1998 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 1998 were collected from a survey of state officials in 1999. 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 1998 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 1998. 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 six types of long term care services: (1) nursing facilities (NF); (2) intermediate care facilities for the mentally retarded (ICF-MR); (3) residential care (or board and care); (4) adult day care; (5) home health agencies; and (6) hospice.

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 facility beds and the predictors of reimbursement rates. The following is a summary of the most important findings from the 1998 descriptive data and from trends over the 1978-1998 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 1998, there were 34.4 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 facility services increase. 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 1998. The percentage aged 85 and over increased from 1.0 percent of the total U.S. population in 1978 to 1.5 in

1998. States show a wide range of ratios of aged population. Alaska has the lowest ratio of aged (5.5 percent aged 65 and over in 1998) while Florida had 18.3 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 FACILITY PROVIDERS

The number of nursing facilities in the nation increased from 14,264 in 1978 to 17,458 in 1998. This represents a 22 percent increase in the 20-year period of 1978-1998 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 1998, a 38 percent increase during the 20 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 103.5 beds in 1998 (a 13 percent increase).

There were 53.4 beds per 1,000 population aged 65 and over in the U.S. in 1978 compared with 52.5 in 1998. The average number of beds per 1,000 population aged 85 and over declined from 610.3 to 445.6 between 1978 and 1998 (a 27 percent decline). Between 1997 and 1998, 33 states showed declines in the ratio of nursing facility beds per 1,000 population aged 65 and over.

Data on nursing facility occupancy rates across states are increasingly difficult to obtain from the state agencies. In 1978, the average nursing facility 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 88.3 percent in 1998 (22 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 78.0 percent in Oregon to a high of 95.0 percent in New York in 1998.

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 1998, 6,553 licensed ICF-MR facilities were identified in the states. This was a decrease of 19 facilities since 1997. The largest number was reported in California (989 facilities). New York and Texas also had large numbers of

facilities relative to those reported by other states.

There were 125,909 licensed ICF-MR beds in the states in 1998. This was a decrease of 2.1 percent over the total beds in 1997. Texas had the largest number of beds, but its beds declined by 0.6 percent since 1997.

The average number of beds per facility was 19.2 beds in 1998. Although there was a slight decrease in the U.S. average number of beds per facility in 1998, the average varied considerably across the states. As with nursing facilities, 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 1.64. 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 96.4 percent in 1998.

Other Residential Care

Residential care is reported in two separate categories: facilities for adults/aged, and facilities for the non-aged, which includes individuals with MR/DD, mental illness, substance abuse and AIDS.

There were 51,227 licensed residential care facilities reported for adults/aged in 1998 (a 2.6 percent increase since 1997 and a 45.7 percent increase over the 35,171 facilities serving the elderly in 1990). The state with the largest number of facilities was California (10,652) and the state with the smallest number of facilities was Wyoming (35).

The total number of licensed residential care beds for adults/aged in the U.S. was 878,804 in 1998 (a 6.0 percent increase since 1997 and a 70.7 percent increase over the 514,749 beds serving the elderly reported in 1990). In 1998 California reported 169,184 beds, over twice as many as Pennsylvania and Florida, 4 times as many as New York, and nearly 6 times as many as Texas. The average number of licensed residential care beds per facility was 17.2 beds in 1998.

The ratio of licensed residential care beds serving adults was 25.5 residential care beds per 1000 population age 65 and over in 1998. These ratios also varied widely across states, from 51.8 beds per population in Oregon to 3.7 beds per 1,000 in Louisiana. The data also show that the ratio of licensed residential care beds per aged population has increased over the 1990-1998 period.

In 1998, there were 13,277 ‘residential care non-aged’ facilities in the U.S., an increase of 10.7 percent since 1997. The number of ‘residential care non-aged’ beds was 102,068 in 1998, an increase of 3.9 percent since 1997.

The increases in residential care for both aged and non-aged populations are, 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.

Home Health Care Agencies

There were a total of 13,537 licensed home health care agencies in the U.S. in 1998. The number increased by 326 percent over the 3,175 in 1989. Since many states were unable to report on the number of agencies licensed in earlier years, the large increase in agencies may in part be an artifact. Texas, Florida, California, and New York reported large numbers of agencies in 1998. The average ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.47 in 1998. Texas had the largest ratios of agencies per aged population (1.81), Pennsylvania had the smallest (0.05).
For the first time, a drop in licensed home health care agencies occurred between the years 1997 and 1998. In 1997 there were 14,062 licensed home health care agencies and in 1998 there were 13,537, a decrease in 3.7 percent. This drop appears to be related to changes in Medicare certification under the Balanced Budget Act of 1997.

Ten states did not license agencies but rather used 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 9,726 agencies in 1998. This was a 235 percent increase in certified agencies over the 1989-1998 period. The number of certified home health care agencies declined 7.3 percent since 1997.

Adult Day Care Centers

Twenty-seven states reported 3,590 licensed adult day care centers in 1998 in the U.S. Pennsylvania and California reported the largest numbers of day care centers in 1998 (627 and 619, 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 1998. Louisiana had the highest ratio of day care centers per population (0.56).

Hospice

In 1998, 43 states reported 1,992 licensed hospice organizations. Texas and Michigan had the most organizations in 1998, with 151 and 120 respectively. Colorado and South Dakota had the fewest licensed hospices, with 2 each. The 1,992 licensed hospices reported in 1998 represented an increase of 2.2 percent since 1997. There were 0.07 licensed hospice organizations per 1000 population aged 65 and over in the U.S in 1998. Wyoming had the highest ratio of hospices (0.25) while California, Florida and Iowa, with 0.01 organizations per 1000 population each had the lowest.

The number of certified hospices increased from 2,254 in 1997 to 2,344 in 1998. This was an increase of 4.0 percent since 1997. In 1998, there were 8 states that

did not license hospice organizations, but used certification instead. Louisiana was the only state that licensed but could not report the number of certified hospices in 1998.

In summary, while the total number of nursing facilities, ICF/MR and home health care agencies have decreased since 1997, the total number of residential care, adult day care and hospice programs have continued to increase in the recent time period. The alternatives to nursing home care have been increasing and may reduce the demand for nursing home care over time. The wide variations in the supply of different LTC providers 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 wide 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 state, Arizona, had no CON. Between 1997 and 1998, 44 states (including the District of Columbia) continued their CON programs and/or moratorium for nursing facilities.

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 1998, 13 states had both a CON and moratorium, 6 states had only a nursing facility 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 1998, 44 states regulated the growth of new nursing facility beds and/or facilities through either a CON and/or a moratorium. Of the total states, 38 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 facilities 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 (35 states in 1998). Of these states, 14 had both a CON and moratorium and 4 had a moratorium only on ICF-MR beds and facilities. Surprisingly, 18 states included residential care facilities under their CON and/or moratorium requirements in 1998, an increase of 8 states since 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 7 states dropped CON during the 1978-1992 period). In 1998, 18 states used a CON alone for home health and 1 state had both a CON and moratorium.

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 facilities and ICF-MR. A number of states also used CON and/moratorium for other long-term care programs.

MEDICAID REIMBURSEMENT RATES

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

NURSING FACILITY REIMBURSEMENT

Reimbursement Methods

Primary data were collected on state Medicaid nursing home reimbursement rates and methods for the 1978-1998 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.

None of the states changed their general nursing home reimbursement methods between 1997 and 1998. The number of states using retrospective reimbursement methods declined from 13 in 1979 to only 1 state (Nebraska) in 1996, and remained so through 1998. The number of states using prospective facility-specific methods was 20 in 1998. The states using prospective class methods (4 in 1978 and 3 in 1998) remained relatively stable over the period. Twenty-four states used prospective adjusted methods in 1998 compared with

only 13 in 1979. Combination methods were used in 3 states in 1979 and in 3 states again in 1998. 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 1998, 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 1997 and 1998. 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 1998, 32 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 1998 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 1998, 33 states used cost reports from 1996, 1997 or 1998 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 1984 (35 states) and 1989 (30 states). By 1998, 26 states used historic costs methods, while 6 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 facilities. 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 diem rate across the states was $30.36. This increased to $45.06 in 1985 and by 1992, it was $73.98. In 1998, the average reimbursement increased to $95.72 from $91.45 in 1997. When inflation was taken into account, the rates increased from $36.84 in 1980 to $58.72 in 1998. Thus, the average inflation adjusted rate increase for the 19-year period was 59 percent, an average of 3.1 percent annually. The inflation-adjusted rates increased 2.7 percent between 1997 and 1998.

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 1998, 18 states used prospective facility specific methods, 13 used retrospective reimbursement, 12 used adjustable upward rates, 3 states used prospective class reimbursement, and 5 used combination methods. The Medicaid reimbursement rates varied from $80.79 per day in Oklahoma to $517.07 per day in Oregon in 1998. The average Medicaid reimbursement rate was $222.29 per day in 1998 (all states including the District of Columbia reported).

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 1998 (including Washington DC). Another 9 states used Medicare principles with state alterations. Nineteen states used a fee schedule for payment to home health agencies. One state used Medicaid 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 $71.26 per visit in 1998 for those 43 states reporting rates. Rates ranged for registered nursing care from $ 26.92 in Indiana to $164.96 in Alaska.

Residential Care

Seventeen 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.

Sub-acute Care

Fifteen states have Medicaid reimbursement rates for sub-acute 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 facility 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 facilities 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 facility.
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 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.

Hospice	Services for the terminally ill provided in the home, a hospital, or long-term care facility. Includes home health services, volunteer support, grief counseling, and pain management.
Hospital-Based Facility:	A nursing 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 facility 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 facility divided by all resident days in the nursing facility, 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.
Sub-acute Care:	Nursing facility 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 facility beds. Hospital sub-acute 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 Facilities

The number of nursing facilities in Alabama decreased slightly since 1997 (231 in 1998 compared to 233). The number of beds also has shown a decrease, from 25,754 in 1997 to 25,713 in 1998. From 1997 to 1998 Alabama experienced a total bed growth rate of -0.16 percent compared to the U.S. average of -0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over was 45.3 in 1998, lower than the U.S. ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

In 1996, the number of ICF/MR facilities in Alabama decreased for the first time since 1989 from 8 to 7 facilities. The number of facilities remained constant through 1998. The number of beds has been steadily decreasing from 1,350 in 1989 to 869 in 1998 (a decrease in 10 beds since 1997). This decrease in both facilities and beds is largely due to a court order to move residents out of ICF/MRs. The ratio of licensed ICF/MR beds per 1000 population in Alabama was 0.20 as compared to the national ratio of 0.47.

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 282 facilities with 7,014 beds in 1998. 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 (12.3 in 1998 compared to 25.5 U.S. average).[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Alabama in 1998. 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 1998. Certified home care agencies grew steadily from 118 in 1989 to 182 in 1996. Since 1996, certified home health agencies decreased by 1 every year, for a total of 180 agencies in 1998.

Hospice

Alabama had 66 licensed hospice organizations in 1998, an increase of 2 since 1997. The ratio of licensed hospice organizations per 1000 population aged 65 and over was 0.12 compared to the US average of 0.07.

CON/Moratorium

Alabama had a CON for nursing facilities from 1979 through 1998, adding a moratorium to it from 1984 through 1989 and then again in 1994 and 1995. Only the CON remained in effect in 1998. A CON was required in 1998 for hospital bed conversion, sub-acute beds, ICF/MRs,[2] home health care and hospices. In 1998 residential care, assisted living and adult day care had neither a CON nor moratorium.

[1] 'Other Residential Care' in Alabama includes therapeutic group homes, residential care homes, residential care/special services, crisis residential programs, adult foster homes, semi-independent living, supported housing, and seriously mentally ill adult residential beds with 516 facilities and 2,488 beds in 1998.

[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	13.1 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	231
Total Beds	25,713
Beds Per Nursing Facility	111.3 (US 103.5)
Average Occupancy Rate	93.1
Beds Per 1000 Population:	
Age 65 and Over	45.3 (US 52.5)
Age 85 and Over	401.8 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.39 (US 6.00)
Expenditures Per 1000 Pop, 1997	$119,580 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care for Mentally Retarded

Total Facilities	7
Total Beds	869
Beds Per 1000 Population	0.20 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	282
Total Beds for Adult/Aged	7,014
Beds Per 1000 Pop, Age 65 and Over	12.4 (US 25.5)
Total Facilities, Other	516
Total Beds, Other	2488

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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	10.86 (US 6.95)
Expenditures Per 1000 Pop, 1997	$29,548 (US $45,711)

Licensed Hospices

Total Organizations	66
Organizations Per 1000 Pop, Age 65 and Over	0.12 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice Care	CON Only

* 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, 1997 was used to calculate an interim FY98 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 FY98 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 FY98.

Cost Centers

Alabama uses four cost centers: 1. operating, ceiling 105% of the median; 2. direct care, ceiling 110% 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 3.0 percent. Gross rental factor was 2.5%.

Reimbursement Rate

The FY98 average reimbursement rate for Alabama was $98.69.

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 $240.91.[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 I998. Alabama Medicaid reimbursed under waiver for other residential care for the aged and for adult day care. Rates were based on a prospective method, with per hour rates of $34.07 for Case Management, $9.57 for Personal Care, $17.27/$9.15 for Respite-Skilled/Unskilled and $10.46 for Home Maker Services, for other residential care for the aged. The average reimbursement rate-day health was $13.87 per day for Adult day care.

[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	$98.69
Percentage Rate Change From Previous Year	4.2%
Peer Groupings	Number of Beds and Ceilings
Year of Cost Report to Set Rate	1997[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	$241.48
Capital Reimbursement Determination	Use Allowance[4]
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	$34.07 per hour
Personal Care	$9.57 per hour
Respite-Skilled/Unskilled	$17.27 per hour/$9.15 per hour
Home Maker	$10.46 per hour

Adult Day Care[3]

Method	Prospective Flat Rate[2]
Reimbursement Program	1915c Waiver
Average Reimbursement Rate-Day Health	$13.87 per day
Facility Type	Day Health
Clients Covered	Aged & Disabled

Sub-Acute Care

No Separate Program

[1] Year ending June 30, 1997.
[2] October 1997 through September 1998
[3] Waiver for Elderly and Disabled
[4] 2% of the acquisition cost of buildings, improvements, and depreciation on the remaining fixed assets.

ALASKA

Nursing Facilities

Nursing facilities in Alaska decreased from 22 in 1994 to 15 in 1998[1]. The number of nursing facility beds dropped from 1,033 in 1994 to 719 in 1998. Since 1995 Alaska has had the fewest nursing facilities and beds in the country. The District of Columbia is ranked second with 21 facilities and 3,055 beds. Although the proportion of Alaska's total population aged 65 and over increased from 4.0 in 1990 to 5.5 in 1998, it was still well below the U.S. 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 1998 (21.1 compared to 52.5).

Intermediate Care Facilities 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, all categories of residential care for the aged were condensed down to one category, 'assisted living.' There were 90 assisted living facilities in 1998 with a total of 1,150 beds. The number of residential care beds per 1000 population aged 65 and over jumped from 13.8 in 1995 to 33.8 in 1998. This rate is higher than the U.S. average of 25.5.[2]

Adult Day Care and Home Health Care

Although adult day care was not licensed in Alaska in 1998, state owned agencies are required to meet standards set by the Older Alaskan Commission. Alaska had 23 licensed home health care agencies in 1998. This represents a decrease of 3 agencies since 1997. Alaska's ratio of home health agencies per 1000 population aged 65 and over (0.68 in 1998) was greater than the national ratio of 0.47.

Hospice

Hospice organizations were not licensed in Alaska in 1998, however, there were 3 certified organizations (no change since 1997).

CON/Moratorium

Alaska had a CON for nursing facilities from 1979 through 1998 with a moratorium added in 1996. [3]ICFMRs[4] were subject to both CON and moratorium in 1998. CON reviews were required for hospital bed conversion, and home health care[5] in 1998. There was neither a CON nor moratorium on residential care, assisted living, hospice or adult day care.

[1] Six of these lost facilities were 'Pioneer Homes' which transferred from nursing facility licensure to 'assisted living.'
[2] 'Other Residential Care' in Alaska includes 135 assisted lLiving facilities with 533 beds.

[3] The moratorium that had been in effect since 1996 for nursing facilities expired in June 1998.
[4] All ICF-MRs were decertified in 1997, the moratorium ended May, 1998.
[5] Home Health Agencies rarely surpass the $1 million threshold to trigger a CON review.

ALASKA

Demographics

Percentage Population 65 and Over	5.5 % (US 12.7 %)
Percentage Population 85 and Over	0.4 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	15
Total Beds	719
Beds Per Nursing Facility	47.9 (US 103.5)
Average Occupancy Rate	84.8
Beds Per 1000 Population:	
Age 65 and Over	21.1 (US 52.5)
Age 85 and Over	359.5 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	1.48 (US 6.00)
Expenditures Per 1000 Pop, 1997	$73,212 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	0
Total Beds	0
Beds Per 1000 Population	0.00 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	90
Total Beds for Adult/Aged	1150
Beds Per 1000 Pop, Age 65 and Over	33.8 (US 25.5)
Total Facilities, Other	135
Total Beds, Other	533

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	23
Agencies Per 1000 Pop, Age 65 and Over	0.68 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.86 (US 6.95)
Expenditures Per 1000 Pop, 1997	$49,830 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice 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 1995 cost report was used to determine rates for the routine portion of FY98 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 FY98.

Adjustments

No significant adjustment was made other than the annual rate setting adjustment of the rate for FY98.

Cost Centers

Three inclusive cost centers were used for reimbursement in Alaska: routine, ancillary, and capital. No limits were applied for FY98.

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 FY98. 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 FY98 average reimbursement rate for Alaska was $253.48, 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. The average reimbursement rate was $560.82. 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	$253.48
Percentage Rate Change From Previous Year	6.74%
Peer Groupings	None
Year of Cost Report to Set Rate	1995
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

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$560.82

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 Facilities

There were 167 nursing facilities in Arizona in 1997 and remained so in 1998. The number of beds increased from 17,579 in 1997 to 18,245 in 1998. In Arizona there was a total bed growth rate of 3.79 percent since 1997, compared to the national average of –0.12 percent. However, despite this growth, the 1998 ratio of beds per 1000 population aged 65 and over remained low at 29.5 compared to the U.S. average of 52.5.

Intermediate Care Facilities for Mentally Retarded

From 1992 through 1996, the number of ICF/MR facilities in Arizona remained constant, maintaining 12 facilities. The number of beds fluctuated within a small range during this same time period, with 271 beds in 1992 and decreasing to 268 beds in 1996. In 1997, facilities decreased to 11 and beds decreased to 223, remaining so in 1998. The ratio of ICF/MR facilities per 1000 total population is lower than the national average (0.05 compared to the U.S. average of 0.47).

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 1,122 in 1997 to 1,193 in 1998. The total number of beds increased from 17,507 in 1997 to 20,148 in 1998. These totals reflect two new categories of care 'assisted living home' and 'assisted living centers', the former having 10 or fewer beds and the latter with more than 10 beds per facility. The ratio of licensed beds per 1000 population aged 65 and over was higher than the national average in 1998 (32.6 compared to the U.S. average of 25.5).

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 1997, and increasing to 28 in 1998. In 1997 there were 126 licensed home health care agencies, a decrease of 20 since 1997. Arizona's ratio of home health care agencies per 1000 population aged 65 and over remains half the national average (0.20 as compared to the U.S. average of 0.47).

Hospice

The number of hospice organizations decreased from 64 in 1997 to 60 in 1998. The ratio of licensed hospice organizations per 1000 population aged 65 and over was 0.10 in 1998, higher than the US ratio of 0.07.

CON/Moratorium

Arizona had a CON for nursing facilities between 1979 and 1981, eliminated it in 1982 and had neither a CON nor moratorium through 1998. In 1998 there was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, residential care, assisted living, 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] In addition to the licensed categories of residential care there were 35 certified but unlicensed 'Adult Foster Care Homes'. These 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 1.5 %)

Licensed Nursing Facilities

Total Facilities	167
Total Beds	18,245
Beds Per Nursing Facility	109.3 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	29.5 (US 52.5)
Age 85 and Over	289.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.89 (US 6.00)
Expenditures Per 1000 Pop, 1997	$3,624 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	11
Total Beds	223
Beds Per 1000 Population	0.05 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,193
Total Beds for Adult/Aged	20,148
Beds Per 1000 Pop, Age 65 and Over	32.6 (US 25.5)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	28
Facilities Per 1000 Pop, Age 65 and Over	0.05 (US 0.16)

Licensed Home Health Care

Total Agencies	126
Agencies Per 1000 Pop, Age 65 and Over	0.2 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.11 (US 6.95)
Expenditures Per 1000 Pop, 1997	$221 (US $45,711)

Licensed Hospices

Total Organizations	60
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 locations (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 1997 cost report was used to set FY98 rates. 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 FY98 weighted average reimbursement rate for Arizona was $93.92.

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 ($65.01) for a RN visit as for a home health aide visit ($26.01). Arizona Medicaid reimbursed under waiver for adult day care using a Capped Fee Schedule 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 Facilities

The number of nursing facilities in Arkansas has fluctuated mildly over the past 20 years. There was an overall increase from 211 facilities in 1980 to 235 in 1998. The number of beds has increased overall, from 22,533 in 1990 to 25,083 beds in 1998. The 1998 numbers represent a decrease in 6 facilities and 290 beds since 1997. Arkansas' 1998 bed growth rate was –1.14 percent compared to the national average of -0.12 percent. The ratio of nursing facility beds per 1000 population aged 65 and over was 69.1 in 1998, greater than the U.S. ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

In 1998, 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 1000 total population, 0.71 in 1998 remained higher than the U.S. national average of 0.47.

Residential Care for Adults/Aged

The number of residential care facilities in Arkansas increased from 130 in 1997 to 132 in 1998. The number of beds increased from 4,506 in 1997 to 4,967 in 1998. The ratio of licensed residential care beds per 1000 population aged 65 and over was 13.7 in 1997, compared to the national ratio (25.5).[1]

Adult Day Care and Home Health Care

Arkansas had 36 licensed adult day care facilities and 8 licensed adult day health care facilities in 1998. This is a total increase of 2 facilities since 1997 and a tripling of the facilities 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 U.S. average). The number of licensed home health care agencies was 251 in 1998 (a decrease of 6 facilities since 1997). Arkansas ratio of home health care agencies per 1000 population 65 and over is higher than the national average (0.69 compared to 0.47 U.S. average).

Hospice

There were 60 hospice agencies in Arkansas in 1998, an increase of 2 facilities since 1997. Arkansas had 0.17 hospice agencies per 1000 population aged 65 and over while the US average was 0.07.

CON/Moratorium

Arkansas had a CON (called a 'permit of approval') for nursing facilities from 1979 through 1998. In 1987 and 1988, and again in 1992 and 1993, a moratorium was added to the CON. In 1998 a CON was also required for residential care, assisted living and home health care. ICF/MRs and hospice were subject to both a CON and moratorium in 1998, while hospital bed conversion and adult day care had neither a CON nor moratorium. In 1998, there were 26 CON applications from nursing facilities, none of these were denied.

[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	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	235
Total Beds	25,083
Beds Per Nursing Facility	106.7 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	69.1 (US 52.5)
Age 85 and Over	570.1 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.56 (US 6.00)
Expenditures Per 1000 Pop, 1997	$120,097 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	40
Total Beds	1,802
Beds Per 1000 Population	0.71 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	132
Total Beds for Adult/Aged	4,967
Beds Per 1000 Pop, Age 65 and Over	13.7 (US 25.5)
Total Facilities, Other	1
Total Beds, Other	60

Licensed Adult Day Care

Total Facilities	44
Facilities Per 1000 Pop, Age 65 and Over	0.12 (US 0.16)

Licensed Home Health Care

Total Agencies	251
Agencies Per 1000 Pop, Age 65 and Over	0.69 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	9.35 (US 6.95)
Expenditures Per 1000 Pop, 1997	$28,989 (US $45,711)

Licensed Hospices

Total Organizations	60
Organizations Per 1000 Pop, Age 65 and Over	0.17 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	No CON or Moratorium
Residential Care	CON Only
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice Care	CON & 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 the 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. The 1979 cost reports were used for FY98. Inflation is 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 FY98.

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 determined 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 FY98 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 with average reimbursement rates of $181.87 for State Facilities and $184.52 for the Private Facilities. Home health services were reimbursed using a fee schedule with a flat rate. RN visits were paid over twice as much ($70.87) as were home health aide visits ($27.74). 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	0%
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 Facilities

The number of nursing facilities in California decreased from 1,464 in 1996 to 1,443 in 1997, and increased to 1,456 in 1998. The number of beds increased from 130,051 beds in 1997 to 131,941 in 1998 after experiencing a decline of 3,076 beds in 1997. In 1998 California had a growth rate of 1.45 percent compared to the national rate of –0.12 percent. California's ratio of licensed beds per 1000 population aged 65 and over (36.5 in 1998), is considerably less than the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in California, including the large ICF/DDs, the smaller ICF/DDHs and ICF/DDNs, have increased steadily since 1989, from 386 to 989 in 1998 (an increase of 36 facilities since 1997). After years of increasing, the number of beds reached 11,352 in 1994 then decreased to 7,400 in 1997. ICF/MR beds increased to 7,438 in 1998.

Residential Care for Adults/Aged

California has two 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 10,539 in 1997and to 10,652 in 1998. California had 169,184 residential care beds in 1998, an increase of 6,695 beds since 1997 and the most residential care beds in the country. The ratio of licensed residential care beds per 1000 population aged 65 and over was 46.8 in 1998, compared to the national ratio of 25.5[1]

Adult Day Care and Home Health Care

California licenses adult day care and adult day support. In 1998, California had a total of 619 facilities, the second highest number of facilities in the country. Home health care agencies increased from 1,058 in 1997 to 1,101 in 1998. The ratio of licensed home health care agencies per 1000 population aged 65 and over, however remains lower than the national average (0.3 compared to 0.47).

