



■ *Information Digest for the
Skilled Nursing Industry*







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Acknowledgements:

Contribution of "Overview of Insurance" in the Industry Overview

Hamilton Insurance Agency (HIA) is a nationally licensed full-service brokerage providing insurance and risk management services to clients in the Long Term Care industry (nursing homes, assisted living facilities, CCRC's, hospitals, etc.). HIA has developed solutions for any healthcare facility's risk transfer needs, including: captives and excess insurance programs, incident and loss reduction programs, and workers' compensation and employee benefits programs for large employee populations.

In addition, HIA was instrumental in assisting HUD in structuring the current insurance limit waiver program as well as working with numerous lenders and HUD in structuring a number of portfolio and reduced insurance requirement refinancing submissions that were eventually approved by HUD Central.

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ISBN 978-0-9818427-5-2
ISSN 1942-7433

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How To Use This Publication

The *Information Digest for the Skilled Nursing Industry* contains two sections.

The first section of the publication is devoted to individual state profiles and Medicare cost report statistical information. The first portion of this section is a profile of the states. Each profile contains the legislative body that regulates nursing homes, basic statistics and demographics, a summary of the certificate of need (CON), bed need methodology, quality assurance fees and the Medicaid rate system for nursing homes. Not every state has a CON, bed need methodology or quality assurance fee. Each state profile will indicate whether or not the state has these programs and will provide a summary of the program if applicable in that state. It should be noted that as of the date of this publication, several states are still in the process of finalizing their budgets. Any significant changes resulting from these budgets will be addressed in the publication's quarterly updates.

The Medicare cost report statistical section of each state profile is developed from Medicare cost reports for 2014, 2015 and 2016. The cost report data only includes Medicare cost reports submitted by nursing facilities and does not represent all licensed facilities. However, the data represents a large enough sample that it provides a realistic estimate of occupancy, payor mix, revenue and expenses trend for each state. Facilities that reported no patient days, facilities with less than a full year of cost report data or facilities with an occupancy percentage below 50% were eliminated from the analysis. Typically, cost report data indicating an occupancy below 50% is due to various exclusions in the cost report data rather than high vacancy levels. In addition, the cost reports, for a minor number of nursing facilities, include some facilities that also contain assisted living wings. The Medicare cost report data does not provide a breakout of assisted living data from nursing home data. However, given that the assisted living wings are typically significantly smaller than the nursing home portions of these facilities, combined with the small sample of nursing facilities with assisted living wings, any changes in the data displayed in the Medicare cost report state profiles as a result of including nursing facilities with assisted living wings were not statistically significant.

Additionally, facilities for mentally retarded and/or developmentally disabled patients or facilities with Title V patients were eliminated from the analysis. A lower quartile, median and upper quartile value is presented for each year. The median value represents the midpoint of the datasets. The lower quartile value represents the midpoint value between the lowest value and the median value, and the upper quartile represents the

midpoint between the highest value and the median value. States with limited datasets, such as Alaska, produce less meaningful results. As with all statistics, more datasets produce more meaningful results.

Each state cost report statistical page contains general information, payor mix, average length of stay, revenue for inpatient and ancillary and operating expense statistics. The general statistics include number of beds, average daily census and occupancy percentages. The Payor Mix statistic is the percentage of total patient days for Medicare, Medicaid and Other payors. The percentages in the tables represent the lower quartile, upper quartile and median values for each payor source. Therefore, the percentages will not add up to 100%. The Average Length of Stay statistics provide the average number of days within Medicare, Medicaid and Other payors. Both revenue and departmental expenses are presented on a per-patient-day (PPD) basis. Revenue statistics only include inpatient and ancillary revenue. Other revenues from outpatient, miscellaneous, home healthcare or other sources were not included as part of this presentation. Departmental expenses are presented in nine categories, which are as follows:

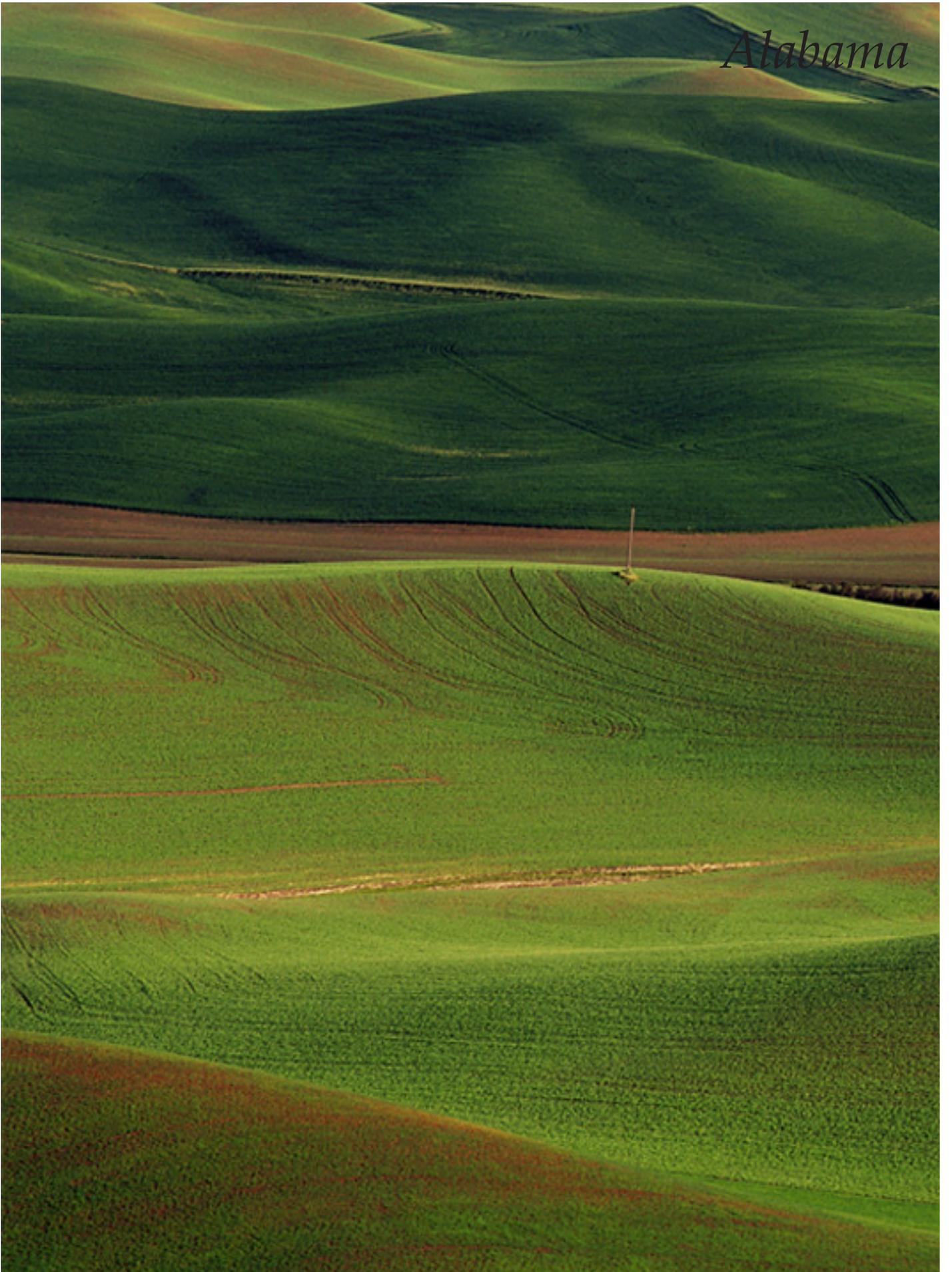
- Employee Benefits;
- Administrative and General;
- Plant Operations;
- Laundry and Linens;
- Housekeeping; Dietary;
- Nursing and Medical Related;
- Ancillary and Pharmacy;
- Social Services.

These are departmental expenses and not the total expenses of a nursing facility. The data does not include capital-related items, property taxes, certain insurance or management fees. All of these departmental expenses are drawn from Worksheet A of the Medicare cost report and include the reclassification adjustments.

The second section of this publication contains the appendices. The appendices include a state summary chart, beds per 1,000 persons aged 65 or older by state, beds per 1,000 persons aged 75 or older by state, a chart indicating the weighted average percentage of days per Medicare RUG classification by state, state quality assurance fee summary and state bed need methodology summary. Appendix A – State Summary Chart provides a state-by-state summary indicating the total number of facilities, licensed beds and average occupancy, as well as whether or not the state has a bed need methodology, moratorium on new beds and CON. The chart will also indicate the type of Medicaid system

as well as the components of the system. Appendix B provides the beds per 1,000 for persons aged 65 and 75 per state. Appendix C provides the weighted average percentage of total Medicare days per RUG Classification per state. Appendix D provides a state-by-state summary of the quality assurance fee and the formula for the calculation. Appendix E provides a state-by-state summary of the bed need calculation. Finally, Appendix F provides occupancy percentages by state for the years 2014, 2015 and 2016

Alabama



INTRODUCTION

Nursing facilities in Alabama are licensed by the Alabama Department of Public Health – Division of Health Care Facilities under the designation of “Nursing Facility.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN ALABAMA	
Licensed Nursing Facilities*	213
Licensed Nursing Beds*	25,310
Beds per 1,000 Aged 65 >**	30.84
Beds per 1,000 Aged 75 >**	77.09
Occupancy Percentage - 2017*	84.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Alabama presently has a moratorium on the acceptance and processing of Certificate of Need (CON) applications for additional skilled nursing beds. The moratorium went into effect on November 21, 2004, and there is no end date designated. Given this factor, there is no exception for the construction of any new nursing facility beds unless it involves the construction of a replacement nursing facility. However, a CON is required for the following scenarios:

- Any purchase of equipment that requires a capital outlay of \$5,995,836 or greater (as of October 1, 2018).
- The furnishing or offering of any new health service.
- The construction of a replacement nursing facility.

The capital outlay is inflated annually. Most recently, the Consumer Price Index All Urban Professional Medicaid Services was utilized to inflate the capital outlay.

BED NEED METHODOLOGY

Alabama’s nursing facility bed need methodology was created by a committee of the Statewide Health Coordinating Council (SHCC), composed of healthcare consumers and providers. The State Health Planning and Development Agency is responsible for updating the nursing facility bed need projections and inventories to provide the most current population and utilization statistics.

The basic methodology employed in Alabama assumes that there should be a minimum of 40 beds per 1,000 people aged 65 and older in each county. The bed need formula is as follows:

$$(40 \text{ beds per thousand}) \times (\text{population 65 and older}) \\ = \text{Projected Bed Need}$$

However, the state suspended the calculation of nursing facility bed need since the establishment of the moratorium.

QUALITY ASSURANCE FEE

Nursing facilities in Alabama are assessed a quality assurance fee, referred to as a facility privilege tax (FPT). The FPT is administered by the Alabama Department of Revenue and is currently \$1,899.96 per bed per year. Effective September 1, 2010, the state imposed a supplemental provider privilege assessment of \$1,063.08, which increased the total FPT to \$2,963.04 per bed per year. This increase was approved by the Centers for Medicare & Medicaid Services (CMS). Per House Bill 383, the state has increased the supplemental provider privilege assessment to \$1,603.08 effective September 1, 2011, which increased the total FPT to \$3,503.04. Effective May 20, 2012, the state implemented an additional monthly supplemental surcharge of \$131.25 (\$1,575 per year). This increased the total FPT to \$5,078.04. Effective September 1, 2012, the monthly surcharge was reduced to \$43.75 (\$525 per year), which decreases the total FPT to \$4,028.04. In addition, a secondary monthly supplemental surcharge of \$33.44 (\$401.28 per year) was established on October 1, 2015. This increased the total FPT to \$4,429.32 effective October 1, 2015. The FPT has not changed since that date.

The inclusion of the supplemental provider privilege assessment and the monthly surcharge in the FPT is scheduled to sunset on August 31, 2020; however, the FPT has typically been extended several times in the past and there is no indication that it will not be extended in the future. Nursing facilities are reimbursed a portion of their FPT charges in the Property cost component. In addition, the state is currently reimbursing nursing facilities for additional costs related to the temporary surcharges as add-ons to the rate. The add-on is determined by dividing the total additional fees by total patient days for the equivalent period.

In addition, nursing facilities that have historically operated below 85.0% occupancy are eligible for a discounted payment of the FPT. FPT payments for these facilities are adjusted for the facility’s occupancy level. This is calculated by multiplying the FPT by the facility’s total licensed beds and then by the facility’s occupancy percentage. Facilities that are not eligible for this discount pay the full cost of the FPT per licensed bed. However, it should be noted that once a nursing facility achieves an occupancy percentage that is 85.0% or greater, that facility is no longer eligible for the discount, even if its occupancy level drops below 85.0% in the future.

MEDICAID RATE CALCULATION SYSTEM

Alabama uses a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

The Alabama Medicaid Agency sets the nursing facility rates in Alabama. The rates reflect four cost components:

- The Direct Patient Care cost component includes expenses related to nursing services, raw food, medical director fees, pharmacy, dental and nursing consultant fees.
- The Indirect Patient Care cost component includes expenses related to plant operations, dietary (less raw foods), laundry (less costs associated with patient personal laundry), activities, social services, housekeeping, beauty and barber

(if provided free of charge by the facility), dietary consultant, social services consultant and other allowable costs.

- **The Operating** cost component includes administrative and management expenses.
- **The Property** cost component is determined using a fair rental system (FRS). A fair rental return (FRR) is a rate of return on current asset values and is used in lieu of depreciation and/or lease payments on land, building and major movable equipment normally used in providing patient care.

Allowable costs are defined by state regulation, based in part on Medicare Manual principles. The Medicaid rate does not include skilled therapies, and the program does not reimburse for ancillary services outside the facility rate. Limitations to allowable costs also include costs associated with a sale or lease (related party transactions).

INFLATION AND REBASING

The effective period of Medicaid rates set for Alabama is from July 1 to June 30. Nursing facility rates are rebased annually using the most recent cost report data available. However, since the fiscal year-end for the majority of nursing facilities in Alabama is June 30, interim rates calculated until the facility's actual rate can be established based on the most recent cost report data.

The interim rate, defined as the lower of the previously reported actual costs per patient day (PPD) or the ceiling rate for the appropriate cost centers/peer group, is applied to cover the period of July 1 to December 31. The applicable allowable rate per day is trended by the Alabama Medicaid Trend Factor. The trend factor used is the National Forecast-Nursing Home Market Basket for the following fiscal year as published by Global Insight. This forecast is published quarterly and the latest forecast available on June 1 each year is used.

The Medicaid Inflation Index is used to inflate certain actual allowable costs from one reporting period for the purpose of computing the actual per diem rate. The Medicaid Inflation Index is based upon the economic indicators published by Global Insight for the Department of Health and Human Services. These indicators are derived from the Market Basket Index of Operating Costs – Skilled Nursing Facility, which is published quarterly. Therefore, the Medicaid Inflation Index for a rate period is the Global Insight Index for the 12-month period ending on the calendar quarter for which the index has been published or made available on October 1 of each year.

When cost reports for the most recent reporting period have been reviewed, providers receive a weighted rate for the remainder of the payment year (usually January 1 to June 30) that reflects the difference between the provider's new rate and the interim rate. This weighted average rate is calculated as follows:

(Actual per diem rate multiplied by 12 - interim rate multiplied by number of months in effect) divided by the remainder of months in the fiscal year

Cost reports for fiscal year-end June 30, 2010, were utilized to establish Medicaid rates effective January 1, 2011. Cost reports for fiscal year-end June 30, 2011, were utilized to establish Medicaid rates that were effective January 1, 2012. However, effective October 1, 2011, the state repealed the inflation adjustment (2.44%) that was applied to previous years' rates to determine interim rates. In addition, no inflation was applied to allowable costs that were used to determine final weighted average rates. However, allowable costs were inflated for the purpose of calculating cost center ceilings. In addition, the calculation of weighted average rates was temporarily adjusted to factor in that nursing facilities received inflated interim rates from July 1, 2011, to September 30, 2011, and received un-inflated interim rates from October 1, 2011, to December 31, 2011. Effective October 1, 2011, the state discontinued utilizing inflated costs when determining rates.

Given this factor, no inflation was utilized to determine interim rates effective July 1, 2012, and July 1, 2013. Cost reports for fiscal year-end June 30, 2012, and June 30, 2013, were utilized to establish Medicaid rates effective January 1, 2013, and January 1, 2014. However, no inflation was applied to allowable costs that were used to determine final weighted average rates.

The ceiling for non-capital cost components were calculated for fiscal year 2013 when the actual Medicaid rates were determined (typically on January 1). The prior year's ceiling is applied to interim rates. Allowable costs were inflated for the purpose of calculating cost center ceilings effective January 1, 2013, and January 1, 2014.

The state established interim rates effective July 1, 2014. State rate setting officials indicated that these rates were adjusted for inflation on October 1, 2014. These rates were retroactively adjusted so that nursing facilities received the reimbursement they would have received if interim rates effective July 1, 2014, were calculated with an inflation adjustment. State rate setting officials indicated that that this was a one-time occurrence and interim rates will be adjusted for inflation on July 1 going forward.

January 1, 2015, rates were based on cost reports ending June 30, 2014. These cost reports were also utilized to determine interim July 1, 2015, rates, which were inflated utilizing the state's standard inflation adjustment. January 1, 2016, rates were determined utilizing June 30, 2015, cost report data, as were interim July 1, 2016, rates. These rates were adjusted utilizing the state's standard inflation adjustment, which equated to 2.78% for non-property costs. Rates were rebased on January 1, 2017, utilizing June 30, 2016 cost report data and the standard inflation adjustment. Interim rates effective July 1, 2017 were determined utilizing the standard inflation adjustment of 2.78%.

Rates effective January 1, 2018 were rebased utilizing June 30, 2017 cost reports, and costs were inflated 2.61%. The inflation rate utilized to convert these rates into interim rates effective July 1, 2018 was 2.81%. January 1, 2019, rates were rebased utilizing June 30, 2018 cost reports, and costs were inflated 3.26%. These rates were inflated 3.08% to determine July 1, 2019 interim rates.

RATE METHODOLOGY

Non-property costs are subject to ceilings, generally determined as a percentage of median reported costs within each cost center. Ceilings are to be limited to the previous year's ceiling increased by no more than four percentage points over the Global Insight inflation index. Should the computed ceiling exceed that index, the lower amount is used. The ceilings for non-property cost components are calculated for a specific fiscal year when the actual Medicaid rates are determined (typically on January 1). The prior year's ceiling is applied to interim rates. Ceilings for operating costs are calculated for two peer groupings based on bed size (75 beds or fewer and more than 75 beds).

The facility-specific Direct Patient Care cost component is calculated to be the lesser of the following:

- The Direct Patient Care cost ceiling, which is \$129.34 effective January 1, 2019. To determine the cost ceiling, the per diem expenses for each nursing facility in each peer group are arrayed and a median is determined. This median is increased by 10%, then by 11% to calculate the cost ceiling; or
- The provider's actual inflated allowable reported cost per patient day increased by an additional 11%.

The facility-specific Indirect Patient Care cost component is calculated to be the lesser of:

- The Indirect Patient Care cost component ceiling that equates to 110% of the median indirect care costs PPD for all facilities; or
- The provider's actual allowable reported costs PPD, plus 50% of the difference between actual allowable costs and the established ceiling. The actual Indirect Patient Care cost component ceiling is \$41.55, effective January 1, 2019.

In order to determine the facility-specific Operating cost component, nursing facilities are grouped into two classes by bed size (75 beds or fewer and more than 75 beds). For each bed-size grouping, providers receive the lesser of the following:

- The Operating cost component ceiling that equates to 105% of the median operating costs PPD; or
- The provider's actual allowable reported costs PPD, adjusted for inflation. The actual Operating cost component ceilings, effective January 1, 2019, were \$32.85 for nursing facilities with 75 or fewer beds and \$28.16 for nursing facilities with greater than 75 beds.

The facility-specific Property cost component is the nursing facility's fair rental payment PPD. This rate component equates to the sum of the facility's rental value, FRR, allowable interest, property taxes and property insurance costs, less a laundry adjustment to the fair rental payment, divided by the facility's reported patient days. The current laundry adjustment equates to 1.5%.

In order to determine a nursing facility's rental value, a current asset value per bed is established. The current asset value (CAV) will initially be set at \$25,000 per bed. The CAV is decreased by 1% for each year of act, or a fraction of 1% for partial years. The reduction cannot exceed 50%, and the CAV has a \$12,500 minimum value. In addition, the values are inflated each year using the Marshall Valuation Service. The inflation adjustment

is limited to no more than 3% per year. The current maximum CAV is \$44,187.25 as of January 1, 2019. Lastly, the CAV of the facility is multiplied by a gross rental factor of 2.5% to determine the facility rental value. For newly renovated nursing facilities, Alabama Medicaid will adjust the CAV and set an interim rate for the facility during the month in which the renovation project is completed. Any improvements that exceed 5% of the applicable standard CAV must be submitted to Alabama Medicaid for approval.

The FRR is calculated in two steps. The first step is that the CAV, net of the balance due on allowable debt incurred to purchase the land, buildings and equipment are multiplied by the current yield on the 30-year U.S. Treasury Bond. The second step is to multiply the CAV by 1.5%, which represents a risk premium of ownership. The sum of these two calculations equates to the FRR.

In addition, fair rental payment includes a component for reimbursement of a nursing facility's FPT charges. The FPT PPD reimbursement amount is calculated by dividing the total FPT charges by the patient days for the same period. This factor is reimbursed on a per-Medicaid-day basis. Lastly, nursing facilities receive a \$1.25 add-on payment to the Indirect Care cost component for providing laundry services. The sum of the Direct Patient Care, Indirect Patient Care, Operating and Property components, plus the laundry services add-on, equates to a nursing facility's total Medicaid reimbursement rate.

According to rate setting officials, the average nursing facility Medicaid rate effective January 1, 2019 is \$206.61, which is greater than the prior average rate (\$202.55) effective January 1, 2018. The average rate effective January 1, 2017 was \$198.20.

MINIMUM OCCUPANCY STANDARDS

The Alabama Medicaid rate calculation methodology does not include minimum occupancy standards.

OTHER RATE PROVISIONS

A developer who constructs, leases or purchases a nursing facility or has a change in category of care can request reimbursement based on an operating budget, subject to the established rate ceilings. However, the nursing facility is subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs.

For recently purchased nursing facilities, the allowable basis to the purchaser of an existing facility in the Medicaid Program is the CAV of the previous owner. For newly constructed nursing facilities, particularly in the year that the facility opened, the most recently computed standard CAV is used to determine the fair rental payment.

Nursing facilities in Alabama are eligible to be reimbursed by Alabama Medicaid if they hold a bed for a resident who requires an absence from the facility for a therapeutic visit. Nursing facilities are reimbursed for a maximum of three bed-hold days per absence from the facility and a total of six bed-hold days per calendar quarter. These bed-hold days are paid at the same per

diem rate as the days when the recipient is in the facility.

Alabama will also provide additional reimbursement for nursing facilities that operate dedicated ventilator care units.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is currently no proposed state legislation that will affect the Medicaid reimbursement methodology in Alabama.

ALABAMA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	86.00	85.00	85.00		115.00	114.00	114.50		150.00	149.00	149.00
Average Daily Census	74.91	72.54	72.31		95.79	95.52	94.05		129.12	127.98	126.32
Occupancy	83.6%	82.1%	80.4%		88.9%	89.0%	88.2%		93.1%	93.1%	92.6%
Payor Mix Statistics											
Medicare	7.9%	7.4%	6.6%		11.5%	10.6%	9.8%		15.2%	14.3%	13.3%
Medicaid	59.7%	60.3%	59.2%		71.0%	71.5%	70.6%		77.8%	77.3%	77.2%
Other	13.5%	15.0%	15.4%		20.6%	20.4%	21.8%		36.4%	32.7%	33.3%
Avg. Length of Stay Statistics (Days)											
Medicare	28.96	27.88	27.92		36.39	36.21	37.82		50.17	51.28	53.91
Medicaid	310.63	300.04	300.76		407.38	379.38	383.27		519.45	501.12	502.42
Other	67.83	62.15	57.72		118.02	102.80	90.83		206.50	166.11	147.96
Revenue (PPD)											
Inpatient	\$182.03	\$187.32	\$189.42		\$196.67	\$199.90	\$201.42		\$214.95	\$222.60	\$223.59
Ancillary	\$35.46	\$35.06	\$36.00		\$46.65	\$46.42	\$47.77		\$66.74	\$69.28	\$68.67
TOTAL	\$221.22	\$225.63	\$226.74		\$245.73	\$245.29	\$248.20		\$281.31	\$296.86	\$292.55
Expenses (PPD)											
Employee Benefits	\$11.83	\$11.53	\$10.74		\$14.36	\$13.92	\$12.98		\$21.17	\$21.60	\$19.51
Administrative and General	\$36.51	\$38.68	\$40.73		\$42.21	\$43.86	\$44.98		\$48.00	\$49.40	\$49.92
Plant Operations	\$9.05	\$9.29	\$9.69		\$10.76	\$10.90	\$11.63		\$12.39	\$12.86	\$13.44
Laundry & Linens	\$2.26	\$2.33	\$2.33		\$2.96	\$2.96	\$3.02		\$3.49	\$3.56	\$3.61
Housekeeping	\$4.84	\$4.97	\$4.90		\$5.98	\$6.35	\$6.13		\$7.35	\$7.67	\$7.51
Dietary	\$15.14	\$15.49	\$15.45		\$17.30	\$17.91	\$17.76		\$20.06	\$20.18	\$20.26
Nursing & Medical Related	\$71.49	\$74.08	\$75.90		\$79.31	\$82.20	\$83.53		\$89.57	\$93.31	\$94.70
Ancillary and Pharmacy	\$21.07	\$20.10	\$21.14		\$28.75	\$27.70	\$28.37		\$37.97	\$35.92	\$36.72
Social Services	\$1.80	\$1.90	\$1.84		\$2.71	\$2.85	\$2.78		\$3.60	\$3.88	\$3.82

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Alaska



INTRODUCTION

Nursing facilities in Alaska are licensed by the Health Facilities Licensing and Certification unit of the Alaska Department of Health and Social Services (DHSS) under the designation of "Nursing Homes." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN ALASKA	
Licensed Nursing Facilities*	6
Licensed Nursing Beds*	249
Beds per 1,000 Aged 65 >**	2.97
Beds per 1,000 Aged 75 >**	7.54
Occupancy Percentage - 2017*	91.10%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

DHSS enacted the Certificate of Need (CON) Program in 1976. For a nursing facility, a CON is required for the following scenarios, provided the total expenditure is \$1,450,000 or more (effective July 1, 2013):

- The construction of a new nursing facility.
- An alteration of the bed capacity.
- An addition of a category of health services.
- The conversion of a hospital or part of a hospital building to a nursing home requires a CON, regardless of cost.

The \$1,450,000 threshold will be effective until July 1, 2014, when it increases to \$1,500,000. By law, the threshold is to be increased by \$50,000 annually on July 1 of each year up to and including July 1, 2014. This will result in the threshold being capped at \$1.5 million on July 1, 2014.

In evaluating each CON application for healthcare services, applicants must meet general review standards and the following service-specific, long-term nursing care review standards:

- A new freestanding long-term nursing facility will not be approved unless the applicant has demonstrated a need for at least 40 beds. For new nursing facilities located within hospitals, there must be a need for at least 15 beds unless the applicant documents use patterns and submits data and analysis that justify a smaller number of beds. The bed need methodology used by the state is detailed in the next section.
- To be considered for approval to expand licensed capacity, a freestanding long-term nursing home must have had an average annual occupancy of at least 90%, and colocated long-term nursing units must have had an average annual occupancy of at least 80% during the preceding three years.
- In a service area with more than one long-term nursing care facility, all facilities must have had an average annual occupancy of at least 90% during the preceding three years before additional beds are approved.
- In order to serve individuals in the most cost effective, least restrictive setting possible, there must be a combination of at least one assisted living bed or adult day care slot for each existing and proposed long-term nursing care bed.
- For a community with a population of 10,000 or less, the

department may approve beds on a case-by-case basis.

BED NEED METHODOLOGY

In order to determine bed need for long-term nursing home beds, a three-step calculation is applied to a specific service area of the state. The first step is used to determine the projected Long-Term Nursing Care Caseload. The caseload is defined as the average daily census (patient days per year/365) of long-term nursing care patients five years from the project implementation date. It is calculated by multiplying specific use rates per 1,000 (determined from data three years prior to the implementation of the proposed project) for four specific age groups (0 to 64 years, 65 to 74 years, 75 to 84 years and 85 years and over) by the projected population for that age group in the fifth year after the project implementation date.

The second step is to determine the projected number of nursing home beds required to meet projected demand. This is accomplished by dividing the caseload by the nursing home target occupancy, defined as 90%.

The third and final step is to multiply the projected number of nursing facility beds by the proposed service area's current share of the population to be served – aged 65 and over – as of the most recent geographic population estimates.

Any existing unmet nursing home bed need is then determined by subtracting the number of current licensed and CON-approved beds from the number of beds projected to be needed in the proposed service area. As of the date of this publication, the state is currently in the process of calculating unmet nursing home bed need.

QUALITY ASSURANCE FEE

Nursing facilities in the state of Alaska are currently not assessed with a quality assurance fee. There are currently no active proposals to implement a quality assurance fee in Alaska.

MEDICAID RATE CALCULATION SYSTEM

Alaska uses a prospective, cost-based Medicaid reimbursement system. Prospective payment rates are determined under one of three methodologies: Basic, Optional or New Facilities. A nursing facility that has 4,000 or fewer total inpatient hospital days as a combined hospital nursing facility or 15,000 or fewer Medicaid nursing days as a non-combined nursing facility during the facility's fiscal year that ended 12 months prior to the beginning of the prospective payment rate year may elect to be reimbursed for nursing services utilizing the Optional Rate System.

COST CENTERS

The Basic reimbursement methodology consists of the following four components:

- The Non-Capital Routine component is equal to the total allowable routine base year costs, excluding Routine Capital Costs for routine costs, divided by the total-long-term care days.
- The Routine Capital component is equal to the total allowable

base year costs, excluding Routine Non-Capital Costs, divided by the total long-term care days. The state does not apply any cost ceilings on nursing facilities' Ancillary and Routine costs.

- **The Ancillary Capital** component is calculated by determining the percentage of capital cost for each Ancillary cost center (these percentages are calculated using data derived from a nursing facility's applicable cost report) and multiplying the percentage by the related Medicaid long-term care Ancillary costs from the base year. These amounts are summed and then divided by total Medicaid long-term care patient days from the base year.
- **The Non-Capital Ancillary** component is determined by subtracting Medicaid Capital Ancillary costs from Medicaid Ancillary cost. This amount is then divided by the facility's Medicaid long-term care days from the base year.

Specific costs included in each component are taken directly from the facilities' Medicare cost reports.

INFLATION AND REBASING

Medicaid rates calculated using the Basic methodology are rebased at least every four years. However, there is no set rebasing year in which all Alaska nursing homes are rebased. The actual rebasing years for nursing facilities in Alaska vary depending on when the facility entered the system. During rebasing years, cost report data used is for the period ending 12 months prior to the new fiscal year. According to the Alaska rate-setting professionals, the majority of the nursing facilities on the basic methodology were rebased in 2012 and 2013, but a small number of nursing facilities (two facilities) were rebased in 2011. Based on these conditions, the next required rebasing of basic rates will be in the 2016 and 2017 calendar years for the majority of the nursing facilities in the state. However, two nursing facilities will have their rates rebased in calendar year 2015.

During both rebasing and non-rebasing years, for facilities under the Basic methodology, base year costs are adjusted for inflation using various factors from the Skilled Nursing Facility Market Basket as published in the most recent quarterly publication of Global Insight's Health Care Cost Review. Allowable capital costs are inflated using the Skilled Nursing Facility Total Market Basket. Allowable non-capital costs are inflated using the CMS Nursing Home Without Capital Market Basket.

Under the Optional rate system, facilities are rebased every four years dependent upon the period of the agreement. For facilities receiving payment under the Optional methodology, following the base year, the capital component is adjusted for inflation at 1.1% per year for each fiscal year, while the non-capital component is adjusted for inflation at 3.0%. Optional agreements require less stringent reporting requirements.

RATE METHODOLOGY

The sum of the base year component rates is adjusted annually for inflation (as described above) to arrive at a facility's prospective payment rate. The capital components of the prospective rate will

also be adjusted for CON assets placed into service, provided that their total value is at least \$5 million. This adjustment will reflect appropriate capital costs for the prospective year based on CON documentation, assets retired in conjunction with the CON and Medicare cost reporting requirements.

At the time of rebasing, the Optional prospective payment methodology is available to facilities that meet one of the following criteria during the facility's fiscal year that ended 12 months before the beginning of its prospective rate year:

- 4,000 or fewer total inpatient hospital days as a combined hospital-nursing facility; or
- 15,000 or fewer Medicaid nursing days as a freestanding nursing facility.

Facilities under the Basic methodology wishing to switch to the Optional system must do so in the first fiscal year following rebasing. Facilities under an Optional agreement may not switch to the Basic methodology until the current agreement expires.

The Optional methodology is calculated in the same manner as the Basic methodology for the base year. The primary difference lies in the inflation process (as previously described).

Historically, the statewide average long-term care Medicaid rate was \$634.09 in 2012 and \$667.98 in 2013. The 2011 rate represents a 5.3% increase from the prior year.

MINIMUM OCCUPANCY STANDARDS

For the Non-Capital Routine and Routine Capital components, long-term care days are the greater of the actual total facility long-term care patient days or 85% of licensed capacity days.

OTHER RATE PROVISIONS

If a new nursing facility is licensed, the rate will be the sum of:

- The swing-bed rate in effect at the start of the facility's rate year, less the average capital cost contained in the swing-bed rate; and
- The new facility's allowable capital costs divided by the greater of the occupancy rate approved in the CON, or 80% of licensed beds.

Rates are then established under the Basic methodology after two full fiscal years of cost data are reported.

When a facility is sold, the increase in the depreciable base is limited to the lesser of one-half of the percentage increase since the date of the seller's acquisition in either the McGraw Hill Construction/Dodge Construction Systems Costs Index for Nursing Homes or the Consumer Price Index for all urban consumers. All related capital costs including interest are limited to the allowable changes in the asset base.

A maximum of 12 leave of absence (LOA) days for therapeutic leave are payable by Medicaid in Alaska. The leave days are for a 12-month period per resident. These LOA days are paid at the same per diem rate as the days when the recipient is in the facility.

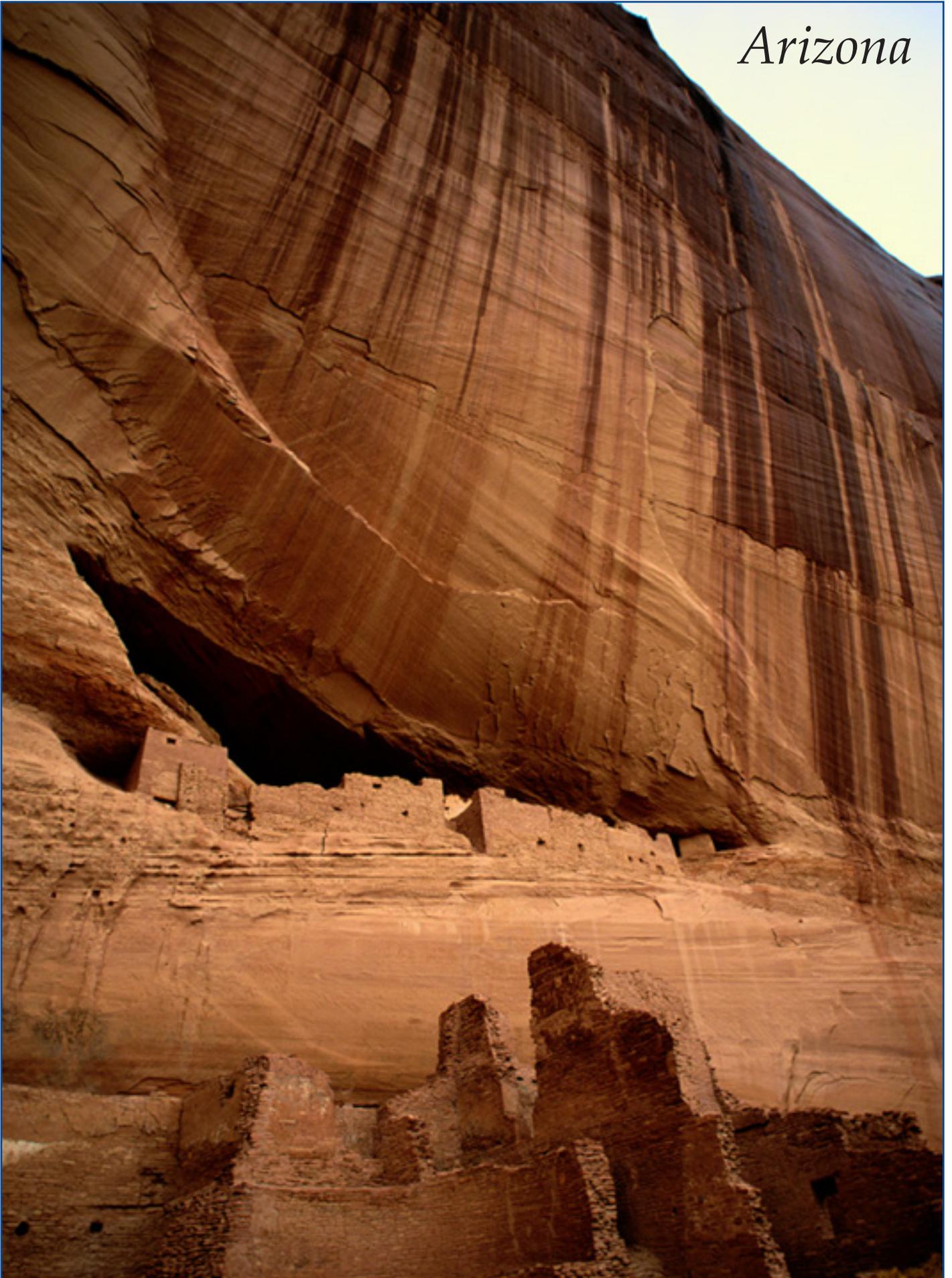
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no changes expected to the Medicaid rate methodology in the immediate future.

ALASKA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	42.00	18.00	18.00		53.50	50.00	50.00		68.25	57.00	61.00
Average Daily Census	39.76	22.69	23.12		55.97	47.22	49.68		87.03	77.38	79.71
Occupancy	85.3%	86.1%	88.3%		95.8%	94.8%	89.8%		98.2%	96.0%	90.7%
Payor Mix Statistics											
Medicare	3.3%	4.4%	5.3%		9.6%	10.0%	11.4%		22.6%	22.3%	25.7%
Medicaid	69.3%	72.6%	73.2%		91.4%	90.3%	90.3%		92.4%	97.7%	97.9%
Other	7.2%	7.9%	7.2%		12.2%	14.0%	9.6%		16.8%	19.1%	12.1%
Avg. Length of Stay Statistics (Days)											
Medicare	35.04	44.72	53.98		36.69	47.53	68.37		41.58	48.69	83.22
Medicaid	398.49	324.30	231.68		746.60	390.00	327.44		1059.54	1041.50	656.67
Other	87.29	56.95	77.30		135.40	77.55	126.80		139.86	108.83	192.57
Revenue (PPD)											
Inpatient	\$599.84	\$670.60	\$680.87		\$661.95	\$931.25	\$945.44		\$832.00	\$1,039.44	\$1,055.97
Ancillary	\$86.25	\$98.88	\$114.73		\$116.45	\$147.71	\$182.07		\$228.93	\$304.40	\$369.78
TOTAL	\$642.61	\$708.15	\$734.80		\$661.95	\$931.25	\$945.44		\$932.75	\$1,039.44	\$1,055.97
Expenses (PPD)											
Employee Benefits	\$13.24	\$7.90	\$8.05		\$16.34	\$13.42	\$16.91		\$35.14	\$17.25	\$17.16
Administrative and General	\$47.66	\$48.75	\$46.80		\$83.13	\$84.60	\$51.92		\$99.32	\$102.58	\$59.79
Plant Operations	\$26.89	\$26.55	\$23.08		\$27.34	\$28.86	\$25.57		\$30.83	\$32.03	\$29.31
Laundry & Linens	\$5.76	\$5.47	\$5.39		\$6.76	\$6.61	\$6.36		\$8.09	\$8.18	\$7.81
Housekeeping	\$10.05	\$9.27	\$11.45		\$11.77	\$11.74	\$19.94		\$21.17	\$22.08	\$25.52
Dietary	\$25.11	\$25.57	\$25.71		\$32.62	\$40.79	\$41.52		\$42.13	\$51.74	\$47.46
Nursing & Medical Related	\$256.55	\$259.86	\$254.26		\$273.43	\$332.13	\$329.20		\$354.49	\$376.37	\$477.18
Ancillary and Pharmacy	\$29.10	\$29.85	\$29.46		\$36.14	\$36.10	\$39.60		\$72.89	\$74.09	\$74.79
Social Services	\$8.31	\$6.80	\$6.65		\$10.37	\$8.74	\$8.56		\$11.81	\$10.76	\$10.51
Comments: The above data is skewed, given that the average sample size over the three-year period is approximately six nursing facilities.											

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Arizona



INTRODUCTION

Nursing facilities in Arizona are licensed by the Arizona Department of Health Services, Division of Licensing Services, Office of Long-Term Care Licensing under the designation of "Nursing Care Institution." The following table summarizes the total number of nursing facilities within the state:

NURSING FACILITIES IN ARIZONA	
Licensed Nursing Facilities*	148
Licensed Nursing Beds*	15,971
Beds per 1,000 Aged 65 >**	13.15
Beds per 1,000 Aged 75 >**	31.81
Occupancy Percentage - 2017*	69.20%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Arizona does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility, or to increase the capacity and services offered at an existing facility. In addition, there is no moratorium on the construction of nursing facility beds in Arizona.

BED NEED METHODOLOGY

Arizona does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

Arizona implemented a skilled nursing facility provider assessment, effective October 1, 2012. The majority of nursing facilities in the state were assessed a fee of \$7.50 per non-Medicare day. Effective October 1, 2014, this assessment was increased to \$10.50 per non-Medicare day. Nursing facilities designated as High Volume Medicaid providers were assessed a fee of \$1.00 per non-Medicare day. Effective October 1, 2014, this assessment was increased to \$1.40 per non-Medicare day. Nursing facilities within continuing care retirement communities (CCRCs), out-of-state nursing facilities, tribally-owned and -operated facilities located on a reservation, the Arizona Veteran's Home and nursing facilities with 58 or fewer beds are exempt from paying the assessment. The assessment fee increased on January 1, 2017 to \$1.80 per non-Medicare day for High Volume Medicaid providers. The fee for the remaining facilities increased to \$15.63 per non-Medicare day.

The standard used to determine High Volume Medicaid Providers changes annually based on a calculation completed by the state. For the rate year beginning October 1, 2018, the standard is 40,740 Medicaid days. Typically, ten to 13 facilities in the state qualify for the lower rate.

Historically, Arizona has reimbursed nursing facilities for paying the assessment fee through quarterly supplemental payments. The state determines these supplemental payments based upon each nursing facility's proportionate share of Medicaid days to total Medicaid days of all nursing facility providers. However, based on The Centers for Medicare and Medicaid Services' (CMS) recent

elimination of supplemental payments through Managed Care Reimbursement Systems, the state was required to development a new, "hybrid" methodology of reimbursing facilities for the skilled nursing facility provider assessment.

This methodology was approved by CMS in early January 2018. Under this methodology, nursing facilities receive two separate sets of quarterly supplemental payments: one set from the state's managed care contractors and one from the state. The payments from the managed care contractor are capped at payments made for the period October 1, 2015, through September 30, 2016. However, payments made the by state are based on actual utilization (similarly calculated to the previous method) and supplement the payments made by the managed care contractors so that total payments equate to those that are calculated by the utilization method.

According to representatives of the Arizona Health Care Association, the new system was implemented without any problems and providers have not experienced any significant differences in reimbursement levels. The state is also considering adjusting payments based on quality measures. It is currently unclear if this will occur.

MEDICAID RATE CALCULATION SYSTEM

The Arizona Health Care Cost Containment System (AHCCCS) is the state's Medicaid program. AHCCCS, which originated in 1982, operates a statewide managed-care system and requires all eligible individuals to enroll in a contracted health plan.

The Arizona Long Term Care System (ALTCS) is the section of the AHCCCS responsible for reimbursement of long-term care services. ALTCS bundles all long-term care services into one package (alternative residential settings, acute, behavioral health, case management, hospice, intermediate care facilities for the mentally retarded and nursing facilities). The agency then contracts with individual organizations (program contractors), which act as gatekeepers that manage individual enrollees' care. The program contractors are awarded contracts at the county level and are directly responsible for providing fee-for-service (FFS) reimbursement to nursing facilities within their region. The FFS rates are a part of the capitated payment to the contractors for ALTCS-covered services. The contractors then negotiate rates with providers. However, these rates cannot be less than the established statewide full FFS rates. ALTCS uses a prospective, price-based rate setting methodology to calculate five specific FFS per diem Medicaid rates. Nursing facilities are categorized into groups based on geography (rural and urban) and the acuity level of an individual resident. However, the program contractors have the authority to negotiate individual rates with nursing facilities. The state-established FFS rates are based on cost report data for all applicable nursing facilities within the state.

INFLATION AND REBASING

According to state law, the state-established FFS rates are supposed to be rebased at least every five years. However, this has not occurred. The state last rebased rates effective October 1, 2010, utilizing the most recent cost report data available. However, this

rebase was only utilized for internal analysis and did not have any impact on nursing facility rates in fiscal year 2011. Prior to this rebase, rates were last rebased effective October 1, 2005, using fiscal year 2003 and 2004 cost report data.

Historically, the rebasing calculations have been made using Medicare cost reports and wage surveys since no Medicaid cost reporting was required for nursing facilities in Arizona. In 2008, facilities were required to file a Medicaid cost report, which incorporates the data necessary for future rebasing calculations.

On an annual basis, excluding rebasing years, rates are updated by applying inflation factors to the rate components as follows:

- During non-rebasing years, the Primary Care cost component is adjusted for inflation based on the prior year rate. For rates effective October 1, 2008, the Direct Care component was inflated approximately 3.3% based on the Employment Cost Index for Skilled Nursing Facilities Total Market Basket published by Global Insight for the first quarter of 2008.
- During non-rebasing years, the Indirect Care cost component is adjusted for inflation based on the prior year rate. For rates effective October 1, 2008, this component was inflated approximately 5.1% based on the Consumer Price Index (all urban consumers, not seasonally adjusted, U.S. city average, medical services) published by Global Insight for the first quarter of 2008.
- During non-rebasing years, the Capital cost component is adjusted for inflation based on the prior year rate. For rates effective October 1, 2008, this component was inflated approximately 3.0% based on the Capital cost component, net of interest, of the Nursing Facility Total Market Basket published by Global Insight for the first quarter of 2008.

Given budgetary restraints, nursing facility rates in fiscal year 2011 were frozen at fiscal year 2010 levels. In addition, fiscal year 2010 rates were previously frozen at fiscal year 2009 levels. Based on significant budget deficits, the state reduced skilled nursing facility Medicaid rates by 5% in fiscal year 2012 (effective October 1, 2011). However, supplemental payments derived from the state's nursing facility provider assessment more than offset the previous 5.0% reduction (\$7.28 to \$9.43) to all non-ventilator level of care rates.

In fiscal year 2013, the state froze Medicaid rates at fiscal year 2012 levels. The state inflated fiscal year 2014 (effective October 1, 2013) and 2015 (effective October 1, 2014) rates by 1.5% and 2.0%, respectively. Rates effective October 1, 2015, were frozen at prior year levels. Rates increased by 1.0% on October 1, 2016, 3.5% on January 1, 2017, 0.3% on July, 2017 and 0.7% on January 1, 2018. The rate increases on January 1, 2017 and January 1, 2018 were related to the increase in the state's minimum wage. In addition, in 2018 the state approved Senate Bill 1520, which provided the funding for a 3.0% increase in Medicaid rates effective October 1, 2018. Effective January 1, 2019 rates increased from 0.7% (Urban and Rural) to 1.3% (Flagstaff) effective January 1, 2019.

Nursing home rates effective October 1, 2019 will increase 4.4%. This includes a 2.6% legislative-approved funding increase and a 1.8% minimum wage increase via Proposition 206. In addition, effective January 1, 2020, nursing facility rates will be increased

an additional 1.3%. Combined, this results in a 5.7% increase in nursing facility rates from October 1, 2018 to January 1, 2020.

COST CENTERS

The nursing facility reimbursement system is designed to categorize nursing facility residents (AHCCCS members) into the following four levels:

- Level 1;
- Level 2;
- Level 3;
- Ventilator dependent, subacute and other specialty care.

There is a designed rate methodology to derive FFS rates for levels 1, 2 and 3. Payments for nursing facility residents who are ventilator dependent, subacute or receiving other specialty care are based on negotiated rates with the program contractor. FFS reimbursements for levels 1, 2 and 3 are based on a three-component system:

- The Primary Care cost component consists of nursing facility care including wages and benefits for registered nurses (RNs), licensed practical nurses (LPNs) and nurse aides.
- The Indirect Care cost component consists of non-nursing, non-capital related activities of a facility, including supplies, housekeeping, laundry and food.
- The Capital cost component includes depreciation, leases, rentals, interest and property taxes.

The capitated FFS per diem reimbursement rate is based on the individual resident's days of care multiplied by the lesser of the charge for the service or the applicable per diem rate for that member's classification, less any payment made by the member or a third party.

RATE METHODOLOGY

In order to calculate the Primary Care component of the FFS rates, an individual rate is developed for care levels 1 through 3, and these rates are adjusted by geographic wage variations in urban and rural areas. These areas are defined by county, with Maricopa, Pima and Pinal counties considered urban and the remaining 12 counties considered rural. Effective July 1, 2017, the state allocated a specific rate for the city of Flagstaff as a separate category. However, a breakout of the primary care component rates for Flagstaff is not provided by the state.

During rebasing years, the Primary Care component is calculated using the following steps:

- Nursing facility residents are classified into three levels of care using a numeric score and weight assigned to each item based on pre-admission screening (PAS) results. Additionally, a standard base amount of nursing minutes is assigned to each member regardless of assessment score to account for meal preparation, night shift, etc.
- After excluding ventilator dependent, subacute and specialty care patients, PAS data is used to determine which services are required for nursing facility residents.
- Nursing time is determined by translating services used into time requirements via standards established using time and motion studies developed by the state of Maryland in the

- design of their payment system for nursing facilities.
- Nursing staff time is then calculated as the sum of nursing time, activity of daily living (ADL) weight and an allocation of overhead. This calculation results in an estimate of the hours needed to provide nursing care in each member class, broken down into RN care, LPN care and nurse aide care.
 - Based on a medical and functional score determined from the PAS data, patients are classified into a level of care (1-3). The nursing facility residents in the upper 4% of levels 1 and 2 are moved into the next highest level.
 - Average nursing minutes for each level of care are calculated by taking the average of total RN, LPN and nurse aide time required for all patients in the same level of care.
 - Nursing time is then translated into the rate component by multiplying the number of minutes for each nursing level of care by average hourly wages. These wages are developed from cost report and/or wage data submitted by Arizona nursing facilities for reporting years ending in the calendar year preceding the effective date of the rate.
 - Wages are inflated to the midpoint of the fiscal year in which the rate becomes effective.

Following these steps, the following six primary care rates exist based on three levels of care and two geographic areas (excluding the Flagstaff rate):

Primary Care Component										
Category	7/1/2017	1/1/2018	% change	10/1/2018	% change	1/1/2019	% change	10/1/2019	% change	
Urban:	Level I	\$69.53	\$70.01	0.7%	\$72.11	3.0%	\$72.62	0.7%	\$75.81	4.4%
	Level II	\$83.98	\$84.57	0.7%	\$87.11	3.0%	\$87.72	0.7%	\$91.58	4.4%
	Level III	\$115.51	\$116.32	0.7%	\$119.81	3.0%	\$120.65	0.7%	\$125.96	4.4%
Rural:	Level I	\$64.69	\$65.14	0.7%	\$67.10	3.0%	\$67.57	0.7%	\$70.54	4.4%
	Level II	\$78.16	\$78.71	0.7%	\$81.07	3.0%	\$81.64	0.7%	\$85.23	4.4%
	Level III	\$109.08	\$109.85	0.7%	\$113.14	3.0%	\$113.94	0.7%	\$118.95	4.4%

The statewide average Primary Care weighted average component rate for all levels was \$62.86 in 2003-2004, \$64.74 in 2004-2005, \$70.68 in 2005-2006, \$72.79 in 2006-2007, \$75.70 in 2007-2008 and \$79.59 in 2008-2009. Due to budgetary constraints, the statewide Primary Care component rate was frozen at the 2008-2009 level in 2010 and 2011. These rates were decreased 5% in fiscal year 2012 and were frozen at 2012 levels in fiscal year 2013. Fiscal year 2014 and 2015 rates were inflated 1.5% and 2.0%, respectively. Fiscal year 2016 rates (effective October 1, 2015) were frozen at prior year levels. Primary Care component rates were initially increased 1.0% at the beginning of fiscal year 2017 (October 1, 2016), but were further increased 3.5% on January 1, 2017 to reflect changes to the state's minimum wage. Rates were then increased an additional 0.3% on July 1, 2017. The state did not initially increase rates at the effective date of the fiscal year 2018 (October 1, 2017). However, the state did provide a minimum wage increase (0.7%) effective January 1, 2018. Primary care rates were increased 3.0% effective October 1, 2018, and from 0.7% (Urban and Rural) to 1.3% (Flagstaff) effective January 1, 2019. The rate increase effective January 1, 2019, was related to a minimum wage increase. The rate will increase 4.4% effective October 1, 2019 and another 1.3% effective January 1, 2020.

The Indirect Care component is a single statewide rate that does not vary by level of care or geographic area. During rebasing years, the statewide average Indirect Care component rate is

calculated using the following steps:

- Each facility's total capital costs are subtracted from total facility costs to determine costs without capital.
- Total facility costs net of capital costs are inflated to the midpoint of the rate year.
- Facility-specific inflated primary care costs (as calculated above) are then subtracted to derive facility-specific indirect costs.
- The facility-specific indirect costs are then divided by the total resident days to calculate an indirect cost per day. A minimum occupancy rate of 85% (based on total nursing facility days) is used when calculating total resident days.
- The facility-specific indirect costs per day are weighted by total Medicaid nursing facility days to determine each facility's total Medicaid indirect costs. The statewide average Indirect Care cost per day is the sum of these weighted costs.

Historically, the Indirect Care component rate was \$45.33 in 2003-2004, \$47.14 in 2004-2005, \$52.11 in 2005-2006, \$58.02 in 2006-2007, \$64.96 in 2007-2008 and \$68.26 in 2008-2009. Due to budgetary constraints, the statewide Indirect Care component rate was frozen at the 2008-2009 level for fiscal years 2010 and 2011. These rates were decreased 5% to \$64.85 in fiscal year 2012 and were frozen at fiscal year 2012 levels in fiscal year 2013. Fiscal year 2014 and 2015 rates were inflated 1.5% and 2.0%, respectively. Fiscal year 2016 rates (effective October 1, 2015) were frozen at prior year levels. Similar to the Primary Care component rates, Indirect Care component rates increased 1.0% effective October 1, 2016, 3.5% effective January 1, 2017, 0.3% effective July 1, 2017, 0.7% effective January 1, 2018, 3.0% effective October 1, 2018, and 0.7% to 1.3% effective January 1, 2019. The rates will increase 4.4% effective October 1, 2019. Based on these inflation adjustments, the Indirect Care component rate is estimated to range from \$77.75 (Urban and Rural) to \$78.30 (Flagstaff) effective October 1, 2019. Indirect Care component rates will increase 1.3% on January 1, 2020.

The Capital component is also a single statewide rate that does not vary by member level of care or geographic area. During rebasing years, the statewide Capital component rate is calculated using the following steps:

- The average cost of constructing a new nursing facility bed and the weighted average age of nursing beds in each facility are determined. The average cost of constructing a new nursing facility bed is derived from a national source for construction costs such as R.S. Means Construction Cost Index. The weighted average age of nursing beds is derived from data supplied by providers via survey and/or cost report.
- The current cost of a new bed is depreciated by the average age of beds in each facility to determine the total current value of nursing facility beds. Depreciation is recognized at 1% per year.
- A rate of return (currently the 10-year U.S. Treasury Bond composite rate plus a risk factor of 2%) is applied to the total current value to determine fair rental value (FRV). The FRV method establishes a current value of a facility based on current construction costs and the age of the facility (adjusted for additions and capital improvements).
- The sum of the FRV for all facilities is divided by total nursing facility patient days (adjusted to a minimum occupancy rate of 85% for each facility) for all applicable facilities.
- Average statewide per day historical costs for property taxes

and insurance are then added to determine the statewide average Capital component.

Historically, the Capital component rate was \$12.00 in 2003-2004, \$13.01 in 2004-2005, \$13.53 in 2005-2006, \$13.83 in 2006-2007, \$14.20 in 2007-2008 and \$14.63 in 2008-2009. Due to budgetary constraints, the statewide Capital component rate was frozen at the 2008-2009 level in fiscal years 2010 and 2011. These rates were decreased 5% to \$13.90 in fiscal year 2012, and were frozen at fiscal year 2012 levels in fiscal year 2013. Fiscal year 2014 and 2015 rates were inflated 1.5% and 2.0%, respectively. Fiscal year 2016 rates (effective October 1, 2015) were frozen at prior year levels. Similar to the Primary Care and Indirect Care component rates, Capital component rates increased 1.0% effective October 1, 2016, 3.5% effective January 1, 2017 0.3% effective July 1, 2017, 0.7% effective January 1, 2018, 3.0% effective October 1, 2018, and 0.7% effective January 1, 2019, and will increase 4.4% effective October 1, 2019 and 1.3% effective January 1, 2020. Based on these inflation adjustments, the Capital component rate is projected to range from \$16.67 (Urban and Rural) to \$16.79 (Flagstaff) effective October 1, 2019.

The total capitated per diem reimbursement rates are calculated by summing the three component rates. Facility-to-facility variance is therefore partially the result of differences in the Primary Care component, which varies by a resident's level of care and the facility's geographic area. However, facility-to-facility variances are primarily due to negotiated rate differences. The current total FFS per diem reimbursement rates for Arizona nursing facilities are as follows:

Total Medicaid Per Diem Rates											
Category	7/1/2017	10/1/2017	% change	1/1/2018	% change	10/1/2018	% change	1/1/2019	% change	10/1/2019	% change
Urban											
Total Rate											
Level I	\$155.01	\$155.01	0.0%	\$155.10	0.7%	\$160.78	3.6%	\$161.89	0.7%	\$168.06	4.4%
Level II	\$169.46	\$169.46	0.0%	\$170.65	0.7%	\$175.77	3.0%	\$176.98	0.7%	\$184.81	4.4%
Level III	\$201.01	\$201.01	0.0%	\$202.42	0.7%	\$208.49	3.0%	\$209.93	0.7%	\$219.22	4.4%
Rural											
Total Rate											
Level I	\$150.18	\$150.18	0.0%	\$151.23	0.7%	\$155.77	3.0%	\$156.84	0.7%	\$163.78	4.4%
Level II	\$163.66	\$163.65	0.0%	\$164.81	0.7%	\$169.75	3.0%	\$170.92	0.7%	\$178.48	4.4%
Level III	\$194.58	\$194.57	0.0%	\$195.94	0.7%	\$201.82	3.0%	\$203.21	0.7%	\$212.20	4.4%
Flagstaff											
Total Rate											
Level I	N/A	\$151.27	N/A	\$152.33	0.7%	\$156.90	3.0%	\$158.96	1.3%	\$165.99	4.4%
Level II	N/A	\$164.83	N/A	\$165.98	0.7%	\$170.96	3.0%	\$173.20	1.3%	\$180.86	4.4%
Level III	N/A	\$195.98	N/A	\$197.35	0.7%	\$203.27	3.0%	\$205.93	1.3%	\$215.04	4.4%

The statewide average total rate for all levels was \$120.19 in 2003-2004, \$124.89 in 2004-2005, \$136.32 in 2005-2006, \$144.64 in 2006-2007, \$154.86 in 2007-2008 and \$162.48 in 2008-2009, which represents a 4.9% increase from the prior year. As noted in the discussion of each rate component, due to budgetary constraints, these rates were frozen at the 2008-2009 levels. These rates were decreased 5% in fiscal year 2012 and were frozen at fiscal year 2012 levels in fiscal year 2013. Fiscal year 2014 and 2015 rates were inflated 1.5% and 2.0%, respectively. Fiscal year 2016 rates (effective October 1, 2015) were frozen at prior year levels. Arizona Rate Setting professionals estimate that the statewide average rate for fiscal year 2016 (effective October 1, 2015) is approximately \$160.09 per day. Average rate data was not available in recent years, but the average rate is anticipated to have increased moderately given the periodic rate increases. Effective July 1, 2016, AHCCCS implemented a Value-Based Purchasing component to total Medicaid rates. Nursing facilities that possess a greater percent of Long Stay Residents assessed and appropriately given the Pneumococcal Vaccine than the Medicare

Nursing Home Compare Arizona Average receive a 1.0% rate increase. Effective October 1, 2017, nursing facilities now eligible for a second 1.0% rate increase if they possess a greater percent of Long Stay Residents assessed and appropriately given the Influenza Vaccine than the Medicare Nursing Home Compare Arizona Average.

