 (US 53.1)
Age 85 and Over	600.5 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.99 (US 6.01)
Expenditures Per 1000 Pop, 1996	$65,539 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	896
Total Beds	14,384
Beds Per 1000 Population	0.74 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	884
Total Beds for Adult/Aged	24,409
Beds Per 1000 Pop, Age 65 and Over	12.5 (US 24.3)
Total Facilities, Other	876
Total Beds, Other	18,185

Licensed Adult Day Care

Total Facilities	249
Facilities Per 1000 Pop, Age 65 and Over	0.13 (US 0.16)

Licensed Home Health Care

Total Agencies	3,237
Agencies Per 1000 Pop, Age 65 and Over	1.65 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	3.96 (US 6.51)
Expenditures Per 1000 Pop, 1996	$16,657 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	Moratorium Only
Hospital Bed Conversion	Moratorium Only
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

TEXAS

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a patient-specific basis with a portion of the rate fixed. No peer groupings were used. The basic reimbursement method was adopted in 1989. A calendar year was used to set annual rates. The 1995 cost reports were used for FY97[1] (CY97). Inflation based on the IPD-PCE, plus other indices per condition were used to trend rates. The minimum occupancy standard was 79.6%.

Adjustments

Rates were adjusted 9/1/97 to account for increase in federally mandated minimum wage.

Cost Centers

Three cost centers were used for setting rates in Texas: 1. general, administration, and dietary (GAD), limited to costs of median facility plus 7%; 2. average recipient care (APC); and 3. Fixed Capital Asset Use Fee (FCAUF), limited to lower of previous FCAUF inflated or an imputed alternative.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, oxygen and patient transportation were averaged into the rate.

Case-Mix Adjusters

Case-mix was adopted April 1989. Texas used TILEs (Texas Index for Level of Effort), modeled after RUGs II. Rates were set on a mix of individual-patient and overall-facility. Only the APC cost center was case-mix adjusted. After adjustment, the APC was added to the GAD and FCAUF. Direct nursing care was accounted for in the case-mix rate. Eleven levels of care were provided.

Capital Costs

The value of capital was determined by appraisal. Texas had a Fixed Capital Asset Use Fee. Two alternative methods existed for calculating the facility fee: the lower of the previous year's fee, adjusted for inflation or an imputed fee capped at the 80th percentile adjusted by inflation and a minimum occupancy standard set at the higher of the state wide average occupancy rate and 85%. While renovation, rental, lease, and interest costs and depreciation were allowable costs on the cost report they were not included in the cost determination database. Rather these costs were reimbursed through the FCAUF, which was determined from appraisals as described above. Facilities were required to submit updated appraisals from their county taxing authorities with each year's cost report.

Reimbursement Rate

The average reimbursement rate for Texas was $70.83 from 1/1/97 - 8/31/97. The average reimbursement rate from 9/1/97 - 12/31/97 was $71.69.

Other Long-Term Care

Texas used the same system for hospital-based as for free-standing nursing facilities and a prospective flat rate for ICF-MRs. Home health visits were paid under Medicare principles. Other residential care was paid under a 1915c waiver by a prospective flat rate by facility type. Adult day health was paid under the state plan on a prospective flat rate.

[1] Texas is on a calendar year therefore FY96 runs January 96 through December 96.

TEXAS

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$71.12 ($70.83 Jan - Aug /Sept -Dec 97 $71.69)
Percentage Rate Change From Previous Year	6.2% Jan - Aug 97/Sept-Dec 97 $7.4%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
Inflation Adjustment	IPD-PCE and Other Indices Per Condition
Minimum Occupancy in Rate-Setting	79.6% (State-Wide Average)
Case-Mix Adjusters	TILES based on RUGs II Resident Care portion of rate was CM adjusted
Capital Reimbursement Determination	Appraisal/Reappraisal
Ancillary Services Included in Rate	Physical Therapy — Occupational Therapy Respiratory Therapy — Non-Prescription Drug Medical Supplies — Durable Med. Equip. Patient Transport — Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Prospective Flat Rate (weighted median)
Average Reimbursement Rate	$136.04
Capital Reimbursement Determination	Historic Cost

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Per Visit	$84.68
Average Reimbursement Rate, HH Aide Visit	$58.64

Other Residential Care For Aged[1]

Method	Prospective Statewide Flat Rate
Reimbursement Program	1915c Waiver
Average Reimbursement Rate by Facility type	
Personal Care Home (assisted living)	
Apt Single	$36.08 per day
Apt Double	$28.43 per day
Non Apt	$24.07 per day
Foster Home: Level of need	
Level 1	$17.68 per day
Level 2	$30.49 per day
Level 3	$61.92 per day

Above rates do not include room and food costs.

Adult Day Care

Method	Prospective Statewide Flat Rate
Reimbursement Program	Under state plan
Average Reimbursement Rate	$12.68 per half day
Facility Type	Did not apply
Clients Covered	Must have medical diagnosis

Sub-Acute Care

No Separate Program

[1] Includes combination of aged & physically disabled clients, which could not be disaggregated.

UTAH

Nursing Homes

The number of nursing homes in Utah increased from 93 in 1987 to 108 in 1997 (no increase since 1996). The number of beds increased from 6,807 in 1987 to 8,528 in 1997 (an increase of 14 beds since 1996). The total bed growth rate for the 10-year period was 25.28 percent, above the national rate of 15.06 percent. The ratio of beds per 1,000 population aged 65 and over increased to 47.4 in 1997, still below the national average of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Utah decreased from 14 in 1990 to 11 in 1995, remaining so through 1997. The number of licensed ICF/MR beds steadily decreased from 1,045 in 1990 to 921 in 1995 and remaining so through 1997. The ratio of licensed ICF/MR beds per 1,000 population in Utah was 0.45, just below that for the nation as a whole (0.48 US average).

Residential Care for Adults/Aged

In 1997, Utah had 109 residential care facilities with 1,956 beds, 24 adult foster care homes with 61 beds, and 8 assisted living facilities (a category of care which began in 1994 in Utah) with 260 beds. There was a total increase of 17 residential care facilities and 287 beds since 1996. The ratio of licensed beds per 1,000 population aged 65 and over was 12.7 in 1997, about half the national ratio (24.3).[1]

Adult Day Care and Home Health Care

There were 77 licensed adult day care facilities in Utah in 1997, an increase of 7 facilities since 1996. There were 106 licensed home health care agencies in 1997, an increase of 10 since 1996. The ratio of licensed home health care agencies per 1000 population age 65 and over was slightly greater than the national ratio, 0.59 compared to 0.50.