Hospice

California had an estimated 36 licensed hospice agencies in 1998, no change since 1997. The number of certified facilities increased from 154 in 1997 to 189 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.01 in 1998 compared to the US ratio of 0.07.

CON/Moratorium

California had a CON for nursing facilities from 1979 to 1986, eliminated it in 1987 and had neither a CON nor a moratorium through 1998. In 1998 there was neither a CON nor a moratorium on hospital bed conversion, ICF/MRs, residential care, assisted living, 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	1.3 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	1,456
Total Beds	131,941
Beds Per Nursing Facility	90.6 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	36.5 (US 52.5)
Age 85 and Over	320.2 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.74 (US 6.00)
Expenditures Per 1000 Pop, 1997	$65,127 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	989
Total Beds	7,438
Beds Per 1000 Population	0.23 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	10,652
Total Beds for Adult/Aged	169,184
Beds Per 1000 Pop, Age 65 and Over	46.8 (US 25.5)
Total Facilities, Other	102
Total Beds, Other	1,264

Licensed Adult Day Care

Total Facilities	619
Facilities Per 1000 Pop, Age 65 and Over	0.17 (US 0.16)

Licensed Home Health Care

Total Agencies	1,101
Agencies Per 1000 Pop, Age 65 and Over	0.3 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.48 (US 6.95)
Expenditures Per 1000 Pop, 1997	$39,886 (US $45,711)

Licensed Hospices

Total Organizations	36
Organizations Per 1000 Pop, Age 65 and Over	0.01 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1995. 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 98.

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 FY98 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 FY98 reimbursement rate for California was $83.12, 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 $93.11 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. The average reimbursement rate was $55.18/day. The clients covered were Aged, Physically Disabled, Mentally Ill, AIDS/HIV, Developmentally Disabled. Sub-acute care was paid a facility-specific rate up to the class median. Pediatric sub-acute was paid using a model with average rates of $440.17 for Ventilator-Bay Area, $415.51 for Ventilator-Others, $395.92 for Non-Ventilator-Bay Area and $371.26 for Non-Ventilator-Others.

CALIFORNIA

Free-Standing Nursing Facilities

Method	Prospective Class
Average Reimbursement Rate	$83.12
Percentage Rate Change From Previous Year	1.94%
Peer Groupings	Geographic Location and Number of Beds
Year of Cost Report to Set Rate	FY ending July 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 Drugs Medical Supplies Oxygen

Hospital-Based Nursing Facilities

Method	Prospective
Average Reimbursement Rate	$190.38

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	$93.11
Capital Reimbursement Determination (all facilities)	Same as Free-Standing Nursing Facilities
Ancillary Services Included in Rate (all facilities)	Same as Free-Standing Nursing Facilities

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	$267.84
Non-Ventilator	$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 Facilities

The number of nursing facilities in Colorado has grown slowly, increasing from 229 in 1996 to 234 in 1998 (an increase of 1 facility since 1997). The number of beds increased from 20,293 in 1996 to 20,720 in 1998 (an increase of 220 beds since 1997). The growth rate in 1998 was 1.07 percent compared to the national rate of -0.12 percent. The state's ratio of licensed nursing facility beds per 1000 population age 65 and over, has remained close to the national ratio (51.5 compared to the U.S ratio of 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities and beds have been steadily decreasing in Colorado as facilities downsize. The number of facilities decreased from 9 in 1989 to 3 in 1998. The number of beds decreased from 1,187 in 1989 to 186 in 1998. In 1998 there was a decrease in 1 facility and 98 beds (a change of –66.7 percent in facilities and –84.3 percent in beds since 1997). Colorado had a ratio of ICF/MR beds per 1000 total population of 0.05, lower that the U.S. average of 0.47.

Residential Care for Adults/Aged

Residential care in Colorado is provided in personal care boarding homes and alternate care facilities.[1] In 1998 there were 456 total facilities with 10,880 beds. This represents an increase of 91 facilities and 3,108 beds since 1997. This increase raised Colorado's ratio of licensed residential care beds per 1000 population aged 65 and over to 27.1, higher for the first time in 10 years than the national ratio (25.5).[2]

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Colorado in 1998. The number of certified home health agencies decreased from 207 in 1997 to 163 in 1998.

Hospice

Colorado had 6 licensed hospice agencies in 1997, decreasing to 2 in 1998. The number of certified hospice agencies increased from 29 in 1997 to 40 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was negligible (less than 0.01) compared to the US average of 0.07.

CON/Moratorium

Colorado had a CON for nursing facilities from 1979 to 1983 but eliminated it in 1984. In 1990 the state instituted a nursing facility moratorium, which remained in effect through 1998[3]. Beginning in1996 and continuing through 1998 there was also a moratorium on hospital bed conversion. ICF/MRs were subject to a moratorium as they are being phased out in California. There was neither a CON nor moratorium on residential care, assisted living, home health care, hospice or adult day care in 1998.

[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	1.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	234
Total Beds	20,720
Beds Per Nursing Facility	88.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	51.5 (US 52.5)
Age 85 and Over	450.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.15 (US 6.00)
Expenditures Per 1000 Pop, 1997	$70,641 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	3
Total Beds	186
Beds Per 1000 Population	0.05 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	456
Total Beds for Adult/Aged	10,880
Beds Per 1000 Pop, Age 65 and Over	27.1 (US 25.5)
Total Facilities, Other	280
Total Beds, Other	1,903

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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.57 (US 6.95)
Expenditures Per 1000 Pop, 1997	$57,351 (US $45,711)

Licensed Hospices

Total Organizations	2
Organizations Per 1000 Pop, Age 65 and Over	0 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98.

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

In July 2000 Colorado will begin using the RUGs III 5.12b Medicaid 34 group system to adjust payment to facilities on a facility wide per diem average basis. The RAI is the MDS 1/30/98. No section S is used.

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 $39818.00. 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 FY98 average reimbursement rate for Colorado was $101.55 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 Private facilities with average reimbursement rate of $165.88 and a retrospective facility-specific method for ICF-MR State facilities with average reimbursement rate of $288.92. 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 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	$101.55
Percentage Rate Change From Previous Year	12.44%
Peer Groupings	None
Year of Cost Report to Set Rate	1997
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	$288.92
Private Facilities	$165.88
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 Facilities

Nursing facility care in Connecticut is provided through chronic/convalescent nursing homes and rest homes. In 1998 there were 321 licensed nursing facilities with 31,948 beds, a decrease of 4 facilities and 64 beds since 1997. In 1998 the growth rate of nursing facility beds was –0.20 percent compared to the national average of –0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over was 68.1 in 1998, greater than the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MRs facilities increased from 117 in 1997 to 123 in 1998. Beds increased from 1,198 in 1997 to 1,308 in 1998. Between the years 1997 and 1998, Connecticut had the highest positive percent change in ICF/MR beds of all the states with 9.2, the U.S. average was –2.1 percent. The ratio of ICF/MR beds per 1000 total population was 0.40 in 1998, compared to the national ratio of 0.47.

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 from 128 in 1989 to 113 in 1997. The number of beds also decreased from 3,248 in 1989 to 3,077 in 1997. In 1998 a small increase to 114 facilities and a decrease to 3,067 beds occurred.[1] The ratio of licensed beds per 1000 population aged 65 and over, continued to be substantially lower than the U.S. ratio in 1998 (6.5 compared to 25.5).

Adult Day Care and Home Health Care

Adult day care was not licensed in Connecticut in 1998. The number of licensed home health care agencies decreased from 124 in 1997 to 102 in 1998.[2] Certified home health care agencies also experienced a decline from 116 in 1997 to 100 in 1998. The ratio of licensed home health agencies per 1000 population 65 and over was 0.22 in 1998, more than half the national ratio of 0.47.

Hospice

There was an increase of 1 licensed hospice agency in Connecticut since 1997, for a total of 29 in 1998. There were 0.06 licensed hospice agencies per 1000 population aged 65 and over compared to the US ratio of 0.07.

CON/Moratorium

Connecticut had a CON for nursing facilities from 1979 through 1990, adding a moratorium to it in 1991. Both remained in effect through 1998. In 1998 there was also a CON and moratorium on hospital bed conversion and ICF/MRs[3]. A CON alone covered residential care homes and hospice[4], while assisted living had a CON only through July 1, 1998. There was neither a CON nor moratorium on home health and adult day care.

[1] '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 131 facilities and 1,772 beds in 1998.

[2] There were also 34 Assisted Living Service Agencies that provide housekeeping and ADL assistance to chronic but stable persons who reside in a managed residential community.

[3] 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.

[4] Inpatient hospice was subject to CON in 1998.

CONNECTICUT

Demographics

Percentage Population 65 and Over	14.3 % (US 12.7 %)
Percentage Population 85 and Over	1.9 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	321
Total Beds	31,948
Beds Per Nursing Facility	99.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	68.1 (US 52.5)
Age 85 and Over	515.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	13.54 (US 6.00)
Expenditures Per 1000 Pop, 1997	$259,397 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	123
Total Beds	1,308
Beds Per 1000 Population	0.40 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	114
Total Beds for Adult/Aged	3,067
Beds Per 1000 Pop, Age 65 and Over	6.5 (US 25.5)
Total Facilities, Other	131
Total Beds, Other	1,772

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	102
Agencies Per 1000 Pop, Age 65 and Over	0.22 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.15 (US 6.95)
Expenditures Per 1000 Pop, 1997	$105,813 (US $45,711)

Licensed Hospices

Total Organizations	29
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 FY98. 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 FY98.

Cost Centers

Connecticut separates reimbursement into four cost centers: administration and general, limited to 100% 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 $4.96. The American Hospital Association guidelines were applied to depreciation. Straight line was used for depreciation.

Reimbursement Rate

The FY98 average reimbursement rate for Connecticut was $133.82, 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. It pays almost four times as much for a RN or LPN visit ($80.66) as for an hour of HH aide visit ($5.05 per quarter hour). 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. The average reimbursement rate by facility type for Social was $45.95 per day and Medical was $49.01 per day, under the 2176 Waiver Reimbursement program.

CONNECTICUT

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$133.83
Percentage Rate Change From Previous Year	5.7%
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	$346.76 (median)
Ancillary Services Included in Rate	Medical Supplies, Patient Transport, Non-Prescription Drug, Physical Therapy, Respiratory Therapy, Durable Medical Equipment

Home Health

Method	Fee with possible add-ons
Fee Per Visit, RN or LPN	$80.66 per visit
Fee for Quarter Hour ,HH Aide Visit	$5.05 per quarter hour
Fee Per Visit, Occupational Therapy	$72.49
Fee Per Visit, Physical Therapy	$70.45

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	$45.95 per day
Medical[1]	$49.01 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 Facilities[1]

The total number of nursing facilities in Delaware has decreased from 53 in 1997 to 48 in 1998. The number of beds has also decreased from 5,492 in 1997 to 5,226 in 1998. In 1998, Delaware had a bed growth rate of -4.84 compared to the national rate of -0.12. There were 54.4 beds per 1000 population aged 65 and over in Delaware in 1998, greater than the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded[1]

The number of ICF/MR facilities in Delaware declined from a high of 13 in 1990 to 4 in 1998 (a decrease of 1 since 1997). The number of licensed beds declined from 460 in 1989 to 350 in 1998 (a decline of 11 beds since 1997). Delaware's 1998 ratio of ICF/MR beds per 1000 total population was 0.47, exactly that of the national ratio.

Residential Care for Adults/Aged[1]

In 1998 Delaware had 'family care' and 'assisted living' as categories of residential care. There were 117 licensed residential care facilities with 749 beds in 1998, a decrease of 8 facilities and 21 beds since 1997. The ratio of licensed beds per 1000 population age 65 and over was 7.8 in 1998 compared to the U.S. ratio of 25.5[2].

Adult Day Care and Home Health Care[1]

Adult day care was not licensed in Delaware in 1998. There were 38 licensed home health care agencies in Delaware in 1998, a decrease of 1 agency since 1997. The ratio of home health agencies per 1000 population aged 65 and over in Delaware was slightly lower than the national ratio (0.4 compared to 0.47).

Hospice

There were 8 licensed hospice agencies in Delaware in 1998, no change since 1997. 3 of these organizations were licensed in Pennsylvania but provide services in Delaware. The ratio of licensed hospice organizations per 1000 population was 0.08 compared to the US average of 0.07.

CON/Moratorium

Delaware had a Certificate of Public Review (CPR) for nursing facilities from 1979 through 1998. In 1998, a CPR was also required for hospital bed conversion. There was neither a CON nor moratorium on ICF/MR, residential care, home health care, hospice or adult day care.

[1] 1997 data was not available so it was an average of 1996 and 1998 data.

[2] 'Other Residential Care' in Delaware includes: neighborhood homes, group homes for people with AIDS, and group homes for the mentally ill, with a total of 67 facilities and 330 beds in 1998.

DELAWARE

Demographics

Percentage Population 65 and Over	13.0 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	48
Total Beds	5,226
Beds Per Nursing Facility	108.9 (US 103.5)
Average Occupancy Rate	86
Beds Per 1000 Population:	
Age 65 and Over	54.4 (US 52.5)
Age 85 and Over	522.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.12 (US 6.00)
Expenditures Per 1000 Pop, 1997	$104,308 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	4
Total Beds	350
Beds Per 1000 Population	0.47 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	117
Total Beds for Adult/Aged	749
Beds Per 1000 Pop, Age 65 and Over	7.8 (US 25.5)
Total Facilities, Other	67
Total Beds, Other	330

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	38
Agencies Per 1000 Pop, Age 65 and Over	0.4 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.25 (US 6.95)
Expenditures Per 1000 Pop, 1997	$9,771 (US $45,711)

Licensed Hospices

Total Organizations	8
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996. The 1997 cost report was used to set the FY98 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 FY98.

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, Case Mix Measurements, Acuity Measurements 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 FY98 average reimbursement rate for Delaware was $108.56 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 no peer groupings and cost center caps), 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. Average reimbursement rate for RN visit was $101.50, while $22.00/hr for HH Aide Visit. 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	$108.56
Percentage Rate Change From Previous Year	4.2%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1997
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	$194.49
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	$101.50
Average Reimbursement Rate, HH Aide Visit	$22.00/hr.

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915cWaiver
Average Reimbursement Rate	$46.89 (Social)
Facility Type	Social, Day health, Alzheimer's[4]
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.
[4] Alzheimer's only was $65.59

DISTRICT OF COLUMBIA

Nursing Facilities

The number of nursing facilities in the District of Columbia decreased from 23 in 1997 to 21 in 1998. There were 3,055 licensed nursing facility beds in D.C. in 1998, a decrease of 69 beds since 1997. The bed growth rate in 1998 was -2.21 percent compared to the national rate of -0.12 percent. The District of Columbia had 41.8 beds per 1000 population aged 65 and over in 1998, less than the national average of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in the District of Columbia increased steadily from 113 in 1991 to 133 in 1998 (an increase of 4 facilities since 1997). ICF/MR beds increased from 748 in 1991 to 860 in 1998 (an increase of 23 licensed beds since 1997). This represents a 1998 ratio of 1.64 licensed beds per 1000 total population, more than 3 times higher than the national ratio of 0.47. D.C. had the highest ratio of licensed ICF/MR beds in all the states in 1998.

Residential Care for Adults/Aged

Residential care in D.C. is provided in community residential facilities. The number of these facilities increased from 208 in 1997 to 216 in 1998. The number of licensed beds also increased from 1,674 in 1997 to 1,724 in 1998. D.C. had a ratio of 23.6 residential care beds per 1000 population age 65 and over in 1998, less than the national ratio of 25.5.

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Washington, D.C. in 1998. There were 17[1] certified home health care agencies in 1998, a decrease of 14 agencies since 1996 and of 2 since 1997.[2]

Hospice

Although hospice agencies were not licensed in the District of Columbia in 1998, there were an estimated 4 certified facilities.

CON/Moratorium

Washington, D.C. had a CON for nursing facilities from 1979 through 1998, with a brief moratorium added to it from October 1988 to February 1989. In 1998 a CON alone was required for hospital bed conversion, residential care, home health care, hospice and adult day care, while there was neither a CON nor moratorium on ICF/MRs.

[1] 5 of the certified agencies are based out of Maryland and Virginia-D.C. has a reciprocal agreement with these states and has no jurisdiction to oversee or monitor these agencies.
[2] Fraud and abuse account for some of this decline 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 1.5 %)

Licensed Nursing Facilities

Total Facilities	21
Total Beds	3,055
Beds Per Nursing Facility	145.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	41.8 (US 52.5)
Age 85 and Over	339.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	9.25 (US 6.00)
Expenditures Per 1000 Pop, 1997	$247,615 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	133
Total Beds	860
Beds Per 1000 Population	1.64 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	216
Total Beds for Adult/Aged	1,724
Beds Per 1000 Pop, Age 65 and Over	23.6 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.37 (US 6.95)
Expenditures Per 1000 Pop, 1997	$28,386 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

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
Adult Day Care	CON Only
Home Health Care	CON Only
Hospice 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 FY98. 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 FY98. 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 FY98. 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 FY98 average reimbursement rate for DC was $179.94 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 home health 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. Sub-Acute care was reimbursed on a Prospective Patient-Specific method. No ventilator available.

[1] There were only three hospital based facilities.

DISTRICT OF COLUMBIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$179.94
Percentage Rate Change From Previous Year	20.9%
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	$242.85

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 Facilities

Florida's nursing facilities increased from 532 in 1988 to 698 in 1998 (an increase of 17 facilities since 1997). The number of beds increased from 61,055 in 1988 to 81,172 in1998, (an increase of 1,254 beds since 1997). The bed growth rate in 1998 was 1.57 percent, compare to the U.S. average rate of –0.12 percent. Although Florida had the highest proportion of total population aged 65 and over (18.3 compared to the U.S. average of 12.7 percent), the ratio of licensed nursing facility beds per 1000 population age 65 and over continued to be substantially lower than the U.S. ratio (29.7 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

Although the number of ICF/MR facilities in Florida has remained at 112 since 1996, the number of beds has increased from 3,538 in 1996 to 3,680 in 1998. Despite this increase, the ratio of ICF/MR beds per 1000 total population remains well below the national average (0.25 compared with 0.47).

Residential Care for Adults/Aged

Florida licenses two categories of residential care for the elderly - assisted living facilities[1] and adult family care homes[2]. The total number of these facilities grew from 1,914 in 1989 to 2,421 in 1998 (an increase of 143 facilities since 1997). The total number of beds increased from 59,180 in 1989 to 67,684 in 1998 (an increase of 2,219 beds since 1997). The ratio of licensed beds per 1000 population aged 65 and over was 24.8 in 1998, greater than the U.S. average ratio of 25.5.[3]

Adult Day Care and Home Health Care

The number of licensed adult day care facilities in Florida increased from 148 in 1997 to 155 in 1998. The number of licensed home health care agencies has been steadily decreasing since 1995 when there were 1,912 facilities, decreasing from 1,448 in 1997 to 1,273 in 1998. Florida's ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.47 in 1998, exactly that of the U.S. ratio.

Hospice

Florida had 40 licensed hospice organizations in 1998, an increase of 1 since 1997. The ratio of licensed hospice organizations per 1000 population aged 65 or more was 0.01 compared to the US average 0.07.

CON/Moratorium

Florida had a CON for nursing facilities from 1979 through 1998. In 1998 a CON alone was required for hospital bed conversion, ICF/MRs, home health care[4], and hospice, while there was neither a CON nor moratorium on residential care and adult day care. There were 89 CON applications submitted for nursing facilities in 1998, of these 47 were denied.

[1] Formerly known as adult congregate living facilities.
[2] Formerly known as adult foster homes.
[3] '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 859 facilities and 5,875 beds in 1998.

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

FLORIDA

Demographics

Percentage Population 65 and Over	18.3 % (US 12.7 %)
Percentage Population 85 and Over	2.1 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	698
Total Beds	81,172
Beds Per Nursing Facility	116.3 (US 103.5)
Average Occupancy Rate	87.09
Beds Per 1000 Population:	
Age 65 and Over	29.7 (US 52.5)
Age 85 and Over	261.8 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.76 (US 6.00)
Expenditures Per 1000 Pop, 1997	$85,361 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	112
Total Beds	3,680
Beds Per 1000 Population	0.25 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,421
Total Beds for Adult/Aged	67,684
Beds Per 1000 Pop, Age 65 and Over	24.8 (US 25.5)
Total Facilities, Other	859
Total Beds, Other	5,875

Licensed Adult Day Care

Total Facilities	155
Facilities Per 1000 Pop, Age 65 and Over	0.06 (US 0.16)

Licensed Home Health Care

Total Agencies	1,273
Agencies Per 1000 Pop, Age 65 and Over	0.47 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.49 (US 6.95)
Expenditures Per 1000 Pop, 1997	$20,148 (US $45,711)

Licensed Hospices

Total Organizations	40
Organizations Per 1000 Pop, Age 65 and Over	0.01 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice Care	CON Only

* 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 FY98. 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 FY98, 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, 1999.

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 FY98 average reimbursement rate for Florida was $97.99, 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, with an average reimbursement rate $10.00/hr (4 hr min) by Facility type, Aged & Physically disabled and AIDS/ARC.

FLORIDA

Free-Standing Nursing Facilities

Method	Prospective Specific Adjusted
Average Reimbursement Rate	$97.99
Percentage Rate Change From Previous Year	2.1%
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 $203.39 Residential/Institutionalized $255.58
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 Facilities

The number of nursing facilities in Georgia has fluctuated since 1980. In 1998, there were 377 facilities, a total increase of 4 facilities since 1997. The number of beds rose to from 40,047 in 1997 to 40,516 in 1998. In 1998, Georgia had a bed growth rate of 1.17 percent compared to the national rate of -0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over was 53.7 in 1998, higher than the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

After a slow but steady decrease from 12 ICF/MR facilities and 2,240 beds in 1991, Georgia had 10 ICF/MR facilities with 1,835 beds in 1998 – no change in facilities or beds since 1997. The ratio of beds per 1000 total population was 0.24 in 1998, nearly half that of the national ratio (0.47).

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 1998, Georgia had 1,877 personal care homes with an estimated 18,296 beds.[1] This is a total decrease of 25 facilities and 244 beds since 1997. In 1998, the ratio of beds per 1000 population aged 65 and over was 24.2 compared to the national ratio of 25.5.

Adult Day Care and Home Health Care

Adult day care was not licensed in Georgia in 1998. The number of licensed home health care agencies gradually increased from 76 in 1990 to 106 in 1998, 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 0.47).

Hospice

The number of licensed and certified hospice agencies in 1998 were 75 and 62 respectively. There had been no change since 1997. Georgia had 0.10 facilities per 1000 population aged 65 and over compared to the US ratio of 0.07.

CON/Moratorium

Georgia had a CON for nursing facilities from 1979 through 1998.[2] In 1998, a CON was also required for hospital bed conversion, ICF/MRs, home health care and some categories of residential care.[3] There was neither a CON nor moratorium on assisted living, hospice or adult day care.

[1] The personal care bed count was a ratio estimate based on the 1997 data and Georgia's 1998 facility count. Georgia closed down several personal care facilities for reasons of non-compliance and other facilities withdrew voluntarily from the program in 1998.

[2] Although there has been no official moratorium for nursing facilities, CON applications are not accepted.

[3] Personal care homes and shelter nursing beds had CON requirements in 1998.

GEORGIA

Demographics

Percentage Population 65 and Over	9.9 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	377
Total Beds	40,516
Beds Per Nursing Facility	107.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	53.7 (US 52.5)
Age 85 and Over	494.1 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.12 (US 6.00)
Expenditures Per 1000 Pop, 1997	$79,638 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	10
Total Beds	1,835
Beds Per 1000 Population	0.24 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,877
Total Beds for Adult/Aged	18,296
Beds Per 1000 Pop, Age 65 and Over	24.2 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.90 (US 6.95)
Expenditures Per 1000 Pop, 1997	$17,392 (US $45,711)

Licensed Hospices

Total Organizations	75
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	No CON or Moratorium
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Adult Day Care	CON Only
Home Health Care	No CON or Moratorium
Hospice 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 re base the rates annually beginning July 1. The FY97 cost report was used for FY98. Inflation based on the DRI was used to trend rates with an adjustment of 9.3%. 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, dietary and supplemental feeding, and tube feeding were included in the rates.

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 FY98 average reimbursement rate for Georgia was $81.08. It is a weighted average of hospital based and 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 was paid under waiver, using a prospective flat rate with Family Model agency reimbursed at $24.66/day and Group Home at $23.66/day. Adult Day Care[1] was paid under waiver, using a Retrospective Patient Specific Rate reimbursed by the Clients Covered. The average reimbursement rates were $44.10 (min 5 hrs) for Level 1, $26.46 (min 3 hrs) for Partial Day – Level 1, $55.13 (min 5 hrs) for Level 2 and $33.08 (min 3 hrs) for Partial Day – Level 2, for Aged and Physically disabled clients. The rate was $38.59 for Physical, Occupational & Speech Therapy.