The above displayed rates do not factor in the additional reimbursement that nursing facilities received from the previously mentioned supplemental payments.

OTHER RATE PROVISIONS

Medicaid reimbursement rates for newly constructed nursing facilities and nursing facilities that have recently changed ownership are calculated using the same methodology.

Arizona reimburses nursing facilities for holding beds for residents absent from the facility due to therapeutic leave or hospitalization. Whether a nursing facility receives bed hold payments is determined by the program contractor case manager on a case-by-case basis. Payments for bed hold days for therapeutic leave days are limited to nine days per contract year. Payments for bed hold days for recipients admitted to a hospital are limited to 12 days per contract year. Nursing facilities are typically reimbursed 100% of their current Level 1 Medicaid rates.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is currently no proposed state legislation affecting the current Medicaid reimbursement methodology in Arizona.

ARIZONA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2015	2016	2017	2015	2016	2017	2015	2016	2017	
Number of Beds	69.50	70.75	70.00	105.50	113.50	110.50	130.50	130.00	133.00	
Average Daily Census	65.79	70.47	62.46	89.07	90.83	87.39	125.14	124.49	116.30	
Occupancy	69.0%	69.0%	67.0%	79.0%	76.0%	76.1%	87.6%	86.1%	85.7%	
Payor Mix Statistics										
Medicare	5.8%	5.6%	5.7%	10.2%	9.7%	9.4%	20.1%	17.6%	18.4%	
Medicaid	52.7%	53.2%	57.3%	67.9%	66.9%	71.6%	78.0%	76.8%	79.5%	
Other	13.4%	14.8%	14.0%	21.4%	20.8%	19.2%	40.0%	36.5%	34.4%	
Avg. Length of Stay Statistics (Days)										
Medicare	20.86	19.63	19.27	24.74	24.02	22.96	29.90	29.59	28.27	
Medicaid	136.67	142.54	115.39	182.51	217.15	195.74	262.52	295.83	301.00	
Other	19.88	20.76	18.83	31.62	34.57	32.90	84.72	108.54	78.02	
Revenue (PPD)										
Inpatient	\$191.65	\$191.59	\$202.27	\$219.54	\$218.93	\$232.55	\$270.70	\$271.98	\$299.98	
Ancillary	\$52.38	\$49.91	\$48.67	\$79.27	\$82.24	\$78.31	\$118.25	\$111.18	\$116.15	
TOTAL	\$264.39	\$263.38	\$274.67	\$316.38	\$312.50	\$320.03	\$384.89	\$371.46	\$430.35	
Expenses (PPD)										
Employee Benefits	\$16.25	\$15.70	\$12.14	\$19.87	\$19.78	\$18.97	\$27.72	\$29.29	\$27.55	
Administrative and General	\$38.28	\$38.86	\$43.82	\$50.46	\$53.64	\$57.73	\$68.98	\$66.07	\$67.94	
Plant Operations	\$9.58	\$9.30	\$9.38	\$11.51	\$11.32	\$11.42	\$16.69	\$15.81	\$17.46	
Laundry & Linens	\$1.24	\$1.59	\$1.64	\$1.99	\$2.20	\$2.42	\$2.84	\$2.86	\$2.95	
Housekeeping	\$4.19	\$4.31	\$4.78	\$5.14	\$5.12	\$5.86	\$7.08	\$6.90	\$7.52	
Dietary	\$14.60	\$14.35	\$14.97	\$17.34	\$17.26	\$18.17	\$25.57	\$24.36	\$28.11	
Nursing & Medical Related	\$76.96	\$80.63	\$85.51	\$90.12	\$93.86	\$102.47	\$117.68	\$117.97	\$122.56	
Ancillary and Pharmacy	\$23.60	\$23.62	\$23.31	\$33.87	\$35.52	\$35.23	\$55.67	\$53.25	\$55.39	
Social Services	\$1.76	\$1.96	\$2.15	\$3.40	\$3.64	\$4.13	\$5.01	\$5.79	\$7.51	

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Arkansas



INTRODUCTION

Nursing facilities in Arkansas are licensed by the Arkansas Office of Long Term Care (OLTC) of the Arkansas Department of Human Services (the Department) under the designation of "Skilled Nursing Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN ARKANSAS	
Licensed Nursing Facilities*	224
Licensed Nursing Beds*	23,574
Beds per 1,000 Aged 65 >**	46.38
Beds per 1,000 Aged 75 >**	113.04
Occupancy Percentage - 2017*	72.10%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Arkansas Health Services Permit Commission (the Commission) and the Arkansas Health Services Permit Agency (the Agency) jointly administer the state's Certificate of Need (CON) program, which is referred to in Arkansas as a "permit of approval" (POA).

Projects requiring a POA include the following:

- The construction of a new nursing facility and the conversion of services and/or renovation of an existing facility resulting in a capital expenditure of \$1,000,000 or more.
- The development of any additional beds at an existing facility (unless exempted by the Agency or by the Commission).
- Any transfer of nursing facility beds from one site to another within the service area.
- Any transfer of a POA from a site location approved for construction to another site. A POA may not be transferred to a county other than the county in which the current POA has been assigned.

Exemptions to the POA program are available in counties that demonstrate a need for additional nursing beds derived by the state's current bed need methodology. In addition, the county must possess an overall nursing facility occupancy level of at least 93% for the most recent period available. Reviews of applications are completed each quarter and may change the number of approved beds in the state.

A nursing facility may acquire up to 10% of its licensed capacity or 10 beds, whichever is greater, if the following certain conditions are met:

- The nursing home averaged 90.0% or greater occupancy according to the most recent 12 month occupancy data available from DHS and
- currently has no Approved but Unlicensed Beds and had no Approved but Unlicensed Beds during the previous 12 month period and
- acquires beds from a facility that averaged 70% or less occupancy for the previous 12 month period according to the most recent 12 month occupancy data available from Dept. of

Human Services and

- is located in a county without a Population Based need and
- has not acquired beds pursuant to this Subsection II. A. in the previous 12 month period.

Beds may not be transferred back or returned to the original facility unless all the requirements of these conditions are satisfied.

Nursing facilities are prohibited from relocating existing beds for purposes of adding on, regardless of whether the add-on is new construction. A facility may be approved for up to a 20% increase of the present licensed capacity when replacing the facility. The sole exception is the case of any facility expanding up to 70 beds. A facility may physically relocate or relocate beds to another county under specific conditions. In addition, the Commission and the Agency may approve the construction of additional beds exceeding its calculated need, when the need is fewer than 10 beds in order to approve a 10-bed increase.

Continuing care retirement communities (CCRCs) and life care providers (LCPs) are governed by the statutory and regulatory provisions relating to applications for long-term care facilities with certain exceptions.

BED NEED METHODOLOGY

As previously mentioned, Arkansas uses a bed need methodology to review applications for the development or expansion of nursing facilities. Arkansas' bed need methodology is calculated using senior population estimates for each service area (county) considered and nursing facility utilization rates for the most recent year. The population-based methodology projects nursing facility bed need using estimated population in four age groups of a service area:

Projected to 2018	
Age Group	Beds per 1,000
Below 65	0.70
65-74	10.0
75-84	39.3
85	160.0

The projection for a service area represents the number of patients estimated to need beds. Since all nursing facilities cannot be expected to operate at 100% occupancy year round, 5% additional beds are added to the initial projection to allow for patient fluctuation. Therefore, the above mentioned figures represent 95% of the total beds needed. The most recent bed need estimates were calculated effective October 1, 2018, and were projected for 2023. The calculation indicates that the state will have a surplus of 1,906 beds in 2023. In addition, none of the counties that demonstrated quantitative bed need possessed the minimum weighted average occupancy level (93.0%) required to assume there is unmet demand in the area.

QUALITY ASSURANCE FEE

The quality assurance fee (QAF) was established in 2001. The QAF is \$13.37 per patient day effective July 1, 2018. This is less than the prior QAF (\$13.65) effective July 1, 2017, but greater than the rates effective July 1, 2016 (\$13.16) and July 1, 2015 (\$13.03), respectively. The total QAF charge is calculated by multiplying total patient days by the QAF. The current fee equates to \$6.0% of the aggregate annual gross receipts for all nursing facilities from the prior six months. Nursing facilities are reimbursed the QAF per Medicaid day as part of their Medicaid rates.

As of February 2007, nursing facilities that provide nursing care exclusively as part of an LCP (life care provider) are exempt from paying the QAF.

MEDICAID RATE CALCULATION SYSTEM

The provider reimbursement unit of Arkansas Medicaid develops reimbursement methodologies and rates for all long-term care facilities. The Arkansas Medicaid reimbursement system is a prospective, cost- and price-based rate setting system. All nursing facilities within the state receive a standard, statewide Indirect, Administrative and Operating cost component rate. Facility-specific rates are calculated for the remaining cost components.

COST CENTERS

The four major cost components are as follows:

- **The Direct Care** cost component encompasses nursing care salaries and related benefits, contract nursing, therapy expenses, pharmacy expenses, medical supplies, raw food, supplements, incontinence supplies and other miscellaneous costs.
- **The Indirect, Administrative and Operating** cost component encompasses administrative and ancillary salaries and related benefits, office expenses, activities and social service expenses, dietary supplies, depreciation expense, housekeeping and laundry supplies, legal and accounting fees, repairs and maintenance, and miscellaneous costs.
- **The Fair Market Rental (FMR)** cost component is used to reimburse nursing facilities for property costs.
- **The QAF** cost component is a statewide standard payment (\$11.35 per Medicaid day) that all nursing facilities receive for paying the QAF.

INFLATION AND REBASING

The rate period and state fiscal year in Arkansas is from July 1 to June 30. The Direct Care and FMR components of the rate are rebased annually utilizing data from cost reports for the previous fiscal year. The statewide Indirect, Administrative and Operating rate is rebased at least once every three years utilizing data from cost reports for the previous fiscal year. Only full-year cost reports are used to establish the Direct Care cost component ceiling and the Indirect, Administrative and Operating cost component rate. Given this factor, the state determines interim rates until the state has completed audits of the prior fiscal year's cost reports. In non-rebasing years, the statewide Indirect, Administrative and Operating cost component rate is inflated by the inflation rate discussed below.

Cost report data for fiscal year 2017 was utilized to rebase the Direct Care; Indirect, Administrative and Operating; and FMR cost component rates in fiscal year 2018. In non-rebasing years, the statewide Indirect, Administrative and Operating cost component rate is inflated by the inflation rate discussed below. The state is currently in an interim rate period (July 1, 2018 to December 31, 2018). It is currently unclear if the state will rebase the statewide Indirect, Administrative and Operating rate in fiscal year 2019.

The provider reimbursement unit may be required to inflate these expenses over a period of time. For all inflation adjustments, unless stated otherwise in the specific area of the plan, the Department will use the *Skilled Nursing Facility Market Basket – Without Capital Index* published by Global Insight for the quarter ending June 30 of the cost reporting period. The inflation index takes effect in the second quarter of the fiscal year. The Department uses the %MOVAVG figure identified for the final quarter of the rate period. This inflation index is utilized to determine interim rates and inflate historical costs. The current inflation index that was applied to fiscal year 2018 rates to calculate July 1, 2018 interim rates is 2.9%.

RATE METHODOLOGY

An interim rate is established at the beginning of each state fiscal year for each facility. The interim rate is calculated by applying the inflation index to the actual per diem rate from the previous rate period. This period is necessary to allow time for providers to complete cost reports while also allowing the Department adequate time to review the cost reports and calculate rates. The interim period is typically from July 1 to December 31. After the actual per diem calculations occur, providers are paid a weighted per diem rate for the portion of the rate year remaining. The weighted per diem rate provides an average payment approximating providers' actual per diem. The following formula is used to calculate the weighted per diem rate:

$$\frac{\{(\text{Actual Per Diem Rate} \times 12) - (\text{Interim Rate} \times \text{Months Used})\}}{\text{Months Remaining}}$$

Facility-specific per diem costs for the Direct Care cost component are established by dividing total allowable costs by total patient days. The per diem costs for all participating nursing facilities are arrayed to determine the Direct Care cost component ceiling. The Direct Care cost component ceiling is established at 105% of the allowable Medicaid Direct Care cost per diem at the 90th percentile of the arrayed per diem costs. Nursing facilities receive their per diem cost adjusted for the inflation index, subject to the ceiling.

Facility-specific per diems for the Indirect, Administrative and Operating cost component are established by dividing total allowable costs by total patient days. The per diem costs for all participating nursing facilities are arrayed to determine the median cost. The statewide Indirect, Administrative and Operating cost component rate equates to 110% of the median, adjusted by the inflation index. In non-rebasing years, a nursing facility's Indirect, Administrative and Operating cost component

rate equates to the facility's interim rate.

The payment for the FMR cost component is calculated annually by adding the return on equity, facility rental factor and the cost of ownership and then dividing the sum of these three subcomponents by the greater of the actual resident days or resident days calculated at the minimum occupancy level. In addition to the annual rate calculation, an occupancy adjustment may be utilized every July 1 for the interim rate.

The return on equity portion of the FMR payment is calculated by taking the current asset value (CAV) of a facility, less the ending loan balance on any loans used to finance fixed assets or major movable equipment, multiplied by the sum of the June 30, 30-year U.S. Treasury Bond yield plus 1.5% as a risk premium. The rental factor is calculated by multiplying the CAV of the facility by 2.5%. The cost of ownership component of the FMR will consist of interest, property taxes and insurance (including professional liability and property) as identified on the facility's cost report. The CAV of a facility is calculated by multiplying its number of beds by the per bed valuation (PBV), less an aging index of 1% for each year of age, not to exceed a 50% reduction in PBV. A facility is considered new in the cost reporting period in which it is licensed. The CAV is recalculated and an appropriate adjustment to the per diem will be made when additional beds are placed in operation.

The PBV is determined by the current cost of constructing and equipping one bed. The PBV is adjusted annually thereafter to reflect changes in construction costs as indicated per the Marshall & Swift Valuation Service. A percentage increase is calculated by dividing the difference between the Comparative Cost Multipliers Construction Index for Little Rock, Arkansas, for the quarter ending January of the cost reporting period and January of the previous year. The annual adjustment percentage will be the lesser of the percentage as calculated above for building classes: 1) masonry bearing walls and 2) wood frame, or 3%.

The sum of a nursing facility's Direct Care, FMR and QAF cost component rates and the statewide Indirect, Administrative and Operating rate equates to a nursing facility's Medicaid per diem rate. Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review or audit. In the case that a provider's per diem is adjusted for any reason, a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period.

MINIMUM OCCUPANCY STANDARDS

The minimum occupancy requirement for the FMR cost component is 80%. FMR per diem rates are calculated by dividing allowable FMR costs by the greater of the nursing facility's total patient days or 80% of total allowable patient days.

OTHER RATE PROVISIONS

Provisional rates are paid to providers who construct, lease or purchase a facility, or an existing facility that has not previously participated in the Medicaid program. The provisional rate will be established as follows:

- The Direct Care per diem rate will be established at the

inflation adjusted ceiling (105% of allowable Medicaid Direct Care cost per diem at the 90th percentile of arrayed Medicaid Direct Care facility cost per diems) for that rate period.

- The Indirect, Administrative and Operating per diem will be the class rate (110% of median) as established for that rate period.
- The FMR payment will consist of a return on equity payment assuming no debt, a facility rental factor, and property taxes and insurance at the industry average. The industry average for property taxes and insurance will be calculated by dividing the total cost for all full-year facilities as identified on facility cost reports by total resident days for the cost reporting period. The per diem payment will be calculated by dividing the sum of the components by total patient days (adjusted for the minimum occupancy requirement, if necessary). Newly constructed facilities will use an occupancy rate of 50% when calculating the per diem for this component.
- Facilities that want to establish their provisional rate assuming a higher percentage of occupancy may do so by supplying projected occupancy figures to the Department. Facilities have the option of providing documents indicating the actual cost of property taxes and insurance to be used for cost of ownership figures. Actual cost of ownership information can be supplied any time during the initial six-month period. The Division will adjust the facility's provisional rate prospectively based on the information provided.

A facility that is new or has changed ownership must submit a six-month cost report that will be used to calculate the actual rate for the facility. The provisional rate is retroactively adjusted to the per diem calculated in the following manner:

- The provider's Direct Care per diem rate will be calculated from the six-month cost report using the inflation index adjusted ceiling for the applicable rate period. For cost reports that span two rate periods, the applicable rate period is the one containing the majority of the days included in the six-month report.
- The Indirect, Administrative and Operating per diem will remain the class rate established in the provisional rate.
- The amount identified as the sum of the components used in the original calculation, as adjusted for actual cost data if applicable, for the FMR payment will remain as established in the provisional rate. The actual per diem amount will be adjusted to reflect the greater of actual occupancy, or the minimum required occupancy for facilities that have changed ownership, or 50% occupancy for new facilities. After the initial six-month reporting period, the FMR payment will be calculated using a minimum occupancy factor for both new facilities and facilities that have changed ownership.

If either the provisional rate or the actual rate calculated from the six-month cost report extends from one rate period to another, appropriate adjustments will be made to the vendor payment. The inflation index will be applied to the Direct Care per diem. The Indirect, Administrative and Operating per diem will be changed to the class rate for the latest rate period. The FMR per diem will be adjusted to reflect any change in the per bed valuation (PBV) for the latest rate period.

Nursing facilities are reimbursed their current Medicaid rate for up to five bed hold days for a patient requiring hospitalization. The facility must be 85% occupied on the last day of the previous month to bill Medicaid for hospital bed hold days. Nursing facilities may be reimbursed at their current Medicaid rate for up to 14 therapeutic home leave days. There is no minimum occupancy factor for therapeutic leave bed hold reimbursement.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is currently no proposed state legislation that will alter the Medicaid calculation in Arkansas.

ARKANSAS COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	84.00	85.00	85.25		103.50	104.50	103.00		120.00	121.00	120.00
Average Daily Census	65.49	66.03	64.65		77.29	76.33	78.38		94.43	94.77	94.98
Occupancy	69.0%	67.6%	67.9%		78.3%	78.5%	77.9%		87.4%	88.0%	87.5%
Payor Mix Statistics											
Medicare	7.8%	7.5%	7.1%		10.2%	10.0%	9.4%		13.7%	13.1%	13.0%
Medicaid	58.8%	61.2%	59.0%		67.4%	67.5%	68.2%		74.6%	74.3%	74.7%
Other	16.0%	17.0%	17.6%		21.8%	21.5%	22.2%		28.7%	28.0%	29.0%
Avg. Length of Stay Statistics (Days)											
Medicare	30.04	29.37	31.98		37.07	36.67	38.40		44.87	47.85	49.02
Medicaid	265.98	229.93	309.09		403.85	343.40	470.34		703.67	585.69	922.26
Other	80.34	78.87	81.03		125.56	107.57	120.56		190.07	155.00	197.52
Revenue (PPD)											
Inpatient	\$176.43	\$182.23	\$180.70		\$193.95	\$197.56	\$199.63		\$215.11	\$212.32	\$218.62
Ancillary	\$24.86	\$28.93	\$28.97		\$36.42	\$39.13	\$42.40		\$61.81	\$59.10	\$67.63
TOTAL	\$198.97	\$208.78	\$210.91		\$220.36	\$229.87	\$238.13		\$252.95	\$269.96	\$285.53
Expenses (PPD)											
Employee Benefits	\$11.00	\$10.45	\$10.53		\$11.95	\$12.15	\$11.92		\$14.28	\$13.65	\$13.50
Administrative and General	\$28.71	\$33.90	\$34.36		\$37.36	\$40.80	\$42.05		\$43.94	\$48.93	\$49.47
Plant Operations	\$7.47	\$7.21	\$7.56		\$8.75	\$8.39	\$8.86		\$10.08	\$9.57	\$10.24
Laundry & Linens	\$1.62	\$1.68	\$1.83		\$2.14	\$2.16	\$2.44		\$2.78	\$2.77	\$3.11
Housekeeping	\$4.45	\$4.56	\$4.65		\$5.22	\$5.29	\$5.63		\$6.75	\$6.69	\$6.86
Dietary	\$15.35	\$14.98	\$15.86		\$17.15	\$17.16	\$17.46		\$19.68	\$19.08	\$19.25
Nursing & Medical Related	\$65.71	\$67.86	\$71.29		\$70.17	\$73.76	\$77.08		\$76.85	\$80.98	\$87.77
Ancillary and Pharmacy	\$14.77	\$16.46	\$15.21		\$21.40	\$23.14	\$23.04		\$30.76	\$29.59	\$29.60
Social Services	\$1.50	\$1.50	\$1.29		\$2.13	\$2.18	\$1.99		\$2.75	\$2.67	\$2.59

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

California



INTRODUCTION

Nursing facilities in California are licensed by the California Department of Public Health (CDPH), Certificates and Licenses Division, under the designation of “Skilled Nursing Facilities.” Prior to July 1, 2007, nursing homes had been licensed by the Department of Health Services, which has since been divided into CDPH and the Department of Health Care Services (DHCS). The DHCS administers the state’s Medi-Cal reimbursement system, which will be detailed later in this overview. The following table summarizes the total number of nursing facilities within the state:

NURSING FACILITIES IN CALIFORNIA	
Licensed Nursing Facilities*	1,031
Licensed Nursing Beds*	155,960
Beds per 1,000 Aged 65 >**	27.85
Beds per 1,000 Aged 75 >**	67.70
Occupancy Percentage - 2017*	91.00%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

California does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility. The CON program in California was terminated in 1986, creating an open market as it relates to new construction and the expansion of existing nursing homes. Potential new developments continue to require licensing as well as notification to the state of intent to build. Construction plans must be in accordance with state codes and meet the approval of the Office of Statewide Health Planning and Development. There is no moratorium on the construction of nursing facility beds in California.

BED NEED METHODOLOGY

California does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

California utilizes a quality assurance fee (QAF) to obtain additional reimbursement for, and to support quality improvement efforts in, licensed skilled nursing facilities. The QAF was established under the Medicaid Long-Term Care Reimbursement Act, Assembly Bill 1629 (AB 1629), which will be discussed in detail in the Medi-Cal section.

The DHCS possesses two different QAF rates. One rate is for nursing facilities with less than 100,000 total resident days and the other is for nursing homes with 100,000 or more total resident days, based on the maximum allowable QAF amount and total resident days for each facility group. The DHCS calculates the total QAF charge by multiplying the appropriate assessment fee by the total resident days.

The QAF was set to expire on July 31, 2013, but was reauthorized by the California Legislature for freestanding skilled nursing

facilities until July 31, 2015. As part of AB 1629, the QAF has been extended for five additional years. An Assembly Bill (ABx4 5) adopted under California’s 2009 State Budget in July 2009 expanded the QAF calculation to include Medicare revenue. The resulting revenue is not passed through to the Medi-Cal reimbursement rate.

The following table identifies the QAF fees since it began:

California Historical QAF Fees		
Rate Year (Effective Aug 1)	Less than 100,000 Bed Days	Less than 100,000 Bed Days
2008/2009	\$9.05	\$8.05
2009/2010	\$11.16	\$10.12
2010/2011	\$13.08	\$11.93
2011/2012	\$14.33 (Aug - Dec 2011)	\$13.43 (Aug - Dec 2011)
2011/2012	\$14.42 (Jan - July 2012)	\$13.46 (Jan - July 2012)
2012/2013	\$15.61	\$14.88
2013/2014	\$15.43	\$14.40
2014/2015	\$16.03	\$15.15
2015/2016	\$16.26	\$15.39
2016/2017	\$15.95	\$14.85
2017/2018	\$15.38	\$14.28
2018/2019	\$15.72	\$14.46

The QAF is paid by each provider on a monthly basis to the DHCS for deposit into the state treasury. For each facility assessed, the QAF is reimbursed for the Medi-Cal portion of its fee (the per diem rate assigned to the facility multiplied by Medi-Cal patient days).

Those facilities identified as Multi-Level Retirement Communities (MLRCs) were exempt from the QAF until October 2010, when SB 853 extended the QAF to these facilities. An MLRC is a provider of a continuum of services, including independent living, assisted living and skilled nursing care on a single campus. However, these facilities are only required to provide more than one level of care and are not licensed as continuing care retirement communities (CCRCs). CCRCs are still exempt from the QAF. The legislation also requires the state to utilize trended forward data instead of historical data to calculate fees and increases to the QAF. The purpose of this legislation is to ensure the general fund would not be impacted by the loss of the QAF.

MEDI-CAL RATE CALCULATION SYSTEM

California’s Medi-Cal program previously reimbursed facilities on a prospective, flat-rate system. AB 1629 converted the Medi-Cal payment system into a cost-based, facility-specific reimbursement system. Medi-Cal now reimburses nursing facilities for improved wages and staffing based on the actual cost of care derived from the facility’s cost reports. It also holds nursing facilities accountable for residents’ quality of life and provides a way for the state to tap into more federal Medicaid dollars.

AB 1629 was signed into law on September 29, 2004, and went into effect on August 31, 2005. The state plan amendment has been approved by the Centers for Medicare & Medicaid Services (CMS). Some of the objectives of this bill are:

- To provide significant incentives to spend more on direct patient care and maintain cost-effective administration. The new system places reimbursement caps on administrative

costs, direct patient care labor costs and capital improvements at different levels. These caps are represented as a specific percentile of all per diem costs for a specific component.

- To provide financial incentives to nursing facilities to improve quality of care, increase staffing and reduce direct caregiver turnover to stabilize the workforce.
- To use the QAF to obtain additional federal reimbursement to nursing facilities, which supports quality improvement efforts at the facilities.
- To improve accountability and quality of care by creating cost centers. In a cost center-based system, if funding that is supposed to be spent on direct labor costs is instead spent on capital and overhead, the facility will be reimbursed less for labor costs the next year.

COST CENTERS

Reimbursement is facility specific and reflects the sum of six cost components as follows:

- **The Labor** cost component includes direct resident care labor and indirect resident care labor. Direct care labor includes wages associated with routine nursing, social services, activities and other direct care personnel. Indirect care labor includes wages associated with staff supporting the delivery of patient care including housekeeping, laundry/linen, dietary, medical records, in-service education and plant operations.
- **The Indirect Care Non-Labor** component includes the non-labor costs related to services supporting the delivery of resident care, including the non-labor portion of nursing, housekeeping, laundry and linen, dietary, in-service education, and plant operations and maintenance costs.
- **The Administrative** cost component includes allowable administrative and general expenses of operating the facility, including a facility's allocated expenditures related to allowable home office costs. This component also includes allowable property insurance costs and excludes expenditures associated with caregiver training, facility license fees and medical records. However, legal and consulting costs for cases not found in favor of facilities are not considered allowable expenses.
- **The Capital** cost component is based on a fair rental value system (FRVS), which reimburses a facility's property costs. The FRVS is used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment and major moveable equipment used in providing resident care.
- **The Direct Pass-Through** cost component is comprised of Medi-Cal's proportional costs for property taxes, facility license fees, liability insurance projected on the prior year's costs, caregiver training, and new state or federal mandates. This also includes QAF reimbursement discussed in the Quality Assurance Fee section.
- **Professional Liability Insurance** cost component includes professional liability insurance costs. Effective August 1, 2010, this expense was removed from the Administrative cost component and made its own cost center.

INFLATION AND REBASING

The rate year in California is from August 1 to July 31. Rates are

updated annually based on the most recent cost report data. Facilities must be audited a minimum of once every three years. Audit adjustment factors from prior fiscal period audits are applied to reported costs. For facilities not audited during the rate setting year, audit adjustments based on the previous audit will be applied to the reported costs during intervening years (if not an audit). Fiscal year 2011 rates were calculated utilizing 2008 cost report data. Nursing facility Medi-Cal rates were not rebased in fiscal year 2012 or fiscal year 2013. However, Medi-Cal rates were rebased on August 1, 2013, and August 1, 2014, utilizing 2011 and 2012 cost report data, respectively.

In a normal rebasing year, Direct Resident Care Labor and Indirect Resident Care Labor costs are inflated forward using an inflation index based on the most recent industry-specific historical wage data available. Indirect Care Non-Labor, Administrative (caregiver training) and liability insurance costs are inflated forward using the California Consumer Price Index (CCPI). Property tax costs are inflated 2% annually. Direct Pass-Through expenses are not inflated. Beginning with fiscal year 2006, Medi-Cal established maximum allowable increases in the weighted average Medi-Cal reimbursement rate from the prior year. The maximum allowable rate increases for fiscal years 2008 to 2019 are as follows:

Fiscal Year	Max. Allowable Rate Increase
2008	5.50%
2009	5.50%
2010	0.00%
2011	3.93%
2012	2.40%
2013	0.00%
2014	2.00%
2015	2.00%
2016	3.62%
2017	3.62%
2018	3.62%
2019	3.62%

The maximum allowable increase for fiscal years 2010 and 2011 was proposed to be 5.0%. However, due to California's fiscal crisis, ABx4 5 (previously discussed in the Quality Assurance Fee section) eliminated the maximum increase and froze the statewide average reimbursement rate for fiscal year 2010 at the fiscal year 2009 level. The statewide average reimbursement rate via SB 853 allowed the statewide average reimbursement rate to increase up to 3.93% for fiscal year 2011. Based on increases to the QAF, in fiscal year 2012 rates were increased 0.426%. Given this factor, there were no updates to individual cost component rates in fiscal year 2012.

Within the exception of minor reduction (\$0.87) in total potential rate add-ons, Medi-Cal rates in fiscal year 2013 (effective August 1, 2012) remained frozen at fiscal year 2012 levels. Therefore, there were no updates to individual cost component rates. As previously mentioned, California rebased Medi-Cal rates effective August 1, 2013. Applicable costs were inflated by the CCPI. However, the rate increase in fiscal years 2014 was limited to assure that the statewide weighted average rate does not increase by greater than 3.0% in either year. In addition, a portion of the funding for the rate increase (approximately 33.3% or the equivalent of a 1.0%

rate increase) was dedicated to the state's soon to be implemented Quality and Accountability (Q&A) program.

The state approved the Q&A program via SB 853. Medi-Cal rates for fiscal year 2012 were to be reduced by 1.0% as a set-aside for the Q&A program. However, the implementation of the program was temporarily suspended until fiscal year 2014. This program will be reimbursed as a separate supplemental payment and is not part of calculated Medi-Cal nursing home rates. Therefore, the net effect of the rebase and the implementation of this program is a 2.0% weighted average rate increase.

The state rebased rates in fiscal year 2015 using 2012 cost report data. This rate increase was limited to assure that the statewide weighted average rate did not increase by greater than 3.0%. In addition, a portion of the funding for the rate increase (approximately 33.3% or the equivalent of a 1.0% rate increase) was again committed to the Q&A Program. Therefore, the net effect of the rebase is a 2.0% weighted average rate increase.

In 2015, the state recently extended the AB 1629 methodology legislatively for the next five years and included a 3.62% annual rate increase.

Fiscal year 2016 rates were based on 2013 cost report data, but were limited to the 3.62% rate increase.

Fiscal year 2017 rates (effective August 1, 2016) were determined utilizing 2014 cost report data, but were limited to the legislatively mandated 3.62% rate increase (prior to add-ons). Fiscal year 2018 and 2019 rates (effective August 1, 2017 and August 1, 2018) were determined based on 2015 and 2016 cost report data, respectively. However, in both years, rates were again limited to the 3.62% rate increase (prior to add-ons).

RATE METHODOLOGY

A nursing facility's per diem reimbursement rate is the sum of its six cost components. In typical rebasing years, allowable inflated costs within each component are divided by patient days, resulting in a facility's per diem rate. The components are subject to applicable maximum allowable reimbursement levels, or ceilings.

The Direct Care Labor and Indirect Care Labor costs of the Labor component are subject to a ceiling equal to the 90th percentile of Direct Care Labor and Indirect Care Labor costs for all facilities. The Indirect Care Non-Labor component is limited to a ceiling equal to the 75th percentile of indirect care non-labor costs for all facilities.

Historically, the Administrative component is limited to a ceiling equal to the 50th percentile of administrative costs for all nursing facilities. However, SB 853 moved Professional Liability Insurance costs to its own cost component and sets a cap of liability insurance costs at the 75th percentile.

The percentiles used to calculate maximum reimbursement for the Direct Care Labor, Indirect Care Labor, Indirect Care Non-Labor and Administrative cost components are computed on a specific

geographic peer group basis. There are seven peer groups in the state. Given that the state recently rebased rates effective August 1, 2018, the state recalculated these benchmarks. The table below presents the fiscal year 2019 maximum rates for each component by peer group:

Peer Group	Counties	Cost Grouping	Total
1	Colusa, Del Norte, Imperial, Kern, Kings, Lake, Lassen, Tulare and Yuba	Direct Care Labor	\$119.42
		Indirect Care Labor	33.00
		Direct/Indirect Care Non-Labor	28.77
		Professional Liability	4.03
		Administration	26.15
2	Butte, Humboldt, Inyo, Madera, Mendocino, Merced, San Luis Obispo, Tehama and Yolo	Direct Care Labor	\$129.85
		Indirect Care Labor	35.57
		Direct/Indirect Care Non-Labor	32.87
		Professional Liability	3.37
		Administration	30.59
3	Calaveras, Glenn, Plumas, San Joaquin, Shasta, Siskiyou, Stanislaus, Sutter and Ventura	Direct Care Labor	\$148.46
		Indirect Care Labor	39.16
		Direct/Indirect Care Non-Labor	30.25
		Professional Liability	3.61
		Administration	32.39
4	Amador, El Dorado, Nevada, Placer and Tuolumne	Direct Care Labor	\$148.84
		Indirect Care Labor	39.22
		Direct/Indirect Care Non-Labor	33.58
		Professional Liability	3.71
		Administration	31.85
5	Los Angeles	Direct Care Labor	\$128.76
		Indirect Care Labor	36.25
		Direct/Indirect Care Non-Labor	28.25
		Professional Liability	3.71
		Administration	31.85
6	Fresno, Orange, Riverside, San Bernardino, San Diego, Santa Cruz and Solano	Direct Care Labor	\$139.80
		Indirect Care Labor	36.25
		Direct/Indirect Care Non-Labor	28.25
		Professional Liability	3.80
		Administration	29.17
7	Alameda, Contra Costa, Marin, Monterey, Napa, Sacramento, San Francisco, San Mateo, Santa Barbara, Santa Clara and Sonoma	Direct Care Labor	\$171.53
		Indirect Care Labor	46.46
		Direct/Indirect Care Non-Labor	33.94
		Professional Liability	3.89
		Administration	35.17

Capital costs are reimbursed based on an FRVS that estimates the value of the capital-related assets necessary to care for Medi-Cal residents in lieu of actual costs and/or lease payments on land, buildings, fixed equipment and major moveable equipment used in providing resident care. The FRVS calculates facility-specific Capital cost component rates and does not categorize nursing facilities into geographic peer groups.

The FRVS is based on formulas developed by the DHCS that estimate facility value based on several factors, including facility age and completed capital improvements, modifications and renovations. In addition, the FRVS uses a recognized market interest factor to derive a rental factor. The FRVS calculates facility-specific Capital cost component rates and does not categorize facilities into peer groups.

The initial age of each facility was determined at the midpoint of the 2005-2006 rate year. Facilities licensed on or before February 1, 1976, had five years subtracted in order to account for any improvements, renovations or modifications. Each year, the facility age is adjusted to make the facility one year older, with a maximum age of 34 years. Following the 2005-2006 rate year, additions and renovations are recognized by lowering the age of the facility. Major capital improvements, modifications or renovations equal to or greater than \$500 per bed on a total licensed bed basis will be converted into an equivalent number of new beds, effectively

lowering the age of the facility on a proportional basis. Future completed capital improvement, modification and renovation expenditures included in the FRVS formula are documented in subsequent cost reports or supplemental schedules. Facility values are not affected by sale or change of ownership.

The FRVS utilizes the following steps:

- Building value is determined by multiplying a facility's total licensed beds by the RS Means estimated cost-per-bed estimate for new construction. The product is multiplied by 400 square feet per bed, then by a geographic location factor.
- Land value (10% of the building value) and equipment value (\$4,000 per bed) are calculated.
- Minimum depreciable value of building and equipment are calculated at 38.8% of building and equipment value.
- Current undepreciated value of building and equipment is determined by multiplying the total building and equipment value by the facility's effective age, and then multiplying the product by a factor of 1.8% per year.
- The current and minimum value of the building and equipment are compared, and the higher value is selected.
- The return on total value (rental factor) is calculated based on the average 20-year U.S. Treasury Bond yield for the calendar year preceding the rate year plus a 2% risk premium subject to a floor of 7% and a ceiling of 10%.
- The rental factor is multiplied by the sum of the previously adjusted estimates of building, land and equipment values to derive the FRVS.
- The per diem amount is calculated by dividing the FRVS by the greater of actual resident days, or occupancy adjusted days, based on the statewide average occupancy rate.

Capital costs based on the FRVS have been limited. As of June 24, 2010, the maximum annual increase for the Capital cost component for all facilities in the aggregate was not to exceed 8% of the prior rate year's FRVS aggregate payment. If the total Capital cost for all facilities in the aggregate for fiscal year 2010 exceeded the value for the prior rate year cost category, the DHCS would have reduced the Capital cost for every facility in equal proportion. Fiscal years 2011 and 2012 rates were subject to an increase within the model and rate structure, as the distribution of funding to the rate components was subject to the overall maximum allowable rate increase. New rates were not established in fiscal year 2013. New FRV rates were determined for fiscal years 2014 and 2015, but as part of the total rate were limited to the overall maximum allowable rate increase (2.0%). In addition, fiscal years 2016 and 2019 FRV rates were limited to the 3.62% maximum allowable rate increase, which will be the policy through the five year period.

In a typical rebasing year, the Direct Pass-Through cost component is not subject to a maximum allowable reimbursement level and is therefore not computed on a geographic peer group basis. However, similar to Capital cost component rates, these rates were not re-established due to the maximum allowable rate increases in fiscal years 2012 to 2013. New Direct Pass-Through cost component rates were determined for fiscal years 2014 and 2015, but as part of the total rate were limited to the overall maximum allowable rate increase (2.0%). In addition, fiscal years 2016 and 2019 Direct Pass-Through rates were limited to the 3.62% maximum allowable rate increase, which will be the policy through the five year period.

In addition to the Medi-Cal rates, in fiscal year 2014 the state began reimbursing nursing homes an annual supplemental payment based on a Quality and Accountability Program (QASP). The implementation of this program was delayed until fiscal year 2014, but benchmarking for the program began July 1, 2011. Nursing facilities are eligible for two types of reimbursement under the program. A standard payment based on established quality of care standards, and reimbursement for nursing facilities that have displayed improvement in these quality of care measures.

Ninety percentage of the reimbursement is allocated to the standard payment, which rewards nursing facilities that perform better than the statewide average for specific quality measures. Eligibility for the program is based on a point-scoring system with a maximum score of 100 points. For fiscal year 2019, quality of care indicators, as well as the points allocated for each indicator that were utilized to determine if facilities are eligible for the additional reimbursement, are as follows:

Q&A Scoring System	
Category	Points
Physical Restraints	11.111
Influenza Vaccination	5.55575
Pneumococcal Vaccination	5.55575
Pressure Ulcers	11.111
Control of Bowel or Bladder	11.111
Urinary Tract Infection	11.111
Self-Report Moderate to Severe Pain (Short-term)	5.55575
Self-Report Moderate to Severe Pain (Long-term)	5.55575
Activities of Daily Living	11.1111
Staff Retention	11.1111
Rehospitalization	11.1111
Total	100.000

These measures were utilized to pay out rewards effective April 1, 2019. Hospital re-admissions within 30 days of being admitted to a nursing facility was added as a new benchmark in fiscal year 2018. Staff retention was established as a new benchmark in fiscal year 2017. The Activities of Daily Living category was added for fiscal year 2016 and was not included in the fiscal year 2015 calculation. All of the other categories were utilized to determine fiscal year 2015 rewards (paid out on April 1, 2015). Nursing facilities that score above the statewide average receive 50% of the points available per category. However, facilities that score above the 75th percentile in the state receive 100% of the points available.

To be eligible for supplemental payments, facilities must achieve a score of at least 50 points. For fiscal year 2015, these facilities were reimbursed \$10.50 per Medi-Cal day. Facilities that achieve a score of over 66.67 are reimbursed approximately 1.5 times the payout per Medicaid day for the facilities that were in the lower tier (50 to 66 points). For fiscal year 2015, this equated to \$15.08 per Medi-Cal day.

For fiscal year 2016, facilities that achieved a score of at least 50 points were reimbursed \$9.96 per Medi-Cal day and facilities that achieved a score of over 66.67 were reimbursed \$14.94 per Medi-Cal day.

For fiscal year 2017, facilities that achieved a score of at least 50 points were reimbursed \$9.21 per Medi-Cal day and facilities that achieved a score of over 66.67 were reimbursed \$13.81 per Medi-

Cal day.

For fiscal year 2018, facilities that achieved a score of at least 50 points were reimbursed \$9.87 per Medi-Cal day and facilities that achieved a score of over 66.67 were reimbursed \$14.80 per Medi-Cal day.

For fiscal year 2019, facilities that achieved a score of at least 50 points were reimbursed \$8.74 per Medi-Cal day and facilities that achieved a score of over 66.67 were reimbursed \$13.11 per Medi-Cal day

The remaining 10.0% of funding for the program is allocated to the top 20% of nursing facilities in the state that displayed improvements in the quality of care measurements from the prior year.

Nursing facilities will be excluded from Q&A reimbursement for the following reasons:

- Facilities with AA or A citations;
- Any days of non-compliance with the state's 3.2 nursing hours per patient day (NHPPD) requirements and
- Facilities with no fee-for-service Medi-Cal days.

Facilities are reimbursed by an annual supplemental payment with the total amount paid out by the state equaling \$90.0 million in fiscal years 2015 through 2019. Funding for the program will remain at \$90 million over the previously mentioned five-year period. Payments for the fiscal year (FY14) prior to this period were only \$36.6 million. Payments for fiscal year 2019 were effective April 1, 2019, and were calculated utilizing state fiscal year 2018 (July 1, 2017, to June 30, 2018) data.

Effective August 1, 2011, the state implemented two new rate add-ons, one for the conversion to MDS 3.0 and one to protect employees against airborne transmitted diseases. All facilities in the state will receive these add-ons, which were \$1.24 per day for the conversion to MDS and \$0.86 for the protection against airborne transmitted diseases. The MDS and protection against airborne transmitted diseases add-ons were decreased to \$0.51 and \$0.25 in fiscal year 2013, respectively. However, this was partially offset by six additional add-ons that will equate to a combined total of \$0.47 per day. This includes add-ons for the Federal Unemployment Tax Act (FUTA) - \$0.11, Informed Consent - \$0.13, Standard Admission Agreement - \$0.02, CMS Revalidation - \$0.02, the Elder Justice Act - \$0.01 and 5010 Implementation - \$0.18. Overall, the total amount of add-on revenue a nursing facility can receive in fiscal year 2013 will be \$1.23 per day, which is a \$0.87 per day reduction from the prior year total (\$2.10).

In fiscal year 2014, MDS Conversion, protection against airborne transmitted diseases, CMS Revalidation and 5010 Implementation add-ons were eliminated. However, the Informed Consent - \$0.13, Standard Admission Agreement - \$0.02 and the Elder Justice Act - \$0.01 add-ons remained the same. In addition, the FUTA add-on increased to \$0.22 and new add-ons were created for the affordable Care act (ACA) Reinsurance Fee and PCORI - \$0.04, ACA Compliance -\$0.66 and HIPAA EFT and E rads - \$0.03. The total combined for all available add-ons in fiscal year 2014 is \$1.11 per Medi-Cal day, which is \$0.12 less than the total for fiscal year

2013.

In fiscal year 2015, the Informed Consent, Standard Admission Agreement and the Elder Justice Act add-ons were eliminated. In addition, the FUTA add-on was decreased to \$0.11, the Affordable Care Act (ACA) Reinsurance Fee and PCORI (\$0.04), ACA Compliance (\$0.66) and HIPAA EFT and E rads (\$0.03) remained the same. Plus an add-on for minimum wage (\$0.07) was implemented. The combined total of all the available add-ons in fiscal year 2015 was \$0.91 per Medi-Cal day, which was \$0.20 less than the total for fiscal year 2014.

The add-ons that were implemented in fiscal year 2016 include the following: Minimum wage (\$0.27); FUTA (\$0.33); ACA Reporting (\$0.54); ICD-10 Transition from ICD-9 (\$0.50) and Paid Sick Leave (\$1.72). The total of these add-ons equates to \$3.36, which is \$2.45 greater than the previous total for fiscal year 2015.

The add-ons for fiscal year 2016 included the following: Minimum wage (\$0.27); FUTA (\$0.33); ACA Reporting (\$0.54); ICD-10 Transition from ICD-9 (\$0.50) and Paid Sick Leave (\$1.72). The total of these add-ons equates to \$3.36, which is \$2.45 greater than the previous total for fiscal year 2015. The add-ons for fiscal year 2017 combined equated to \$3.06 as follows: Minimum wage (\$0.45); FUTA (\$0.22); ACA Reporting (\$0.54); Payroll Based Journal (\$0.13) and Paid Sick Leave (\$1.72). Total of the add-ons for fiscal year 2018 significantly decreased to \$1.39. This includes the following add-ons: Minimum wage (\$1.05); FUTA (\$0.10); Payroll Based Journal (\$0.13) and Standards of Participation (\$0.04).

The add-ons for fiscal year 2018 total \$1.58, including the following: 2016-17 FUTA add-on - \$0.05; 2017-18 FUTA add-on - \$0.05; Minimum Wage (1/1/17 AB 10) - \$0.15; Minimum Wage (1/1/17 SB 3) - \$0.17; Minimum Wage (1/1/18 SB 3) - \$0.78; Payroll Based Journal - \$0.13; Standards of Participation - \$0.04; and ACA Employer Mandate - \$0.19.

The add-ons for fiscal year 2019 total \$3.13, including the following: Minimum Wage (1/1/17 SB 3) - \$0.07; Minimum Wage (1/1/18 SB 3) - \$1.36; Minimum Wage (1/1/19 SB 3) - \$0.32; Standards of Participation - \$1.32; and LGBT training - \$0.06.

Historically, the total statewide weighted average per diem rate was \$142.11 in fiscal year 2006 (as adjusted for 2006-2007 mandates), \$148.59 in fiscal year 2007, \$152.14 in fiscal year 2008, \$161.81 in fiscal year 2009, \$164.27 in fiscal year 2010, \$173.34 in fiscal year 2011, \$177.74 in fiscal year 2012. The weighted average rate in fiscal year 2013 is \$178.12, which represents a 0.2% increase from the prior year. In fiscal year 2014, the weighted average increased to \$182.87, a 2.7% increase from the prior rate. The fiscal year 2015 weighted average rate increased 2.1% to \$186.79. In addition, the weighted average rate increased to \$197.76, which is 5.9% greater than the prior rate. This partially reflects increases in the rate add-ons. In fiscal year 2017 the weighted average increased to \$204.64, which equates to a 3.5% increase from the prior year average. The weighted average increased 1.9% to \$208.65 in fiscal year 2018. The weighted average rate for fiscal year 2019 increased 5.2% to \$219.57.

MINIMUM OCCUPANCY STANDARDS

Medi-Cal methodology does not utilize any minimum occupancy standards.

OTHER RATE PROVISIONS

Newly constructed nursing facilities with no cost history or an existing facility newly certified to participate in the Medi-Cal program will receive an interim reimbursement rate based on the peer grouped weighted average Medi-Cal reimbursement rate. Once the new nursing facility has submitted six months of audited cost data, its facility-specific rate will be calculated according to the methodology set forth by the state.

Nursing facilities that experience a change of ownership are not qualified for increases in reimbursement rates associated with the change of ownership. In instances where the previous owner

participated in the Medi-Cal program, the state will reimburse the new owner the per diem payment rate of the previous provider until the new owner or operator has submitted six or more months of audited cost data.

Nursing homes in California are eligible to be reimbursed by Medi-Cal for holding a bed for a resident that required hospitalization. Bed hold reimbursement is limited to a maximum of seven days per hospitalization. The nursing home is reimbursed its current per diem rate minus a per diem raw food cost. Effective August 1, 2018, this per diem is \$7.92.

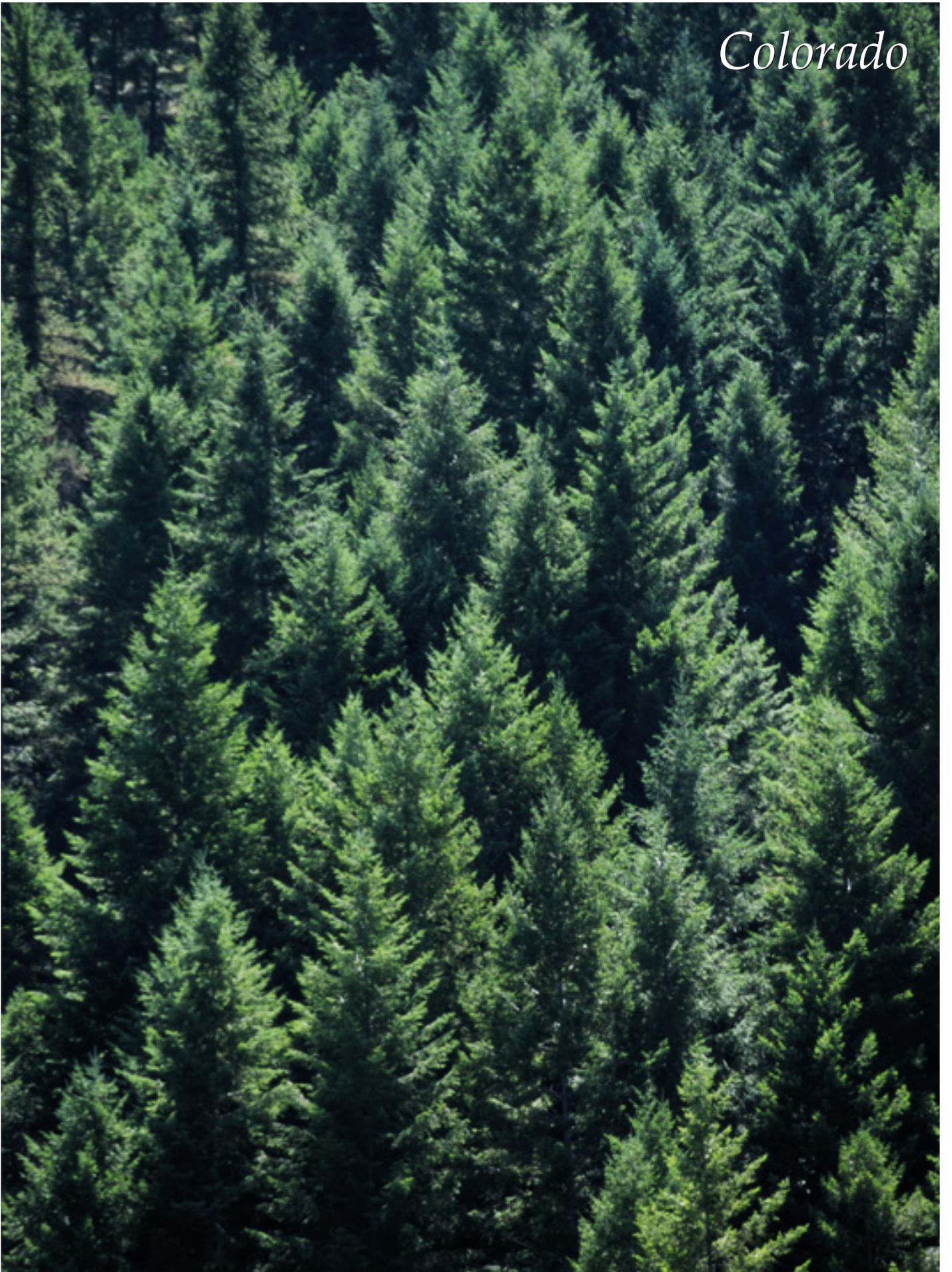
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the effective date of this overview, there is no significant planned or proposed legislation that would impact the state's reimbursement system.

CALIFORNIA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	65.00	62.00	62.00		99.00	99.00	99.00		120.00	120.00	120.00
Average Daily Census	60.08	59.68	63.28		88.02	87.76	88.24		113.74	113.54	121.05
Occupancy	84.6%	84.4%	84.1%		89.9%	89.3%	89.3%		93.2%	92.7%	92.8%
Payor Mix Statistics											
Medicare	7.4%	7.6%	7.0%		13.3%	13.4%	12.8%		20.8%	19.9%	19.8%
Medicaid	41.9%	47.1%	45.1%		64.1%	67.9%	66.8%		76.1%	76.9%	77.4%
Other	10.9%	9.9%	9.3%		20.0%	18.6%	18.3%		50.8%	46.7%	48.2%
Avg. Length of Stay Statistics (Days)											
Medicare	30.23	29.31	29.20		38.62	38.81	38.01		53.04	53.93	55.18
Medicaid	177.88	176.30	177.92		320.45	314.53	312.76		526.90	613.34	582.67
Other	28.02	27.41	25.85		51.33	52.60	46.42		131.17	125.53	116.18
Revenue (PPD)											
Inpatient	\$210.68	\$216.09	\$220.13		\$248.15	\$253.94	\$256.57		\$303.50	\$315.48	\$315.33
Ancillary	\$46.26	\$48.42	\$47.50		\$84.06	\$81.61	\$85.34		\$141.71	\$135.44	\$136.56
TOTAL	\$280.48	\$288.43	\$286.82		\$349.09	\$359.05	\$360.03		\$439.68	\$445.22	\$451.59
Expenses (PPD)											
Employee Benefits	\$17.23	\$17.83	\$17.52		\$21.69	\$22.51	\$23.29		\$29.94	\$30.55	\$30.52
Administrative and General	\$53.89	\$56.02	\$56.89		\$64.91	\$67.33	\$68.97		\$79.25	\$80.93	\$81.77
Plant Operations	\$8.26	\$8.46	\$8.88		\$9.98	\$10.44	\$10.90		\$12.87	\$13.13	\$13.73
Laundry & Linens	\$2.50	\$2.58	\$2.59		\$3.23	\$3.44	\$3.50		\$4.21	\$4.51	\$4.54
Housekeeping	\$4.70	\$4.96	\$5.19		\$5.69	\$6.12	\$6.32		\$7.06	\$7.61	\$7.71
Dietary	\$15.29	\$15.92	\$16.61		\$17.32	\$18.02	\$18.78		\$20.31	\$21.52	\$21.91
Nursing & Medical Related	\$80.46	\$84.04	\$89.12		\$92.13	\$98.00	\$102.81		\$108.89	\$115.56	\$120.56
Ancillary and Pharmacy	\$22.36	\$23.15	\$22.47		\$34.21	\$33.78	\$33.23		\$48.71	\$47.49	\$47.77
Social Services	\$3.53	\$3.82	\$4.18		\$5.00	\$5.36	\$5.76		\$6.56	\$7.07	\$7.44

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Colorado



INTRODUCTION

Nursing facilities in Colorado are licensed by the Colorado Department of Public Health and Environment (DPHE), Health Facilities and Emergency Medical Services Division under the designation of “Long-Term Care Facilities.” Nursing facilities in the state are designated into classes by the DPHE. For the purpose of this analysis, this document will only focus on Class I nursing facilities, which include freestanding and hospital-based nursing facilities. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN COLORADO	
Licensed Nursing Facilities*	211
Licensed Nursing Beds*	19,599
Beds per 1,000 Aged 65 >**	24.41
Beds per 1,000 Aged 75 >**	64.59
Occupancy Percentage - 2017*	81.40%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Colorado does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the bed capacity and services offered at an existing facility. The state operated a CON program from 1973 to 1987. However, Colorado currently has a moratorium on the construction of any new Medicaid-licensed nursing home beds. As of the date of this document, no end date to the moratorium has been established. Any nursing home not already Medicaid licensed as of February 1, 1990, must meet certain criteria to apply for enrollment in the state nursing home Medicaid reimbursement program. These criteria are detailed in the following section of this overview. Nursing facilities exempt from this moratorium are as follows:

- A change of ownership or placement into receivership of a nursing home if the ownership change or receivership action involves no increase to its previously approved Medicaid bed total, or
- A replacement facility for existing residents in a facility owned/operated by the applicant under the following conditions:
 - The replacement facility is located no more than five miles from the existing facility.
 - The number of beds in the replacement facility is limited to the original number of Medicaid-certified beds being replaced.
 - Residents living in the original facility at the time it is closed are given the right of first refusal for beds in the replacement facility.
 - Facilities that provide a specific treatment or service that the state has determined is lacking in a specific area.

BED NEED METHODOLOGY

Approval or denial of an application for Medicaid certification of a new nursing facility depends on whether or not the facility will provide needed beds to an under-served geographical area.

To qualify as an under-served geographical area of the state, the application must demonstrate that:

- The new nursing facility is located in the service area defined by the application.
- The service area shall be no more than two contiguous counties in the state.
- The service area shall have a nursing facility bed to population ratio of less than 40 beds per 1,000 persons over the age of 75 years.
- The occupancy of existing nursing facilities in the proposed service area exceeds 90% for the six months preceding the filing date of the application, as demonstrated by the nursing facility quarterly census statistics maintained by DPHE.

QUALITY ASSURANCE FEE

Nursing facilities in Colorado are assessed a quality assurance fee (QAF), which is part of a new Medicaid reimbursement system. The current QAF (effective July 1, 2019) is \$15.26 per non-Medicare day for facilities with 55,000 or fewer Medicaid days and \$2.04 for nursing facilities with more than 55,000 Medicaid days. The state caps the QAF at \$12.00 per non-Medicare day plus the inflation adjustment. The prior QAFs (effective July 1, 2018) were \$14.80 per non-Medicare day for facilities with 55,000 or less total patient days and \$2.77 for nursing facilities with greater than 55,000 total patient days.

The following facilities are granted a waiver from paying the QAF:

- A nursing facility that is part of a continuing care retirement facility (CCRC);
- nursing facilities owned or operated by the state;
- hospital-based nursing facilities; and
- nursing facilities with 45 or fewer beds.

In addition, the QAF is used to fund 100% of the state’s obligation of various supplemental payments to nursing facilities.

The QAF is reimbursed via a separate supplemental payment. The QAF supplemental payment is determined by multiplying the facility’s percentage of total Medicaid, hospice and PACE (Program of All-Inclusive Care for the Elderly) days from total patient days by the projected total annual provider fees to be paid during the rate year. This amount is calculated annually, but paid out in equal monthly installments. Calendar year 2018 patient days were utilized to calculate the supplemental payment for fiscal year 2020.

MEDICAID RATE CALCULATION SYSTEM

Effective July 1, 2008, Colorado began the phase-in of a conversion from a prospective cost-based, case-mix adjusted facility-specific rate setting system, to a combination cost- and price-based case-mix adjusted rate setting system. Specially, the Administrative and General Service cost component was converted from a facility-specific cost-based rate to a statewide price. The state fully phased-in the new system on July 1, 2011.

In addition, effective July 1, 2010, Colorado implemented several supplemental rate payments that will be funded by the QAF and sent through the Medicaid Managed Information System (MMIS), which is now referred to as the Colorado Interchange

(“Interchange”).

Effective July 1, 2019, the state altered the rate calculation methodology. However, the methodology is still a combination cost- and price-based, case mix adjusted system. This overview will focus on how rates were calculated effective July 1, 2019 and will be determined in the future.

COST CENTERS

Colorado uses the following three cost centers to calculate its facility-specific rates.

- The Health Care cost component is separated into two categories, costs related to Direct Health Care (director of nursing, RNs, LPNs, nurses’ aides, orderlies, contract nursing and related benefits) and costs related to Indirect Health Care (non-prescription drugs, purchases, rental and repair expenses for healthcare equipment and supplies, depreciation and interest for major healthcare equipment, any expenses related to providing medical transportation, copier and computer expenses related to equipment utilized by healthcare staff, raw food, social services, activities, medical records, medical directorship, therapies, medical supplies and liability insurance).
- The Administration and General cost component includes salaries and related benefits for the dietary, housekeeping, maintenance, laundry, administration departments, advertising and public relations expenses, recruitment costs, office supplies, telephone costs, legal and consulting fees (non-healthcare), computer expenses related to non-healthcare departments, licenses and permits (non-healthcare), business related travel expenses, all insurance (accept liability insurance), facility memberships and dues, miscellaneous administrative expenses, non-medical transportation vehicle expenses, purchases, rentals and repairs of equipment related to administrative duties, allowable interest not covered by the FRV allowance or expenses included in the Capital cost component, depreciation and rental costs of non-fixed equipment (non-healthcare related), property taxes, property insurance, mortgage interest, and repairs and improvements to property not covered by the FRV allowance.
- The Capital cost component is a fair rental value (FRV) system based upon an appraisal using the Boeckh Commercial Building Valuation System.

Employees who perform both administrative and healthcare services will have their time and expenses allocated between the two cost centers.

INFLATION AND REBASING

Nursing facility rates are rebased annually using the most recent cost report data available. July 1, 2019 rates were rebased utilizing calendar year 2017 cost reports. All participating nursing facilities have their initial Medicaid rate established on July 1. The overall Medicaid rates are re-established (adjusted for case mix) 11 months preceding the nursing facility’s fiscal year end and six months later. However, if either of these dates is July 1, the facility will only have two rates calculated during the rate year. Effective July 1, 2010, any adjustments to a facility’s core per diem

rate for acuity (case mix) are reimbursed to a nursing facility in the subsequent year as a monthly supplemental payment to the nursing facility. This supplemental payment is referred to as the Acuity Adjustment.