CON/Moratorium

Utah had a CON for nursing homes from 1980 to 1984. It eliminated the CON in 1985 and had not reinstated it through 1997. However, in 1989, the state instituted a moratorium, which did remain in effect through 1997. In 1997 there was neither a CON nor moratorium on hospital bed conversions, residential care, assisted living, home health care, hospice or adult day care, but there was a moratorium only on ICF/MRs.

[1] 'Other Residential Care' in Utah includes 70 residential treatment facilities with 431 beds for people with mental retardation.

UTAH

Demographics

Percentage Population 65 and Over	8.7 % (US 12.7 %)
Percentage Population 85 and Over	1.0 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	108
Total Beds	8,528
Beds Per Nursing Facility	79.0 (US 102.7)
Average Occupancy Rate	79.9
Beds Per 1000 Population:	
Age 65 and Over	47.4 (US 53.1)
Age 85 and Over	426.4 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.74 (US 6.01)
Expenditures Per 1000 Pop, 1996	$42,683 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	11
Total Beds	921
Beds Per 1000 Population	0.45 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	141
Total Beds for Adult/Aged	2,277
Beds Per 1000 Pop, Age 65 and Over	12.7 (US 24.3)
Total Facilities, Other	431
Total Beds, Other	70

Licensed Adult Day Care

Total Facilities	77
Facilities Per 1000 Pop, Age 65 and Over	0.43 (US 0.16)

Licensed Home Health Care

Total Agencies	106
Agencies Per 1000 Pop, Age 65 and Over	0.59 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	1.91 (US 6.51)
Expenditures Per 1000 Pop, 1996	$23,788 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	Moratorium Only
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

UTAH

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility flat rate and facility specific historic nursing cost with inflator. The basic reimbursement method was adopted in 1990. A state fiscal year was used to set annual rates beginning July 1. The 1995 cost report were used for FY97. Inflation based on a UT market basket was used to trend rates. No minimum occupancy standard was set.

Adjustments

No retroactive adjustments to the initial rates are made.

Cost Centers

Eight cost centers are used for setting reimbursement rates in Utah: 1. nursing, limited to 120% of the median; 2. housekeeping, 3. laundry and linen, 4. plant operation, 5. administration 6. dietary 7. Capital and 8. recreation and social. Costs are limited using percentiles.

Ancillary Services

Respiratory therapy, occupational therapy non-prescription drugs, medical supplies, durable medical equipment, and non-emergency patient transportation are included in the rate.

Case-Mix Adjusters

No case-mix adjusters are used in Utah except for historical nursing costs. A single level of care is provided for each facility.

Capital Costs

The value of capital was determined by historic cost limited to March 1981 cost. For capital-interest expenses, nursing facilities used the actual interest, subject to a ceiling. Depreciation applied to the 1981 cost report. The straight-line method was used for depreciation with a maximum depreciation period of 35 years. Each facility receives a minimum property allowance in the flat rate.

Reimbursement Rate

The FY97 average reimbursement rate for Utah was $78.53, weighted by days of care.

Other Long-Term Care

Utah used the same system for hospital-based as for free-standing nursing facilities, and Medicare principles for the state operated facility of developmentally disabled. State ICF-MR's rates averaged over two and a half times those for nursing facilities, while private ICF-MR rates were on average less than 40% higher than those for nursing facilities. Home health was paid according to a fee schedule with flat rates, paying twice the average rate for a RN visit ($79) as for a home health aide visit ($39). Other residential care for the aged was covered under waiver, using patient-specific contract negotiation. Adult day care was covered using prospective facility-specific methods. Sub-acute care used prospective patient-specific methodology.

UTAH

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$78.53
Percentage Rate Change From Previous Year	3.4%
Peer Groupings	None
Year of Cost Report to Set Rate	1994
Inflation Adjustment	UTAH Market Basket
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusted	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Respiratory Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Non-Emergency Transport, DME

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$78.53[1]

ICF-MR

Method	
State Facilities	Retrospective Medicare Principles
Private Facilities	Retrospective Flat Rate
Average Reimbursement Rate	
State Facilities	$208.00[1]
Private Facilities	$107.95
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$81.75
Average Reimbursement Rate, HH Aide Visit	$34.35

Other Residential Care For Aged[2]

Method	Patient-Specific & Contract Negotiation
Reimbursement Program	1915c Wavier
Average Reimbursement Rate By Facility Type	
Group Home	$81.62 per day[1]

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915c
Average Reimbursement Rate by Facility Type	
Social	$28.18 per day
Clients Covered	Aged

Sub-Acute Care

Method	Prospective Patient-Specific
Average Rate: Pediatric Ventilator Care	$502.32 per day

[1] Estimate

[2] Also includes Dental/Vision

VERMONT

Nursing Homes

The number of nursing homes has remained relatively constant in Vermont, decreasing from 50 facilities in 1987 to 48 in 1995 and remaining so through 1997. The number of beds had been slowly increasing from 3,442 in 1987 to 3,848 in 1996, with a decrease to 3,838 in 1997. The total bed growth rate for the 10-year period was 11.50 percent, less than the national rate of 15.06 percent. The ratio of nursing home beds per 1,000 population aged 65 and over in 1997 was 53.3, just greater than the national ratio of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MRs in Vermont decreased from 12 in 1989 to 2 in 1997 (a decrease of 1 facility since 1996). The number of licensed ICF/MR beds decreased from 266 in 1989 to 54 in 1994, when the state's largest ICF/MR closed. There were 12 licensed ICF/MR beds in 1997, the smallest number for any state. At 0.02, the ratio of licensed ICF/MR beds per 1,000 population was one of the smallest in the country and well below the national ratio of 0.48.

Residential Care for Adults/Aged

Vermont provides residential care in level 3 and level 4 residential facilities. In 1997, there were 70 of the former with 1,638 beds, and 50 of the latter with 550 beds. Since 1996 there has been a net reduction of 16 facilities and 202 beds. The ratio of licensed beds per 1,000-population aged 65 and over was above the national ratio in 1997, with 30.4 compared to 24.3[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Vermont in 1997. Home health care was not licensed but in 1997 there were 13 certified agencies, as there has been since 1992.