GEORGIA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$78.43 weighted average free standing only
Percentage Rate Change From Previous Year	8.0%
Peer Groupings	by Category of Service and Bed Size
Year of Cost Report to Set Rate	1996
Inflation Adjustment	9.3%
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 Therapy, Recreational & Speech, Dietary Supplemental Feeding, Tube Feeding

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$96.55

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$217.98
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	$24.66 per day
Group Home	$23.66 per day

Adult Day Care

Method	Prospective Patient-specific Rate
Reimbursement Program	1915c Waiver
Facility Type	Combination of Activities
Average Reimbursement Rate by Clients Covered	
Aged, Physically Disabled	
Level I	$44.10 minimum 5 hours
Partial Day	$26.46 minimum 3 hours
Level 2	$55.13 minimum 5 hours
Partial Day	$33.08 minimum 3 hours
Physical, Occupational and Speech Therapy	$38.59

Sub-Acute Care

No Separate Program

HAWAII

Nursing Facilities

The number of nursing facilities in Hawaii increased from 44 in 1997 to 46 in 1998. In 1998 there were 3,973 licensed beds, an increase of 25 beds since 1997. Between 1994 and 1998 the total bed growth in Hawaii was 13.2 percent, more than three times the national average of 4.16 percent for the same period. Hawaii's bed growth rate in 1998 alone was 0.63 percent compared to the national average of –0.12 percent. Although Hawaii's ratio of licensed nursing facility beds per 1000 population aged 65 and over has increased since 1995, the 1998 ratio (25.1) was less than half the national average of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Hawaii increased from 13 facilities in 1991 to 23 facilities in 1998. The number of beds has decreased, however, from 208 in 1991 to 137 in 1998. Since 1997, there was no change in either facilities or beds in Hawaii. Hawaii's ratio of licensed ICF/MR beds per 1000 total population was 0.11 in 1998, much lower than the national average of 0.47.

Residential Care for Adults/Aged

There were 561 residential care facilities with 2,867 beds[1] in Hawaii in 1998, an total increase of 14 facilities and 72 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 18.1 in 1998, below the national ratio (25.5).[2]

Adult Day Care and Home Health Care

Hawaii licenses adult day care and adult day health centers. In 1998 there were 21 of the former and 9 of the latter, a total increase of 3 facilities since 1997. Hawaii's ratio of adult day care facilities per 1000 population aged 65 and over was 0.19 in 1998, slightly higher than the national average of 0.16. There were 26 licensed home health care agencies in Hawaii in 1998, a decrease of 1 since 1997. Hawaii had the second fewest in the country (Alaska had the fewest with 23 agencies). Hawaii's ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.16 in 1998, well below the national ratio of 0.47.

Hospice

Although Hawaii did not license hospice organizations there were 9 certified organizations in 1998.

CON/Moratorium

Hawaii had a CON for nursing facilities from 1979 through 1998[3]. In 1998, a CON was also required for hospital bed conversion, ICF/MRs, residential care[4], home health care and hospice. There was neither a CON nor moratorium on adult day care.[5]

[1] The total number of 'Residential Care for Adults/Aged' beds includes 41 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 185 beds and 23 special treatment facilities with 570 beds.

[3] Hawaii strongly discourages nursing home applications. State representatives claim that the probability of disapproval is 99%. Hawaii is one step away from having a moratorium.

[4] Only one category of residential care requires a CON: special treatment facilities.

[5] In 1998, adult day health had a CON requirement.

HAWAII

Demographics

Percentage Population 65 and Over	13.3 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	46
Total Beds	3,973
Beds Per Nursing Facility	86.4 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	25.1 (US 52.5)
Age 85 and Over	248.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.31 (US 6.00)
Expenditures Per 1000 Pop, 1997	$127,253 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	23
Total Beds	137
Beds Per 1000 Population	0.11 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	561
Total Beds for Adult/Aged	2,867
Beds Per 1000 Pop, Age 65 and Over	18.2 (US 25.5)
Total Facilities, Other	64
Total Beds, Other	755

Licensed Adult Day Care

Total Facilities	30
Facilities Per 1000 Pop, Age 65 and Over	0.19 (US 0.16)

Licensed Home Health Care

Total Agencies	26
Agencies Per 1000 Pop, Age 65 and Over	0.16 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	0.63 (US 6.95)
Expenditures Per 1000 Pop, 1997	$1,873 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 1995 cost report was used for FY98. 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 four 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 1995 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 FY98 average reimbursement rate for Hawaii was $130.42, 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	$130.42
Percentage Rate Change From Previous Year	- 1.6%
Peer Groupings	Free-Standing vs. Hospital, ICF vs. SNF
Year of Cost Report to Set Rate	1995
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	$198.25

ICF-MR

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$236.24
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 Facilities

The number of nursing facilities in Idaho increased from 87 facilities and 6,457 beds in 1997 to 89 facilities and 6,677 beds in 1998. In 1998 the total bed growth rate was 3.41 percent, compared to the national rate (-0.12 percent). The ratio of licensed nursing facility beds per 1000 population aged 65 and over continued to be below the national ratio (48.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

In Idaho, the number of ICF/MR facilities and beds steadily increased from 38 facilities and 531 beds in 1990 to 62 facilities and 572 beds in 1998. These numbers represent an increase of 4 facilities and a decrease of 3 beds since 1997. The ratio of ICF/MR beds per 1000 total population was 0.47, exactly that of the national ratio.

Residential Care for Adults/Aged

Idaho had three categories of residential care for adults/aged in 1998. There were 152 residential care facilities for the elderly with 3,814 beds, 34 "combined" facilities with 787 beds providing care to the elderly as well as to developmentally disabled and mentally retarded clients, and 12 adult foster homes with 47 beds. This was a decrease of 1 facility and an increase of 202 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 33.4, higher than the national ratio of 25.5.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Idaho in 1998. There were 74 licensed home health care agencies in Idaho in 1998, a decrease of 18 agencies since 1997. There were 0.53 home health care agencies per 1000 population aged 65 and over in 1998, higher than the national ratio of 0.47.

Hospice

There were 28 licensed hospice agencies in 1998, 2 fewer than in 1997. Idaho had a ratio of 0.20 facilities per 1000 population aged 65 and over, compared to the 1998 US ratio of 0.07.

CON/Moratorium

Idaho had a CON for nursing facilities between 1979 and 1982 but eliminated it in 1983 and has had neither a CON nor moratorium through 1998. In 1998, there was neither a CON nor moratorium on hospital bed conversion, 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. A total of 41 facilities and 507 beds existed in 1998.

IDAHO

Demographics

Percentage Population 65 and Over	11.3 % (US 12.7 %)
Percentage Population 85 and Over	1.4 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	89
Total Beds	6,677
Beds Per Nursing Facility	75.0 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	48.0 (US 52.5)
Age 85 and Over	392.8 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.93 (US 6.00)
Expenditures Per 1000 Pop, 1997	$85,253 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	62
Total Beds	572
Beds Per 1000 Population	0.47 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	198
Total Beds for Adult/Aged	4,648
Beds Per 1000 Pop, Age 65 and Over	33.4 (US 25.5)
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	74
Agencies Per 1000 Pop, Age 65 and Over	0.53 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.53 (US 6.95)
Expenditures Per 1000 Pop, 1997	$20,790 (US $45,711)

Licensed Hospices

Total Organizations	28
Organizations Per 1000 Pop, Age 65 and Over	0.2 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996 cost reports were used for FY98. 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 is proposed legislation which would implement a case-mix system effective January 1, 2000.

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 $3.71 to $13.86 depending on facility age, type facility, and major capital improvements.

Reimbursement Rate

The estimated FY98 average reimbursement rate for Idaho was $94.26, 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. ICF-MR reimburses the same ancillary services as nursing facilities with the exception of Respiratory Therapy and Speech Therapy, but includes Active Treatment. Home health agencies were reimbursed using Medicare principles with state alterations that included a cap for RN payment, with an average rate of $103.26, over two and a half times that for home health aide visits with an average rate of $36.41. Sub-acute care was paid using a negotiated average patient-specific rate of $177.06[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	$94.26
Percentage Rate Change From Previous Year	9.2%
Peer Groupings	None[1]
Year of Cost Report to Set Rate	1996
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	$122.65

ICF-MR

Method	Prospective Effective 10/1/96
Average Reimbursement Rate	$189.55
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]	$177.06

[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 Facilities

The number of nursing facilities in Illinois decreased slightly from 810 in 1997 to 808 in 1998. The number of beds increased from 107,072 in 1997 to 108,222 in 1998. The bed growth rate was 1.07 percent compared to the national rate of -0.12 percent. Illinois' ratio of beds per 1000 population aged 65 and over was well above the national ratio in 1998 (72.3 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

In Illinois, the number of ICF/MR facilities steadily increased from 193 in 1990 to 325 in 1996. Since 1996 the number of facilities decreased to 308 in 1998 (a loss of 9 facilities since 1997).[1] The number of beds increased from 6,520 in 1990 to 11,306 in 1998. In 1998 the ratio of ICF/MR beds per 1000 total population was 0.94, twice that of the national ratio of 0.47.

Residential Care for Adults/Aged

Illinois had 47 sheltered care facilities with a total of 7,480 beds in 1998. This was an increase of 1 facility and 38 beds since 1997. The ratio of licensed residential care beds per 1000 population aged 65 and over remained far lower than the national ratio in 1998 (5.0 compared to 25.5).[2]

Adult Day Care and Home Health Care

Adult day care was not licensed in Illinois in 1998. There were 455 licensed home health care agencies in 1998, a decrease of 37 since 1997. The ratio of home health care agencies per 1000 population aged 65 and over in Illinois was still lower than the national ratio (0.3 compared to 0.47).

Hospice

Illinois had 113 licensed hospice agencies in 1998, 1 fewer than in 1997. The ratio of licensed hospice agencies per 1000 population aged 65 or over was 0.08 in Illinois, compared to the US ratio of 0.07.

CON/Moratorium

Illinois had a CON for nursing facilities from 1979 through 1998. In 1998 a CON was also required for hospital bed conversion, sub-acute beds[3], ICF/MRs and residential care. There was neither a CON nor moratorium on home health, hospice or adult day care.

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

[2] 'Other residential care' in Illinois includes: community integrated living arrangements and skilled pediatric facilities with a total of 41 facilities and 1,572 beds in 1998.

[3] Prior to 1998 sub-acute had not been a separate category in Illinois. In 1998 the CON requirement for sub-acute beds was a pilot program.

ILLINOIS

Demographics

Percentage Population 65 and Over	12.4 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	808
Total Beds	108,222
Beds Per Nursing Facility	133.9 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	72.3 (US 52.5)
Age 85 and Over	581.8 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.86 (US 6.00)
Expenditures Per 1000 Pop, 1997	$105,142 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	308
Total Beds	11,306
Beds Per 1000 Population	0.94 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	47
Total Beds for Adult/Aged	7,480
Beds Per 1000 Pop, Age 65 and Over	5.0 (US 25.5)
Total Facilities, Other	41
Total Beds, Other	1,572

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	455
Agencies Per 1000 Pop, Age 65 and Over	0.3 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.28 (US 6.95)
Expenditures Per 1000 Pop, 1997	$21,703 (US $45,711)

Licensed Hospices

Total Organizations	113
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98 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 FY98 was $180.42.

[1] This includes general use stock drugs only.

ILLINOIS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$74.23[1]
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	$103.66
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	$42.80
Average Reimbursement Rate, HH Aide Visit	$42.80
Speech, Occupational, and Physical Therapist	$42.80

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	$127.94-$199.80
Ventilator	$310.21
Multiple, Complex Diagnosis	$143.00-$191.00

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

INDIANA

Nursing Facilities

The number of nursing facilities in Indiana decreased from 592 in 1996 to 571 in 1998 (a loss of 19 facilities since 1997) . The number of beds also decreased from 68,602 in 1996 to 6,3350 in 1998 (a loss of 1,159 beds since 1997). In 1998 the bed growth rate was -1.80 percent compared to the national growth rate of –0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over in 1998 was 85.6 compared to the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Indiana increased from 13 in 1990 to 18 in 1994 where it remained through 1998. The number of beds also increased from 997 in 1990 to 1,767 in 1996, remaining at this count through 1998. The ratio of ICF/MR beds per 1000 total population was 0.30 in 1998, compared to the national average of 0.47.

Residential Care for Adults/Aged

There were 42 residential care facilities with 3,088 beds in Indiana in 1998, an increase of 11 facilities and 613 beds since 1997. This is a ratio of 4.2 licensed beds per 1000 population aged 65 and over, compared to the national average of 25.5[1].

Adult Day Care and Home Health Care

Adult day care was not licensed in Indiana in 1998. There were 277 licensed home health care agencies in 1998, a decrease of 158 since 1997 and a ratio of agencies per 1000 population aged 65 and over less than the national ratio (0.37 compared to 0.47).

Hospice

Indiana had 61 licensed hospice agencies in 1998, a decrease of 6 since 1997. In 1998, Indiana had 0.08 licensed hospice agencies per 1000 population aged 65 and over. The US ratio was 0.07.

CON/Moratorium[3]

Indiana had a CON for nursing facilities from 1979 through 1995[2] starting again in 1997and continuing through 1998. In 1998 there was a CON requirement for hospital bed conversion, while ICF/MRs had both a CON and moratorium[3]. Neither a CON nor moratorium were required for residential care, home health, hospice or adult day care.

[1] 'Other Residential Care' in Indiana includes 563 group homes with 5,825 beds for persons with mental retardation.

[2] In July 1996 the Governor vetoed a renewal of the CON program and it was terminated. In January, 1997 the Indiana General Assembly voted to override the veto, making CON in effect again July 1997

[3] The ICF/MR moratorium was defacto.

INDIANA

Demographics

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

Licensed Nursing Facilities

Total Facilities	571
Total Beds	63,350
Beds Per Nursing Facility	110.9 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	85.6 (US 52.5)
Age 85 and Over	719.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.84 (US 6.00)
Expenditures Per 1000 Pop, 1997	$120,930 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	18
Total Beds	1,767
Beds Per 1000 Population	0.30 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	42
Total Beds for Adult/Aged	3,088
Beds Per 1000 Pop, Age 65 and Over	4.2 (US 25.5)
Total Facilities, Other	563
Total Beds, Other	5,825

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	277
Agencies Per 1000 Pop, Age 65 and Over	0.37 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	1.83 (US 6.95)
Expenditures Per 1000 Pop, 1997	$7,818 (US $45,711)

Licensed Hospices

Total Organizations	61
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

INDIANA

Reimbursement

Free-Standing Nursing Facilities

Methods

Indiana implemented a case mix reimbursement system effective October 1, 1998. Over time, the state had previously put elements of the current system in place. For example, the prior system allowed for separate reimbursement rates for several different levels of patient care. Furthermore, since June 1996, all Medicaid-certified nursing facilities have been required to electronically transmit minimum data set information to the state for use in developing the current case mix system. A facility fiscal year cost report is used to rebase rates annually. Historical costs were trended forward using the HCFA/SNF inflation index.

Adjustments

Costs were adjusted to reflect allowable costs based on the rate setting criteria. Allowable costs are then compared to medians for each rate component established on a state-wide basis. Each rate component is also subject to an overall rate limitation. .

Cost Centers.

The current case mix system is made up four components; direct care, indirect care, administrative and capital. The remaining components are reimbursed based on allowable per patient day cost.

Ancillary Services

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

Case-Mix Adjusters

The direct care component is based on resource needs as measured by the RUGIII resident classification system.

Capital Costs

The capital component is established using a fair rental value methodology.

Reimbursement Rate

The average nursing facility case-mix per diem rate for Indiana. Was $80.32 for FY 98..

Other Long-Term Care

Indiana used the same system for hospital-based as for free-standing nursing facilities.ICF/MRr were reimbursed through a prospective rate setting method. A facility fiscal year cost report was used to set and rebase rates annually. Historical casts were trended forward using the HCFA/SNF inflation index. A minimum occupancy standard was set at 90%.

Home health agencies were reimbursed using a fee schedule. RN services were reimbursed at arate of $26.92 per hour, plus $26.72 per visit for overhead per visit. Adult day care was paid using a retrospective flat rate. The OMPP does not reimburse for sub-acute care. The OMPP utilizes acute-care DR6 rates-acute care DR6 level of care rates, (i.e. psychiatric, burn, and rehabilitation) and distinct part level of care rates.

INDIANA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$80.32
Percentage Rate Change From Previous Year	0%
Peer Groupings	Statewide
Year of Cost Report to Set Rate	1996
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 Facilities

The number of nursing facilities in Iowa decreased slightly from 481 in 1997 to 479 in 1998. The number of beds decreased from 35,198 in 1997 to 35,131 in 1998. In 1998 the total bed growth rate was -0.19 percent compared to the national rate of -0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over, however, remained high in 1998 (81.5 compared to the national average of 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities increased from 46 in 1990 to 122 in 1998. The number of beds has also increased from 2,588 in 1990 to 3,026 in 1998. There was no change in the number of facilities and beds since 1997. In 1998 there was a ratio of 1.06 ICF/MR beds per 1000 total population in Iowa, more than two times higher than the national average of 0.47.

Residential Care for Adults/Aged

The number of residential care facilities has continued to decrease in Iowa, from 202 in 1989 to 159 in 1998. The number of beds has continued to decrease as well, from 7,667 in 1989 to 6,093 to 1998. There was a total decline of 8 facilities and 191 beds since 1997. The ratio of licensed beds per 1000 population 65 and over was 14.1 in 1998, lower than the national ratio of 25.5.[1]

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Iowa in 1998. There were 194 certified home health care agencies in Iowa in 1998, a decline of 12 agencies since 1997.

Hospice

Iowa had 5 licensed and 57 certified hospice agencies in 1998, no change in licensed facilities but an increase of 1 certified facility since 1997. The ratio of licensed hospice agencies was 0.01 per 1000 population aged 65 and over compared to the US average of 0.07.

CON/Moratorium

Iowa had a CON for nursing facilities from 1979 through 1998. In 1998 a CON was required for hospital bed conversion, and both a CON and moratorium were in effect for ICF/MRs[2]. Neither a CON nor moratorium were required on residential care, home health care, hospice or adult day care in 1998. 9 nursing facility CON applications were submitted in Iowa in 1998, none of these were denied.

[1] 'Other Residential Care' in Iowa includes: residential care facilities for persons who are mentally retarded and for persons with mental illness. 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 2,582. In 1998, facilities and beds decreased to 162 and to 1,861 respectively.

[2] The moratorium on ICF/MRs ended June 30, 1998.

IOWA

Demographics

Percentage Population 65 and Over	15.1 % (US 12.7 %)
Percentage Population 85 and Over	2.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	479
Total Beds	35,131
Beds Per Nursing Facility	73.3 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	81.5 (US 52.5)
Age 85 and Over	548.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	9.01 (US 6.00)
Expenditures Per 1000 Pop, 1997	$105,478 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	122
Total Beds	3,026
Beds Per 1000 Population	1.06 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	159
Total Beds for Adult/Aged	6,093
Beds Per 1000 Pop, Age 65 and Over	14.1 (US 25.5)
Total Facilities, Other	162
Total Beds, Other	1,861

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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.10 (US 6.95)
Expenditures Per 1000 Pop, 1997	$34,703 (US $45,711)

Licensed Hospices

Total Organizations	5
Organizations Per 1000 Pop, Age 65 and Over	0.01 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1997/1998 cost report or previous six months was used for FY98. Inflation based on CPI and an incentive were used to trend rates. Occupancy was set at minimum of 80%.

Adjustments

A January 1998 adjustment was made in May 1998, 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, Physical Therapy, Occupational Therapy, Respiratory Therapy 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 FY98 average reimbursement rate for Iowa nursing facility was $71.70, and $125.59 for skilled nursing facility services.

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. The Ancillary Services included in the rate are Physical Therapy, Occupational Therapy, Respiratory Therapy including those in Free Standing 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 (NF) $125.59 (SNF)
Percentage Rate Change From Previous Year	5.3%
Peer Groupings	None
Year of Cost Report to Set Rate	1997/98 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 Facilities

In 1998 Kansas had approximately 407[1] licensed nursing facilities and 26,309 beds, a decrease of approximately 83 nursing facilities and 5,330 beds since 1997.[2] The bed growth rate in 1998, was –16.85 percent compared to the national rate of -0.12 percent. The 1998 ratio of licensed nursing facility beds per 1000 population aged 65 and over remained higher than the national ratio (74.3 compared to the U.S. ratio of 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Kansas reached 48 in 1991 then decreased steadily to 42 in 1997, then to 36 in 1998. The number of beds decreased from 988 in 1991 to 888 in 1997 and then to 657 in 1998. The ratio of ICF/MR beds per 1000 total population was 0.25 in 1998, lower than the national ratio of 0.47.

Residential Care for Adults/Aged

Kansas had 199 residential care facilities with 6,026 beds in 1998 - a decrease of 19 facilities and an increase of 319 beds since 1997[1]. The ratio of licensed beds per 1000 population aged 65 and over has been increasing since 1992 but remains below the national ratio (17.0 compared to 25.5).[2]

Adult Day Care and Home Health Care

Adult day care became licensed in Kansas in 1995 when there were 3 facilities. By 1997 there were 20 licensed facilities, this decreased to 9 in 1998. In 1998, Kansas had the lowest ratio of licensed adult day care facilities in the states with 0.03 compared to the U.S. ratio of 0.16. There were 205 licensed home health care agencies in Kansas in 1998, a decline of 207 since 1997, and yet a ratio of agencies per 1000 population aged 65 greater than that of the national ratio (0.58 compared to 0.47).

Hospice

The number of licensed hospice agencies increased from 31 in 1997 to 33 in 1998. Kansas' ratio of licensed hospice agencies per 1000 population was 0.09 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

Kansas had a CON for nursing facilities between 1979 and 1984 but eliminated it in 1985 and has had neither a CON nor moratorium through 1998. In 1998 neither a CON nor moratorium were required on hospital bed conversions, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] The 407 facility count is our estimate as the data was not available. The estimate was an average of the 1997 and 1999 facility data collected from Kansas.
[2] This decrease in nursing facilities is accounted for by a trend toward assisted living and residential care. According to a Kansas state official some nursing facilities are converting beds to residential care.
[1] Although there was growth in other categories of residential care in 1998, there was a loss of 43 boarding home facilities and 234 beds. According to a Kansas state official many boarding home facilities did not renew their licenses in 1998.
[2] 'Other Residential Care' in Kansas includes 14 nursing facilities for mental health with 891 beds.

KANSAS

Demographics

Percentage Population 65 and Over	13.5 % (US 12.7 %)
Percentage Population 85 and Over	1.9 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	407
Total Beds	26,309
Beds Per Nursing Facility	64.6 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	74.3 (US 52.5)
Age 85 and Over	515.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.44 (US 6.00)
Expenditures Per 1000 Pop, 1997	$85,753 (US $114,494)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	36
Total Beds	657
Beds Per 1000 Population	0.25 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	199
Total Beds for Adult/Aged	6,026
Beds Per 1000 Pop, Age 65 and Over	17.0 (US 25.5)
Total Facilities, Other	14
Total Beds, Other	891

Licensed Adult Day Care

Total Facilities	9
Facilities Per 1000 Pop, Age 65 and Over	0.03 (US 0.16)

Licensed Home Health Care

Total Agencies	205
Agencies Per 1000 Pop, Age 65 and Over	0.58 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.07 (US 6.95)
Expenditures Per 1000 Pop, 1997	$56,352 (US $45,711)

Licensed Hospices

Total Organizations	33
Organizations Per 1000 Pop, Age 65 and Over	0.09 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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, 1997 (FY98). The rate 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 request and documentation. Property fee can be adjusted when capital expenditure thresholds are met and for audit adjustments. Rates can be changed based on audit adjustments.

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, durable medical equipment, 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 FY98 average reimbursement rate for Kansas was $71.94, 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. The average rate for public facilities is $289.55 and $130.53 for private facilities. The capital reimbursement was determined on actual costs for public facilities and on historic costs 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. The average rate for a Health Care Attendant I and II were $12.00 to $13.25 per hour, Adult Day Care at $13.00 (1-5 hours) and Personal Emergency Response System at $20.00 per month. Adult Day Care used a fee for service method. The average rate for social is $20.00/day and $23.00/day for Day Health, reimbursed under 1915c waiver.

KANSAS

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Weighted Average Reimbursement Rate	$71.94
Percentage Rate Change From Previous Year	7.2%
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., Non Emergent Transportation, Occupational Therapy

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	$289.55[1]
Private Facilities	$130.53[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
Adult Day Care	$13.00 (1-5 hours)
Personal Emergency Response System	$20.00 per month
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.
[2] Averaged by number of facilities.
[3] Includes combination of aged & physically disabled clients, which could not be disaggregated.

KENTUCKY

Nursing Facilities

The number of nursing facilities and beds in Kentucky fluctuated but increased from 232 facilities and 21,318 beds in 1987 to 326 facilities and 26,950 beds in 1997. In 1998 the number of facilities remained constant but the number of beds increased slightly to 27,096. The bed growth rate in 1998 was 0.54 percent compared to the national rate of -0.12 percent). The ratio of licensed nursing facility beds per 1000 population aged 65 and over was higher than the national ratio in 1998 (55.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

There were 9 ICF/MR facilities in Kentucky from 1990 to 1994. By 1997 ICF/MR facilities increased to 13, then decreased to 12 facilities in 1998. The total number of ICF/MR beds remained constant at 1,203 from 1990 to 1995, increasing with some fluctuation to 1,208 in 1998 (a decrease of 6 beds since 1997). The ratio of licensed ICF/MR beds per 1000 total population was 0.31 in 1998 (below the national ratio of 0.47.)

Residential Care for Adults/Aged

Kentucky licenses two categories of residential care - personal care homes and family care homes. In 1998 there were 195 of the former with 6,821 beds and 311 of the latter with approximately 857 beds - a total decrease of 51 facilities and 395 beds since 1997. Kentucky's ratio of licensed beds per 1000 population aged 65 and over, 15.6, remained below the national ratio (25.5) in 1998.[1]

Adult Day Care and Home Health Care

There were 82 licensed adult day care facilities in Kentucky in 1998, an increase of 15 since 1997. There were 127 licensed home health care agencies in 1998, an increase of 7 since 1997. The ratio of licensed home health care agencies per 1000 population aged 65 and over (0.26) less than the national ratio (0.47) in 1998.

Hospice

The number of licensed hospice agencies increased from 28 to 29 between 1997 and 1998. Kentucky's ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.06 in 1998, just under the US ratio of 0.07.

CON/Moratorium

In 1998, Kentucky required a CON for nursing facilities.[2] In 1998, a CON was also required for hospital bed conversion, residential care, home health care, hospice and adult day care while ICF/MRs had both a CON and moratorium. Assisted living had neither a CON nor moratorium in 1998.