At the beginning of each facility’s new rate period, the inflation adjustment is applied to all costs except interest and costs covered by the FRV allowance. Allowable costs derived from the cost reports will be adjusted from the midpoint of the cost report period to the midpoint of the rate period by the percentage change in the Skilled Nursing Facility Market Basket Without Capital Inflation Index published by Global Insight, Inc.

RATE METHODOLOGY

A nursing facility’s total Medicaid rate (Core Component Rate) is the sum of the Health Care, Administrative and General and Capital cost components as well as all of the applicable add-ons. In addition, nursing facilities eligible for supplemental rate payments are funded by the QAF. In an effort to contain rising Medicaid costs, Colorado implemented the General Fund Limit Percentage to assure that rates do not increase above budgeted levels. This percentage will annually limit the rate of growth that can be reimbursed through Interchange.

The Core Component Rate is multiplied by the General Fund Limit Percentage (90.9% effective July 1, 2019) to determine the IC Rate prior to applying the Safety Net calculation. The Safety Net calculation was put in place effective July 1, 2019 to assure that nursing facilities’ rates did not decrease by more than five percent from their fiscal year 2019 IC Rate. As part of this calculation, the initial IC rate (effective July 1, 2019) is divided by the facility’s fiscal year 2019 IC rate. If the percentage calculated is less than 95.0%, then the Safety Net Calculation is applied. As such, nursing facilities receive the lesser of their Core Rate or the fiscal year IC rate multiplied by 95.0%. If the percentage calculated is 95.0% or greater, nursing facilities receive their Core Component Rate adjusted for the General Budget Limit Percentage. The Safety Net Calculation will be eliminated effective July 1, 2020.

Regardless, nursing facilities cannot receive a rate greater than the calculated Core Component Rate. However, nursing facilities can receive a supplemental payment (dependent on funding) that reimburses the facilities for the difference between Core Component Rate and IC Rate after the Safety Net Adjustment, if the Core Component Rate is greater. This accomplished by multiplying the difference by the nursing facility’s total Medicaid patient days for a prior period. For payments effective July 1, 2019, these payments are based on 2018 calendar year Medicaid patient days. This calculation is then adjusted by the percentage funded. Effective July 1 2019, this percentage is 40.61%.

Dependent on funding, nursing facilities are also reimbursed nine additional monthly supplemental payments. These include reimbursement for facilities treating cognitively impaired residents, residents with severe mental health conditions and developmental disabilities that are classified by Medicaid’s preadmission screening and the resident review assessment tool as Level II (PASRR II), facilities that meet the PASRR II criteria and are identified as possessing a specialized behavioral health

program, a Pay for Performance program, an Acuity Adjustment, a Rate True-Up (prior and current year adjustments), the Core Component Adjustment (previously detailed) and reimbursement of the QAF (previously detailed). These supplemental payments will be funded by revenue generated from the QAF.

The following is a description of how the Core Component Rate and the majority of supplemental payments are calculated:

The per diem costs for the Direct Health Care and Indirect Health Care cost portions of the Health Care cost component are initially derived by dividing the allowable costs by the total resident days for the cost report period. The Direct Nursing portion of the component is adjusted semiannually for case mix changes using a 34-group version of the RUG III system. A facility-wide case mix index (CMI), Medicaid CMI and statewide average CMI are utilized in the rate calculation system. The facility-wide CMI is the average of quarterly resident acuity indices for the quarters that most closely coincide with the cost reporting period. The Medicaid CMI is a two-quarter average of the two periods used in the previous rate calculation. The statewide average CMI is an average CMI for all facilities in the state as of July 1.

This data is compiled by the state to adjust the upper payment limit for the Direct Health Care portion of the Health Care cost component. The facility's direct nursing costs are adjusted by the ratio of the statewide CMI to the facility's CMI to allow comparison to this upper limit. This estimate is summed with the facility's Indirect Health Care cost per diem to determine the upper limit. The overall Health Care component rate paid to a facility is equal to the lesser of (1) the facility's case-mix adjusted allowable Direct nursing costs plus Indirect Health Care costs or (2) a ceiling rate defined as 125% of industry average case-mix adjusted direct healthcare costs and indirect healthcare costs.

The upper payment limit is allocated to the facility's Direct Health Care and Indirect Health Care cost by the percentage of the facility's costs related to each subcomponent. This amount is then multiplied by the ratio of the facility-wide average CMI to the statewide average CMI. After this has been completed, the lower of the upper limit or the facility's Direct Health Care per diem cost is then multiplied by the facility's Medicaid Acuity Ratio to derive the facility-specific Direct Health Care portion of the Health Care cost component. A facility's Medicaid Acuity Ratio is calculated by dividing the facility's Medicaid CMI by its facility-wide CMI. These estimate than adjusted for by the inflation factor.

The Indirect Health Care portion of the Health Care cost component will be the lesser of the facility's allowable Indirect Health Care cost component per diem cost or the facility-specific Indirect Health Care maximum reimbursement rate. In addition, effective July 1, 2009, any increase in direct and indirect healthcare costs and raw food costs shall not exceed 8.0% per year.

The Administrative and General Services cost component price is determined for two peer groups, nursing facilities with 60 or less licensed beds (Peer Group I) and nursing facilities with greater than 60 licensed beds (Peer Group II). For the most recent price calculated July 1, 2012, the standard price for Peer Group I and II nursing facilities equates to 110% and 105% of the median per diem

cost for all nursing facilities within its peer group, respectively.

The FRV or appraised value means the determination of the depreciated cost of replacement of a capital-related asset to its current owner. Nursing facility appraisals occur once every four years and shall be based on the Boeckh Commercial Underwriter's Valuation System for Nursing Homes. These appraisals are used to determine the base value, which is the value of the capital related assets. During years in which an appraisal is not completed, base value is equal to the most recent appraisal value increased or decreased by 50% of the Means Square Foot Costs Book, a publication of RS Means Company, Inc. The base value is subject to a maximum base value not to exceed the prior year's base value per bed, plus the percentage rate of change. The maximum base value is \$101,740 per bed for rates effective July 1, 2019. If a nursing facility is renovated during a non-appraisal year, the cost of these renovations on a per diem basis is added to the base value.

The base value plus improvements/renovations made since the last appraisal is then multiplied by a rental rate, currently set at 8.25% (the average annualized composite rate for U.S. Treasury Bonds issued for periods of 10 years or more plus 2%). The rental rate shall not exceed 10.75% or fall below 8.25%. The resulting amount is the fair rental allowance, which is divided by the facility's total patient days (subject to the minimum occupancy requirement) to determine the per diem FRV rate.

As previously mentioned, the state reimburses nursing facilities for several additional supplemental payments that skilled nursing facilities are now eligible to receive in addition to standard Medicaid rates. These include supplemental payments to reimburse facilities that treat cognitively impaired residents; residents with severe mental health conditions and developmental disabilities that are classified by Medicaid's preadmission screening and resident review assessment tool as Level II (PASRR II); facilities that meet the PASRR II criteria and are identified as possessing a specialized behavioral health program; a Pay for Performance program; the Rate True-Up (previously detailed); the Prior Year True-Up Payment; the Acuity Adjustment (previously detailed); the Core Component payment (previously detailed) and reimbursement of the QAF (previously detailed). These supplemental payments will be funded by revenue generated from the QAF.

Revenue derived from the QAF will first be used to pay the QAF offset payment, then the Acuity Adjustment, then the Pay-for-Performance program, then payments for residents who have moderately to severe mental health conditions, cognitive dementia or acquired brain injury, and then the supplemental Medicaid payments for the General Fund Cap Fund and Rate-True Up. With the exception of the General Fund Growth Cap and Rate True-Up, which are 40.61% funded, all of the supplemental payments were 100.0% funded in fiscal year 2020.

Nursing facilities that provide care to residents with cognitive dementia or acquired brain injury will be eligible for a supplemental payment based on a resident's score on the Cognitive Performance Scale (CPS), which can range from zero (intact) to six (very severe impairment). The state will determine for each nursing facility its

percentage of Medicaid residents with CPS scores of 4, 5 or 6. In addition, the state will calculate a statewide mean and a standard deviation from the mean. Based on these scores, nursing facilities will receive the following additional reimbursement per eligible Medicaid day (effective July 1, 2014):

- Nursing facilities with a CPS percentage greater than the mean plus one standard deviation - \$1.53.
- Nursing facilities with a CPS percentage greater than the mean plus two standard deviations - \$3.06.
- Nursing facilities with a CPS percentage greater than the mean plus three standard deviations - \$4.59.

If the expected average additional payment for those residents receiving an additional payment is less than 1% of the average nursing facility rate (prior to rate add-ons), the above rates will be proportionately increased or decreased in order to have an expected average Medicaid additional payment equal to 1% of the average nursing facility rate prior to add-on payments.

This supplemental payment is determined annually to coincide with the July 1 rate setting process. However, these payments will be paid out in equal monthly installments. Each facility's aggregate additional payment will be determined by multiplying the additional payment per diem by Medicaid days with a CPS score of four or more. The supplemental payment will be calculated by dividing the facility's previously determined aggregate CPS amount by the facility's expected Medicaid patient days. Expected Medicaid patient days will be determined using the Medicaid claims data for the calendar year ending prior to the July 1 rate setting date.

Nursing facilities are also eligible for a supplemental payment if the facility provides specialized behavioral services to residents who have severe mental health conditions that are classified as a PASRR level II. The additional payment or per diem PASRR II rate equates to 2% of the statewide average per diem rate for the three combined cost components. The supplemental payment is calculated by dividing the facility's previously determined aggregate PASRR II amount by the facility's expected Medicaid patient days. Expected Medicaid patient days will be determined using the Medicaid claims data for the calendar year ending prior to the July 1 rate setting date. The same calculation is utilized to determine supplemental payments for facilities that meet the PASRR II criteria and are identified as possessing a specialized behavioral health program.

Nursing facilities are eligible for a Pay for Performance quality of care incentive. This payment will be based on the domains of quality of life, quality of care and facility management. Nursing facilities will be awarded points if they meet or exceed each performance measure. Nursing facilities will be eligible for a maximum of 100 points and the potential additional reimbursement will be as follows

- 0 – 20 points - no additional reimbursement.
- 21 – 45 points - \$1.00 per diem add-on.
- 46 – 60 points - \$2.00 per diem add-on.
- 61 – 79 points - \$3.00 per diem add-on.
- 80 – 100 points - \$4.00 per diem add-on.

If the expected average payment for those facilities receiving a supplemental payment is less than 1.25% of the statewide average

per diem base rate, the above per diem rates are proportionately increased or decreased to produce an expected average Medicaid additional payment equal to the previously mentioned standard. No facility with substandard deficiencies will be considered eligible for this add-on. These calculations will be determined annually to coincide with the July 1 rate setting process.

Lastly, since several nursing facilities experienced a change in their prior year audited Core Component Rate, the prior year Rate True-Up Supplemental Payment reimburses (if necessary) a nursing facility for an adjustment to a Rate True-Up Supplemental Payment paid in the prior year as a result of the rate change.

A nursing facility's monthly supplemental payment will be the sum of the supplemental payments for General Fund Growth Cap, the Rate True-up, the Acuity Adjustment, reimbursement of the QAF, the CPS payment, the PASRR II payments (resident- and facility-specific) the Pay for Performance Program, the Prior Year Rate True-Up Payment and the Core Component Rate Payment. All of these supplemental payments are dependent on revenue generated from the QAF. Therefore, in a given fiscal year, these supplemental payments may not be fully funded. For example, in fiscal year 2020, the General Fund Growth Cap and Rate True-Up were only 41.60% funded.

MINIMUM OCCUPANCY STANDARDS

No minimum occupancy adjustment is applied to the Health Care cost component. An 85% minimum occupancy adjustment is applied to the Administrative and General Services cost component. However, this occupancy adjustment is not applied to nursing facilities located in rural communities. Rural communities are defined as follows:

- A county with a total population of less than 15,000.
- A municipality or unincorporated portion of a county with a total population of less than 15,000 that is located more than 10 miles from a municipality with a total population of greater than 15,000.

A minimum occupancy of 90% is applied to the calculation of the Capital/FRV rate.

OTHER RATE PROVISIONS

For new providers entering the Medicaid program as a result of a change of ownership that does not require a new license from DPHE, the existing Medicaid provider agreement continues in effect, together with all associated rights and responsibilities. For all other new providers entering the program, the interim rates are equal to the most recent statewide average weighted rate. This rate remains in effect until a new rate is established based on the first cost report submitted by the new facility.

Colorado Medicaid will not reimburse nursing facilities for holding beds as a result of a resident requiring admission to a hospital. The state's Medicaid program will reimburse a nursing facility at its current rate for a maximum of 42 days per calendar year for holding a bed for a resident that required therapeutic care at another facility.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is currently no proposed state legislation that would affect the Medicaid calculation in Colorado.

COLORADO COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	60.00	60.75	60.00		93.00	90.50	91.00		117.00	116.00	116.00
Average Daily Census	59.35	60.02	58.98		80.27	79.26	80.31		102.98	103.91	106.88
Occupancy	78.3%	77.4%	77.1%		82.8%	84.0%	84.9%		88.9%	89.7%	89.3%
Payor Mix Statistics											
Medicare	4.4%	4.3%	3.9%		7.8%	7.7%	6.7%		12.9%	12.6%	11.2%
Medicaid	56.8%	58.0%	57.9%		69.1%	69.9%	70.7%		77.4%	78.7%	81.3%
Other	16.3%	14.7%	13.2%		25.1%	23.3%	21.4%		38.3%	37.4%	36.5%
Avg. Length of Stay Statistics (Days)											
Medicare	26.74	26.68	25.60		33.79	35.23	34.24		45.83	51.98	53.61
Medicaid	283.51	278.58	270.57		370.51	364.37	377.71		548.17	518.05	534.76
Other	49.88	37.07	36.51		95.23	77.89	69.73		169.01	150.40	132.14
Revenue (PPD)											
Inpatient	\$222.11	\$233.31	\$240.24		\$252.26	\$264.51	\$278.36		\$305.52	\$338.22	\$349.71
Ancillary	\$29.07	\$28.61	\$27.28		\$47.24	\$43.57	\$44.93		\$71.84	\$71.13	\$67.83
TOTAL	\$265.64	\$275.86	\$284.25		\$307.34	\$329.20	\$341.23		\$380.80	\$441.21	\$451.44
Expenses (PPD)											
Employee Benefits	\$16.65	\$18.46	\$16.26		\$21.02	\$22.72	\$22.80		\$27.90	\$29.43	\$29.29
Administrative and General	\$40.05	\$41.72	\$45.18		\$47.89	\$50.03	\$53.70		\$57.53	\$59.36	\$67.12
Plant Operations	\$9.25	\$9.23	\$9.55		\$10.84	\$10.97	\$10.95		\$13.27	\$12.65	\$12.85
Laundry & Linens	\$1.90	\$1.93	\$1.91		\$2.52	\$2.63	\$2.63		\$3.21	\$3.51	\$3.57
Housekeeping	\$4.50	\$4.45	\$4.61		\$5.65	\$5.70	\$5.84		\$6.95	\$7.09	\$7.41
Dietary	\$16.38	\$16.78	\$17.40		\$19.28	\$20.37	\$20.83		\$23.58	\$24.14	\$24.99
Nursing & Medical Related	\$83.30	\$87.52	\$89.72		\$97.30	\$99.78	\$105.59		\$110.71	\$113.79	\$118.30
Ancillary and Pharmacy	\$15.71	\$14.89	\$14.57		\$22.37	\$21.79	\$21.80		\$32.07	\$31.17	\$31.51
Social Services	\$3.08	\$3.34	\$3.61		\$4.73	\$4.90	\$5.10		\$6.44	\$6.55	\$7.33

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Connecticut



INTRODUCTION

Nursing facilities in Connecticut are licensed by the Connecticut Department of Public Health (DPH). The DPH licenses two categories of nursing facilities: (1) chronic and convalescent nursing homes (CCNH) for skilled or rehabilitative care and (2) rest homes with nursing supervision (RHNS) for custodial care. Approximately 95% of the beds in Connecticut are CCNH. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN CONNECTICUT	
Licensed Nursing Facilities*	226
Licensed Nursing Beds*	26,499
Beds per 1,000 Aged 65 >**	52.72
Beds per 1,000 Aged 75 >**	102.76
Occupancy Percentage - 2017*	87.70%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Office of Health Care Access (OHCA) regulates the Certificate of Need (CON) program and imposes a permanent moratorium on the construction of new nursing facility beds. In addition, a Certificate of Need (CON) is required for the following scenarios:

- The relocation of beds from one licensed facility to another licensed facility.
- The development of any additional function or services, or the reduction or termination of a service.
- Nursing facilities must obtain a CON prior to closing.
- Any facility which proposes (1) a capital expenditure exceeding \$1 million, which increases facility square footage by more than 5,000 square feet or 5% of the existing square footage, whichever is greater, (2) a capital expenditure exceeding \$2 million, or (3) the acquisition of major medical equipment requiring a capital expenditure in excess of \$400,000, including the leasing of equipment or space.

In January 2013, the governor, the Office of Policy and Management, and the Department of Social Services released the State's Strategic Plan to Rebalance Long-Term Services and Supports (LTSS). One of the goals of this program is to implement a strategic, coordinated approach to reducing beds where projections indicate that they will not be needed, and ensuring nursing facilities diversify their services to reflect the home care trends. This included introducing a Nursing Home Diversification Program, which provided \$40 million of funding through state fiscal year 2017 to nursing homes that are interested in diversifying their services to include home and community-based services.

BED NEED METHODOLOGY

As part of the state's Strategic Rebalancing Plan, the state implemented a bed need methodology that projects need for nursing home beds by labor market. Based on the state's goal of shifting the balance from nursing home care to home community based services, the state projects a surplus of 2,995 beds in 2015, 4,999 beds in 2020 and 7,208 in 2025.

QUALITY ASSESSMENT FEE

Connecticut assesses nursing facilities with a quality assessment fee on non-Medicare days, which is referred to as a resident day user fee. Effective October 1, 2011, the state increased its user fee to \$21.02 per non-Medicare resident day for privately owned nursing facilities with 230 beds or fewer and \$16.13 for non-privately owned nursing facilities or privately owned nursing facilities with greater than 230 beds. The increase in these fees coincides with the termination of the Tax Relief and Health Care Act of 2006 on September 30, 2011. This act reduced the maximum quality assessment fee that states could charge from 6.0% to 5.5% of total revenue. The current user fee equates to 6.0% of total revenue.

Prior to this increase, the user fees were \$19.26 per non-Medicare resident day for privately owned nursing facilities with 230 beds or fewer and \$14.78 for non-privately owned nursing facilities or privately owned nursing facilities with greater than 230 beds. These rates equated to 5.5% of total revenue and were effective July 1, 2011. These rates represent the first increase in the state user fees since July 1, 2005. The user fees effective that date were \$15.90 per non-Medicare resident day for privately owned nursing facilities with 230 beds or fewer and \$12.20 for non-privately owned nursing facilities or privately owned nursing facilities with greater than 230 beds.

Continuing care retirement communities (CCRCs) are exempt from paying the assessment fee. There are currently 16 nursing homes associated with CCRCs and 13 are exempt from the assessment fee under the federal waiver. Under state regulations, nursing facilities are to be reimbursed the Medicaid portion of the applicable resident day user fee as an add-on to their Medicaid rates. However, given budgetary restraints, nursing facilities are currently not receiving any add-ons related to user fee expenses.

MEDICAID RATE CALCULATION SYSTEM

Connecticut utilizes a prospective, cost-based, facility-specific Medicaid rate setting system.

COST CENTERS

The Connecticut rate setting system consists of the following five cost components:

- The Direct Care cost component includes salaries and related fringe benefits for registered nurses, nurse aides and contract nursing.
- The Indirect Care cost component includes all expenses related to dietary, housekeeping and laundry, as well as professional fees and patient care related expenses and supplies.
- The Administration/General cost component includes all expenses related to administration, and maintenance and plant operations.
- The Capital Related cost component includes property taxes, insurance expenses, equipment leases and equipment depreciation.
- The Property cost component utilizes a fair rental value (FRV) allowance in lieu of interest and building depreciation expenses.

INFLATION AND REBASING

Under previous state regulations, Connecticut is required to rebase nursing facility Medicaid rates no more than once every two years and no less than every four years. In addition, the state is permitted to use the most recent cost reports for determining the Property cost component (FRV allowance). This enables facilities to receive additional reimbursement to account for debt service and cost related to major capital improvements. The last official rebasing of nursing facility rates was in July 2005 when the legislature introduced the state's assessment fee. For the rate period effective July 1, 2005, 2003 cost report data was utilized to rebase rates. The state used 2007 cost report data to determine fiscal year 2008 pass-through expenses. However, given that the state has implemented a 0% increase in fiscal year 2008 Medicaid rates, this rebase had no impact.

Connecticut was scheduled to rebase fiscal year 2010 rates utilizing 2007 cost report data. However, given budget limitations, nursing facility rates (including Property cost component rates) were frozen until fiscal year 2012. Rates effective July 1, 2010, were supposed to be calculated utilizing 2007 and 2009 cost report filings. The 2009 data was to be used to determine non-capital costs and 2007 data was to be used to determine capital costs. In addition, unless a nursing facility had written approval by the state (CON approval) for any expansion or renovation, nursing facilities were not being reimbursed for any additional expenses related to property improvements.

Under the past regulations, the state was also required to inflate allowable costs from the midpoint of the cost report year to the midpoint of the rate year utilizing the Regional Consumer Price Index and the projected value of that index (by Global Insight). Reductions to the inflation update have been included in the statute for certain rate periods to promote efficiency and to limit the update to meet necessary cost increases. However, the state is no longer required to utilize any established inflation index. In addition, with limited exceptions, the Connecticut Legislature has ignored the previous rebasing and inflation methodology in the state regulations and has based nursing facility rates on the state's annual appropriations budget. Typically, this is facilitated by inflating the prior year's Medicaid rate by an inflation factor determined by the Connecticut Legislature that coincides with the budget. Rates effective July 1, 2007, were inflated from the previous year by 2.9%. Given budgetary restraints, nursing facility rates were not increased for the fiscal years beginning July 1, 2008, July 1, 2009, and July 1, 2010.

Based on the additional funding generated from increasing the quality assessment fee, the state increased nursing facility non-property rates effective July 1, 2011, by approximately 3.7% in fiscal year 2012. The net effect of this adjustment was an approximate 1.0% overall rate increase. This rate increase did not include a rebasing of costs. In addition, effective July 1, 2012, the state increased nursing facility rates by 0.33%. Also, effective January 1, 2013, the state allocated \$1,000,000 of additional funding to nursing facilities that completed CON approved renovations from 2008 to 2011.

In fiscal year 2014 (effective July 1, 2013) the state rebased allowable costs utilizing 2011 cost report data; however, with the

exception of a limited increase in FRV rates for some facilities, the state froze fiscal year 2014 rates at June 30, 2013, levels. This essentially eliminated the impact of any rebase. In addition, effective September 1, 2013, the state implemented a 0.273% rate reduction.

The state did provide funding (\$10,000,000) over a two-year period for increases in FRV rates for facilities that completed CON-approved renovations. This increase was applied after the overall 0.273% rate reduction. According to Connecticut rate setting professionals, the state has paid out approximately \$1.8 million per year in additional reimbursement for approved renovations. However, with the exception of FRV rate increases, nursing facility rates have essentially been frozen from fiscal year 2015 (effective July 1, 2014) through fiscal year 2017 (effective July 1, 2016). With the exception of slight changes to FRV rates, fiscal year 2018 rates (July 1, 2017) remained unchanged. This also applies to rates effective from July 1, 2018, to October 31, 2018. However, effective November 1, 2018, nursing facilities received a 2.0% rate increase. Nursing facilities were only eligible for this inflation adjustment if they made an equivalent wage increase.

The state's annual rate period is from July 1 to June 30 and the cost report period is from October 1 to September 30. The methodology described below is based on Connecticut state law, but has only been utilized to calculate interim rates since the last actual rebasing (July 1, 2005).

RATE METHODOLOGY

The methodology described below is based on Connecticut state law, but has only been utilized to calculate interim rates since the last rebasing (July 1, 2005). A discussion of interim rates will be provided later in this section. This rate setting methodology will also be utilized if the state rebases Medicaid rates in the future. Based on this methodology, a nursing facility's overall Medicaid rate equates to the sum of its Direct Care, Indirect Care, Administrative/General, Capital Related and Property cost component rates, plus any relevant add-ons.

Connecticut separates nursing facilities by licensing type into two separate peer groups when determining Medicaid rate ceilings. These peer groups are CCNH and RNHS. Per diem costs for the Direct Care, Indirect Care, Administrative/General and Capital Related cost components are determined by dividing total allowable inflated costs by total patient days (adjusted by the occupancy requirement, if applicable). Per diem costs for the Direct Care, Indirect Care and Administrative/General cost components are arrayed by peer groups and median costs are determined. Facility costs, calculated on a per diem basis by category, are limited to maximums established as percentages of median costs for these cost components. The allowable cost maximums for each peer group are 135% (Direct), 115% (Indirect) and 100% (Administrative/General).

Connecticut further separates nursing facilities (by licensing type) by geographic region, when determining the Direct Care allowable cost maximum. Nursing facilities located in Fairfield County typically incur higher labor costs (wages and benefits) than the remainder of the state. Therefore, the Direct Care allowable cost

maximums for facilities located in Fairfield County are calculated separately from the rest of the state. Given that the state has not rebased rates since July 2005, these standards have not significantly increased in several years.

The system provides a rate increase adjustment or “efficiency allowance” to facilities with lower costs in the Indirect and Administrative cost categories. The incentive for both cost components equates to 25% of the difference between the facility’s applicable cost per day and the component’s statewide median cost per day.

Costs included in the Capital Related cost component are direct pass-through expenses (adjusted for occupancy). The Property cost component rate is determined utilizing an FRV methodology. The FRV allowance for a specific nursing facility is calculated by amortizing the base value of the property over its remaining useful life and applying a rate of return (ROR) to the base value. The base value equates to the original acquisition or development cost of the facility and the remaining useful life is estimated utilizing Medicare standards. The ROR is based on the Medicare borrowing rate. The maximum ROR is 11%. Nonprofit facilities receive the lower of their FRV allowance or Medicaid allowable interest and depreciation costs. The adjusted FRV is divided by total resident days (adjusted for the occupancy requirement, if applicable) to calculate the FRV per diem rate.

In a rebasing year, nursing facilities that are not receiving an interim rate are eligible to receive an add-on to their Medicaid rates.

Effective July 1, 2015, the state enacted a wage enhancement incentive program. Approximately \$35.6 million of funding was dedicated to this program, which reimburses nursing facilities based on projected costs related to actual increases in wages for direct service, housing service, laundry service and professional care of residents service staff, as well as increases in benefits and contributions to existing pension plans. These increases were required to be implemented by June 30, 2016. According to rate setting officials, on average this wage enhancement will result in a \$2.91 rate increase per facility. The add-on amounts were determined as a proportion share of total funding based on projected cost. This reimbursement was retrospective in nature and subject to audit by the state.

According to Connecticut rate setting officials, the calculation of the wage incentive add-on was a one-time occurrence. However, in fiscal years 2017 through 2019, nursing facilities continue to be reimbursed their wage incentive add-on calculated effective July 1, 2015.

A nursing facility’s rate increase is limited from year to year. Rates effective July 1, 2007, were limited to a 2.9% increase from the prior year. Rates may exceed the increase limits only to account for additional allowable property costs. However, since a rate freeze was applied to July 1, 2008, July 1, 2009, and July 1, 2010, rates, no maximum rate increase was required. The rate increases for rates beginning July 1, 2011, and July 1, 2012, were limited to the previously mentioned inflation adjustments.

For rates effective July 1, 2007, and July 1, 2008, the average Medicaid rate was \$215.37 per day. For rates effective July 1, 2009, and July 1, 2010, the average rate was \$218.00 per day. The average rates effective July 1, 2011, and July 1, 2012, were \$227.21 and \$224.41, respectively. For fiscal year 2014, the state indicated that July 1, 2013, rates could not be greater than rates effective June 30, 2013. In addition, July 1, 2013, rates could not decrease by more than 1% of June 30, 2013, rates. The average rate effective July 1, 2013, was \$228.00. However, this may not reflect the 0.273% rate decrease effective September 1, 2013. The average rate effective July 1, 2014, was \$227.41, which reflects that rates remained relatively flat. The average rate increased 1.4% to \$230.59 in fiscal year 2016 and then increased 1.0% to \$232.94 in fiscal year 2017. The average rate decreased slightly to \$231.68 effective July 1, 2017, and increased slightly to \$233.07 effective July 1, 2018.

These rates include prospective and interim rates for all facilities. Individual properties paid under the interim rate structure are subject to a settlement process. The settlement process is facility specific and depends on the facts and circumstances specific to each facility that is paid under the interim rate structure.

The Commissioner may grant an interim rate when a facility changes ownership, has a significant change in licensed bed capacity or is in financial distress. In these cases, there is a cost settlement process for the interim rate periods subject to rate setting provisions and any conditions related to the interim rate. In the past, it was typical for the Department to issue 30 to 50 interim rates annually related to major capital projects, ownership changes and hardship situations. However, the state has not issued a “hardship” rate in several years and rate setting officials have indicated that it is unlikely that any hardship rates will be issued in the future.

MINIMUM OCCUPANCY STANDARDS

For rate computation purposes, allowable costs are divided by the higher of reported total resident days for the year or facility occupancy at 90% of licensed capacity. Connecticut decreased the minimum occupancy percentage from 95% to 90% effective July 1, 2013.

OTHER RATE PROVISIONS

For newly constructed nursing facilities, the operator of the facility must submit a budget and a rate request to the Commissioner, which is utilized to determine the facility’s interim Medicaid rate. However, after the facility has maintained a stabilized occupancy level (95%) for a 12-month period, the facility’s Medicaid rate is recalculated based on cost report data for this period. If a nursing facility’s costs are below the interim rate, the facility must reimburse the state for any overage payments made to the facility. However, given the moratorium on the development of new nursing facility beds in Connecticut, industry consultants indicate that there have not been any new nursing facilities developed in the state in recent years.

If a nursing facility changes ownership, the new owner can request a rebased rate for the facility. However, the Commissioner

can deny the request. Any rate established will be considered an interim rate. In addition, after the accumulation of 24 months of cost data, a cost settlement is completed. If a nursing facility's costs are below the interim rate, the facility must reimburse the state for any overage payments made to the facility.

Typically, the settlement process for nursing facilities that have to reimburse the state for overage fees can range from a one-time payment to a payment plan that extends over a 12-month period.

Nursing facilities in Connecticut are eligible to be reimbursed by Medicaid for holding a bed for a resident that requires hospitalization or therapeutic leave. The nursing facility is reimbursed 100% of its current per diem rate under both scenarios. Bed hold for hospitalization is reimbursed a maximum of 15 days per hospitalization, provided that the nursing facility documents that it has a vacancy rate of no more than three beds or 3% of licensed capacity (whichever is greater) at the time of the absence. Bed hold reimbursement for therapeutic leave is limited to a maximum of 21 days per calendar year, provided that the nursing facility

documents that it has a vacancy rate of not more than four beds or 4% of licensed capacity (whichever is greater) at the time of the absence.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

The Connecticut Department of Social Services will be transitioning Medicaid nursing facility reimbursement from a cost-based methodology to a prospective acuity-based or case mix payment system. However, the state is waiting for the implementation of Medicare's new Patient Driven Patient Model (PDPM) system on October 1, 2019, before designing the new methodology. According to State Rate Setting Representatives, the state most likely will not implement a new system until 2020.

CONNECTICUT COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	76.00	86.50	75.50		120.00	120.00	120.00		144.00	144.00	144.00
Average Daily Census	77.17	72.38	70.76		105.23	102.83	102.03		126.84	125.83	124.06
Occupancy	86.2%	83.4%	80.4%		90.5%	89.4%	89.6%		93.8%	93.6%	94.0%
Payor Mix Statistics											
Medicare	8.5%	7.5%	7.1%		11.5%	10.5%	10.0%		16.9%	15.5%	13.6%
Medicaid	62.6%	60.9%	63.4%		71.3%	71.5%	73.0%		79.5%	80.1%	80.7%
Other	10.9%	11.4%	10.3%		17.1%	17.6%	16.6%		24.9%	24.6%	24.6%
Avg. Length of Stay Statistics (Days)											
Medicare	26.13	24.88	23.86		33.53	32.21	31.42		43.65	40.92	41.79
Medicaid	300.97	331.07	306.07		447.75	460.92	447.52		680.96	667.14	669.33
Other	47.13	47.26	47.09		78.98	70.23	72.14		145.34	134.56	125.36
Revenue (PPD)											
Inpatient	\$296.49	\$310.10	\$305.47		\$388.76	\$392.67	\$404.43		\$439.41	\$449.01	\$464.64
Ancillary	\$32.69	\$36.23	\$32.35		\$53.23	\$54.22	\$50.74		\$79.91	\$79.46	\$75.84
TOTAL	\$351.32	\$367.29	\$362.10		\$443.40	\$454.97	\$461.73		\$515.87	\$523.23	\$539.03
Expenses (PPD)											
Employee Benefits	\$30.16	\$31.31	\$31.69		\$38.78	\$39.27	\$40.15		\$48.30	\$48.41	\$51.87
Administrative and General	\$47.74	\$49.06	\$49.11		\$51.94	\$53.54	\$53.85		\$56.97	\$60.15	\$63.09
Plant Operations	\$11.43	\$11.10	\$11.49		\$14.03	\$14.07	\$14.33		\$17.65	\$17.09	\$17.46
Laundry & Linens	\$3.15	\$3.17	\$3.25		\$3.95	\$4.14	\$4.10		\$5.14	\$5.38	\$5.23
Housekeeping	\$6.35	\$6.60	\$6.80		\$7.69	\$7.84	\$7.98		\$9.39	\$9.78	\$9.68
Dietary	\$18.25	\$18.67	\$18.89		\$20.33	\$20.98	\$21.17		\$23.65	\$24.83	\$24.85
Nursing & Medical Related	\$100.86	\$104.72	\$103.53		\$108.86	\$112.35	\$112.37		\$121.19	\$121.63	\$123.95
Ancillary and Pharmacy	\$21.29	\$22.32	\$21.39		\$29.20	\$29.28	\$28.03		\$38.68	\$38.46	\$36.59
Social Services	\$2.65	\$2.63	\$2.59		\$3.58	\$3.52	\$3.56		\$4.50	\$4.50	\$4.55

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Delaware



INTRODUCTION

Nursing facilities are licensed by the Delaware Division of Health and Social Services under the designation of "Nursing Home." Nursing homes can be licensed as skilled, intermediate, or a combination of both. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN DELAWARE	
Licensed Nursing Facilities*	40
Licensed Nursing Beds*	4,250
Beds per 1,000 Aged 65 >**	24.37
Beds per 1,000 Aged 75 >**	61.75
Occupancy Percentage - 2017*	89.70%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Certificate of Need (CON) program was replaced with the Certificate of Public Review program in June 1999. The review program is managed by the Delaware Health Resources Board (the Board).

A certificate of public review is required for the following:

- The construction, development or other establishment of a healthcare facility or the acquisition of a nonprofit healthcare facility.
- Any capital expenditure in excess of \$5,800,000 (the Board may exempt from review capital expenditures when determined to be necessary for maintaining the physical structure of a facility and not related to direct patient care).
- A change in bed capacity of a healthcare facility that increases the total number of beds by more than 10 beds or more than 10% of total licensed bed capacity, whichever is less, over a two-year period.
- The acquisition of major medical equipment.

BED NEED METHODOLOGY

The state annually completes a bed need methodology based on a three-step process that determines the threshold that must be met for a Certificate of Public Review to be granted for additional nursing beds.

The first step in this process is calculating the base year average daily census (ADC) for the counties of Kent, Sussex and New Castle, which are used as planning areas. This is determined by dividing the base year total patient days by 365. The projected ADC is then calculated by multiplying the base year ADC by a population change factor (PCF). The PCF is the weighted average of the projected population change in the age 64 and younger, age 65 to 74, age 75 to 84, and age 85 and older cohorts. In each age cohort, the population growth rate is weighted by the percentage of admissions. The result of this weighted average calculation is the PCF. However, if the ADC in the base year is less than the ADC in the previous year, and the percentage of occupancy in private nursing homes is less than 95%, then the PCF will be equal to 1.0. If the PCF is less than 1.0, the lesser factor is used. The final step is to divide the projected ADC by 0.90 (the occupancy factor), which equates to the projected bed need. Based on the most recent bed need

methodology completed by the state effective July 2013, there will be a shortage of 438 beds in 2018. The Board may adjust the projection upward or downward by no more than 10% when it is concluded that the formula is overestimating or underestimating bed need. There are currently no proposed changes to the bed need methodology. However, an oversupply (55 beds) is projected for Kent County, while surpluses of 217 and 276 beds are projected for New Castle and Sussex counties, respectively.

The Board may adjust the projection upward or downward by no more than 10% when it is concluded that the formula is overestimating or underestimating bed need. There are currently no proposed changes to the bed need methodology.

QUALITY ASSURANCE FEE

The Centers for Medicare and Medicaid (CMS) recently approved a quality assessment fee (QAF) that is effective June 1, 2012. Facilities exempt from paying the QAF are government owned facilities, nursing facilities that exclusively serve children, nursing facilities with 46 beds or less and nursing facilities within continuing care retirement communities (CCRC). For a nursing facility within a CCRC to be exempt from paying the QAF, the CCRC must possess twice as many assisted living beds as nursing facility beds.

The initial QAF for the non-exempt facilities was \$8.35 per non-Medicaid day for nursing facilities with 45,000 or greater Medicaid patient days and \$15.19 per non-Medicare day for nursing facilities with less than 45,000 patient days. Effective June 1, 2013, the QAFs were changed to \$8.56 for facilities with more than 44,000 Medicaid days and \$16.15 for all other non-exempt facilities. Effective June 1, 2014, the QAFs were changed to \$10.11 for facilities with more than 44,000 Medicaid days and \$19.07 for all other non-exempt facilities. The current QAFs (effective June 30, 2015) are \$13.65 for facilities with more than 44,000 Medicaid days and \$25.76 for all other non-exempt facilities.

The state utilizes the funding generated from the QAF to provide additional Medicaid reimbursement for all nursing facilities in the state. Effective July 1, 2012, exempt nursing facilities received a \$26.00 per Medicaid day add-on, nursing facilities that were charged the \$8.35 QAF received a \$34.35 per Medicaid day add-on and nursing facilities that were charged the \$15.19 QAF received a \$41.19 per Medicaid day add-on.

However, effective June 1 2013, the state changed the reimbursement methodology to conform to CMS' methodology. The rate add-on for the QAF is now determined by first calculating the Medicaid share of each nursing facility. The Medicaid share of the QAF for each provider is determined by taking the total QAF estimate for the year for each provider multiplied by the ratio of Medicaid days to total days from the historical cost report year used in establishing the assessment rates. Most of the remaining available funds generated from the QAF and the federal match (net of the funding required for the first part of this calculation) are allocated as an equal per diem times Medicaid days of each facility again using the historical period. A small portion of the remainder is allocated to reimburse Medicaid hospice days.

A nursing facility's total add-on is a combination of the Medicaid

share of the assessment, the equal per diem multiplied by historical Medicaid days and the hospice add-on multiplied by historical Medicaid hospice days. The add-on varies for the majority of the facilities

Effective June 1, 2015, the add-on for exempt, non-public facilities is \$34.75. The add-ons for all other facilities (including public facilities) range from \$45.25 to \$60.51.

MEDICAID RATE CALCULATION SYSTEM

Delaware's existing nursing facility Medicaid rate is prospective, facility-specific and adjusted for case mix. Effective April 1, 2012, Delaware converted its Medicaid reimbursement system to a managed care model. The program is known as Diamond State Health Plans. Under the system, the state makes monthly capitation payments to health plans responsible for providing and coordinating services to the aged and disabled population, including long-term care. Long-term care providers are, in turn, reimbursed by the two health plans, Highmark Health Options and United Health Community Plan. For the first three years after implementation of this program, the MCOs are required to reimburse nursing facilities at fee-for-service rates determined by the state. After the conclusion of this three-year period, the MCOs were supposed to have the authority to negotiate rates with nursing facilities. However, as of the current rate period (rates effective June 1, 2015, to May 31, 2016) nursing facilities are still be reimbursed their fee-for-service rates. It is currently unclear if this will continue in future rate periods.

COST CENTERS

The per diem rate is comprised of the following five rate components:

- **The Primary Patient Care** cost component includes costs associated within the provision of basic nursing care for nursing home patients and is inclusive of nursing staff salaries, fringe benefits and training costs.
- **The Secondary Patient Care** cost component includes costs associated with other patient care costs that directly affect patient health status and quality of care and is inclusive of clinical consultants, social services, raw food, medical supplies and nonprescription drugs, dietitian services, dental services (in public facilities only) and activities personnel.
- **The Support Services** cost component includes costs for departments that provide supportive services other than medical care and is inclusive of dietary, operation and maintenance of the facility, housekeeping, laundry and linen, and patient recreation.
- **The Administrative** cost component includes costs that are not patient related and is inclusive of owner/administrator salary, medical and nursing director salary (excluding such time spent in direct patient care), administrative salaries, medical records, working capital, benefits associated with administrative personnel, home office expenses, management of resident personal funds, and monitoring and resolving patient's rights issues.
- **The Capital** cost component includes costs associated with the purchase and lease of property, plant and equipment and is inclusive of lease costs, mortgage interest, property taxes

and depreciation.

INFLATION AND REBASING

The state fiscal year for Delaware is from July 1 to June 30. The rate year for privately owned nursing facilities is from January 1 to December 31, and the rate year for state-owned nursing facilities is from October 1 to September 30. The Primary Patient Care cost component is rebased every year based on the preceding year's cost reports. The ceilings for Secondary Patient Care, Support Services, Administrative and Capital cost components are rebased every four years and inflated by the CMS Total Skilled Nursing Facility Market Basket Index for interim years. All of the ceilings were rebased effective January 1, 2008. A facility's prior year cost reports are tested against the ceilings and adjusted on a year-to-year basis. The state initially rebased rates effective January 1, 2009, based on cost report data for the period ending June 30, 2008, and a wage survey completed in May 2008. However, given budgetary issues, the state repealed the rebase and inflation adjustment on April 1, 2009. Nursing facility Medicaid rates have been frozen at rates effective January 1, 2008, since this date.

When the state passed its QAF, it was determined that the additional funding generated from the QAF would be reimbursed to nursing facilities as a rate add-on. Given this factor, nursing facility cost component rates remained frozen at rates effective January 1, 2008, and will remain frozen until at least May 31, 2016. It is currently unclear if the state will rebase rates. The following section is a summary of how the state would calculate cost component rates in an unfrozen rebasing year.

RATE METHODOLOGY

The Primary Patient Care cost component is based on a patient index system. Currently, there are eight patient care classifications, each of which has a corresponding rate associated with the Primary Patient Care cost component. A patient is initially classified through the state's pre-admission screening program. Nurses employed by Delaware Health and Social Services, Division of Medicaid and Medical Assistance (the Department) review the patient's classification within 31 to 45 days of the initial assignment. Twice a year, the Department reviews the patient's classification and informs the nursing facility of any changes. The classification is based on an evaluation and scoring system performed by a Medicaid review nurse. Within each of the patient classifications for the Primary Patient Care rate, there are three potential add-ons.

The first add-on is for rehabilitation, which is equal to an additional 20% of the Primary Patient Care rate component. To be considered for the added reimbursement, a facility must develop and prepare an individual rehabilitative/preventive care plan. The second add-on is for psychosocial, which is equal to an additional 10% of the Primary Patient Care cost component. The specific psychosocial behaviors considered for the added reimbursement are those needing additional nursing staff intervention in the provision of personal and nursing care, for behaviors such as verbal and physically disruptive actions, inappropriate social behavior, non-territorial wandering or other similar problems as designated by the Department. The third is a combination of the

rehabilitation and psychosocial add-ons. This adjustment equates to a 20% increase of the Primary Patient Care rate for rehabilitation and an additional 10% of this adjusted rate for psychosocial.

The rates for each classification for the Primary Patient Care cost component are established in three groups: Group A: Private facilities in New Castle County; Group B: Private facilities in Kent and Sussex counties; Group C: Public facilities. The Primary Patient Care component rates are the same for each facility within a group. These rates are calculated by multiplying the 75th percentile hourly wage rates of RNs, LPNs and aides by standard nursing time factors for each base level of acuity. The hourly wage rates are established based upon the reported wages and hours in the cost reports for RNs, LPNs and aides within a peer group, which are adjusted for training and fringe benefits.

The Medicaid per diem rate is calculated by adding the Primary Patient Care rate (for which a patient qualifies) to the facility's basic rate component. The basic rate component is the sum of a facility's Secondary Patient Care, Support Services, Administrative and Capital costs payments, and is specific to each facility. Given that there are eight potential Primary Patient Care levels and three add-ons, there are 32 possible rate combinations in the state.

Secondary Patient Care per diem rates are reimbursed at the lower of a facility's cost or a ceiling of 115% of median per diem costs for each category of facility.

The ceiling for the Support Services cost component is set at 110% of median support costs per day for the appropriate category of facility; maintaining costs below this ceiling results in an incentive

payment of 25% of the difference between the facility's actual per day cost and the applicable ceiling, up to a maximum incentive of 5% of the ceiling amount.

The ceiling for the Administrative cost component is set at 105% of median costs per day for the appropriate category of facility. Facilities are entitled to an incentive payment of 50% of the difference between actual costs and the ceiling, limited to 10% of the ceiling amount.

The Capital cost component per diem rate is calculated on a statewide basis and is subject to a rate floor and rate ceiling. The

dollar amounts representing the 20th percentile of actual per diem capital cost (floor) and the 80th percentile of actual per diem capital cost (ceiling) are calculated. The facility's prospective rate is equal to its actual cost when the facility's costs are greater than or equal to the floor, and less than or equal to the ceiling. The prospective rate is equal to the lower of the floor or 125% of actual cost when the facility's costs are below the floor. The prospective rate is equal to the higher of the ceiling or 95% of actual cost when the facility's costs are greater than the ceiling.

MINIMUM OCCUPANCY STANDARDS

The patient days used to determine the per diem rates for the four non-primary components are subject to a minimum occupancy standard, which, for established facilities, equates to the lesser of actual patient days, or 90% of the facility's total available patient days, whichever is greater. The patient day amount for new facilities equals actual patient days for the period of operation, or estimated days based on a 75% occupancy standard, whichever is greater.

OTHER RATE PROVISIONS

Medicaid reimbursement for bed hold days is available for no more than seven days within any 30-day period, provided the nursing facility agrees to hold the bed for the resident. The nursing facility is reimbursed the Medicaid rate that the facility received for the patient prior to hospitalization. When a patient is hospitalized longer than seven days, the facility may ask the family to pay privately to hold the bed. Upon property transfers, the capital asset value that is used in the determination of the Capital cost component is not to increase by more than the lesser of one-half of the percentage increase in the Dodge Construction Index or in the Consumer Price Index for All Urban Consumers applied in the aggregate of the capital asset value that was measured at the time of the seller's acquisition to the current date of transfer.

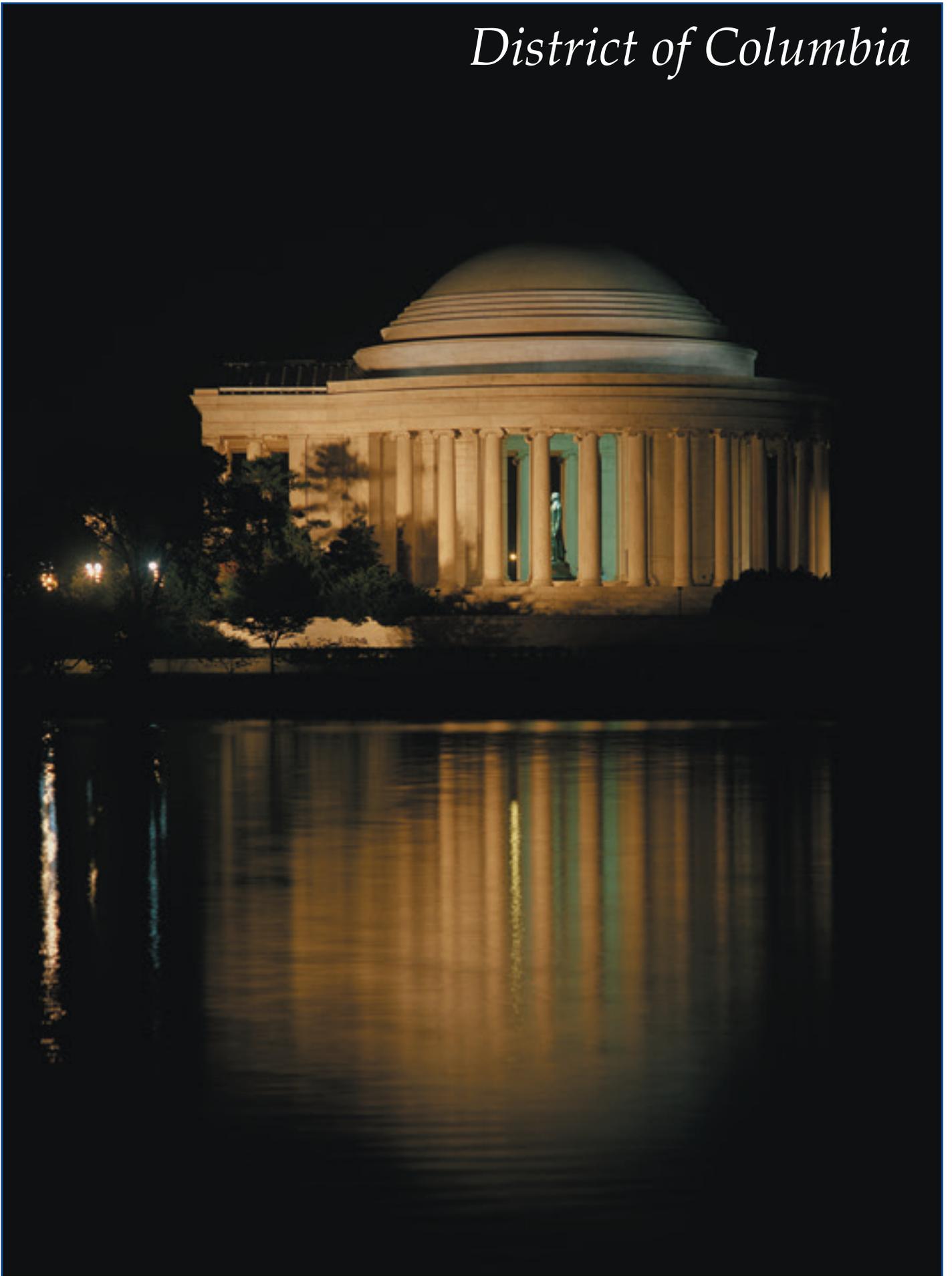
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is no current or proposed legislation that would affect the Medicaid rate calculation in Delaware.

DELAWARE COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	91.50	90.00	96.00		115.00	110.00	120.00		137.50	136.00	138.00
Average Daily Census	94.69	96.78	96.73		113.67	114.19	111.71		138.85	129.83	141.67
Occupancy	85.7%	87.0%	86.3%		90.4%	90.6%	90.7%		92.8%	93.1%	94.5%
Payor Mix Statistics											
Medicare	9.7%	9.4%	7.3%		15.2%	14.8%	13.8%		22.0%	22.1%	21.5%
Medicaid	53.5%	49.6%	50.3%		66.8%	64.9%	65.9%		75.6%	72.3%	76.0%
Other	10.4%	10.5%	10.5%		15.2%	16.6%	16.7%		38.8%	66.7%	51.3%
Avg. Length of Stay Statistics (Days)											
Medicare	26.43	26.54	27.89		31.16	34.35	32.43		38.23	40.74	38.10
Medicaid	257.95	268.73	283.07		422.71	473.50	534.29		677.45	603.74	673.59
Other	45.57	53.95	50.78		80.68	80.78	68.94		177.69	396.53	229.00
Revenue (PPD)											
Inpatient	\$258.83	\$274.68	\$299.32		\$305.80	\$324.40	\$324.70		\$344.76	\$355.01	\$375.22
Ancillary	\$49.17	\$44.30	\$47.19		\$73.80	\$61.86	\$59.05		\$96.95	\$117.00	\$125.06
TOTAL	\$329.72	\$340.39	\$342.69		\$414.88	\$420.34	\$433.38		\$493.38	\$523.44	\$569.29
Expenses (PPD)											
Employee Benefits	\$20.12	\$21.07	\$18.89		\$25.33	\$29.16	\$23.09		\$43.74	\$45.83	\$44.78
Administrative and General	\$42.37	\$49.20	\$49.68		\$53.67	\$61.63	\$63.41		\$60.56	\$68.67	\$71.14
Plant Operations	\$10.56	\$10.43	\$11.07		\$12.68	\$12.40	\$12.23		\$17.84	\$19.13	\$19.01
Laundry & Linens	\$2.15	\$1.71	\$1.85		\$3.17	\$3.24	\$3.41		\$4.09	\$4.67	\$4.82
Housekeeping	\$5.31	\$5.37	\$5.16		\$6.23	\$6.13	\$6.71		\$8.42	\$8.51	\$8.34
Dietary	\$16.96	\$17.60	\$18.03		\$19.23	\$20.07	\$19.99		\$23.81	\$24.41	\$24.87
Nursing & Medical Related	\$98.01	\$98.81	\$101.04		\$107.74	\$105.29	\$111.80		\$121.51	\$124.58	\$124.05
Ancillary and Pharmacy	\$25.70	\$22.46	\$23.62		\$36.18	\$34.43	\$34.08		\$43.48	\$46.39	\$47.39
Social Services	\$1.66	\$1.58	\$1.67		\$2.63	\$3.01	\$3.30		\$4.09	\$4.00	\$4.28
Comments: The fluctuations in ALOS and Payor Mix Statistics reflect the limited number of nursing facilities in Delaware.											

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

District of Columbia



INTRODUCTION

Nursing facilities in the District of Columbia (D.C.) are licensed by the Health Care Facilities Division of the Health Regulation Administration under the designation of “Nursing Homes.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN DC	
Licensed Nursing Facilities*	13
Licensed Nursing Beds*	2,062
Beds per 1,000 Aged 65 >**	24.07
Beds per 1,000 Aged 75 >**	59.01
Occupancy Percentage - 2017*	91.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

A Certificate of Need (CON) is required in D.C. for the following:

- The construction, development or establishment of a new nursing facility.
- A capital expenditure exceeding \$2,500,000.
- A capital expenditure in excess of \$1,500,000 for the acquisition of major medical equipment.
- The relocation of beds from one facility to another.
- Redistribute the beds of a health care facility by ten beds or ten percent, whichever is less, in any two-year period.
- The offering of any health service that was not offered on a regular basis by the healthcare facility within the previous 12-month period.
- The acquisition of an existing nursing facility by purchase, lease, or other arrangement.

There is currently no moratorium on the construction of new nursing homes or proposed changes to the CON process in D.C.

BED NEED METHODOLOGY

There is currently no bed need methodology for nursing home beds in D.C.

QUALITY ASSESSMENT FEE

The quality assessment fee (QAF) is a fee collected from each D.C. nursing facility by the District Office of Tax and Revenue. The proceeds of the fee are placed into a Nursing Facility Quality of Care Fund, which was established in 2005 and provides additional services and support for nursing facilities. The current QAF for fiscal year 2019 (effective October 1, 2018) is \$5,925.99 per licensed bed annually. The previous QAFs for fiscal years 18, 17, 16, 15 and 14 were \$5,575.88, \$5,348.16, \$5,506.19, \$5,752.63 and \$5,473.93, respectively. Nursing facilities are not reimbursed for QAF fees as part of their Medicaid rates or as supplemental payments.

MEDICAID RATE CALCULATION SYSTEM

Effective February 1, 2018, D.C. converted to a prospective, cost-and price-based, case mix adjusted resident-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. Each facility receives a specific RUG rate (utilizing

the RUG IV, 48 RUG Grouper) per resident. The RUG rate for a resident only changes based on a change in medical condition. Prior to this system, D.C. utilized a prospective, cost-based, facility-specific rate system that adjusted rates semiannually for case mix index (CMI).

COST CENTERS

D.C. utilizes the following three cost centers to calculate its resident-specific Medicaid rates:

- The Nursing and Resident Care cost component is a peer group specific price that includes costs associated with nursing services, non-prescription drugs and pharmacy consultant services, medical supplies, laboratory services, radiology services, physical, speech and occupational therapy services provided to Medicaid beneficiaries, respiratory therapy services, behavior health services and oxygen therapy. This price is adjusted for the specific CMI associated with the resident’s applicable RUG category
- The Routine and Support cost component is a peer group specific price that includes costs associated with dietary and nutrition services (including raw food), laundry and linen services, housekeeping, plant and operations, volunteer services, administrative and general salaries, professional services – non-healthcare related, non-capital related insurance, travel and entertainment, general and administrative, medical director and related clerical costs, non-capital related interest expense, social services, resident activities, staff development, medical records, routine personal hygiene items and services, and central supplies.
- The Capital cost component includes cost associated with equipment rental, depreciation and amortization, interest on capital debt, facility rental, real estate taxes and capital related insurance, property insurance, and other capital-related expenses. This rate is facility specific.

INFLATION AND REBASING

Prior to February 1, 2018, facility-specific Nursing and Resident Care cost component rates were recalculated every six months to adjust for the nursing facility’s case mix index (CMI). The rate year in D.C. was from October 1 to September 30. The District was required to rebase Medicaid rates every three years. However, DC often experienced delays in rebasing rates. Rates were also adjusted for inflation based on CMS’ Prospective Payment System Skilled Nursing Facility Input Price Index.

RATE METHODOLOGY

Both the Nursing and Resident Care and Routine and Support Services cost components consist of determining peer group specific prices and floors for both components. The Nursing and Resident Care price is adjusted for CMI based on the resident’s RUG category. DC places facilities in one of three peer groups as follows:

- Peer Group One: All freestanding nursing facilities with more than 75 Medicaid certified beds;
- Peer Group Two: All freestanding nursing facilities with 75 or less Medicaid certified beds; and
- Peer Group Three: All hospital-based nursing facilities.

District of Columbia

The first step in determining these two prices is to determine the facility-specific per diem cost per cost component. The facility's allowable costs for each cost component (Nursing & Resident Care and Routine & Support Services) is divided by the greater of the facility's total occupied paid bed days (including paid reserve bed days) or 93.0% of certified total facility beds days available during the cost reporting period. In addition, each facility's Nursing and Resident Care per diem will be case-mix neutralized by dividing it by the total facility CMI. For rates determined February 1, 2018, the total facility CMI is the average facility-wide CMI for the three calendar quarters beginning January 1, 2015 to September 30, 2015.

The facility-specific costs are then arrayed by cost component and peer group and median costs are determined. The Nursing and Resident Care median per peer group is then multiplied by an adjustment factor to equate to the adjusted price. The facility per peer group is as follows: Peer Group 1 – 1.035, Peer Group II – 1.300 and Peer Group III - 1.540. The peer group Routine and Support Services prices are calculated utilizing the same methodology. However, the adjustment factors for the Routine and Support Services prices are as follows: Peer Group 1 – 1.020, Peer Group 2 – 1.240 and Peer Group 3 – 1.150. The floor for both prices equates to 91.0% of the equivalent peer group median.

After the peer group Nursing and Resident Care prices are determined, these prices are multiplied by the resident-specific CMI to calculate the resident-specific Nursing and Resident care rate. The resident specific CMI is determined by categorizing residents into the appropriate RUG IV, 48 RUG Grouper category.

Facility-specific capital rates are determined by calculating allowable capital expenses by the greater of the facility's total occupied paid bed days (including paid reserve bed days) or 93.0% of certified total facility beds days available during the cost reporting period.

The facility's peer group Routine and Support price, facility-specific Capital rate are added to the resident-specific Nursing and Resident Care rate to determine each facility's resident-specific rate.

In addition to these rates, DC will pay additional add-ons for residents that require Ventilator, Behaviorally Complex care and Bariatric care.

Effective February 1, 2018, DC also implemented a Quality Improvement Program (QIP). Participating in reporting quality data is mandatory for all facilities in the District. However,

participation in the QIP is optional. As part of this program, the District will establish performance guidelines for facilities. Reimbursement for the program will begin in fiscal year 2020 (effective October 1, 2019) and will be based on performance data for the period of October 1, 2018 to September 30, 2019. Facilities will potentially receive performance payments if they attain a performance score at or above the 75th percentile for nursing facilities or display improvement from prior performance evaluations. The District will calculate and distribute performance payments based on available funds from the Nursing Quality of Care Fund.

MINIMUM OCCUPANCY STANDARDS

The total resident days utilized to determine the facility-specific per diem rates for each cost category is the greater of the nursing facility's actual paid resident days (including paid reserve bed days) or 93% of total available resident days.

OTHER RATE PROVISIONS

A new provider's reimbursement rate for the Routine and Support Component cost component is the related Peer Group day-weighted median. The reimbursement rate for Nursing and Resident Care cost component per diem is the related peer group day-weighted case mix neutralized median. The Capital cost component per diem equates to the greater of the base year day-weighted average per diem for facilities in the assigned peer group, or the median capital rate for the peer group

A nursing facility with a change of ownership on or after a specific date determined by the District is reimbursed at the same rate established for the nursing facility prior to the change of ownership, except the capital per diem will be the greater of the base year day-weighted average per diem of facilities in the assigned peer group or the capital rate for the nursing facility prior to the change of ownership.