CON/Moratorium

Vermont required a CON for nursing homes from 1980 through 1997. In 1997 a CON was also required for hospital bed conversions, ICF/MRs, home health care, and hospice, while there was neither a CON nor moratorium on residential care, assisted living or adult day care. There was 1 nursing home CON application submitted in 1997, which was not denied.

[1] 'Other residential care' in Vermont includes 29 therapeutic community residences with 284 beds. This was a new category for 1997.

VERMONT

Demographics

Percentage Population 65 and Over	12.3 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	48
Total Beds	3,838
Beds Per Nursing Facility	80.0 (US 102.7)
Average Occupancy Rate	94.1
Beds Per 1000 Population:	
Age 65 and Over	53.3 (US 53.1)
Age 85 and Over	426.4 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.65 (US 6.01)
Expenditures Per 1000 Pop, 1996	$115,312 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	2
Total Beds	12
Beds Per 1000 Population	0.02 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	120
Total Beds for Adult/Aged	2,188
Beds Per 1000 Pop, Age 65 and Over	30.4 (US 24.3)
Total Facilities, Other	29
Total Beds, Other	284

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.19 (US 6.51)
Expenditures Per 1000 Pop, 1996	$99,115 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

VERMONT

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1983. A state fiscal year was used to set annual rates beginning July 1. The earliest cost report used for FY97 was FY1994. Inflation based on DRI was used to trend rates. The minimum occupancy standard was set at 90% except for facilities with twenty or fewer beds.

Adjustments

Quarterly adjustments were made to the rates.

Cost Centers

Costs were separated into ten categories: 1. nursing, limited to 115% of the median; 2. resident care, limited to 105% of median; 3. indirect care, limited to 100% of the median; 4. ancillary, 5. director of nursing, 6. property, 7. OBRA, and 8. special adjustments.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, speech therapy, inhalation therapy, and oxygen were included in the rate. Ancillaries were a separate rate component.

Case-Mix Adjusters

Case-mix was adopted January 1, 1992. In July 1992, Vermont developed a special score, which narrowly defined 29 classes. In October 1992, a one time add-on was included for Workers Compensation Insurance. RUG's III factors, plus a behavioral component, were used in their case-mix system. Case-mix reimbursement was set on and overall-facility basis. The direct nursing care category was the case-mix portion of the rate.

Capital Costs

The value of capital was determined by the historic cost. For capital-interest expense, nursing facilities used actual interest expense. Refinancing (interest only), renovation, and rental costs and leases (not for related party) were allowable costs. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Vermont was approximately $100.46, weighted by days of care.

Other Long-Term Care

Vermont used the same system for hospital-based as for free-standing nursing facilities, but retrospective methods for ICF-MR, with an average rate over three times higher than for nursing facilities. Home health rates were set by a fee schedule with flat rates, on a per-visit basis for RN services ($59) but by the quarter-hour for home health aide services ($5.25). Adult day care was covered under waiver, using a retrospective reimbursement method.

VERMONT

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific Adjusted
Average Reimbursement Rate	$100.46
Percentage Rate Change From Previous Year	3.3%
Peer Groupings	None
Year of Cost Report to Set Rate	1994
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	90% (20 or fewer beds can be waivered)
Case-Mix Adjusted	RUGS III, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Medical Supplies, Non-Prescription Drug, Speech Therapy, Inhalation Therapy, Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$375.20
Ancillary Services Included in the Rate	Same as Free-Standing Nursing Facilities plus Physician Services

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$59.00 per diem
Average Reimbursement Rate, HH Aide Visit	$5.47 per quarter hour

Other Residential Care For Aged

No Medicaid Program

Method	Per diem rate
Enhanced Residential Care	$30.00 per day

Adult Day Care

Method	Retrospective Flat Rate
Reimbursement Program	2176 Waiver
Average Reimbursement Rate	$6.00 per hour
Facility Type	Social and Dementia/Alzheimer's Disease
Clients Covered	Aged and Physically disabled

Sub-Acute Care

No Separate Program

VIRGINIA

Nursing Homes

The number of nursing homes in Virginia has been steadily increasing, growing from 203 in 1987 to 290 in 1997 (an increase of 5 facilities and 236 beds since 1996). The number of beds has been steadily increasing as well, growing from 23,541 in 1987 to an estimated 31,388 in 1997. The total bed growth rate for the 10-year period was 33.33 percent, more than 2 times the national rate (15.06 percent). The ratio of nursing home beds per 1,000 population aged 65 and over, however, remained lower than the national ratio in 1997 (41.5 compared to 53.1).

Intermediate Care for Mentally Retarded

From 1992 to 1994 there were 16 ICF/MRs in Virginia, increasing to 19 in 1996, and in 1997 decreasing to 18. The number of licensed ICF/MR beds has fluctuated but has generally increased from 2,649 in 1996 to 2,694 in 1997. The ratio of licensed ICF/MR beds per 1,000 total population was just less than the national ratio (0.4 in 1997, compared to 0.48).

Residential Care for Adults/Aged

Virginia provides residential care in adult care residences, formerly called 'homes for adults'. In 1997 there were 589 adult care residences with 28,416 beds, an increase of 13 facilities and 816 beds since 1996. In 1997, Virginia's ratio of residential care beds per 1,000-population aged 65 and over was 37.6, higher than the national ratio of 24.3.

Adult Day Care and Home Health Care

There were 53 licensed adult day care facilities in Virginia in 1997, no change since 1996, but an increase of 2 since 1995. There were 91 licensed home health care agencies in 1997, an increase of 29 since 1996.

CON/Moratorium

Virginia had a CON for nursing homes from 1980 through 1997, adding a moratorium to it in 1987 that remained in effect, with the CON, through June, 1996. In 1997 there was also a CON/moratorium on hospital bed conversions, while there was neither a CON nor moratorium on residential care, home health care, hospice or adult day care. There was a CON in effect for ICF/MRs. There were 5 nursing home CON applications submitted in 1997, 2 of which were denied[1].

[1] Two of the approved CON proposals were for increases in the supply of nursing facilities; both were for the establishment of nursing home units at new retirement communities. The two denied projects involved expanding existing facilities in conjunction with equivalent reductions in licensed bed capacity of other nursing homes.