[1] 'Other Residential Care' in Kentucky includes: 39 group homes with 312 beds for mental retardation and 13 psychiatric treatment facilities with 104 beds.

[2] Kentucky has had a CON requirement since at least 1979.

KENTUCKY

Demographics

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

Licensed Nursing Facilities

Total Facilities	326
Total Beds	27,096
Beds Per Nursing Facility	83.1 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	55.0 (US 52.5)
Age 85 and Over	475.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.07 (US 6.00)
Expenditures Per 1000 Pop, 1997	$117,231 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	12
Total Beds	1,208
Beds Per 1000 Population	0.31 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	506
Total Beds for Adult/Aged	7,678
Beds Per 1000 Pop, Age 65 and Over	15.6 (US 25.5)
Total Facilities, Other	52
Total Beds, Other	416

Licensed Adult Day Care

Total Facilities	82
Facilities Per 1000 Pop, Age 65 and Over	0.17 (US 0.16)

Licensed Home Health Care

Total Agencies	127
Agencies Per 1000 Pop, Age 65 and Over	0.26 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	18.72 (US 6.95)
Expenditures Per 1000 Pop, 1997	$43,262 (US $45,711)

Licensed Hospices

Total Organizations	29
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* Opinion of State Health Planning Officials.

KENTUCKY

Reimbursement

Free-Standing Nursing Facilities

Methods

The FY 98 methodology deviates from the previous methodology used in the rate setting process for medicaid nursing facilities. The methodology was based on the latest 7-1-97 case-mix rate adjusted for case mix, audit revisions and other adjustments. The rate was inflated by 5.8% and no adjustments will be made except for quarterly case-mix updates. The 1996 cost report was used as the basis for the 7-1-98 rate. No other inflation factor was used. The minimum occupancy standard remained 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 capital costs segment remained the same. It used historic costs to determine the Capital costs. All facilities that were sold since October, 1985 was eligible for an add on based on factoring a $3 million pool. Another $3 million pool was included in this methodology in order to relieve any facility of cost that the new inflation factor would not cover. This was a special request form and the facility could recover the entire amount or a factored amount of the cost. This extenuating circumstance had to involve the entire facility and was not to be used for resident specific items.

Reimbursement Rate

The FY98 reimbursement rate for Kentucky was $88.81, calculated by days of care and weighted by three-month rate periods.

Other Long-Term Care

The hospital-based facilities were included in the above methodology. Pediatric, ICF-MR, Institute for Mental Disease (IMD) were not included in the above methodology. The reimbursement for these facilities remained the same full-cost methodology. ICF-MR average reimbursement rate was $221.07(not weighted, includes state facilities). Home Health used retrospective facility-specific method and the rates were $81.21 for a RN Visit and $29.98 for a HH Aide Visit. Adult Day Care used Prospective Facility-Specific method and Adult Day Health Rate was $27.40/1/2 unit. There was no separate program for Sub-Acute Care.

KENTUCKY

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$88.81
Percentage Rate Change From Previous Year	7.0%
Peer Groupings	Geographic Location by Urban/Rural
Year of Cost Report to Set Rate	1996
Inflation Adjustment	Case-Mix and 5.8% inflation
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, Oxygen, Speech Therapy, Pharmacy, Lab Procedures

Hospital-Based Nursing Facilities

Method	Similar to Free-Standing Nursing Facilities

ICF-MR

Method	Similar to Free-Standing Nursing Facilities
Average Reimbursement Rate	$221.07/day (not weighted, includes state facilities) ICFMR - full cost facility

Home Health

Method	Retrospective Facility-Specific
Average Reimbursement Rate, RN Visit	$81.21
Average Reimbursement Rate, HH Aide Visit	$29.98

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Facility Specific
Program	Health Care Model
Adult Day Health Rate	$27.40/ per half unit

Sub-Acute Care

No Separate Program

LOUISIANA

Nursing Facilities

The number of nursing facilities in Louisiana has fluctuated but has shown an overall increase from 325 in 1988 to 349 in 1998. The number of beds has increased, from 36,855 in 1988 to 40,059 in 1998. Between 1997 and 1998 there was an increase of 2 facilities, but a decrease of 1,569 beds.[1] In 1998 there was a total bed growth rate of –3.77 percent, compared to the national rate of -0.12 percent. Louisiana's ratio of licensed beds per 1000 population aged 65 and over has been consistently above the national ratio (in 1998, 79.5 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities increased steadily from 367 in 1991 to 469 in 1998 (an increase of 3 facilities since 1997). The number of ICF/MR beds increased with some fluctuation from 6,450 in 1991 to 6,762 in 1998 (a decrease of 18 beds since 1997). In 1998, the ratio of beds per 1000 population was more than triple the national ratio with 1.55 compared to 0.47.

Residential Care for Adults/Aged

There were 113 adult residential care facilities with 1,867 beds in Louisiana in 1998. This is a decrease of 15 facilities and 248 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 3.7 in 1998, the lowest of all the states. The national ratio was 25.5.

Adult Day Care and Home Health Care

In 1998, there were a total of 258 adult day care facilities (no change in facilities since 1997). Also in 1998, there were 24 adult day health centers, an increase of 10 centers since 1997[2]. Louisiana had a ratio of agencies per 1000 population aged 65 and over that was much higher than the national ratio in 1998 (0.56 compared to 0.16). There were 465 licensed home health care agencies in 1998, a decrease of 78 agencies since 1997. The ratio of home health agencies per 1000 population aged 65 and over was 0.92 in 1998, compared to the national ratio of 0.47.

Hospice

Louisiana had 38 licensed hospice agencies in 1998, a decrease of 1 facility since 1997. There are no certified hospice agencies. In Louisiana, the ratio of licensed hospices per 1000 population aged 65 and over was 0.1 compared to the US average of 0.07.

CON/Moratorium

Louisiana had a CON (called a 'facility need review' program)[3] for nursing facilities from 1979 to 1998. In 1997 and 1998, nursing facilities were subject to a moratorium. In 1998 a CON alone was required for ICF/MRs. Neither a CON nor moratorium were required on hospital bed conversions, residential care, home health care, hospice or adult day care.

[1] Options other than nursing facilities are being utilized in Louisiana, such as home health.

[2] 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.

[3] 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	11.5 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	349
Total Beds	40,059
Beds Per Nursing Facility	114.8 (US 103.5)
Average Occupancy Rate	81.3
Beds Per 1000 Population:	
Age 65 and Over	79.5 (US 52.5)
Age 85 and Over	715.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.92 (US 6.00)
Expenditures Per 1000 Pop, 1997	$108,794 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	469
Total Beds	6,762
Beds Per 1000 Population	1.55 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	113
Total Beds for Adult/Aged	1,867
Beds Per 1000 Pop, Age 65 and Over	3.7 (US 25.5)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	282
Facilities Per 1000 Pop, Age 65 and Over	0.56 (US 0.16)

Licensed Home Health Care

Total Agencies	465
Agencies Per 1000 Pop, Age 65 and Over	0.92 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.09 (US 6.95)
Expenditures Per 1000 Pop, 1997	$9,026 (US $45,711)

Licensed Hospices

Total Organizations	48
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON Only
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98 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 FY98 weighted average reimbursement rate for Louisiana was $65.54.

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	$65.54
Percentage Rate Change From Previous Year	7.2%
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	Non-State: $133.39[1] State: $203.15[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]	$33.69
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 Facilities

The number of nursing facilities in Maine has fluctuated but overall has shown a decrease from 148 facilities in 1988 to 134 in 1997 and to 128 in 1998. The number of beds also has fluctuated, decreasing from 9,599 in 1988 to 9,174 in 1997 and to 8,820 in 1998. Despite the reduction in beds, and a negative growth rate over the 1988-1998 period (-8.15 percent compared to the U.S rate of 12.18 percent), Maine has maintained a ratio of licensed nursing facility beds per 1000 population aged 65 and over just under that of the national ratio. In 1998 the ratio was 50.4, compared to 52.5 nationally.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Maine decreased from 48 in 1991 to 30 in 1998. The number of ICF/MR beds also decreased from 474 in 1991 to 304 in 1998. These counts represent a decrease of 3 facilities and 30 beds since 1997. The ratio of ICF/MR beds per 1000 total population in Maine was 0.24 in 1998, nearly half the U.S. ratio of 0.47.

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 decreased from 739 in 1997 to 686 in 1998. The total number of beds increased from 6,153 in 1997 to 6,257 in 1998. The ratio of licensed beds per 1000 population aged 65 and over, 35.8, continued to be greater than the national ratio in 1998 (25.5).[1]

Adult Day Care and Home Health Care

There were 49 licensed adult day care facilities in Maine in 1998, a decrease of 6 since 1997. There were 82 licensed home health care agencies in 1998, a decrease of 8 since 1997 and a ratio of agencies per 1000 population aged 65 and over of 0.47, exactly that of the national ratio.

Hospice

The number of licensed hospice agencies increased from 28 in 1997 to 29 in 1998. Maine had a ratio of 0.17 licensed hospices per 1000 population aged 65 and over while the US average was 0.07.

CON/Moratorium

Maine had a CON alone for nursing facilities from 1979 to 1980, adding a moratorium to the CON in 1981 that remained in effect through 1998. In 1998 both hospital bed conversion and ICF/MRs[2] were subject to a CON as well as moratorium. There was neither a CON nor moratorium on residential care, home health care, hospice or adult day care. There were 9 nursing facility CON applications in 1998, none were denied.

[1] 'Other Residential Care' in Maine includes 4 psychiatric facilities with 448 beds.

[2] ICF/MRs had a defacto moratorium in 1998.

MAINE

Demographics

Percentage Population 65 and Over	14.1 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	128
Total Beds	8,820
Beds Per Nursing Facility	68.9 (US 103.5)
Average Occupancy Rate	88
Beds Per 1000 Population:	
Age 65 and Over	50.4 (US 52.5)
Age 85 and Over	400.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.05 (US 6.00)
Expenditures Per 1000 Pop, 1997	$130,116 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	30
Total Beds	304
Beds Per 1000 Population	0.24 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	686
Total Beds for Adult/Aged	6,257
Beds Per 1000 Pop, Age 65 and Over	35.8 (US 25.5)
Total Facilities, Other	4
Total Beds, Other	448

Licensed Adult Day Care

Total Facilities	49
Facilities Per 1000 Pop, Age 65 and Over	0.28 (US 0.16)

Licensed Home Health Care

Total Agencies	82
Agencies Per 1000 Pop, Age 65 and Over	0.47 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.70 (US 6.95)
Expenditures Per 1000 Pop, 1997	$58,648 (US $45,711)

Licensed Hospices

Total Organizations	29
Organizations Per 1000 Pop, Age 65 and Over	0.17 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98[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+.2.0

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 FY98 average reimbursement rate for Maine was $115.77, 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 ($80.53) was more than twice that of the HH Aide visit ($37.62). 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	$115.77
Percentage Rate Change From Previous Year	1.7%
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	$170.64

ICF-MR

Method	Actual cost or variable rate inflated forward
Average Reimbursement Rate	$256.29
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	$80.53
Average Reimbursement Rate, HH Aide Visit	$37.62

Other Residential Care For Aged

No Medicaid Program[1]

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	$409.62- $491.37

[1] Maine has an MRDD Program for Developmentally Disabled, which was not specifically for the aged.

MARYLAND

Nursing Facilities

Nursing facilities in Maryland increased from 260 facilities and 30,703 beds in 1997 to 265 facilities and 30,756 beds in 1998. In 1998 Maryland had a total bed growth rate of 0.17 percent, compared to the national rate of -0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over was just less than the national ratio in 1998 (52.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

Maryland is in the process of downsizing and closing ICF/MR facilities resulting in a decrease in facilities from 11 in 1989 to 4 in 1998. Beds decreased from 1,819 in 1989 to 848 in 1998. These counts represent no change in facilities since 1996 but a decrease in 295 beds since 1997. The ratio of ICF/MR beds per 1000 total population was 0.17 in 1998, well below the U.S. ratio of 0.47.

Residential Care for Adults/Aged

Maryland licenses four categories of residential care – assisted living, senior (group) assisted living, congregate housing facilities and continuing care retirement facilities. In 1998 there were 2,799 total facilities with 21,858 beds, an increase of 606 facilities and 1,627 beds since 1997. Substantial bed growth has increased the ratio of licensed beds per 1000 population aged 65 and over from 7.1 in 1990 to 36.9 in 1998 - well above the 1998 national ratio of 25.5.[1]

Adult Day Care and Home Health Care

There were 125 licensed adult day care facilities in Maryland in 1998, an increase of 5 since 1997. There were 76 licensed home health care agencies in Maryland in 1998, a decrease of 12 agencies since 1997. The 1998 ratio of home health care agencies per 1000 population aged 65 and over was 0.13, less than half the national ratio of 0.47.

Hospice

There were 35 licensed hospices in Maryland in 1997, increasing to 38 in 1998. Maryland had 0.06 licensed hospices per 1000 population aged 65 and over, compared to the US ratio of 0.07.

CON/Moratorium

Maryland required a CON for nursing facilities from 1979 through 1998[2]. In 1998 a CON was also required for hospital bed conversion, sub-acute beds, ICF/MRs, residential care, home health care, and hospice. There was neither a CON nor moratorium on assisted living or adult day care.

[1] 'Other Residential Care' in Maryland includes 28 substance abuse facilities with 577 beds and approximately 400 'project home' facilities with 745 beds (for persons 18+ years old with disabilities including AIDS).

[2] Maryland has a 'projected need' formula in effect until the year 2000. This is something like a moratorium, but written into the state plan.

MARYLAND

Demographics

Percentage Population 65 and Over	11.5 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	265
Total Beds	30,756
Beds Per Nursing Facility	116.1 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	52.0 (US 52.5)
Age 85 and Over	480.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.18 (US 6.00)
Expenditures Per 1000 Pop, 1997	$100,465 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	4
Total Beds	848
Beds Per 1000 Population	0.17 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,799
Total Beds for Adult/Aged	21,858
Beds Per 1000 Pop, Age 65 and Over	36.9 (US 25.5)
Total Facilities, Other	428
Total Beds, Other	1,322

Licensed Adult Day Care

Total Facilities	125
Facilities Per 1000 Pop, Age 65 and Over	0.21 (US 0.16)

Licensed Home Health Care

Total Agencies	76
Agencies Per 1000 Pop, Age 65 and Over	0.13 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.73 (US 6.95)
Expenditures Per 1000 Pop, 1997	$44,148 (US $45,711)

Licensed Hospices

Total Organizations	38
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 FY98. 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 FY98.

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 FY98 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	0%
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 Facilities

Nursing facilities and beds in Massachusetts showed overall growth between the years 1987 and 1997, an increase of 35 facilities and 11,555 beds during those years. 1998 brought a decrease of 83 facilities and 3,452 beds (with a total of 516 facilities and 54,881 beds). Massachusetts had a total growth rate in 1998 of –5.92 percent, compared to the national rate of -0.12 percent. The ratio of licensed nursing facility beds per 1000 population aged 65 and over has been well over the national ratio since at least 1980 (in 1998, 63.7 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities dropped from 83 in 1991 to 7 in 1993, remaining at 7 through 1998. This drop was due to a change in licensure which converted the smaller ICF/MRs to "home and community based waiver facilities". Beds decreased from 3,320 in 1991 to 1,496 in 1998.[1] Massachusetts is currently downsizing ICF/MRs by decertifying beds as they become empty. The ratio of beds per 1000 total population was 0.24 in 1998, well below the national ratio of 0.47.

Residential Care for Adults/Aged

Massachusetts provides residential care through rest homes and assisted living facilities. In 1998 there were 154 rest homes with 4,234 beds and 104 assisted living facilities with 5,955 rooms[2]. This represents an increase of 14 facilities and a decrease of 28 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 11.8 in 1998, well below the national ratio of 25.5.

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in Massachusetts in 1998. However, in 1998 there were 217 certified home health agencies, up from 205 in 1997.

Hospice

There were 44 licensed and 44 certified hospices in Massachusetts in 1997, with no change in 1998. In 1998 there were 0.05 licensed hospice agencies per 1000 population aged 65 and over. The US average ratio was 0.07.

CON/Moratorium

Massachusetts had a CON (known as a determination of need) for nursing facilities from 1979 through 1998, with a moratorium added to it in 1991 that remained in effect through 1998. In 1998 there was a CON as well as moratorium on hospital bed conversion, 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 1998 there were 5 nursing facility CON applications, none 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	14.0 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	516
Total Beds	54,881
Beds Per Nursing Facility	106.4 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	63.7 (US 52.5)
Age 85 and Over	485.7 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.93 (US 6.00)
Expenditures Per 1000 Pop, 1997	$197,538 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	7
Total Beds	1,496
Beds Per 1000 Population	0.24 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	258
Total Beds for Adult/Aged	10,189
Beds Per 1000 Pop, Age 65 and Over	11.8 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.40 (US 6.95)
Expenditures Per 1000 Pop, 1997	$84,609 (US $45,711)

Licensed Hospices

Total Organizations	44
Organizations Per 1000 Pop, Age 65 and Over	0.05 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* Opinion of State Health Planning Officials.

MASSACHUSETTS

Reimbursement

Free-Standing Nursing Facilities

Methods

In 1998 the commonwealth began the transition from a facility-specific prospective reimbursement method to a statewide standard payment model. In 1998, payments were based on facility-specific rate for most facilities. The method employed peer groupings of level of care by case-mix. The 1996 cost reports were used to determine the nursing and other operating payment base for FY98. Capital costs were based on 1993 costs. An inflation factor of 5.12% was applied to non-capital costs. The minimum occupancy standard was set at 96%. Facilities will be blended over time to statewide standard payments for nursing and other operating costs. In 1998, a total payment adjustment was applied to nursing facility rates. No facility's rate was lowered from the 1998 level, and no facility rate increased more than 9% of the 1998 level.

Adjustments

No adjustments were made outside the regular rate setting procedures.

Cost Centers

The rate is composed of three primary cost groupings; nursing, other operating, and capital. The nursing component is adjusted to reflect patient acuity.

Ancillary Services

Non-prescription drugs, in house medical supplies, and in house physician services were included in the rate. They are combined under the other operating component of the rate.

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 categories are collapsed into 4 payment categories..

Capital Costs

1998 capital payment rates equaled the 1998 fixed cost and equity per diems. Facilities with capital per diems over $17.29 received the higher of $17.29 or 90% of the 1998 capital payment. The 1998 capital payment for existing capital was based on historic cost and imputed value. Straight line was used for buildings. A return allowable was 7.85%. New facilities, replacement facilities and new beds were paid at $17.29 per day.

Reimbursement Rate

The FY98 average reimbursement rate for Massachusetts was $116.63, calculated by days of care and weighted by case-mix.

Other Long-Term Care

Hospital-based nursing facilities were paid based on the standard payment model. 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 homes 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	$116.63
Percentage Rate Change From Previous Year	4.2%
Peer Groupings	Geographic Location (level of care by region)
Year of Cost Report to Set Rate	1996 nursing and other operating; 1993 capital
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	$450.20
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 Facilities

The number of nursing facilities in Michigan decreased from 458 in 1997 to 457 in 1998. The number of beds increased from 51,866 in 1997 to 51,886 in 1998. In the 10-year period between 1988 and 1998 Michigan had an overall bed growth rate of 1.83 percent, less than one-sixth the national rate (12.18 percent). The ratio of nursing facility beds per 1000 population aged 65 and over continued to be below the national ratio in 1998, (42.4 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Michigan increased steadily between 1989 and 1996 from 308 to 504. Facilities decreased to 407 in 1997 and remained so in 1998.[1] The number of ICF/MR beds increased from 3,052 in 1989 to 3,554 in 1995. In 1996 beds dropped to 3,494 and by 1997 and 1998 had decreased to 2,787. The ratio of ICF/MR beds per 1000 population was well below the national ratio in 1998, (0.28 compared to 0.47).

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, congregate care facilities, and county infirmaries). In 1998 there were 4,673 total facilities, a drop of 25 since 1997. The number of beds increased by 1,005 beds between 1997 and 1998 (from 45,186 to 46,191) and the ratio of licensed beds per 1000 population aged 65 and over remained high, 37.8 compared to 25.5 nationally.

Adult Day Care and Home Health Care

Adult day care was not licensed in Michigan in 1998. Home health care was not licensed in 1998, but there were 251 certified home health care agencies, an increase of 1 since 1997.

Hospice

Michigan had 120 licensed hospice agencies in 1998, an increase of 4 facilities since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.1 in 1998, compared to the US average ratio of 0.07.

CON/Moratorium

Michigan required a CON for nursing facilities from 1979 through 1998. In 1996 a moratorium was instituted for Medicaid reimbursed beds in nursing facilities that continued through 1998. In 1998 a CON was also required for hospital bed conversion and ICF/MRs, while there was neither a CON nor moratorium on residential care, home health care, hospice or adult day care.

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

MICHIGAN

Demographics

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

Licensed Nursing Facilities

Total Facilities	457
Total Beds	51,886
Beds Per Nursing Facility	113.5 (US 103.5)
Average Occupancy Rate	88.8
Beds Per 1000 Population:	
Age 65 and Over	42.4 (US 52.5)
Age 85 and Over	373.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.61 (US 6.00)
Expenditures Per 1000 Pop, 1997	$88,184 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	407
Total Beds	2,787
Beds Per 1000 Population	0.28 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	4,673
Total Beds for Adult/Aged	46,191
Beds Per 1000 Pop, Age 65 and Over	37.8 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.99 (US 6.95)
Expenditures Per 1000 Pop, 1997	$26,961 (US $45,711)

Licensed Hospices

Total Organizations	120
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996 Cost report was used for FY98. 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 $35,000 per bed.

Reimbursement Rate

The FY98 average reimbursement rate for Michigan was $96.05, 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	$91.49
Percentage Rate Change From Previous Year	8.7%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1996
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	$119.91
Capital Reimbursement Determination	Historic Cost, Depreciation Costs

ICF-MR

Method[1]	Retrospective Facility-Specific
Average Reimbursement Rate	$221.01
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	$360.18[2]

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

[2] Estimate.

MINNESOTA

Nursing Facilities

The number of nursing facilities in Minnesota has remained fairly constant, but showing a decrease from 446 in 1988 to 435 in 1998 (a decrease of 3 facilities since 1997). The number of beds has remained fairly constant as well, with 44,984 beds in 1988 and 43,782 beds in 1998 (a decrease of 521beds since 1997). The 1998 nursing bed growth rate was -1.18 compared to the US rate of -0.12. The ratio of licensed nursing facility beds per 1000 population aged 65 and over has been consistently far greater than the national ratio (in 1998, 75.1 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Minnesota decreased from 355 in 1991 to 267 in 1998. The number of beds also decreased from 5,774 in 1991 to 3,389 in 1998. This represents a decrease in 16 facilities and 415 beds since 1997. The ratio of ICF/MR beds per 1000 total population in Minnesota was higher than the U.S. ratio (0.72 compared to 0.47).

Residential Care for Adults/Aged

Minnesota has three categories of residential care - board and care, adult foster care and board and lodging. There were 3,307 total facilities with 17,400 beds in 1998, a decrease of 85 facilities and 321 beds since 1997. In 1998 the ratio of beds per 1000 population aged 65 and over was above the national ratio (29.8 compared to 25.5)[1].

Adult Day Care and Home Health Care

There were 103 licensed adult day care facilities in Minnesota in 1998, an increase of 4 since 1997. There were 767 licensed home health care agencies in 1998, an increase of 52 since 1997. The ratio of home health agencies per 1000 population aged 65 and over was 1.32, the second highest ratio in the country (Texas had the highest ratio with 1.81). The national average in 1998 was 0.47.

Hospice

While there was a decrease in the number of licensed hospice agencies between the years 1997 and 1998 (91 in 1997 and 89 in 1998), there was an increase in the number of certified hospices during the same years (63 in 1997 and 66 in 1998). The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.15 in 1998 compared to the US average of 0.07.

CON/Moratorium

Minnesota had a CON for nursing facilities between 1979 and 1982. In 1983, a moratorium was added and in 1984, the CON was removed. The moratorium on nursing facilities remained in effect through 1998. In 1998 there was also a moratorium on hospital bed conversion and residential care for the developmentally disabled. There was neither a CON nor moratorium on ICF/MRs[2], assisted living, 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 450 facilities and 6,751 beds.

[2] In Minnesota a needs determination process is done on a county level. The limit is 7,000 beds state-wide. In 1998 Minnesota had 3,389 beds.