Bed hold days for hospitalization and therapeutic leave may not exceed 18 days during any 12-month period beginning on October 1 and ending on September 30. Payment for bed hold days is 100% of the facility's per diem.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, there are no significant changes planned to the state's Medicaid rate calculation methodology.

DISTRICT OF COLUMBIA COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2015	2016	2017	2015	2016	2017	2015	2016	2017	
Number of Beds	60.00	69.75	60.00	164.00	172.00	164.00	230.00	237.25	230.00	
Average Daily Census	107.13	142.39	108.06	169.96	173.13	172.82	224.02	225.41	215.27	
Occupancy	89.3%	90.6%	89.3%	90.2%	92.9%	92.8%	92.8%	94.8%	94.4%	
Payor Mix Statistics										
Medicare	6.0%	6.7%	6.2%	7.2%	7.8%	8.9%	7.9%	10.5%	11.9%	
Medicaid	20.4%	26.9%	10.8%	81.8%	84.9%	53.5%	87.0%	85.8%	85.2%	
Other	75.6%	52.3%	72.0%	92.1%	89.9%	88.1%	92.8%	93.0%	91.1%	
Avg. Length of Stay Statistics (Days)										
Medicare	35.22	34.47	35.90	45.71	51.14	46.58	51.83	63.42	58.28	
Medicaid	303.63	241.67	574.88	312.00	307.93	643.92	662.20	581.11	906.84	
Other	223.63	218.03	357.67	732.30	727.16	728.86	2376.67	1609.18	1183.00	
Revenue (PPD)										
Inpatient	\$250.74	\$265.55	\$282.97	\$277.01	\$317.23	\$327.52	\$350.02	\$379.55	\$371.52	
Ancillary	\$28.41	\$26.96	\$24.69	\$37.03	\$41.03	\$33.23	\$43.50	\$44.74	\$45.72	
TOTAL	\$292.28	\$308.22	\$326.03	\$299.97	\$342.24	\$352.16	\$387.04	\$422.23	\$422.96	
Expenses (PPD)										
Employee Benefits	\$3.72	\$6.89	\$5.38	\$16.24	\$12.49	\$17.03	\$25.01	\$24.33	\$27.60	
Administrative and General	\$46.95	\$47.04	\$45.68	\$59.88	\$50.54	\$55.56	\$66.92	\$66.18	\$80.71	
Plant Operations	\$13.03	\$12.83	\$12.99	\$17.34	\$17.18	\$19.20	\$29.72	\$28.99	\$30.37	
Laundry & Linens	\$2.06	\$2.22	\$2.86	\$4.10	\$4.65	\$4.81	\$4.58	\$5.04	\$5.18	
Housekeeping	\$7.34	\$7.10	\$7.85	\$9.27	\$8.51	\$9.40	\$14.09	\$11.42	\$13.90	
Dietary	\$19.17	\$18.99	\$20.06	\$21.92	\$22.68	\$23.87	\$40.18	\$31.80	\$38.51	
Nursing & Medical Related	\$96.85	\$101.16	\$106.01	\$104.44	\$105.04	\$125.05	\$129.54	\$131.90	\$143.59	
Ancillary and Pharmacy	\$16.91	\$16.47	\$17.64	\$20.88	\$19.46	\$19.67	\$24.14	\$23.85	\$26.26	
Social Services	\$2.93	\$2.44	\$2.76	\$3.49	\$2.88	\$3.98	\$8.66	\$8.27	\$9.69	
Comments: The above data may be moderately skewed, given that the average sample size over the three-year period is approximately 14 nursing facilities.										

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Florida



INTRODUCTION

Nursing facilities in Florida are licensed by the Agency for Health Care Administration (AHCA) under the designation of "Long-Term Care Services." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN FLORIDA	
Licensed Nursing Facilities*	677
Licensed Nursing Beds*	81,915
Beds per 1,000 Aged 65 >**	18.93
Beds per 1,000 Aged 75 >**	43.62
Occupancy Percentage - 2017*	86.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Certificate of Need (CON) process was enacted in Florida in 1973. CONs for nursing homes in Florida are allocated based on a need determination calculation projected ahead over a three-year horizon within a given district or subdistrict and are assessed twice a year. There are 11 districts in the state, each of which may contain multiple subdistricts/counties.

In Florida, all healthcare related projects, unless otherwise exempt, must obtain a CON for:

- The addition of nursing facility beds, by new construction or alteration.
- The new construction or establishment of additional nursing facilities or a replacement healthcare facility when the replacement facility is not located on the same site or within one mile of the existing facility.
- An increase in the number of beds for comprehensive rehabilitation.

In 2000, the Florida Legislature placed a moratorium on the issuance of CONs for additional nursing facility beds from July 1, 2006, to July 1, 2011. In 2006, the Legislature extended the moratorium until July 1, 2011.

The moratorium was extended legislatively until Medicaid managed care is fully implemented statewide or October 1, 2016, whichever was sooner. The managed care system was implemented on a regional basis, with the first region enrolling on August 1, 2013. The remaining three regions were implemented on March 1, 2014. Based on this factor, the Florida House of Representatives recently approved House Bill 287, which temporarily eliminated the moratorium on issuance of CONs for additional nursing facility beds effective July 1, 2014.

In addition, the bill resulted in the following significant changes to the State's CON policy:

- The legislation provided AHCA with the authorization to issue CONs for the construction of a total of 3,750 new nursing home beds from July 1, 2014, to June 30, 2017.
- Created an exemption from nursing home CON review for a nursing home that is adding up to 30 beds or 25% of the number of beds in the facility being replaced, whichever is lower.

This legislation resulted in the state resuming the calculation of nursing home bed need, which has been suspended since July 1, 2001. This also included establishing a positive CON application factor for an applicant in a subdistrict where bed need has been determined to exist.

All of the allowed 3,750 new beds were awarded to nursing facilities by the end of 2015. In addition, the time period in which new beds would be approved has since ended (July 1, 2014, to June 30, 2017). However, effective July 1, 2017, the state decided to eliminate the moratorium and will use a semi-annual batch cycle methodology to determine if the state will allow the development of any new beds.

The most recent Batch Cycle report was issued on March 29, 2019. The state determined that there was unmet demand within 11 sub-districts and a total demand for 499 new beds in the state. Nursing home operators had until April 15, 2019 to submit a letter of intent and until May 15, 2019 to submit an application for the development of new nursing home beds.

The state will make a decision on these applications by August 16, 2019. It is unclear when the state is scheduled to issue its next Batch Cycling Report. The bed need methodology that the state utilizes to determine unmet demand will be detailed further in the next section of this overview.

BED NEED METHODOLOGY

The bed need calculation is projected over a three-year horizon within a given district or subdistrict and was initially supposed to be assessed twice a year (January 1 and July 1). However, given that the state has had a moratorium on the issuance of CONs for nursing home beds since July 1, 2001, AHCA had not published need for nursing home beds for several years since that date. However, with the end of the moratorium on July 1, 2014, the state resumed the calculation of nursing home bed need.

The bed need calculation is projected over a three-year horizon within a given district or subdistrict and is assessed twice a year (January 1 and July 1). The first step in the bed need methodology is to multiply the district's projection of the area's 65 to 74 and 75-plus populations by its corresponding estimated bed rates. These two figures are combined to project the district's gross bed need. The estimated bed rate for the 65 to 74 population is determined by dividing the total number of licensed nursing home beds in the area by the sum of the district's current 65 to 74 population and six times the 75-plus population. The district's estimated bed rate for the 75-plus population is six times the estimated 65 to 74 population.

The projected district gross bed need total is then allocated to its subdistricts. The allocation of nursing home beds for a subdistrict is determined by multiplying the figure resulting from the district's need assessment by the ratio of the number of licensed nursing home beds within the subdistrict to the total number within the district and by the ratio of the average six-month subdistrict occupancy rate for all licensed nursing homes divided by 92%. The net nursing home bed need for a subdistrict is calculated by subtracting the number of existing licensed nursing

beds and approved beds within a subdistrict from the gross bed need estimate.

If the average occupancy of all licensed nursing homes within a subdistrict is under 85%, then the net bed need is automatically zero, and no CONs will be issued within that subdistrict.

The state recently determined nursing home bed need effective March 29, 2019. The state concluded that there was unmet demand in 11 sub-districts and total unmet demand for 499 beds in the state.

QUALITY ASSURANCE FEE

In late January 2009, the governor signed a bill enacting a nursing facility quality assurance fee (NFQAF) as a way to increase matched funds. Effective September 1, 2016, the fee is \$24.59 per non-Medicare day for nursing facilities with less than 53,000 Medicaid patient days and \$4.53 for nursing facilities with equal to or greater than 53,000 Medicaid patient days. The prior fees (effective September 1, 2015) were \$24.58 for nursing homes with less than 53,000 Medicaid patient days and \$2.24 for nursing facilities with equal to or greater than 53,000 Medicaid patient days. The NFQAF is calculated to equate to a percentage of total nursing facility revenue (not to exceed the federal maximum for quality assessment fees of 6.0% of total revenues).

Effective September 1, 2017, the NFQAF was \$24.92 per non-Medicare day for nursing facilities with less than 53,000 Medicaid patient days and \$5.60 for nursing facilities with equal to or greater than 53,000 Medicaid patient days. Effective October 1, 2018, the NFQAF increased to \$25.48 per non-Medicare day for nursing facilities with less than 53,000 Medicaid patient days and the NFQAF for nursing facilities with equal to or greater than 53,000 Medicaid patient days decreased to \$5.06.

The state also established a uniformity-based waver. Nursing facilities within CCRCs, hospital-based facilities and nursing facilities with 45 or fewer licensed beds will not be required to pay the NFQAF.

Nursing facilities that pay the NFQAF are eligible to be reimbursed for the fee through a Quality Assessment-Medicaid Share. The Quality Assessment-Medicaid Share is calculated as follows:

$$\text{(Total Patient Days - Medicare Patient Days) / Total Patient Days} = \text{Non-Medicare Utilization}$$

$$\text{Non-Medicare Utilization} \times \text{NFQAF} = \text{NFQAF-Medicaid Share}$$

MEDICAID RATE CALCULATION SYSTEM

Effective October 1, 2018, Florida converted to a prospective, price-based, facility-specific rate setting methodology. Previously, Florida AHCA had used a prospective, cost based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The implementation of the new priced based system will be phased in from October 1, 2018 to September 30, 2023.

Effective March 1, 2014, the state fully implemented its Medicaid managed care system for long-term care reimbursement. Under the system, the Managed Care Organizations (MCOs) will be required to reimburse nursing homes in an amount at least equal to the nursing facility-specific payment rate set by AHCA; however, mutually acceptable higher rates may be negotiated for medically complex care.

A description of the rate methodology that state will utilize effective October 1, 2018 to determine nursing facility rates, is as follows:

COST CENTERS

All costs of a provider fall into one of the following four components that comprise the final reimbursement rate:

- The Direct Patient Care cost component includes salaries and benefits providing nursing services including registered nurses (RNs), licensed practical nurses (LPNs) and certified nursing assistants (CNAs) who deliver care directly to residents as well as contract labor costs for these staffing categories.
- The Indirect Patient Care cost component includes all other patient care costs (activities, social services, dietary, other nursing care, supplies and therapies, etc.).
- The Operating cost component includes all other costs, not including property cost and return on equity or use allowance costs (administration, housekeeping, laundry, utilities, liability insurance, plant operations, etc.).
- The Property cost component includes costs related to the ownership or leasing of a nursing facility. Such costs may include property taxes, insurance, interest and depreciation, or rent. Facilities are reimbursed through fair rental value (FRV) system in lieu of these costs. However, property taxes and property insurance are reimbursed as a direct pass-through of expenses.

INFLATION AND REBASING

In Florida, rates are determined based on the facility's grouping within one of six total categories (based on geographic location and facility size) and are set annually for the period of September 1 to August 31, based on the latest cost reports received by October 31 and April 30, respectively. Prior to September 1, 2015, the state determined rates on a semi-annual basis on January 1 and July 1 of each year. Under the old reimbursement system, Florida rebased nursing facility Medicaid rates effective as of September 1, 2017. However, rates effective October 1, 2018, are utilizing cost report data that was used to calculate rates effective September 1, 2016. These rates are projected to be rebased every four years. Representatives of the Florida Healthcare Association

have indicated that rates will be rebased on October 1, 2021.

Non-property facility costs are inflated by the product of the following calculation: the Florida Nursing Home Cost Inflation Index (FNHCII) at the midpoint of the prospective rate period, divided by the midpoint of the nursing facility’s cost report period. The FNHCII is determined utilizing the Global Insight Nursing Facility Market Basket of Routine Costs indices for the following three cost centers:

- Salaries and Benefits;
- Dietary;
- All Other.

Non-property cost components are weighted based on budget share of these three costs centers as follows:

Component/Sub-Component	Direct Patient Care	Indirect Patient Care	Operating
Salaries and Benefits	100.00%	55.75%	57.89%
Dietary	0.00%	6.23%	5.18%
Others	0.00%	38.02%	36.93%

The sum of the budget share percentages multiplied by the cost center indices are summed for each cost component/subcomponent and equate to the specific FNHCII.

Rates determined through the FRV system are adjusted for inflation by utilizing the most recent Square Foot Costs with RS Means Data provided by Gordian Publication available on March 31 of the year in which the rate period begins.

In prior years, after facility-specific nursing Medicaid rates have been determined, Florida has adjusted these rates downward to account for budget shortfalls. The Medicaid Trend Adjustment was the percentage by which each nursing facility’s calculated Medicaid rate is reduced to determine its final rate.

The Medicaid Trend Adjustment for the rates effective January 1, 2015, September 1, 2015, and September 1, 2016, were 1.7%, 3.4% and 4.5%, respectively. The Medicaid Trend Adjustment for rates effective September 1, 2017, was 5.8%.

Effective October 1, 2018, the state no longer uses a Medicaid Trend Adjustment. However, the state does apply a Budget Neutrality Adjustment to assure that costs do not exceed funding. In addition, the state also approved a \$138 million funding increase for October 1, 2018 rates. However, effective July 1, 2019, nursing facility rates were reduced to reflect that this funding increase was a one-time event. This does not appear have been clearly communicated by the state, and several industry professionals were surprised at this decision.

Although the rate year for nursing homes is from October 1 to September 30, the state’s budget is from July 1 to June 30. The reduction implemented on July 1, 2019, reflects that the state fiscal year budget for 2020 (July 1, 2019 to June 30, 2020) does not include the \$138 million. Rates effective July 1, 2019 were adjusted to reflect funding levels that were projected for nursing facility rates prior to the state’s \$138 million dollar increase. Therefore, this transaction is more of a recalibration adjustment, as opposed

to an actual rate cut.

In order to implement this decision, July 1, 2019 rates were calculated by reducing the percentage of funding allocated to the quality program from 7.5% to 6.0% of total non-property payments and reducing the percentage of the median cost used to determine the Direct Patient Care Price from 105.0% to 100.0%. The impact of this change was an approximate 4.4% reduction from nursing facility Medicaid rates effective October 1, 2018. It is projected that funding for the quality program will increase to 6.5% in fiscal year 2020.

Total funding for fiscal year 2020 rates is anticipated to reflect July 1, 2019 rates as opposed to October 1, 2018 rates. However, this is in line with what was initially projected for nursing facility rates prior to the \$138 million increase.

RATE METHODOLOGY

The methodology for the new system consists of determining direct care, indirect care and operating statewide prices for two geographic peer groups (north and south). These prices are set at an amount equivalent to a specific percentage of median costs for the respective peer group.

All applicable per diem costs for all cost components and classes are arrayed and cost component medians for peer groups are determined. The direct care, indirect care and operating statewide prices equate to 105.0%, 92.0% and 86.0% of the median costs for the peer groups, respectively. Initially, the direct care price was supposed to be set at 100.0% of the median; however, based on the \$138 million of additional funding provided, the direct care price was increased to 105.0%. It was later determined that this increase in funding was a one-time event. Therefore, nursing facility reimbursement levels effective July 1, 2019 were adjusted to reflect that nursing facilities would not receive the additional \$138 million in funding in state fiscal year 2020 (July 1, 2019 to June 30, 2019). Given this factor, the percentage of the median cost utilized to determine the price was reduced to 100.0% effective July 1, 2019. It is anticipated that, given that funding levels will reflect July 1, 2019 rates, the median utilized to calculate the percentage will remain at 100.0%.

The new system also includes per diem floors. The per diem floors reduce a facility’s per diem component rate if the facility’s specific per diem cost is less than an established threshold. In this scenario, facilities’ rates are reduced by the difference between their actual per diem cost and the established threshold. The thresholds are 95.0% of the direct care price and 92.5% of the indirect care price. There is no per diem floor for the operating price.

The state also utilizes a Fair Rental Value System (FRVS) to determine property rates, and reimburses some property expenses (real estate, property taxes and property insurance) as a direct pass-through expense. The FRVS rate is based on the following factors: the current number of beds at the facility, the facility’s total square footage, the age of the facility and the cost of any renovations completed at the facility. The methodology used to determine FRVS rates has not yet been added to the state’s statutes, but the following represents the most recent estimate of

how FRVS rates are being calculated.

The first step in the calculation is to determine the square footage per bed at the facility. This determined by dividing the square footage of the building by the facility's number of beds. This estimate is limited to a minimum square footage per bed of 350 square feet and a maximum square footage per bed of 500 square feet. The adjusted square footage per bed is then multiplied by the RS Means Cost Per Square Foot Estimate and the RS Means Location Factor. The factor of this calculation is then allocated between "building" and "land" values, with the building value equating to 90% and the land value equaling 10% of the total amount. In addition, an initial "equipment value" is determined for the facility. This is determined by multiplying the facility's total number of beds by an \$8,000 per bed allowance.

The building and equipment values are then adjusted for depreciation. Depreciation is estimated by multiplying the combined value of the estimates by the age of the facility and a depreciation factor of 1.5% per year. The age of the facility is adjusted for recent renovations of the development of additional beds.

The sum of the building, equipment and land value is reduced by the estimated depreciation. This estimate equates to the Fair Rental Value. The Fair Rental Value is multiplied by the Fair Rental Rate (8.0%) to equate to the Fair Rental Reimbursement. This estimate is divided by the occupancy per year per bed estimate to equate to the FRVS rate. The occupancy per year per bed estimate is determined by multiplying the greater of the facility's occupancy or the minimum occupancy requirement (90%) by 365.25.

Real Estate and Personal Property Taxes and Property Insurance are reimbursed as a pass-through payment calculated as the total cost divided by the total patient days.

Effective October 1, 2018, the state implemented a new Quality Incentive Program (QIP). Funding for the program equates to 7.5% of total October 1, 2018, non-property related payments. QIP utilizes quality metrics to reward high performing facilities. Quality measures on which facilities are judged include process measures (flu vaccine, usage of antipsychotic drugs and physical restraints), outcome measures (prevalence of urinary tract infections, pressure ulcers, falls, incontinence and decline in ADLs) and structural measures (direct care staffing levels, CMS' Five-Star Rating System and credentialing options/awards). Effective July 1, 2019, this percentage was reduced to 6.0% to reflect budget limitations. It is anticipated that the percentage will increase to 6.5% on October 1, 2019.

Nursing facilities that pay the NFQAF are eligible to be reimbursed for the fee through a Quality Assessment-Medicaid Share that is facility-specific. Nursing facilities are also eligible to receive an add-on for providing ventilator care.

A nursing facility's Medicaid reimbursement rate is calculated as the sum of the following: the direct care, indirect care and operating prices, the quality add-on, FRVS rates, pass-through property expense rates (real estate taxes, property taxes and property insurance), the NFQAF Medicaid Share and the Ventilator Add-

on. These rates are adjusted by the Budget Neutrality Adjustment.

In addition, nursing facilities are guaranteed that they will not be reimbursed less than their September 1, 2016 rates until October 1, 2021. In addition, nursing facility rates from October 1, 2021 until October 1, 2023 will not be less than 95.0% of their rates effective September 1, 2016. However, it is anticipated that the state will rebase the prices on October 1, 2021, utilizing updated cost report data. Representatives of the Florida Healthcare Association have indicated that this should result in a significant decrease in the number of facilities that are required to utilize the hold harmless provision. Also, effective October 1, 2018, nursing facility rates are capped at 110.05228% of their hold harmless rate.

Effective January 1, 2013, the weighted average Medicaid nursing facility rate was \$210.11 per day, which represents a slight increase from the weighted average rate (\$209.16) effective July 1, 2012. The weighted average rate (\$213.23) increased 1.5% on July 1, 2013, and 0.4% to \$214.07 on January 1, 2014.

Effective July 1, 2014, the weighted average rate increased 4.5% to \$223.71. This was the result of increased state and NFQAF revenues, which enabled the state to significantly backfill previous funding reductions.

The average rate effective January 1, 2015, was \$228.76, which represents a 2.3% increase from the rate effective July 1, 2014 (\$223.71). However, the average rate effective September 1, 2015, decreased slightly to \$227.71. This reflects a decrease in total NFQAF revenue. The statewide average slightly increased to \$228.79 effective September 1, 2016, and increased to \$231.57 effective September 1, 2017. The average rate effective October 1, 2018, increased to \$242.55. However, given budget limitations, the average rate was reduced to \$232.28 effective July 1, 2019.

MINIMUM OCCUPANCY STANDARD

The FRVS system per diem rate are determined assuming that the applicable nursing facility is 90% occupied.

OTHER RATE PROVISIONS

For facilities that have experienced a change of ownership, the new owner/operator will assume the prior owner/operator's rate. Newly constructed facilities receive the price level without floors for direct, indirect, and operating; the median score for quality; and property taxes and insurance that they submit prior to the initial rate being set.

Florida Medicaid reimburses nursing facilities for reserving a bed for hospitalization or therapeutic leave if the facility's Medicaid certified beds are at least 95% occupied. Nursing facilities are reimbursed up to eight days per occurrence of a qualifying hospitalization leave at 100% of the facility's current Medicaid rate. Nursing facilities are reimbursed up to 16 days per calendar year for qualified therapeutic leave at 100% of the facility's current rate.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the continued implementation of the new rate system, there are no proposed changes to the state’s Medicaid reimbursement system.

FLORIDA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	100.00	104.00	101.00		120.00	120.00	120.00		120.00	120.50	120.00
Average Daily Census	93.47	94.45	92.61		110.10	110.04	110.15		122.47	120.00	121.20
Occupancy	84.8%	84.5%	84.2%		90.8%	90.3%	90.4%		94.0%	93.9%	93.8%
Payor Mix Statistics											
Medicare	11.6%	11.0%	10.2%		16.4%	15.5%	14.4%		24.4%	23.5%	23.1%
Medicaid	48.0%	50.5%	50.2%		63.6%	63.6%	63.2%		73.2%	72.8%	72.9%
Other	12.0%	12.8%	12.9%		18.2%	18.9%	19.7%		27.8%	28.3%	28.2%
Avg. Length of Stay Statistics (Days)											
Medicare	30.22	29.11	28.35		36.29	36.20	35.45		46.99	46.07	45.98
Medicaid	240.39	222.05	223.23		342.23	301.86	306.14		520.92	485.21	461.36
Other	34.15	33.44	33.04		51.84	49.93	48.93		111.28	91.75	89.34
Revenue (PPD)											
Inpatient	\$232.86	\$243.50	\$250.63		\$254.51	\$262.44	\$271.30		\$294.42	\$300.23	\$304.97
Ancillary	\$60.87	\$60.30	\$59.50		\$87.20	\$88.36	\$85.90		\$131.89	\$127.01	\$125.76
TOTAL	\$306.93	\$314.26	\$318.12		\$350.03	\$360.20	\$366.56		\$425.04	\$432.22	\$437.27
Expenses (PPD)											
Employee Benefits	\$12.11	\$12.10	\$12.67		\$17.53	\$17.84	\$17.41		\$25.23	\$26.33	\$26.26
Administrative and General	\$54.98	\$53.68	\$54.79		\$62.85	\$60.20	\$63.45		\$70.12	\$67.82	\$71.05
Plant Operations	\$9.25	\$9.22	\$9.48		\$10.95	\$11.03	\$11.26		\$13.80	\$13.80	\$13.93
Laundry & Linens	\$2.19	\$2.21	\$2.30		\$2.77	\$2.85	\$2.91		\$3.38	\$3.35	\$3.52
Housekeeping	\$4.73	\$4.77	\$4.89		\$5.85	\$5.95	\$5.92		\$7.35	\$7.42	\$7.24
Dietary	\$14.78	\$14.98	\$15.39		\$17.05	\$17.30	\$17.65		\$20.72	\$21.59	\$21.69
Nursing & Medical Related	\$82.38	\$84.71	\$89.34		\$94.42	\$98.69	\$100.36		\$106.89	\$111.63	\$112.32
Ancillary and Pharmacy	\$27.93	\$27.85	\$28.09		\$37.59	\$37.90	\$37.36		\$49.88	\$50.11	\$51.06
Social Services	\$2.77	\$2.52	\$2.58		\$4.23	\$4.09	\$4.37		\$6.58	\$6.63	\$6.89

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Georgia



INTRODUCTION

Nursing facilities in Georgia are licensed by the Office of Healthcare Facility Regulations, a division of the Department of Community Health under the designation of “Nursing Facilities” or “Skilled Nursing Facilities.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN GEORGIA	
Licensed Nursing Facilities*	335
Licensed Nursing Beds*	37,008
Beds per 1,000 Aged 65 >**	25.66
Beds per 1,000 Aged 75 >**	68.04
Occupancy Percentage - 2017*	85.30%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

The Department of Community Health, Division of Health Planning regulates healthcare services in the state of Georgia through the Certificate of Need (CON) program. Georgia’s CON program was established by the General Assembly in 1979.

In the state of Georgia, a CON is required for the following:

- Development or construction of a new nursing facility.
- The construction or renovation project or any other capital expenditure that exceeds the construction threshold of \$3,068,601.
- Purchasing or leasing major medical equipment that exceeds the threshold amount for equipment acquisition of \$1,324,921.
- Offering a healthcare service that was not provided on a regular basis during the previous 12-month period.
- Adding additional beds.

These thresholds are effective on July 1, 2018, and are inflated annually using the Consumer Price Index (CPI).

In 1996, the Department of Community Health adopted a batching review process when reviewing CON applications for nursing home beds. The batch review process considers all applications for nursing home beds simultaneously. To accomplish this goal, the Division of Health Planning uses a nursing facility bed need methodology. The bed need calculation, which is completed every six months (March and September), is used to calculate bed need for 12 state service delivery regions. If there is a determined need within a region, a batching notification is published and made available. The batching review process does not apply to nursing home renovation or replacement projects that do not involve additional beds.

BED NEED METHODOLOGY

Georgia’s bed need methodology is based on a three-year planning horizon. The need for additional nursing home beds in a state service delivery region is determined by using a population-based formula, which is the sum of the following:

- A ratio of 0.43 beds per 1,000 projected horizon year resident population age 64 and younger.
- A ratio of 9.77 beds per 1,000 projected horizon year resident

population age 65 through 74.

- A ratio of 32.5 beds per 1,000 projected horizon year resident population age 75 through 84.
- A ratio of 120.00 beds per 1,000 projected horizon year resident population age 85 and older.

In addition to the above bed need calculation, demand for services in a state service delivery region is measured by the cumulative facility bed utilization rate, which is determined by dividing the bed days available for resident care by the actual bed days of resident care.

In order for the batching cycle to be opened for the consideration of new or expanded nursing home applications, during the most recent past survey year, a minimum occupancy threshold of 95% must be met or exceeded within the state service delivery region. In Georgia, an exemption may be allowed for the establishment of a new Medicare distinct part skilled nursing unit in a county that does not have an existing Medicare unit.

New nursing facilities are required to meet minimum bed size requirements in a rural or urban county. Freestanding nursing facilities in a rural county must have a minimum of 60 beds, with a minimum of 100 beds in an urban county. A hospital-based nursing facility in a rural county must have a minimum of 10 beds and a maximum of 20 beds, and a minimum of 20 beds and a maximum of 40 beds in an urban county. A retirement community-based nursing facility must have one nursing home bed for each four residential units, with a minimum of 20 beds and a maximum of 30.

There are currently no proposed changes to the bed need methodology.

QUALITY ASSURANCE FEE

The quality assurance fee (QAF) in Georgia is referred to as the provider fee. The state’s Nursing Home Provider Fee Act was enacted on July 1, 2003, and requires that all nursing homes pay a fee based on the number of patient days of service provided other than those paid by the Medicare program. As of July 1, 2012, the rate is \$17.10 per non-Medicare patient day. This represents a 3.0% increase from the prior QAF (\$16.61) effective February 1, 2012. QAF increases correspond with Medicaid rate rebases effective the same dates. More detail on these rebasings will be included in the Inflation and Rebasings Section of this overview.

Nursing facilities in the state receive a \$17.10 add-on payment to their Medicaid rate to reimburse for the provider fee. Facilities exempt from the provider fee include continuing care retirement centers, the top 10 nursing facilities that are public or not for profit ranked by number of patient days, state or federally operated nursing facilities and facilities that do not charge for services.

MEDICAID RATE CALCULATION SYSTEM

Georgia uses a prospective, cost-based, case mix, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. Effective July 1, 2009, Georgia approved significant changes to its rate calculation system. These changes

include the conversion of the property payment system to a fair rental value (FRV) system and the development of an additional quality of care incentive add-on.

COST CENTERS

Georgia uses the following five cost centers to calculate its facility-specific Medicaid rates:

- Routine and Special Services includes nursing staff wages and benefits, nursing supplies, nursing contracted services, other nursing expenses, physician salaries and wages, physician supplies, contracted physician services, other physician expenses, intravenous, occupational, physical, respiratory and speech therapy wages and benefits, therapy supplies, therapy contracted services, non-prescription drugs, equipment rental, medical director expenses and related party expenses.
- Laundry and Housekeeping includes laundry and housekeeping salaries and benefits, laundry and housekeeping supplies, linen replacements, contracted laundry and housekeeping services, other laundry and housekeeping expenses, and related party expenses.
- Administrative and General includes administrative wages and benefits, supplies, contracted services, legal and accounting expenses, amortization, dues and subscriptions, travel and continuing education expenses, communication expenses, advertising, taxes and licenses, insurance, interest expense – working capital (short term), home office allocation expenses, beauty and barber shop, medical records, religious services, in-service training expenses, nursing aide training expenses (including wages, benefits, supplies and contracted services), and non-operating expenses (canteen and gift shop, office and other rental expense, and medical care review).
- Dietary includes dietary wages and benefits, supplies, dietary contracted services, raw food, dietary supplements, tube feeding supplies, other dietary expenses and related party expenses.
- Property and Related Costs utilizes an FRV system to reimburse a nursing facility on the basis of the estimated value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. However, property taxes and insurance are reimbursed as pass-through expenses.

Effective July 1, 2018, the state will change in how it reimburses nursing facilities for general and professional liability insurance expense. Currently, the expense is included in the Administrative & General cost component. The state is going to carve out the liability insurance expense as its own separate cost component (GL/PL add-on).

INFLATION AND REBASING

Based on state regulations, nursing facility Medicaid rates are supposed to be rebased annually using the most current cost report data available. However, this typically has not occurred in recent years. The state most recently rebased rates on July 1, 2014, utilizing 2012 cost reports. Rates had previously been rebased on July 1, 2012, utilizing fiscal year 2009 and 2010 cost report data, respectively.

In recent years, Georgia has inflated the non-property portion of Medicaid per diem rates forward using a growth allowance. No growth allowance was provided for non-property rates from July 1, 2013 to June 30, 2016. However, a 3.0% growth allowance was applied to non-property rates in both fiscal year 2017 and 2018. Georgia also adjusts nursing facility rates quarterly utilizing the Resource Utilization Groups III (RUG-III) Version 5.12b, 34-group, index maximizer model.

The state and the Centers for Medicare and Medicaid (CMS) have approved the implementation of a 10.3% growth allowance effective July 1, 2018. This and the rebasing of the new GL/PL add-on based on expense data effective June 30, 2018, should result in an increase in nursing facility Medicaid rates.

As previously mentioned, the state will carve out general and professional liability expense as a separate cost component (GL/PL add-on). Historically, this expense has been included in the Administrative and General cost component. However, the state has not rebased rates since July 1, 2014, utilizing 2012 cost report data. This will reduce the Administrative and General cost component, but the new General and Professional Liability (GL/PL add-on) will be based on each facility's liability insurance cost, effective June 30, 2018. Given that costs have most likely increased since 2012, this will result in an overall rate increase because the new component will be greater than what will be removed from of the Administrative and General cost component.

This change is pending approval of a State Plan Amendment by the Centers for Medicare and Medicaid (CMS). However, both representatives of the Georgia Healthcare Association and the Georgia rate setting agency are confident this will occur. The state anticipates \$15.5 million of new funding for this component. This add-on will be initially calculated as a direct pass-through of expenses from the period of July 1, 2017, to June 30, 2018. However, currently not all available expense data for nursing facilities in the state is available. If total GL/PL expense in the state exceeds the estimated state funding for the add-on (\$15.6 million), nursing facilities may have their add-ons decreased proportionately to reflect the limits of the funding.

It is currently unclear at what frequency the state will rebase the GL/PL add-on. State rate setting officials have indicated that any potential rebasings will be based on available funding.

RATE METHODOLOGY

The total allowed per diem billing rate for nursing facilities is the summation of the allowed per diem, efficiency per diem, growth allowance and other rate add-ons. The allowed per diem is equal to the summation of the lesser of the net per diem or the standard per diem for each of the cost components. The lesser of the net or standard per diem is then adjusted by the growth allowance.

A net per diem is determined from the costs of operations for an individual facility. An individual facility's net per diem per cost component is calculated by dividing the associated allowable costs by total patient days. An individual facility's net per diem for the Dietary, Laundry and Housekeeping and Administrative and General cost components is the summation of the cost associated

with each component divided by the total patient days. Relative to Routine and Special Services, the per diem is determined on a case mix neutral basis. There are additional criteria associated with the FRV system used to determine the Property and Related component net per diem.

The standard per diem for each of the four cost centers is determined after facilities are separated in distinct groups based upon like characteristics pertaining to a particular cost center. Facilities are grouped according to what type of facilities they were as of June 30, 2007. The groups are then arranged from the facility with the lowest net per diem to the facility with the highest net per diem. The standard per diem is then established as either a percentile or a percentage of the median. The maximum cost per diem equates to the standard per diem for each component. Standard per diems were recalculated for rates effective February 1, 2012, July 1, 2012 and July 1, 2014. Standards have not been increased since that date. However, the Administrative and General Standard will be recalculated effective July 1, 2018 to reflect that the general and professional liability insurance expenses will be removed from that component.

The standard per diem for the Administrative and General cost component is 105% of the median cost per day within each peer group. The standard per diem is the 90th percentile for the Routine and Special Services cost component and the 85th percentile for the Laundry and Housekeeping cost component. The standard per diem for the Dietary cost component is the 60th percentile for the hospital-based nursing facility peer group and the 90th percentile for the freestanding nursing facility peer group.

The Routine and Special Services net per diem is adjusted quarterly for case mix. The initial allowable costs per diem are case mix neutralized by dividing them by the facility's specific all resident case mix index (CMI) for the base year period. The adjusted per diem for all applicable nursing facilities are arrayed to determine the standard per diem at the 90th percentile. The lower of the adjusted net per diem or standard per diem is then inflated for the growth allowance and multiplied by the facility-specific Medicaid CMI for the quarter prior to the effective date of the current Medicaid rate.

Prior to July 1, 2009, the determination of the Property and Related cost component rates utilized the McGraw Hill Construction/Dodge Index Method to determine reimbursement, with standard per diem rates calculated using four subcomponents and a 90% maximum of available patient days for each facility. Effective July 1, 2009, Georgia determines Property and Related cost component rates utilizing an FRV system.

Nursing facilities under the FRV system are reimbursed on the basis of the estimated value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. The initial FRV per diem rate is calculated as follows:

- Effective July 1, 2009, the value per square foot is \$141.10, which is derived from the 2009 RS Means Building Construction cost data for nursing homes. The value per square foot is adjusted by an R.S. Means location factor (based on the facility's zip code) as well as a Construction Cost Index

set at 1.000. In future rate years, the value per square foot will be based on R.S. Means Construction cost data effective the June 1 prior to the rate's effective date. The current value effective July 1, 2017 is \$187.15 per square foot.

- A nursing facility's replacement value is calculated by multiplying the facility's adjusted cost per square foot by the maximum allowed total square footage. The lesser of the nursing facility's actual square footage or the facility's total number of licensed beds multiplied by 700 square feet is utilized in the calculation.
- An estimate of equipment value is added to the initial replacement value to determine the total facility value excluding land. The equipment value is calculated by multiplying the number of licensed beds by \$6,000, then by an initial equipment cost index of 1.000.
- The total facility value excluding land is adjusted by depreciation to determine the depreciated replacement value. The amount depreciated is determined by multiplying the adjusted facility age by a 2% depreciation rate. The initial facility age is the lesser of the facility's actual age or 25 years. In future rate periods, the effective age of the facility will be adjusted to reflect substantial renovations.
- An estimate of land value is added to the depreciated replacement value to determine the total depreciated replacement value and land. The value of the land is determined by multiplying the facility replacement value by 15%.
- The total depreciated replacement value and land is then multiplied by a rental rate to determine the annual rental amount. The initial rental rate is 9.0% effective July 1, 2009.
- The annual rental amount is divided by the greater of the facility's total resident days or 85% of the facility's total potential licensed resident days to determine the Property and Related cost component per diem rate.
- The resulting figure of these calculations comprises the Property and Related net per diem as established under the FRV system. In recent years, costs for property taxes and property insurance are direct pass-through expenses on a per diem basis.

The efficiency per diem for each of the components is the difference between the standard per diem and net per diem, multiplied by 75%. The efficiency per diem for each of the five cost centers is zero (\$0.00) when the net per diem is equal to or greater than the standard per diem in any cost center, or if the net per diem is equal to or less than 15% of the standard per diem. The maximum efficiency payment for each cost center is as follows:

- Routine and Special Services - \$0.53 per diem;
- Dietary - \$0.22 per diem;
- Laundry and Housekeeping - \$0.41 per diem;
- Administrative and General - \$0.37 per diem.

In addition to the above-mentioned rate components, nursing facilities may be eligible for an add-on derived from the Quality Improvement Initiative Program. In order to be eligible for the incentives, a facility must enroll in the program. Incentives include:

- A staffing adjustment equal to 1% of the allowed per diem for Routine and Special Services. To qualify, a nursing facility must demonstrate that it meets the state’s minimum staffing levels.
- An adjustment factor based on the percentage of Medicaid patients whose cognitive performance scale scores are moderately severe to very severe.

The cognitive performance scale add-on is calculated as a percentage of the allowed per diem for Routine and Special Services as follows:

Percentage of Residents with Moderately Severe to Very Severe Dementia	Percentage of the Allowable Routine and Special Services Per Diem
< 20%	0.0%
20% - 30%	1.0%
30% - 45%	2.5%
45% - 100%	4.5%

A quality incentive adjustment was implemented on July 1, 2009. The state awards an additional incentive add-on to certain nursing home providers that meet specific criteria for quality measures as determined by the state. This incentive is determined utilizing a point system based on clinical, alternative clinical and non-clinical measurements. Clinical and alternative clinical measures include, but are not limited to, the prevalence of residents with pressure sores; residents that are required to be restrained; residents with moderate to severe pain; residents that have received an influenza vaccine; residents with unplanned weight loss or gain; residents receiving antipsychotic medication; residents that have developed ulcers; and residents without catheters. Non-clinical measures include, but are not limited to, the employee satisfaction survey and retention rates of employees. Nursing facilities are eligible for an incentive ranging from 1 % to 2% of the Routine and Special Services cost component rate depending on their overall score.

In addition to the above incentive add-ons, nursing facilities in Georgia receive a \$17.10 per diem add-on for reimbursement of the state’s provider fee.

The average nursing facility Medicaid rate effective July 1, 2017 was \$181.31. This rate is 3.4% greater than the rate effective July 1, 2016 (\$175.38). the average rate effective July 1, 2015 was \$168.44

MINIMUM OCCUPANCY STANDARDS

With the exception of the net per diem calculation for the Property and Related cost component, Georgia’s Medicaid rate methodology does not utilize minimum occupancy standards. As previously mentioned, the minimum occupancy standard used in calculating the Property and Related cost component, utilizing the FRV system, is 85%.

OTHER RATE PROVISIONS

When there is a change in ownership, the new owners receive the prior owner’s per diem rate until a cost report basis can be used to establish a new per diem rate. Newly enrolled facilities are reimbursed the lower of projected costs, or the growth allowance and the appropriate Property and Related net per diem plus 90% of the appropriate cost center ceilings, until a cost report can be used to determine a rate. The total allowed per diem rate for newly constructed facilities with more than 50 beds is equal to 95% of the four non-property and related standard per diem amounts plus the appropriate growth allowance and Property and Related net per diem.

Payments for patient leave days or for bed hold days during a patient’s hospitalization are made at 75% of the rate paid for days when a patient is on-site at a facility. Nursing facilities can be reimbursed up to seven days per absence for hospitalization or eight days per absence for therapeutic leave. In addition, the payment rate for patient leave days and bed hold days excludes any compensation for the provider fee.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the implementation of the GL/PL add-on, the state is not considering significant changes to the rate calculation methodology

GEORGIA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	76.50	78.00	77.25		100.00	100.00	100.00		132.50	133.25	128.00
Average Daily Census	69.15	70.11	68.96		89.53	90.34	90.04		116.37	115.41	112.87
Occupancy	82.2%	81.8%	80.4%		88.7%	89.0%	87.7%		92.5%	92.8%	92.0%
Payor Mix Statistics											
Medicare	6.4%	6.0%	5.5%		9.2%	8.7%	8.8%		13.8%	13.1%	13.4%
Medicaid	64.9%	65.3%	65.1%		74.7%	74.5%	75.4%		81.9%	81.6%	81.8%
Other	15.0%	16.0%	15.3%		29.3%	29.5%	27.3%		90.2%	90.3%	91.2%
Avg. Length of Stay Statistics (Days)											
Medicare	29.73	32.00	33.01		40.37	43.03	42.53		56.45	59.12	57.01
Medicaid	311.38	282.01	251.96		431.13	443.89	377.76		651.96	611.86	531.58
Other	75.37	66.78	57.96		146.69	148.90	126.85		308.62	288.99	230.57
Revenue (PPD)											
Inpatient	\$175.35	\$182.59	\$182.55		\$200.79	\$211.93	\$217.94		\$223.86	\$230.64	\$239.65
Ancillary	\$27.78	\$28.56	\$29.34		\$45.50	\$43.52	\$44.74		\$72.07	\$69.71	\$72.66
TOTAL	\$213.83	\$228.99	\$234.08		\$245.31	\$255.28	\$262.85		\$286.57	\$292.01	\$305.03
Expenses (PPD)											
Employee Benefits	\$13.30	\$12.89	\$12.06		\$15.60	\$15.19	\$14.63		\$20.17	\$20.38	\$19.78
Administrative and General	\$34.38	\$38.90	\$40.73		\$40.88	\$44.08	\$46.72		\$49.28	\$50.52	\$54.81
Plant Operations	\$8.26	\$8.40	\$8.58		\$9.42	\$9.67	\$10.14		\$11.28	\$11.95	\$12.04
Laundry & Linens	\$1.95	\$1.97	\$2.00		\$2.57	\$2.59	\$2.55		\$3.30	\$3.13	\$3.14
Housekeeping	\$4.89	\$5.20	\$5.09		\$6.03	\$6.55	\$6.51		\$7.46	\$7.79	\$7.86
Dietary	\$14.18	\$14.81	\$15.18		\$15.61	\$16.33	\$16.86		\$17.44	\$18.29	\$18.57
Nursing & Medical Related	\$60.72	\$65.67	\$67.75		\$74.10	\$78.97	\$81.55		\$87.22	\$91.25	\$93.41
Ancillary and Pharmacy	\$16.61	\$17.45	\$17.50		\$22.72	\$22.91	\$23.99		\$32.64	\$30.99	\$32.57
Social Services	\$1.93	\$1.99	\$2.11		\$3.11	\$3.06	\$3.30		\$4.53	\$4.25	\$4.38

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Hawaii



INTRODUCTION

Nursing facilities in Hawaii are licensed by the Hawaii Department of Health, Office of Health Care Assurance, under the designation of "Skilled Nursing Facilities and Intermediate Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN HAWAII	
Licensed Nursing Facilities*	31
Licensed Nursing Beds*	3,016
Beds per 1,000 Aged 65 >**	12.06
Beds per 1,000 Aged 75 >**	28.25
Occupancy Percentage - 2017*	76.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Hawaii has operated a Certificate of Need (CON) program since 1974. The Hawaii Health Planning and Development Agency administers the CON program. A CON is required for the following scenarios:

- The construction, expansion/renovation or modification of a skilled nursing facility that results in a total capital expenditure in excess of the expenditure minimum (\$4,000,000 for capital expenditures, \$1,000,000 for new/replacement medical equipment and \$400,000 for used medical equipment).
- To substantially modify, decrease or increase the scope or type of health service rendered.
- To increase, decrease or change the class of usage of the bed complement of a skilled nursing facility.
- The relocation of licensed beds from one facility to another site.

CON applications are judged on a case-by-case basis based on public need for the facility or service. The cost of the facility or service must be determined to be reasonable in light of the benefits it will provide and its impact on healthcare costs.

BED NEED METHODOLOGY

Effective July 1, 2009, Hawaii applied a new bed methodology to be utilized when considering CON applications. This methodology consists of a three-step process that includes: 1) defining a target area for a nursing facility; 2) multiplying the population within the target area by national utilization rates to determine need, and; 3) comparing need estimates to current Hawaii licensed long-term care bed usage and supply. If calculated need is greater than the supply of beds, it is anticipated that there is unmet demand for services. Typically, a nursing facility's target area is defined as either the county or island in which the facility is located. According to professionals from the Hawaii Health Planning and Development Agency, bed need is determined on a case-by-case basis. Prior to the development of this methodology, Hawaii utilized a 95% occupancy threshold to determine bed need.

QUALITY ASSURANCE FEE

Hawaii established a quality assessment fee effective July 1, 2012. The quality assessment fee is referred to as the "Provider Fee." The current Provider Fee, effective January 1, 2016, equates to

\$13.46 per patient day for nursing facilities with 65,000 or fewer Medicaid days and \$5.85 for nursing facilities with greater than 65,000 Medicaid patient days. The fees were increased from the prior Provider Fees (effective January 1, 2015) on July 1, 2015, to their current levels. The Provider Fees effective January 1, 2015, were \$11.85 per patient day for nursing facilities with 65,000 or fewer Medicaid days and \$5.15 for nursing facilities with greater than 65,000 Medicaid patient days. The following facility types are excluded from paying the fee: Nursing facilities with 28 or fewer beds; nursing facilities owned or operated by Hawaii Health Systems Corporation; and continuing care retirement facilities.

Nursing facilities are reimbursed for the Provider Fee through two methods. The first method of reimbursement is a Medicaid rate add-on, which equates to the actual fee that the facility is paying. The second form of reimbursement is a supplemental payment that is based on a nursing facilities percentage of Medicaid revenue from total Medicaid revenue in the state.

MEDICAID RATE CALCULATION SYSTEM

Effective February 1, 2009, Hawaii converted its Medicaid reimbursement system to a managed care model. The program is known as QUEST Expanded Access (QExA). Prior to this conversion, Hawaii completed a six-year phase-in to the acuity system from the previously utilized cost-based, facility-specific prospective payment system (PPS) effective October 1, 2008.

Under the system, the Department of Human Services, Med-Quest Division, makes monthly capitation payments to health plans responsible for providing and coordinating services to the aged, blind or disabled (ABD) population, including long-term care. Long-term care providers are, in turn, reimbursed by the five health plans, UnitedHealthcare Community Plan, Ohana Health Plan, HMSA, Kaiser Permanente and AlohaCare. Effective January 1, 2015, the state is expanding from utilizing two to five health plans.

The state's contracted reimbursement agent (Myers and Stauffer) is still calculating fee for service nursing facility Medicaid rates utilizing the current methodology in place. However, the managed care plans have the authority to negotiate rates on a facility by facility basis. Since the conversion to the managed care system, the managed care plans have used Myers and Stauffer calculated rates as the basis for establishing new facility rates. However, they are not required do so.

COST CENTERS

The state's reimbursement system fee-for-service reimbursement methodology utilizes the following three cost components to determine Medicaid rates:

- The Direct Care cost component includes wages and benefits associated with direct nursing (nursing aides, registered nurses and licensed practical nurses), as well as physician-ordered maintenance therapy services and the costs of nursing and medical supplies not separately billable to patients.
- The Capital cost component includes all allowable capital-related operating costs, including rent, interest, depreciation,

equipment lease and rental, property taxes, and insurance related to capital assets.

- **The General and Administrative** cost component includes all additional allowable costs incurred in providing care, including wages, benefits and supplies associated with dietary, housekeeping, laundry, plant operations and medical records. This component also includes liability insurance expense and any attorneys' fees related to the settlement of malpractice claims.

INFLATION AND REBASING

As previously mentioned, Hawaii completed a six-year transition from a cost-based PPS system to a price-based acuity system on July 1, 2008. This transition originated on July 1, 2003, which is the last time Hawaii rebased Medicaid rates. Medicaid rates effective July 1, 2008, were calculated utilizing 2001 cost report data. Allowable costs were inflated from the midpoint of the cost report to the midpoint of the rate period utilizing the DRI Market Basket Index, which has since been replaced by an inflation index provided by Global Insight. The rate year in Hawaii is from July 1 to June 30. The state also adjusts nursing facility rates semiannually for case mix.

Hawaii has annually increased the acuity rate system standard prices since July 1, 2003, by multiplying the rates/prices by an update factor based on the Global Insight First Quarter Health Care Cost Review. Prior to applying the update factor, the Direct Care cost component price is first adjusted for a nursing facility's case mix index (CMI) and then added to the Capital and General and Administrative prices. The inflation factor was 3.5% for fiscal year 2009 rates. Fiscal year 2010 rates remained flat. With the exception of a 0.8% inflation adjustment, fiscal year 2011 rates remained relatively unchanged from fiscal year 2010 rates, due to budgetary constraints. In fiscal year 2012, managed care plans reduced nursing facility rates by approximately 3.0%.

Based on revenue to be generated by the Provider Fee the state was able to increase the capitation rates paid to the managed care plans, which in turn back-filled the previous rate reduction (effective July 1, 2012). This essentially equates to a 3.0% increase from fiscal year 2012 rates.

Hawaii's regulations do not require the state to rebase the statewide standard prices at any set frequency. Representatives from Myers and Stauffer have continued to calculate new rates on a semiannual basis. However, there has been no rebasing since July 1, 2008. In addition, there is no indication of if the managed care plans utilize this data when negotiating rates. Also, neither the managed care plans nor Med-Quest publishes nursing home Medicaid rates.

Based on data provided by Myers and Stauffer, the average calculated rate in the state has only increased 1.1% from \$244.67, effective July 1, 2013, to \$247.38, effective January 1, 2016. In addition, any increase in calculated rates is most likely the result of semiannual acuity adjustments. Also, it should be noted that these averages are based on rates calculated by Myers and Stauffer, and actual rates paid to nursing facilities may vary from these rates.

Effective July 1, 2016 Myers and Stauffer applied a 2.4% increase to CMI adjusted total Medicaid rates. Per state law, rates were also adjusted for case mix on January 1, 2017. Effective July 1, 2017, Myers and Stauffer also applied a 2.9% rate increase to CMI adjusted total Medicaid rates, which were adjusted for CMI on January 1, 2018, rates, which were adjusted for CMI. Effective July 1, 2018, a 2.8% inflation adjustment was applied to rates, which were then adjusted for CMI on January 1, 2019. As previously mentioned, actual rates that nursing homes are reimbursed via the MCOs are not available to the public. However, representatives of the Health Care Association indicated that nursing facilities are currently being reimbursed at levels similar to their recently calculated rates..

RATE METHODOLOGY

The following is a summary of how Hawaii would calculate Medicaid rates in a rebasing year utilizing the state's current methodology. However, is currently unclear if managed care plans will utilize this system in the future. Under the current system, nursing facility rates are to be adjusted semiannually for a facility's CMI in both rebasing and non-rebasing years. While the state has not had its contractor (Myers and Stauffer) calculate rebased rates since fiscal year 2009, it is apparent that nursing facility rates are still being adjusted semiannually for acuity.

In a rebasing year, the facility-specific per diem costs for all three cost components are determined by dividing allowable inflated costs by total resident days. The facility-specific per diem costs are arrayed by cost component and a median per diem cost is determined. The statewide standard price for each of these components is determined as a percentage of the component-specific median as follows: Direct Care cost component price – 110% of the median; Administrative and General cost component price – 103% of the median; and Capital cost component price – 100% of the median.

Prior to determining the Direct Care cost component price, facility-specific per diem costs are first case mix neutralized by dividing the facility's per diem cost by the facility's CMI for all payors. The all-payor CMI is derived from the base cost report period.

The case mix classification system utilized in the acuity rate setting system is the RUG III, 34-group classification system. Calculation of the facility-specific CMI is based on data from the Minimum Data Set (MDS), a component of the federally mandated Resident Assessment Instrument. MDS data is utilized to classify residents into one of 34 mutually exclusive groups representing the residents' relative direct care resource requirements. Case mix weights per RUG category are Hawaii-specific and were originally calculated as a blend of 1991 and 1995-1997 national staff time measurements weighted by Hawaii-specific nurse wage rates. The Hawaii-specific case mix weights were updated in 2007. The Direct Care cost component price is adjusted semiannually by a nursing facility's snapshot all-payor CMI to determine the facility-specific Direct Care cost component rate. The snapshot CMIs are the weighted average CMI for all residents for the calendar quarter two quarters prior to the rate effective date.

The facility-specific case mix adjusted Direct Care cost component

rate is added to the statewide standard prices for the Administrative and General and Capital cost components and the general excise tax and county surcharge (if applicable) tax per diem costs to calculate a nursing facility's total Medicaid rate.

The general excise tax is a tax applied to all businesses in Hawaii and is reimbursed as a direct pass-through expense. The general excise tax per diem cost is determined by multiplying a nursing facility's total Medicaid rate (excluding the tax per diem costs) by the current general excise tax (4.166%). In addition, nursing facilities located within Honolulu County (Oahu Island) are assessed an additional county surcharge tax. Nursing facilities located in Honolulu County are reimbursed this tax as a direct pass-through expense. The county surcharge per diem cost is determined by multiplying a nursing facility's Medicaid rate (excluding the tax per diem costs) by 0.546%.

MINIMUM OCCUPANCY STANDARDS

A minimum occupancy percentage of 90% is applied to the calculation of facility-specific Capital cost component per diem costs. The greater of the facility's actual total patient days or 90% of the facility's total allowable patient days are utilized to calculate the per diem costs.

OTHER RATE PROVISIONS

Newly constructed facilities receive the standard statewide price for each cost component. A CMI of 1.0 is utilized to calculate the facility-specific Direct Care cost component rate until sufficient case mix data is available for the facility.

Nursing facilities that have experienced a change of ownership receive the prior owner's rate until an adequate amount of case mix data is accumulated to determine a facility-specific Direct Care cost component rate.

Hawaii Medicaid reimburses nursing facilities for reserving beds for residents absent from the facility due to therapeutic leave. Nursing facilities are reimbursed a maximum of three days per absence and 12 days per year (consecutive 12 months from the first date of service) for therapeutic leave. Payment for reserving a bed under both scenarios equates to the nursing facility's current Medicaid per diem rate.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

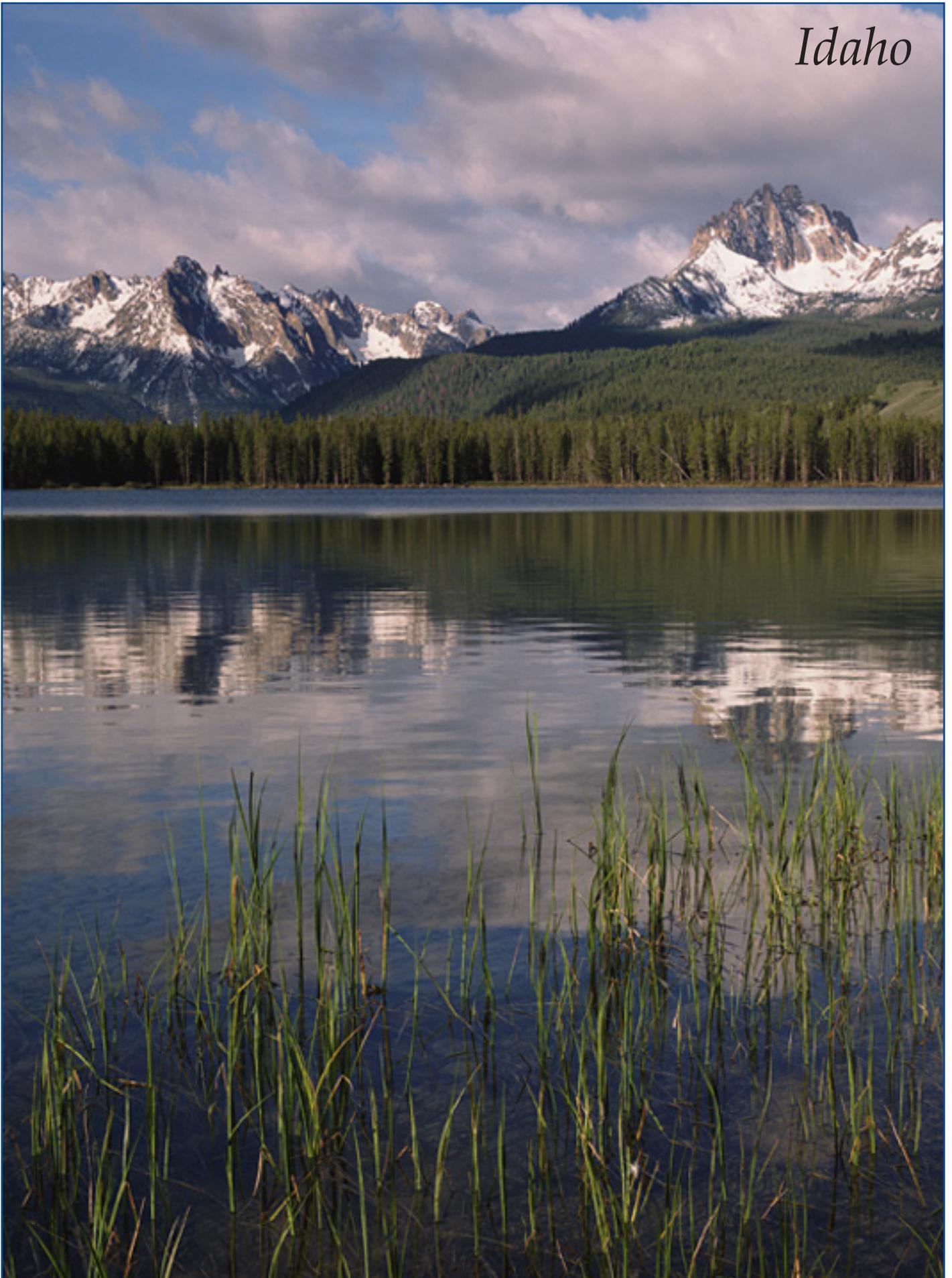
As of the date of this overview, there are no known significant proposed changes to the state's reimbursement methodology.

HAWAII COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	71.50	80.25	83.50		93.50	94.50	97.50		112.50	117.00	117.00
Average Daily Census	77.15	69.19	75.63		93.65	88.37	87.05		111.20	105.39	108.77
Occupancy	87.9%	85.7%	85.7%		92.4%	91.2%	89.8%		94.9%	92.6%	92.8%
Payor Mix Statistics											
Medicare	5.2%	3.9%	4.4%		7.2%	5.4%	6.4%		11.2%	9.7%	8.5%
Medicaid	38.7%	53.9%	52.9%		60.9%	68.3%	66.4%		72.4%	76.5%	71.0%
Other	20.7%	17.5%	23.6%		33.0%	29.8%	28.6%		75.5%	63.3%	50.1%
Avg. Length of Stay Statistics (Days)											
Medicare	31.54	29.89	27.18		34.67	34.06	31.56		37.58	38.34	35.14
Medicaid	330.80	393.56	328.54		467.00	525.90	411.38		613.22	690.20	583.69
Other	48.72	43.52	47.95		76.00	95.01	70.78		123.49	159.49	112.76
Revenue (PPD)											
Inpatient	\$302.82	\$310.27	\$345.21		\$365.52	\$357.78	\$391.39		\$421.11	\$405.88	\$431.75
Ancillary	\$33.85	\$29.28	\$52.00		\$60.96	\$70.56	\$80.29		\$92.51	\$116.55	\$115.05
TOTAL	\$345.37	\$366.18	\$416.64		\$457.80	\$454.85	\$480.49		\$520.04	\$487.49	\$531.41
Expenses (PPD)											
Employee Benefits	\$32.63	\$30.26	\$32.65		\$37.54	\$36.02	\$39.86		\$43.40	\$43.99	\$46.81
Administrative and General	\$60.36	\$72.86	\$65.52		\$75.41	\$76.89	\$78.18		\$83.46	\$87.24	\$89.01
Plant Operations	\$13.69	\$14.11	\$13.83		\$16.60	\$17.30	\$16.67		\$19.66	\$20.64	\$19.87
Laundry & Linens	\$2.94	\$2.80	\$3.62		\$3.62	\$3.95	\$4.62		\$5.32	\$5.08	\$5.29
Housekeeping	\$6.30	\$6.92	\$7.09		\$7.05	\$8.19	\$7.81		\$8.50	\$10.17	\$9.43
Dietary	\$21.58	\$21.72	\$23.22		\$23.98	\$26.03	\$28.09		\$29.34	\$33.89	\$31.64
Nursing & Medical Related	\$98.30	\$108.18	\$112.53		\$113.02	\$117.46	\$123.47		\$126.04	\$139.58	\$136.05
Ancillary and Pharmacy	\$16.40	\$16.55	\$20.66		\$28.42	\$28.71	\$31.63		\$42.06	\$40.90	\$44.38
Social Services	\$2.47	\$2.50	\$2.38		\$3.09	\$2.81	\$3.12		\$4.47	\$6.09	\$4.58

Comments: The above data may be moderately skewed, given that the average sample size over the three-year period is approximately 30 nursing facilities.