VIRGINIA

Demographics

Percentage Population 65 and Over	11.2 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	290
Total Beds	31,388
Beds Per Nursing Facility	108.2 (US 102.7)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	41.5 (US 53.1)
Age 85 and Over	402.4 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.00 (US 6.01)
Expenditures Per 1000 Pop, 1996	$56,998 (US $111,686)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	18
Total Beds	2,694
Beds Per 1000 Population	0.40 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	589
Total Beds for Adult/Aged	28,416
Beds Per 1000 Pop, Age 65 and Over	37.6 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	53
Facilities Per 1000 Pop, Age 65 and Over	0.07 (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.79 (US 6.51)
Expenditures Per 1000 Pop, 1996	$15,089 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

VIRGINIA

Reimbursement

Free-Standing Nursing Facilities

Methods

A combination of methods was used for setting Medicaid reimbursement for nursing facility care in the state of Virginia. The retrospective portion of the rate was for capital, while the prospective was for operating, both direct and indirect. This method was based on a facility-specific rate, limited by a peer group ceiling. Providers are grouped by their fiscal year ending cost report for calendar quarter application of the annual inflation factor to determine their prospective rate and operating ceilings. The method employs a peer grouping for geographic location by metro/rest of state. The basic reimbursement method was adopted in 1990. Inflation based on the Virginia-Specific DRI is used to trend rates. Effective 7/1/95 the direct cost ceiling was adjusted by an additional amount to allow a higher rate for nursing facilities whose bed size is between 1 and 90 beds. DRI was used to trend rates. The minimum occupancy standard was set at 95% for plant and operation.

Adjustments

Virginia's rate was adjusted. The state sets semi-annual rates for the operating portion; therefore it was adjusted during a fiscal year.

Cost Centers

Three cost centers were used for setting reimbursement rates in Virginia: 1. direct, limited by peer group median from 1990 (adjusted for inflation); 2. indirect; and 3. plant (capital).

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, and non-prescription drugs were included in the rate.

Case-Mix Adjusters

Case-mix was adopted 1991. Case-mix was based on a resource-based measure or Patient Intensity Rating System (PIRS). Only the direct portion of the rate was case-mixed. Three levels of care were provided.

Capital Costs

The value of capital was determined by historic cost. For capital interest expense, nursing facilities used the Medicare System. Refinancing, renovation, and rental costs and leases were allowable costs. Allowable interest was limited to the prevailing interest rate. The straight-line method and the American Hospital Association guidelines were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Virginia was $77.37, weighted by days of care. The capital portion of the rate was $8.56.

Other Long-Term Care

Virginia had the same system for hospital-based and free-standing nursing facilities. A retrospective method with caps for ICF-MR averaged almost two and one half times nursing facility rates. Home health used a fee schedule with ranges much higher for RN than for home health aide visits. Adult day care was under waiver, using a prospective flat method. Payment methodology for specialized care (sub-acute) was changed as of December 1, 1996, to be provider specific for costs related to rendering this level of care, subject to operating cost ceilings which will be updated by inflation factors in the same manner as the routine rate limitations are updated. Direct operating costs are adjusted by patient intensity factor determined by the RUG-111 application. Ancillary costs and plant costs are reimbursed on a retrospective basis.

VIRGINIA

Free-Standing Nursing Facilities

Method	Combination Facility-Specific
Average Reimbursement Rate	$77.37
Percentage Rate Change From Previous Year	3.0%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1996
Inflation Adjustment	DRI
Minimum Occupancy in Rate-Setting	95% (except for first year facilities)
Case-Mix Adjusted	Resource-Based Measure, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific (capped)
Average Reimbursement Rate	$195.77
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	Range: $66.15 - $180.44
Average Reimbursement Rate, HH Aide Visit	Range: $39.25 - $55.90

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Provider Specific Per Diem
Reimbursement Program	2176 Waiver
Average Reimbursement Rate	$28.00 per diem (6 hours)
Facility Type	Social
Clients Covered	Aged

Sub-Acute Care

Method	Prospective Flat
Average Rate	$352.00

WASHINGTON

Nursing Homes

Over the past 10-years the number of nursing homes in Washington has fluctuated within a narrow range. There were 299 facilities in 1987, decreasing to 294 in 1996 and decreasing again to 286 in 1997. The number of beds in Washington has similarly fluctuated. In 1987 there were 28,439 licensed beds decreasing to 27,724 in 1997, an increase of 168 beds since 1996. The total bed growth rate for the period 1987 to 1997 was -2.51 percent. The ratio of nursing home beds per 1000 population aged 65 and over continued to be lower than the national ratio in 1997 (42.9 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities increased from 6 in 1989 to a high of 16 in 1992 and, has been slowly decreasing since then. In 1997 there were 8 ICF/MR facilities (a decrease of 3 facilities since 1996). The total number of licensed ICF/MR beds has fluctuated but overall has decreased from 1,907 in 1989 to 1,096 in 1997 (a decrease of 154 beds since 1996). The ratio of beds per 1,000 total population was 0.2 in 1997, less than half the national ratio of 0.48.

Residential Care for Adults/Aged

Washington provides residential care in adult family homes and boarding homes. There were 2,299 of the former with 10,539 beds and 383 of the latter with 19,071 beds in 1997, a total decline of 8 facilities and an increase of 4,797 beds since 1996. With the increases in beds, the ratio of residential care beds per 1000 population aged 65 and over grew from 36.5 in 1995 to 45.8 in 1997, well above the national ratio of 24.3.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Washington in 1997. There were 163 licensed home health care agencies in 1997, an increase of 2 since 1996. The ratio of home health agencies per 1000 population age 65 and over, at 0.25 was half that of the national ratio (0.50).

CON/Moratorium

Washington required a CON for nursing homes from 1978 through 1997 (with a brief moratorium added to it in 1993 that was dropped in 1994). In 1997 a CON was also required for hospital bed conversions and home health care, and hospice, while there was neither a CON nor moratorium on ICF/MRs, residential care or adult day care. There were 2 nursing home CON applications submitted in 1997, both were denied.

[1] 'Other Residential Care' in Washington includes 8 boarding homes for the mentally retarded with 52 beds and 108 residential mental health treatment facilities with 1,726 beds.