MINNESOTA

Demographics

Percentage Population 65 and Over	12.3 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	435
Total Beds	43,782
Beds Per Nursing Facility	100.6 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	75.1 (US 52.5)
Age 85 and Over	527.5 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.07 (US 6.00)
Expenditures Per 1000 Pop, 1997	$179,843 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	267
Total Beds	3,389
Beds Per 1000 Population	0.72 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	3,307
Total Beds for Adult/Aged	17,400
Beds Per 1000 Pop, Age 65 and Over	29.9 (US 25.5)
Total Facilities, Other	450
Total Beds, Other	6,751

Licensed Adult Day Care

Total Facilities	103
Facilities Per 1000 Pop, Age 65 and Over	0.18 (US 0.16)

Licensed Home Health Care

Total Agencies	767
Agencies Per 1000 Pop, Age 65 and Over	1.32 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	18.11 (US 6.95)
Expenditures Per 1000 Pop, 1997	$98,771 (US $45,711)

Licensed Hospices

Total Organizations	89
Organizations Per 1000 Pop, Age 65 and Over	0.15 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1997 cost reports were used for FY98. Inflation based on the CPI was used to trend rates. The minimum occupancy standard was 80% 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 FY98 weighted reimbursement rate for Minnesota was $106.65, 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 ($51.00) for an RN visit as for a home health aide visit ($39.00). 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	$106.47
Percentage Rate Change From Previous Year	4.6%
Peer Groupings	Geographic Location by Region
Year of Cost Report to Set Rate	1997
Inflation Adjustment	CPI
Minimum Occupancy in Rate-Setting	80% 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
Average Reimbursement Rate	$145.45
State Facilities	no data
Private Facilities	$138.41
Capital Reimbursement Determination (private facilities)	Historic Cost

Home Health

Method	Medicare Principles with State Alterations
Average Reimbursement Rate, RN Visit	$51.00
Average Reimbursement Rate, HH Aide Visit	$39.00

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	$255.05 per day

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

MISSISSIPPI

Nursing Facilities

The number of nursing facilities has remained fairly constant in Mississippi, increasing with some fluctuation from 172 in 1989 to 180 in 1998 (an increase of one facility since 1997). The number of beds has fluctuated but has shown an overall increase from 15,450 in 1989 to 17,501 in 1998 (an increase of 166 beds since 1997). The total bed growth rate for this 10-year period was 15.99 percent, higher than the national rate of 12.18 percent. The 1998 bed growth rate was 0.96 percent compared to –0.12 percent. The ratio of nursing facility beds per 1000 population aged 65 and over, however, remained just below the national ratio in 1998 (52.1 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Mississippi essentially remained constant with 12 facilities from 1989 to 1996. In 1997 the facilities increased to 13 and remained so through 1998. The number of ICF/MR beds increased during this period from 1,622 beds in 1989 to 2,293 in 1997 and to 2,500 in 1998. The ratio of ICF/MR beds per 1000 total population was 0.91 in 1998, nearly twice the national ratio of 0.47.

Residential Care for Adults/Aged

Residential care in Mississippi is provided in personal care homes. There were 165 homes in 1998 with 3,441 beds, an increase of 6 homes and 49 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over remained well below the national ratio in 1998 (10.2 compared to 25.5).[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Mississippi in 1998. There were 69 licensed home health care agencies in 1998, a drop of 1 since 1997. The ratio of licensed agencies per 1000 population aged 65 and over was 0.21, less than half the national ratio of 0.47.

Hospice

In Mississippi in 1998 there were 38 licensed hospice agencies, an increase of 5 facilities since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.11 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

Mississippi had a CON for nursing facilities in 1980 and added a moratorium to it in 1981. Both remained in effect through 1998. In 1998 the CON/moratorium also covered hospital bed conversion, sub-acute beds[2], ICF/MRs, psychiatric residential treatment facilities and home health care. There was neither a CON nor moratorium for assisted living, hospice or adult day care. 3 nursing facility CON applications were submitted in 1998, 2 of these were denied.

[1] 'Other Residential Care' in Mississippi included 5 psychiatric treatment facilities with 196 beds.

[2] Medicare sub-acute beds were exempt from CON and Moratorium.

MISSISSIPPI

Demographics

Percentage Population 65 and Over	12.2 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	180
Total Beds	17,501
Beds Per Nursing Facility	97.2 (US 103.5)
Average Occupancy Rate	94.64
Beds Per 1000 Population:	
Age 65 and Over	52.1 (US 52.5)
Age 85 and Over	437.5 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.54 (US 6.00)
Expenditures Per 1000 Pop, 1997	$110,494 (US $114,494)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	13
Total Beds	2,500
Beds Per 1000 Population	0.91 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	165
Total Beds for Adult/Aged	3,441
Beds Per 1000 Pop, Age 65 and Over	10.2 (US 25.5)
Total Facilities, Other	5
Total Beds, Other	185

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	69
Agencies Per 1000 Pop, Age 65 and Over	0.21 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.59 (US 6.95)
Expenditures Per 1000 Pop, 1997	$3,878 (US $45,711)

Licensed Hospices

Total Organizations	38
Organizations Per 1000 Pop, Age 65 and Over	0.11 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	CON & Moratorium
Adult Day Care	No CON or Moratorium
Home Health Care	CON & Moratorium
Hospice 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 1996 cost reports were used for FY98. 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 FY98 average reimbursement rate for Mississippi was $80.60.

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	$80.60
Percentage Rate Change From Previous Year	5.0%
Peer Groupings	Number of Beds
Year of Cost Report to Set Rate	1996
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	$151.16
Ancillary Services Included in Rate	Non-Prescription Drug, Oxygen, Medical Supplies, Patient Transport

Home Health

Method	Medicare Principles
Average Reimbursement Rate, RN Visit	$74.20
Average Reimbursement Rate, HH Aide Visit	$27.16
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 Facilities

Between 1997 and 1998, a decrease of 5 facilities and 120 beds occurred in Missouri. The number of nursing facilities in Missouri has fluctuated but has shown an increase over a ten-year period, increasing from 577 in 1989 to 623 in 1998. The number of beds has also fluctuated but increased overall from 52,337 in 1989 to 59,287 in 1998. The total bed growth rate in 1998 was -0.20 percent, compared to the national rate (-0.12 percent). In 1998 the ratio of licensed beds per 1000 population aged 65 and over was greater than the national ratio (79.6 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Missouri decreased from 41 facilities and 2,035 beds in 1989 to 20 facilities and 1,474 beds in 1998. This represents a decrease of 2 facilities and 77 beds since 1997. The ratio of ICF/MR beds per 1000 total population was 0.27 in 1998 - substantially lower than the U.S. ratio of 0.47.

Residential Care for Adults/Aged

Missouri provides residential care in type 1 and type 2 residential facilities. In 1998, there were 672 total facilities with 21,740 beds, a decrease of 21 facilities and 570 beds since 1997. Despite this decrease Missouri maintained a ratio of licensed beds per 1000 population aged 65 and over greater than that of the national ratio (in 1998, 29.2 compared to 25.5).[1]

Adult Day Care and Home Health Care

Missouri licenses medical model adult day care and social model adult day care. In 1998, there were 57 of the former and 4 of the latter, a total increase of 7 facilities since 1997. There were 238 licensed home health care agencies in Missouri in 1998, a decrease in 48 agencies since 1997. Missouri continued to have a ratio of licensed home health care agencies per 1000 population aged 65 and over below the national ratio (in 1998, 0.32 compared to 0.47).

Hospice

Missouri had 73 licensed hospice agencies in 1998, a decrease of 3 since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.10 compared to the US ratio of 0.07.

CON/Moratorium

Missouri had a CON for nursing facilities between 1980 and 1982 and added a moratorium in 1983. Both the CON and moratorium remained in effect through 1998. In 1998, the CON/moratorium also covered hospital bed conversion[2], ICF/MRs and residential care. Neither a CON nor moratorium were required for home health care, hospice or adult day care.

[1] 'Other Residential Care' in Missouri includes residential care for MR/DD, congregate living and individualized living, for a total of 1,382 facilities and 12,273 beds. The bed count is partially estimated as data was not available for residential care MR/DD.

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

MISSOURI

Demographics

Percentage Population 65 and Over	13.7 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	623
Total Beds	59,287
Beds Per Nursing Facility	95.2 (US 103.5)
Average Occupancy Rate	78.65
Beds Per 1000 Population:	
Age 65 and Over	79.6 (US 52.5)
Age 85 and Over	605.0 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.69 (US 6.00)
Expenditures Per 1000 Pop, 1997	$115,063 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	20
Total Beds	1,474
Beds Per 1000 Population	0.27 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	672
Total Beds for Adult/Aged	21,740
Beds Per 1000 Pop, Age 65 and Over	29.2 (US 25.5)
Total Facilities, Other	1,382
Total Beds, Other	12,273

Licensed Adult Day Care

Total Facilities	61
Facilities Per 1000 Pop, Age 65 and Over	0.08 (US 0.16)

Licensed Home Health Care

Total Agencies	238
Agencies Per 1000 Pop, Age 65 and Over	0.32 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.65 (US 6.95)
Expenditures Per 1000 Pop, 1997	$20,892 (US $45,711)

Licensed Hospices

Total Organizations	73
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON & Moratorium
Residential Care	CON & Moratorium
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98 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 and caps were set for the three expense type cost centers:
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 FY98 average reimbursement rate for Missouri was $88.34.

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	$88.34
Percentage Rate Change From Previous Year	5.99%
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	$229.48
Private Facilities	Prospective Facility-Specific
Average Reimbursement Rate	$136.88
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	$42.70 per diem
Facility Type	Day Health
Clients Covered	Aged, Physically & Developmentally Disabled, Mentally Ill

Sub-Acute Care

No Separate Program

MONTANA

Nursing Facilities

The number of nursing facilities in Montana has fluctuated but overall there has been an increase from 100 in 1989 to 109 in 1998 (an increase of 3 facilities since 1997). The number of beds also has fluctuated, but increased from 6,911 in 1989 to 7,827 in 1998 (an increase of 174 beds since 1997). This represents a total bed growth rate of 2.27 percent in 1998, greater than the national rate of -0.12 percent. Montana has been consistently above the national ratio in nursing facility beds per 1000 population aged 65 and over (in 1998, 66.9 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MRs in Montana has remained 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 through 1998. The ratio of licensed beds per 1000 total population well below the national ratio (0.19 compared to 0.47).

Residential Care for Adults/Aged

Residential care in Montana is provided in personal care homes, adult foster care homes, and retirement homes. In 1998 there were a total of 254 facilities and 5,320 beds, an increase of 26 facilities and 1,365 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over increased from 7.6 in 1990 to 45.5 in 1998, substantially higher than the national ratio of 25.5[1].

Adult Day Care and Home Health Care

There were 51 licensed adult day care facilities in Montana in 1998, an increase of 6 since 1997. There were 63 licensed home health care agencies in 1998, an increase of 1 since 1997. The ratio of licensed home health care agencies per 1000 population aged 65 and over was slightly higher than the national ratio in 1998 (0.54 compared to 0.47).

Hospice

The number of licensed hospice agencies was 23 in 1997, remaining at 23 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.2 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

Montana has required a CON for nursing facilities since 1980. In 1998 a CON was also required for hospital bed conversion and home health care. Both a CON and moratorium were in effect for ICF/MRs in 1998. Neither a CON nor moratorium were required on residential care, hospice or adult day care.

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

MONTANA

Demographics

Percentage Population 65 and Over	13.3 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	109
Total Beds	7,827
Beds Per Nursing Facility	71.8 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	66.9 (US 52.5)
Age 85 and Over	521.8 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.61 (US 6.00)
Expenditures Per 1000 Pop, 1997	$110,461 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	3
Total Beds	170
Beds Per 1000 Population	0.19 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	254
Total Beds for Adult/Aged	5,320
Beds Per 1000 Pop, Age 65 and Over	45.5 (US 25.5)
Total Facilities, Other	11
Total Beds, Other	439

Licensed Adult Day Care

Total Facilities	51
Facilities Per 1000 Pop, Age 65 and Over	0.44 (US 0.16)

Licensed Home Health Care

Total Agencies	63
Agencies Per 1000 Pop, Age 65 and Over	0.54 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	Not Available (US 6.95)
Expenditures Per 1000 Pop, 1997	Not Available (US $45,711)

Licensed Hospices

Total Organizations	23
Organizations Per 1000 Pop, Age 65 and Over	0.2 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice 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 1996 cost reports were used for FY98. 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 FY98 rate.

Cost Centers

Four cost centers were used for setting reimbursement rates: 1. direct nursing, limited to 109% of median; 2. property, limited to $11.50; 3. operating, limited to 103% of the median; and 4. operating incentive equal to the lesser of ten percent of median operating cost or 27% 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. Only the direct nursing care portion of the rate was adjusted. 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 FY98 average reimbursement rate for Montana was $87.54, weighted by days of care. On average, the operating rate was $48.43 and capital was $7.78.

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 case-mix system in FY99 for rate setting in year 2000.

MONTANA

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$87.54
Percentage Rate Change From Previous Year	1.92%
Peer Groupings	None
Year of Cost Report to Set Rate	1996
Inflation Adjustment	DRI-SNF
Minimum Occupancy in Rate-Setting	None
Case-Mix Adjusters	TNCA[1] System, Direct Nursing was CM Adjusted
Capital Reimbursement Determination	Historic Cost and Rental Value
Ancillary Services Included in Rate	Non-Prescription Drug Medical Supplies Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities

ICF-MR

Method	Retrospective Facility-Specific
Average Reimbursement Rate	$287.43
Cost Centers	None
Capital Reimbursement Determination	Historic Cost
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee for Service
Flat Reimbursement Rate, RN Visit	$60.43
Flat Reimbursement Rate, HH Aide Visit	$26.99

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Patient-Specific
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Facility	
Social (Aged)	$6.00 per hour
Habilitation (Physically Disabled)	$30.32 per diem
Clients Covered	Aged and Physically Disabled

Sub-Acute Care

Method	Prospective Patient-Specific
Average Rate: Traumatic Brain Injury	$129.00

[1] Tennessee National Corporation Abstract (TNCA) System.

NEBRASKA

Nursing Facilities

The number of nursing facilities in Nebraska has grown slowly, increasing from 240 in 1989 to 248 in 1998. The number of nursing facility beds has fluctuated but has remained essentially constant, increasing from 18,858 in 1989 to 19,277 in 1998 (with an increase of 1,051 beds since 1997). The total bed growth rate in 1998 was 5.77 percent, compared to the national growth rate of –0.12 percent. The state's ratio of nursing facility beds per 1000 population aged 65 and over, however was very high (in 1998, 84.2, compared to the national ratio of 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Nebraska fluctuated between 4 and 5 since 1989. In 1998 there were 4 ICF/MR facilities with no change since 1995. The number of beds decreased from 798 in 1989 to 733 in 1997 and to 710 in 1998. Nebraska's ratio of ICF/MR beds per 1000 total population was slightly below the national ratio in 1998 (0.43 compared to 0.47).

Residential Care for Adults/Aged

Nebraska provides residential care in assisted living[1] and boarding homes. In 1998 there were 161 total facilities with 6,746 beds, an increase of 13 facilities and 672 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 29.5 - greater than the national ratio of 25.5 in 1998[2].

Adult Day Care and Home Health Care

Adult day care facilities were not licensed in Nebraska in 1998. There were 120 licensed home health care agencies in 1998, a decrease of 5 agencies since 1997 and a ratio of agencies per 1000 population aged 65 and over of 0.52, higher than the national ratio of 0.47.

Hospice

Nebraska first licensed hospice agencies in 1998 when there were a total of 29 facilities. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.13 in 1998, higher than the US average of 0.07.

CON/Moratorium

Nebraska had a CON for nursing facilities from 1980 though 1998. There was neither a CON nor moratorium on hospital bed conversion, residential care, home health care, hospice or adult day care. In 1998 there was a CON on ICF/MRs. There were no nursing facility CON applications submitted in 1998.

[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 230 facilities and 2,044 beds.

NEBRASKA

Demographics

Percentage Population 65 and Over	13.8 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	248
Total Beds	19,277
Beds Per Nursing Facility	77.7 (US 103.5)
Average Occupancy Rate	87
Beds Per 1000 Population:	
Age 65 and Over	84.2 (US 52.5)
Age 85 and Over	567.0 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	11.66 (US 6.00)
Expenditures Per 1000 Pop, 1997	$133,214 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	4
Total Beds	710
Beds Per 1000 Population	0.43 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	161
Total Beds for Adult/Aged	6,746
Beds Per 1000 Pop, Age 65 and Over	29.5 (US 25.5)
Total Facilities, Other	230
Total Beds, Other	2,044

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	120
Agencies Per 1000 Pop, Age 65 and Over	0.52 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.65 (US 6.95)
Expenditures Per 1000 Pop, 1997	$10,669 (US $45,711)

Licensed Hospices

Total Organizations	29
Organizations Per 1000 Pop, Age 65 and Over	0.13 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	No CON or Moratorium
Residential Care	No CON or Moratorium
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1997 cost reports were used for setting the interim CY98 rates. The 1998 cost report were used to set the final FY1998 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 FY98.

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 FY98 average reimbursement rate for Nebraska was $81.96[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 $80.34 for a RN visit and $44.00 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	$81.96
Percentage Rate Change From Previous Year	6.86%
Peer Groupings	Geographic & OBRA 87 nursing waivers
Year of Cost Report to Set Rate	1997, 1998[1]
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	$209.83
Private Facilities	$157.81
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	$80.34
Average Reimbursement Rate, HH Aide Visit	$44.00

Other Residential Care For Aged

No Medicaid Program

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	2176 Waiver & Social Service Block Grant
Flat Reimbursement Rate	Per diems: $30.00 waiver & $19.50 Social Service Block Grant
Facility Type	Day Health and Dementia/Alzheimer's Disease & Medial Rehabilitation
Clients Covered	Aged & Physically Disabled and AIDS/HIV[2]

Sub-Acute Care

Method	Prospective Facility-Specific Contracts
Average Rates	
Ventilator	$492.37 Based on CY 1998 Contract
Medically Complex Sub-acute	$556.39 Based on CY 1998 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 Facilities

The number of nursing facilities in Nevada has been growing slowly but steadily, increasing from 34 in 1989 to 47 in 1998 (an increase of 4 facilities since 1997). During this period there has also been an increase in the number of beds with 3,175 in 1989 and 4,384 in 1998 (an increase of 193 beds since 1997). The total bed growth rate for the ten-year period was 42.58 percent, over 3 times the national rate of 12.18 percent, but, despite this growth, the ratio of nursing facility beds per 1000 population aged 65 and over (21.9) was less than half the national ratio (52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MRs increased from 3 in 1989 to 19 in 1998. The number of beds increased from 193 in 1990 to 264 in 1998. This represents an increase of 2 facilities and 22 beds since 1997. In Nevada the ratio of ICF/MR beds per 1000 total population in 1998 was 0.15, substantially less than the national ratio of 0.47.

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 1998 there were 263 of the former with 3,116 beds and 39 of the latter with 401 beds, a total growth of 18 facilities and 408 beds since 1997. Despite this increase, the ratio of licensed beds per 1000 population aged 65 and over remained lower than the national ratio in 1998 (17.6 compared to 25.5).[2]

Adult Day Care and Home Health Care

Nevada had 12 licensed adult day care facilities in 1998, a gain of 2 facilities since 1997. There were 61 licensed home health care agencies in Nevada in 1998, 12 fewer agencies than in 1997. Nevada's 1998 ratio of agencies per 1000 population aged 65 and over was below the national ratio (0.31 compared to 0.47).

Hospice

The number of licensed hospice agencies decreased from 14 in 1997 to 11 in 1998. Nevada had a ratio of 0.06 licensed hospice agencies in 1998 just under the US ratio of 0.07.

CON/Moratorium

Nevada had a CON for nursing facilities 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 1998 there was neither a CON nor moratorium on nursing facilities, hospital bed conversion, ICF/MRs, residential care, home health care, hospice or adult day care.

[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 14 facilities and 338 beds in 1998.

[3] The CON for nursing facilities 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	0.9 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	47
Total Beds	4,384
Beds Per Nursing Facility	93.3 (US 103.5)
Average Occupancy Rate	86.8
Beds Per 1000 Population:	
Age 65 and Over	21.9 (US 52.5)
Age 85 and Over	292.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.23 (US 6.00)
Expenditures Per 1000 Pop, 1997	$40,185 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	19
Total Beds	264
Beds Per 1000 Population	0.15 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	302
Total Beds for Adult/Aged	3,517
Beds Per 1000 Pop, Age 65 and Over	17.6 (US 25.5)
Total Facilities, Other	14
Total Beds, Other	338

Licensed Adult Day Care

Total Facilities	12
Facilities Per 1000 Pop, Age 65 and Over	0.06 (US 0.16)

Licensed Home Health Care

Total Agencies	61
Agencies Per 1000 Pop, Age 65 and Over	0.31 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.05 (US 6.95)
Expenditures Per 1000 Pop, 1997	$12,211 (US $45,711)

Licensed Hospices

Total Organizations	11
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1995 cost reports were used for setting the FY98 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 FY98.

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 FY98 average reimbursement rate for Nevada was $86.71.

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 $201.93. Home health payment used a fee schedule with flat rates, much higher for RN visits ($57.92) than for home health aide visits ($24.65). 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	$86.17
Percentage Rate Change From Previous Year	1.70%
Peer Groupings	None
Year of Cost Report to Set Rate	1996
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[2]
Average Reimbursement Rate	$201.93
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	$57.92
Average Reimbursement Rate, HH Aide Visit	$24.65

Other Residential Care For Aged

No Medicaid Program[1]

Adult Day Care

Method	Prospective Flat Rate
Reimbursement Program	2176 Waiver
Average Reimbursement Rate	$32.57 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] Residential Care was for the Mentally Retarded.
[2] Interim rate adjusted by audit.

NEW HAMPSHIRE

Nursing Facilities

The number of nursing facilities in New Hampshire slowly increased from 71 in 1989 to 93 in 1997 and to 94 in 1998. The number of nursing facility beds decreased from 6,808 in 1989 to 8,169 in 1996 and then increased to 8,172 in 1998. In 1998 the bed growth rate was 0.86 percent, higher than the national rate of –0.12 percent. The ratio of licensed beds per 1000 population aged 65 and over remained greater than the national ratio in 1998 (57.5 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

New Hampshire's ICF/MR facilities decreased from 8 in 1989 to 1 in 1996, remaining at 1 facility through 1998. 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 1998. New Hampshire's ratio of ICF/MR beds per 1000 total population was 0.02 in 1998, substantially less than the national ratio of 0.47. New Hampshire and Vermont ranked with the fewest beds per capita in 1998.

Residential Care for Adults/Aged

New Hampshire provides residential care in residential care home facilities and supported residential care facilities. In 1998 there were 80 of the former with 959 beds and 61 of the latter with 2,071 beds[1], a total increase of 5 facilities and 80 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 21.3 compared to the national ratio of 25.5.

Adult Day Care and Home Health Care

There were 18 licensed adult day care facilities in New Hampshire in 1998, an increase of 2 facilities since 1997. There were 116 licensed home health care agencies in 1998, no change since 1997. In 1998 New Hampshire's ratio of licensed home health agencies per 1000 population aged 65 and over was 0.82 - greater than the national ratio of 0.47.

Hospice

The number of licensed hospices increased from 24 in 1997 to 25 in 1998. The ratio of licensed hospice per 1000 population aged 65 and over was 0.18 compared to the US ratio of 0.07.

CON/Moratorium

New Hampshire required a CON for nursing facilities from 1980 through 1998. In 1995 a moratorium was added to the CON which remained through 1998[2]. In 1998 a CON alone was required for hospital bed conversion, while there was neither a CON nor moratorium on ICF/MRs, residential care, home health care, hospice or adult day care.

[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.

[2] New Hampshire's nursing facility moratorium has been extended to 12/31/01.

NEW HAMPSHIRE

Demographics

Percentage Population 65 and Over	12.0 % (US 12.7 %)
Percentage Population 85 and Over	1.5 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	94
Total Beds	8,172
Beds Per Nursing Facility	86.9 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	57.5 (US 52.5)
Age 85 and Over	454.0 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.26 (US 6.00)
Expenditures Per 1000 Pop, 1997	$156,220 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	1
Total Beds	26
Beds Per 1000 Population	0.02 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	141
Total Beds for Adult/Aged	3,030
Beds Per 1000 Pop, Age 65 and Over	21.3 (US 25.5)
Total Facilities, Other	1,100
Total Beds, Other	1,650

Licensed Adult Day Care

Total Facilities	18
Facilities Per 1000 Pop, Age 65 and Over	0.13 (US 0.16)

Licensed Home Health Care

Total Agencies	116
Agencies Per 1000 Pop, Age 65 and Over	0.82 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.02 (US 6.95)
Expenditures Per 1000 Pop, 1997	$97,349 (US $45,711)

Licensed Hospices

Total Organizations	25
Organizations Per 1000 Pop, Age 65 and Over	0.18 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98.

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 FY98 average reimbursement rate for New Hampshire was $115.07, 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	$115.07
Percentage Rate Change From Previous Year	4.1%
Peer Groupings	Year of Cost Report to Set Rate 1997
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 Facilities

The number of nursing facilities decreased from 357 in 1997 to 355 in 1998. The number of nursing facility beds increased from 49,688 in 1997 to 49,871 in 1998. The total bed growth rate in 1998 was 0.37 percent compared to the national average of –0.12 percent. In 1998 the ratio of licensed nursing facility beds per 1000 population aged 65 and over in New Jersey remained lower than the national ratio (45.1 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in New Jersey has fluctuated between 8 and 11 since 1989, decreasing from 10 in 1997 to 9 in 1998. The number of beds also fluctuated, but overall there has been a decrease from 3,789 in 1989 to 3,636 in 1998 (a decrease of 494 beds since 1997). New Jersey's ratio of ICF/MR beds per 1000 total population was 0.45 in 1998, just under the national ratio of 0.47.

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 1998, there were 443 total facilities and 19,210 total beds, a decrease of 11 facilities, but an increase of 2,482 beds since 1997.[1] The ratio of licensed beds per 1000 population aged 65 and over remains lower than the national ratio in 1998 (17.4 compared to 25.5).

Adult Day Care and Home Health Care

New Jersey licenses freestanding adult day health care facilities and adult day programs. In 1998 there were 51 of the former and 36 of the latter, and increase of 6 total facilities since 1997. New Jersey had 80 licensed home health care agencies in 1998, no change in facilities since 1997. In 1998, a ratio of agencies per 1000 population 65 and over of 0.07 - much lower than the national ratio of 0.47.

Hospice

Although New Jersey did not license hospice in 1998, there were 45 certified facilities- a decrease of 1 facility since 1997.

CON/Moratorium

New Jersey had a CON for nursing facilities from 1980 through 1998 (there was a brief moratorium added in 1991 which was taken away in 1992). In 1998 a CON was also required for hospital bed conversion, sub-acute beds[2], ICF/MRs, residential care[3], assisted living, and home health care. Neither a CON nor moratorium were required for hospice or adult day care in 1998.