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Idaho



INTRODUCTION

Nursing facilities in Idaho are licensed by the Department of Health and Welfare, Bureau of Facility Standards under the designation of “Skilled Nursing Facilities.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN IDAHO	
Licensed Nursing Facilities*	73
Licensed Nursing Beds*	5,990
Beds per 1,000 Aged 65 >**	22.35
Beds per 1,000 Aged 75 >**	56.74
Occupancy Percentage - 2017*	66.00%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Idaho does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility. In addition, there is no moratorium on the construction of nursing facility beds in Idaho. However, Idaho licensing professionals have indicated that due to state budget and staffing issues, the developers of new nursing facility beds in the state are experiencing significant delays in getting new beds certified for Medicaid and Medicare. In addition, given the high nursing facility vacancy rate in the state (approximately 30.0%), approving new nursing facility beds is not a priority in the state.

BED NEED METHODOLOGY

Idaho does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

House Bill 260 was approved by the governor on April 23, 2009, which implemented a nursing facility quality assessment fee (QAF) effective July 1, 2009. The original QAF was \$3.00 per non-Medicare day. However, the QAF was increased to \$11.74, effective July 1, 2010, and to \$19.94 effective July 1, 2011. The QAF was moderately decreased to \$19.83 effective July 1, 2012, and decreased again to \$15.52 effective July 1, 2013. Effective July 1, 2014, the QAF increased to \$16.39 per non-Medicare day. The QAF again increased to \$16.84 effective July 1, 2015. State-owned nursing facilities are exempt from paying the fee. When the QAF legislation was initially passed, the QAF could not exceed 2.0% of net patient revenue. However, this maximum was changed to 5.5% for fiscal year 2011 and to 6.0% effective October 1, 2011. The current QAF effective July 1, 2018 is \$14.97 per non-Medicare day, which is a decrease from the prior fee of \$16.07 per non-Medicare day (effective July 1, 2017).

Effective October 1, 2011, the QAF is assessed and reimbursed on an annual basis. Nursing facilities receive an annual supplemental lump sum payment based upon the state’s Upper Payment Limit (UPL) calculation and their Medicaid volume. Prior to October 1, 2011, nursing facilities were reimbursed quarterly for paying the QAF.

The first step in this calculation is to determine each privately owned nursing facility’s UPL. The UPL is determined individually for each nursing facility by taking the difference between each facility’s estimated average Medicare and average Medicaid rate multiplied by Medicaid resident days. These estimates are combined for all privately owned nursing facilities in the state to determine the total UPL. The revenue generated from the state’s QAF is adequate enough to support the payout of the total UPL. Once total UPL is determined, each nursing facility’s lump sum payment is determined by multiplying the nursing facility’s proportionate percentage of total Medicaid days in the state for the cost report period utilized to determine the UPL.

The state has indicated that on 7/1/2020 the state will link reimbursement from the QAF/UPL calculation to quality measures. The quality measures will consist of nine minimum data set (MDS) long-stay standards including antipsychotic medication use, urinary tract infections, pressure ulcers, indwelling catheter, decline in late-loss ADLs, decline in mobility, physical restraints, moderate to severe pain, falls with major injury and long-stay hospitalization rates. Points will be calculated in increments of 20 (20, 40, 60, 80, 100) using the same methodology used by the Centers for Medicare and Medicaid (CMS) for their Five Star Rating System.

In the fiscal years leading up to the implementation of the system, the state will issue “shadow payments”, which will project the impact of the new system and allow nursing facilities time to educate themselves and adapt to the new system. This period will also give the facilities time to improve their quality scores with the goal of being able to receive 100% of available payments when the actual payments are made (when the program goes live on 7/1/2020).

MEDICAID RATE CALCULATION SYSTEM

Idaho uses a prospective, cost-based, facility-specific, case mix adjusted, rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The current system replaced the former retrospective system over the course of a phase-in period that began on July 1, 1999. As of July 1, 2001, all nursing facilities in the state are reimbursed under the current system.

COST CENTERS

The reimbursement rate for a nursing facility is the sum of the following components:

- The Direct Care component includes direct nursing salaries and benefits, routine nursing supplies, nursing administration, the direct portion of Medicaid-related ancillary services, social services and raw food.
- The Indirect Care component includes costs associated with administrative and general, activities, laundry and linen, dietary (not including raw food), plant operations and maintenance, medical records and housekeeping.
- The Property component, for freestanding nursing facilities, is based on a property rental rate that includes compensation for major movable equipment but not for minor movable equipment. The property rental rate is paid in lieu of payment for amortization, depreciation and interest for financing the

cost of land and depreciable assets. Hospital-based nursing facilities receive actual costs as pass-through expenses.

INFLATION AND REBASING

Idaho law indicates that rates are supposed to be rebased annually and are effective July 1 of each year through the following June 30. Cost report data from January 1, 2017, to December 31, 2017, was used to calculate Medicaid rates effective July 1, 2018.

Idaho law indicates that costs used in establishing a facility's reimbursement rate, as well as the statewide limits, are supposed to be indexed forward from the midpoint of the cost report period to the midpoint of the rate year using the inflation factor, plus 1% per annum. For use in establishing nursing facility rates, the inflation factor is the Skilled Nursing Facility (SNF) Market Basket as published by Global Insight or its successor. Given budget limitations, no inflation adjustments have been applied to fiscal years 2011 through 2016 rates. However, since October 1, 2012, costs were inflated for the purpose of calculating Direct Care and Indirect Care rate component limits. Direct and Indirect Care cost limits are not allowed to decrease below the limits for the base year (cost report period used to determine current rates).

House Bill 123, which was approved in the first regular legislative session of 2009, enacted a 2.7% decrease in nursing facility Medicaid rates for fiscal year 2010. Idaho state veterans homes were exempt from this reduction. This rate reduction was also applied to fiscal years 2011 through 2016 rates. However, the rate reductions in fiscal years 2010 through 2016 were substantially offset by the supplemental payment for the reimbursement of paying the QAF. Reductions in fiscal years 2013 through 2016 were also offset by the rebasing of costs on October 1, 2012, July 1, 2014 and July 1, 2015. Idaho Medicaid has indicated that it will likely continue to apply the 2.7% reduction in the future.

Effective October 1, 2012, the state rebased nursing facility rates utilizing 2011 cost report data. As part of this rebase, the state established nursing facilities with behavioral care units (BCUs) as a separate peer group for the purpose of calculating Direct Care and Indirect Care rates. More detail on this adjustment will be included in the "Rate Methodology" section of this overview. The state also rebased rates on July 1, 2014, utilizing 2013 cost report data. The state rebased rates and cost component ceilings effective July 1, 2015, utilizing 2014 cost report data.

RATE METHODOLOGY

All costs included in the Direct Care cost component, with the exception of raw food and Medicaid-related ancillary costs, are adjusted based on the facility's case mix indices. The Medicaid case mix indices used in establishing each facility's rate are based on the RUG III, Version 5.12, 34-group index maximization model and are recalculated quarterly. Each facility's rate is adjusted accordingly.

The Direct Care component of a facility's rate is the lesser of the facility's inflated Direct Care per diem base year cost or a cost limit for that type of provider. Prior to October 1, 2012, the state utilized two peer groups: freestanding nursing facilities and urban/rural, hospital-based facilities. However, effective this date,

the state removed nursing facilities with BCUs from these peer groups and established two additional peer groups: freestanding nursing facilities and urban/rural, hospital-based facilities with BCUs.

The lower of the inflated per diem cost or limit is then multiplied by the ratio of Medicaid case mix index (CMI) to facility-wide CMI to establish the Direct Care rate component. The Direct Care cost limit for non-BCU freestanding nursing facilities and urban hospital-based facilities is 128% and the cost limit for non-BCU rural hospital-based facilities is 155% of the case mix-adjusted median. The Direct Care cost limited for freestanding nursing facilities and urban hospital-based facilities with BCUs is 185% and the cost limit for rural hospital-based facilities with BCUs is 224% of the case mix-adjusted median.

The median is derived from the case mix-adjusted costs of the facility at the midpoint of beds in the array, not facilities. Case mix-adjusted costs are the facility's per diem Direct Care costs adjusted to the statewide average case mix. This is done by dividing the per diem Direct Care costs by the facility-wide CMI for the cost report period and multiplying the result by the statewide average CMI for that same period.

Since the limit is at the statewide average CMI rather than at the individual facility's CMI, it is subsequently adjusted for each facility by multiplying it by the ratio of the facility-wide CMI to the statewide average CMI. It is then compared to the facility's per diem inflated Direct Care costs.

The Indirect Care component of a facility's rate is the lesser of the facility's inflated Indirect Care per diem costs, or the Indirect per diem cost limit. The same peer groups established to determine Direct Care cost limits are utilized to determine Indirect Care component cost limits. The initial Indirect Care per diem cost for an individual nursing facility is calculated by dividing the total allowable inflated Indirect Care costs by total resident days. The Indirect Care per diem costs for all nursing facilities by category are structured from lowest to highest and a median is calculated.

The Indirect Care limit for freestanding nursing facilities and urban hospital-based facilities is 123.25% of the median and the Indirect Care limit for rural hospital-based facilities is 147.25% of the median. These percentages are consistent by property type (freestanding nursing facilities and urban hospital-based facilities, or rural hospital-based facilities) and are the same for peer groups with or without BCUs.

For the Property cost component, hospital-based nursing facilities receive actual costs as pass-through expenses. Facilities other than hospital-based nursing facilities are paid a property rental rate, and are also reimbursed the Medicaid share of property taxes and reasonable property insurance. The Medicaid share is determined by the ratio of Medicaid patient days to total patient days.

The property rental rate is based upon current construction costs, the age of the facility, the type of facility and major expenditures made to improve the facility. The amount paid for each Medicaid day of care (R) is calculated based on the following formula:

$$R = \text{"Property Base"} \times 40 - \text{"Age"} / 40 \times \text{"Change in Building Costs"}$$

"Property Base" is equal to \$13.19 as of October 1, 1996, for all freestanding nursing facilities. "Age" is the effective age of the building, set by subtracting the year in which the facility was constructed from the year in which the rate is to be applied. No facility can be assigned an effective age of over 30 years, and each facility's effective age has been frozen at its July 1, 1991 level. "Change in Building Costs" is a number that is adjusted each calendar year to reflect the reported annual change in the Building Cost Index for a Class D building in the western region, as published by the Marshall & Swift Valuation Service or the Consumer Price Index for Renter's Costs, whichever is greater. In some occurrences, Idaho will adjust the effective age of a building if the nursing facility has undergone significant renovations or rehabilitation.

Due to the separate cost limits established for freestanding and hospital-based facilities, there are different statewide average rates each year. For rates effective July 1, 2012, the statewide average rate was \$187.17 for freestanding and urban hospital-based facilities and \$236.53 for rural hospital-based facilities. As previously mentioned, effective October 1, 2012, the state created two new peer groups for establishing nursing facility Medicaid rates. Therefore, there are now four nursing facility statewide average rates. For October 1, 2012, the average rate per peer group is as follows: freestanding and urban hospital-based facilities without a BCU at \$181.99, rural hospital-based facilities without a BCU at \$228.25, freestanding and urban hospital-based facilities with a BCU at \$254.58, and rural hospital based facilities with a BCU at \$290.73. Effective July 1, 2013, the average rates are as follows: freestanding and urban hospital-based facilities without a BCU at \$186.91, rural hospital-based facilities without a BCU at \$239.61, freestanding and urban hospital-based facilities with a BCU at \$239.13 and rural hospital-based facilities with a BCU at \$268.89.

Average rates were not available for fiscal years 2015 and 2016. However, effective July 1, 2014, the median rates are as follows: freestanding and urban hospital-based facilities without a BCU – \$201.01; rural hospital-based facilities without a BCU – \$230.98; freestanding and urban hospital-based facilities with a BCU – \$258.43; and rural hospital-based facilities with a BCU – \$289.08. The median rates effective July 1, 2015, are as follows: freestanding and urban hospital-based facilities without a BCU – \$208.12; rural hospital-based facilities without a BCU – \$241.98; and freestanding and urban hospital-based facilities with a BCU – \$266.31. There is no median for rural hospital-based facilities with a BCU because there were no facilities in fiscal year 2016 within that category.

For fiscal years 2018 and 2019, average rate date was limited to freestanding nursing facilities and rural hospital-based facilities. Effective July 1, 2017 and July 1, 2018, the average rates for all freestanding nursing facilities were \$225.10 and \$238.91, respectively. The averages rates for rural hospital-based facilities were \$260.30 effective July 1, 2017 and \$267.23 effective July 1, 2018.

MINIMUM OCCUPANCY STANDARDS

In order to equitably allocate fixed costs to the Medicaid patients in cases where a facility is not maintaining reasonable occupancy levels, an adjustment is made. No occupancy adjustment is made, however, against property reimbursement paid in lieu of property costs. If a facility maintains an average occupancy of less than 80% of a facility's capacity, the total property costs are prorated based on an 80% occupancy rate. The facility's average occupancy percentage is subtracted from 80% and the resultant percentage is multiplied by the total fixed costs to determine the non-allowable fixed costs. For freestanding nursing facilities and urban hospital-based nursing facilities, the adjustment is made only on property insurance and real estate tax expenses. However, the adjustment applies to all property expenses for rural hospital-based facilities since all of these facilities' property expenses are pass-through expenses.

There are no minimum occupancy standards for the Direct Care and Indirect Care components.

OTHER RATE PROVISIONS

Newly constructed facilities are reimbursed at the median rate for skilled-care facilities of the same type (freestanding or hospital-based) for the first three full years of operation. During the period of limitation, the facility's rate is modified each July 1 to reflect the current median rate for skilled-care facilities of that type. After the first three full years, the facility will have its rate established at the next July 1 with the existing facilities.

New providers resulting from a change in ownership of an existing facility receive the previous owner's rate until the new owner has a cost report that qualifies for rate setting criteria.

Idaho does not reimburse nursing facilities for bed hold days resulting from a resident requiring hospitalization. Idaho does reimburse nursing facilities for bed hold days resulting from a resident requiring therapeutic leave, assuming the nursing facility is 95% occupied and that the facility also charges private pay patients for holding a bed. Nursing facilities are reimbursed 75% of their standard rates for three consecutive days and 15 days per calendar year.

Effective July 1, 2014, the state implemented a managed care reimbursement system for dually eligible (Medicare and Medicaid) beneficiaries known as the Medicare Medicaid Coordinated Plan (MMCP). The system is operated by Blue Cross Blue Shield of Idaho (BCBS of Idaho) and Molina Healthcare of Idaho.

Participation in the program is not mandatory. In addition, for Medicaid-eligible nursing home stays, BCBS of Idaho is not allowed to reimburse nursing facilities less than their rates established by the state.

However, effective November 1, 2018, the state is introducing Idaho Medicaid Plus, which will begin with a test market of Twin Falls County. This program is a plan for dual eligible beneficiaries that coordinates most of their Medicaid benefits through a health plan. Unlike MMCP, participation in this program will be mandatory for residents of Twin Falls County. The impact of this program is still being determined.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the planned changes to the reimbursement of the QAF and the “test market” for the potential new managed care system, there are no other planned changes to the state reimbursement methodology or reimbursement system.

IDAHO COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	50.00	50.00	46.00		70.50	68.00	66.00		110.50	111.00	110.50
Average Daily Census	43.22	36.86	34.50		60.63	60.64	56.14		73.10	74.95	78.09
Occupancy	66.9%	65.1%	66.8%		74.5%	72.9%	74.6%		82.3%	85.4%	84.1%
Payor Mix Statistics											
Medicare	5.9%	6.2%	5.6%		11.4%	11.9%	8.8%		20.0%	18.8%	18.9%
Medicaid	48.4%	50.2%	46.3%		62.5%	63.4%	61.4%		68.7%	71.7%	69.4%
Other	17.5%	15.6%	17.8%		22.2%	23.4%	25.3%		32.7%	36.7%	38.9%
Avg. Length of Stay Statistics (Days)											
Medicare	28.37	25.61	22.62		31.66	32.02	28.79		39.81	38.58	35.53
Medicaid	231.09	219.74	252.51		301.53	307.27	361.53		436.19	357.39	493.88
Other	46.10	45.26	47.29		72.61	79.72	67.41		164.63	146.27	134.25
Revenue (PPD)											
Inpatient	\$236.38	\$226.28	\$233.91		\$251.75	\$267.49	\$286.89		\$291.94	\$323.69	\$331.56
Ancillary	\$45.52	\$45.09	\$43.22		\$66.92	\$67.72	\$67.21		\$103.62	\$113.78	\$113.78
TOTAL	\$303.45	\$313.60	\$319.45		\$338.36	\$356.88	\$358.41		\$387.80	\$404.06	\$416.18
Expenses (PPD)											
Employee Benefits	\$21.53	\$22.38	\$20.86		\$26.92	\$26.09	\$30.44		\$34.67	\$36.33	\$37.63
Administrative and General	\$44.86	\$44.12	\$45.68		\$52.03	\$60.77	\$54.42		\$65.30	\$66.30	\$65.17
Plant Operations	\$9.49	\$9.51	\$10.75		\$11.37	\$11.61	\$11.82		\$13.65	\$13.72	\$13.57
Laundry & Linens	\$2.06	\$2.21	\$1.51		\$3.02	\$2.91	\$2.61		\$3.99	\$3.74	\$3.40
Housekeeping	\$4.31	\$4.97	\$5.14		\$5.41	\$5.79	\$6.20		\$6.62	\$6.69	\$7.59
Dietary	\$17.43	\$17.49	\$18.23		\$18.72	\$19.30	\$20.23		\$22.23	\$22.97	\$24.04
Nursing & Medical Related	\$79.07	\$80.17	\$94.24		\$96.24	\$104.35	\$109.99		\$108.60	\$128.32	\$123.56
Ancillary and Pharmacy	\$24.10	\$24.04	\$23.69		\$37.25	\$34.83	\$34.42		\$49.74	\$58.03	\$54.01
Social Services	\$2.72	\$2.49	\$2.78		\$3.64	\$3.53	\$3.64		\$4.87	\$5.33	\$5.02

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Illinois



INTRODUCTION

Nursing facilities in Illinois are licensed and regulated by the Illinois Department of Public Health (IDPH) - Office of Health Care Regulation (OHCR) under the category of "Long-Term Care (LTC) facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN ILLINOIS	
Licensed Nursing Facilities*	689
Licensed Nursing Beds*	99,510
Beds per 1,000 Aged 65 >**	51.09
Beds per 1,000 Aged 75 >**	123.05
Occupancy Percentage - 2017*	73.70%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

In Illinois, the Certificate of Need (CON) program was established in 1974 as a result of the Health Facilities Planning Act. The Health Facilities Planning Board (HFPB) administers the CON program. A CON is required for the following scenarios:

- The construction or modification of a nursing facility that exceeds the capital expenditure threshold of \$7,617,959.
- Any substantial change in a nursing facility's bed capacity by increasing the total number of beds or by distributing beds among various categories of service or by relocating beds from one physical facility or site to another by more than 20 beds or by more than 10% of total bed capacity as defined by the HFPB, whichever is less, over a two year period..
- Any substantial change in the scope of service or functional operation of a nursing facility.
- The proposed establishment or discontinuation of a nursing facility or category of service.
- The acquisition of any major medical equipment that exceeds the capital expenditure threshold of \$7,617,959.

Continuing care retirement communities (CCRCs) must contain one licensed long-term care bed for every five apartments or independent living units. Facilities operated by the federal government are exempt. The capital expenditure thresholds were revised effective July 1, 2018.

BED NEED METHODOLOGY

Illinois utilizes a bed need methodology when considering CON applications. The bed need methodology is based on the expected utilization rates per 1,000 population for three age cohorts (ages 0 to 64, 65 to 74, and 75 and older) in the state's 11 Health Service Areas (HSAs), which include 95 smaller Planning Areas (PAs). The HSAs are as follows:

- HSA 1 - Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside and Winnebago counties;
- HSA 2 - Bureau, Putnam, Henderson, Warren, Marshall, Stark, Fulton, Knox, LaSalle, McDonough, Peoria, Tazewell and Woodford counties;
- HSA 3 - Brown, Schuyler, Calhoun, Pike, Morgan, Scott, Adams, Cass, Christian, Greene, Hancock, Jersey, Logan, Macoupin, Mason, Menard, Montgomery and Sangamon

counties;

- HSA 4 - Coles, Cumberland, Champaign, Clark, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, McLean, Macon, Moultrie, Piatt, Shelby and Vermilion counties;
- HSA 5 - Alexander, Pulaski, Edwards, Wabash, Gallatin, Hamilton, Saline, Johnson, Massac, Hardin, Pope, Clay, Crawford, Effingham, Fayette, Franklin, Jackson, Jasper, Jefferson, Lawrence, Marion, Perry, Randolph, Richland, Union, Washington, Wayne, White and Williamson counties;
- HSA 6 - city of Chicago;
- HSA 7 - Cook and DuPage counties;
- HSA 8 - Kane, Lake and McHenry counties;
- HSA 9 - Grundy, Kankakee, Kendall and Will counties;
- HSA 10 - Henry, Mercer and Rock Island counties;
- HSA 11 - Bond, Clinton, Madison, Monroe and St. Clair counties.

The bed need calculation requires the determination of the PA use rate and the HSA minimum and maximum use rates. The PA and base HSA use rates are calculated by dividing total patient days (derived from facilities within either the PA or HSA) attributed to an age group by the applicable projected age group population for the area. The minimum and maximum use rates for the HSA are calculated by multiplying the base use rate by 60% and 160%, respectively. One of the three calculated use rates is utilized to determine unmet demand for nursing facility beds in an HSA. The most recent use rates were calculated using 2015 utilization data.

The PA use rate (per age cohort) is utilized if it is within the range of the HSA minimum and maximum use rates for each age group. If the PA use rate for a specific age cohort exceeds the equivalent HSA maximum use rate, then the HSA maximum rate for that age group is utilized. If the PA use rate for a specific age group falls below the equivalent HSA minimum use rate, then the HSA minimum use rate for that age group is utilized.

After the appropriate use rates for each age cohort are determined, they are multiplied by the applicable projected population to calculate projected patient days for each age group in that area. The use rates are utilized to calculate the PA's average daily census, which is divided by a 90% occupancy factor to calculate the gross bed need in the PA. The existing beds in the PA are subtracted from the gross bed need estimate to determine the PA's net bed need. Effective September 1, 2017, projected bed need is calculated for 2020 utilizing population data derived from the 2010 census. The following table summarizes the most recent bed need data:

LONG-TERM CARE BED INVENTORY UPDATES			
2020			
Planning Area	Calculated Bed Need 2020	Existing Beds	Additional Beds Needed or (Excess Beds) in 2020
HSA 1	5,529	5,926	-397
HSA 2	6,616	7,622	-1,006
HSA 3	5,888	6,758	-870
HSA 4	6,426	7,954	-1,528
HSA 5	5,808	6,710	-902
HSA 6	11,744	14,100	-2,356
HSA 7	24,706	26,893	-2,187
HSA 8	7,692	7,938	-246
HSA 9	4,663	4,273	390
HSA 10	1,684	1,886	-202
HSA 11	4,384	4,920	-536
Totals	85,140	94,980	-9,840

QUALITY ASSURANCE FEE

Illinois nursing facilities are assessed a quality assurance fee known as a Nursing Home License Fee, which was established in 1993. The current Nursing Home License Fee is \$1.50 per licensed nursing facility bed day. Given budgetary constraints, nursing facilities in Illinois are not reimbursed by the state for Nursing Home License Fee expenses. All funding generated from the Nursing Home License Fee, including federal matching funds, is required to fund the state's Medicaid program.

Effective July 1, 2011, Illinois began charging nursing facilities a second quality assessment fee. This fee is \$6.07 per non-Medicare patient (occupied) day. The assessment is collected monthly, and the proceeds of the assessment and additional federal matching revenue are utilized to fund the state's Medicaid reimbursement system. Only the state's five Subpart T nursing facilities (mental health treatment facilities) are exempt from this provider assessment.

MEDICAID RATE CALCULATION SYSTEM

Illinois uses a prospective, cost-based, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. Effective January 1, 2007, Illinois converted to a case mix methodology, which is utilized to determine a nursing facility's Nursing and Direct Care cost component reimbursement rate. Under the new system, Nursing and Direct Care cost component rates are based on quarterly minimum data set (MDS) assessments of each facility's Medicaid residents. However, this system was not fully phased-in until May 1, 2011 when the state approved the additional quality assessment fee. Rates from January 1, 2007, to April 30, 2011, were a blending of the facility's rate effective December 31, 2006, and the rate calculated utilizing the case mix methodology.

With the exception of rate reductions, May 1, 2011, rates were effective until the state implemented a new reimbursement system utilizing the RUG IV, 48-Grouper to adjust for case mix effective January 1, 2014. This system was phased in from January 1, 2014, to December 31, 2014. The rate methodology section of this overview will focus on how rates were calculated during the phase-in period and how they are projected to be calculated on in the future.

COST CENTERS

Illinois uses the following three cost centers to calculate its facility-specific Medicaid rates:

- The Nursing and Direct Care cost component consists of expenses associated with direct care, nursing and other group care-related health and treatment services. The rate includes payment for assisting patients in meeting basic functional and special health needs and for providing rehabilitative and restorative nursing care services.
- The Support cost component consists of general service and administration costs associated with residential care. It includes costs of food, laundry, housekeeping, utilities, maintenance, administration, insurance, dietary and general office services.

- The Capital cost component is determined using a fair rental value (FRV) system. An FRV and a rate of return are used in lieu of depreciation and/or lease payments on land, building and major movable equipment normally used in providing patient care. Nursing facilities are reimbursed real estate tax costs as pass-through expenses.

INFLATION AND REBASING

Although the rate year for Illinois is from July 1 to June 30, the state completed a limited rebasing of Medicaid rates on January 1, 2009. For rates effective January 1, 2009, the state inflated allowable support costs derived from either 2003 or 2004 cost reports to January 1, 2006.

There was no inflation or rebasing of costs in fiscal years 2011 and 2012. Effective July 1, 2010, Illinois approved Public Act 96-0959, froze rates on April 1, 2011, at rates effective January 1, 2011. These rates were initially to be frozen until the state had approved and implemented a new methodology for adjusting Nursing and Direct Care case rates for patient acuity. Nursing facility rates were to be retroactively adjusted to April 1, 2011, after this new methodology was approved. However, these rates remained frozen until May 2011, when the state converted to 100.0% MDS rates. In addition, with the exception of rate reductions, May 1, 2011, rates remained frozen until January 1, 2014, when the state implemented a new reimbursement system. This partially reflected that the state's MDS reimbursement system utilized the MDS 2.0 assessment tool to adjust the statewide standards used to calculate Nursing and Direct Care cost component rates. Effective October 1, 2010, nursing facilities are required by CMS to use the MDS 3.0 assessment tool that is utilized for Medicare's RUG IV, 48-RUG Grouper, reimbursement system. Given this factor, the state was unable to collect acuity data to adjust the standards and therefore did not adjust May 1, 2011, Nursing and Direct Care cost component rates.

Support cost component rates for nursing facilities were rebased on January 1, 2009, utilizing either 2003 or 2004 cost report data. However, given the state's budgetary constraints, these expenses were only inflated to January 1, 2006. Illinois has standard inflation factors built into the Support cost component rate calculation. With the exception of the rebasing on January 1, 2009, the state has not utilized these factors in several years, and there is no indication that the state will utilize these factors in the future. Support cost component rates effective July 1, 2009, were frozen at January 1, 2009, levels. These rates remained the same until July 1,

2012. In addition, with the exception of a rate reduction on July 1, 2012, Capital cost component rates for nursing facilities have not been significantly altered since 2001.

Given budgetary restraints, the state legislature has approved SB2840, which implements rate reductions effective July 1, 2012. These rate reductions will be implemented by decreasing Support and Capital cost component rates by 1.7%. In addition, Nursing and Direct Care cost components rates will be reduced 10.0% for residents classified into one of the four lowest RUG IV categories (PA1, PA2, BA1 and BA2). Nursing and direct care rates for residents classified in the remaining categories will only

be reduced by 1.0%. State rate setting officials have estimated that the overall reduction equated to an average rate reduction (2.6%), which is similar to the decrease received by other healthcare facilities in the state.

As part of the conversion to the RUG IV system, the state recalculated Nursing and Direct Care cost component rates on January 1, 2014. These calculations reflected that the state provided \$64 million of additional funding for nursing home reimbursement. This resulted in a 6.3% increase in the average nursing facility Medicaid rate (\$137.48) effective January 1, 2014. Capital cost components rates have essentially remained unchanged since July 1, 2012 (the most recent rate reduction). Support cost component rates were frozen from July 1, 2012, to June 30, 2014, however, the rates were increased 8.17% effective July 1, 2014.

However, effective May 1, 2015, the state has made a budget rightsizing adjustment. Overall, the state applied a 2.25% rate reduction to fiscal year 2015 rates (7/1/14 to 6/30/15). In addition, since most of fiscal year 2015 had already passed the state made a retroactive adjustment by reducing all rate components 12.6% from May 1, 2015, to June 30, 2015. This reduction was after rates were adjusted for case mix. Illinois rate add-ons were not reduced.

Effective July 1, 2015, the state backfilled the rate reduction and nursing facilities rates were returned to July 1, 2014 levels adjusted for CMI. Since that date, with the exception of quarterly CMI adjustments to Nursing and Direct Care rates, nursing facilities have remained unchanged. In fiscal year 2019 (effective July 1, 2018) rates continued to be frozen at July 1, 2014 levels with the exception of adjustment for case mix. However, the recently approved amendment to Senate Bill 1814 (2020 Budget Implementation Act) will provide an additional \$240 million in funding for nursing home reimbursement in fiscal year 2020 (Effective July 1, 2019). The details of how this increase in funding is proposed to be utilized are included in the "Proposed Changes to the Medicaid Rate Calculation" section of this overview. However, these details are limited, and there is currently no clear indication of how this increase will be implemented in the rate calculation, as well as what financial impact it will have on nursing facilities.

RATE METHODOLOGY

This analysis will focus on how the state calculated rates effective the transition period (January 1, 2014, and January 1, 2015) and how the state was projected to calculate rates after January 1, 2015. It should be noted that the changes to the reimbursement methodology only altered how the state calculated Nursing and Direct Care cost component rates. With the exception of rate reductions, Capital cost component rates have remained relatively unchanged since July 1, 2001. In addition, Capital cost component rates effective through the transition period equated to rates effective July 1, 2012, when the state last reduced Capital cost component rates. As previously mentioned Capital rates were reduced during fiscal year 2015, which equates to temporary weighted average reduction of 2.25%. Effective July 1, 2015, Capital rates were reestablished at July 1, 2014 (at rate levels prior

to the reduction), and have remained unchanged since that date.

Similar to the Capital cost component rates, with the exception of the budgeted rate reduction (1.7% effective July 1, 2012) and increase (8.17% effective July 1, 2014) and subsequent 2.25% weighted average reduction for the July 1, 2014 to June 30, 2015 rate year. Support cost component rates have not been recalculated since January 1, 2009. Illinois rate setting officials also indicated that they do not anticipate Support cost component rates to change in the near future. Overall, it is currently unclear when the state will next recalculate Capital and Support cost component rates, and what methodology it will use to do so. For the purpose of this overview, this section will detail how Support and Capital cost component rates would be calculated utilizing the methodology that was in place (and is currently in law) when the rates were last calculated.

Under the current methodology, Illinois uses a case mix based system to establish Nursing and Direct Care cost component rates. A nursing facility's Nursing and Direct Care cost component rate is based on a measure of its patient case mix, which reflects the individual needs of patients within the facility and the actual services they are being provided. Based on the quarterly MDS assessment for each Medicaid-eligible resident, specific categories of direct care services are assessed for each resident and the data is compiled to determine the case mix index (CMI) for each facility. Effective January 1, 2014, the state utilizes the RUG IV, 48 Grouper system to determine CMI.

Effective January 1, 2014, a nursing facility's Nursing and Direct Care cost component rate equates to the product of the statewide RUG IV base per diem rate, multiplied by the applicable regional wage adjuster and by each facility's Medicaid day-weighted average CMI, which is redetermined on a quarterly basis. The RUG IV base rate effective January 1, 2014, was determined by dividing the pool of funds available for distribution of case mix by base year case mix, rate adjusted weighted patient days.

The first step utilized to determine the pool of funds was to multiply each nursing facility's Nursing and Direct Care cost component rate effective July 1, 2012, by each facility's base year patient days. Base year patient days were determined by multiplying the number of Medicaid residents in each nursing facility based on the MDS comprehensive assessments for Medicaid residents on the last day of the quarter used to establish the base rate, then multiplied by 365. This total is summed for all applicable nursing facilities. The product of this calculation was then increased by \$13 million to adjust for the exclusion of nursing facilities designated as Class I IMDs, facilities in which over 50% of residents have a primary diagnosis of mental illness.

The base year case mix, rate adjusted weighted patient days is determined by adjusting the previously defined base year resident days by each facility's weighted CMI. The weighted CMI is defined as the number of Medicaid residents as indicated by MDS data multiplied by the associated case weight for the RUG IV, 48 Grouper model utilizing the index maximization method, with the exception of RUGs PA1, PA2, BA1 and BA2. The case weights utilized for these categories are as follows: PA1 - 0.45;

PA2 - 0.49; BA1 - 0.53; and BA2 - 0.58

Nursing facilities are assigned one of 11 regional wage adjusters based on HSA groupings and adjusters in effect on April 30, 2012 as follows:

Planning Area	Regional Wage Factor
HSA 1	0.9401
HSA 2	0.8677
HSA 3	0.8752
HSA 4	0.8903
HSA 5	0.8463
HSA 6	1.0600
HSA 7	1.0600
HSA 8	1.0576
HSA 9	1.0472
HSA 10	0.9145
HSA 11	0.9420

The Medicaid day-weighted average CMI is determined by summing the total case mix weights for all Medicaid eligible residents on the last day of the quarter two periods prior to the rate effective date by the total number of Medicaid residents for that period. In addition, the state utilizes the average Medicaid CMI to adjust Nursing and Direct Care rates on a quarterly basis. For example rates effective July 1, 2014 were calculated utilizing an average CMI determined on the December 31, 2013 picture date.

Based on the above described calculation, the RUG IV base year per diem rate equated to \$83.49 effective January 1, 2014. The state inflated this per diem rate to \$85.25 effective July 1, 2014.

During the transition period (January 1, 2014, to December 31, 2014), a nursing facility's Nursing and Direct Care cost component rates were also adjusted as follows:

- If a nursing facility's transition Nursing and Direct Care cost component rate is greater than its rate effective July 1, 2012, the nursing facility's rate will equate to its July 1, 2012 rate plus 88.0% (the transition factor) of the difference between its July 1, 2012 rate and transition rate.
- If a nursing facility's transition Nursing and Direct Care cost component rate is less than its rate effective July 1, 2012, the nursing facility's rate will equate to its July 1, 2012 rate plus 13.0% (the transition factor) of the difference between its July 1, 2012 rate and transition rate.

Effective January 1, 2015, the Nursing and Direct Care cost component rate calculation will remain the same with the exception of the elimination of the aforementioned transition adjustment and the inflation of the RUG IV base year per diem rate. However, with the exception of the temporary rate reduction in fiscal year 2015 (July 1, 2015 to June 30, 2015), the RUG IV base year per diem rate has remained unchanged since July 1, 2014. It is currently unclear when the state will next inflate or recalculate the RUG IV base year.

As previously mentioned, with the exception of rate reductions or inflation adjustments, the state has not recalculated Support cost component rates since January 1, 2009. Below is a summary of the

current Support cost component methodology in law, which was utilized to calculate January 1, 2009 rates. The likelihood of this methodology being utilized again to calculate new Support cost component rates is unclear.

In order to determine a nursing facility's Medicaid rate, Illinois separates nursing facilities into seven geographic-based peer groups as follows:

Illinois Geographic-Based Peer Group	
Peer Group	Location
I	Northwestern section of Illinois
II	Central section of Illinois
III	West central section of Illinois
IV	Southern section of Illinois
V	Northwestern section of Illinois, including the city of Chicago and Cook County
VI	Northeastern portion of Illinois located directly south of Chicago and Cook County
VII	Portion of Illinois that is located in the St. Louis, Missouri Metropolitan Statistical Area

The calculation of the Support cost component rate includes the calculation of per diem rates for the two subcomponents, General Services and General Administration. Under state regulations, a specific inflation factor is required to be applied to a nursing facility's allowable costs for each subcomponent. This inflation factor is based on the nursing facility's beginning and ending cost report period. However, the state typically has not been able to fund these increases in cost in recent years. The allowable inflated costs for both subcomponents are summed and divided by total patient days (adjusted for the minimum occupancy requirement, if necessary) to determine the facility-specific Support cost component per diem cost.

The facility-specific per diem costs for all applicable nursing facilities are arrayed by peer group, and the 35th and 75th percentile per diem costs are determined for each peer group. The maximum allowable Support cost component rate equates to the 75th percentile of the peer group's per diem costs. If a nursing facility's Support cost component per diem cost is below the 35th percentile per diem cost, that facility is reimbursed its facility-specific per diem cost plus 50% of the difference between its per diem cost and the 75th percentile cost. However, the facility is subject to a ceiling that equates to 50% of the difference between the 35th and 75th percentile per diem costs, plus \$0.05. If a nursing facility's Support cost component per diem cost is above the 35th percentile, but below the 75th percentile, the facility's rate equates to its facility-specific per diem cost plus 50% of the difference between its per diem cost and the 75th percentile cost.

With limited exceptions, the state has not recalculated nursing facilities' Capital cost component rates since July 1, 2001. The likelihood of the state recalculating Capital cost component rates in the future is unclear. Under state regulations, a nursing facility's Capital cost component rate is predominantly determined through an FRV system. A blended FRV per bed is multiplied by a rate of return and converted to a per diem cost.

The facility-specific per-bed FRV is an average of the uniform building value per bed and the nursing facility's historical inflated value per bed. Both values are determined utilizing the base year

of the nursing facility. The base year of the facility is determined by calculating a weighted average year of construction based on the facility's historical improvement costs by year. The state has established specific uniform building values per bed for base years between 1970 and 2000. The state has not updated these base values since 2001. If a facility was constructed after 2000, the 2000 uniform building value is assumed for the facility. If a nursing facility's base year is prior to 1970, it receives the 1970 uniform building value.

The facility-specific value per bed is determined by multiplying the total construction costs per bed (historical construction costs/total beds) by an inflation factor determined by the state that is based on the facility's base year. The average of the facility-specific uniform building value per bed and historical value per bed cannot exceed 120% of the uniform building value per bed. The lesser of the average value or the maximum allowable value is divided by the total number of patient days for a single bed at 93% occupancy (339 days), which is then multiplied by the rate of return. This equates to the Capital cost component per diem cost. A per diem cost for real estate taxes and for equipment, rent, vehicle expenses and working capital is added to the Capital cost component per diem cost to determine a facility's Capital cost component rate. Facility-specific real estate taxes have not been rebased since July 1, 2001. The add-on for equipment, rent, vehicle expenses and working capital is a median cost of these expenses that equates to \$2.50 per diem. This add-on has not been updated since 2001.

Nursing facilities that have undergone renovations resulting in a greater than 10% increase in Capital costs can apply for a new Capital cost component rate.

Effective October 1, 2009, an MDS payment methodology was implemented to provide a rate add-on for residents who require ventilator care. The most current add-on (effective January 1, 2014) is \$208 per day. The state will also grant nursing facilities with one of three rate add-ons for residents with traumatic brain injuries (TBI). The most current add-ons (effective January 1, 2014) are \$264.17 per day for Tier I, \$486.49 for Tier II and \$767.46 for Tier III. According to Illinois rate setting officials, effective July 1, 2017 no facilities in the state are currently applying for, or receiving this add-on.

Effective July 1, 2014, nursing facilities are also eligible for an Alzheimer's/dementia add-on. The add-on is calculated by dividing the total number of residents with Alzheimer's disease and/or dementia (derived from the MDS verification list) by the total number of Medicaid-eligible residents. The product of this calculation is multiplied by \$0.63. Effective the same date, nursing facilities are also eligible for a rate add-on for residents with a serious mental illness (SMI) who are assessed at one of the four lowest RUG categories (PA1, PA2, BA1 and BA2). This methodology used to calculate this add-on is the same as Alzheimer's/dementia add-on. However, the product of the initial calculation (total SMI residents/total Medicaid eligible residents) is multiplied by \$2.67.

Lastly, effective January 1, 2015, nursing facilities will also receive a \$5.00 per day add-on for TBI patients whose acuity level is below the required criteria to be eligible for the TBI add-on.

The average rebased rate effective July 1, 2010 is \$118.65 per day, which is a 1% increase from the previous average rates of \$117.76 effective July 1, 2009, and \$117.48 effective January 1, 2009. The average rate effective January 1, 2011 (\$120.63) did not significantly vary from the rate effective July 1, 2010. When the state fully converted to the MDS rates effective May 1, 2011, the average rate increased 10.2% to \$132.89. However, as previously mentioned, the state reduced nursing facility rates effective July 1, 2012, which resulted in a 2.6% reduction in the average rate (\$129.39). Upon implementation of the RUG IV system, the state provided \$64 million of additional funding for nursing home reimbursement. This resulted in a 6.3% increase in the average rate (\$137.48) effective January 1, 2014.

Effective July 1, 2014, the average rate increased five percent to \$144.35. The average rate has continued to moderately increase effective July 1, 2015 (\$147.80), July 1, 2016 (\$151.43), and July 1, 2017 (\$153.39) and July 1, 2018 (\$153.16). Given there has been no inflation or recalculating of cost since July 1, 2014, these changes are directly related to increases in facility CMI's. However, as previously mentioned, the state will be providing approximately \$240 million of additional funding for nursing home reimbursement in fiscal year 2020 (effective July 1, 2019). The financial impact of this increase is still to be determined.

MINIMUM OCCUPANCY STANDARDS

The Capital cost component per diem cost is calculated assuming that a nursing facility will maintain a 93.0% occupancy percentage. If a nursing facility's occupancy percentage is below 93.0%, the General Administration and General Services cost subcomponent per diem costs will be determined utilizing the facility's total patient days, plus one-third of the difference between the facility's actual total patient days and the facility's total patient days at 93.0% occupancy.

OTHER RATE PROVISIONS

The Capital cost component rate for a newly constructed nursing facility will be determined utilizing the FRV system. The applicable peer group median real estate tax per diem cost will be utilized to determine the portion of the rate attributed to reimbursement of real estate taxes. The nursing facility's rate for the Nursing and Direct Care and Support cost components will equate to the applicable peer group median per diem cost. The Nursing and Direct Care component rate will be recalculated after the facility has generated a quarter of MDS data. If a nursing facility experiences a change of ownership, the new owner will receive the old owner's rate until the facility has accumulated a quarter of MDS data.

SB 2840 eliminated the reimbursement of nursing facilities for reserving a bed for an absence related to a hospitalization or therapeutic level. Illinois Medicaid had previously reimbursed nursing facilities for reserving a bed for hospitalization or therapeutic leave, assuming the facility had an occupancy of

93% or greater and Medicaid represented the primary payor source of at least 90% of the facility's residents. Nursing facilities were reimbursed up to 10 days per episode of a qualifying hospitalization leave at 75% of the facility's current Medicaid rate. Nursing facilities were reimbursed up to seven consecutive days per episode, or 10 days per month, for qualified therapeutic leave at 75% of the facility's current rate.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

The state of Illinois legislature recently approved (June 1, 2019) an amendment to Senate Bill 1814 (2020 Budget Implementation Budget Act), which approved the state's fiscal year 2020 budget. Included in this budget is an approximately \$240 million increase in funding for nursing home reimbursement. However, the details of how this increase in funding will be utilized in the rate calculation, or any potential changes to the rate calculation, are currently not available.

The bill does provide a preliminary indication on how the funds should be utilized as follows:

- Approximately \$70 million of funding will be dedicated to the establishment of a direct care staffing add-on. This state has recently passed legislation that will increase the state's minimum wage from \$8.25 to \$9.75 on January 1, 2020, with the goal of increasing the minimum wage to \$15.00 by 2025.
- Approximately \$136 million will be dedicated to the rebasing of Support cost component rates utilizing the most current cost report data available.
- Approximately \$34 million will be dedicated to a hold harmless provision, which will assure that a nursing facility's new Medicaid rates effective July 1, 2019, will not be less than the facility's rate effective June 30, 2019.

Overall, the financial impact this increase of funding will have on nursing homes is still to be determined

ILLINOIS COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	60.00	60.00	62.00		99.00	98.00	99.00		142.00	142.50	148.00
Average Daily Census	64.82	64.73	64.30		89.55	88.55	88.13		125.78	127.42	127.18
Occupancy	67.8%	67.7%	65.8%		77.9%	77.5%	76.5%		86.0%	86.2%	84.9%
Payor Mix Statistics											
Medicare	7.0%	6.7%	6.4%		10.9%	10.5%	10.2%		17.4%	16.4%	16.8%
Medicaid	38.8%	38.2%	34.7%		53.9%	53.1%	53.6%		70.0%	69.1%	71.8%
Other	19.9%	21.9%	20.4%		34.6%	35.8%	35.1%		51.7%	54.0%	56.0%
Avg. Length of Stay Statistics (Days)											
Medicare	32.41	31.94	29.82		41.00	41.70	38.85		52.74	55.14	50.36
Medicaid	164.75	184.51	162.21		257.77	321.35	276.45		403.77	474.40	444.06
Other	88.75	89.25	78.83		169.82	169.30	149.15		378.27	339.46	304.64
Revenue (PPD)											
Inpatient	\$164.24	\$168.16	\$171.62		\$195.72	\$205.72	\$210.67		\$248.12	\$260.68	\$275.55
Ancillary	\$23.54	\$25.40	\$25.10		\$46.99	\$49.36	\$50.73		\$93.78	\$95.56	\$98.08
TOTAL	\$193.74	\$198.49	\$204.01		\$243.09	\$253.36	\$265.60		\$331.64	\$353.78	\$367.08
Expenses (PPD)											
Employee Benefits	\$11.87	\$12.17	\$12.56		\$16.23	\$16.02	\$16.33		\$24.76	\$23.86	\$24.62
Administrative and General	\$31.80	\$32.78	\$34.83		\$42.19	\$43.38	\$44.79		\$52.31	\$54.90	\$57.22
Plant Operations	\$7.93	\$8.01	\$8.02		\$9.68	\$9.58	\$9.86		\$12.04	\$12.25	\$12.76
Laundry & Linens	\$1.69	\$1.72	\$1.71		\$2.35	\$2.40	\$2.37		\$3.22	\$3.24	\$3.33
Housekeeping	\$4.54	\$4.64	\$4.78		\$5.49	\$5.56	\$5.75		\$6.71	\$6.80	\$6.99
Dietary	\$13.61	\$13.55	\$14.09		\$15.93	\$16.01	\$16.55		\$19.46	\$19.50	\$20.58
Nursing & Medical Related	\$56.59	\$58.91	\$62.53		\$67.96	\$70.56	\$75.03		\$84.01	\$84.96	\$94.24
Ancillary and Pharmacy	\$15.97	\$15.69	\$16.34		\$25.34	\$24.46	\$25.54		\$39.06	\$38.40	\$40.87
Social Services	\$3.75	\$3.92	\$4.20		\$5.29	\$5.47	\$5.73		\$7.67	\$7.97	\$8.30

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Indiana



INTRODUCTION

Nursing facilities in Indiana are licensed and regulated by The Indiana State Department of Health (ISDH), Division of Long-Term Care, as "Comprehensive Care Facilities" (CCF). The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN INDIANA	
Licensed Nursing Facilities*	554
Licensed Nursing Beds*	52,904
Beds per 1,000 Aged 65 >**	50.81
Beds per 1,000 Aged 75 >**	124.49
Occupancy Percentage - 2017*	72.20%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

Effective March 25, 2018, the Indiana Legislature and Governor signed Senate Bill 190, which establishes a Certificate of Need ("CON") Program for Indiana. The program is scheduled to be implemented on July 1, 2019, but certain parameters of the program still need to be finalized. Prior this bill, Indiana did not maintain a Certificate of Need (CON) program. However, a moratorium on the construction of new nursing facility beds was enacted on July 1, 2006. Although the overall moratorium terminated on June 30, 2014, the state modified portions of the moratorium conditions in 2011 and extended it to July 1, 2016, and then to June 30, 2018. In order to bridge the gap between when the CON legislation was approved and when it will be implemented, the moratorium has been extended to June 30, 2019. This moratorium will be eliminated on July 1, 2019, when the CON program becomes active.

Specifically, the certification or conversion of nursing facility beds for participation in the Medicaid program cannot be approved unless the statewide nursing facility occupancy percentage is greater than 95%. In addition, there is no restriction on the addition of newly licensed nursing facility beds if they will be certified only for Medicare or not certified at all.

The following scenarios are exempt from the moratorium:

- A hospital that proposes to convert no more than 30 acute-care beds to nursing facility beds, or no more than 20 acute-care beds to skilled care nursing facility beds.
- The construction of a replacement nursing facility. In addition, nursing facilities in Indiana can transfer licensed beds from one facility to another.
- The construction of a small house health facility, which cannot contain more than 50 beds. The state cannot approve the licensure of more than 100 new beds designated for small house health facilities.
- A nursing facility within a continuing care retirement community (CCRC).

In addition, exceptions to the moratorium may be issued for nursing facility beds dedicated to providing services to residents with the following medical conditions: the need for ventilator care; a medically stable brain and high spinal cord trauma; a major progressive neuromuscular disease; or HIV.

BED NEED METHODOLOGY

Indiana has not utilized a bed need methodology since 2004 and currently does not have a bed need methodology in place. However, as part of Senate Bill 190, the state has approved the usage of a bed need methodology that will be effective July 1, 2019. This methodology will be used to assess CON applications. Aspects of the methodology still need to be finalized.

QUALITY ASSESSMENT FEE

The quality assessment fee (QAF) in Indiana was recently extended through June 30, 2017. Effective July 1, 2014, the current QAF is \$16.37 per non-Medicare patient day (with fewer than 62,000 patient days) or \$4.09 (with 62,000 or greater patient days or government owned). Nursing beds located in a CCRC, hospital-based facilities and the state veterans' home are exempt from the QAF. The QAF current equates to approximately 4.75% of total revenue, which is below the maximum allowable QAF (6.0% of total revenue) by the Centers for Medicare and Medicaid (CMS). In addition, effective July 1, 2014, the state changed the previously mentioned total patient day threshold from 70,000 to 62,000.

The previous QAFs, effective October 1, 2012, were \$16.00 per non-Medicare day for nursing facilities with fewer than 70,000 patient days and \$4.00 for nursing facilities with equal to or greater than 70,000 patient days. The QAFs effective July 1, 2011, were \$14.70 per non-Medicare day for nursing facilities with fewer than 70,000 patient days and \$3.68 for nursing facilities with equal to or greater than 70,000 patient days. The increase in the QAFs (effective October 1, 2012) were applied to partially offset the implementation of a 5.0% total Medicaid rate reduction effective July 1, 2011.

The QAF is included in Medicaid reimbursement as an add-on to the Medicaid rate. The Medicaid reimbursement rate paid to nursing facilities includes a rate add-on for the nursing facility QAF that nursing facilities pay to the state. The add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recent completed cost report. The 5.0% rate reduction is not applied to the QAF add-on.

When the QAF was initially developed by the state, 80% of the revenue it generated was utilized to fund the Medicaid rate calculation system. Effective July 1, 2009, this amount was reduced to approximately 60%. The percentages for fiscal years 2012 and 2013 were 67.1% and 66.5%, respectively. The percentage for fiscal year 2014 was 70.6%. This percentage will be utilized by the state for the foreseeable future.

MEDICAID RATE CALCULATION SYSTEM

The Indiana Medicaid reimbursement system is a prospective, cost-based, case mix adjusted, facility-specific rate setting system. In 2009, Indiana approved significant changes to its rate setting system, and these alterations were implemented effective January 1, 2010. The most significant of these changes was the conversion of the Administrative cost component from a facility-specific cost-based rate to a statewide price, which will be discussed later in this overview.

COST CENTERS

Indiana uses the following five cost centers to calculate its facility-specific Medicaid rates:

- **The Direct Care** cost component includes all expenses related to nursing and nursing aide services, nursing consulting services, pharmacy consultants, medical director services, nursing aid training, medical supplies, oxygen and medical records.
- **The Indirect Care** cost component includes expenses related to dietary services and supplies, raw food, patient laundry services and supplies, patient housekeeping services and supplies, plant operations services and supplies, utilities, social services, activity supplies and services, recreational supplies and services, and repairs and maintenance.
- **The Administrative** cost component includes expenses related to administrator and co-administrator services, owners' compensation (including director's fees) for patient related services, services and supplies related to a home office, office and clerical staff, legal and accounting fees, advertising, travel, telephone, license dues and subscriptions, office supplies, working capital interest, state gross receipt taxes, utilization review costs, liability insurance, and management and other consulting fees.
- **The Capital** cost component includes a fair rental value allowance, property insurance and property taxes.
- **The Therapy** cost component includes all expenses related to providing therapy services to Medicaid residents, including audiology, physical therapy, speech therapy, occupational therapy and respiratory therapy.

INFLATION AND REBASING

Indiana annually rebases nursing facility Medicaid rates utilizing the most recent cost report data available. All allowable costs are adjusted for inflation using the CMS Nursing Home Without Capital Market Basket Index published by Global Insight. The adjustments will be made from the midpoint of the cost report year to the midpoint of the effective rate year. The state utilizes a July 1 to June 30 rate.

As previously mentioned, Indiana imposed a 5.0% rate reduction effective July 1, 2011. This reduction was effective until December 31, 2013. The state rebased rates effective July 1, 2012, and July 1, 2013. However, the 5.0% rate reduction was applied to these rebased rates. The rate reduction was decreased from 5% to 3% effective January 1, 2014. This change was also incorporated for Medicaid rates calculated from fiscal year 2015 to fiscal year 2019. Rates were also rebased for each fiscal year within this period.

RATE METHODOLOGY

The majority of non-capital cost component rates for nursing facilities in Indiana is generally set at the lower of the facility's specific per diem cost or an established rate ceiling. The rate ceilings are typically set a level above the median cost for all facilities within the state. The median for each cost component is determined through an array of the facility-specific per diem costs for all applicable nursing facilities. Prior to determining the component-specific rate ceilings, a profit ceiling is set for the Direct Care, Indirect Care and Capital cost components. The profit ceilings are also set a percentage above

the applicable median (lower than the percentage used to determine the rate ceiling), and nursing facilities are eligible for an add-on to their per diem cost if their per diem cost is below the profit ceiling. This add-on is typically determined by multiplying the difference between the facility-specific per diem cost and the rate ceiling by a specific percentage. In addition, these add-ons are subject to adjustment based on the Nursing Facility Quality add-on score. This add-on will be further detailed later in this overview.

Effective July 1, 2016, Indiana utilizes the Resource Utilization Group (RUG) IV system to adjust facility-specific Direct Care cost component rates quarterly for changes in CMI for the facility's Medicaid residents. The state utilizes 48 RUG categories. Prior to this date, the state had utilized the RUG III, 34 RUG Grouper. The initial facility-specific Direct Care cost component per diem cost is determined by dividing allowable inflated direct care costs by total patient days (adjusted for the minimum occupancy requirement if necessary). The facility-specific Direct Care cost component per diem costs are first case mix neutralized and then adjusted for the facility average CMI (for all payors) prior to determining the rate ceiling for the component. This is accomplished by dividing the facility-specific Direct Care cost component per diem cost by the facility average CMI for the same period as the cost report data.

Effective January 1, 2010, the state reduced the CMI adjustment for residents who have limited physical functioning problems as well as no cognitive impairments or incontinence issues. A lower CMI is applied for residents who are classified into one of four reduced physical functioning RUG categories (PB2, PB1, PA2 and PA1) and possess mild to no cognitive impairment.

The Direct Care cost component profit ceiling is set at 110% of the median of the facility-specific case mix neutral per diem costs. If a facility's case mix neutral per diem cost is less than the ceiling, a nursing facility is eligible to receive a profit add-on that equates to 30% of the difference. The sum of the facility-specific case mix neutral per diem cost and the profit add-on cannot exceed the Direct Care cost component ceiling of 120% of the median. The lower of case mix neutral per diem cost (plus the incentive) or the ceiling is then multiplied by the facility's Medicaid case mix to determine the Direct Care cost component rate. The facility-specific Medicaid CMI is derived from the calendar quarter two quarters prior to the rate effective date. The weighted median Direct Care cost for nursing facilities as of July 1, 2018, is \$82.86.

Effective January 1, 2010, nursing facilities' incentive payments are subject to the nursing facility quality of care assessment. This assessment is derived from the states Nursing Facility Quality add-on, which was recently altered effective July 1, 2013. The calculation of this add-on will be detailed later in this section. However, nursing facilities' Direct Care component profit incentives will equate to the facility's tentative profit add-on multiplied by the applicable percentage contained in the following table:

Total Quality Score	Allowed Direct Care Profit Add-on Percentage
84 - 100	100%
19 - 83	100% + [(Total Quality Score - 84) / 66]
18 and below	0%

Facility-specific Indirect Care cost component per diem costs are determined by dividing allowable inflated costs by total patient days (adjusted for the minimum occupancy requirement if necessary). The profit ceiling for this component is 105% of the median cost for all applicable nursing facilities. The profit add-on that a nursing facility is eligible to receive equates to 60% of the difference between the facility-specific per diem cost and the profit ceiling. The sum of the facility-specific per diem cost and the profit add-on cannot exceed the Indirect Care cost component ceiling of 115% of the median. The weighted median Indirect Care cost for nursing facilities as of July 1, 2018, is \$44.37. In addition, a nursing facility's Indirect Care profit add-on (effective January 1, 2010) is subject to the same restrictions previously described for the Direct Care profit add-on.

Effective October 1, 2011, the facility-specific Administrative cost component per diem rates were equal to 110% of the average allowable cost of the median patient day of all the facilities in the state. This represented an increase in the percentage (100.0%) utilized to reimburse rates effective July 1, 2011. Effective July 1, 2012, and July 1, 2013, the percentage decreased to 108.0% and 100.0%, respectively. The percentage equated to 100.0% in fiscal year 2019 (effective July 1, 2018). The statewide Administrative cost component rate effective July 1, 2018, is \$23.14.

Medicaid allowable therapy expenses for Indiana nursing facilities are reimbursed as direct pass-through expenses and are not subject to any rate ceilings. As such, nursing facilities are not eligible for any profit add-ons related to therapy expenses. The facility-specific Therapy cost component per diem rate equates to allowable inflated therapy expenses divided by total patient days. Any expenses related to providing therapy services that were allocated to any other cost component (administrative expenses) are reallocated to the therapy cost component. The weighted median Therapy cost component rate for nursing facilities as of July 1, 2018, is \$0.61.

A nursing facility's Capital cost component rate consists of two components, an Fair Rental Value (FRV) allowance and allowable inflated property tax and property insurance costs for the most recent cost report period. It is not updated annually.

Nursing facilities are reimbursed for the use of facilities and equipment, regardless of whether or not they are owned or leased, by means of a FRV allowance. Reimbursement calculated through the FRV allowance is in lieu of the costs of all depreciation, interest, lease, rent or other consideration paid for use of the property. This includes all central office facilities and equipment whose patient care-related depreciation, interest or lease expense is appropriately allocated to the facility. The first step in determining the FRV allowance is to calculate the statewide median average historic cost of property per bed.

This median is calculated by first determining for each nursing facility (not acquired through an operating lease agreement), on a per bed basis, the historical cost of allowable patient-related property. These costs include land, building, improvements, vehicles and equipment. Land, building, and improvements will be adjusted for changes in valuation by inflating the reported allowable patient-related historical cost of property from the later

of July 1, 1976, or the date of facility acquisition to the present based on the change in the RS Means Construction Index. For each nursing facility, an average cost per bed (per year of construction) is calculated based on inflated costs.

The facility-specific average per-bed costs by year of construction are arrayed, and the statewide median cost is determined. The median cost effective July 1, 2018, is \$116,874. After the median has been determined, a nursing facility's FRV is calculated by multiplying the facility's total number of beds by the median cost per bed. A nursing facility's FRV allowance is then determined by multiplying its FRV by a rental rate. The rental rate will be a simple average of the U.S. Treasury Bond, 10-year amortization, constant maturity rate plus 3%, in effect on the first day of the month that the index is published for each of the 12 months immediately preceding the rate's effective date. The rental rate will be updated quarterly on January 1, April 1, July 1 and October 1. The rental rate effective April 1, 2019, is 5.891%.