WASHINGTON

Demographics

Percentage Population 65 and Over	11.5 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	286
Total Beds	27,724
Beds Per Nursing Facility	96.9 (US 102.7)
Average Occupancy Rate	84.2
Beds Per 1000 Population:	
Age 65 and Over	42.9 (US 53.1)
Age 85 and Over	369.7 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	4.40 (US 6.01)
Expenditures Per 1000 Pop, 1996	$86,828 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	8
Total Beds	1,096
Beds Per 1000 Population	0.20 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,682
Total Beds for Adult/Aged	29,610
Beds Per 1000 Pop, Age 65 and Over	45.8 (US 24.3)
Total Facilities, Other	116
Total Beds, Other	1778

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	163
Agencies Per 1000 Pop, Age 65 and Over	0.25 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	0.72 (US 6.51)
Expenditures Per 1000 Pop, 1996	$959 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

WASHINGTON

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement[1] for nursing facility care, based on a facility-specific rate. The method employed the peer grouping of geographic location by MSA region. The basic reimbursement method was adopted in 1980. The 1994 calendar year cost report was the basis for state fiscal year 1997 rates. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was set at 90%.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY97.

Cost Centers

Six cost centers were used for setting reimbursement rates in Washington: 1. nursing services, limited by peer group to 125% of the median; 2. food (raw), limited to 125% of the median by peer group; 3. operations, limited to 125% of the median by peer group; 4. administrative, limited to 110% of the median by peer group; 5. property; and 6. financing (return on investment). Administration and operation (all other) was considered a general limit on operating costs.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, and non-prescription drugs were included in the rate. Ancillary cost were attributable only to Medicaid recipients.

Case-Mix Adjusters

No case-mix adjusters were used in Washington. They do have an exceptional care level that affects a few facilities or days of care, other wise a single level of care is provided. A case-mix system was set for implementation in FY99.

Capital Costs

The value of capital was determined by a historic cost or appraisal. The historic cost was used primarily followed by appraisals, and then market value. Capital-interest expenses were not paid. Renovation was an allowable cost. The straight line method and the American Hospital Association guidelines were used for depreciation. Washington employed a return on investment based on net equity. The rate of return allowed was 10% of net.

Reimbursement Rate

The FY97 average reimbursement rate for Washington was $109.03 weighted by days of care.

Other Long-Term Care

Washington had the same system for hospital-based and free-standing nursing facilities, and contracted rates for ICF-MR that averaged over one and one half times as high for private and over three-times as high for state ICF-MRs as for nursing facilities. Home health rates were set by a fee schedule with flat rates by geographic area, with RN rates nearly twice as high ($84.20) as home health aide rates ($45.30). Resdential care used prospective class methods. Adult day care used prospective facility-specific methods.

[1] Washington state defines rates as payment rather than reimbursement.

WASHINGTON

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$109.03
Percentage Rate Change From Previous Year	6.0%
Peer Groupings	Geographic Location by MSA Region
Year of Cost Report to Set Rate	1994
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	90%
Case-Mix Adjusters	None
Capital Reimbursement Determination	Historic Cost or Appraisal
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Respiratory Therapy, Non-Prescription Drug, Speech Therapy

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State	Combination
Private	Contracted Facilities Similar to Free-Standing
Facilities Average Reimbursement Rate	State Facilities $355.00; Private Facilities $182.78
Capital Reimbursement Determination (all facilities)	Historic Cost

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit/HH Aide Visit	$84.20[1] /$45.30[1]

Other Residential Care For Aged[2]

Method	Prospective Class
Reimbursement Program	Covered under State Plan and/or 1915c Waiver
Facility Type	Adult Family Home and Residential Care
Flat Reimbursement Rate By Facility Type	
Adult Family Homes	COPES Waiver-$39.59/day
State Plan Services Personal Care	$6.18/hr.(120 hr./Mo maximum)
Residential Care	COPES Waiver-$37.80/day
State Plan Medicaid Personal Care	$23.24/day +$6.00/hr. (30 hr./ Mo maximum)
Residential Care Assisted Living	COPES Waiver-$59.00/day

Adult Day Care

Method	Prospective Facility Specific
Reimbursement Program	Covered under State Plan (rehabilitation services)
Average Reimbursement Rate by Facility Type	Day Health-$41.74[3], AIDS-$56.90
Clients Covered	Aged; Physically & Developmentally Disabled; Mentally Ill; Substance Abuse; AIDS/HIV; and Pediatric

Sub-Acute Care

No Separate Program

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[1] Regional Area averages divided by ten areas.

[2] Includes combination of clients, which could not be disaggregated.

[3] State plan with transportation, $36.74 w/o transportation

WEST VIRGINIA

Nursing Homes

The number of licensed nursing homes in West Virginia grew from 113 in 1987 to 141 in 1997. Between 1987 and 1997 the number of beds increased from 9,581 to 11,282. The total bed growth rate for this period was 17.75, greater than the national rate of 15.06. With the additional beds the ratio of licensed beds per 1,000 population aged 65 and over grew to 41.2, still lower the national ratio of 53.1.

Intermediate Care for Mentally Retarded

The number of ICF/MR facilities in West Virginia increased from 46 in 1989 to 63 in 1995, and remaining so through 1997. The number of licensed ICF/MR beds has fluctuated, but overall has increased from 574 in 1989 to 601 in 1997 (with a decline of 68 beds since 1996). In West Virginia the ratio of licensed ICF/MR beds per 1,000 total population was 0.33 in 1997, below the national average of 0.48.

Residential Care for Adults/Aged

West Virginia provides licensed residential care in personal care homes and board and care facilities. In 1997, there were 60 of the former with 1,682 beds and 77 of the latter with 230 beds, a total decrease of 9 facilities and 1,211 beds since 1996. The ratio of licensed beds per 1,000 population aged 65 and over was 7.0, less than one-third the national ratio of 24.3.

Adult Day Care and Home Health Care

West Virginia started licensing adult day medical care in 1997, there were 2 facilities. In 1997 there were 83 adult day behavioral health facilities, an increase of 2 facilities since 1996. Home health care was not licensed in West Virginia in 1997, however there were 89 certified home health care agencies, an increase of 4 since 1996.