[1] Although New Jersey experienced a decline in facilities and beds in the residential health category as well as in boarding home facilities, there was a large increase in assisted living. Assisted living increased from 21 facilities and 1,633 beds in 1997 to 50 facilities and 4,303 beds in 1998.

[2] The sub-acute bed CON began in August 1998.

[3] The residential care CON was lifted as of August 1998.

NEW JERSEY

Demographics

Percentage Population 65 and Over	13.6 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	355
Total Beds	49,871
Beds Per Nursing Facility	140.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	45.1 (US 52.5)
Age 85 and Over	389.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.12 (US 6.00)
Expenditures Per 1000 Pop, 1997	$138,332 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	9
Total Beds	3,636
Beds Per 1000 Population	0.45 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	443
Total Beds for Adult/Aged	19,210
Beds Per 1000 Pop, Age 65 and Over	17.4 (US 25.5)
Total Facilities, Other	5
Total Beds, Other	336

Licensed Adult Day Care

Total Facilities	87
Facilities Per 1000 Pop, Age 65 and Over	0.08 (US 0.16)

Licensed Home Health Care

Total Agencies	80
Agencies Per 1000 Pop, Age 65 and Over	0.07 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.53 (US 6.95)
Expenditures Per 1000 Pop, 1997	$60,061 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON Only
ICF/MRs	CON Only
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice 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. A minimum occupancy standard was set at 95% for property capital and property operating and 85% for general services, nursing and all special patient care.

Adjustments

We do not have a semi-annual adjustment of the nursing component.

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 100% for 99+ beds), b. administration (limited by imputed formula), c. other general service (limited to 100% 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 FY98 average rate was $115.76, 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	$115.76
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 Facilities

The number of nursing facilities in New Mexico increased from 85 facilities in 1997 to 86 in 1998. The number of beds decreased from 7,305 in 1997 to 7,060 in 1998. The total bed growth rate in 1998 was -3.35, compared to the national rate of –0.12. The 1998 ratio of nursing facility beds per 1000 population aged 65 and over remained lower than the national ratio (35.7 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in New Mexico increased from 50 in 1997 to 54 in 1998. The number of beds increased as well, from 444 in 1997 to 479 in 1998. The ratio of ICF/MR beds per 1000 total population was 0.28 in 1998 - below the national ratio of 0.47.

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 1998 there were 254 total facilities with 4,619 beds, an increase of 1 facility and a decrease in 25 beds since 1997. New Mexico's ratio of licensed beds per 1000 population aged 65 and over was less than the national ratio in 1998 (23.3 compared to 25.5).[1]

Adult Day Care and Home Health Care

New Mexico had 14 licensed adult day care facilities in 1998, a decline of 1 since 1998. There were 151 licensed home health care agencies in New Mexico in 1997, a decrease of 17 since 1997, and a ratio of agencies per 1000 population aged 65 and over (0.76) that continued to be above the national ratio (0.47) in 1998.

Hospice

The number of licensed hospice organizations dropped from 36 in 1997 to 34 in 1998. New Mexico's ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.17 compared to the US ratio of 0.07.

CON/Moratorium

New Mexico required a CON for nursing facilities from 1979 through 1983. The CON was eliminated in 1984 and the state had neither a CON nor moratorium through 1998. In 1998 there was neither a CON nor moratorium on hospital bed conversion, ICF/MRs, residential care, home health care, hospice or adult day care.

[1] 'Other Residential Care' in New Mexico includes adult residential treatment and adult developmentally disabled facilities, with a total of 17 facilities and 162 beds.

NEW MEXICO

Demographics

Percentage Population 65 and Over	11.4 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	86
Total Beds	7,060
Beds Per Nursing Facility	82.1 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	35.7 (US 52.5)
Age 85 and Over	320.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.33 (US 6.00)
Expenditures Per 1000 Pop, 1997	$76,605 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	54
Total Beds	479
Beds Per 1000 Population	0.28 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	254
Total Beds for Adult/Aged	4,619
Beds Per 1000 Pop, Age 65 and Over	23.3 (US 25.5)
Total Facilities, Other	17
Total Beds, Other	162

Licensed Adult Day Care

Total Facilities	14
Facilities Per 1000 Pop, Age 65 and Over	0.07 (US 0.16)

Licensed Home Health Care

Total Agencies	151
Agencies Per 1000 Pop, Age 65 and Over	0.76 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.55 (US 6.95)
Expenditures Per 1000 Pop, 1997	$4,506 (US $45,711)

Licensed Hospices

Total Organizations	34
Organizations Per 1000 Pop, Age 65 and Over	0.17 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1997 cost report were used for FY98. 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 FY98.

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 FY98 average reimbursement rate for New Mexico was $129.04, 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	$129.04
Percentage Rate Change From Previous Year	15.9%
Peer Groupings	Type of Ownership (state/non-state)
Year of Cost Report to Set Rate	1997
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	$182.75
Level Two	$175.53
Level Three	$153.69
Capital Reimbursement System	Combination[1]
Ancillary Services Included in Rate	Physical Therapy, Occupational Therapy, Non-Prescription Drug, Medical Supplies, Patient Transport, Oxygen, Speech[2], Recreation[2], Psychology[2], Dietary Supplements[2], Durable Medical Equipment

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 Facilities

The number of nursing facilities in New York has grown slowly but steadily, increasing from 617 in 1989 to 667 in 1997 and to 673 in 1998. The number of beds has been steadily increasing as well, growing from 102,595 in 1989 to 117,091 in 1997 and to 118,885 in 1998. The growth rate over this 10 year period was 16.06 compared to the national average of 12.18. Despite this growth, however, the ratio of nursing facility beds per 1000 population aged 65 and over remained lower the national ratio in 1998 (49.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

In 1998 there were 825 ICF/MR facilities in New York with approximately 11,600 beds. This total includes 19 large facilities and 806 small community based facilities with an average of 12 beds each. This was a decrease of 9 facilities and 730 beds since 1997. The ratio of ICF/MR beds per 1000 total population was 0.64 in 1998 - compared to the national ratio of 0.47.

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 1,332 total facilities with 41,328 beds in 1998, a decrease of 11 facilities and an increase of 1,993 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over remained lower than the national ratio (in 1998, 17.0 compared to 25.5).[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 1998 there were 484 total facilities, an increase of 14 facilities since 1997. There were 963 licensed home health care agencies in New York in 1998, an increase of 2 since 1997. The ratio of home health care agencies per 1000 population aged 65 and over was slightly lower than the national ratio in 1998 (0.40 compared to 0.47).

Hospice

Although hospice was not licensed in New York in 1998, there were 54 certified hospice agencies (no change since 1997).

CON/Moratorium

New York required a CON for nursing facilities from 1980 through 1998 (there was a brief moratorium added to it in 1986 that was dropped in 1987). In 1998 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 1998.

[1] 'Other residential care' in New York includes 'adult residences' which is mostly utilized by mentally ill residents. In 1998 there were 9 facilities and 464 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	13.3 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	673
Total Beds	118,885
Beds Per Nursing Facility	176.6 (US 103.5)
Average Occupancy Rate	95
Beds Per 1000 Population:	
Age 65 and Over	49.0 (US 52.5)
Age 85 and Over	395.0 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.34 (US 6.00)
Expenditures Per 1000 Pop, 1997	$259,445 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	825
Total Beds	11,600
Beds Per 1000 Population	0.64 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,332
Total Beds for Adult/Aged	41,328
Beds Per 1000 Pop, Age 65 and Over	17.1 (US 25.5)
Total Facilities, Other	9
Total Beds, Other	464

Licensed Adult Day Care

Total Facilities	484
Facilities Per 1000 Pop, Age 65 and Over	0.2 (US 0.16)

Licensed Home Health Care

Total Agencies	963
Agencies Per 1000 Pop, Age 65 and Over	0.4 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	23.83 (US 6.95)
Expenditures Per 1000 Pop, 1997	$224,833 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

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
Adult Day Care	CON Only
Home Health Care	CON Only
Hospice 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 1996 cost report was used for FY98 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, electrocardiolgy 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 FY98 average reimbursement rate was $158.93, 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 $77.30 for a registered nurse visit and a home health aide hourly visit at $19.20 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	$158.93
Percentage Rate Change From Previous Year	4.7%
Peer Groupings	Type of Ownership and Number of Beds
Year of Cost Report to Set Rate	1983/1996
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	$188.02

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	$77.30 by visit
Average Reimbursement Rate, HH Aide Visit	$19.20 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 Facilities

The number of nursing facilities in North Carolina increased from 278 in 1989 to 424 in 1998 (an increase of 3 facilities since 1997). The number of beds also increased during this period, growing from 25,218 in 1989 to 41,046 (an increase of 231 beds since 1997). The bed growth rate in 1998 was 0.57, compared to the national rate of -0.12. The ratio of licensed beds per 1000 population aged 65 and over, however, remained lower than the national ratio in 1998 (43.3 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in North Carolina increased from 301 in 1991 to 332 in 1998. The number of ICF/MR beds also increased from 4,912 in 1991 to 5,225 in 1998. No change in facilities or beds in North Carolina had occurred since 1997. North Carolina's ratio of ICF/MR beds per 1000 total population was 0.69, above the national ratio of 0.47 in 1998.

Residential Care for Adults/Aged

North Carolina licenses residential care by size - family care homes have 6 residents or less, homes for the aged have 7 or more residents. There were 767 of the former with 4,212 beds and 535 of the latter with 30,381 beds in 1998, a total increase of 7 facilities and 415 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over continued to be greater than the national ratio in 1998 (36.5 compared to 25.5).[1]

Adult Day Care and Home Health Care

The number of adult day care facilities in North Carolina was 100 in 1998, an increase of 10 facilities since 1997. There were 883 licensed home health care agencies in North Carolina in 1998, an increase of 45 since 1997, and a ratio of licensed agencies per 1000 population aged 65 and over of 0.93 (almost double the national ratio of 0.47).

Hospice

The number of licensed hospice agencies increased from 54 in 1997 to 60 in 1998. The ratio of licensed hospice per1000 population aged 65 and over was 0.06 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

North Carolina required a CON for nursing facilities between 1980 and 1998, with a brief moratorium added to it between 1981 and 1983. In 1998 a CON was also required for hospital bed conversion, ICF/MRs, home health care and hospice. There was neither a CON nor moratorium for adult day care, while licensed adult care homes[2] and assisted living had a moratorium only in 1998.

[1] 'Other Residential Care' in North Carolina includes: 212 group homes for mentally disabled adults with 1,226 beds, and 1,604 mental health facilities with 8,990 beds.

[2] A trial moratorium was in effect for adult care homes in 1988.

NORTH CAROLINA

Demographics

Percentage Population 65 and Over	12.5 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	424
Total Beds	41,046
Beds Per Nursing Facility	96.8 (US 103.5)
Average Occupancy Rate	93.15
Beds Per 1000 Population:	
Age 65 and Over	43.3 (US 52.5)
Age 85 and Over	406.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.60 (US 6.00)
Expenditures Per 1000 Pop, 1997	$102,205 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	332
Total Beds	5,225
Beds Per 1000 Population	0.69 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,302
Total Beds for Adult/Aged	34,593
Beds Per 1000 Pop, Age 65 and Over	36.5 (US 25.5)
Total Facilities, Other	1,816
Total Beds, Other	10,216

Licensed Adult Day Care

Total Facilities	100
Facilities Per 1000 Pop, Age 65 and Over	0.11 (US 0.16)

Licensed Home Health Care

Total Agencies	883
Agencies Per 1000 Pop, Age 65 and Over	0.93 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.20 (US 6.95)
Expenditures Per 1000 Pop, 1997	$50,031 (US $45,711)

Licensed Hospices

Total Organizations	60
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 FY98 Inflation based on a North Carolina market basket 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 FY98 average reimbursement rate for North Carolina was $95.12, weighted by days of care.

Other Long-Term Care

North Carolina used the same system for hospital-based as for free-standing nursing facilities, a prospective[2] facility-specific method for ICF-MR (Private) and prospective flat rate for ICF-MR(State) facilities. ICF-MR average reimbursement rates for State Facilities is $235.00 and Private Facilities is $196.38. The capital reimbursement was determined by Historic Cost for all ICF-MR facilities. Home health used Prospective Pay Rate and reimbursed at a maximum of $85.85 for a RN visit and a maximum rate of $39.27 for a HH Aide Visit. Other Residential Care for Aged reimbursed using Prospective Patient Specific (capped) method, under a waiver, at $26.00 per hour. The facility type included were Group Home, Family Home, Foster Home and Boarding Home. There were no separate programs for Adult Day Care and Sub-Acute Care.

[1] Five State facilities.

[2] Interim rate with cost settlement.

NORTH CAROLINA

Free-Standing Nursing Facilities

Method	Combination Facility-Specific, Adjusted	
Average Reimbursement Rate	$95.12[1]	
Percentage Rate Change From Previous Year	2.48%	
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	$85.85
Maximum Reimbursement Rate, HH Aide Visit	$39.27

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, 1997 through September 30, 1998.
[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 Facilities

The number of nursing facilities in North Dakota dropped from 94 in 1989 to 83 in 1991 and then rose to 88 in 1996, remaining at 88 facilities through 1998. In 1989, there were 6,948 nursing facility beds; in 1998, there were 7,020 beds (a decrease of 104 beds since 1997). The total bed growth rate for 1998 was -1.46, compared to the national rate of -0.12, but the ratio of licensed beds per 1000 population aged 65 and over remained well above the national ratio in 1998 (76.3 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

There were 66 ICF/MR facilities with 780 beds in North Dakota in 1998, no change since 1996. The ratio of ICF/MR beds per 1000 total population in North Dakota was 1.22 in 1998, compared to the national ratio of 0.47.

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 1998 there were 103 of the former with 248 beds and 42 of the latter with 1,465 beds, a total increase of 11 facilities and 11 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over (18.6) remained less than the national ratio (25.5) in 1998.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in North Dakota in 1998. There were 46 licensed home health care agencies in 1998, no change since 1997. The ratio of licensed agencies per 1000 population aged 65 and over was just over the national ratio in 1998 (0.5 compared to 0.47).

Hospice

North Dakota had 15 licensed hospice agencies in 1998, an increase of 1 facility since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.16, compared to the US ratio 0.07.

CON/Moratorium

North Dakota had a CON for nursing facilities from 1970 through 1994. In 1995 the CON was dropped and replaced by a moratorium. In 1998 a moratorium also was in effect for hospital bed conversion, ICF/MRs, and residential care (basic care). Neither a CON nor moratorium were in effect for home health care, hospice or adult day care in 1998.

[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 1.5 %)

Licensed Nursing Facilities

Total Facilities	88
Total Beds	7,020
Beds Per Nursing Facility	79.8 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	76.3 (US 52.5)
Age 85 and Over	501.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.88 (US 6.00)
Expenditures Per 1000 Pop, 1997	$169,312 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	66
Total Beds	780
Beds Per 1000 Population	1.22 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	145
Total Beds for Adult/Aged	1,713
Beds Per 1000 Pop, Age 65 and Over	18.6 (US 25.5)
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	0.5 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.41 (US 6.95)
Expenditures Per 1000 Pop, 1997	$62,435 (US $45,711)

Licensed Hospices

Total Organizations	15
Organizations Per 1000 Pop, Age 65 and Over	0.16 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	Moratorium Only
ICF/MRs	Moratorium Only
Hospital Bed Conversion	Moratorium Only
Residential Care	Moratorium Only
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1997 cost report was used for calendar 1998 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 FY98.

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 CY98 average reimbursement rate for North Dakota was $94.31, 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	$94.31
Percentage Rate Change From Previous Year	3.6%
Peer Groupings	None
Year of Cost Report to Set Rate	June 1997
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	$187.86[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 $178.16, average government owned $338.29.

OHIO

Nursing Facilities

The number of nursing facilities in Ohio decreased from 1,138 in 1989 to 982 in 1997 and to 959 in 1998. The number of beds increased from 88,530 in 1989 to 91,103 in 1997 and then decreased to 90,996 in 1998[1]. In 1998 Ohio had a bed growth rate of –0.12 percent, exactly that of the national rate. The ratio of nursing facility beds per 1000 population aged 65 and over was above the national ratio in 1998 (60.6 compared to 52.5), as it has been for many years.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities increased from 217 in 1990 to 451 in 1998, beds increased from 7,456 in 1990 to 8,809 in 1998. This represents and increase of 4 facilities and 24 beds in Ohio since 1997. The ratio of ICF/MR beds per 1000 total population was 0.79 in 1998, higher than the national ratio of 0.47.

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 1998 there were 1,325 total facilities with 36,869 beds, an increase of 16 facilities and 1,005 beds since 1997 -a ratio of licensed beds per 1000 population aged 65 and over less than the national ratio (24.6 compared to 25.5).

Adult Day Care and Home Health Care

Adult day care was not licensed in Ohio in 1998. Home health care was not licensed but in 1998, but there were 405 certified home care agencies, a decrease of 35 since 1997.

Hospice

There were 105 licensed hospice agencies in 1997, these decreased to 104 in 1998. The ratio of licensed hospices per 1000 population aged 65 and over was 0.07 in Ohio, the same ratio as that of the US average.

CON/Moratorium

Ohio had a CON for nursing facilities from 1980 through 1998, with a moratorium added in 1983. Since then the moratorium had been eliminated and restarted several times. The nursing facility moratorium was in effect in 1998. In 1998 there was neither a CON nor moratorium on hospital bed conversion, 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 1.5 %)

Licensed Nursing Facilities

Total Facilities	959
Total Beds	90,996
Beds Per Nursing Facility	94.9 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	60.6 (US 52.5)
Age 85 and Over	532.1 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	7.77 (US 6.00)
Expenditures Per 1000 Pop, 1997	$158,485 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	451
Total Beds	8,809
Beds Per 1000 Population	0.79 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,325
Total Beds for Adult/Aged	36,869
Beds Per 1000 Pop, Age 65 and Over	24.6 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.79 (US 6.95)
Expenditures Per 1000 Pop, 1997	$26,804 (US $45,711)

Licensed Hospices

Total Organizations	104
Organizations Per 1000 Pop, Age 65 and Over	0.07 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* Opinion of State Health Planning Officials.

OHIO

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective, adjusted methodology was used to set Medicaid rates. Total costs were divided by days to establish per diem costs in four cost centers. NFs received the lower of costs or the ceiling inflated from the mid-point of the cost report period to the mid-point of the rate year. Per diem reimbursement was based on actual, allowable, desk-reviewed costs for the calendar year preceding the fiscal year in which the rate is paid (e.g., calendar year 1996 data were used for the rate year July 1, 1997 to June 30, 1998). The Consumer Price Index (CPI) was used to trend Other Protected Costs, Indirect Care Costs and Capital Costs for inflation. The Employment Cost Index was used to trend Direct Care Costs. The greater of inpatient days or 95% of bed days was the denominator for per diem Capital Costs. The minimum occupancy standard is 80% for capital reimbursement of new facilities in their first three months of operation.

Adjustments

The only adjustments to the prospective rates are quarterly case-mix adjustments and the reconsideration of rates under extreme circumstances or extreme hardships.

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] Capital Costs are limited by a ceiling of $16.33. The direct care cost ceiling is rebased each fiscal year. The indirect care cost ceiling is rebased in even fiscal years.

Ancillary services

Ancillary services included in the rate for NFs include respiratory therapy, medical supplies, durable medical equipment, non- prescription drugs, and ambulatory patient transportation.

Case-Mix Adjusters

Case mix was re-implemented the start of a new reimbursement methodology, effective July 1, 1993. The NF case-mix payment methodology is based on Resource Utilization Groups version III (RUGs III system, which uses the Minimum Data Set plus (MDS+) resident assessment instrument.

Capital Costs

Capital was valued by historic cost. The straight-line method and The American Hospital Association guidelines were used for depreciation. Capital costs[3] include three subcategories: cost of ownership, non-extensive renovations, and return on net equity. To determine a NF per diem capital rate, 88.65% of actual, allowable, desk-reviewed cost of ownership expense plus 85% of non-extensive renovation expense was divided by the greater of total inpatient days or 85% of total bed days, subject to an inflation-adjusted, maximum capital cost limit. A capital cost-efficiency incentive was based on 50% of the difference between desk-reviewed, actual, allowable, per diem cost of ownership and the applicable efficiency incentive ceiling for each NF. Return on net equity was calculated based on each proprietary NF's asset/liability balance sheet, subject to a ceiling of $1.00 per resident day.

Reimbursement Rate

The estimated average proposed payment rate for NFs for FY98 was $108.96.

Other Long-Term Care

The same method was used for hospital-based as for free-standing NFs, with a similar method for ICF-MR. Home care was paid under a fee schedule with flat rates, twice as high ($41.41) for RN as for home health aide visits ($20.71). Adult day care, under waiver, had a prospective class method. Sub-acute care payment used prospective facility-specific negotiated rates.

[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	$108.96
Percentage Rate Change From Previous Year	7.1%
Year of Cost Report to Set Rate	1996 Calendar Year
Inflation Adjustment	CPI, Employment Cost Index
Minimum Occupancy in Rate-Setting	80% New Facilities (first three months)
Case-Mix Adjusters	85% for the Indirect Care Cost Centers
Capital Reimbursement Determination	95% for the Capital Cost Center
Ancillary Services included in Rate	RUGs III, Direct Care Case-mix Adjusted
	Historic Cost
	Respiratory Therapy — Non-Prescription Drug
	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 Nursing Facilities[1]
Average Reimbursement Rate	
State Facilities	$259.26
Private Facilities	$175.21
Ancillary Services Included in Rate	
State Facilities	Include All Ancillary Services
Private Facilities	Same as NF's but also Includes
	Physical Therapy — Occupational Therapy
	Speech Therapy — Audiology

Home Health

Method: Lesser of Medicaid Maximum or Usual and Customary Charge	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$41.41
Average Reimbursement Rate, HH Aide Visit	$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 Facilities

The number of nursing facilities in Oklahoma fluctuated but increased from 420 facilities in 1989 to 450 in 1998 (an increase in 24 facilities since 1997). Bed growth has fluctuated but overall has shown an increase from 32,975 in 1989 to 36,857 in 1998 (an increase of 1,552 beds since 1997). The bed growth rate in 1998 was 4.40, greater than the national rate of -0.12. In 1998 the ratio of licensed beds per 1000 population aged 65 and over was 82.3 compared to the U.S. average of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Oklahoma increased from 23 in 1989 to 45 in 1998. The number of beds has similarly increased from 2,056 in 1989 to 2,709 in 1998. These 1998 counts represent an increase of 4 facilities and 6 beds since 1997. The ratio of ICF/MR beds per 1000 total population was 0.81 in 1998, greater than the national ratio of 0.47.

Residential Care for Adults/Aged

Oklahoma had 176 licensed residential care homes with a total of 6,567 beds in 1998, a decrease of 3 facilities and 208 beds since 1997.[1] In 1998, the ratio of licensed beds per 1000 population aged 65 and over was less than the national ratio (14.7 compared to 25.5)

Adult Day Care and Home Health Care

Oklahoma had 21 licensed adult day care facilities in 1998, an increase of 1 since 1997. In 1998 there were 412 licensed home health care agencies, a decrease of 108 agencies since 1997. The ratio of agencies per 1000 population aged 65 and over was nearly two times the national ratio (0.92 compared to 0.47).

Hospice

There were 82 licensed hospice agencies in 1998, no change since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.18 in 1998, higher than the US ratio of 0.07.

CON/Moratorium

Oklahoma required a CON for nursing facilities from 1980 through 1998. In 1998 a CON was also required for hospital bed conversion 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]Assisted living was a new program in Oklahoma in 1998. There were 12 facilities but the bed count was not available. We were unable to estimate the bed data as previous data did not exist.

OKLAHOMA

Demographics

Percentage Population 65 and Over	13.4 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	450
Total Beds	36,857
Beds Per Nursing Facility	81.9 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	82.3 (US 52.5)
Age 85 and Over	646.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.23 (US 6.00)
Expenditures Per 1000 Pop, 1997	$85,727 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	45
Total Beds	2,709
Beds Per 1000 Population	0.81 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	176
Total Beds for Adult/Aged	6,567
Beds Per 1000 Pop, Age 65 and Over	14.7 (US 25.5)
Total Facilities, Other	32
Total Beds, Other	1,084

Licensed Adult Day Care

Total Facilities	21
Facilities Per 1000 Pop, Age 65 and Over	0.05 (US 0.16)

Licensed Home Health Care

Total Agencies	412
Agencies Per 1000 Pop, Age 65 and Over	0.92 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.44 (US 6.95)
Expenditures Per 1000 Pop, 1997	$34,680 (US $45,711)

Licensed Hospices

Total Organizations	82
Organizations Per 1000 Pop, Age 65 and Over	0.18 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996 cost report were used for FY98. Inflation based on the DRI was used to trend rates. No minimum occupancy standard was used to set rates.

Adjustments

Additional adjustments were required for FY 1998.

Cost Centers

Three cost centers were used: 1. operating, an overall general limit, limited by the weighted mean; 2. administrative service, limited to $2.50 per patient day; and capital, limited to $6.43 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 $6.43 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 $6.43 (same as capital allowance) was paid.

Reimbursement Rate

The FY98 averaged flat reimbursement rate for Oklahoma was $64.20.

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 22% 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	$64.20	
Percentage Rate Change From Previous Year	13.0%	
Peer Groupings	None	
Year of Cost Report to Set Rate	1996	
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	$406.61	
Private Facilities	$80.79	
Ancillary Services Included in Rate		
All Facilities:	Physical Therapy	Physicians Services
Occupational Therapy	Non-Prescription Drug	Medical Supplies
	Patient Transport	Durable Medical 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 Facilities

The number of nursing facilities in Oregon has been steadily decreasing, from 187 in 1989 to 168 in 1998 (a decrease of 4 facilities since 1997). The number of beds decreased from 15,381 in 1989 to 14,190 in 1998. The bed growth rate in 1998 was -1.96 compared to the national average of -0.12. The 1998 ratio of licensed beds per 1000 population aged 65 and over remained well below the national ratio, 32.8 compared to 52.5.