The sum of the FRV allowance and the allowable property tax and property insurance costs is divided by total patient days (adjusted for the occupancy requirement, if necessary) to determine the facility-specific Capital cost component per diem cost. Nursing facilities are reimbursed the lesser of the facility-specific per diem cost or the component ceiling, which equates to the median cost in the state. The statewide Capital cost component median cost effective July 1, 2018, is \$20.36.

Nursing facilities are also eligible to receive a profit add-on that equates to 60% of the difference between the facility-specific per diem cost and the ceiling. In addition, nursing facilities' Capital profit add-ons (effective January 1, 2010) are subject to the same restrictions previously described for the Direct Care profit add-on.

Effective July 1, 2003, Indiana established two Medicaid rate add-ons. The Nursing Home Report Card add-on was for facilities that provide an improved quality of care. Previously, the assessment add-on, known as the Improved Quality of Care add-on, was based on an assessment tool (Nursing Home Report Card) that measured the quality of care provided at a specific nursing home. A nursing facility was eligible to receive a rate add-on ranging from \$1.50 to \$3.00 based on its report card score. However, from the time of the program's inception, the state did not adjust nursing facility rates for the report card score, so facilities that initially received the Quality of Care add-on continued to receive the add-on. Effective January 1, 2010, the state amended its Quality of Care add-on calculation, renaming it the Nursing Home Report Card add-on. A nursing facility's report card score is determined based on the latest published data available as of the end of each state fiscal year.

Effective July 1, 2013, the state implemented a new calculation to determine the Nursing Facility Quality add-on called the Value-Based Purchasing (VBP) System. The Nursing Facility Quality add-on and cost component profit incentives are now determined utilizing nursing facilities' state survey results and seven separate staffing measures. The state Report Card Score that was previously used to determine 100% of the performance add-on was decreased to equate to 75% of the new VBP quality

score and the remaining 25% will depend on facility performance with staff retention, turnover and nursing hours per resident day.

The Nursing Facility Quality add-on is based on a nursing facility's total quality points as detailed in the following tables:

Nursing Facility Quality Add-on	
Nursing Facility Total Quality Score	Add-on
0-18	\$0
19-83	\$14.30 - $((84 - \text{Nursing Facility Total Quality Score}) \times 0.216867)$
84-100	\$14.30

The maximum allowable quality points for each category are determined as follows:

Category	Points
Nursing Home Report Care Score	75
Normalized Weighted Average Nursing Hours Per Resident Day	10
Nursing Facility's RN/LPN Retention Rates	3
Nursing Facility's CNA Retention Rates	3
Nursing Facility's Annual RN/LPN Turnover Rate	1
Nursing Facility's Annual CNA Turnover Rate	2
Number of Administrators Employed Within the Last Five (5) Years	3
Number of DONs Employed Within the Last Five (5) Years	3
Total	100

Specifically, the methodology utilized to determine the number of quality points for the Report Card Score is as follows:

Quality Points Based on Report Card Score	
Report Card Score	Quality Points Awarded
0 - 82	75
83 - 265	Proportional quality points awarded as follows: $75 - ((\text{facility report card score} - 82) \times 0.407609)$
266 and above	0

Effective July 1, 2018, the median Nursing Facility Quality add-on in the state was \$11.05.

The state has agreed to a two-year phase-in of changes to the VBP system. For rates effective July 1, 2018, the methodology of calculating the add-on will remain the same. The following is a summary of the proposed changes:

- Effective July 1, 2019, 30% of the add-on will be based on quality measures, 55.0% will be based on report card scores, 10.0% will be based on staff retention and 5.0% will be based on advance care planning certificates.
- Effective July 1, 2020, the quality measures percentage will increase to 60.0% and the record card percentage will decrease to 25.0%. The percentages for the other categories will remain the same.

This new methodology has yet to be finalized or published by the state.

The second add-on is for special care units (SCUs) that cater to Alzheimer's/dementia residents and operate an SCU for such residents, as demonstrated by resident assessment data as of March 31 of each year. This add-on is only received for residents who are located within an SCU. The maximum SCU add-on is

\$12.00 per diem. However, the overall add-on is calculated on a total patient day basis. Effective July 1, 2018, the average SCU add-on was \$1.35.

Indiana may increase Medicaid reimbursement to nursing facilities that provide inpatient services to more than eight ventilator-dependent residents. Additional reimbursement will be provided to the facilities at a rate of \$11.50 per Medicaid resident day.

The median nursing facility rate effective July 1, 2018 (some rates are effective April 1, 2019) is \$200.58. This represents a 2.3% increase from the median rate effective October 1, 2017 (\$196.13). The median rate effective July 1, 2017 is \$188.47. Median and/or average rate estimates were unavailable for fiscal years 2015 (effective July 1, 2014) and 2016 (effective July 1, 2015). As of October 1, 2013, the statewide average Medicaid rate is \$173.15 which represents a 2.5% increase from the rate (\$168.92) effective January 1, 2012. The January 1, 2012, and October 1, 2013, average rates reflect the 5.0% rate reduction and the increased add-ons. The statewide average Medicaid rate was \$151.57 effective July 1, 2010, \$150.75 effective July 1, 2009, \$141.01 effective July 1, 2008, and \$135.02 effective July 1, 2007.

MINIMUM OCCUPANCY STANDARDS

A minimum occupancy standard is applied to the calculation of the fixed costs portion of the facility-specific per diem costs for the Direct Care, Indirect Care and Capital cost components. For the Direct Care and Indirect Care cost components, 25% and 37% of costs, respectively, are considered fixed and are subject to an occupancy standard. The minimum occupancy requirement for these cost components is as follows:

- For nursing facilities with fewer than 51 beds, an 85% occupancy standard will be applied.
- For nursing facilities with greater than 50 beds, a 90% occupancy standard will be applied. Allowable fixed costs per patient day for capital-related costs are calculated based on an occupancy rate greater than 95% or the provider's actual occupancy rate, as determined by the most recent historical period.

A facility's rates may be reestablished without meeting the minimum occupancy requirement if the following conditions are met to the satisfaction of the state office:

- The provider demonstrates that its current resident census has increased to the minimum occupancy level or greater since the end of the last fiscal year, based on the most recently reviewed cost report data, and remained at that level for no less than 90 days.
- The provider demonstrates that its resident census has increased by at least 15% since the end of the last fiscal year based on the most recently reviewed cost report data.

OTHER RATE PROVISIONS

Initial interim rates for new nursing facilities will be set at the median per diem cost for the Direct Care, Therapy, Indirect Care and Administrative cost components, and 80% of the median per diem cost for the Capital cost component. Before the provider's first annual rate review, the Direct Care cost component portion

of the initial interim Medicaid rate will be adjusted retroactively to reflect changes occurring in the first and second calendar quarters of operation in the provider's CMI for Medicaid residents. The rate will also be adjusted prospectively after the second quarter to reflect changes in the provider's CMI for Medicaid residents. The nursing facility is subject to a rate review in the next rate period after it has accumulated six months of cost report data.

Nursing facilities that have experienced a change of ownership will receive the Medicaid rate calculated based on the previous owner's cost report and case mix data. The nursing facility is subject to a rate review in the next rate period after it has accumulated six months of cost report data.

Effective February 1, 2011, the state of Indiana eliminated any reimbursement for reserving a bed for hospitalization or therapeutic leave.

INTERGOVERNMENTAL TRANSFERS

In the 2009 legislation session, Indiana approved the Intergovernmental Transfer (IGT) Program. Similar to the quality assessment fees (i.e. provider taxes) this is another mechanism that states use to draw extra matching funds from the Centers of Medicare and Medicaid (CMS). This typically involves temporarily transferring funds from local/county hospitals to the state. The state claims this as Medicaid funding provided by the state, which CMS matches at the state's Federal Medical Assistance Percentage (FMAP). These percentages range from approximately 50.0% to 76.93% in fiscal year 2019. After collecting the matching funds from CMS, the state reimburses county hospitals for their contributions and provides them with a portion of the additional funds generated through the IGT program.

The first step in determining this reimbursement is to calculate each facility's Upper Payment Limit (UPL). States pay hospitals under Medicaid reimbursement methodologies established in the State Plan, then estimate how much more the hospitals would have been paid for the services under Medicare principles. The difference between the payments and the estimate is the amount that is available for additional reimbursement and is referred to as the UPL.

Under this program, county or municipal hospitals or non-state governmental organizations (NSGOs) have been buying nursing facility licenses that allow the hospitals to draw down additional federal dollars based on the difference between the Medicaid UPL and the Medicaid rate. Typically, the previous nursing home owner manages the facility. In fiscal year 2018 (July 1, 2017, to June 30, 2018) there were an estimated 515 nursing homes in Indiana that participated in the program. For the third quarter of fiscal year 2019 (January 1, 2019 to April 30, 2019), the number of participating nursing facilities increased to 508.

The UPL is determined individually for each nursing facility by taking the difference between each facility's estimated Medicare and Medicaid rate multiplied by Medicaid resident days. Prior to October 1, 2012, each NSGO facility's upper payment limit was added together to arrive at an aggregate upper payment limit amount for all NSGO facilities. The aggregate upper payment limit was then distributed to each NSGO nursing facility based on each facility's Medicaid resident days to the total Medicaid resident days for all NSGO facilities. However, CMS recently approved a state plan amendment that altered the reimbursement methodology for the program (retroactively adjusted to October 1, 2012). Based on this change, a nursing facility's IGT reimbursement equates to the facility's UPL (Adjusted Medicare Rate - Medicaid Rate x Total Medicaid Days). The state adjusts Medicare rates to exclude expenses (pharmacy, laboratory, radiology) not reimbursed by Medicaid. The funding for the IGT remained budget neutral after CMS approved the state plan amendment.

Supplemental payments are made quarterly to the hospitals and never directly to the nursing homes. Typically, nursing facilities are reimbursed a specific pre-agreed upon portion of IGT revenue. However, prior to determining this amount, the county hospitals first reimburse themselves for the funds that they temporarily transferred to the state. While these amounts vary by county hospital, based on conversations with an existing skilled nursing facility operator in Indiana, this percentage typically averages approximately 33.0% for their facilities. The remaining 67% of the IGT-generated revenue is then divided between the county hospital and the skilled nursing facility. The aforementioned operator indicated that their skilled nursing facilities typically receive 50% of the remaining funds.

For fiscal year 2018, the average UPL payment to county hospitals was \$116.46 per Medicaid day, with an average annual payment of \$1,965,051. Assuming that county facilities typically reimburse themselves 33.0% of these funds and reimburse the nursing facilities half of the remaining funds, the average annual payment to the nursing home operators in the state is \$648,467 per facility.

Nursing home operators that have sold their facilities to county hospitals are engaged as management companies for facilities, and are typically reimbursed their portion of the IGT revenue through management fees.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Representatives of the state's rate setting consultant (Myers and Stauffer) indicated that the state will be altering the methodology for its report card add-on in fiscal year 2019 (see above).

INDIANA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	66.00	66.00	67.75		96.00	90.00	92.00		123.00	117.00	117.00
Average Daily Census	59.28	57.22	56.80		79.77	76.81	76.59		108.03	102.76	99.00
Occupancy	69.6%	68.3%	67.0%		78.8%	77.9%	76.6%		86.8%	85.3%	84.4%
Payor Mix Statistics											
Medicare	8.1%	7.5%	6.8%		11.9%	11.2%	10.1%		16.1%	15.4%	14.8%
Medicaid	53.1%	41.3%	40.3%		64.9%	64.7%	65.3%		73.0%	73.7%	75.6%
Other	17.6%	17.6%	16.7%		30.4%	30.5%	33.2%		84.4%	74.0%	78.6%
Avg. Length of Stay Statistics (Days)											
Medicare	38.06	35.18	32.20		47.36	41.84	42.29		60.36	56.11	57.66
Medicaid	261.36	235.65	296.20		424.17	352.04	465.72		713.58	696.59	761.34
Other	87.52	94.21	85.66		157.19	161.31	144.72		292.88	277.64	273.65
Revenue (PPD)											
Inpatient	\$216.99	\$224.50	\$223.06		\$241.53	\$248.86	\$246.66		\$274.21	\$281.14	\$276.83
Ancillary	\$45.93	\$44.58	\$43.00		\$63.48	\$61.68	\$59.13		\$92.62	\$84.48	\$84.13
TOTAL	\$269.70	\$276.40	\$272.43		\$311.37	\$315.31	\$306.06		\$365.12	\$370.57	\$359.43
Expenses (PPD)											
Employee Benefits	\$15.48	\$16.69	\$17.55		\$20.21	\$20.58	\$21.18		\$23.74	\$23.47	\$24.58
Administrative and General	\$34.22	\$33.40	\$33.40		\$42.08	\$41.35	\$41.53		\$52.94	\$50.24	\$52.96
Plant Operations	\$9.62	\$9.51	\$9.82		\$11.19	\$11.30	\$11.80		\$13.71	\$14.04	\$14.46
Laundry & Linens	\$1.83	\$1.60	\$1.50		\$2.50	\$2.35	\$2.44		\$3.15	\$3.06	\$3.14
Housekeeping	\$3.60	\$3.84	\$3.89		\$4.53	\$4.73	\$5.03		\$5.77	\$6.27	\$6.92
Dietary	\$14.07	\$14.49	\$14.92		\$15.51	\$16.10	\$16.66		\$17.95	\$18.78	\$19.62
Nursing & Medical Related	\$67.96	\$71.18	\$73.58		\$73.92	\$77.58	\$81.73		\$80.95	\$85.84	\$91.43
Ancillary and Pharmacy	\$23.62	\$23.24	\$22.06		\$30.40	\$29.43	\$28.07		\$39.85	\$39.57	\$37.99
Social Services	\$2.40	\$2.69	\$2.95		\$4.06	\$4.22	\$4.47		\$5.74	\$5.97	\$5.94

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Iowa



INTRODUCTION

Nursing facilities in the state of Iowa are licensed by the Iowa Department of Inspections and Appeals (DIA) Health Facilities Division (HFD) under the designation of "Nursing Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN IOWA	
Licensed Nursing Facilities*	402
Licensed Nursing Beds*	27,891
Beds per 1,000 Aged 65 >**	51.92
Beds per 1,000 Aged 75 >**	117.58
Occupancy Percentage - 2017*	77.50%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Iowa Department of Health (IDH) administers the Certificate of Need (CON) program within the state.

In Iowa, a CON is required for the following:

- Construction, development, modernization, replacement, renovation or relocation of intermediate care or skilled nursing care beds in nursing homes or hospitals. However, the replacement of a nursing facility does not require a CON if the new facility is located within the same county. In addition, the modernization of a nursing facility does not require a CON if it does not result in the development of any new services.
- Expanding bed capacity in intermediate care or skilled nursing care facilities or designated units in hospitals.

IDH considers a bed need methodology when reviewing CON applications.

BED NEED METHODOLOGY

The IDH annually calculates long-term care bed need figures using a five-year population projection. Iowa projects the approximate number of intermediate and skilled nursing beds needed to serve a projected population for rural and urban counties using the following formulas:

In rural counties the total long-term bed need is equal to:

$$[.09 \times (65 + \text{population}) + .0015 \times (64 - \text{population})] \times 110\%$$

In urban counties total long-term bed need is equal to:

$$[.07 \times (65 + \text{population}) + .0015 \times (64 - \text{population})] \times 110\%$$

Population projections from the Department of Economic Development are used for the determination of long-term beds. The state assumes that intermediate and skilled nursing beds represent two-thirds of the total long-term care demand. The remaining portion of demand is attributed to residential care

facilities. The most recent bed need analysis, completed in May 2019, projects unmet demand in 2021 for long-term care beds in 72 counties and a total unmet demand for 9,239 beds in the state.

There are currently no proposed changes to Iowa's bed need methodology.

QUALITY ASSURANCE FEE

The Department of Human Services has implemented a nursing facility quality assurance assessment fee (QAAF) based on facilities' non-Medicare patient days effective April 1, 2010. Nursing facilities are assessed \$1.00 per non-Medicare patient day if the facility is: licensed for less than or equal to 46 beds, is designated as a continuing care retirement community (CCRC) or has annual Medicaid patient days of 26,500 or greater. The assessment is \$5.26 per non-Medicare patient day for all other nursing facilities. These rates remained unchanged from April 1, 2010, to July 1, 2015. However, effective July 1, 2011, the number of licensed beds required to be eligible for the \$1.00 fee was reduced from 50 to 46 beds. In addition, on July 1, 2015, the state recalculated its QAAF so that it equates to 3.0% of non-Medicare revenue in the state. Based on this factor, the QAAF for nursing facilities licensed for less than or equal to 46 beds, nursing facilities designated as a continuing care retirement community (CCRC) or those with annual Medicaid patient days of 26,500 or greater was increased to \$1.36 per non-Medicare day and the fee for all other nursing facilities increased to \$7.13.

Nursing facilities are reimbursed for the QAAF through a quality assurance assessment pass-through and a quality assurance assessment add-on. The quality assurance assessment pass-through is added to a nursing facility's current Medicaid rate. The amount of the pass-through equates to the per-patient-day assessment that the facility pays. The quality assurance assessment add-on is \$10 per Medicaid patient day and is added to the Medicaid per diem reimbursement rate. Hospital-based and government-owned nursing facilities are exempt from paying the QAAF.

Effective July 1, 2019, the QAAF for nursing facilities licensed for less than or equal to 46 beds, nursing facilities designated as a continuing care retirement community (CCRC) or those with annual Medicaid patient days of 21,000 or greater was increased to \$2.45 per non-Medicare day and the fee for all other nursing facilities will increase to \$12.75. The standard for higher volume Medicaid providers also changes from 26,500 Medicaid patient days to 21,000 Medicaid patient days. The methodology utilized to reimbursement nursing facilities for QAAF will stay the same; however, the quality assurance assessment will increase to \$15.00 effective July 1, 2019.

MEDICAID RATE CALCULATION SYSTEM

Iowa uses a prospective, cost-based, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

Iowa uses two cost centers to calculate its facility-specific Medicaid rates:

- The Direct Care cost component includes costs associated with the salaries and benefits of registered nurses, licensed practical nurses, certified nursing assistants, rehabilitation nurses and contracted nursing service.
- The Non-Direct Care cost component includes administrative, environmental, property and support care costs.

INFLATION AND REBASING

Nursing facilities are rebased biannually using cost report data reported two years prior. All participating nursing facilities have their initial Medicaid rate established on July 1. However, the overall Medicaid rates are adjusted quarterly for changes in case mix of Medicaid residents.

Under the previous regulations, the CMS Total Skilled Nursing Facility Market Basket Index was supposed to be used to inflate costs from the midpoint of the cost report period to the beginning of the rate period (July 1). This factor has been limited in recent years to adjust for budget limitations. Given the state's budgetary limitations, nursing facility costs were only inflated from the midpoint of the cost report period to June 30, 2008. In addition, effective December 1, 2009, the state implemented a 5% inflation reduction through June 30, 2010. However, after the state implemented the QAAF, this rate reduction was reduced to 3% effective December 1, 2009. This adjustment was a rollback in the Market Basket Index as applied to the rate setting formulas. The amount applied to each facility specifically depended upon the fiscal year end of the nursing facility. For fiscal year 2011, the state restored nursing facility rates to what they would have been if no reduction was applied to July 1, 2009, rates. However, no additional inflation adjustment was applied.

For fiscal year 2012, the applicable Market Basket Index was rolled back (decreased) 75.0% due to budget limitations. This equated to an approximate annual inflation adjustment (0.5%). However, the state's appropriations for nursing homes increased due to a combination of rebasing, inflation adjustments and an increasing Medicaid percentage. Nursing facility base rates (rates prior to adjustment for case mix) remained the same in fiscal year 2013.

Iowa issued all four fiscal year 2014 rates (July 1, 2013; October 1, 2013; January 1, 2014; and April 1, 2014) and all applicable retroactive payments in June 2014. These rates were rebased utilizing 2012 cost report data and all of these rates will be adjusted for case mix. Allowable costs were inflated from the midpoint of the cost report period to January 1, 2012. For facilities with a fiscal year end of December 31, this will result in two quarters of deflation, and for facilities with fiscal year ends of June 30, there will be no inflation. However, this was offset by the state utilizing more current cost report data (fiscal years ending within calendar year 2012) than used in the previous rebase (effective July 1, 2011, to 2010 cost report data). Fiscal year 2014 rates reflect that the budget for nursing facility Medicaid reimbursement increased 5.9% from the prior year's rates.

The state did not rebase rates in fiscal year 2015, and to reflect budget limitations, prior utilized costs were inflated from the

mid-point of the cost report period to December 31, 2001, plus 0.4% using the previously mentioned inflation index. This results in the deflation of some costs. Overall, this adjustment resulted in an approximate state average rate increase of 0.4%.

Fiscal year 2016 rates were determined utilizing cost report data for fiscal years ending within calendar year 2014. This data was inflated/deflated from the mid-point of the cost report period to January 1, 2012, utilizing the previously mentioned inflation index. According to the Iowa Health Care Association, \$17 million of additional funding for nursing facility rates was dedicated to this rebasing. The association estimates that this results in an average rate increase of \$9.00. The state did not rebase rates on July 1, 2016 and therefore rates did not significantly increase. The state did rebase rates on July 1, 2017, utilizing 2016 cost report data. However, this rebase was limited to a total \$7.5 increase in funding for nursing home reimbursement. July 1, 2018 rates were limited to changes related to CMI and did not significant change from prior year rates.

The state has indicated that it will rebase rates on July 1, 2019. Iowa Rate Setting Professionals have indicated that this rebase will result an approximate \$37 to \$39 million increase in Medicaid funding for nursing home reimbursement.

RATE METHODOLOGY

The Medicaid reimbursement rate is based on allowable cost for Direct Care and Non-Direct Care components, plus a potential excess payment allowance. However, the state has not funded/issued excess payment allowances in almost a decade.

A nursing facility's per diem allowable Direct Care cost component is calculated by dividing total reported allowable costs by total inpatient days during the reporting period. The total reported allowable costs are then adjusted using an inflation factor. The per diem allowable Direct Care cost component is then neutralized by dividing the facility's per diem direct care costs by the facility's cost report period case mix index (CMI).

The resident classification system used to determine all case mix indices is the Resource Utilization Groups - III (RUG-III) Version 5.12b, 34 group, index maximizer model developed by the Centers for Medicare & Medicaid Services (CMS). The model is used to calculate the average CMI and adjusts the direct care costs in the determination of the Direct Care patient day weighted median and a facility's reimbursement rate.

A nursing facility's per diem allowable Non-Direct Care cost component is arrived at by dividing total reported allowable costs by total inpatient days during the reporting period. The total reported allowable costs are then adjusted using an inflation factor. Patient days for the purpose of calculating administrative, environmental and property expenses is the greater of inpatient days or 85% of the licensed capacity of the facility.

Patient day weighted medians are then established for each rate component and are used to establish rate component limits and excess payment allowances, if any. The per diem neutralized Direct Care cost component and the per diem Non-Direct Care

cost component for each facility are arrayed from lowest to highest to determine each cost component's patient day weighted median cost based on the number of patient days provided by facilities. The patient day weighted medians are recalculated using the latest completed cost report with a fiscal year end of the preceding December 31 or earlier. When patient day weighted medians are recalculated, inflation is applied from the midpoint of the cost report period to the first day of the state fiscal year rate period.

The Direct Care rate component limit is 120% of the per diem weighted median. The Non-Direct Care rate component limit is 110% of the per diem weighted median. In Direct Care, facilities are paid the lower of their neutralized cost or the ceiling multiplied by their Medicaid CMI, while in Non-Direct Care, payment is the lower of the cost or the ceiling. Additional reimbursement is available for nursing facilities that have completed a total replacement, new construction or major renovations.

There are two additional types of reimbursement, the enhanced Non-Direct Care rate add-on and the Capital Cost per diem add-on. A nursing facility can request either add-on if the facility has undergone replacement or major renovations costing greater than \$1.5 million. If a nursing facility receives either or both add-ons, the Non-Direct Care rate component limit is increased to 120% of the per diem weighted median. These add-ons are determined based on the additional capital costs the nursing facility will incur due to a total replacement, renovation or major renovation. As of the date of this publication, only a moderate number of nursing facilities have requested this add-on. In addition, given budget reductions, the total funds available to be paid to nursing facilities that qualify for additional funding for major renovations and is estimated to be approximately \$500,000 in fiscal year 2019.

The statewide average rate has not significantly increased from fiscal year 2016 (effective July 1, 2015) to fiscal year 2019 (effective July 1, 2018). Specifically, the statewide average rate for the last for fiscal years is as follows: July 1, 2015 - \$172.00; July 1, 2016 - \$172.44; July 1, 2017 - \$174.06; and July 1, 2018 - \$175.17.

The statewide average rate effective July 1, 2014 (\$163.22) barely increased from the equivalent rate (\$162.58) effective July 1, 2013. However, the rate effective July 1, 2013, represents a 5.8% from the statewide average rate the statewide average rate (\$153.64) effective July 1, 2012. This is not significantly greater than the average rate (\$152.35), effective July 1, 2011 (including the QAAF add-on), and 6.9% greater than the average rate (\$143.71), effective July 1, 2010. However, this reflects that the state did not implement the QAAF (or the QAAF add-on) until April 1, 2010.

Effective April 1, 2016, Iowa converted to Medicaid Managed Care Reimbursement System known as the Iowa Health Link Program. Under this program, nursing facilities still receive their fee-for-service rates (calculated utilizing the above-described system).

MINIMUM OCCUPANCY STANDARDS

For the purpose of computing allowable per diem administrative, environmental and property expenses, the greater of a facility's total patient days, or 85% of the facility's maximum annual patient days, are used in the calculation. Effective December

1, 2009, the state initially increased the minimum occupancy requirement from 85% to 90%. However, the state reinstated the 85% minimum occupancy requirement (effective December 1, 2009) after the QAAF was implemented.

OTHER RATE PROVISIONS

The Medicaid rate for a new facility is the sum of the patient day weighted median cost for the Direct Care and Non-Direct Care cost components. After the first full calendar quarter of operation, the per diem weighted median cost for the Direct Care cost component is adjusted by the facility's average Medicaid CMI. After the completion of the new facility's first fiscal year, rates are established in the same manner previously described above.

A new owner is reimbursed using the previous owner's per diem rate adjusted quarterly for changes in the Medicaid average CMI. The facility must submit a financial and statistical report for the period from beginning of actual operation under new ownership to the end of the facility's fiscal year. Subsequent financial and statistical reports must be submitted annually for a 12-month period ending with the facility's fiscal year. The facility must notify the Iowa Department of Human Services accounting firm of the date its fiscal year will end.

No increase in the value of property is allowed when determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner either continues the schedule of depreciation and interest established by the previous owner, or the new owner may claim the actual rate of interest expense. The results of the actual rate of interest expense cannot be higher than would be allowed under the Medicare principles of reimbursement and will be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner. Other acquisition costs of the new owner, such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property, are not allowed.

Effective December 1, 2010, the state eliminated any payments for bed hold days for both hospital and therapeutic leave.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

According to Iowa rate setting professionals, the state is proposing to implement an Upper Payment Limit (UPL)/Intergovernmental Transfer (IGT) program. As part of this program, privately owned nursing homes will transfer ownership to county or municipal hospitals or non-state governmental organizations (NSGOs) in order to take advantage of additional matching funds available to these facilities. The state has also indicated that payments to nursing facilities through this program will be linked to quality measures. The state is still finalizing this program and will have to submit a state plan amendment to the Centers for Medicare and Medicaid (CMS) for approval of the program. Iowa rate setting professionals have indicated that the earliest the program could be implemented would be in mid-2020. As of the date of this overview, it is unclear if this program will be implemented.

IOWA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	49.00	49.00	48.00		62.00	64.00	62.00		83.00	86.00	83.50
Average Daily Census	39.28	39.21	37.68		52.08	52.77	51.31		71.80	72.07	68.82
Occupancy	71.9%	70.5%	69.1%		81.2%	80.5%	79.0%		89.5%	89.4%	87.9%
Payor Mix Statistics											
Medicare	4.2%	3.8%	4.0%		6.3%	5.9%	6.0%		8.6%	8.1%	8.3%
Medicaid	37.4%	36.6%	36.7%		47.8%	47.4%	46.9%		58.0%	59.0%	59.5%
Other	34.3%	33.0%	32.7%		45.7%	45.5%	46.7%		56.8%	57.9%	56.5%
Avg. Length of Stay Statistics (Days)											
Medicare	29.02	28.19	27.46		40.09	39.68	37.91		53.70	52.27	49.25
Medicaid	364.99	221.25	253.97		545.88	481.07	429.98		801.95	842.15	752.91
Other	141.16	133.28	124.62		235.20	231.68	202.83		353.38	357.22	332.20
Revenue (PPD)											
Inpatient	\$171.12	\$173.07	\$182.81		\$187.46	\$193.43	\$202.84		\$214.02	\$217.29	\$230.27
Ancillary	\$18.95	\$20.52	\$14.75		\$28.63	\$31.51	\$30.52		\$43.44	\$45.70	\$49.01
TOTAL	\$189.94	\$196.29	\$204.07		\$215.79	\$224.34	\$231.27		\$249.53	\$256.20	\$267.40
Expenses (PPD)											
Employee Benefits	\$8.42	\$9.55	\$9.15		\$13.92	\$14.40	\$14.34		\$18.41	\$19.63	\$19.88
Administrative and General	\$21.98	\$21.13	\$22.79		\$28.51	\$29.12	\$29.82		\$33.83	\$35.55	\$37.05
Plant Operations	\$8.54	\$8.77	\$9.14		\$10.02	\$10.50	\$10.79		\$12.45	\$12.61	\$13.15
Laundry & Linens	\$2.07	\$1.96	\$2.05		\$2.81	\$2.86	\$2.79		\$3.47	\$3.68	\$3.67
Housekeeping	\$3.89	\$3.93	\$4.14		\$4.90	\$5.05	\$5.23		\$5.92	\$6.04	\$6.58
Dietary	\$16.57	\$16.81	\$17.16		\$19.43	\$19.96	\$20.08		\$22.09	\$22.51	\$23.29
Nursing & Medical Related	\$70.93	\$74.36	\$78.18		\$80.38	\$84.48	\$89.74		\$94.80	\$97.41	\$105.40
Ancillary and Pharmacy	\$10.06	\$10.15	\$10.76		\$14.18	\$14.67	\$15.63		\$19.89	\$20.81	\$22.32
Social Services	\$1.14	\$1.29	\$1.39		\$2.03	\$2.13	\$2.21		\$3.17	\$3.48	\$3.51

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Kansas



INTRODUCTION

Nursing facilities in Kansas are licensed by the Kansas Department of Aging's Licensure, Certification and Evaluation Commission under the designation of "Adult Care Homes." The agency separates nursing facilities into traditional nursing facilities and nursing facilities that cater to the mentally ill. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN KANSAS	
Licensed Nursing Facilities*	288
Licensed Nursing Beds*	19,941
Beds per 1,000 Aged 65 >**	43.89
Beds per 1,000 Aged 75 >**	102.59
Occupancy Percentage - 2017*	80.00%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

A Certificate of Need (CON) is not required to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility. In addition, there is no moratorium on the construction of nursing facility beds in Kansas.

BED NEED METHODOLOGY

Kansas does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSESSMENT FEE

Effective July 1, 2010, Kansas approved the establishment of a quality assessment fee (QAF) known as a nursing facility provider assessment (NFPA).

The NFPA is assessed on a per-licensed-bed basis with a maximum potential fee of \$4,908. This fee increased from \$1,950 to \$4,908 per-licensed-bed effective July 1, 2016. The additional revenue generated from this rate increase was utilized to fund the state's Medicaid rate rebase effective July 1, 2016. Effective July 1, 2016, the NFPA is currently \$818 per licensed bed for nursing facilities with fewer than 46 beds, nursing facilities with more than 25,000 Medicaid days and nursing facilities within continuing care retirement communities (CCRCs) that were registered with the Kansas Insurance Department prior to July 1, 2010. Prior to July 1, 2016, this fee was \$325 per licensed bed. The remaining facilities in the state are assessed a fee of \$4,908 per licensed bed.

Kansas reimburses nursing facilities for paying the NFPA as a pass-through add-on to their Medicaid rates. The add-on is determined by multiplying total licensed beds by the applicable NFPA. The result of this calculation is divided by total inpatient days to equate to the add-on. Total inpatient days are derived from the calendar year cost report preceding the start of the fiscal rate year. For the current rate period (fiscal year 2020), inpatient days utilized to determine reimbursement of the NFPA will be derived from 2016 to 2018 cost reports. The state's minimum occupancy requirement is not applied to this calculation.

MEDICAID RATE CALCULATION SYSTEM

Kansas uses a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

Kansas uses the following cost components and a Real and Personal Property Fee Add-on to calculate its facility-specific Medicaid rates:

- The Operating cost component includes salaries and related benefits for administration and plant and operations, non-medical contract labor, consulting and professional fees, legal and accounting fees, applicable owner/related compensation, real and personal property taxes, liability insurance and other administrative expenses.
- The Indirect Health Care cost component includes salaries and related benefits for dietary, housekeeping, laundry, medical records, therapists, social workers, activities directors, pharmacy, expenses related to applicable owner/related compensation, consulting services, utilities, food, linen and bed materials, other supplies, transportation, resident activity expenses, nursing aid and other healthcare training.
- The Direct Health Care cost component includes salaries and related benefits for licensed practical nurses, nursing aides, registered nurses, restorative/rehabilitation aides, expenses related to applicable owner/related compensation, contract nursing and nursing supplies.
- The Real and Personal Property Fee Add-on is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease or with re-enrollment in the Medicaid program.

Expenses related to non-working owners are not allowable expenses. In addition to the cost components and the Real and Personal Property Fee Add-on, nursing facilities are eligible for two incentive add-ons. Each cost component and the Real and Personal Property Fee Add-on incorporate upper payment limits.

INFLATION AND REBASING

Allowable expenses are traditionally inflated from the midpoint of the cost report year to the midpoint of the rate year utilizing the National Skilled Nursing Facility Market Basket Without Capital Index, published by Global Insight. Inflation is not applied to owner/related party expenses, interest expenses, and real and personal property taxes. No additional inflation was applied to nursing home rates for fiscal year 2010.

Medicaid rates are calculated utilizing average data derived from the three most recent cost reports.

There is a provision for rebasing Real and Personal Property fees when capital expenditure thresholds are met (\$25,000 for nursing facilities with 50 or less beds and \$50,000 for nursing facilities with greater than 50 beds). The original property fees remain constant, but the additional factor for the rebasing is added. Real and Personal Property fees were originally calculated based on

1985 cost report data. The inflation factor for Real and Personal Property fees is the Global Insight National Skilled Nursing Facility Total Market Basket Index. The add-on is inflated from June 1 of the prior rate year to July 1 of the current rate year.

From January 1, 2010, to July 12, 2010, Kansas implemented a 10% rate cut for all nursing facilities. The state retroactively reimbursed nursing facilities for the rate cut after the NFPA was approved by CMS and implemented by the state. Fiscal year 2011 rates were rebased utilizing cost report data for 2007, 2008 and 2009. In addition, allowable costs were inflated based on the previously mentioned index and calculation. Fiscal year 2012 rates were effective July 1, 2011, and were rebased utilizing cost report data for 2008, 2009 and 2010. In addition, allowable costs were inflated based on the previously mentioned index and calculation.

No rebase or inflation adjustments were completed in fiscal year 2013 and rates remained frozen at fiscal year 2012 levels with the exception of slight changes related to audited cost report data. These rates remained frozen until January 1, 2014, when the state increased allowable operating, indirect healthcare and direct healthcare cost centers by a 1.25% trending factor. The state rebased rates effective July 1, 2014, utilizing 2010, 2011 and 2012 cost reports. Allowable costs were inflated by the previously mentioned index; however, costs were only inflated to December 31, 2012, to reflect funding available for nursing facility reimbursement. Rates effective July 1, 2015, were not rebased, but did receive an inflation adjustment.

The state rebased rates effective July 1, 2016, utilizing 2013, 2014 and 2015 cost reports. Allowable costs were inflated by the previously mentioned index from the mid-point of the cost report period to June 30, 2016. A 4.47% budget reduction was applied to July 1, 2016, rates. However, as a result of the rebase, the average Medicaid rate in the state increased by 5.80% from July 1, 2015, to July 1, 2016.

The state rebased rates effective July 1, 2017, utilizing 2014, 2015 and 2016 cost reports. Allowable costs were inflated by the previously mentioned index from the mid-point of the rate year. A 3.65% budget reduction was applied. However, because of the rebase, the average Medicaid rate in the state increased by 3.8% from July 1, 2016, to July 1, 2017.

The state rebased rates effective July 1, 2018, utilizing 2015, 2016 and 2017 cost reports. Allowable costs were inflated by the state's inflation index from the mid-point of the cost report period to the mid-point of the rate year. No budget reduction was applied to fiscal year 2019 rates. In addition, the state rebased rates effective July 1, 2019, utilizing 2016, 2017 and 2018 cost reports. The state's normal inflation adjustment was applied to allowable costs.

RATE METHODOLOGY

The facility-specific, allowable, historical per diem costs for each cost component are calculated by dividing the allowable inflated expenses by total resident days (adjusted for the minimum

occupancy requirement, if applicable). The median for each cost component is weighted based on total resident days. The upper limits for the components and the Real and Personal Property Fee Add-on are calculated as a percentage of the median determined from a total resident day weighted array of each of the inflated cost components and the property fees. A nursing facility is reimbursed the lesser of the facility-specific per diem cost or the upper payment limit. The upper payment limits for the cost components are as follows:

Upper Payment Limits - Fiscal Year 2020		
Cost Center	Limit Formula	Per Day Limit
Operating	110% of the Median Cost	\$39.13
Indirect Health Care	115% of the Median Cost	\$54.45
Direct Health Care	130% of the Median Cost	\$129.95
Real/Personal Property Fee	105% of the Median Cost	\$10.01

Salaries and other compensation to owners of the facility are also limited by an upper payment limit. This limit is based on data provided by the Kansas Civil Service classifications and wages for comparable positions. The compensation paid to owners and related parties is allocated to the appropriate cost center for the type of service provided.

The Direct Health Care per diem and the Direct Health Care upper payment limit are adjusted semi-annually to account for the nursing facility's case mix and those of all active nursing facilities in the state, respectively. Nursing facilities are required to submit minimum data sets (MDS) to the state on a quarterly basis for each resident of the facility. Prior to January 1, 2016, the state had adjusted Direct Health Care rate components on a quarterly basis.

This data is compiled by the state to determine the statewide case mix index (CMI) used to adjust the upper payment limit of the Direct Health Care cost component. The facility's Direct Health Care per diem cost is adjusted by the ratio of the statewide CMI to the facility's CMI to allow comparison to the upper limit. The lower of the upper payment limit or the facility's Direct Health Care per diem cost adjusted to the statewide average CMI is then divided by the statewide average CMI and multiplied by the facility's Medicaid CMI to derive the facility-specific Direct Health Care cost component rate.

Nursing facilities that meet certain outcome criteria are eligible to receive an incentive add-on to their Medicaid rate. The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons that providers can earn for various outcome measures. The total of all the per diem add-ons for which a provider qualifies is their incentive factor. Effective July 1, 2018, the state increased from five to six add-ons by creating a quality measures add-on. Overall, the total add-on a nursing facility can receive increased from \$5.50 to \$7.50 effective July 1, 2018. Originally, the Kansas Cultural Change/Person-Centered Care Incentive Program (PEAK) incentive add-on was part of the incentive program. However, the state removed it from the incentive and it is now reimbursed as a separate add-on.

The table below summarizes the incentive factor outcomes and per diem add-ons effective July 1, 2019:

Outcome Measures	Incentive
1) CMI adjusted staffing ratio \geq 75th percentile or CMI adjusted staffing < 75th percentile but improved \geq 10%	\$3.00 \$0.50
2) Staff retention rate > 75th percentile Contracted Labor <10% of total direct health care labor costs or Staff retention rate < 75th percentile but increased \geq 10%	\$2.50 \$0.50
5) Medicaid occupancy \geq 65%	\$0.75
6) Quality Measure > 75th Percentile	\$1.25
Total Incentive Per Diem Add-on	\$7.50

The PEAK incentive program includes six different incentive levels to recognize nursing facilities that are either pursuing a cultural change, have made major achievements in the pursuit of cultural changes, have met minimum competencies in person-centered care, have sustained person-centered care or mentor other facilities on person-centered care. These incentives are awarded as follows:

Incentive	Peak Nursing Home Incentive Program Eligibility	Per Diem Add-on	Duration
Level 0 - The Foundation	Home completes the Kansas Cultural Change Instrument (KCCI) evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	\$0.50	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level I - Pursuit of Cultural Change	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 must return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	\$0.50	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level II - Cultural Change Achievement	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes must start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	\$1.00	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.
Level III - Person Centered Care Home	Demonstrates minimum competency as a person-centered care home. This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	\$2.00	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level IV - Sustained Person Centered Care Home	Homes earn person-centered care home award two consecutive years.	\$2.50	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level V - Person Centered Care Mentor Home	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	\$3.00	Available beginning July 1 following confirmation of the mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

The maximum incentive for this program is \$3.00.

Effective July 1, 2019, the average Medicaid rate in the state increased 2.9% to \$195.71. The average Medicaid rate (\$190.24) effective July 1, 2018, is approximately 7.04% greater than the average rate (\$177.73), effective July 1, 2017. The average rates effective July 1, 2016, and July 1, 2015, were \$171.18 and \$160.38, respectively.

MINIMUM OCCUPANCY STANDARDS

The total resident days utilized to calculate the Operating and Indirect Health Care per diem costs (less food and utilities) for facilities with more than 60 beds is the greater of the actual

resident days or 85% of the maximum occupancy, based on the number of licensed beds to be used in the per diem calculation. There are two exceptions to the minimum occupancy rule for facilities with more than 60 beds as follows:

- The rule does not apply to a provider who is allowed to file a projected cost report for an interim rate.
- The first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historical cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

OTHER RATE PROVISIONS

If a nursing facility changes ownership, the per diem rate for the first 24 months is calculated on the base cost data for the previous owner. Beginning with the first day of the 25th month of operation, the payment rate is based on the historical cost data for the first calendar year submitted by the new owner. The per diem rate for newly constructed nursing facilities will be based on a projected cost report. The nursing facility will remain in new enrollment status until the base cost report data is reestablished.

Nursing facilities in Kansas are eligible to be reimbursed by Medicaid for holding a bed for a resident who requires hospitalization or therapeutic leave. Bed hold reimbursement is limited to a maximum of 10 days per hospitalization, and a total of 18 therapeutic leave days per year. There is no limit on the total number of days that a resident can be admitted to a hospital per year. The nursing facility is reimbursed 67% of its current per diem rate under both scenarios.

Kansas converted to a managed care Medicaid reimbursement system effective July 1, 2012. The state selected three managed care organizations (MCOs) to operate the system. However, the MCOs are required to reimburse nursing facilities at a rate that, at a minimum, equates to the rate calculated utilizing the above-described rate calculation system.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no proposed changes to the state's Medicaid rate calculation.

KANSAS COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	45.00	45.00	45.00		60.00	60.00	60.00		85.00	84.75	83.50
Average Daily Census	41.06	37.97	36.86		52.76	52.57	50.79		77.20	73.53	70.13
Occupancy	77.6%	75.0%	72.7%		86.2%	82.8%	82.4%		91.3%	90.4%	90.4%
Payor Mix Statistics											
Medicare	6.0%	5.4%	5.5%		8.6%	8.3%	8.4%		12.9%	13.1%	12.3%
Medicaid	42.7%	44.7%	47.2%		54.5%	56.3%	58.0%		63.9%	67.0%	69.4%
Other	28.6%	26.4%	23.3%		41.4%	39.1%	37.6%		67.0%	58.4%	59.4%
Avg. Length of Stay Statistics (Days)											
Medicare	29.74	28.62	28.00		41.00	40.25	38.88		61.47	61.43	63.25
Medicaid	309.81	292.67	301.97		426.63	416.71	423.44		641.49	633.19	667.67
Other	130.98	117.23	106.57		200.93	175.83	174.57		309.70	281.86	251.83
Revenue (PPD)											
Inpatient	\$164.82	\$167.59	\$171.71		\$183.61	\$188.14	\$192.91		\$213.67	\$219.87	\$224.81
Ancillary	\$24.06	\$23.63	\$27.88		\$39.97	\$40.98	\$43.04		\$69.19	\$62.70	\$64.29
TOTAL	\$193.59	\$195.66	\$204.36		\$227.80	\$231.56	\$237.53		\$295.28	\$293.87	\$310.16
Expenses (PPD)											
Employee Benefits	\$13.76	\$13.02	\$13.12		\$17.33	\$17.15	\$17.83		\$22.05	\$22.55	\$23.28
Administrative and General	\$25.03	\$26.13	\$27.52		\$31.58	\$35.84	\$37.46		\$40.91	\$45.83	\$47.45
Plant Operations	\$9.33	\$9.91	\$10.17		\$11.09	\$11.98	\$12.37		\$14.59	\$15.51	\$16.05
Laundry & Linens	\$1.73	\$1.83	\$1.81		\$2.45	\$2.45	\$2.36		\$3.15	\$3.16	\$3.00
Housekeeping	\$4.34	\$4.31	\$4.28		\$5.15	\$5.14	\$5.42		\$6.78	\$7.06	\$6.93
Dietary	\$16.25	\$16.42	\$16.48		\$19.14	\$19.33	\$19.76		\$23.89	\$23.09	\$23.85
Nursing & Medical Related	\$66.12	\$69.29	\$73.13		\$74.88	\$79.95	\$83.89		\$90.02	\$93.51	\$97.65
Ancillary and Pharmacy	\$13.48	\$13.29	\$14.16		\$20.59	\$20.44	\$21.56		\$29.43	\$29.29	\$28.90
Social Services	\$2.20	\$2.22	\$2.43		\$3.53	\$3.66	\$3.93		\$5.65	\$5.72	\$6.07

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Kentucky



INTRODUCTION

Nursing facilities in Kentucky are licensed by the Division of Health Care Facilities and Service, part of the Office of the Inspector General in the Kentucky Cabinet for Health and Family Services (CHFS). Long-term care nursing facilities are separated into three categories: Nursing Facility (NF), Nursing Home (NH) and Alzheimer's Facility (ALZ). In addition, all three categories include hospital-based long-term care beds. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN KENTUCKY	
Licensed Nursing Facilities*	285
Licensed Nursing Beds*	27,540
Beds per 1,000 Aged 65 >**	37.87
Beds per 1,000 Aged 75 >**	95.70
Occupancy Percentage - 2017*	85.40%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Cabinet for Health and Family Services - Division of Certificate of Need (CON) administers the state's CON program. In the current regulations, a CON is required for a nursing facility under the following scenarios:

- The construction of a new nursing facility or the expansion of an existing facility (including increasing bed capacity).
- The construction of a replacement facility.
- Any substantial change in a health service.

The transfer or relocation of existing CON approved nursing facility beds from one CON approved nursing facility to another CON approved nursing facility shall be consistent with the following:

- The number of nursing facility beds being applied for is equal to or less than the net county NF bed need;
- The proposed transfer or relocation is within the same county, to a contiguous county or to a county within the same Area Development District;
- The transfer of licensed nursing facility beds does not result in a need for additional nursing facility beds in the county of the transferring facility using the State Health Plan methodology for net county nursing facility bed need;
- More than ten nursing facility beds shall not be transferred from a licensed nursing facility within a period of one year;
- The facility transferring the beds is located in a county that has an average annual nursing facility bed occupancy of 95% as reported in the most recently published Kentucky Annual Long-Term Care Services Report;
- The facility receiving the beds is located in a county that has an average annual nursing facility bed occupancy of $\geq 95\%$ annual occupancy as reported in the most recently published Kentucky Annual Long-Term Care Services Report; and
- The transfer of licensed nursing facility beds does not result in a need for additional nursing facility beds in the county of the transferring facility using the State Health Plan methodology for net county nursing facility bed need.

Any capital expenditure (including major medical equipment) exceeding \$3,319,893 (effective July 1, 2019).

Nursing facility beds within a continuing care retirement community (CCRC) are exempt from the CON process. However, approval is restricted to non-Medicare and Medicaid certified beds. In addition, CCRCs are limited by a Certificate of Compliance, which indicates that CCRCs are only allowed to develop one nursing facility bed for every four non-nursing facility living units within the community.

Though no official CON moratorium currently exists, the state has a substantial bed surplus, which precludes the issuance of CONs for new beds. This statewide bed surplus overrides the determination of bed need within a county, which would typically allow for the granting of CONs for new long-term care beds within that county. The calculation used to determine the bed surplus will be detailed in the following section of this overview.

BED NEED METHODOLOGY

The need for additional nursing facility beds in each county will be calculated as $A = B - C$, where:

- A = Net county NF bed need;
- B = The number of patients from the applicant's proposed county of location who found NF bed placement in a noncontiguous county as reported in the most recently published Kentucky Annual Long-Term Care Services Report; and
- C = The average number of empty beds in the county of application and all counties contiguous to the county of application. The average number of empty beds for a county shall be calculated by multiplying the number of non-state owned and non-CCRC licensed NF beds by the occupancy percentage for the county as reported in the most recently published Kentucky Annual Long-Term Care Services Report.

Based on the most recent bed need calculation completed by the state (effective September 4, 2019), there is a surplus of nursing facility beds in every county within the state, with a statewide surplus of 23,172 nursing facility beds.

QUALITY ASSURANCE FEE

Kentucky assesses nursing facilities with a quality assurance fee (QAF) referred to as bed tax assessment. The current bed tax assessment is \$1.82 per non-Medicare resident day for nursing facilities with 60 or fewer beds, \$12.85 per non-Medicare resident day for non-hospital based nursing facilities with 60,000 or fewer resident days, \$4.12 per non-Medicare patient day for non-hospital based nursing facilities with greater than 60,000 resident days and \$3.64 per non-Medicare resident day for hospital-based nursing facilities. All these fees are effective July 1, 2013. Nursing facilities are reimbursed for the bed tax assessment as an add-on to the nursing facility's Medicaid rate, which will be detailed later in this overview. Kentucky's bed tax assessment is in compliance with the federal standard, which sets the tax at a maximum of 6.0% of revenue.

MEDICAID RATE CALCULATION SYSTEM

The nursing facility Medicaid reimbursement system in Kentucky utilizes a prospective, price-based and case mix adjusted Medicaid reimbursement system. The state reimburses facilities based upon two peer groups, rural and urban, also known as the “price.” The price is composed of non-capital cost components. Nursing facilities are reimbursed the capital costs utilizing a fair rental value system (FRV). In addition, a portion of the standard price is adjusted quarterly for each individual facility’s case mix index (CMI). Effective July 1, 2008, the state switched from using a snapshot method of determining CMI (last day of quarter) to a time-weighted method. The time-weighted methodology weighs the number of days in a quarter that a resident is at a certain RUG level to determine the average CMI.

COST CENTERS

Kentucky utilizes the following six price components to calculate its facility-specific Medicaid rates:

- The Case Mix Adjusted Labor cost component reflects reimbursement for salaries and wages of registered nurses, licensed practical nurses and nursing assistants along with activities and medical records; a proportionate allocation of allowable employee benefits; and the direct allowable cost of utilizing registered nurses, licensed practical nurses and nurse aide staff from outside staffing companies.
- The Case Mix Adjusted Non-Labor cost component reflects reimbursement for medical and activity supplies along with education and training.
- The Non-Case Mix Adjusted Labor cost component reflects reimbursement for salaries and wages of social services, dietary, housekeeping, maintenance and laundry.
- The Non-Case Mix Adjusted Non-Labor cost component reflects reimbursement for raw food, medical and dietary consultants, and administration (including the offset to the bed tax assessment fee).
- The Non-Capital Facility Related cost component reflects historical average costs for property insurance, property taxes, repairs and utilities.
- The Capital cost component reflects the cost of capital and is reimbursed under a FRVS based upon actual depreciated cost appraisals using the E.H. Boeckh/Marshall & Swift valuation model.

INFLATION AND REBASING

Nursing facility rates are adjusted quarterly for CMI for each facility. The state fiscal year and rate period in Kentucky is from July 1 to June 30. In Kentucky, current regulations indicate that the standard price for non-property, price-based nursing facilities is rebased once every four years and adjusted for inflation every July 1. The state most recently rebased the standard prices effective July 1, 2008, utilizing 2006 cost report data. In non-rebasing years, the standard prices are adjusted for inflation on July 1 based on an inflationary adjustment determined by state appropriations. For fiscal years 2011 and 2012, the inflation adjustments for non-capital costs were 1.8% and 1.5%, respectively. Effective July 1, 2012, non-capital costs were inflated 0.5%. Non-capital rates were inflated 2.0% effective July 1, 2013. Non-capital rates were only increased 0.1% since then, effective July 1, 2014, July 1, 2015, July

1, 2016, July 1, 2017, and July 1, 2018. It is unclear when the state will next rebase non-capital rates.

Based on state regulations, nursing facilities are required to be reappraised every five years. The state reappraised all Kentucky nursing facilities in the first quarter of 2014. Prior to this, the state had not reappraised nursing facilities since fiscal year 2009. In non-appraisal years, appraised values are supposed to be inflated annually utilizing the R.S. Means Construction Cost Index. However, in fiscal years 2013 and 2014, appraised values were increased 0.5% and 2.0%, respectively.

Rates effective July 1, 2014, were calculated utilizing the 2014 appraisals. In appraisal years, a partial year inflation adjustment (from January to June of the fiscal year) is applied to appraised values. Effective July 1, 2014, this equated to 0.05%. Capital rates effective July 1, 2015, July 1, 2016, July 1, 2017 and July 1, 2018 were all inflated by 0.1%. The state re-appraised nursing homes in early 2019. In addition, non-Capital rate components were inflated 3.1% effective July 1, 2019.

RATE METHODOLOGY

As previously mentioned, Kentucky sets standard prices for all of the non-capital cost components for the rural and urban peer groups. The Case Mix Adjusted and Non-Case Mix Adjusted prices were initially established based upon a departmental staffing model developed through a collaborative effort of the industry and state agency multiplied by the industry-wide average wage and benefit rates determined through either cost reports or a wage survey. The state last rebased the standard prices utilizing 2006 cost report data. It should be noted that by solely utilizing cost report data to calculate standard prices, the state has ignored the model-based pricing approach that was utilized to calculate prior prices. The staffing hours used in setting the price are the same for all facilities and the wage and benefit rates differ for urban and rural locations. There is no requirement that facilities staff at the levels for which they are being reimbursed.

The standard prices effective July 1, 2019, for both rural and urban facilities are as follows:

Category	Rural	Urban
Case Mix Adjusted Labor Cost Component	\$71.02	\$83.74
Case Mix Adjusted Non-Labor Cost Component	\$9.29	\$10.96
Non-Case Mix Adjusted Labor Cost Component	\$16.48	\$18.90
Non-Case Mix Adjusted Non-Labor Cost Component	\$39.00	\$44.31
Non-Capital Facility Related	\$5.82	\$5.82
Price Per Day of Service	\$141.61	\$163.73

Kentucky utilizes the Resource Utilization Groups-III (RUG-III) Version, 34-group, resident classification system to adjust a portion of nursing facilities’ non-capital prices for case mix. A nursing facility’s Medicaid Minimum Data Set (MDS) will be utilized to determine its CMI each quarter, and its CMI will be applied to the case mix adjustable portion of its standard price.

The Case Mix Adjusted Labor and Non-Labor cost components are adjusted quarterly for the facility’s CMI, based on the facility’s case mix for residents who are dually eligible for Medicaid and Medicare. The CMI data is derived from the calendar quarter that is two quarters prior to the effective date of the rate. The standard

price (Labor or Non-Labor) for the appropriate peer group is multiplied by the facility's CMI to determine the facility-specific Case Mix Adjusted Labor and Non-Labor rates for the facility. These rates are added to the remaining prices for the non-capital portion of the rate to determine the facility's non-capital rate per day of service.

Nursing facilities in Kentucky are reimbursed for Capital costs through an FRV system. The Capital cost component rate for a nursing facility is determined by multiplying the facility's total appraised value (less accumulated depreciation) by a rental rate. The total appraised value is a sum of the facility's building, equipment and land uses, as determined by periodic appraisals of the facility, utilizing the E.H. Boeckh/Marshall & Swift valuation model. In addition, any accumulated depreciation is calculated based on the principles of this model. A facility's total value of the building may not exceed \$56,116 per bed effective July 1, 2018. The facility-specific building value per bed is determined by dividing the total value of the building, less accumulated depreciation, by the total number of licensed beds. A facility's equipment value is calculated by multiplying the facility's total number of licensed beds by \$2,000. The estimate is deducted by accumulated depreciation.

The value of a nursing facility's land is multiplied by the sum of the facility building and equipment values (less accumulated depreciation) by 10.0%. The sum of the building, equipment and land values is then multiplied by the rental rate to determine total reimbursable capital costs. The rental rate equates to the 20-year U.S. Treasury Bond rate for the first business day after May 31 of the most recent year, plus a 2.0% risk factor. The rental may not be less than 9.0% or greater than 11.0%. A facility's Capital cost per diem rate equates to the total reimbursable Capital costs divided by the facility's total patient days (adjusted for the minimum occupancy requirement, if necessary). Kentucky nursing facilities are also reimbursed a \$12.85 add-on (effective July 1, 2013) based on the bed tax assessment, which represents the Medicaid portion of the increase in the bed tax assessment fee on July 1, 2004. This add-on is built into the Non-Case Mix Adjusted cost component price.

The average Medicaid rate, effective January 1, 2012, in Kentucky is \$172.84. This represents a 1.5% increase from the previous rate (\$170.29). The average rate effective July 1, 2013, is \$178.72, which is a 3.3% increase from the rate effective January 1, 2012. The average rate effective October 1, 2014, was \$180.93, which is 1.2% greater than the estimate effective July 1, 2013. The Average Medicaid rates effective July 1, 2015 (\$182.23), July 1, 2016 (\$182.47), July 1, 2017 (\$187.75) and July 1, 2018 (\$187.52) did not significantly change the October 1, 2014 rates. This reflects the lack of inflation and rebasing of rates in recent years. The average rate effective July 1, 2019 increased 4.1% to \$195.17.

MINIMUM OCCUPANCY STANDARDS

The facility-specific Capital cost component per diem rate for both peer groups will be calculated utilizing the greater of actual resident days or 90% of the total available resident days.

OTHER RATE PROVISIONS

If a change of ownership occurs, the nursing facility will receive the appropriate standard prices for all non-capital cost components. The new owner shall receive the Capital cost component rate of the previous owner unless the NF is eligible for a reappraisal and files an updated provider application with the Medicaid Program. The CMI for the facility under the previous ownership is utilized to determine the Case Mix Adjusted rate components until the new owner/operator has accumulated a sufficient amount of CMI data. A newly constructed facility will receive the appropriate standard prices for all non-capital components. In addition, the facility's Case Mix Adjusted cost components will be calculated using a CMI of 1.00 until a calendar quarter of CMI data is established for the facility. The facility's Capital cost component is set at the maximum rate level until an appraisal is completed, whereupon the rate for the facility's Capital cost component will be determined utilizing the FRV system. Kentucky Medicaid reimburses nursing facilities for reserving a bed for residents absent from the facility due to hospitalization or therapeutic leave. Nursing facilities are reimbursed a maximum of 14 days per calendar year for hospital leave and 10 days per calendar year for therapeutic leave. If the nursing facility's occupancy percentage at the date of the absence is below 95%, the facility is reimbursed at 50% of its current rate. If the nursing facility's occupancy percentage at the date of the absence is at or above 95%, the facility is reimbursed at 75% of its current rate.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are no planned or proposed significant changes to the state's Medicaid reimbursement system.