CON/Moratorium

West Virginia had a CON for nursing homes from 1980 through 1997, adding a moratorium to it in 1987 that remained in effect through 1997. In 1997 there was also a CON/moratorium on ICF/MRs, while a CON only on hospital bed conversions, home health care, and hospice. There was neither a CON nor moratorium on residential care or adult day care. There were 3 nursing home CON applications submitted in 1997, none of which were denied.

WEST VIRGINIA

Demographics

Percentage Population 65 and Over	15.1 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	141
Total Beds	11,282
Beds Per Nursing Facility	80.0 (US 102.7)
Average Occupancy Rate	94.4
Beds Per 1000 Population:	
Age 65 and Over	41.2 (US 53.1)
Age 85 and Over	376.1 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	6.32 (US 6.01)
Expenditures Per 1000 Pop, 1996	$120,419 (US $111,686)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	63
Total Beds	601
Beds Per 1000 Population	0.33 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	137
Total Beds for Adult/Aged	1,912
Beds Per 1000 Pop, Age 65 and Over	7.0 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	85
Facilities Per 1000 Pop, Age 65 and Over	0.31 (US 0.16)

Licensed Home Health Care

Total Agencies	Not Licensed
Agencies Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.27 (US 6.51)
Expenditures Per 1000 Pop, 1996	$4,496 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Home Health Care	CON Only
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

WEST VIRGINIA

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employs a peer grouping by number of beds. The basic reimbursement method was adopted in 1981. Rates were set semi-annually beginning April and October and reported on a calendar year. The preceding six month cost reports (Jan. to June and July to Dec.) were used for FY97. Inflation based on the CPI and case-mix were used to trend rates. The minimum occupancy standard was set at 95%.

Adjustments

Two rate periods are used to set rates per year.

Cost Centers

Ten cost centers were used for setting reimbursement rates in West Virginia: 1. nursing and restorative[1], 2. capital; 3. laundry & housekeeping, limited to the mean; 4. dietary, limited to the mean; 5. administration, limited to the mean; 6. medical records, limited to the mean; 7. tax & insurance, limited to the 90th percentile, 8. maintenance, limited to the 90th percentile; 9. utilities, limited to the 90th percentile; and 10. activities, limited to the 90th percentile.

Ancillary Services

Physical therapy, non-prescription drugs, medical supplies, oxygen and physician services were included in the rate within the appropriate cost center.

Case-Mix Adjusters

Case-mix was adopted 1979. West Virginia used its own patient assessment factors developed in the late 1970's and MDS+ acuity measurement. Indirect and direct nursing care was based on case-mix. Nineteen possible levels of care were provided.

Capital Costs

The value of capital was determined by appraisal and rental value. For capital-interest expenses, nursing facilities used the prevailing market rate. They have a gross fair rental system. Appraisals were conducted with no maximum appraised value. They use a "model" facility standard methodology called Standard Appraised Value (SAV). A capitalization rate was established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment. The Band of Investment approach was used to blend the fixed income capital and the equity capital which produces a rate which may be changed semi-annually to reflect current money values. The band of investment sets a 75:25 debt-services to equity ratio. The interest rate was the base FNMA current at time of original indebtedness, modified for non-profit facilities.

Reimbursement Rate

The FY97 average reimbursement rate for West Virginia was $104.04 weighted by days of care.

Other Long-Term Care

West Virginia used the same system for hospital-based and ICF-MR facilities as for free-standing nursing facilities. Home health was paid under Medicare principles, both RN and home health aide visits averaging the same ($54). Other residential care under an MR-DD waiver was prospectively set with a flat rate.

[1] Floating nursing cap and acuity levels on each home.

WEST VIRGINIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$101.04
Percentage Rate Change From Previous Year	10.9%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	Preceding Six Months Cost Reports
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	95%
Case-Mix Adjusted	Acuity Measurement
	Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Appraisal and Rental Value
Ancillary Services Included in Rate	Physical Therapy Occupational Therapy
Non-Prescription Drugs	Medical Supplies
Physician Services	Oxygen

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Prospective Facility-Specific (fee plus per diem)
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate (all facilities)	$260.35
Capital Reimbursement Determination (all facilities)	Standard Appraisal Value
Ancillary Services Included in Rate	
All Facilities	Physical Therapy Occupational Therapy
	Respiratory Therapy Non-Prescription Drug
State Facilities Only	Medical Supplies Oxygen
Private Facilities Only	Patient Transport

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$41.00-$91.77 ($54.00 average)
Average Reimbursement Rate, HH Aide Visit	$32.80-$81.00 ($54.00 average)

Other Residential Care For Aged

No Medicaid Program[1]

Adult Day Care

No Medicaid Program

Sub-Acute Care

No Separate Program

[1] MR-DD Waiver in place since 1984.

WISCONSIN

Nursing Homes

The number of nursing homes in Wisconsin fluctuated but increased slightly from 431 in 1987 to 432 in 1997. The number of beds a decreased from 51,243 in 1987 to 47,988 in 1997, a decrease of 171 beds since 1996. The total bed growth rate for the period 1987 to 1997 was –6.35 percent compared to the national average of 15.06. In 1997, as in the past, Wisconsin had a ratio of licensed beds per 1,000 population aged 65 and over greater than the national ratio (70.3 compared to 53.1).

Intermediate Care for Mentally Retarded

The number of licensed ICF/MR facilities in Wisconsin increased from 40 in 1989 to 60 in 1992 and has been steadily declining ever since, reaching a total of 41 in 1997 (a decline of 1 facility since 1996). The number of beds has been steadily declining in since 1992, was 3,532 in 1997 (a decline of 194 beds since 1996). Despite these reductions, the ratio of licensed ICF/MR beds per 1,000 total population in Wisconsin for 1997 was 0.68, greater than the national ratio of 0.48.

Residential Care for Adults/Aged

Wisconsin provides residential care in community based facilities, adult family homes and assisted living[1]. Community based care increased from 1,301 facilities and 18,655 beds in 1996 to 1,320 facilities and 20,196 beds in 1997. An increase has occurred in adult family homes with 379 facilities and 1,504 beds in 1996 compared to 463 facilities and 1,795 beds in 1997. This was a net increase of 124 facilities and 2,606 beds since 1996. In 1997 the ratio of licensed residential care beds per 1,000 population in Wisconsin was 33.3, above the national ratio of 24.3.