Intermediate Care Facilities for Mentally Retarded

Oregon has been downsizing its ICF/MR program and trying to move people into group homes. In 1993 through 1996 there were 2 facilities with 546 beds. Although the number of facilities remained at 2 in 1997 and 1998, the number of beds decreased to 335 and 286 beds respectively. The ratio of ICF/MR beds per 1000 total population was 0.09 in 1998, much lower than the national ratio of 0.47.

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 1998 there were a total of 3,939 facilities with 22,422 beds, an increase of 11 facilities and 1,041 beds since 1997. In 1998 Oregon had a ratio of licensed beds per 1000 population aged 65 and over more than twice that of the national ratio (51.8 compared to 25.5).

Adult Day Care and Home Health Care

Adult day care was not licensed in Oregon in 1998. The number of licensed home health care agencies decreased from 520 in 1997 to 412 in 1998. The ratio of licensed agencies per 1000 population 65 and over was less than half the national ratio (0.21 compared to 0.47).

Hospice

Although Oregon did not license hospice organizations, there were 41 certified facilities in 1998.

CON/Moratorium

Oregon required a CON for nursing facilities from 1980 through 1998. In 1998 a CON was also required for hospital bed conversion, while there was neither a CON nor moratorium on ICF/MRs, residential care, assisted living, home health care, hospice or adult day care.

OREGON

Demographics

Percentage Population 65 and Over	13.2 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	168
Total Beds	14,190
Beds Per Nursing Facility	84.5 (US 103.5)
Average Occupancy Rate	78
Beds Per 1000 Population:	
Age 65 and Over	32.8 (US 52.5)
Age 85 and Over	267.7 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.66 (US 6.00)
Expenditures Per 1000 Pop, 1997	$50,567 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	2
Total Beds	286
Beds Per 1000 Population	0.09 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	3,939
Total Beds for Adult/Aged	22,422
Beds Per 1000 Pop, Age 65 and Over	51.8 (US 25.5)
Total Facilities, Other	119
Total Beds, Other	800

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	89
Agencies Per 1000 Pop, Age 65 and Over	0.21 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.88 (US 6.95)
Expenditures Per 1000 Pop, 1997	$67,296 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

OREGON

Reimbursement

Free-Standing Nursing Facilities

Methods

A prospective flat system was used for setting Medicaid reimbursement for nursing facility care since July 1, 1997. It is an all-inclusive rate system that includes reimbursement for services, supplies and facility equipment required for care by state and federal standards. In addition, facilities are eligible to receive an add-on established to cover the costs of implementation of the Oregon minimum wage law.

Under the flat rate model, two rates are used: the basic rate is the all-inclusive standard, statewide payment for all long-term care services provided to a resident of a nursing facility. The medically qualified residents are paid complex medical add-on rate, which is 40% of the basic rate, in addition to the basic rate. Qualified pediatric residents will receive a flat all-inclusive pediatric rate. The prospective flat rate is set based on the allowable total cost after the costs are inflated by the DRI Index. The costs are derived from the previous year Nursing Facility Financial Statements.

Adjustments

No interim rate adjustment is used under the flat rate system of reimbursement.

Cost Centers

Since the flat rate reimbursement system is based on all-inclusive rate, the indirect and direct care costs are not used.

Ancillary Services

Physical therapy (if PT is on staff), occupational therapy, respiratory therapy, medical supplies, patient transportation, and oxygen[1] were included in the direct portion of the rate.

Case-Mix Adjusters

No case-mix adjusters were used in Oregon. No case-mix has been planned for Oregon. Two care levels-basic and complex medical add-on rates are provided.

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 FY97-98 average reimbursement rate for Oregon was $89.18, weighted by patient days. The weighted average rate alsoincludes the pediatric rate paid to qualified nursing residents.

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] Only part of the cost of Oxygen.

OREGON

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate (weighted,non-pediatric)	$89.18
Percentage Rate Change From Previous Year	9.0%
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	None
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	$517.07
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	$53.42 per visit
Average Reimbursement Rate, HH Aide Visit	$53.42 per visit

Other Residential Care For Aged

Method	Retrospective Facility-Specific/Class
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Service	
Foster Home (Adult)	$ 758.79 per month
Residential Care	$ 792.44 per month
Assisted Living	$1329.40 per month

Adult Day Care

Method	Retrospective Contract Negotiation
Reimbursement Program	2176 Waiver
Average Reimbursement Rate by Facility Type	
Day Health	$450.83 per month
Clients Covered	Aged

Sub-Acute Care

No Separate Program

PENNSYLVANIA

Nursing Facilities

The number of nursing facilities in Pennsylvania steadily increased from 697 facilities in 1989 to 822 facilities in 1998 (with an increase of 12 facilities since 1997). The number of beds has been steadily increasing as well, growing from 87,980 in 1989 to 97,571 in 1998 (a decrease of 17 beds since 1997). The bed growth rate in 1998 was -0.02, compared to the national rate of -0.12. The ratio of licensed beds per 1000 population aged 65 and over remained less than the national ratio in 1998 (51.2 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MRs in Pennsylvania fluctuated but increased overall from 161 facilities in 1989 to 230 in 1998. The number of beds also fluctuated, but decreased in overall from 7,761 in 1989 to 6,338 in 1998. Facilities decreased by 21 and beds by 938 since 1997. The ratio of ICF/MR beds per 1000 total population was higher than the national ratio (in 1998, 0.53 compared to 0.47).

Residential Care for Adults/Aged

There were 1,775 personal care homes with 68,751 beds providing residential care in Pennsylvania in 1997. This was an increase of 87 facilities and 8,681 beds since 1997. The additional beds raised the ratio of licensed beds per 1000 population aged 65 and over up from 31.5 in 1997 to 36.1 in 1997, greater than the national ratio of 25.5.[1]

Adult Day Care and Home Health Care

There were 240 licensed adult day care facilities, 207 licensed adult training facilities for the mentally retarded/mentally ill, and 180 vocational training day facilities for the disabled in Pennsylvania in 1998, a total increase of 6 facilities since 1997. There were 97 licensed home health care agencies in 1998, a decrease of 1 since 1997. The ratio of licensed home health care agencies per 1000 population was 0.05 compared to the national ratio of 0.50. In 1998, Pennsylvania had the fewest licensed home health care agencies in all the states.

Hospice

Pennsylvania did not license hospice organizations in 1998, however, there were 118 certified facilities.

CON/Moratorium

Pennsylvania required a CON for nursing facilities from 1980 through 1996. In 1997 there was no longer a CON for nursing facilities. In 1998, neither a CON nor moratorium were required for nursing facilities, hospital bed conversion, ICF/MRs, residential care, assisted living, home health care, hospice or adult day care.

[1] 'Other Residential Care' in Pennsylvania includes: regular community homes, large community homes, family living homes and community residential rehabilitation with a total of 3,121 facilities and 15,640 beds in 1998.

PENNSYLVANIA

Demographics

Percentage Population 65 and Over	15.9 % (US 12.7 %)
Percentage Population 85 and Over	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	822
Total Beds	97,571
Beds Per Nursing Facility	118.7 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	51.2 (US 52.5)
Age 85 and Over	441.5 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.39 (US 6.00)
Expenditures Per 1000 Pop, 1997	$160,708 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	230
Total Beds	6,338
Beds Per 1000 Population	0.53 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,775
Total Beds for Adult/Aged	68,751
Beds Per 1000 Pop, Age 65 and Over	36.1 (US 25.5)
Total Facilities, Other	3,017
Total Beds, Other	11,867

Licensed Adult Day Care

Total Facilities	627
Facilities Per 1000 Pop, Age 65 and Over	0.33 (US 0.16)

Licensed Home Health Care

Total Agencies	97
Agencies Per 1000 Pop, Age 65 and Over	0.05 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	1.63 (US 6.95)
Expenditures Per 1000 Pop, 1997	$3,362 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 7/1/97-6/30/98 was $114.23.

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	$114.23
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	$67.00
Average Reimbursement Rate, HH Aide Visit	$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 Facilities

The number of nursing facilities in Rhode Island decreased from 107 in 1989 to 104 in 1997, and increased to 106 in 1998. The number of nursing facility beds has fluctuated but has shown an overall increase from 9,904 in 1989 to 10,638 in 1998 (a decrease of 97 beds since 1997). Despite this rate of growth (-0.90 in 1998, compared to –0.12 nationally), Rhode Island has steadily maintained a ratio of beds per 1000 population aged 65 and over greater than the national ratio (in 1998, 69.1 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of licensed ICF/MR facilities in Rhode Island declined significantly between 1989 and 1998 (from 115 facilities down to 5)[1]. The number of ICF/MR beds has similarly declined from 920 in 1989 to 49 in 1998. The ratio of ICF/MR beds per 1000 total population in Rhode Island was 0.05, much lower than the national ratio of 0.47 in 1998.

Residential Care for Adults/Aged

The number of residential care facilities in Rhode Island has increased slowly but steadily from 29 in 1989 to 60 in 1998 (an increase of 1 facility since 1997). There were 2,349 beds in 1998, an increase of 223 since 1997. Although, the ratio of licensed beds per 1000 population aged 65 and over increased from 3.8 in 1989 to 15.3 in 1998, it is still less than the national ratio of 25.5.

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 1998 there were 17 total adult day care facilities[2] licensed in Rhode Island, no change in the number of facilities since 1997. There were 50 licensed home health care agencies in Rhode Island 1998, an increase of 9 since 1997. In 1998 the ratio of agencies per 1000 population aged 65 and over was 0.32 compared to the national ratio of 0.47.

Hospice

Rhode Island had 8 licensed hospice agencies in 1998, no change since 1997. In 1998 Rhode Island had a ratio of 0.05 licensed hospice agencies per 1000 population aged 65 and over, compared to the US ratio of 0.07.

CON/Moratorium

Rhode Island required a CON for nursing facilities from 1980 through 1998. In 1996 a moratorium on nursing facilities was implemented and continued through 1998. In 1998 both a CON and moratorium were required for hospital bed conversion and hospice. Neither a CON nor moratorium were required for ICF/MRs, residential care, assisted living, home health care[3], or adult day care.

[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 1998.

[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	15.6 % (US 12.7 %)
Percentage Population 85 and Over	2.0 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	106
Total Beds	10,638
Beds Per Nursing Facility	100.4 (US 103.5)
Average Occupancy Rate	92
Beds Per 1000 Population:	
Age 65 and Over	69.1 (US 52.5)
Age 85 and Over	531.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	10.49 (US 6.00)
Expenditures Per 1000 Pop, 1997	$220,016 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	5
Total Beds	49
Beds Per 1000 Population	0.05 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	60
Total Beds for Adult/Aged	2,349
Beds Per 1000 Pop, Age 65 and Over	15.3 (US 25.5)
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	50
Agencies Per 1000 Pop, Age 65 and Over	0.32 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	11.05 (US 6.95)
Expenditures Per 1000 Pop, 1997	$136,029 (US $45,711)

Licensed Hospices

Total Organizations	8
Organizations Per 1000 Pop, Age 65 and Over	0.05 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice Care	CON & 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 CY9 for FY98. 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 FY98 was $103.97.

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	$103.97
Percentage Rate Change From Previous Year	2.4%
Peer Groupings	None
Year of Cost Report to Set Rate	CY1993 4
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 Support, 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	$38.00 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 Facilities

The number of nursing facilities in South Carolina has steadily increased, growing from 149 in 1989 to 193 in 1998, (with no increase in facilities since 1997). The number of beds increased from 14,133 in 1989 to 18,406 in 1998 (an increase of 252 beds since 1997). The bed growth rate in 1998 was 1.39 compared to the national rate of -0.12. The ratio of nursing facility beds per 1000 population aged 65 and over, however, remained below the national ratio in 1998 (39.3 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

South Carolina has been making an effort to downsize its larger ICF/MR facilities. In 1998, there were 155 facilities with 2,724 beds, a decrease of 3 facilities and 207 beds since 1997. Despite the decrease however, the 1998 ratio of ICF/MR beds per 1000 total population remained higher than the national ratio (0.71 compared to 0.47).

Residential Care for Adults/Aged

The number of community residential care facilities in South Carolina increased from 390 in 1990 to 512 in 1998 (an increase of 33 facilities since 1997). The number of beds also increased from 6,670 in 1990 to 12,630 beds in 1998 (an increase of 1,629 beds since 1997). South Carolina had a ratio of licensed beds per 1000 population aged 65 and over greater than that of the national ratio in 1998 (27.0 compared to 25.5).

Adult Day Care and Home Health Care

There were 73 licensed adult day care facilities in South Carolina in 1998, an increase of 13 since 1997. There were 89 licensed home health care agencies in 1998, a decline of 2 since 1997. In 1998, the ratio of licensed home health care agencies per 1000 population aged 65 and over was less than half the national ratio (0.19 compared to 0.47).

Hospice

South Carolina had 40 licensed hospice agencies in 1998, an increase of 4 facilities since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.09, just higher than the US ratio of 0.07.

CON/Moratorium

South Carolina had a CON for nursing facilities from 1980 through 1998. In 1998 there was also a CON on hospital bed conversion, ICF/MRs,[1] home health care and hospice. Neither a CON nor moratorium were in effect for residential care, assisted living or adult day care. There were 6 nursing facility CON applications submitted in 1998, 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	12.2 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	193
Total Beds	18,406
Beds Per Nursing Facility	95.4 (US 103.5)
Average Occupancy Rate	93
Beds Per 1000 Population:	
Age 65 and Over	39.3 (US 52.5)
Age 85 and Over	400.1 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.25 (US 6.00)
Expenditures Per 1000 Pop, 1997	$73,412 (US $114,494)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	155
Total Beds	2,724
Beds Per 1000 Population	0.71 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	512
Total Beds for Adult/Aged	12,630
Beds Per 1000 Pop, Age 65 and Over	27.0 (US 25.5)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	73
Facilities Per 1000 Pop, Age 65 and Over	0.16 (US 0.16)

Licensed Home Health Care

Total Agencies	89
Agencies Per 1000 Pop, Age 65 and Over	0.19 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.68 (US 6.95)
Expenditures Per 1000 Pop, 1997	$32,575 (US $45,711)

Licensed Hospices

Total Organizations	40
Organizations Per 1000 Pop, Age 65 and Over	0.09 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice Care	CON Only

* 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 1996 cost report was used for FY98. 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 FY98 average reimbursement rate for South Carolina was $82.75, 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	$82.75
Percentage Rate Change From Previous Year	6.0%
Peer Groupings	Number of Beds and Type of Ownership
Year of Cost Report to Set Rate	September 1996
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	$179.02
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-$100.67 (Average-$74.31)
Average Reimbursement Rate, HH Aide Visit	$15.05-$55.46 (Average-$37.08)

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 Facilities

The number of nursing facilities in South Dakota has remained very constant, ranging from 118 in 1989 to 115 in 1998 (no change since 1991). The number of beds has been steadily declining since 1993, with 8,256 beds in 1993 and 8,025 in 1998 (there was a decrease of 72 beds since 1997). The bed growth rate in 1998 was -0.89 percent, compared to the national rate of -0.12 percent. The ratio of beds per 1000 population aged 65 and over remained well above the national ratio in 1998 (75.7 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities decreased from 19 in 1989 to 4 in 1998 (a decrease of 5 facilities since 1997). The number of beds similarly declined from 671 in 1989 to 276 in 1998 (a decrease of 161 beds since 1997). In 1998, for the first time since at least 1989, the ratio of ICF/MR beds per 1000 population was less than the U.S. average (0.37 compared to the national average of 0.47).

Residential Care for Adults/Aged

South Dakota licenses assisted living centers and adult foster care. In 1998 there were 111 of the former and 73 of the latter. This represents an increase of 28 facilities since 1997. Assisted living beds grew from 1,588 in 1997 to 2,057 in 1998, adult foster care beds increased from 157 in 1997 to 162 in 1998, an increase of 474 total beds since 1997. Despite the additional beds, the ratio of licensed beds per 1000 population aged 65 and over was less than the national ratio (20.9 compared to 25.5).

Adult Day Care and Home Health Care

Neither adult day care nor home health care were licensed in South Dakota in 1998. In 1998 there were 13 certified adult day care facilities and 48 certified home health care agencies, no change in the former and a decrease of 8 in the latter since 1997.

Hospice

South Dakota had 2 licensed and 14 certified hospice agencies in 1998, no change in either category since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.02 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

South Dakota had a CON for nursing facilities from 1980 to 1987. In 1988, the state eliminated the CON and instituted a moratorium, which remained in effect through 1998. In 1998 hospital bed conversion was subject to moratorium only. There was neither a CON nor moratorium for 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	2.1 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	115
Total Beds	8,025
Beds Per Nursing Facility	69.8 (US 103.5)
Average Occupancy Rate	91.9
Beds Per 1000 Population:	
Age 65 and Over	75.7 (US 52.5)
Age 85 and Over	501.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.49 (US 6.00)
Expenditures Per 1000 Pop, 1997	$134,405 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	4
Total Beds	276
Beds Per 1000 Population	0.37 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	184
Total Beds for Adult/Aged	2,219
Beds Per 1000 Pop, Age 65 and Over	20.9 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.64 (US 6.95)
Expenditures Per 1000 Pop, 1997	$53,614 (US $45,711)

Licensed Hospices

Total Organizations	2
Organizations Per 1000 Pop, Age 65 and Over	0.02 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1995 cost reports (calendar year) were used for FY98. 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 FY98.

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 $9.72 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 6.7%, subject to overall capital limitation.

Reimbursement Rate

The FY98 average reimbursement rate for South Dakota was $76.96, 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 Facilities

The number of nursing facilities in Tennessee increased from 291 in 1989 to 362 in 1998. The number of beds also increased from 34,690 in 1989 to 39,545 in 1998. The 1998 counts represent a decrease of 2 facilities and 1,201 beds since 1997. The bed growth rate in 1998 was -2.95 percent compared to the national rate of -0.12 percent. The ratio of nursing facility beds per 1000 population aged 65 and over remained above the national ratio in 1998 (58.2 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The total number of licensed facilities has increased fairly steadily since 1989, while the number of beds has declined since 1992. The total number of ICF/MR facilities decreased from 86 in 1997 to 83 in 1998, while the number of beds increased from 1,762 in 1997 to 1,852 in 1998. The ratio of ICF/MR beds per 1000 total population was 0.34 in 1998, below the national ratio of 0.47.

Residential Care for Adults/Aged

Tennessee provides residential care in residential homes for the aged[1] and assisted care.[2] In 1998, there were 204 of the former with an estimated 4,470 beds and 93 of the latter with an estimated 5,028 beds, a total decrease of 17 facilities and 59 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over, however, remained well below the national ratio in 1998 (14.0 compared to 25.5)[3].

Adult Day Care and Home Health Care

Adult day care was not licensed in Tennessee in 1998. There were 258 licensed home health agencies in Tennessee in 1998, a decrease of 51 since 1997. The 1998 ratio of home health agencies per 1000 population aged 65 and over was below the national average, 0.38 compared to 0.47.

Hospice

Tennessee had 57 licensed hospice agencies in 1998, an increase of 3 facilities since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.08, just higher than the US ratio of 0.07.

CON/Moratorium

Tennessee required a CON for nursing facilities from 1980 through 1998. In 1998 a CON was also required for hospital bed conversion, ICF/MRs[4], mental health residential treatment facilities, home health care, and hospice. Neither a CON nor moratorium were required for assisted living or adult day care.

[1] Formerly titled institutional homes for the aged and residential homes for the aged, these consolidated in 1998.
[2] Assisted care was a new category in 1998.
[3] 'Other residential care' in Tennessee includes alcohol and drug detox, alcohol and drug residential rehabilitation ,alcohol and drug halfway houses and residential hospice with a total of 137 facilities and an estimated 821 beds in 1998.

[4] Tennessee had a defacto moratorium in 1998.

TENNESSEE

Demographics

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

Licensed Nursing Facilities

Total Facilities	362
Total Beds	39,545
Beds Per Nursing Facility	109.2 (US 103.5)
Average Occupancy Rate	90.8
Beds Per 1000 Population:	
Age 65 and Over	58.2 (US 52.5)
Age 85 and Over	513.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.85 (US 6.00)
Expenditures Per 1000 Pop, 1997	$111,652 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	83
Total Beds	1,852
Beds Per 1000 Population	0.34 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	297
Total Beds for Adult/Aged	9,498
Beds Per 1000 Pop, Age 65 and Over	14.0 (US 25.5)
Total Facilities, Other	137
Total Beds, Other	821

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	258
Agencies Per 1000 Pop, Age 65 and Over	0.38 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	0.11 (US 6.95)
Expenditures Per 1000 Pop, 1997	$23 (US $45,711)

Licensed Hospices

Total Organizations	57
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 FY98. 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 FY98 average reimbursement rate for Tennessee was $83.16, 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	$83.16
Percentage Rate Change From Previous Year	0.7%
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	$315.13
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 Facilities

The number of nursing facilities in Texas increased from 1,113 in 1989 to 1,344 facilities in 1997. In 1998 facilities decreased to 1,331.The number of beds has followed a similar pattern growing from 114,923 in 1989 to 129,708 in 1997, but increasing to 131,172 in 1998. The bed growth rate in 1998 was 1.13 percent, above the national rate of -0.12 percent. The ratio of beds per 1000 population aged 65 and over remained greater than the national ratio in 1998 (65.6 compared to 52.5).

Intermediate Care Facilities 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 decreased slightly from 896 in 1997 to 894 in 1998. The number of beds decreased from 14,384 in 1997 to 14,304 in 1998. The ratio of ICF/MR beds per 1000 total population was well above the national ratio (in 1998, 0.72 compared to 0.47).

Residential Care for Adults/Aged

Texas provides residential care in personal care homes. In 1998, there were 1,042 facilities with 29,844 beds, an increase of 158 facilities and 5,435 beds since 1997. Despite the increases, the ratio of licensed beds per 1000 population aged 65 and over remained well below the national ratio in 1998 (14.9 compared to 25.5)[1].

Adult Day Care and Home Health Care

The number of licensed adult day care facilities in Texas increased from 249 in 1997 to 292 in 1998. The number of licensed home health care agencies increased from 3,237 in 1997 to 3,613 in 1998 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 1000 population aged 65 and over in Texas was 1.81, over three times the national ratio of 0.47.

Hospice

The number of licensed hospice agencies decreased from 156 in 1997 to 151 in 1998. Despite this decrease, the ratio of licensed hospice agencies remained higher than that of the US average (0.08 compared to 0.07).

CON/Moratorium

Texas had a CON for nursing facilities between 1980 and 1984. In 1985, the state eliminated the CON and instituted a moratorium, which remained in effect through 1998. In 1998 there was also a moratorium on hospital bed conversion 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 864 facilities and 18,472 beds.

TEXAS

Demographics

Percentage Population 65 and Over	10.1 % (US 12.7 %)
Percentage Population 85 and Over	1.1 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	1,331
Total Beds	131,172
Beds Per Nursing Facility	98.6 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	65.6 (US 52.5)
Age 85 and Over	577.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.83 (US 6.00)
Expenditures Per 1000 Pop, 1997	$68,040 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	894
Total Beds	14,304
Beds Per 1000 Population	0.72 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,042
Total Beds for Adult/Aged	29,844
Beds Per 1000 Pop, Age 65 and Over	14.9 (US 25.5)
Total Facilities, Other	864
Total Beds, Other	18,097

Licensed Adult Day Care

Total Facilities	292
Facilities Per 1000 Pop, Age 65 and Over	0.15 (US 0.16)

Licensed Home Health Care

Total Agencies	3,613
Agencies Per 1000 Pop, Age 65 and Over	1.81 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.48 (US 6.95)
Expenditures Per 1000 Pop, 1997	$27,998 (US $45,711)

Licensed Hospices

Total Organizations	151
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996 cost reports were used for FY98[1] (CY98). Inflation based on the IPD-PCE, plus other indices per condition were used to trend rates. The minimum occupancy standard was 78.8%.

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 FY98 runs January 98 through December 98.

TEXAS

Free-Standing Nursing Facilities

Method	Prospective Patient-Specific
Average Reimbursement Rate	$70.83 Jan-Aug 97/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	1996
Inflation Adjustment	IPD-PCE and Other Indices Per Condition
Minimum Occupancy in Rate-Setting	78.8% (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 Facilities

The number of nursing facilities in Utah increased from 96 in 1989 to 107 in 1998 (a decrease of 1 since 1997). The number of beds increased from 7,216 in 1989 to 8,615 in 1998 (an increase in 87 beds since 1997). The bed growth rate in 1998 was 1.02 percent, compared to the national rate of -0.12 percent. The ratio of beds per 1000 population aged 65 and over was 46.8 in 1998, below the national average of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Utah decreased from 14 in 1990 to 10 in 1998 (a decrease of 1 facility since 1997). The number of licensed ICF/MR beds decreased from 1,045 in 1990 to 921 in 1995 and remained so through 1998. The ratio of licensed ICF/MR beds per 1000 population in Utah was 0.44, just below that for the nation as a whole (0.47 U.S. average).

Residential Care for Adults/Aged

In 1998, Utah had 106 residential care facilities with 1,836 beds, 20 adult foster care homes with 44 beds, and 13 assisted living facilities with 506 beds. There was a total decrease of 2 residential care facilities and an increase of 109 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 13.0 in 1998, nearly half the national ratio (25.5).[1]

Adult Day Care and Home Health Care

There were 67 licensed adult day care facilities in Utah in 1998, a decrease of 10 facilities since 1997. There were 95 licensed home health care agencies in 1998, a decrease of 11 since 1997. The ratio of licensed home health care agencies per 1000 population age 65 and over was slightly greater than the national ratio, 0.52 compared to 0.47.

Hospice

Utah's number of licensed hospice agencies increased from 15 in 1997 to 21 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.11 compared to the US ratio of 0.07.