KENTUCKY COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	67.00	65.00	65.00		97.00	95.00	96.00		120.00	120.00	120.00
Average Daily Census	65.22	60.54	61.35		88.14	85.30	86.15		110.18	108.07	108.39
Occupancy	83.3%	82.1%	82.0%		89.3%	88.4%	87.8%		93.7%	93.3%	93.0%
Payor Mix Statistics											
Medicare	8.9%	8.4%	7.9%		12.2%	11.4%	11.3%		15.1%	14.3%	14.9%
Medicaid	61.7%	61.2%	63.5%		72.1%	72.9%	73.8%		78.6%	77.8%	78.8%
Other	10.8%	10.5%	9.6%		17.4%	17.3%	15.3%		39.2%	37.6%	25.8%
Avg. Length of Stay Statistics (Days)											
Medicare	34.19	34.30	34.41		44.73	44.33	44.50		57.65	55.85	55.19
Medicaid	346.96	312.02	329.05		534.62	551.81	535.56		777.06	768.47	807.99
Other	87.38	70.87	66.07		129.47	128.58	98.14		228.52	214.73	176.80
Revenue (PPD)											
Inpatient	\$192.28	\$198.13	\$199.97		\$210.87	\$217.38	\$219.78		\$235.80	\$243.04	\$247.90
Ancillary	\$51.93	\$51.63	\$52.84		\$66.71	\$72.04	\$76.76		\$107.70	\$112.91	\$114.59
TOTAL	\$247.73	\$258.25	\$263.89		\$285.04	\$302.37	\$308.57		\$338.29	\$343.98	\$356.95
Expenses (PPD)											
Employee Benefits	\$14.34	\$13.67	\$13.42		\$18.56	\$19.02	\$18.89		\$22.49	\$22.54	\$22.08
Administrative and General	\$36.29	\$39.28	\$39.74		\$46.10	\$45.90	\$48.82		\$56.50	\$54.16	\$60.22
Plant Operations	\$8.83	\$8.84	\$8.97		\$10.42	\$10.60	\$10.69		\$12.75	\$13.23	\$13.64
Laundry & Linens	\$1.83	\$1.88	\$2.05		\$2.53	\$2.54	\$2.90		\$3.17	\$3.26	\$3.31
Housekeeping	\$4.41	\$4.36	\$4.44		\$5.26	\$5.35	\$5.38		\$6.60	\$6.36	\$6.56
Dietary	\$14.42	\$14.73	\$15.10		\$16.27	\$16.45	\$16.88		\$18.62	\$18.65	\$18.71
Nursing & Medical Related	\$66.99	\$67.96	\$70.42		\$73.47	\$75.55	\$78.33		\$84.37	\$86.66	\$88.63
Ancillary and Pharmacy	\$24.06	\$22.87	\$23.91		\$29.84	\$28.33	\$29.46		\$37.20	\$35.25	\$37.24
Social Services	\$1.72	\$1.63	\$1.69		\$2.90	\$2.47	\$2.93		\$4.51	\$4.69	\$4.75

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Louisiana



INTRODUCTION

Nursing facilities in Louisiana are licensed by the Department of Health and Hospitals (DHH) - Office of the Secretary, Bureau of Health Services Financing, Health Standards Section, under the designation of "Nursing Home." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN LOUISIANA	
Licensed Nursing Facilities*	263
Licensed Nursing Beds*	33,129
Beds per 1,000 Aged 65 >**	46.76
Beds per 1,000 Aged 75 >**	117.64
Occupancy Percentage - 2017*	76.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The existing Certificate of Need (CON) law provides for a moratorium on additional nursing facilities and additional beds in nursing facilities until July 1, 2022. This was enacted by Act 278, passed during the 2010 regular session of Louisiana's Legislature. The DHH may license, but not certify, up to 30 additional beds for a CCRC for Medicaid participation. These beds may only be used by those who possess a life care contract with the CCRC.

BED NEED METHODOLOGY

Given the state's moratorium on the construction of new nursing facility beds and an excess of existing beds, the state has not utilized a bed need calculation in several years.

QUALITY ASSURANCE FEE

Nursing facilities in Louisiana are required to pay a quality assurance fee (QAF), referred to as a provider fee. It is assessed as a \$12.08 charge per patient day, which is effective September 1, 2016. The previous QAF was \$10.00 per patient day. Relative to Medicaid days, the provider fee is reimbursed as an add-on to the facility's Medicaid rate.

MEDICAID RATE CALCULATION SYSTEM

Louisiana uses a prospective, price-based, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The DHH - Office of the Secretary, Bureau of Health Services Financing sets the Medicaid reimbursement rates for skilled nursing facilities in Louisiana. On January 1, 2003, the price-based, prospective payment reimbursement system was established for nursing facilities, based on recipient care needs that incorporate acuity measurements via the Resource Utilization Group III (RUG III) resident classification methodology. This system establishes a facility-specific reimbursement rate for Medicaid residents and also provides enhanced reimbursement for Medicaid residents requiring skilled nursing services for infectious disease and technology dependent care.

COST CENTERS

Louisiana uses the following four cost centers to calculate its facility-specific Medicaid rates:

- **The Direct Care and Care Related** cost component includes the subcomponents Direct Care and Care Related cost. The Direct Care subcomponent includes wages, benefits and contract services related to registered nurses (RNs), licensed practical nurses (LPNs) and certified nurse aides (CNAs). The Care Related cost subcomponent includes costs indirectly related to clinical resident care services provided to Medicaid recipients, such as nursing administration, social services, activities, medical directorship, pharmacy consulting, nursing supplies, raw food, and therapy and ancillary services.
- **The Administrative and Operating** cost component includes expenses attributable to the general administration and operation of the facility, including dietary (excluding raw food), housekeeping, laundry, maintenance, utilities and administration.
- **The Capital** cost component is the portion of the Medicaid rate attributable to depreciation, capital related interest, rent and/or lease and amortization expenses.
- **The Pass-Through** cost component includes property tax and property insurance, as well as reimbursement for the Medicaid portion of the provider fee.

INFLATION AND REBASING

Medicaid rates are calculated based on Louisiana nursing facility cost reports and other statistical data. The base per diem weighted median costs and rates are required to be rebased at least once every two years using the most recent cost reports available as of April 1 (prior to the July 1 rate setting). However, the state can select to rebase rates on a more frequent basis. Louisiana rebased Medicaid rates effective July 1, 2016, utilizing 2014 cost report data. However, the state did not rebase rates effective July 1, 2015. This represented the first time in seven years that the state had not rebased rates. In addition, according to the Louisiana Health Care Association, the state is more likely to rebase rates on a semi-annual basis going forward. This has been the case in recent years. The state did not rebase rates on July 1, 2017, but did rebase July 1, 2018 rates based on 2016 cost report data.

Non-capital expenses are inflated using the Global Insight DRI Index from the midpoint of the cost report period to the midpoint of the rate year. Medicaid rates in Louisiana are set for the period of July 1 to June 30. For rate periods between rebasing, the Global Insight Index is applied to the base per diem weighted medians and rates.

In 2006, Louisiana established the Medicaid Trust Fund for the Elderly ("Trust"). The Trust is funded by inter-governmental transfers (IGTs) and is utilized to offset budget deficits for the state's Medicaid program. In recent years, funds from the Trust were utilized to "back fill" significant potential rate reductions. As a result the balance of the Trust has been reduced nearly 50% from \$808,635,614 in 2008 to \$409,430,606 in 2010. In addition, the Trust is projected to continue to decrease in the future. Given this factor, the long-term viability of the Trust is in question.

In fiscal year 2013, even with the funds allocated from the Trust, the state was still required to implement two nursing facility rate reductions. The first reduction was a \$1.68 rate cut that effective from July 1, 2012, to September 30, 2012. The second rate reduction was a \$1.91 rate cut to be effective from October 1, 2012, to June 30, 2013.

No rate reductions were applied to fiscal year 2014 rates. Also, state rate-setting officials indicated that the state will rebase rates on July 1, 2014, which will include applying the full inflation adjustment to allowable costs dictated by law.

In late 2014 Louisiana residents approved a constitutional amendment that provided additional protection for nursing facility rates. This act requires the legislature to provide the necessary funds to maintain a statewide average rate equivalent to the average rate for fiscal year 2014 (\$161.69). In addition, it does not allow the Governor to reduce Medicaid rates without receiving consent from two-thirds of the elected members of the state house and senate. Also, cuts to nursing home reimbursement are not allowed to be any greater than cuts to other Medicaid programs.

The act created the Louisiana Medical Assistance Trust Fund, which ensures that the matching revenue generated from nursing facility provider fees cannot be used to fund other Medicaid programs.

RATE METHODOLOGY

In rebasing years, the per diem Direct Care subcomponent is determined by dividing each facility's inflated allowable direct care costs derived from the base year cost report by the facility's actual total resident days during the cost reporting period. The per diem neutralized Direct Care subcomponent is calculated by dividing each facility's per diem Direct Care subcomponent by the facility cost report period case mix index (CMI). The RUG-III Index maximization model is used as the resident classification system to determine all case mix indices, using data from the minimum data set (MDS) submitted by each facility. Each resident in the facility with a completed and submitted assessment, is assigned one of 34 RUG III categories on the first day of each calendar quarter.

The per diem Care Related cost subcomponent is determined by dividing each facility's allowable inflated care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period.

The per diem case mix neutralized Direct Care subcomponent and the per diem Care Related cost subcomponent are summed for each nursing facility. Each facility's per diem result is arranged from low to high, and the per diem weighted median cost is determined. In addition, the component's percentage represents the total determined for each facility. Effective July 1, 2011, the statewide Direct Care and Care Related rate is established at 112.4% of the Direct Care and Care Related per diem weighted median cost. Prior to this effective date, the statewide Direct Care and Care Related rate was set at 110.0% of the Direct Care and Care Related per diem weighted median cost. The statewide

Direct Care and Care Related rate is \$88.41 effective July 1, 2018.

The statewide Direct Care and Care Related rate is apportioned between the per diem Direct Care subcomponent and the per diem Care Related cost subcomponent using the facility-specific percentages. The Direct Care subcomponent of the statewide rate is adjusted quarterly to account for changes in the facility-wide average CMI. Each facility's specific Direct Care and Care Related rate is the sum of its case mix adjusted Direct Care subcomponent of the statewide rate, plus its Care Related cost subcomponent of the statewide rate.

The statewide Direct Care and Care Related floor is established at 94.0% of the Direct Care and Care Related per diem weighted median cost. If there is a rate reduction, the Direct Care spending floor is decreased by 1.0% for each \$0.30 reduction in the average Medicaid rate, not to be reduced to below 90.0% of the median.

The statewide Direct Care and Care Related floor should be apportioned between the per diem Direct Care subcomponent and the per diem Care Related cost subcomponent using the facility-specific percentages. The Direct Care subcomponent of the statewide floor is adjusted quarterly to account for changes in the facility-wide average CMI. Each facility's specific Direct Care and Care Related floor is the sum of its case mix adjusted Direct Care subcomponent of the statewide floor, plus its Care Related cost subcomponent of the statewide floor.

On an annual basis, a comparison is made between each facility's per diem Direct Care and Care Related cost and the Direct Care and Care Related floor. If the cost the facility incurs is less than the floor, the difference between these two amounts multiplied by the number of Medicaid days paid during the cost reporting period is remitted to the Bureau of Health Services Financing.

The per diem Administrative and Operating cost component is determined by dividing each facility's allowable inflated administrative and operating cost during the base year cost reporting period by its actual total resident days during the base year cost reporting period. Each facility's per diem Administrative and Operating cost component is arranged from low to high, and the per diem weighted median cost is determined. The statewide Administrative and Operating price is established at 107.5% of the Administrative and Operating per diem weighted median cost. The statewide Administrative and Operating price is \$51.59 effective July 1, 2018.

The Capital cost component rate is based on a fair rental value (FRV) reimbursement system. Under an FRV system, a facility is reimbursed on the basis of the estimated current value of its capital assets. Thus, a facility's bed value is based on its age and total square footage. A facility's current value is determined by multiplying the statewide-established value per square foot (plus a value per square foot for land) by the square footage per bed for the nursing facility. The initial base-line value per square foot utilized is \$97.47, plus \$9.75 for land. For inflation purposes, the effective date of these values is January 1, 2003. The value per square foot is indexed forward annually to the midpoint of the rate year using the change in the per diem unit cost listed in the three-fourths column of the RS Means Building Construction Data

Publication, adjusted by the weighted average total city cost index for New Orleans, Louisiana. The cost index for the midpoint of the rate year is estimated using a two-year moving average of the two most recent indices. The value effective July 1, 2018, is \$211.00 per square foot for building and land.

The square footage used is not to be less than 300 square feet nor more than 450 square feet per licensed bed. When a room is converted to a private room under the Medicaid private room conversion program, the square footage calculation is made as if the conversion never occurred. As a result, the facility is not penalized for exceeding the maximum square footage per bed if the result is private room conversions.

The calculated current value is then increased by the product of total licensed beds multiplied by \$4,000 for equipment. The result is indexed using the previously mentioned cost index. For inflation purposes, the effective date of the per bed equipment value is January 1, 2003. The value per bed effective July 1, 2016, is \$7,256. This indexed value is depreciated, not including the portion related to land, at 1.25% per year according to the weighted age of the facility. Bed additions, replacements and renovations lower the weighted age of the facility. The maximum age of a nursing facility is 30 years. Therefore, nursing facilities are not depreciated to an amount less than 62.5%, or $100\% - (1.25\% \times 30)$, of the new bed value. There is no recapture of depreciation.

A facility's annual FRV is calculated by multiplying its current value by a rental factor. The rental factor is the 20-year U.S. Treasury Bond rate, as published in the Federal Reserve Bulletin, using the average for the calendar year preceding the rate year, plus a risk factor of 2.5%, with an imposed floor of 9.25% and a ceiling of 10.75%. The annual FRV is divided by the greater of the facility's annualized actual resident days during the cost reporting period, or 85.0% of its annualized licensed capacity, to determine the FRV per diem or the Capital component rate. The minimum occupancy requirement was increased from 70.0% to 85.0% effective July 1, 2011.

The initial age of a facility used in the FRV calculation is determined based on its year of construction. The age of each facility is further adjusted by one year each July 1, up to the maximum age of 30 years. If a facility adds new beds, these new beds will be averaged in with the age of the original beds, and the weighted average age for all beds is used. If a facility performs a major renovation/replacement project with a capitalized cost equal to or greater than \$500 per bed, the cost completed during the 24-month period prior to a July 1 rate year will be used to determine the equivalent number of new beds that project represents.

The equivalent number of new beds will then be used to determine the weighted average age of all beds. The equivalent number of new beds from a renovation is determined by dividing the cost of the renovation/replacement by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation.

The Pass-Through component of the rate includes the facility's property tax, insurances costs and provider fee reimbursement. The facility's per diem property tax and property insurance cost

is determined by dividing its allowable inflated property tax and property insurance cost during the base year cost reporting period by its actual total resident days. The provider fee reimbursement is a \$12.08 per diem add-on to a nursing facility's overall rate. The Pass-Through rate is the sum of the facility's per diem property tax and property insurance cost indexed forward, plus the provider fee add-on.

Louisiana nursing facilities may also have Medicaid rates increased by a private room conversion add-on, a bed buy-back add-on or a sprinkler system add-on. Operators may voluntarily, but permanently, surrender a licensed bed in exchange for an incentive Medicaid payment of \$5 per occupied day if the room is converted from a multi-occupancy room to a private room occupied by a Medicaid patient. Operators may purchase an existing nursing home and receive a Medicaid incentive payment for a period of five years provided that the purchased nursing home is closed and the licensed beds surrendered. The incentive payment is based on the number of licensed beds in the closed facility and the increase in occupancy of the buyer. Nursing facilities are eligible for a \$0.15 per day add-on for a five-year period if they upgrade their sprinkler system. However, the deadline to file for the add-on was January 1, 2008. There are currently nursing facilities in the state that are receiving this add-on. However, no additional facilities will receive the add-on in the future.

A nursing facility's total Medicaid rate equals the sum of the facility's Direct Care and Care Related, Administrative and Operating, Capital and Pass-Through cost components plus any applicable add-ons. The average rate effective July 1, 2016, was \$172.82, which represents a 3.6% increase in the average rate (\$166.80) effective July 1, 2015. The average rate effective July 1, 2014 (\$165.56) is similar to the July 1, 2015 rate, which reflects that there was no rebase of rates in fiscal year 2015.

The average rate effectively July 1, 2016, was \$172.82, which represents a 3.6% increase in the average rate (\$166.80) effective July 1, 2015. The average rate effective July 1, 2014 (\$165.56) is similar to the July 1, 2015 rate, which reflects that there was no rebase of rates in fiscal year 2015. . Average rate data was not available for July 1, 2017 or July 1, 2018.

The average Medicaid reimbursement rate in the state is \$161.69 per patient day for rates effective July 1, 2013. This represents a 6.1% increase of the rate (\$152.35), effective July 1, 2012. The average Medicaid rates effective July 1, 2011, and July 1, 2010, were \$148.18 and \$144.18, respectively.

MINIMUM OCCUPANCY STANDARDS

With the exception of the calculation of the FRV, there are no minimum occupancy standards used in the Louisiana Medicaid rate calculation methodology.

OTHER RATE PROVISIONS

New facilities are reimbursed using the statewide average CMI to adjust the statewide Direct Care and Care Related rate and the statewide Direct Care and Care Related floor. After the first

Louisiana

full calendar quarter of operation, the statewide Direct Care and Care Related rate and floor will be adjusted by the facility's case mix. The Capital rate paid to a new facility is based on its age and square footage. An interim Capital rate is paid to a new facility at the statewide average Capital rate for all facilities until the actual Capital rate is determined.

Rates paid to facilities that have changed ownership are based upon the acuity and capital data of the prior owner. After the first full calendar quarter of operation, the rate will be based upon the acuity and capital data of the new owner.

Nursing facilities are also reimbursed for residents who are Medicaid eligible, but temporarily require hospitalization or therapeutic home leave. Effective February 20, 2009, the state reduced bed hold reimbursement from 75% of a nursing facility's current Medicaid rate to 10% of the nursing facility's current Medicaid rate, plus 90.0% of the provider fee add-on (\$12.08 per

day) if the nursing facility has an occupancy percentage below 90%. Nursing facilities with an occupancy rate equal to or greater than 90.0% are reimbursed 90.0% of the applicable per diem rate (including the provider fee add-on). However, effective July 1, 2013, nursing facilities with an occupancy rate equal to or greater than 90.0% are reimbursed ten percent of the applicable per diem rate in addition to the provider fee amount.

The state reimburses nursing facilities for a maximum of seven bed hold days per year for a hospital-related absence and 15 days per year for therapeutic leave. The changes implemented by the state have resulted in a significant reduction in bed hold reimbursement for the majority of nursing facilities in the state.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no other significant changes planned to the state Medicaid reimbursement methodology.

LOUISIANA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	102.00	103.00	103.00		124.00	123.50	122.00		145.00	148.00	146.00
Average Daily Census	71.75	76.26	78.28		97.17	99.26	97.90		119.47	119.47	120.10
Occupancy	65.3%	67.0%	68.1%		78.8%	79.7%	79.1%		88.8%	89.8%	89.3%
Payor Mix Statistics											
Medicare	7.2%	7.1%	7.3%		9.9%	9.7%	9.8%		13.5%	12.8%	12.5%
Medicaid	67.6%	69.1%	68.3%		75.5%	76.0%	75.4%		80.1%	80.3%	80.3%
Other	10.1%	9.9%	10.5%		14.8%	15.0%	14.9%		21.1%	21.1%	21.3%
Avg. Length of Stay Statistics (Days)											
Medicare	45.95	47.98	48.75		58.19	59.68	61.97		77.49	74.04	84.06
Medicaid	437.38	437.44	434.13		614.20	663.33	689.88		992.88	1106.94	1039.42
Other	88.67	81.74	83.32		130.43	131.44	133.94		260.59	212.63	205.93
Revenue (PPD)											
Inpatient	\$160.73	\$165.56	\$169.44		\$173.09	\$177.29	\$183.55		\$200.04	\$200.42	\$201.55
Ancillary	\$26.33	\$28.11	\$30.63		\$43.61	\$41.58	\$44.09		\$64.05	\$62.02	\$63.09
TOTAL	\$197.40	\$202.63	\$207.49		\$223.19	\$227.51	\$236.87		\$247.07	\$250.12	\$258.63
Expenses (PPD)											
Employee Benefits	\$5.43	\$4.72	\$5.50		\$10.90	\$10.44	\$11.22		\$13.34	\$13.05	\$14.20
Administrative and General	\$34.02	\$34.66	\$37.13		\$38.75	\$39.62	\$43.20		\$46.88	\$46.41	\$49.08
Plant Operations	\$8.19	\$7.94	\$8.32		\$9.50	\$9.26	\$9.67		\$11.18	\$11.19	\$11.69
Laundry & Linens	\$1.68	\$1.72	\$1.69		\$2.06	\$2.16	\$2.14		\$2.72	\$2.65	\$2.68
Housekeeping	\$4.18	\$4.16	\$4.26		\$5.01	\$4.89	\$5.07		\$6.21	\$6.01	\$6.15
Dietary	\$13.05	\$13.08	\$13.42		\$14.19	\$14.16	\$14.60		\$15.96	\$15.84	\$16.15
Nursing & Medical Related	\$59.20	\$60.57	\$62.74		\$63.21	\$64.41	\$66.46		\$69.51	\$70.46	\$73.49
Ancillary and Pharmacy	\$16.84	\$16.88	\$17.67		\$21.92	\$21.70	\$22.96		\$28.38	\$28.71	\$30.16
Social Services	\$1.24	\$1.29	\$1.25		\$1.64	\$1.67	\$1.67		\$2.35	\$2.31	\$2.35

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Maine



INTRODUCTION

Nursing facilities in Maine are licensed by the Maine Department of Health and Human Services (DHHS) Licensing and Regulatory Services Division in the long-term care category as “Nursing Facilities”. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MAINE	
Licensed Nursing Facilities*	95
Licensed Nursing Beds*	5,659
Beds per 1,000 Aged 65 >**	21.14
Beds per 1,000 Aged 75 >**	52.78
Occupancy Percentage - 2017*	89.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

A Certificate of Need (CON) is required for the following:

- Any transfer of ownership of a nursing facility through acquisition by lease or donation.
- Any transfer of control or management of a nursing facility.
- Any capital expenditure in excess of \$3,620,916, including the acquisition of medical equipment, effective January 1, 2018.
- Any increase in the licensed bed complement of a facility.
- The construction, development or other establishment of a new or replacement facility or the addition of nursing facility services to a hospital.

The development of any new health service that results in a capital expenditure of \$3,473,571 or more and annual operating expenses of \$1,157,857 or more for the third year after the service is offered, effective January 1, 2018.

There is an indefinite moratorium on the development of new nursing facility beds in Maine.

BED NEED METHODOLOGY

Maine currently has a bed need methodology listed in its CON regulations, but state CON professionals have indicated that this methodology has not been utilized in several years. In this methodology, statistical bed need is based upon no more than 110 beds/1,000 persons over the age of 75 in the most current census. The DHHS utilized the Maine hospital analysis areas contained in Maine Health 1998, or as amended, to determine geographic need. The state recently completed an internal study to determine bed need. This data is currently not available to the public.

QUALITY ASSURANCE FEE

Maine assesses applicable nursing facilities with a quality assurance fee (QAF) that was introduced in the state fiscal year beginning July 1, 2002. The QAF is assessed as a percentage of total patient service revenue. Effective October 1, 2011, the Tax Relief and Health Care Act of 2006 terminated. This act temporarily reduced the maximum QAF from 6.0% to 5.5% of total revenue. Therefore, the ceiling reverted to 6.0% on October 1, 2011. Given this change, Maine increased its quality assessment fee from

5.5% to 6.0% of total revenue effective October 1, 2011. Nursing facilities are reimbursed the Medicaid portion of the QAF as a pass-through expense in the Fixed cost component.

MEDICAID RATE CALCULATION SYSTEM

Maine uses a prospective and retrospective, cost-based, facility-specific, case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The Medicaid Program in Maine is referred to as MaineCare. Maine recently approved changes to its rate calculation methodology effective July 1, 2014. Although the state is still waiting for the Center of Medicare and Medicaid (CMS) to approve these changes, the state is currently reimbursing nursing facilities rates calculated utilizing the new system. For the purpose of this overview, the rate methodology section of this overview will focus on the new system that the state is currently utilizing to determine rates.

COST CENTERS

Maine uses the following three cost categories to calculate its facility-specific Medicaid rates:

- The Direct Care cost component includes salary, wages and benefits for registered nurses (excluding director of nursing), licensed practical nurses, nurse aides, patient activities personnel, ward clerks, and contractual labor, along with fringe benefits, payroll taxes, qualified retirement plan contributions, group insurance, cafeteria plans, medical supplies and drugs that are supplied as part of the regular rate of reimbursement.
- The Routine cost component includes costs (including wages and related benefits) for the following cost centers: administrative services and professional fees (including accounting fees); fiscal services (not including accounting fees); plant and operation and maintenance, including utilities; laundry and linen; housekeeping; medical records; subscriptions related to resident care; employee education; dietary; motor vehicle expense; clerical; office supplies/telephone; conventions and meeting; EDP bookkeeping/payroll; association fees; food, vitamins and food supplements; director of nursing; social services; pharmacy consultant; dietary consult; and medical director.
- The Fixed cost component includes depreciation on buildings, fixed and movable equipment, motor vehicles, land improvements and amortization of leasehold improvements, real estate and personal property taxes, property and liability insurance, interest on long-term debt, rental expenses, amortization of finance costs, amortization of start-up costs and organizational costs, motor vehicle insurance, administration training, water and sewer fees for the initial connection, a portion of the acquisition cost for the rights to a nursing facility license, the provider fee and payments for MaineCare utilization.

INFLATION AND REBASING

Nursing facility rates are determined quarterly for each facility. The rate period in Maine is from July 1 to June 30. Maine had scheduled a rebasing for rates effective July 1, 2008, using 2005 cost report data. However, the rebasing was initially completed

utilizing an inflation policy that was not supported by existing policy, and rebased rates were recalculated utilizing revised policy implemented on March 15, 2009. However, the state revised this policy effective September 29, 2009, and reissued rates. The final revised policy included the CMS Nursing Home Without Capital Market Basket Index published by Global Insight as the state's inflation index. Non-property costs were inflated from the end of the facility's base cost report year to July 1, 2008, utilizing this index. These rates also reflected the incorporation of a regional wage cost adjustment utilized to determine Direct Care cost component rates.

Rates effective July 1, 2009, were determined utilizing this revised policy. However, allowable costs utilized to determine July 1, 2009, rates were not inflated past July 1, 2008. Nursing facilities also received a one-time payment to distribute the remaining balance of the 2009 nursing facility rebasing appropriation. The total initial funding available was approximately \$6,829,632, which was allocated to nursing facilities based on the Medicaid incremental cost increase for each qualifying facility.

Maine did not rebase Medicaid rates in fiscal years 2010 and 2011 or provide any additional inflation to Direct Care costs. However, the state provided a 12.37% inflation adjustment to Routine costs in fiscal year 2011. No inflation adjustment was applied to fiscal years 2012 and 2013 rates. However, as of October 1, 2011, the state provided a 2.0% cost of living adjustment for front-end staff wages. As part of this increase, nursing facilities must demonstrate a 2% increase in the average wage and benefit rate per hour for front-line employees for their first fiscal years ending after July 1, 2013, from the average wage and benefit rate per hour for front-line employees that was in effect for their fiscal years ending 2008. If the nursing facilities cannot demonstrate that 2% increase to the satisfaction of the state, then the state will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front-line employees for the first fiscal years ending after July 1, 2013, should have been if it had been increased by 2% and what it was.

Rates effective July 1, 2014, were rebased utilizing 2011 cost report data and the inflation adjustments required by state regulations. In addition, the state is now required to rebase rates every two years. Prior to this change, the state did not have any required rebasing frequency. In addition, effective the same date, the state changed the inflation indexes utilized to determine nursing facility Medicaid rates as follows: Routine costs will be adjusted for inflation utilizing the United States Department of Labor (USDOL) Consumer Price Index (CPI) for Medical Care Services - Nursing Home and Adult Day Care Services index and Direct care costs will be adjusted for inflation utilizing the USDOL CPI, Historical CPI for Urban Wage Earners and Clerical Workers - Nursing Home and Adult Day Care Services Index. During rebasing years, allowable costs are inflated from the end of the base year to December 31 of the applicable rate year.

The state did not rebase rates on July 1, 2015, but did apply the above mentioned inflation rates to allowable costs. The state did rebase rates on July 1, 2016, utilizing 2013 rates and the inflation adjustments required by state regulations. Allowable costs were again inflated on July 1, 2017 utilizing the state mandated inflation

indexes. According to rate setting officials, the state will rebase rates effective July 1, 2018 utilizing 2015 cost report data.

Expenses utilized to calculate the Fixed cost component are rebased annually utilizing the most recent cost report data. However, the Fixed cost component rate is retrospective, so fixed costs are not inflated from the cost report period to the rate period.

RATE METHODOLOGY

A nursing facility's Direct Care cost component rate is a case mix adjusted rate that is determined quarterly utilizing the Resource Utilization Groups III (RUG III) Version, 45 group (including one unclassified group), resident classification system. The RUG III system is used to determine individual resident and average facility case mix indices (CMIs) based on data derived from the minimum data sets (MDS) submitted by each facility. This system requires the classification of residents into groups, which are similar in resource utilization by use of the case mix resident classification groups, and a weighting system that quantifies the costliness of caring for different classes of residents to determine a facility's CMI. A quarterly assessment of each resident must be completed and submitted every 92 days. Residents that do not meet the classification standards of 44 established RUG categories are placed into an unclassified RUG category.

In order to determine maximum allowable Direct Care cost component rates for Maine nursing facilities, facilities are categorized into peer groups as follows:

- Peer Group I - Hospital-based nursing facilities.
- Peer Group II - Freestanding nursing facilities with less than or equal to 60 beds.
- Peer Group III - Freestanding nursing facilities with greater than 60 beds.

In rebasing years, facility-specific per diem costs are arrayed by peer group to determine a median cost, which is utilized to determine the component rate ceiling. Facility-specific Direct Care cost component per diem costs are determined by dividing allowable Direct Care costs by total resident days. However, the facility-specific per diem costs are first case mix neutralized and adjusted for a regional cost index prior to determining the median and rate ceiling. This is accomplished by dividing a facility's Direct Care cost component per diem cost by the facility's base year CMI and then by the regional cost index.

The base year CMI is calculated in two steps. The first step is to multiply the number of MaineCare residents in each RUG category for the base-year cost report period (excluding residents in the unclassified group) by the CMI weight for the relevant RUG group. The sum of the product of these calculations is then divided by the total number of MaineCare residents (excluding residents in the unclassified group) to determine the facility's base year CMI. However, the state did not have complete data for the cost report period (2011) utilized in the recent rebasing (July 1, 2014). Given this factor, the state was required to temporarily adjust the calculation in order to determine the facility's base year CMI.

For rates effective July 1, 2014, the facility base year CMI was calculated as follows: the first step was to calculate the nursing

facility's 2011 average Direct Care case mix adjusted rate by dividing each facility's gross direct care payments received for their 2011 base year by their 2011 base year MaineCare direct care resident days. The second step is to divide the facility's 2011 average direct care case mix adjusted rate by the facility's 2005 base year direct care rate to determine the facility's base year CMI. State rate setting officials have indicated that the state will resume utilizing the standard calculation to determine facility-specific base year CMIs the next time the state rebases rates (July 1, 2016) utilizing the appropriate data for the base year cost report period (2013 cost reports).

As previously mentioned, a nursing facility's facility-specific per diem cost will also be adjusted by a regional cost index based on the facility's location. Nursing facilities will be classified into one of the following four regions:

- Region 1 - Cumberland, Knox, Lincoln, Sagadahoc and York counties;
- Region 2 - Androscoggin, Franklin, Kennebec, Oxford and Somerset counties;
- Region 3 - Penobscot, Piscataquis, Waldo, Hancock and Washington counties;
- Region 4 - Aroostook County.

The regional cost index is calculated for each region from base year adjusted costs inflated to December 31 for the applicable rate period. The lowest cost region will be provided an index of 1.00. The other regional indices are computed by determining 50% of the percentage difference in cost between that region and the lowest cost region. The current regional cost indexes are as follows: Region 1 - 1.09; Region II - 1.03; Region III - 1.00; and Region IV - 1.00.

Once the facility-specific case mix neutralized per diem costs have been determined, the costs are inflated and arrayed for each peer group and a median is determined. Under state regulations, the rate ceiling for all three of the peer groups is determined to be a percentage of the peer group median. The percentage utilized to determine current ceilings for all three Peer Groups is 110.0%, effective July 1, 2014. This is an increase from the prior percentage (88.73%). In non-rebasing years, the peer group Direct Care cost component ceiling is increased by an inflation rate determined by the state.

A nursing facility's case mix neutralized per diem rate will be adjusted quarterly, by multiplying the rate by the facility's MaineCare CMI for the most recent MDS assessment as of the 15th day of the most recent prior quarter.

Nursing facilities are also eligible for a Direct Care cost component add-on. Facilities' direct care rates will be increased by 25% of the excess of the base year Direct Care cost inflated to December 31 of the applicable rate year (currently December 31, 2013), over the Direct Care rate, as determined using the facility-specific average CMI for the base year. The add-on is limited to \$15.00 per day.

In prior years, a Hold Harmless provision was applied to July 1, 2009, and July 1, 2010, Direct Care cost component rates if a nursing facility's July 1, 2009, and July 1, 2010, rates were less than its July 1, 2008, rate. This provision was eliminated in fiscal

year 2012. However, the state reestablished the Hold Harmless for fiscal year 2014. If a nursing facility's Direct Care cost component rate effective July 1, 2014, is less than the equivalent rate effective April 1, 2014, the rate was increased by the differential between these two rates.

The rate ceiling for the Routine cost component will be calculated utilizing the same peer groups as the Direct Care cost component. Facility-specific Routine cost component per diem costs are calculated by dividing allowable inflated routine costs by total residents. Facility-specific Routine cost component per diem costs are arrayed by peer group and a median is determined. The percentage utilized to determine current ceilings for all three peer groups is 110.0%, effective July 1, 2014. This is an increase from the prior percentage (88.73%). In non-rebasing years, the peer group Routine cost component ceiling is increased by the applicable cost report inflation rate determined by the state.

In addition, a Hold Harmless provision was applied to July 1, 2011, Routine cost component rates if a nursing facility's July 1, 2011, rate is less than its July 1, 2008 rate. The state reestablished the Hold Harmless for fiscal year 2014. If a nursing facility's Routine cost component rate effective July 1, 2014, is less than the equivalent rate effective April 1, 2014, the rate was increased by the differential between these two rates. The Hold Harmless provision was renewed in 2015, but has since expired.

A nursing facility's Fixed cost component rate is derived from the most recent cost report data available. Fixed cost expenses are direct pass-through expenses and a nursing facility's Fixed cost component per diem rate is determined by dividing allowable fixed cost expenses by total patient days (adjusted for the occupancy requirement, if necessary). The Fixed cost component rate is a retrospective rate and allowable fixed costs are not inflated from the cost report period to the effective date of the rate. There are no established rate ceilings for the Fixed cost component.

A nursing facility's Fixed cost component rate will be adjusted through a cost settlement process that is in place to assure that nursing facilities are reimbursed their actual allowable fixed costs that occurred during the rate year. Upon audit of the nursing facility's cost report for the applicable rate year, if a nursing facility's actual fixed costs were greater than the amount the facility was reimbursed, the state will pay the difference to the facility. In addition, if the nursing facility was reimbursed at an amount greater than the facility's actual costs, the facility is required to pay back the overpayment to the state. This repayment can range from a one-time payment to a payment plan. The cost settlement process typically occurs a few years after the rate period, given that the state typically does not audit a specific year's cost report until a few years after it occurred.

Effective July 1, 2014, Maine established payments for nursing facilities with higher than normal MaineCare (Medicaid) utilization levels. Nursing facilities that have MaineCare utilization rates greater than 70.0% of their annual total days of care will receive payments of \$0.40 per reimbursed MaineCare day for each 1% over 70%.

Nursing facilities are permitted by Maine to bank or decertify licensed beds, providing the space left vacant (from bed-banking) in the building is not utilized to create private rooms. Upon the banking or decertifying of beds, a nursing facility's Routine cost component allowable costs would be decreased by a percentage equal to the percentage of resident days decreased by the banking of beds. A nursing facility's Direct Care cost component will also be reduced utilizing the same methodology, but only half the calculated cost reduction will be deducted from the facility's allowable costs.

Nursing facilities are initially reimbursed utilizing a prospective Medicaid rate. However, these facilities are subject to a cost settlement process. Nursing facilities that incur allowable Direct Care costs during their fiscal year that are less than their average prospective rate for direct care will receive their actual cost. In addition, nursing facilities that incur allowable Direct Care costs during their fiscal year in excess of their average prospective rate for direct care will receive no more than the amount allowed by the prospective rate.

A nursing facility's routine care reimbursement is also subject to a cost settlement process. Nursing facilities that incur allowable Routine costs less than their prospective rate for Routine costs may retain any savings as long as they are used to cover Direct Care costs. Nursing facilities that incur allowable Routine costs during their fiscal year in excess of the Routine cost component of the prospective rate will receive no more than the amount allowed by the prospective rate.

Typically, the state does not audit actual cost reports for a rate year until two to three years after the actual rate year. Repayment options for nursing facilities can range from a one-time lump sum payment to a reduction in a nursing facility's current prospective rate until the facility has repaid the debt to the state.

The average rate in Maine effective July 1, 2017, was \$184.44, which is 1.6% greater than the average rate (\$181.49) effective July 1, 2016.

MINIMUM OCCUPANCY STANDARDS

The facility-specific Fixed cost component per diem cost for Peer Group III nursing facilities will be calculated utilizing the greater of actual or 90.0% of the total resident days, and the facility-specific Fixed cost component per diem cost for Peer Group II nursing facilities will be calculated utilizing the greater of actual or 85.0% of the total resident days.

OTHER RATE PROVISIONS

For a newly constructed nursing facility, the basis for establishing the facility's rate through the CON review is the lesser of the rate supported by the costs submitted by the applicant (projected

budgeted costs) or the statewide base year median for the Direct Care and Routine cost components inflated to the current period. The Office of MaineCare Services must approve the fixed costs determined through the CON review process.

New facilities without current case mix data for their resident population will use 1.000 for the base year CMI for the prospective rate calculation for the first, second and third rate setting periods. The quarterly CMI will also be set at 1.000. For the fourth rate setting period, the base year index will be calculated based on the average case mix of all of the nursing facility's MaineCare residents excluding the unclassified group as of the 15th day of the fourth month after the fiscal year begin date of the pro forma cost report.

If a nursing facility experiences a change of ownership, the Direct Care and Routine cost component rates will be the lesser of the rate of the seller or the rate supported by the costs submitted (projected budgeted costs) by the purchaser of the facility. The Fixed cost component recognized by the MaineCare program will be determined through the CON review process. The Office of MaineCare Services must approve fixed costs determined through the CON review process. For a nursing facility experiencing a change of ownership, its Direct Care cost component rate will be adjusted for the facility's actual CMI utilizing the state's standard methodology.

Nursing facilities not required to file a CON application that are currently participating in the MaineCare program and undergo replacement and/or renovation will have their appropriate cost components adjusted to reflect any change in allocated costs. However, the rates established for the affected cost components will not exceed the state median rates for facilities in its peer group. In those instances that the data supplied by the nursing facility to the state indicates that any one component rate should be less than the current rate, MaineCare will assign the lower rate for that component to the nursing facility.

Nursing facilities in Maine are reimbursed their current Medicaid rate for holding a semiprivate bed for a resident requiring hospitalization or therapeutic leave. Effective April 1, 2013, nursing facilities are reimbursed a maximum of seven days per absence that results from an inpatient hospitalization, as long as the resident is expected to return to the nursing facility. Effective July 1, 2013, nursing facilities can be reimbursed for a maximum of 20 days per fiscal year (July 1 to June 30) for an absence that results from therapeutic leave.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the state waiting for CMS approval of the previously discussed changes to the rate methodology, there are currently no changes expected to the Medicaid rate methodology in the immediate future.

MAINE COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	41.00	42.00	40.00		62.00	61.00	61.00		79.00	78.50	79.50
Average Daily Census	56.31	54.07	52.84		72.29	70.41	68.22		101.86	101.15	96.60
Occupancy	88.7%	87.5%	85.0%		92.3%	90.7%	89.7%		94.1%	94.2%	93.2%
Payor Mix Statistics											
Medicare	6.7%	5.7%	4.6%		10.1%	10.1%	8.0%		14.9%	13.4%	13.3%
Medicaid	41.2%	44.5%	42.4%		55.4%	58.3%	57.2%		65.5%	72.3%	71.1%
Other	16.1%	14.0%	14.4%		34.9%	30.7%	31.5%		51.0%	46.5%	49.3%
Avg. Length of Stay Statistics (Days)											
Medicare	23.67	23.20	23.71		27.40	28.00	29.09		33.04	36.81	36.66
Medicaid	277.52	231.46	320.31		399.18	361.46	413.27		502.22	490.72	547.68
Other	62.57	57.58	60.46		159.14	160.43	192.69		495.12	434.15	467.76
Revenue (PPD)											
Inpatient	\$242.51	\$246.63	\$250.60		\$293.13	\$307.25	\$301.34		\$349.28	\$350.69	\$356.52
Ancillary	\$40.87	\$42.39	\$37.36		\$64.44	\$59.87	\$56.52		\$101.11	\$101.72	\$88.64
TOTAL	\$293.81	\$296.36	\$287.28		\$361.45	\$375.68	\$365.85		\$407.09	\$451.42	\$450.46
Expenses (PPD)											
Employee Benefits	\$17.22	\$17.96	\$17.63		\$20.36	\$21.78	\$22.39		\$27.59	\$30.21	\$28.48
Administrative and General	\$31.58	\$33.73	\$35.72		\$43.44	\$45.29	\$46.37		\$50.67	\$54.92	\$57.78
Plant Operations	\$10.30	\$9.43	\$9.88		\$11.62	\$11.74	\$11.95		\$13.34	\$13.51	\$13.69
Laundry & Linens	\$1.98	\$2.00	\$2.13		\$2.66	\$2.71	\$2.68		\$3.76	\$3.59	\$3.70
Housekeeping	\$4.45	\$4.50	\$4.66		\$5.69	\$5.73	\$5.80		\$7.01	\$7.12	\$7.39
Dietary	\$16.32	\$16.62	\$17.62		\$19.35	\$19.80	\$20.31		\$21.55	\$22.53	\$23.29
Nursing & Medical Related	\$75.46	\$86.18	\$83.80		\$92.54	\$98.75	\$103.89		\$103.67	\$113.90	\$119.87
Ancillary and Pharmacy	\$15.23	\$15.15	\$14.27		\$23.71	\$23.74	\$20.94		\$31.86	\$33.86	\$33.49
Social Services	\$2.37	\$2.37	\$2.31		\$3.12	\$3.11	\$3.06		\$4.23	\$4.22	\$4.17

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Maryland



INTRODUCTION

Nursing facilities in Maryland are licensed by the Department of Health and Mental Hygiene (DHMH), through the Office of Health Care Quality (OHCQ) under the designation of “Nursing Homes.” The agency separates nursing facilities into two categories: Comprehensive Care Facilities (CCF) or Extended Care Facilities (ECF). A CCF is defined as “a facility that admits patients suffering from disease or disabilities or advanced age requiring medical service and nursing service rendered by or under the supervision of a registered nurse.”¹ An ECF is defined as “a facility, which offers subacute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous hospital services.”² The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MARYLAND	
Licensed Nursing Facilities*	226
Licensed Nursing Beds*	28,117
Beds per 1,000 Aged 65 >**	30.44
Beds per 1,000 Aged 75 >**	75.76
Occupancy Percentage - 2017*	87.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

In Maryland, an individual or organization is required to obtain a Certificate of Need (CON) for the development of any new healthcare facility or an expansion of services. The CON program is intended to ensure that new healthcare services and facilities are developed as needed, based on the publicly developed measures of cost effectiveness, quality of care, and geographic and financial access to care. The Maryland Health Care Commission (MHCC) reviews and approves the proposed healthcare facility and service projects. Approved projects are awarded a CON, and must be executed within an approved spending level and on a timely basis.

In Maryland, a CON is required for the following scenarios:

- Establishing, building or developing a new healthcare facility.
- Relocating an existing healthcare facility to another site.
- Changing the bed capacity when the change is greater than 10 beds or 10% of the total bed capacity.
- Changing the type of healthcare services offered by a healthcare facility.
- Exceeding a threshold of \$6,150,000 (effective April 11, 2018) established by Maryland statute when creating a healthcare facility capital expenditure.

A CON merger exemption rule is applicable to the merger and/or consolidation involving nursing homes. The exemption assures that nursing homes meet statutory requirements, will provide more efficient and effective healthcare services and the merger/acquisition is in the public interest. Other conditions required for this exception include replacing at least one obsolete physical plant, attaining or maintaining the proportion of Medicaid participation applicable for each involved facility's jurisdiction or

region, and providing Medicare-certified beds in each involved facility. In addition, existing nursing homes may apply for a waiver when seeking to increase or decrease bed capacity. A facility cannot have more than 10 unlicensed waiver beds at any given time. The MHCC will only authorize waiver beds if the facility has the physical space needed to accommodate the waiver beds under the current licensing requirements, and all of the facility's existing beds have been licensed and operational at the same site for at least two years.

Continuing care retirement communities (CCRCs) may apply for a CON for nursing home beds. If awarded, these beds can be fully Medicaid and Medicare certified. Without a CON, CCRCs must limit the total number of nursing beds located on a campus to 20% of the independent living units in facilities with 300 or more units and 24% of the independent living units in facilities with fewer than 300 beds.

There is no moratorium on the construction of new beds in Maryland. In addition, there are no proposed changes to the CON program.

BED NEED METHODOLOGY

The MHCC has developed a long-term care bed need methodology used to help determine if an applicant's proposed new nursing facility or expansion of services satisfies an unmet need in a specific jurisdiction. The jurisdictions considered are western Maryland, Montgomery County, southern Maryland, central Maryland and the Eastern Shore. The MHCC also calculates bed need at the county level. The calculation includes the selection of a base year and a target year. The base year is the most current calendar year for which all utilization and population data used in the projections is available. The target year is the year to which projections are calculated and is seven years after the base year.

The gross bed need is derived by multiplying adjusted historical nursing facility utilization rates for specific age groups to these populations within the five jurisdictions of the state. Historically, these utilization rates were calculated by dividing the base year patient days (by age group and jurisdiction) by the base year total population (by age group and jurisdiction) and multiplying the result by 1,000. The utilization rates used in the most recent bed need methodology (2016) were reduced by 5% and applied to the total populations in all of the jurisdictions to determine gross bed need. In addition, gross bed need is also adjusted to account for Maryland out- and in-migration trends from the surrounding states of Pennsylvania, Delaware, Virginia, West Virginia and the District of Columbia.

The next step in the calculation is to determine net bed need. Net bed need for each jurisdiction of care is the difference between the gross bed need for the jurisdiction and the current inventory of nursing facility beds within the jurisdiction obtained from program records of the OHCQ. The current inventory includes licensed, delicensed and waiver beds.

Maryland

The most recent State Health Plan need projection (effective September 11, 2016) identifies a 2016 adjusted bed need in the counties of Frederick, Harford, Howard, Queen Anne's, St. Mary's and Worcester.

The most recent State Health Plan need projection (effective October 3, 2014) identifies a 2016 adjusted bed need in the counties of Frederick, Harford, Howard, Queen Anne's, and St. Mary's.

QUALITY ASSESSMENT FEE

In the fourth quarter of calendar year 2007, the Centers for Medicare & Medicaid Services (CMS) approved the quality assessment fee waiver program under Senate Bill 101, authorizing the DHMH to impose a provider fee, known as the quality assessment fee (QAF), on Maryland nursing facilities. The QAF begins on the first day of the state fiscal quarter in the year the fee was approved and is therefore retroactive to October 1, 2007. A non-uniform assessment is utilized. The five facilities with the greatest Medicaid volume pay a reduced per diem assessment of \$1.59 per non-Medicare day. The assessment fee for all other facilities is \$5.18 per non-Medicare day. Funds generated by the assessment are used to improve Medicaid reimbursements for nursing homes and restore reimbursement levels that were reduced for cost containment purposes in fiscal years 2006 and 2007. The bill includes a provision that excludes CCRCs and nursing facilities with less than 45 beds from the QAF.

Effective July 1, 2008, the QAF was \$1.96 and \$6.69 per non-Medicare day. Effective August 1, 2009, the assessment fee for the five facilities with the greatest Medicaid volume was decreased to \$1.75 per non-Medicare day, and the assessment fee for all other facilities was decreased to \$6.62 per non-Medicare day. Effective July 1, 2010, as part of HB 151/SB 141 (Budget Reconciliation and Financing Act of 2010), the QAF was increased from 2.0% to 4.0% of non-Medicare revenue. This equated to a QAF of \$14.01 per non-Medicare day for most nursing facilities and \$4.40 per day for the five with the greatest Medicaid volume. Both of these rates represent significant increases from the prior rates. In addition, the Act designates that at least 65% of revenue generated from the QAF will be used to supplement Medicaid nursing home reimbursement, including an unspecified portion of the quality incentive program.

Effective July 1, 2011, the QAF was increased from 4.0% to 5.5% of non-Medicare revenue. This equated to a QAF of \$19.94 per non-Medicare day for most nursing facilities and \$5.32 per day for the five with the greatest Medicaid volume. Effective July 1, 2012, the state increased the QAF to equate to 6.0% of non-Medicare revenue. This equated to a QAF of \$22.94 per non-Medicare day for most nursing facilities and \$5.55 per day for the five with the greatest Medicaid volume. Effective July 1, 2013, the fees changed to \$23.59 per non-Medicare day for most nursing facilities and \$5.41 for the five with the greatest Medicaid volume. Effective January 1, 2015, the fees are projected to change to \$24.32 per non-Medicare day for most nursing facilities and \$5.97 for the five with the greatest Medicaid volume.

The current QAF fees are \$7.15 per non-Medicare day for the

five highest Medicaid-volume nursing facilities and \$25.83 per non-Medicare day for the remaining applicable facilities. This represents only slight increases over the prior fiscal year (effective July 1, 2017) fees of \$7.03 per non-Medicare day for the five highest Medicaid-volume nursing facilities and \$25.49 per non-Medicare day for the remaining applicable facilities. The fees effective July 1, 2016, were \$5.50 per non-Medicare day for the five highest Medicaid-volume nursing facilities and \$25.00 per non-Medicare day for the remaining applicable facilities.

Maryland reimburses nursing facilities for the QAF as an add-on to the Medicaid rate. This add-on approximately equates to total estimated fees divided by total patient days.

MEDICAID RATE CALCULATION SYSTEM

Effective January 1, 2015, the state converted to a prospective, RUG-based, case mix adjusted, price-based rate setting methodology. Prior to this change, Maryland utilized a retrospective, cost-based, non-RUG, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

All facilities must submit MDS 3.0 data on each resident through the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System. Medicare and Medicaid use this information to reimburse facilities. The department then analyzes all resident roster data and assigns a RUG score to each resident. The department also determines a statewide and facility-specific case mix. Reimbursements are based on the case mix of the Medicaid residents in each facility. The department determines facility specific rates on a quarterly basis. Details of the current rate setting methodology are as follows.

COST CENTERS

Maryland uses the following four cost categories to calculate its facility-specific Medicaid rates:

- The Administrative and Routine cost component includes expenses for administrative, medical records, training, dietary, laundry, housekeeping, operations and maintenance, and capitalized organization and start-up cost.
- The Other Patient Care cost component includes pharmacy, recreational activities, patient care consultant services, unprepared food costs, social services, medical director administrative costs and religious services.
- The Capital cost component, which is determined by calculating a Fair Rental Value (FRV) rate in lieu of reimbursement for capital costs. Real estate taxes are also reimbursed as part of this component as a pass-through expense.
- The Nursing Services cost component includes all nursing service expenses related to patient care.

INFLATION AND REBASING

Nursing facility non-capital rates/prices are required by state law to be rebased every two to four years based on the discretion of the state rate-setting agency. As part of the conversion to the new system, rates were rebased on January 1, 2015, utilizing both fiscal and calendar year 2012 cost report data. Non-capital nursing facility rates were most recently rebased on July 1, 2018, utilizing both fiscal and calendar year 2015 cost report data. According to the state, this rebase results in an average three percent rate increase over the prior year rates. It is currently unclear when the state will next rebase costs. The rate year for Maryland is from July 1 to June 30.

The costs utilized to determine non-capital prices/rates are inflated from the midpoint of each cost reporting period to the midpoint of the current rate year by an index factor determined by the state.

Capital/FRV rates are based on appraisals of nursing facilities that must be completed once every four years. Not all nursing facilities are appraised as of the same effective date. The real estate taxes portion of capital rates are derived from a nursing facility's most recent desk reviewed cost report, available two months before the start of the rate year.

RATE METHODOLOGY

With the exception of capital rates, a maximum allowable reimbursement level (price) is determined for each component. Nursing services rates are adjusted quarterly based on facility-specific Medicaid case mix data. Each price is calculated as a percentage of median cost for all nursing facilities within a specific peer group. Nursing facilities are subject to the price/maximum for their specific peer group. The first step in the calculation of all non-capital prices is to divide each nursing facility's inflated applicable costs per cost component by total patient days. The calculation of facility-specific administrative and routine costs is subject to a minimum occupancy requirement. As such, nursing facilities' administrative and routine costs are divided by the greater of the facility's actual total patients days or total projected days at full occupancy multiplied by the statewide average occupancy (plus 1.5%). Capital rates (including the real estate taxes expense) are also adjusted by the minimum occupancy requirement.

For the Administrative and Routine and Other Patient Care cost components, nursing facilities are allocated into four peer groups as follows:

- Baltimore Metropolitan Area, including Anne Arundel, Baltimore, Carroll, Harford and Howard counties;
- Baltimore City;
- Washington D.C. region, including Charles, Montgomery and Prince George's counties;
- Non-metropolitan region, including Allegany, Calvert, Caroline, Cecil, Dorchester, Frederick, Garrett, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Washington, Wicomico and Worcester counties.

After the per diem costs for all applicable facilities are arrayed for each peer group, the Administrative and Routine and Other

Patient Care prices are set at the 1.025% and 1.07% of the peer group median costs, respectively. Nursing facilities are reimbursed the lesser of their facility-specific cost or the application peer group price.

Peer groups utilized for Nursing Services cost component/price are as follows:

- Baltimore city and county;
- Central Maryland, including Anne Arundel, Carroll and Howard counties;
- Washington D.C. region, including Charles, Frederick, Montgomery and Prince George's counties;
- Non-metropolitan region including Calvert, Caroline, Cecil, Dorchester, Harford, Kent, Queen Anne's, St. Mary's, Somerset, Talbot, Wicomico and Worcester counties;
- Western Maryland, including Allegany, Garrett and Washington counties.

Prior to arraying the inflated facility-specific nursing services per diems by peer group, facility-specific costs are first case mix normalized. This is determined by multiplying the inflated facility-specific costs by the statewide average case mix index (CMI) and then dividing the product of this calculation by facility-specific cost report CMI. Once this is completed, the price for each peer group equates to 1.0825% of the case-mix normalized nursing services median cost per peer group.

The applicable peer group price and the non-case mix normalized facility-specific per diem costs are then both adjusted quarterly by multiplying the estimates by the facility-specific average Medicaid CMI (for the quarter prior to the rate) and then dividing the product of this calculation by the statewide average CMI. This results in the determination of the facility-specific Medicaid CMI adjusted per diem cost and the Medicaid CMI adjusted peer group price. The Medicaid adjusted peer group price is then multiplied by 95.0% and is compared to the facility-specific Medicaid CMI adjusted per diem. If a nursing facility's facility-specific Medicaid CMI per diem is greater than 95.0% of the adjusted price, the nursing facility's Nursing Services rate component equates to 95.0% of the adjusted price. If a nursing facility's facility-specific Medicaid CMI adjusted per diem cost is less than 95.0% of the adjusted price, a nursing facility's Nursing Services rate component equates to 95.0% of the adjusted price, less the difference between the nursing facility facility-specific Medicaid adjusted CMI per diem and 95.0% of the adjusted price.

As previously mentioned, capital rates are calculated utilizing an FRV calculation. The basis of the FRV rate is an appraisal of the nursing facility that estimates the value of nursing facility's building, land and equipment. The most recent appraisal is utilized for the calculation and each facility must be appraised every four years. The combined value of the building, land and equipment is divided by the total number of licensed beds to determine the appraised value per bed. This value is compared to the maximum allowable value per bed estimate (\$120,000 per bed – effective July 1, 2018). The lesser of the nursing facility's value per bed or the maximum allowable value per bed is multiplied by the total number of licensed beds to determine the nursing facility's gross value. For facilities in the city of Baltimore, the

gross value is multiplied by ten percent to determine the facility's FRV. For all other facilities, gross value is multiplied by eight percent. The facility's FRV is then divided by the greater of the facility's actual total patient days, or total patient days at full occupancy multiplied by a minimum occupancy requirement. The minimum occupancy requirement will be further detailed later in this overview. The product of this calculation is added to the pass-through real estate taxes expense to determine the nursing facility's FRV rate.

A nursing facility's Resident Care rate equates to the four component rates, plus the QAF add-on. However, prior to the adding the QAF add-on, the sum of the four components is multiplied by a budget neutrality adjustment. Nursing facilities can also receive an Administrative Rate. This is the rate that nursing facilities receive for residents that no longer require nursing care. This rate equates to the sum of the facility's Administrative and Routine, Other Patient Services and Capital rates, 50% of the facility's Nursing Services rate and the QAF add-on.

The state also has specific rate additions for residents that require support services, a bariatric bed and negative pressure wound therapy, as well as a facility-specific ventilator care rate.

The average Resident Care rate effective July 1, 2018, (excluding ventilator care rates) is \$256.95. This represents a 3.1% rate increase from average rate (\$249.12) effective July 1, 2017. The average rate effective July 1, 2016, is \$244.23.

MINIMUM OCCUPANCY STANDARDS

Administrative and Routine and Capital cost component rates are subject to a minimum occupancy requirement. As such, applicable facility-specific costs (or FRV values) are divided by the greater of the facility's actual total patients days or total projected days at full occupancy multiplied by the statewide average occupancy (plus 1.5%). Effective July 1, 2018, this percentage equates to 90.82%.

OTHER RATE PROVISIONS

Effective July 1, 2010, Maryland implemented a pay-for-performance incentive program. The implementation of this program was delayed from July 1, 2009. CCRCs and nursing facilities with less than 45 beds are not eligible for participation in the program. The quality measures utilized include the following: Maryland Health Care Commission Family Satisfaction Survey (40%); Staffing Levels and Staff Stability in Nursing Homes (40%); MDS Quality Indicators (16%); Employment of Infection Control Professional (2%); and Staff Immunizations (2%).

Each facility is given a total score based on these categories. Facilities representing the highest 35% of scores receive a quality incentive payment within a range of \$2.55 to \$5.09 per Medicaid day. In addition, facilities that do not receive a pay-for-performance incentive will be eligible for a pay-for-improvement incentive. Facilities whose overall score has improved are eligible for an incentive payment within a range of \$0.61 to \$1.21. Maryland reimburses eligible nursing facilities for these incentive programs via lump sum payments.

For new facilities, the FRV rate will be based on the lower of the facility's construction costs plus the assessed land value divided by the number of licensed beds, or the maximum appraised value per bed. A new nursing facility will be assigned the statewide average Medicaid CMI until assessment data is submitted for the nursing facility and is used in the quarterly rate determination. The nursing facility will also assigned the Nursing Services Rate, Other Patient Care Price, and Administrative and Routine Price for the facility's geographic region. The FRV will be calculated utilizing the greater of the total estimated resident days or days at full occupancy multiplied by the occupancy standard. Upon providing the real estate bills to the state, which incorporate the new construction at least 15 days prior to the start of operations or the beginning of a calendar quarter, the real estate tax per diem shall be calculated in accordance with the state regulations. The facility will also receive a QAF add-on that will be initially based on estimated assessment days for the facility.

For replacement facilities, the FRV rate will be calculated as the same as new facilities. For the remaining rate components, the facility will receive the previous facility's rates until such time that a new rate is calculated for the facility. For a change of ownership, the facility will be still be paid the old owner's rate except for the period of time the facility is operating under a waiver of occupancy in which the FRV rate will be calculated utilizing estimated resident days.

Payment for bed hold days for therapeutic home leave days is the sum of the per diem payments in Administrative and Routine, Other Patient Care and Capital cost centers. Payment is made to hold a recipient's bed for the first 18 days for therapeutic home leave days. Effective July 1, 2012, the state eliminated reimbursement for hospital bed-hold days. Previously, the state reimbursed nursing facilities to hold a recipient's bed for the first 15 days of an acute-hospital stay at 50.0% of the therapeutic leave rate.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are presently no significant planned or proposed to the Maryland Medicaid rate calculation.

State rate setting officials have indicated that more details on the system will be available near the end of 2014. It is also speculated that the new system will at least initially be designed to be budget neutral to previous reimbursement levels.