Adult Day Care and Home Health Care

Adult day care was not licensed in Wisconsin in 1997. There were 197 licensed home health care agencies in 1997, a decrease of 11 agencies since 1996. Wisconsin's ratio of agencies per 1,000 population 65 and over was lower than the national ratio (0.29 compared to 0.50).

CON/Moratorium

Wisconsin had a CON for nursing homes from 1980 through 1997[2]. In 1981 the state instituted a moratorium, which remained in effect through 1997. In 1997 there was also a CON/moratorium on hospital bed conversions, and ICF/MRs, while there was neither a CON nor moratorium on residential care, assisted living, home health care, hospice or adult day care. There were 38 CON applications for nursing facilities, none of which were denied.

[1] 'Assisted living' was a new residential care category in 1997, increasing the total number of residential care facilities and beds by 21 and 774 respectively.

[2] Wisconsin no longer reviews the building of new facilities for replacement beds, reviewing only beds to be added to the total.

WISCONSIN

Demographics

Percentage Population 65 and Over	13.2 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	432
Total Beds	47,988
Beds Per Nursing Facility	111.1 (US 102.7)
Average Occupancy Rate	88.8
Beds Per 1000 Population:	
Age 65 and Over	70.3 (US 53.1)
Age 85 and Over	545.3 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	8.38 (US 6.01)
Expenditures Per 1000 Pop, 1996	$141,776 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	41
Total Beds	3,532
Beds Per 1000 Population	0.68 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,804
Total Beds for Adult/Aged	22,765
Beds Per 1000 Pop, Age 65 and Over	33.3 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	197
Agencies Per 1000 Pop, Age 65 and Over	0.29 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	2.54 (US 6.51)
Expenditures Per 1000 Pop, 1996	$13,557 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

WISCONSIN

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in the early 1980's. A state fiscal year was used to set annual rates beginning July 1. The earliest cost report used for FY97 was 1994. Inflation based on a WI market basket was used to trend rates. The minimum occupancy standard was set at 91%.

Adjustments

No adjustments to the initial rates were made.

Cost Centers

Seven cost centers were used for setting reimbursement rates in Wisconsin: 1. direct care, limited to 110% of the median (regionally adjusted); 2. support services, limited to 102% of the median; 3. administration and general, limited to 102% of the median; 4. cost share and incentive payment; 5. fuel and utilities, limited to 120% of the median (regionally adjusted by heating degree days; 6. property tax; and 7. capital. A comprehensive limit on operating cost is 102% of the median.

Ancillary Services

Non-Prescription Drugs, Medical Supplies[1], and Durable Medical Equipment[1] were included in the rate.

Case-Mix Adjusters

Case-mix[2] like adjusters were used in Wisconsin. Patient characteristics were used to set rates, based on an acuity measurement. The rates for special patient characteristics were overall facility based. The direct nursing portion of the rate was adjusted. Eight levels of care were provided.

Capital Costs

The property payment (gross fair rental system) was based upon an equalized value of a facility's buildings, relating to ownership and/or rental. It was a target amount based on a service factor that includes depreciation; interest on plant asset loans; amortization of construction-related costs; lease and rental expenses; and property and mortgage insurance. Systematic reduction of debt was used for interest and principal payments. The maximum term did not exceed 40 years. Annual principal payments or deposits were made to an interest bearing, segregated account resulting in repayment of debt at loan maturity, otherwise 30 years were used to amortize. Interest income was then offset against allowed interest expense. Refinancing was allowed but limited to original loan plan. Interest was limited to same as original loan plus cost of asset acquisitions allowed in refinancing. Allowable property-related expenses were limited to 15%. Appraisal were used for Medicaid rate purposes with interest limited to 6.9% (undepreciated) and 8.9% (replacement cost). These figures were also the rental factors.

Reimbursement Rate

The FY97 average reimbursement rate for Wisconsin was $85.85, weighted by days of care.

Other Long-Term Care

Wisconsin used the same system for hospital-based as for free-standing nursing facilities, and the same system for private ICF-MRs, with rates averaging about 30% higher than for nursing facilities. For state ICF-MRs, a retrospective method was used that resulted in rates over three-times as high as in nursing facilities. Home health visits were paid based on maximum allowable fees of Medicare cost reports. Reimbursement is based on the lesser of the usual and customary charges or the Medicaid maximum allowable fee. RN visits ($78.50) for part-time, intermittent skilled nursing. Home health aide visits were ($37). Adult day care was covered under waiver, using retrospective patient-specific methodology.

[1] Limited inclusion.
[2] Wisconsin did not consider their system case-mixed.

WISCONSIN

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$85.85
Percentage Rate Change From Previous Year	7.2%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
Inflation Adjustment	WI Market Basket
Minimum Occupancy in Rate-Setting	91%
Case-Mix Adjusted	System similar to Case-mix
Capital Reimbursement Determination	Rental Value (see text)
Ancillary Services Included in Rate	Medical Supplies[1] Durable Med. Equip.[1] Non-Prescription Drugs[2]

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	
State Facilities	Retrospective Facility-Specific
Private Facilities	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	
State Facilities	$255.20
Private Facilities	$118.20
Capital Reimbursement Determination (all facilities)	Historic Cost
Ancillary Services Included in Rate	
State Facilities	Included All Ancillary Services
Private Facilities	Same as Free-Standing Nursing Facilities

Home Health

Method	Maximum allowable fees based on Medicare cost reports.
Average Reimbursement Rate, RN Visit	$78.50
Average Reimbursement Rate, HH Aide Visit	$37.00

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Retrospective Patient-Specific
Reimbursement Program	2176 Wavier
Facility Type	Social, Day Health, and Dementia/Alzheimer's
Average Reimbursement Rate Range by Clients Covered	
Aged, Physically & Mentally Disabled, AIDS/ARC	$20-38 range per diem
Developmentally Disabled	$7-15 range per diem

Sub-Acute Care

No Separate Program

[1] Limited inclusion.

[2] Added October 1993.

WYOMING

Nursing Homes

The number of nursing homes in Wyoming increased steadily from 31 in 1987 to 38 in 1996 and remaining so in 1997. The number of nursing home beds grew slowly from 2,411 in 1987 to 3,077 in 1997 (a decline of 49 beds since 1996). However, the total bed growth rate for the period 1987 to 1997 was well above the national rate (27.62 percent compared to 15.06 percent) and the 1997 ratio of beds per 1,000 population aged 65 and over remained above the national ratio (57.0 compared to 53.1).