CON/Moratorium

Utah had a CON for nursing facilities from 1980 to 1984. The CON was eliminated in 1985. In 1989, the state instituted a moratorium, which remained in effect through 1998. In 1998 neither a CON nor moratorium were required for hospital bed conversion, residential care, assisted living, home health care, hospice or adult day care. ICF/MRs had a moratorium in 1998[2].

[1] 'Other Residential Care' in Utah includes 70 residential treatment facilities with 431 beds for people with mental retardation.

[2] The ICF/MR moratorium was to control the Medicaid certification of new providers.

UTAH

Demographics

Percentage Population 65 and Over	8.8 % (US 12.7 %)
Percentage Population 85 and Over	1.0 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	107
Total Beds	8,615
Beds Per Nursing Facility	80.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	46.8 (US 52.5)
Age 85 and Over	410.2 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.60 (US 6.00)
Expenditures Per 1000 Pop, 1997	$42,121 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	10
Total Beds	921
Beds Per 1000 Population	0.44 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	139
Total Beds for Adult/Aged	2,386
Beds Per 1000 Pop, Age 65 and Over	13.0 (US 25.5)
Total Facilities, Other	70
Total Beds, Other	431

Licensed Adult Day Care

Total Facilities	67
Facilities Per 1000 Pop, Age 65 and Over	0.36 (US 0.16)

Licensed Home Health Care

Total Agencies	95
Agencies Per 1000 Pop, Age 65 and Over	0.52 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	2.05 (US 6.95)
Expenditures Per 1000 Pop, 1997	$28,048 (US $45,711)

Licensed Hospices

Total Organizations	21
Organizations Per 1000 Pop, Age 65 and Over	0.11 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 1996 cost report were used for FY98. 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 FY98 average reimbursement rate for Utah was $83.11, 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. For a RN visit ($79), home health aide visit ($35). 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	$83.11
Percentage Rate Change From Previous Year	5.8%
Peer Groupings	None
Year of Cost Report to Set Rate	1996
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	RespiratoryTherapy, Occupational Therapy, Medical Supplies, Durable Med. Equip., Non-Prescription Drug, Non-Emergency Patient Transport

Hospital-Based Nursing Facilities

Method	Same as Free-Standing Nursing Facilities
Average Reimbursement Rate	$83.11[1]

ICF-MR

Method	
State Facilities	Retrospective Medicare Principles
Private Facilities	Retrospective Flat Rate
Average Reimbursement Rate	
State Facilities	$218.00[1]
Private Facilities	$113.57
Ancillary Services Included in Rate	Same as Free-Standing Nursing Facilities

Home Health

Method	Fee Schedule with Flat Rate
Average Reimbursement Rate, RN Visit	$79.06
Average Reimbursement Rate, HH Aide Visit	$35.40

Other Residential Care For Aged[2]

Method	Patient-Specific & Contract Negotiation
Reimbursement Program	1915c Waiver
Average Reimbursement Rate By Facility Type	
Group Home	$84.00 per Day[1]

Adult Day Care

Method	Prospective Facility-Specific
Reimbursement Program	1915c
Average Reimbursement Rate by Facility Type	
Social	$29.00 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 Facilities

The number of nursing facilities has remained relatively constant in Vermont, decreasing from 51 facilities in 1989 to 48 in 1995 and remaining so through 1998. The number of beds increased from 3,653 in 1989 to 3,848 in 1998 (an increase of 10 beds since 1997). The bed growth rate in 1998 was 0.26 percent, compared to the national rate of -0.12 percent. The ratio of nursing facility beds per 1000 population aged 65 and over in 1998 was 52.7, just greater than the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in Vermont decreased from 12 in 1989 to 2 in 1998 (with no decrease since 1997). 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 by 1998, the smallest number for any state. Vermont along with New Hampshire, with a ratio of 0.02 licensed ICF/MR beds per 1000 population had the smallest ratio in the country and well below the national rate of 0.47.

Residential Care for Adults/Aged

Vermont provides residential care in level 3 and level 4 residential facilities. In 1998, there were 71 of the former with 1,702 beds, and 46 of the latter with 475 beds. Since 1997 there has been a net reduction of 3 facilities and 11 beds. The ratio of licensed beds per 1000 population aged 65 and over was above the national ratio in 1998, with 29.8 compared to 25.5.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Vermont in 1998. Home health care was not licensed but in 1998 there were 13 certified agencies, as there has been since 1992.

Hospice

Although Vermont did not license hospices in 1998, there were 13 certified hospice agencies.

CON/Moratorium

Vermont required a CON for nursing facilities from 1980 through 1998. In 1998 a CON alone was also required for hospital bed conversion, ICF/MRs, therapeutic community residences, home health care, and hospice, while neither a CON nor moratorium were required on other types of residential care, assisted living or adult day care.

[1] 'Other residential care' in Vermont includes 29 therapeutic community residences with 284 beds in 1998.

VERMONT

Demographics

Percentage Population 65 and Over	12.3 % (US 12.7 %)
Percentage Population 85 and Over	1.6 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	48
Total Beds	3,848
Beds Per Nursing Facility	80.2 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	52.7 (US 52.5)
Age 85 and Over	427.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.56 (US 6.00)
Expenditures Per 1000 Pop, 1997	$112,358 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	2
Total Beds	12
Beds Per 1000 Population	0.02 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	117
Total Beds for Adult/Aged	2,177
Beds Per 1000 Pop, Age 65 and Over	29.8 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.52 (US 6.95)
Expenditures Per 1000 Pop, 1997	$105,775 (US $45,711)

Licensed Hospices

Total Organizations	Not Licensed
Organizations Per 1000 Pop, Age 65 and Over	Not Licensed (US 0.07)

Certificate of Need (CON) or Moratorium

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

* 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 FY98 was FY1996 for the nursing category and 1994 for resident/indirect care. 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 based on updated Case-mix scores and changing property or ancillary component.

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. 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. In July 1998, Vermont adopted new rules which revised the Case-mix classification system returning to the original 44 classes but weighted for Vermont nursing salaries. Only the case-mix weights of the Medicaid Population are used in the caculation of a facilities overall Case-mix average.

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 FY98 average reimbursement rate for Vermont was approximately $104.10, 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	$104.10
Percentage Rate Change From Previous Year	3.3%
Peer Groupings	None
Year of Cost Report to Set Rate	1996 for Nursing, 1994 for Resident/Indirect
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	$5.50 per quarter hour

Other Residential Care For Aged

No Medicaid Program

Method	Per diem rate
Enhanced Residential Care	$30.00 per day/35.00/40.00 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 Facilities

The number of nursing facilities in Virginia has been steadily increasing, growing from 234 in 1989 to 292 in 1998 (an increase of 2 facilities since 1997). The number of beds has been steadily increasing as well, growing from 26,588 in 1989 to 31,438 in 1998 (an increase of 50 beds since 1997). The 1998 bed growth rate was 0.16 percent, more than the national rate (-0.12 percent). The ratio of nursing facility beds per 1000 population aged 65 and over, however, remained lower than the national ratio in 1998 (41.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

The number of licensed ICF/MR facilities increased overall from 9 in 1989 to 17 in 1998. The number of licensed ICF/MR beds has increased from 105 in 1989 to 2,682 in 1998. This represents a decrease of 1 facility and 12 beds since 1997. The ratio of licensed ICF/MR beds per 1000 total population was just less than the national ratio (0.39 in 1998, compared to 0.47).

Residential Care for Adults/Aged

Virginia provides residential care in adult care residences, formerly called 'homes for adults'. In 1998 there were 626 adult care residences with 30,961 beds, an increase of 37 facilities and 2,545 beds since 1997. In 1998, Virginia's ratio of residential care beds per 1000 population aged 65 and over was 40.4, higher than the national ratio of 25.5.

Adult Day Care and Home Health Care

There were 55 licensed adult day care facilities in Virginia in 1998, an increase of 2 facilities since 1997. There were 61 licensed home health care agencies in 1998, a decrease of 30 agencies since 1997. The ratio of licensed home health care agencies per 1000 population aged 65 and over was 0.08 compared to the U.S. ratio of 0.47 (Virginia ranked 3rd among the states with the lowest ratio per capita).

Hospice

The number of licensed hospice agencies increased from 56 in 1997 to 60 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.08 compared to the US ratio of 0.07.

CON/Moratorium

Virginia had a CON for nursing facilities from 1980 through 1998. In 1998 there was a CON alone on hospital bed conversion[1] 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] A moratorium for hospital bed conversion ended 7/1/97.

VIRGINIA

Demographics

Percentage Population 65 and Over	11.3 % (US 12.7 %)
Percentage Population 85 and Over	1.2 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	292
Total Beds	31,438
Beds Per Nursing Facility	107.7 (US 103.5)
Average Occupancy Rate	91
Beds Per 1000 Population:	
Age 65 and Over	41.0 (US 52.5)
Age 85 and Over	383.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.06 (US 6.00)
Expenditures Per 1000 Pop, 1997	$57,133 (US $114,494)
Adequacy of Bed Supply*	Under Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	17
Total Beds	2,682
Beds Per 1000 Population	0.39 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	626
Total Beds for Adult/Aged	30,961
Beds Per 1000 Pop, Age 65 and Over	40.4 (US 25.5)
Total Facilities, Other	Not Available
Total Beds, Other	Not Available

Licensed Adult Day Care

Total Facilities	55
Facilities Per 1000 Pop, Age 65 and Over	0.07 (US 0.16)

Licensed Home Health Care

Total Agencies 61	
Agencies Per 1000 Pop, Age 65 and Over	0.08 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	3.02 (US 6.95)
Expenditures Per 1000 Pop, 1997	$16,810 (US $45,711)

Licensed Hospices

Total Organizations	60
Organizations Per 1000 Pop, Age 65 and Over	0.08 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 indirect 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. 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 is 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 FY98 average reimbursement rate for Virginia was $79.47, weighted by days of care. The capital portion of the rate was $8.47.

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	$79.47
Percentage Rate Change From Previous Year	2.7%
Peer Groupings	Geographic Location
Year of Cost Report to Set Rate	1997
Inflation Adjustment	DRI-VASPEC.
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	$202.19
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: $67.97 - $185.40
Average Reimbursement Rate, HH Aide Visit	Range: $40.33 - $56.50

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	Combination Facility-Specific (capped)
Average Rate	$312.37

WASHINGTON

Nursing Facilities

Over the past 10-years the number of nursing facilities in Washington has fluctuated within a narrow range, but decreased overall. There were 296 facilities in 1989, decreasing to 286 in 1997 and decreasing again to 285 in 1998. The number of beds in Washington has similarly fluctuated. In 1989 there were 28,636 licensed beds decreasing to 27,204 in 1998 (a decrease of 520 beds since 1997). The total bed growth rate for this 10-year period was -4.42 percent compared to the U.S. rate of 12.18 percent. The bed growth rate in Washington in 1998 was –1.88 while the national rate was –0.12 percent. The ratio of nursing facility beds per 1000 population aged 65 and over continued to be lower than the national ratio in 1998 (41.7 compared to 52.5).

Intermediate Care Facilities 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 1998 there were 8 ICF/MR facilities (no change in facilities since 1997). The total number of licensed ICF/MR beds has fluctuated but overall has decreased from 1,907 in 1989 to 1,096 in 1998 (also no change since 1997). The ratio of beds per 1000 total population was 0.19 in 1998, less than half the national ratio of 0.47.

Residential Care for Adults/Aged

Washington provides residential care in adult family homes and boarding homes. There were 2,202 of the former with 11,006 beds and 474 of the latter with 21,074 beds in 1998, a total decline of 6 facilities and an increase of 2,470 beds since 1997. The ratio of residential care beds per 1000 population aged 65 and over grew from 28.5 in 1989 to 49.2 in 1998, well above the national ratio of 25.5.[1]

Adult Day Care and Home Health Care

Adult day care was not licensed in Washington in 1998. There were 159 licensed home health care agencies in 1998, a decrease of 4 since 1997. The ratio of home health agencies per 1000 population age 65 and over, at 0.24 was nearly half that of the national ratio (0.47).

Hospice

Washington had 39 licensed hospice agencies in 1998, no change since 1997. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.06 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

Washington required a CON for nursing facilities from 1978 through 1998 (with a brief moratorium added to it in 1993 that was dropped in 1994). In 1998 a CON alone was also required for hospital bed conversion, ICF/MRs, home health care and hospice, while there was neither a CON nor moratorium for residential care, assisted living or adult day care.

[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	1.4 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	285
Total Beds	27,204
Beds Per Nursing Facility	95.5 (US 103.5)
Average Occupancy Rate	Not Available
Beds Per 1000 Population:	
Age 65 and Over	41.7 (US 52.5)
Age 85 and Over	344.4 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	4.15 (US 6.00)
Expenditures Per 1000 Pop, 1997	$84,886 (US $114,494)
Adequacy of Bed Supply*	Over Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	8
Total Beds	1,096
Beds Per 1000 Population	0.19 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	2,676
Total Beds for Adult/Aged	32,080
Beds Per 1000 Pop, Age 65 and Over	49.2 (US 25.5)
Total Facilities, Other	116
Total Beds, Other	1,778

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	159
Agencies Per 1000 Pop, Age 65 and Over	0.24 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	0.74 (US 6.95)
Expenditures Per 1000 Pop, 1997	$1,083 (US $45,711)

Licensed Hospices

Total Organizations	39
Organizations Per 1000 Pop, Age 65 and Over	0.06 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	CON Only
Hospice Care	CON Only

* 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 1998 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 FY98.

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 FY98 average reimbursement rate for Washington was $116.00 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	$116.00
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	$84.20[1]
Average Reimbursement Rate, HH Aide Visit	$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 (rehab. 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

[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 Facilities

The number of licensed nursing facilities in West Virginia grew from 117 in 1989 to 145 in 1998. Between 1989 and 1998 the number of beds increased from 9,855 to 11,560. This represents an increase of 4 facilities and 278 beds since 1997. The total bed growth rate for this 10-year period was 18.41, greater than the national rate of 12.18. The bed growth rate in 1998 was 2.46 compared to the national rate of –0.12. With the additional beds the ratio of licensed beds per 1000 population aged 65 and over grew to 42.0, still lower the national ratio of 52.5.

Intermediate Care Facilities for Mentally Retarded

The number of ICF/MR facilities in West Virginia increased from 46 in 1989 to 63 in 1997, and decreased to 62 facilities in 1998. The number of licensed ICF/MR beds had steadily increased from 574 beds in 1989 to a high of 669 in 1996. Since then, ICF/MR beds decreased by 154 beds for a total of 515 beds in 1998. In West Virginia the ratio of licensed ICF/MR beds per 1000 total population was 0.28 in 1998, below the national average of 0.47.

Residential Care for Adults/Aged

West Virginia provides licensed residential care in personal care homes and board and care facilities. In 1998, there were 57 of the former with 2,291 beds and 76 of the latter with 844 beds, a total decrease of 4 facilities and 27 beds since 1997. The ratio of licensed beds per 1000 population aged 65 and over was 11.4, less than half the national ratio of 25.5.

Adult Day Care and Home Health Care

In 1998 there were 83 adult day behavioral health facilities and 2 adult day medical care facilities, no change since 1997. Home health care was not licensed in West Virginia in 1998, however there were 84 certified home health care agencies, a decrease of 5 since 1997.

Hospice

The number of licensed hospice agencies decreased from 26 in 1997 to 24 in 1998. The ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.09 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

West Virginia had a CON for nursing facilities from 1980 through 1998, adding a moratorium in 1987 that remained in effect through 1998. In 1998 West Virginia had both a CON and moratorium on ICF/MRs. A CON alone was required on hospital bed conversion, behavioral health residential care, home health care, hospice and medical model adult day care.

WEST VIRGINIA

Demographics

Percentage Population 65 and Over	15.2 % (US 12.7 %)
Percentage Population 85 and Over	1.7 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	145
Total Beds	11,560
Beds Per Nursing Facility	79.7 (US 103.5)
Average Occupancy Rate	91.3
Beds Per 1000 Population:	
Age 65 and Over	42.0 (US 52.5)
Age 85 and Over	372.9 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	6.43 (US 6.00)
Expenditures Per 1000 Pop, 1997	$131,006 (US $114,494)
Adequacy of Bed Supply*	Not Available

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	62
Total Beds	515
Beds Per 1000 Population	0.28 (US 0.47)

Other Licensed Residential 133

Total Beds for Adult/Aged	3,135
Beds Per 1000 Pop, Age 65 and Over	11.4 (US 25.5)
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 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	22.96 (US 6.95)
Expenditures Per 1000 Pop, 1997	$74,049 (US $45,711)

Licensed Hospices

Total Organizations	24
Organizations Per 1000 Pop, Age 65 and Over	0.09 (US 0.07)

Certificate of Need (CON) or Moratorium

Nursing Facilities	CON & Moratorium
ICF/MRs	CON & Moratorium
Hospital Bed Conversion	CON Only
Residential Care	CON Only
Home Health Care	CON Only
Hospice Care	CON Only

* 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 FY98. 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, occupational therapy, respiratory therapy non-prescription drugs, medical supplies, oxygen and 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 FY98 average reimbursement rate for West Virginia was $106.27 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	$106.27
Percentage Rate Change From Previous Year	5.1%
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, Respiratory Therapy, Durable Medical Equipment

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)	$262.12
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	$46.00-$81.24 ($65.00 average)
Average Reimbursement Rate, HH Aide Visit	$31.49-$81.24 ($65.00 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 Facilities

The number of nursing facilities in Wisconsin fluctuated but decreased slightly from 434 in 1989 to 429 in 1998 (a decrease in 3 facilities since 1997). The number of beds decreased from 50,072 in 1989 to 48,135 in 1998 (an increase of 147 beds since 1997). The bed growth rate in 1998 was 0.31 percent compared to the national average of -0.12 percent. In 1998, as has been true for at least 15 years, Wisconsin had a ratio of licensed beds per 1000 population aged 65 and over greater than the national ratio (69.7 compared to 52.5).

Intermediate Care Facilities 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, to a total of 41 facilities in 1998 (no change in the number of facilities since 1997). The number of beds steadily declined starting in 1992, with 4,520 beds and decreased to 3,510 beds in 1998(a decline of 12 beds since 1997). Despite these reductions, the ratio of licensed ICF/MR beds per 1000 total population in Wisconsin for 1998 was 0.67, greater than the national ratio of 0.47.

Residential Care for Adults/Aged

Wisconsin provides residential care in community based residential, adult family homes and assisted living. There were a total of 1,922 residential care facilities with 23,853 beds in 1998. This was a net increase of 118 facilities and 1,088 beds since 1997. In 1998 the ratio of licensed residential care beds per 1000 population in Wisconsin was 34.5, higher than the national ratio of 25.5.

Adult Day Care and Home Health Care

Adult day care was not licensed in Wisconsin in 1998. There were 192 licensed home health care agencies in 1998, a decrease of 5 agencies since 1997. Wisconsin's ratio of agencies per 1000 population 65 and over was lower than the national ratio (0.28 compared to 0.47).

Hospice

The number of licensed hospice agencies increased from 66 in 1997 to 69 in 1998. Wisconsin's ratio of licensed hospice agencies per 1000 population aged 65 and over was 0.1 in 1998, compared to the US ratio of 0.07.

CON/Moratorium

Wisconsin had a CON for nursing facilities from 1980 through 1998[1]. In 1981 the state instituted a moratorium, which remained in effect through 1998. In 1998 there was a CON as well as moratorium on hospital bed conversion and ICF/MRs, while there was neither a CON nor moratorium on residential care, assisted living, home health care, hospice or adult day care. In 1998 there were no nursing facility CON applications.

[1] Wisconsin no longer reviews the building of new facilities that are 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	1.8 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	429
Total Beds	48,135
Beds Per Nursing Facility	112.2 (US 103.5)
Average Occupancy Rate	86.3
Beds Per 1000 Population:	
Age 65 and Over	69.7 (US 52.5)
Age 85 and Over	517.6 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	8.09 (US 6.00)
Expenditures Per 1000 Pop, 1997	$142,162 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	41
Total Beds	3,510
Beds Per 1000 Population	0.67 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	1,922
Total Beds for Adult/Aged	23,853
Beds Per 1000 Pop, Age 65 and Over	34.5 (US 25.5)
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	192
Agencies Per 1000 Pop, Age 65 and Over	0.28 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	9.78 (US 6.95)
Expenditures Per 1000 Pop, 1997	$19,966 (US $45,711)

Licensed Hospices

Total Organizations	69
Organizations Per 1000 Pop, Age 65 and Over	0.1 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice 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 FY98 was 1996. 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 107% 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 FY98 average reimbursement rate for Wisconsin was $91.70, 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 average reimbursement rate of $129.50. For state ICF-MRs, a retrospective method was used, with average reimbursement rate of $302.93. Home health visits were paid using Medicare principles with state alterations involving flat rates, with RN visits at $78.50 and home health aide visits at $37. Adult day care was covered under waiver, using retrospective patient-specific methodology. The average Reimbursement Rate Range by Clients Covered for Aged Physically & Mentally Disabled, AIDS/AR were $20-38 range per diem and $7-15 range per diem for Developmentally Disabled.

[1] Limited inclusion.
[2] Wisconsin did not consider their system case-mixed.

WISCONSIN

Free-Standing Nursing Facilities

Method	Prospective Facility-Specific
Average Reimbursement Rate	$91.70
Percentage Rate Change From Previous Year	6.81%
Peer Groupings	None
Year of Cost Report to Set Rate	1996
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	$302.93
Private Facilities	$129.50
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.

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Nursing Facilities

The number of nursing facilities in Wyoming increased steadily from 33 in 1989 to 40 in 1998 (an increase of 2 facilities since 1997). The number of nursing facility beds grew slowly from 2,721 in 1989 to 3,134 in 1998 (an increase of 57 beds since 1997). The bed growth rate in 1998 was above the national rate (1.85 percent compared to -0.12 percent) and the 1998 ratio of beds per 1000 population aged 65 and over remained above the national ratio (56.0 compared to 52.5).

Intermediate Care Facilities for Mentally Retarded

From 1990 to 1998, Wyoming has had one licensed ICF/MR facility. The number of beds in this facility increased with some recent fluctuation from 90 in 1990 to 152 in 1998 (a decrease in 12 beds since 1997). The ratio of licensed ICF/MR beds per 1000 population in Wyoming was 0.32 as compared to the national ratio of 0.47.

Residential Care for Adults/Aged

Wyoming provides residential care in boarding homes and assisted living facilities. In 1997 there were 25 boarding homes with 391 beds, decreasing to 24 facilities and 387 beds in 1998. There were 11 assisted living facilities with 814 beds in 1997, with no change in facilities but increasing to 914 beds in 1998. This represents a decrease of 1 facility and an increase of 96 beds since 1997[1]. The ratio of licensed beds per 1000 population aged 65 and over was less than the national ratio in 1998 (23.2 compared to 25.5).

Adult Day Care and Home Health Care

Adult day care was not licensed in Wyoming in 1998. In 1998 there were 58 licensed home health care agencies, an increase of 1agency since 1997. The ratio of licensed home health care agencies per 1000 population age 65 and over was more than twice the national ratio (1.04 compared to 0.47).

Hospice

Wyoming had 14 licensed hospice agencies in 1998, no change since 1997. Wyoming had the highest ratio of licensed hospice agencies per 1000 population aged 65 and over, 0.25 in 1998- the US ratio was 0.07.

CON/Moratorium

Wyoming had a CON for nursing facilities between 1980 and 1986, eliminated it in 1987, and re-instituted it (as an 'intent to construct' approval process for the construction of nursing facilities) in 1990. It remained in effect through 1998[2]. In 1998 there was neither a CON nor moratorium for hospital bed conversion, ICF/MRs, residential care, assisted living, home health care, hospice or adult day care.

[1] In 1997 there was a decrease in boarding home facilities and beds and an increase in assisted living facilities and beds. This change represented the transfer of residents out of boarding homes 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.

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Demographics

Percentage Population 65 and Over	11.5 % (US 12.7 %)
Percentage Population 85 and Over	1.3 % (US 1.5 %)

Licensed Nursing Facilities

Total Facilities	40
Total Beds	3,134
Beds Per Nursing Facility	78.4 (US 103.5)
Average Occupancy Rate	83.9
Beds Per 1000 Population:	
Age 65 and Over	56.0 (US 52.5)
Age 85 and Over	522.3 (US 445.6)
Medicaid:	
Recipients Per 1000 Pop, 1997	5.32 (US 6.00)
Expenditures Per 1000 Pop, 1997	$96,423 (US $114,494)
Adequacy of Bed Supply*	Adequate Supply

Licensed Intermediate Care Facilities For Mentally Retarded

Total Facilities	1
Total Beds	152
Beds Per 1000 Population	0.32 (US 0.47)

Other Licensed Residential Care

Total Facilities for Adult/Aged	35
Total Beds for Adult/Aged	1,301
Beds Per 1000 Pop, Age 65 and Over	23.2 (US 25.5)
Total Facilities, Other	6
Total Beds, Other	60

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	58
Agencies Per 1000 Pop, Age 65 and Over	1.04 (US 0.47)
Medicaid:	
Recipients Per 1000 Pop, 1997	10.28 (US 6.95)
Expenditures Per 1000 Pop, 1997	$85,067 (US $45,711)

Licensed Hospices

Total Organizations	14
Organizations Per 1000 Pop, Age 65 and Over	0.25 (US 0.07)

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
Adult Day Care	No CON or Moratorium
Home Health Care	No CON or Moratorium
Hospice Care	No CON or Moratorium

* Opinion of State Health Planning Officials.

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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 1997 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 FY98 average reimbursement rate for Wyoming was $93.78, 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.

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Free-Standing Nursing Facilities

Method	Prospective Facility-Specific, Adjusted
Average Reimbursement Rate	$93.78
Percentage Rate Change From Previous Year	1.5%
Peer Groupings	None
Year of Cost Report to Set Rate	1997 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

ICF-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.