Intermediate Care for Mentally Retarded

From 1992 to 1997, there has been one licensed ICF/MR facility in Wyoming. The number of beds in this facility has increased from 90 in 1992 to 164 in 1996 and 1997. The ratio of licensed ICF/MR beds per 1,000 population in Wyoming was 0.34 as compared to the national ratio of 0.48.

Residential Care for Adults/Aged

Wyoming provides residential care in board and care homes and assisted living facilities. In 1996 there were 30 board and care homes with 647 beds, decreasing to 25 facilities and 391 beds in 1997. There was 1 assisted living facility with 55 beds in 1996, increasing to 11 facilities and 814 beds in 1997. This represents an increase of 5 total facilities and 503 beds since 1996[1]. The ratio of licensed beds per 1,000 population aged 65 and over was less than the national ratio in 1997 (22.3 compared to 24.3).

Adult Day Care and Home Health Care

Adult day care was not licensed in Wyoming in 1997. In 1997 there were 57 licensed home health care agencies. The ratio of licensed home health care agencies per 1000 population age 65 and over was 1.06 compared to the national ratio of 0.50.

CON/Moratorium

Wyoming had a CON for nursing homes between 1980 and 1986, eliminated it in 1987, and re-instituted it (as an 'intent to construct' approval process for the construction of nursing homes) in 1990. It remained in effect through 1997[2]. In 1997 there was neither a CON nor moratorium on hospital bed conversions, ICF/MRs, residential care, assisted living, home health care, hospice or adult day care. There were no new 'intent to construct' nursing home applications submitted in 1997.

[1] There is a relationship between the decrease in board and care homes and the increase in assisted living facilities in 1997. This change represents the transfer of residents out of board and care and into assisted living.

[2] The law states that no nursing home building shall occur in a town unless other nursing facilities in that same town have a greater than 97% occupancy rate.

WYOMING

Demographics

Percentage Population 65 and Over	11.3 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.4 %)

Licensed Nursing Facilities

Total Facilities	38
Total Beds	3,077
Beds Per Nursing Facility	81.0 (US 102.7)
Average Occupancy Rate	81.2
Beds Per 1000 Population:	
Age 65 and Over	57.0 (US 53.1)
Age 85 and Over	512.8 (US 468.1)
Medicaid:	
Recipients Per 1000 Pop, 1996	5.29 (US 6.01)
Expenditures Per 1000 Pop, 1996	$96,835 (US $111,686)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care for The Mentally Retarded

Total Facilities	1
Total Beds	164
Beds Per 1000 Population	0.34 (US 0.48)

Other Licensed Residential Care

Total Facilities for Adult/Aged	36
Total Beds for Adult/Aged	1,205
Beds Per 1000 Pop, Age 65 and Over	22.3 (US 24.3)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	Not Licensed
Facilities Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.16)

Licensed Home Health Care

Total Agencies	57
Agencies Per 1000 Pop, Age 65 and Over	1.06 (US 0.50)
Medicaid:	
Recipients Per 1000 Pop, 1996	9.45 (US 6.51)
Expenditures Per 1000 Pop, 1996	$77,135 (US $40,969)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	No CON or Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

WYOMING

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective method was used for setting Medicaid reimbursement for nursing facility care, based on a facility-specific rate. The method employed no peer groupings. The basic reimbursement method was adopted in 1989. A facility fiscal year was used to set annual rates, most coinciding with the state fiscal year beginning July 1. The 1996 cost report or the most recent settled cost report was used. Inflation based on the SNF Market Basket was used to trend rates. The minimum occupancy standard, set at 90%, was used for capital only.

Adjustments

For per diem rates, with rate effective dates on or after July 1, 1997, 90% of the cost associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs, shall be non-allowable costs and 100% of Medicare bed days shall be removed.

Cost Centers

Three cost centers were used: 1. health care, limited to 125% of the median; 2. operating, limited to 105% of the median; and 3. capital cost.

Ancillary Services

Physical therapy, occupational therapy, respiratory therapy, non-prescription drugs, medical supplies, durable medical equipment, patient transportation, and oxygen were included in the rate. They were in the health care component.

Case-Mix Adjusters

No case-mix adjusters were used in Wyoming. One level of care was provided.

Capital Costs

The value of capital was determined by historic cost. For capital-interest expenses, nursing facilities used the actual interest expense. Refinancing, renovation and rental costs and leases were allowable costs. A cap was placed on allowable interest rates. The straight-line method and useful life determination were used for depreciation.

Reimbursement Rate

The FY97 average reimbursement rate for Wyoming was $92.41, weighted by days of care.

Other Long-Term Care

Wyoming used the same system for hospital-based and free-standing nursing facilities and the same approach for ICF-MR, which had average rates three-times nursing facility rates. Home health used a fee schedule with flat rates 70% higher for RN visits ($60) than for home health aide visits ($35). Adult day care was reimbursed under waiver using a prospective class method.

WYOMING

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted	
Average Reimbursement Rate	$92.41	
Percentage Rate Change From Previous Year	7.5%	
Peer Groupings	None	
Year of Cost Report to Set Rate	1996 or Most Recent	
Inflation Adjustment	SNF Market Basket, DRI (McGraw-Hill)	
Minimum Occupancy in Rate-Setting	90%	
Case-Mix Adjusted	None	
Capital Reimbursement Determination	Historic Cost	
Ancillary Services Included in Rate	Physical Therapy	Occupational Therapy
	Respiratory Therapy	Medical Supplies
	Non-Prescription Drug	Oxygen
	Durable Med. Equip.	Patient Transport

Hospital-Based Nursing Facilities

Method Same as Free-Standing Nursing Facilities

IFC-MR

Method Same as Free-Standing Nursing Facilities		
Average Reimbursement Rate	$368.93[1]	
Ancillary Services Included in Rate	Physical Therapy	Occupational Therapy
Respiratory Therapy	Medical Supplies	
Non-Prescription Drug	Patient Transport	
	Oxygen	

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$60.00
Average Reimbursement Rate, HH Aide Visit	$35.00

Other Residential Care for Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	2176 Waiver
Reimbursement Flat Rate	$5 per hour (up to 8 hours per day)
Facility Type	ADDC Centers
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill, AIDS/HIV

Sub-Acute Care

No Separate Program

[1] A single facility.