MARYLAND COST REPORT STATISTICS										
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values			
	2015	2016	2017	2015	2016	2017	2015	2016	2017	
Number of Beds	92.00	90.25	90.25	120.00	120.00	120.00	154.25	154.75	155.25	
Average Daily Census	85.94	86.60	85.96	114.77	113.59	114.22	140.97	141.04	140.63	
Occupancy	85.0%	84.9%	83.4%	89.8%	90.0%	88.9%	93.1%	92.8%	92.7%	
Payor Mix Statistics										
Medicare	11.7%	10.7%	10.9%	16.9%	15.6%	15.5%	22.7%	21.0%	20.8%	
Medicaid	54.2%	52.6%	55.3%	63.5%	64.1%	66.4%	72.7%	73.5%	75.9%	
Other	15.6%	15.4%	11.3%	46.2%	55.4%	17.8%	82.6%	83.7%	60.2%	
Avg. Length of Stay Statistics (Days)										
Medicare	28.91	29.01	27.96	34.18	33.15	33.27	40.01	41.21	40.33	
Medicaid	263.27	258.87	256.21	364.54	376.11	426.24	669.36	598.94	658.94	
Other	69.56	62.56	38.23	160.67	167.77	80.87	290.05	311.97	250.65	
Revenue (PPD)										
Inpatient	\$263.27	\$269.42	\$279.67	\$308.32	\$312.95	\$319.54	\$353.19	\$366.51	\$379.54	
Ancillary	\$55.98	\$54.84	\$58.78	\$74.69	\$78.38	\$83.20	\$106.31	\$115.57	\$112.87	
TOTAL	\$331.63	\$340.02	\$361.48	\$391.61	\$404.46	\$421.78	\$470.19	\$482.16	\$506.49	
Expenses (PPD)										
Employee Benefits	\$18.12	\$17.07	\$16.83	\$23.24	\$21.02	\$22.07	\$33.76	\$33.18	\$33.50	
Administrative and General	\$54.40	\$55.65	\$57.05	\$63.73	\$64.01	\$65.21	\$77.38	\$77.89	\$78.99	
Plant Operations	\$10.25	\$10.68	\$10.61	\$12.70	\$12.87	\$12.96	\$16.85	\$16.68	\$16.63	
Laundry & Linens	\$2.90	\$2.99	\$3.19	\$3.69	\$3.95	\$4.17	\$4.80	\$4.93	\$4.95	
Housekeeping	\$5.55	\$5.50	\$5.38	\$6.71	\$6.99	\$6.82	\$8.26	\$8.78	\$8.38	
Dietary	\$16.45	\$16.64	\$17.07	\$19.27	\$19.17	\$19.44	\$23.78	\$23.79	\$24.22	
Nursing & Medical Related	\$93.44	\$95.40	\$97.23	\$103.45	\$106.59	\$107.40	\$120.84	\$120.37	\$120.44	
Ancillary and Pharmacy	\$29.72	\$27.22	\$28.14	\$38.39	\$36.41	\$37.01	\$49.43	\$47.22	\$46.21	
Social Services	\$2.37	\$2.51	\$2.74	\$3.74	\$3.78	\$3.89	\$5.01	\$5.15	\$5.32	

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Massachusetts



INTRODUCTION

Nursing facilities in Massachusetts are licensed by the Massachusetts Department of Public Health, under the designation of “Long Term Care Facilities.” The agency separates long-term care facilities into four categories:

- An Intensive Nursing and Rehabilitation Care Facility (Level I) provides continuous skilled nursing care and restorative services.
- A Skilled Nursing Care Facility (Level II) provides continuous skilled nursing care, restorative services and other therapeutic services.
- A Supportive Nursing Care Facility (Level III) provides routine nursing services and periodic availability to skilled nursing, restorative and other therapeutic services.
- A Residential Care Facility (Level IV) provides a supervised supportive and protective living environment and support services to seniors who do not require nursing care or other medically related services on a routine basis. Residential care facilities are not comparable to nursing facilities and are excluded from the Medicaid rate calculation for nursing facilities and this overview.

The following table summarizes nursing facilities within the state. Residential care facilities are not included in this table:

NURSING FACILITIES IN MASSACHUSETTS	
Licensed Nursing Facilities*	438
Licensed Nursing Beds*	49,751
Beds per 1,000 Aged 65 >**	43.82
Beds per 1,000 Aged 75 >**	104.21
Occupancy Percentage - 2017*	85.20%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Massachusetts maintains a Certificate of Need (CON) program, which is administered by the Determination of Need Office of the Department of Public Health, and is referred to as a Determination of Need (DON). In Massachusetts, any substantial capital expenditure for the construction of a nursing facility or a substantial change in the services to any facility cannot be approved by the DON department. No substantial capital expenditure or change of services will be allowed by the state unless the Department of Public Health determines there is a need for the capital expenditure or new service.

Specifically, a DON is required for a capital investment of \$2,058,278 (effective October 1, 2019).

Existing homes can add up to 12 beds once during the life of a facility without a DON if spending thresholds are not exceeded. Massachusetts established a moratorium on applications for new nursing facility beds in 1990. The state extended the expiration date of this moratorium to May 2016.

The DON recently updated its DON regulations to modernize some of the conditions that a developer would have to achieve to obtain a DON. However, the DON recently released a memorandum on January 27, 2017 indicating that since the department currently

anticipates the state possesses a surplus of over 7,000 nursing beds in 2020, the department will not be accepting any applications for new beds. The state also communicated that it will not be updating its bed need methodology. This effectively results in an indefinite moratorium on the construction of new nursing facility beds in the state.

However, the DON issued a new memorandum on May 31, 2019 that proposes to end the moratorium for facilities that meet one of the following four conditions:

- Demonstrated ability to treat substance misuse and mental health disorders in a long term care setting, including the ability to provide medication-assisted treatment and psychiatric medications/treatments;
- Ability to provide safe and innovative models of care for individuals with dementia;
- Reduces the risk of homelessness by improving housing stability; or
- Addresses unmet cultural or linguistic needs of a population.

In addition, any facility applying for a DON must possess a minimum Medicaid payor percentage of 65.0%. DON Representatives indicated that the department is currently considering comments regarding this policy, and as of the date of this overview there is no indication if the moratorium will be lifted.

BED NEED METHODOLOGY

Massachusetts’ previously utilized a bed need methodology that was determined by the DON department. The methodology applied national age-specific nursing facility utilization rates (per 1,000 population) determined by the National Center for Health Statistics to the 2008 and 2015 populations for Massachusetts to determine bed need.

Specifically, the age-specific utilization rates were multiplied by the Massachusetts total population per age cohort, which are then summed to calculate total gross bed need. The last step in the calculation was to determine total net bed need. Total net bed need was determined by deducting the total number of existing nursing facility beds in the state and the total number of nursing facility beds that had been approved for construction in the state (but are not yet licensed) from gross total bed need. If this calculation resulted in a positive number, it was determined that there was need for additional nursing facility beds in the state. If this calculation resulted in a negative number, it was considered that there is a surplus of nursing facility beds within the state. The calculation for 2015 results in a surplus of 10,772 beds.

However, as previously mentioned, the DON recently issued a memorandum effective January 27, 2017 communicating that the department will not be calculating bed need in immediate future given that in 2015 the department determined the state will possess a surplus of 7,000 beds in 2020. Therefore, any plans for the development of a new bed need methodology have been put on hold. It is currently unclear if the DON will determine bed need if the moratorium on DONs is lifted.

QUALITY ASSURANCE FEE

Nursing facilities within Massachusetts are assessed a quality assurance fee per non-Medicare resident day that is administered by the Massachusetts Division of Health Care Finance and Policy. The quality assurance fee is referred to as a Nursing Facility User Fee and varies based on three nursing facility categories. The state collects the fees owed by nursing facilities on a quarterly basis over an annual quality assessment collection period that is from April 1 to March 31. The Nursing Facility User Fees effective July 1, 2010 to October 1, 2016, were as follows:

Facility Class	Facility Type	User Fee Per Diem
Class I	All nursing facilities not included in Class II, III and IV	\$18.41
Class II	Nonprofit continuing care retirement facilities	\$1.84
Class III	Nonprofit nursing facilities that had greater than 66,000 Medicaid resident days	\$1.84

For the fiscal year 2017 annual collection period, the state increased the quality assurance fee to a weighted average estimate of \$20.32 for Class I facilities and \$2.03 for Class II and III facilities. The increase in the user fee generated an additional \$15 million in revenue for nursing homes. However, the state was slow in implementing the change and still charged nursing facilities the old rates for the first two quarters (April 1, 2016 to June 30, 2016 and July 1, 2016 to September 30, 2016) of the fiscal year 2017 collection period. Given that this resulted in the state under-collecting quality assurance revenue, the state increased the Class I fee to \$22.22 and Class II and III fee to \$2.22 (effective October 6, 2016) to achieve the revenue goal for the year. These increased fees were charged for the last two quarters (October 1, to December 2016 and January 1 to March 31) of the annual collection period.

For the fiscal year 2018 collection period (April 1, 2017 to March 31, 2018) the state will collect a weighted average quality assessment fee of \$20.86 for Class I nursing facilities and \$2.08 for Class II and III facilities. However, for the first quarter of this period (April 1, 2017 to June 30, 2017) that state still charge the rates (Class I - \$22.22 and Class II - \$2.22) effective October 6, 2016. In order to have the annual fees collected equate to weighted averages fees of \$20.86 (Class I) and \$2.08 (Class II and III), the state will charge Class I facilities a fee of \$20.40 (Class I) and \$2.04 (Class II and III) for the remaining three quarters of the collection period (July 1, 2017 to March 31, 2018). Effective July 1, 2018 the Class I fee increased to \$21.73 and the Class II and III fee increased to \$2.17. These fees were unchanged on July 1, 2019.

Nursing facilities (Class IV nursing facilities) that meet the following three criteria are exempt from paying the user fee:

- Less than 125 licensed beds as of March 26, 2016;
- are located Barnstable, Franklin, Middlesex, Norfolk or Plymouth counties; and
- have a Medicaid utilization rate of less than 10% or greater than 90%.

MEDICAID RATE CALCULATION SYSTEM

Massachusetts utilizes a prospective, price-based, resident-specific, level of care rate setting methodology to calculate Medicaid rates for nursing facilities.

COST CENTERS

Massachusetts utilizes the following three cost components to calculate Medicaid reimbursement rates:

- **The Nursing** cost component consists of wages and related benefits for directors of nursing, registered nurses, licensed practical nurses, nursing aides, nursing assistants, orderlies and nursing purchased services.
- **The Other Operating** cost component consists of both administration and general costs and other operating expenses. Administrative and general costs include administrative salaries and related benefits, office supplies, telephone expenses, conventions and meeting expenses, help wanted advertisements, licenses and dues, administrative education and training, insurance (malpractice), and management company variable and fixed costs. Other operating costs include, but are not limited to, medical supplies, pharmacy expenses, education expenses, staff development expenses, automobile expenses, and wages and related benefits for the following departments or positions: plant and maintenance; operations; dietary; laundry; housekeeping; ward clerks; medical records librarian; medical director; advisory physicians; social services; indirect restorative and recreation therapy; quality assurance; management minute questionnaire nurses; and staff development coordinator.
- **The Capital** cost component is comprised of building depreciation, a financing allowance (in lieu of interest expense), building insurance, real estate taxes, excise taxes (non-income portion), rent and other fixed costs.

Standard per diem rates are calculated for both the Nursing and Other Operating cost components. For the Capital cost component, the rate level is established based upon when a nursing facility's licensed beds became operational and the facility's capital payment as of July 31, 2007.

INFLATION AND REBASING

Reimbursement rates are effective for the state fiscal year of July 1 to June 30. Nursing facility rates must be rebased every four years under state law. Rates effective July 1, 2007, are based on cost reports submitted for the cost report year ending 2005. Given budget limitations, nursing facility rates were frozen until October 1, 2014, when the state rebased rates utilizing 2007 cost report data. This resulted in moderate increases in nursing facility rates. With the exception of an increase in the User Fee add-on and the implementation of a Direct Care add-on (both effective October 1, 2015), nursing facility rates were frozen in fiscal year 2016. However, rates moderately increased (through an increase of the user fee add-on) in fiscal year 2017 based on revenue generated from the increase in the user fee.

Fiscal year 2018 and 2019 rates did not significantly change from the prior year's rates on a weighted average basis. This reflects that nursing home rate funding levels remained relatively the same from fiscal year 2017 to 2019. In addition, any changes in nursing facility rates over this period are typically related to changes in the user fee add-on.

Capital costs utilized to determine the Capital cost component rate for nursing facilities licensed prior to February 1998 are also

based on 2005 capital cost data. However, these costs are not inflated.

Effective October 1, 2020, the state implemented significant changes to its nursing home Medicaid rate calculation. This included the rebasing of the rates utilizing 2014 cost reports. In addition, as previously mentioned, the rate year in Massachusetts is from July 1 to June 30. However, since these changes were not implemented until October 1, 2019, these rates were increased by annualization adjustments to reflect the additional reimbursement that nursing facilities should have received from July 1, 2019 to September 30, 2019. These adjustments will be eliminated on July 1, 2020.

RATE METHODOLOGY

Total Medicaid rates for nursing facilities in Massachusetts are the sum of the applicable standard payment for the Nursing cost component, the standard payment for the Other Operating cost component, the applicable standard payment for the Capital cost component and various add-ons.

Massachusetts establishes 10 standard Nursing cost component rates for nursing facilities based on the case mix acuity of the nursing facility's residents. The rate a nursing facility receives is based on a resident's total number of management minutes. Management minutes measure a resident's required care intensity and are determined through a management minute questionnaire. The questionnaire is completed semiannually, including upon admission of the resident. Based on the semiannual survey of resident care information, residents are classified into one of 10 categories and nursing facilities are reimbursed (effective October 1, 2019) for these residents as follows:

Resident Categories		
Payment Group	Management Minute Range	Standard Payment
H	0 - 30	\$14.60
J and K	30.1 - 110	\$39.97
L and M	110.1 - 170	\$69.57
N and P	170.1 - 225	\$97.73
R and S	225.1 - 270	\$119.83
T	270.1 and above	\$148.71

The rates were last rebased on October 1, 2019, and ranged from a 0.1% to 0.9% increase from the prior rates effective July 1, 2018. October 1, 2014, rates were frozen for fiscal years 2016 through 2018. For the period of October 1, 2019, through June 30, 2020, nursing facilities will also receive the following annualization adjustment:

Annualization Adjustment - Resident Categories		
Payment Group	Management Minute Range	Standard Payment
H	0 - 30	\$0.01
J and K	30.1 - 110	\$0.02
L and M	110.1 - 170	\$0.19
N and P	170.1 - 225	\$0.17
R and S	225.1 - 270	\$0.36
T	270.1 and above	\$0.36

Prior to October 1, 2019, Massachusetts established one statewide Other Operating cost component standard per diem rate for all nursing facilities. However, effective October 1, 2019, the state now

establishes Other Operating cost component standard per diems for each nursing class. These per diems are as follows:

Operating Cost Standard Payments	
Nursing Facility Group	Standard Payment
I	\$99.96
II	\$82.88
III	\$82.88
IV	\$80.98

Prior to the calculation of these new rates, the statewide standard Other Operating cost component rate (effective October 1, 2015) was \$76.96, which was frozen at the rate calculated on October 1, 2014. In particular, the Class I nursing facility other operating standard per diem rate is significantly greater than the prior statewide rates. However, this reflects that effective October 1, 2019 the state now reimburses nursing facilities for the Nursing Home User Fee as part of this rate component.

The most recent Nursing User Fee Add-ons paid out prior to October 1, 2019 were included in the above rates. These add-ons are as follows:

Nursing Facility User Fee Add-ons		
Facility Class	Facility Type	User Fee Add-on
Class I	All nursing facilities not included in Class II, III and IV	\$18.98
Class II	Nonprofit continuing care retirement facilities	\$1.90
Class III	Nonprofit nursing facilities that had greater than 66,000 Medicaid resident days	\$1.90

Prior to October 1, 2019, if a nursing facility's beds were licensed after February 1, 1998, the facility's Capital cost component rate was a standard amount that is determined based on the facility's licensing date as follows:

Date that New Facilities and Licensed Beds Became Operational	Standard Payment
February 1, 1998 to December 31, 2000	\$17.29
January 1, 2001 to June 30, 2002	\$18.24
July 1, 2002 to August 31, 2004	\$20.25
September 1, 2004 to June 30, 2006	\$22.56
July 1, 2006 to July 31, 2007	\$25.82
August 1, 2007 to July 31, 2008	\$27.30
August 1, 2008 to September 30, 2016	\$28.06
October 1, 2016 - Forward	\$37.60

The Capital cost component rate for nursing facilities that were licensed prior to February 1, 1998, was determined based on the facility's allowable basis of fixed assets and capital costs. Allowable capital costs included in the rate component consist of depreciation, a financing contribution (in lieu of interest) and rent and leasehold expenses. A nursing facility's allowable basis was determined to be the lesser of the facility's actual construction costs or the maximum capital expenditure approved for each category of assets by the Massachusetts Public Health Council.

The state would allow depreciation on the building, improvements and equipment based on the determined allowable basis for fixed assets. Depreciation was calculated utilizing the straight-line method of determining depreciation, assuming maximum use life standards established by the state.

The financing contribution was calculated by multiplying the

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allowable basis of fixed assets, less accumulated depreciation, by 7.625%. Allowable rent and leasehold expenses were the lesser of the following:

- The average rental or ownership costs of comparable facilities, or
- The reasonable and necessary costs of the facility, including interest, depreciation, real property taxes and property insurance.

Allowable capital costs were summed and divided by total patient days (adjusted for the minimum occupancy requirement, if necessary) to determine the nursing facility's Capital cost component per diem cost. If a nursing facility's prior Capital cost component per diem rate effective September 30, 2014, was less than \$17.29, the facility's Capital cost component per diem rate was the greater of its September 30, 2014, rate or the payment determined (effective October 1, 2018) per the following table. Again, this payment table applies solely to nursing facilities that were licensed prior to February 1, 1998:

2005 Capital Costs Per Diem	Standard Payment
\$0.00 to \$4.00	\$4.45
\$4.01 to \$6.00	\$6.18
\$6.01 to \$8.00	\$8.15
\$8.01 to \$10.00	\$10.13
\$10.01 to \$12.00	\$12.11
\$12.01 to \$14.00	\$14.08
\$14.01 to \$16.00	\$16.06
\$16.01 to \$17.29	\$17.29

If a nursing facility's Capital cost component rate for the prior rate year was greater than or equal to \$17.29, the facility's Capital cost component rate would equal its previous rate. However, effective October 1, 2019, nursing facilities now receive standard capital payments based on the county in which the facility is located as follows:

Capital Payments	
County	Standard Payment
Berkshire, Franklin, Hampden & Hampshire	\$14.08
Middlesex & Suffolk	\$16.06
Branstable, Dukes, Nantucket	\$18.04
Bristol, Essex, Norfolk, Plymouth & Worcester	\$14.08

However, the state also maintains a hold harmless provision for capital rates. Nursing facilities' rates effective October 1, 2019, cannot be more than \$2.80 less than the rate the nursing facility was receiving prior to the implementation of October 1, 2019, rates.

Effective October 1, 2015, the state also established a facility-specific direct care staff add-on ranging from \$0.08 per day to \$2.72 per day. According to the Massachusetts Health Care Association, this add-on averaged approximately \$0.22 per day. Effective October 1, 2018, this was converted into a supplemental payment, which was paid out via three separate payments on October 1, 2018, January 1, 2019 and April 1, 2019. The average total payment for the nine-month period was \$100,525 per participating nursing home. Effective October 1, 2019, the state now reimburses the direct care staff add-on as part of a nursing

facilities' Medicaid rates. The average add-on payment effective October 1, 2019, is \$5.09. In addition, for the period of October 1, 2019, to June 30, 2020, nursing facilities also will receive an annualization adjustment, which averages \$0.86 effective October 1, 2019.

Each facility must spend the entire amount of its direct care staff payment revenue for the following staff employed by the facility: certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), dietary aides, housekeeping aides, laundry aides, activities staff and social workers.

Effective January 1, 2019, nursing facilities are also eligible for a Preadmission Screening and Resident Review (PASRR) supplemental for specific residents that received a Level II Determination Notice from the Department of Developmental Services and/or the Department of Mental Health stating that the Medicaid-eligible individual meets the PASRR criteria for intellectual disability, developmental disability or serious mental illness. In addition, to receive the add-on the nursing facility must be determined to be an appropriate setting to meet the member's needs. Subject to available funding, the add-on is \$5.38 per day.

Effective October 1, 2019, nursing facilities are eligible for two quality achievement and improvement payments as follows: a Quality Achievement and Improvement add-on and a High Medicaid Quality Achievement and Improvement add-on. Both of these add-ons are reimbursed separately from a nursing facility's Medicaid rate as supplemental payments. Specifically, nursing facilities can receive a \$1.35 per diem payment per Medicaid day if the facility meets one of the following criteria:

- A nursing facility received a score of at least 124 on the state's nursing facility performance tool as of July 1, 2019, and at least four stars for the overall rating from the Centers for Medicare and Medicaid (CMS) Five-Star Quality Rating Tool;
- A nursing facility received a score of at least 124 on the state's nursing facility performance tool as of July 1, 2019, and at least four stars for the staffing rating from the CMS Five-Star Quality Rating Tool;
- A nursing facility's score from the state's nursing facility performance tool increased by at least three points from July 1, 2018, to July 1, 2019, or the CMS rating increased by one star over the same period.

In addition, nursing facilities that meet the above requirements are eligible for the High Medicaid Quality Achievement and Improvement add-on if a nursing facility's combined Medicaid days (including managed care days), Senior Care Option days and Program of All-Inclusive Care for the Elderly (PACE) days, as reported in the facility's 2017 cost report, equates to 75.0% or greater of the facility's total patient days. The add-on equates to a \$2.96 payment per Medicaid day.

Three additional add-ons were created effective October 1, 2019: a Three Star Plus add-on, a High Medicaid Occupancy add-on and a Cape of the Island add-on. Similar to the High Medicaid Quality Achievement and Improvement add-on, nursing facilities can receive a \$1.26 per Medicaid day add-on if their Medicaid payor percentage is greater than 75.0%. In addition, nursing facilities can receive an additional add-on of \$1.26 per Medicaid day if they

have a CMS Star Rating score of three stars or greater. For the period of October 1, 2019, to June 30, 2019, facilities also receive a \$0.42 annualization adjustment for both add-ons. Lastly, if a nursing facility is located in either Dukes, Nantucket or Barnstable counties, they are eligible to receive a \$1.26 per Medicaid day “Cape of the Island” add-on, plus the \$0.42 annualization adjustment.

Excluding the supplemental payments and the annualization adjustments, after the rebasing of rates effective October 1, 2019, the average nursing facility rate per category (six total rates) increased from a range of 6.2% to 11.6%.

MINIMUM OCCUPANCY STANDARDS

The total resident days utilized to calculate all of the cost components and subcomponents will be the lesser of the facility’s actual total resident days or 96% of the facility’s total available resident days.

OTHER RATE PROVISIONS

Newly constructed nursing facilities will receive the standard payments for the nursing and other operating cost components. The resident-specific Nursing cost component rate will be determined based on an assessment of the resident upon admission. Nursing facilities that were constructed after November 1, 2019, may be eligible for a capital rate of \$34.80.

A facility that experiences a change of ownership will receive the appropriate standard Nursing and Other Operating cost component rates. In addition, based on the new methodology developed to determine capital rates, it is assumed that nursing facilities would receive the standard rate for the county in which they are located regardless of change of ownership.

Massachusetts Medicaid reimburses nursing facilities for reserving a bed for two types of leave from the facility: medical leave (hospitalization) and non-medical leave (therapeutic leave). Nursing facilities are reimbursed up to 10 days per episode of a qualifying hospitalization at \$80.10 per day. Nursing facilities are reimbursed up to 10 days per 12-month period for a temporary absence for non-medical leave at \$80.10 per day. The 12-month period begins on the resident’s first day of non-medical leave

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this report, there are currently no significant changes proposed to the Medicaid rate calculation. However, the state legislature is currently working on approving legislation that would result in an additional \$7.5 million in Medicaid funding for nursing homes.

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MASSACHUSETTS COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	84.00	83.00	82.00		120.00	120.00	120.00		142.00	142.00	142.00
Average Daily Census	76.33	75.20	73.65		104.68	102.99	103.13		122.58	122.84	123.41
Occupancy	83.7%	82.8%	81.4%		89.6%	89.3%	88.5%		93.6%	93.3%	92.6%
Payor Mix Statistics											
Medicare	7.3%	6.2%	6.4%		10.8%	9.7%	9.7%		15.5%	14.0%	14.3%
Medicaid	50.3%	50.7%	51.2%		62.4%	61.9%	61.3%		72.7%	71.3%	72.1%
Other	16.9%	18.5%	17.9%		25.7%	26.5%	26.7%		37.4%	39.2%	37.6%
Avg. Length of Stay Statistics (Days)											
Medicare	24.57	22.57	21.84		31.34	31.29	28.61		43.01	42.43	39.83
Medicaid	236.42	231.65	247.73		388.57	369.22	394.70		654.91	571.18	722.58
Other	54.69	57.31	53.64		96.09	97.08	92.85		212.59	196.32	180.74
Revenue (PPD)											
Inpatient	\$272.09	\$277.74	\$272.91		\$326.11	\$345.56	\$329.50		\$384.72	\$403.84	\$409.30
Ancillary	\$38.44	\$36.06	\$40.29		\$58.90	\$56.12	\$57.92		\$86.31	\$82.78	\$82.98
TOTAL	\$320.44	\$323.90	\$321.88		\$387.09	\$412.49	\$414.07		\$466.62	\$475.24	\$480.66
Expenses (PPD)											
Employee Benefits	\$19.09	\$19.05	\$19.05		\$23.12	\$22.92	\$23.14		\$28.31	\$28.11	\$28.55
Administrative and General	\$47.38	\$48.39	\$52.32		\$56.75	\$57.60	\$60.40		\$65.03	\$67.39	\$68.58
Plant Operations	\$11.20	\$10.99	\$11.32		\$13.18	\$12.49	\$13.07		\$15.73	\$15.55	\$15.73
Laundry & Linens	\$2.75	\$2.99	\$2.87		\$3.30	\$3.51	\$3.65		\$4.16	\$4.40	\$4.42
Housekeeping	\$4.57	\$4.92	\$5.34		\$5.56	\$5.91	\$6.35		\$7.00	\$7.42	\$8.03
Dietary	\$16.50	\$16.94	\$18.04		\$18.83	\$19.23	\$20.52		\$21.80	\$22.40	\$23.56
Nursing & Medical Related	\$91.91	\$95.83	\$103.25		\$101.27	\$105.21	\$112.73		\$112.30	\$116.77	\$122.27
Ancillary and Pharmacy	\$20.42	\$19.89	\$20.54		\$28.43	\$27.15	\$27.80		\$36.04	\$35.46	\$34.88
Social Services	\$2.83	\$2.91	\$2.97		\$3.63	\$3.71	\$3.83		\$4.90	\$5.03	\$5.08

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Michigan



INTRODUCTION

Nursing facilities in Michigan are licensed by the Department of Licensing and Regulatory Affairs (LARA), Bureau of Community and Health Systems. Nursing facilities in Michigan are categorized into one of six long-term care designations. This analysis will focus on freestanding, non-governmental facilities (Class I) and hospital-based long-term care and county-owned medical care facilities (Class III). The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MICHIGAN	
Licensed Nursing Facilities*	426
Licensed Nursing Beds*	46,329
Beds per 1,000 Aged 65 >**	27.48
Beds per 1,000 Aged 75 >**	67.69
Occupancy Percentage - 2017*	80.30%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Michigan Certificate of Need (CON) Commission is empowered by the Michigan Department of Community Health (MDCH) to review and approve CON applications in the state. The CON Commission requires that an individual or organization obtain a CON for the following scenarios:

- A proposed increase in the number of beds in an existing nursing facility or the relocation of licensed beds from one site to another.
- The acquisition of an existing health facility.
- The operation of a new health facility.
- The construction of a replacement facility or the construction of replacement beds
- The construction of a new nursing facility or the conversion of an existing building into a nursing home.
- The initiation, replacement or expansion of covered clinical services.
- Capital expenditure projects for construction and renovations that cost greater than \$3,352,000, effective January 1, 2019. The capital expenditure threshold is indexed annually by the state based on the Consumer Price Index.

For the purpose of the review of CON applications, nursing facilities in Michigan are designated into one of 82 planning areas within the state. The CON Commission considers the impact of the proposed development on the existing nursing facilities within these planning areas when reviewing CON applications. To assist with this process, the CON Commission and MDCH have developed a bed need methodology that determines the unmet bed need in each of the 82 planning areas. This methodology will be detailed further in the following section.

A facility may propose replacement beds within a replacement zone. A replacement zone is defined as follows:

- For a rural or micropolitan statistical area county, the replacement zone is considered to be the same planning area as the existing licensed site.
- For a county that is not a rural or micropolitan statistical county, the replacement zone is within the same planning

area as the existing licensed site and within a three-mile radius of the existing licensed site.

An existing nursing facility proposing to relocate its existing beds will not be required to comply with the needed nursing home bed supply if the nursing home that is transferring the beds and the nursing home that is receiving the beds are located in the same planning area.

An operator proposing to construct a new nursing facility, increase the number of beds in a planning area, or construct a replacement facility outside of a replacement zone must demonstrate that the proposed increase will not result in the total number of beds in a planning area exceeding the needed bed supply set by the MDCH. A facility may request and be approved for the construction of a maximum of 20 additional beds if the net bed need in the applicable planning area is greater than zero, but equal to or less than 20 beds.

In addition, the construction of additional beds that is greater than the unmet bed need for a planning area may be approved under the following conditions:

- A Class I or Class III nursing facility that is proposing to increase its total number of beds has maintained an occupancy percentage of 97.0% for each of the 12 most recent continuous quarters for which verifiable data is available.
- The number of proposed additional beds is equivalent to reduce the occupancy percentage in the planning area to the average daily census adjustment factor used to calculate bed need for each planning area (see next section).

The CON Commission uses a ranking system called comparative review when considering multiple applications for CONs. This system is a numerical point system weighted for categories, such as the level of Medicaid and Medicare participation, the applicant's compliance record with applicable federal and state safety and operating standards, the developer's credit history, the facility's level of specialty services offered and the facility's design. Nursing facilities projected to have a higher Medicaid census that are fully certified for both Medicaid and Medicare have a better chance of receiving CON approval.

Effective June 2, 2008, the CON Commission implemented quality measures that are considered for all CON applications. At the time of application, the applicant must provide a report demonstrating that it does not meet any of following conditions in 14% or more (but no more than five facilities) of its nursing facilities:

- A state enforcement action (in Michigan or another state) within the last three years that results in license revocation, receivership and/or reduction of licensed bed capacity.
- Filing for bankruptcy within the last three years.
- State survey citations at twice the state average for Level D or above citations (excluding life safety citations).
- Currently being listed as a Special Focus Nursing Facility by the Centers for Medicare and Medicaid (CMS).
- Outstanding debts related to the Quality Assurance Assessment program, bankruptcy proceedings, termination of a Medical Assistance Provider Enrollment and Trading Partner Agreement initiated by the state or by any licensing and certification agency in another state.

Applicants that fail to meet these requirements may be denied a CON.

BED NEED METHODOLOGY

As previously mentioned, the CON Commission uses a bed need calculation to assist in the review of CON applications. This calculation uses the actual statewide age specific nursing home use rates using data from the base year that are applied to 85 specific planning regions. The age cohorts for each planning area are Age 0 - 64 years, Age 65 - 74 years, Age 75 - 84 years and Age 85 and older. The number of nursing home beds needed in a planning area is determined by the following steps:

- Determine the population for the planning year for each separate planning area in all the age cohorts.
- Multiply each population age cohort by the corresponding use rate.
- Sum the patient days determined by the above calculations per planning area, which results in the total needed patient days.
- Divide the total patient days by 365 (366 for leap years) to obtain the projected average daily census (ADC).
- Divide the ADC by the ADC adjustment factor (0.90 if the ADC is less than 100 and 0.95 if greater than 100).
- The resulting figure represents gross nursing home bed need in a planning area for the planning year. The total number of existing nursing home beds in a planning area is then subtracted to determine net bed need.

The CON Commission designates the base year and the planning year used in applying the bed need methodology and the effective date of the bed need numbers. The CON Commission may modify the base year based on data obtained from the comparable MDCH survey instruments or Medicaid cost report data. The MDCH calculates use rates for each of the age cohorts and biennially presents the revised use rates based on the most recent base year information. The most recent bed need estimates for Michigan were released in 2018, utilizing a base year of 2013. Demand is projected for 2018.

The calculation estimates that none of the planning districts have a need for additional beds. However, four of these planning areas have a projected need of ten or fewer beds. Overall, the calculation results in a total surplus of 3,950 beds needed in the state. For approval of additional or new beds, a facility and the planning area must maintain a minimum occupancy of 97% for the past 12 continuous quarters. As previously mentioned, these bed need estimates are incorporated as part of the standards considered when reviewing a CON application.

QUALITY ASSURANCE ASSESSMENT PROGRAM

Nursing facilities in Michigan are currently assessed a provider fee, which is referred to as a quality assurance assessment program (QAAP). The QAAP is a specific per diem fee or tax that is applied to a nursing facility's total number of non-Medicare patient days. The amount of the QAAP is determined based on the level of revenue required to fund a portion of the state's cost increases for these facilities related to Medicaid services. Effective October 1, 2016, the state established the following QAFs: \$2.00

per non-Medicare day for nursing facilities with under 40 beds; \$16.60 per non-Medicare day for nursing facilities with greater than 51,000 Medicaid days; and \$24.20 per non-Medicare day for all other nursing facilities. However, effective January 1, 2017, the state increased the rate for all other nursing facilities to \$24.25.

These rates represent only slight increases from the rates effective October 1, 2015, for nursing facilities with greater than 51,000 Medicaid days (\$16.30) and all other nursing facilities (\$24.05). The state increased the rate for facilities with greater than 51,000 Medicaid days (\$18.30) and all other nursing facilities (\$26.15) effective October 1, 2017. The rate (\$2.00) for facilities with under 40 beds remained unchanged. The state has yet to determine the provider fees for the fiscal year beginning October 1, 2018, but it is not anticipated to significantly change.

In addition, effective October 1, 2017, the state implemented its Quality Measure Initiative (QMI). In order to fund the program, the state applied a second QAAP for facilities with greater than 51,000 Medicaid days and for all other nursing facilities. Nursing facilities with less than 40 beds were excluded from the second QAAP. The fees effective October 1, 2017, were \$2.20 per non-Medicare day for nursing facilities with greater than 51,000 Medicaid days and \$3.35 per non-Medicare day for all other nursing facilities. These fees have not yet been updated for fiscal year 2019, but are not anticipated to significantly change. This second QAAP generated approximately an additional \$65 million in funding for nursing homes.

Effective October 1, 2018 QAAP fees are \$2.00 per non-Medicare day for nursing facilities with under 40 beds, \$19.25 per non-Medicare day for nursing facilities with greater than 51,000 Medicaid days and \$26.15 per non-Medicare day for all other nursing facilities. In addition, due to budget shortfalls, the state has temporarily increased the QAAP for all other facilities to \$32.45 from August 1, 2019 to September 30, 2019. The state is in the process of determining QAAP fees for fiscal year 2020 (effective October 1, 2019). However, it is anticipated that the fee for all other nursing facilities will revert back to a level that is similar to the fee effective October 1, 2019.

The QMI fees effective October 1, 2018 were \$1.45 per non-Medicare day for nursing facilities with greater than 51,000 Medicaid days and \$2.95 per non-Medicare day for all other nursing facilities. Fees for October 1, 2019 have yet to be determined.

The state also reimburses nursing facilities a portion of the QAAP. The methodology used to determine the reimbursable amount will be detailed in the Medicaid section. Continuing care retirement communities are excluded from paying the QAAP.

MEDICAID

Michigan uses a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. As previously mentioned, Michigan categorizes nursing facilities into six different groupings. However, this analysis will only focus on Medicaid reimbursement for Class I (freestanding, non-governmental) facilities and Class III (hospital-based and county medical care) facilities. Medicaid payment rates

are typically set 30 calendar days in advance of the state's fiscal year, which is October 1 through September 30.

INFLATION AND REBASING

The reimbursement rates for Michigan nursing facilities are calculated using data from a facility's specific cost report for the calendar year prior to the year in which the rate is set. Michigan rebased Medicaid rates effective October 1, 2018, utilizing 2017 cost reports.

Under state Medicaid policy, the state is required to inflate non-property costs utilizing the state's cost index from the end of a facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated. Therefore, if a nursing facility's cost report year-end is after October 1, 2014, its expenses are typically deflated back to October 1, 2014, utilizing the state's cost index. The cost index being utilized by the state is the Global Insight's Skilled Nursing Facility Market Basket with Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Cost Review. However, the state chose not to default expenses back to October 1, 2011, for the calculation of fiscal year 2013 Medicaid rates (effective October 1, 2012). The state did deflate costs back to October 1 when determining fiscal year 2014, 2015, 2016, 2017, 2018 and 2019 (effective October 1, 2018) Medicaid rates. The state is still in the process of finalizing its budget, which will be used to determine October 1, 2019 rates.

COST COMPONENTS

Michigan uses the following two cost components to calculate its facility-specific Medicaid rates as follows:

- **The Plant** cost component consists of allowable costs for real estate, personal property taxes, interest expense and specific lease expenses. For Class I nursing facilities, the Plant cost component also consists of the return on current asset value. The return on current assets is calculated using the historical cost of capital assets and is a per diem amount representing a use allowance on facility assets. Class III nursing facilities' Plant costs are based only on depreciation and interest expense, since these facilities are nonprofit facilities and do not pay property taxes.
- **The Variable** cost component consists of base and support costs incurred for routine nursing care. The base and support costs are separated into two subcomponents as follows:
 - **The Base** cost subcomponent includes costs associated with activities associated with direct resident care, including payroll and related benefit expenses for the departments of nursing, nursing administration, dietary, laundry, activities, social services, consulting costs and medical and nursing supply costs included in the base cost departments.
 - **The Support** cost subcomponent includes costs associated with administrative and ancillary expenses such as payroll and related benefits for the departments of administration, housekeeping, maintenance of plant operations, medical records, medical director, consulting services, equipment maintenance and repairs, purchased services and contract labor not specific to base care.

RATE METHODOLOGY – PLANT COST COMPONENT FOR CLASS I NURSING FACILITIES

The Plant cost component rate for a Class I nursing facility consists of the sum of the property tax/interest expense/lease cost subcomponent per diem cost plus the return on current asset value cost subcomponent per diem rate.

The property tax/interest expense/lease cost subcomponent per diem cost is determined by dividing allowable costs by total patient days (adjusted for the minimum occupancy requirement, if necessary). Interest expenses are limited by Michigan's Capital Asset Value Borrowing Limit and Deficit Reduction Act (DefRA). With the exception of these limits, property tax, interest expense and lease expenses are direct pass-through expenses.

The return on current asset value per diem rate is calculated by multiplying the lesser of the facility-specific current asset value or the current asset limit by a tenure factor. The product of this calculation is divided by total patient days (adjusted for the minimum occupancy requirement, if necessary) and added to the property tax/interest expense/lease cost subcomponent per diem to equal the Plant cost component. However, only the portion of the nursing facility assets having a use related to routine nursing resident care is included for reimbursement under the return on current asset value subcomponent. The current asset value for each asset is the historical cost of that asset multiplied by the difference between its asset value update factor and the equivalent asset value obsolescence factor. Current asset values are updated annually based on the most recent audited or reviewed cost reports. A nursing facility's current asset value is the sum of the current asset values for the various asset types. It is then divided by the facility's total nursing facility beds to calculate the facility's current asset value per bed.

The asset value update factor used to calculate current asset value is specific to each asset. Land improvements, buildings, building improvements, and fixed building and movable equipment are updated using the Marshall & Swift Valuation Service Construction Cost Index for Class A Buildings in the central United States. The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements and fixed building equipment have an obsolescence factor of 0.03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of 0.10 of each year that the asset has been in service.

The current asset limit is calculated annually based on the historical costs of construction and other asset acquisition costs for facilities opened on or after January 1, 1975. The historical costs are updated using the Marshall & Swift Valuation Service Construction Cost Index for Class A Buildings. The current asset limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. Effective October 1, 2018, the current asset limit was increased from \$79,000 to \$84,500 per bed. The current asset limit floor is 30% of the current asset limit (\$25,350 as of October 1, 2018).

The tenure factor is dependent on the nursing facility's number of full years of continued license as of the beginning of the Medicaid rate year. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table:

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	0.0250
2	0.0275
3	0.0300
4	0.0325
5	0.0350
6	0.0375
7	0.0400
8	0.0425
9	0.0450
10	0.0475
11	0.0500
12	0.0525

If a facility is sold or totally replaced, years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

The tenure factor is multiplied by the lesser of the nursing facility's current asset value limit to calculate the return on current asset value. The result is then divided by total patient days (adjusted for the occupancy requirement, if necessary) and added to the per diem property tax/interest expense/lease Plant cost to estimate the Plant cost component for Class I nursing facilities.

RATE METHODOLOGY – PLANT COST COMPONENT FOR CLASS III NURSING FACILITIES

The Plant cost component rate for Class III nursing facilities is the lesser of the facility-specific per diem Plant cost or the Class III nursing facility Plant cost limit. The facility-specific Plant cost is the sum of the facility-specific depreciation, property taxes, interest and specific lease expenses calculated on a per-patient-day basis.

A nursing facility's allowable per diem plant cost is the sum of depreciation expense, interest expense and allowable lease costs divided by total resident days as determined from the provider's cost report (adjusted for the occupancy requirement, if necessary). A facility with a change in facility asset costs may qualify for Plant cost limit updates.

The Class III Plant cost limit is the maximum reimbursement rate, expressed as per-resident-day amount, for a facility's new construction. The Class III Plant cost limit is the sum of the per diem subcomponent limits for depreciation expense, interest expense, property taxes and financing fees. All of the Class III facilities are nonprofit and do not pay property taxes. The limit has not been adjusted to account for this fact, and it continues to include an amount for property taxes.

The maximum reimbursement rate for the Depreciation subcomponent is a sum based on the mean of the surveyed

values of depreciable assets and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in accordance with the Medicare Principles of Reimbursement. The per diem depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations, which have a direct impact on Plant costs. The update factor utilized for this component is the Economic Index Release as published under the U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Table for Non-Residential Structures.

The maximum reimbursement rate for the Interest subcomponent is based on the surveyed mean of interest rates paid and the mean asset values for facilities constructed during the initial three-year survey time period. The per-resident-day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the interest component limit is updated by applying an index of change in interest rates for home mortgage loans to the interest rate used to calculate the original interest component limit. A facility that undergoes a change of ownership is eligible for an update to the individual facility Plant cost limit.

The maximum allowable reimbursement for the Property Taxes subcomponent is based on the mean of property taxes of the surveyed taxable properties. The per diem Property Taxes subcomponent limit is updated using the same update factor utilized for the Depreciation subcomponent limit.

The maximum reimbursement for the Financing Fees subcomponent is based on the mean of financing fees of the surveyed construction. The per-resident-day financing fees component limit is updated using the same update factor used for the Depreciation subcomponent limit update. The update factor is applied to the original Financing Fees component limit. The maximum amount for each subcomponent is summed and the total is the overall limit for the facility.

RATE METHODOLOGY – VARIABLE COST COMPONENT

The Variable cost component rate for Class I and III nursing facilities equates to the sum of a facility's Base and Support cost subcomponents. The Variable cost component (base plus support) costs are subject to rate ceiling reimbursement limits. The Support cost component is subject to an additional limit, which is dependent on individual facility bed size and class. A nursing facility's Base cost subcomponent per diem cost is calculated by dividing the facility's allowable variable Base costs by total patient days (adjusted for the occupancy requirement, if necessary).

A nursing facility's Support cost subcomponent per diem is calculated by multiplying the facility's Base cost subcomponent per diem cost by the lesser of the facility's Support-to-Base (S/B) Ratio or S/B ratio limit for that nursing facility bed-size group. This amount is then divided by the nursing facility's total patient days (adjusted for the occupancy requirement, if necessary). The facility S/B ratio is allowable Support costs divided by the allowable Base costs for the cost reporting period. The provider's S/B ratio is rebased annually from the most recent cost period,

regardless of ownership.

The individual provider's S/B ratio is limited to the S/B ratio bed size group limit of the provider's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150 and 151+ nursing facility beds. The limit equates to the 80th percentile of the S/B ratios for nursing facilities in the same bed-size group.

The facility-specific Base and Support cost subcomponent per diem costs are summed to calculate the Variable base rate. The facility-specific Variable base rates for all applicable nursing facilities are arrayed by category (Class I and III nursing facilities), and the Variable base cost limit is calculated to equate to the 80th percentile of the Medicaid days.

The lesser of a nursing facility's Variable cost component cost or the Variable base cost limit is then increased by an economic inflation rate. The economic inflation rate is determined by the state legislative appropriations process that determines the annual economic inflation percentage for Class I and Class III nursing facilities. The current economic inflation rate is zero. Effective October 1, 2018, the variance base cost limit increased from \$205.87 to \$216.19. This increase was the result of the state's normal rate rebasing policy.

RATE METHODOLOGY – TOTAL REIMBURSEMENT

Medicaid reimbursement also include a QAAP supplemental payment. As previously mentioned, nursing facilities in Michigan are assessed a QAAP on their non-Medicare patient days. Nursing facilities in the state are partially reimbursed for this fee on a monthly basis by receiving an increased payment for Medicaid services. The monthly gross adjustment is calculated by multiplying one-twelfth of the facility's historical total Medicaid resident days (for the last cost report period) by the facility's quality assurance supplement (QAS) per resident day. The QAS is equal to the lesser of the facility's Variable cost component per diem for Class III publicly-owned nursing facilities, the Variable base rate, or Class I Variable cost limit times the quality assurance assessment factor determined by the MDCH. The current quality assessment factor is 21.76% for fiscal year 2019.

Class I and III nursing facilities that provide special dietary services (for religious reasons) and nursing aide training and competency evaluation programs are eligible to receive additional rate add-ons above any reimbursement limitations.

As previously mentioned, effective October 1, 2017, the state recently implemented a QMI program. This program is funded by an additional QAAP and generated approximately \$65 million in additional Medicaid funding for nursing homes in fiscal year 2018. As part of this program, the state utilizes CMS' Five Star Rating System to set standards that nursing facilities would need to reach in order to receive payments. Payments are adjusted based on a facility's Medicaid payor percentage.

Nursing facilities are reimbursed for this program monthly as a supplemental payment. However, total reimbursement is calculated on an annual basis. Nursing facilities receive an annual reward per bed based on the facility's star rating. Effective October 1, 2017, nursing facilities were awarded \$800 per bed for the first star, and \$452.68 per star per bed for each additional star. The maximum award per bed was \$2,610.72 (five stars). Effective October 1, 2018, the reward for one star (\$800) remained the same; however, the reward for each additional star decreased to \$368.69. The maximum award per bed is \$2,274.76 (five stars).

In addition, nursing facilities only receive 100.0% of the calculated reward if they possess a Medicaid payor percentage of greater than 63.0%. Nursing facilities with a Medicaid payor percentage between 50.0% and 63.0% receive 75.0% of the payment and facilities with less than 50.0% Medicaid receive a percentage of payment that equates to their current Medicaid percentage.

Nursing facilities must complete an annual resident satisfaction survey and must not be classified as a Special Focus Facility by CMS to receive a reward.

MINIMUM OCCUPANCY STANDARDS

A minimum occupancy requirement is applied to the calculation of all of a nursing facility's rate components. For all components, allowable costs are divided by the higher of reported total resident days for the year or facility occupancy at 85.0% of licensed capacity.

OTHER RATE PROVISIONS

New nursing facilities are reimbursed the average Variable cost component rate per facility class. A replacement nursing facility receives the Variable cost component rate the facility it is replacing would receive. These facilities' Variable cost component rates will be calculated utilizing the standard methodology for existing facilities, after these facilities have accumulated six months of cost report data. The Plant cost component rate for both new and replacement nursing facilities is based on the facility's actual Plant costs, limited to the component limits per nursing class.

Nursing facilities that have changed ownership receive the same Variable cost component that the prior owner would have received. Class III nursing facilities will also receive the same Plant cost component rate as the prior owner would have received. Plant cost component rates for Class I nursing facilities that have changed ownership are recalculated given the change in the tenure factor and land value.

Michigan Medicaid reimburses nursing facilities for reserving a bed for residents absent from the facility due to hospitalization or therapeutic leave. Nursing facilities are reimbursed if the resident returns to the facility within 10 days for hospital leave. However, nursing facilities are only reimbursed for a maximum of 18 days per 365-day period for therapeutic leave. The 365-day period begins on the day the resident is discharged.

The nursing facility must have a current occupancy of 97.5% or above to be eligible for bed hold reimbursement for hospital leave. The bed hold reimbursement rate for a resident requiring hospitalization is a single rate, regardless of facility class. The rate is calculated annually. The rate determination utilizes the Class I nursing facility average variable cost for the state fiscal year. The hospital bed hold rate equates to the average variable cost multiplied by 95.0% (to estimate the room and board expense) and 66.0% (to estimate the salary and wage expense). The current reimbursement rate (effective October 1, 2018) for holding a bed for hospital leave is \$121.81 per diem. Nursing facilities are reimbursed at 95.0% of their current rate for holding a bed for a therapeutic leave. There is no occupancy requirement for nursing facilities being reimbursed for holding a bed for therapeutic leave.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this document, there is no current or proposed state legislation affecting the current Medicaid reimbursement methodology in Michigan.

MICHIGAN COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	77.00	79.50	78.00		103.00	103.00	102.00		139.75	134.50	134.25
Average Daily Census	70.62	66.01	65.27		93.19	91.21	89.51		119.32	118.28	116.25
Occupancy	80.5%	76.0%	74.2%		86.7%	84.4%	84.4%		91.7%	91.2%	89.7%
Payor Mix Statistics											
Medicare	8.9%	8.1%	7.6%		13.0%	12.3%	11.0%		20.1%	17.7%	16.8%
Medicaid	48.7%	47.6%	49.6%		64.3%	62.4%	65.0%		73.1%	72.9%	73.5%
Other	17.3%	18.5%	17.3%		25.1%	29.1%	27.3%		46.8%	61.4%	50.8%
Avg. Length of Stay Statistics (Days)											
Medicare	29.25	27.54	23.89		36.47	36.15	31.64		46.10	46.36	44.20
Medicaid	238.74	248.02	215.37		358.86	372.60	331.79		581.56	588.02	562.42
Other	50.26	44.71	40.47		79.03	81.43	75.25		145.68	162.07	131.64
Revenue (PPD)											
Inpatient	\$248.99	\$246.16	\$253.45		\$274.63	\$277.59	\$287.13		\$319.15	\$321.72	\$326.89
Ancillary	\$49.64	\$47.83	\$48.89		\$79.64	\$72.69	\$72.38		\$121.48	\$110.24	\$115.71
TOTAL	\$313.05	\$311.73	\$317.33		\$359.74	\$356.92	\$368.21		\$422.51	\$413.07	\$424.04
Expenses (PPD)											
Employee Benefits	\$18.24	\$19.21	\$19.46		\$24.72	\$25.32	\$25.78		\$33.22	\$33.38	\$34.01
Administrative and General	\$44.25	\$45.05	\$46.40		\$53.17	\$55.33	\$55.08		\$61.10	\$62.29	\$63.12
Plant Operations	\$10.55	\$10.72	\$11.23		\$12.91	\$13.43	\$13.54		\$16.25	\$18.06	\$18.23
Laundry & Linens	\$2.76	\$2.85	\$2.69		\$3.60	\$3.82	\$3.77		\$4.52	\$4.63	\$4.89
Housekeeping	\$5.12	\$5.34	\$5.46		\$6.61	\$6.75	\$6.81		\$8.25	\$8.25	\$8.36
Dietary	\$17.64	\$18.10	\$18.59		\$20.10	\$20.56	\$21.26		\$24.33	\$24.26	\$25.36
Nursing & Medical Related	\$80.82	\$84.46	\$87.76		\$93.58	\$96.77	\$101.21		\$110.49	\$113.92	\$120.89
Ancillary and Pharmacy	\$22.40	\$21.55	\$21.70		\$30.23	\$28.65	\$28.38		\$44.88	\$41.16	\$40.92
Social Services	\$2.45	\$2.51	\$2.55		\$3.97	\$4.06	\$3.90		\$5.84	\$5.97	\$5.90

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Minnesota



INTRODUCTION

Nursing facilities in Minnesota are licensed by the Minnesota Department of Health (MDH) under the designation of "Nursing Homes." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MINNESOTA	
Licensed Nursing Facilities*	345
Licensed Nursing Beds*	26,083
Beds per 1,000 Aged 65 >**	29.85
Beds per 1,000 Aged 75 >**	71.30
Occupancy Percentage - 2017*	85.30%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Minnesota does not have a Certificate of Need (CON) program. However, there has been a moratorium on nursing bed construction since 1984, which was established to control nursing home expenditure growth and enable existing facilities to adequately meet the needs of the state's elderly population. The moratorium applies to the licensure and medical assistance certification of new nursing home beds and construction projects exceeding \$1,580,945.

Under the state law for licensed beds on layaway status, a nursing facility may lay away up to 50% of its licensed beds. Beds on layaway do not count toward capacity days calculations bed hold requirements. Beds on layaway may be brought back online at any time six months after the effective date of layaway. Beds may remain on layaway for up to 10 years. The minimum time frame a bed must be on layaway was reduced from one year to six months effective July 1, 2013.

Pursuant to Minnesota state law, the state may allow exceptions to the moratorium for the renovation, replacement, upgrading, or relocation of a nursing home. Generally, exceptions are made in cases involving the relocation of current beds as long as the relocation is deemed cost neutral to the state. Minnesota also provides an exception for the development of nursing facilities in "extreme hardship" areas. For a county to be considered an extreme hardship area, the following conditions must exist:

- The area must possess an insufficient number of beds per thousand as determined by the Department of Human Services. The estimate is determined using standard beds per thousand factors per people age 65 and older, per five-year age groups. Population estimates utilized are derived from the most recent census and population projections of the county at the 20th percentile, weighted by each group's most recent nursing home utilization;
- There must be a high level of out-migration for nursing facility services associated with a described area from the county or counties of residence to other Minnesota counties, as determined by the commissioner of human services, using an amount greater than the out-migration of the county ranked at the 50th percentile as a standard;
- And an adequate level of availability of non-institutional long-term care services must exist.

BED NEED METHODOLOGY

With the exception of the previously mentioned hardship area standards, Minnesota does not possess a formal bed need methodology.

QUALITY ASSURANCE FEE

Minnesota's quality assurance fee (nursing home license surcharge) was enacted on July 1, 1993. Originally, the surcharge was calculated at \$620 per licensed bed annually. The surcharge increased to \$625 per licensed bed on July 1, 1994, and remained at that level until August 15, 2002, when it increased to \$990 per licensed bed. Since July 15, 2003, the surcharge has been set at \$2,815 per bed. This fee is paid on a monthly basis. There are currently no proposed changes to the nursing home license surcharge.

Nursing facilities are reimbursed for a portion of provider fees, which will be included as part of the external fixed rate component for the new Medicaid reimbursement system that went into effect on October 1, 2008. Under the new system, nursing facilities will receive a Medicaid per diem reimbursement of \$8.86 for the provider fee.

As Minnesota has a rate equalization policy, in which a nursing facility's private pay semiprivate rate cannot exceed the facility's Medicaid rate plus the add-on for the quality assurance fee, nursing facilities effectively have the ability to incorporate the fee as part of the rates charged to private pay residents.

MEDICAID RATE CALCULATION SYSTEM

Effective October 1, 2008, DHS began to phase in a new method for determining operating payment rates based on cost report data. The new methodology determined both facility-specific and resident-specific rates. Prior to this system, nursing facility rates were determined utilizing a facility-specific and resident-specific contract-based system that is administered by the Department of Human Services (DHS). The contract system (also known as the alternative payment system, or APS) uses a methodology based on a former cost-based system to derive the initial contracted Medicaid rate. The state planned to phase in the new system over a seven-year period. Given budgetary issues, the state suspended the phase-in from October 1, 2009, to December 31, 2015.

This reflects that effective January 1, 2016, the state implemented a new rate calculation known as the Value-Based Reimbursement (VBR) System. By doing this, the state eliminated the prior two rate calculations and the phase-in. The new rate calculation is a prospective cost- and price-based, which utilizes case mix adjustments to determine resident-specific non-capital rate components. The remainder of this overview will focus solely on the new system.

The state also developed a new Quality Improvement Incentive Payment (QIIP) system effective October 1, 2015.

COST CENTERS

Under the old cost-based system, reimbursement rates were set prospectively for each rate year based on allowable expenses within the following four major components:

- **The Care-Related Operating** cost component includes costs for nursing, activities, social services, raw food, therapy costs and other direct care costs. The nursing portion of this cost is adjusted case mix utilizing the RUG IV, 48-Grouper resident classification system.
- **The Other Operating** cost component included dietary services (excluding raw food and dietary consulting), laundry and linen, housekeeping, plant operations and maintenance, general and administrative, and property insurance.
- **The External Fixed** rate component includes reimbursement for the nursing facility license surcharge (quality assurance fee), licensure fees, scholarships, long-term care consultation, resident and family councils, planned closure rate adjustments and single-bed incentives. The External Fixed Rate also includes costs associated with the Public Employee Retirement Act (PERA), as well as property insurance, real estate taxes, special assessments and payments made in lieu of real estate taxes.
- **The Property** cost component included costs that were calculated as the sum of the following factors: base property rate; incremental increase or decrease under modified rental formula; capital repair and replacement payment; equity incentive and refinancing incentive.

INFLATION AND REBASING

Inflation adjustments for non-property rates from October 1, 2008, to December 31, 2015, were specifically determined based on appropriations from the state legislature. In recent years Minnesota has experienced budget shortfalls. Given this factor, no inflation adjustment was utilized to determine rates from October 1, 2008, to August 31, 2013. This includes fiscal years 2009 to 2013 rates. Effective September 1, 2013, the state inflated operating rates 3.75%. However, with the exception of small adjustments to reflect the increase in the state's minimum wage, no adjustments were made to October 1, 2015, rates.

Under the old methodologies, Property Cost component rates are inflated using the CPI-U (Consumer Price Index for all Urban Consumers). For rates effective October 1, 2009, and October 1, 2010, these inflation adjustments were 1.84% and 1.73%, respectively. However, property rates have been frozen from October 1, 2010, to December 31, 2018. The state had initially planned to recalculate property rates effective January 1, 2017, utilizing a to-be-developed new rate calculation, which would be based on a Fair Rental Value ("FRV") system. This did not occur, but the state is still considering the development of an FRV calculation as part of a proposed law (House Bill 2414) that would alter the overall rate calculation. It is unclear if this legislation will be passed. Details of this legislation are provided in the "Changes to Medicaid Rate Calculation" section of this overview. Given the delays in determining a new property rate, property rates were increased 2.45% effective January 1, 2019.

As previously mentioned, effective January 1, 2016, the state converted to a new rate calculation. This included changing

the state to a January 1 to December 31 rate year. Prior to this adjustment, the rate year for nursing homes in Minnesota was October 1 to September 30. January 1, 2016 rates were rebased utilizing cost reports for the period ending September 30, 2014. Under the new system the state is required to rebase rates on an annual basis. However, no inflation is applied to rebased costs. The state has rebased non-property rates each of the last three rate periods effective January 1, 2017, January 1, 2018, and January 1, 2019, respectively. January 1, 2019 rates are based on 2017 cost report data.

RATE METHODOLOGY

The Care Related Cost per diem for each facility will equal the facility's total direct care costs divided by its standardized days. Standardized patient days are calculated by multiplying the annual case mix score with the total days, or summing the total of each specific case mix class with the number of days in that class. Case mix weights for the RUG IV, 48-Grouper model are utilized to make this adjustment.

A Care Related cost component limit will be determined for each nursing home based on its quality score, utilizing its most recently available data as provided in the Minnesota Nursing Home Report card. Report Care scores range from 0 to 100. For a facility with a quality score of zero, the Care Related limit will be 89.375% of the statewide median. For all other facilities the limit will be increased from this amount by their quality score multiplied by 0.5625. Therefore, a facility with the quality score of 100, the highest possible score, will have a Care Related limit of 145.625% of the median. The lower of the subject's adjusted per diem expense or the limit is adjusted by applying the Facility Average Case Mix Index RUG weights to the above to calculate facility-specific Medicaid rates for each RUG category. The case mix adjusted resident-specific (based on the RUG category) Care Related Operating rate component is added to the Other Operating, External Fixed and Property rate components to calculate the total Medicaid rate per RUG category.

In addition, during the first 30 calendar days after admission, the total payment rate for a case mix classification is increased by 20 percent.

The Other Operating rate component is a statewide price for all nursing facilities. The Other Operating price equates to 105% of the median per diem cost for the state.

There are several sub-components of the External Fixed rate component. Nursing facilities receive a per diem reimbursement for the surcharge per diem that equates to \$8.86 as part of their External Fixed rate component. The portion of the External Fixed rate component related to the license fee equates to the fee divided by the actual resident days.

The Planned Closure Rate Adjustment (PCRA) allows nursing facilities to receive incentive payments for delicensing beds. The calculation of the PCRA uses the number of beds closed, the number of beds receiving the PCRA and a PCRA factor. The state eliminated this program effective October 31, 2011, but planned closure rate adjustments that were already included in facilities'

rates were not be affected by the end of the program. Any facility that had a planned closure application approved prior to the termination of this program still had 18 months to act on it. However, the state reinstated the PCRA in fiscal year 2014. The PCRA is reimbursed as part of the External Fixed rate component.

The portions of the External Fixed Rate component related to PERA, allowed health insurance, real estate taxes, special assessments and payments in lieu of taxes are calculated by dividing the actual costs of these categories by the facility's actual resident days.

Since July 1, 2005, nursing facilities in Minnesota can receive additional reimbursement if they convert multiple-bed rooms into single-bed rooms. Effective July 1, 2006, the state introduced a performance-based incentive program. Under this provider-initiated program, nursing facilities can submit proposals to the state that aim at improving the quality and efficiency of nursing home care. Provider-initiated projects are selected through a competitive process and are funded up to 5.0% of the weighted average operating payment rate. Both of these incentives are reimbursed as part of the External Fixed rate component. Lastly, by achieving a pre-determined quality improvement goal, nursing facilities can be reimbursed a maximum of \$3.50 per Medicaid day for the state's QIIP program as part of the External Fixed rate component.

Property rates have essentially not been re-calculated since October 1, 2008, and were not been inflated from October 1, 2010 to December 31, 2018. Property rates were inflated 2.45% effective January 1, 2019.

As part of the conversion to the new rate calculation, effective January 1, 2016, nursing facilities rates are held harmless to rates effective December 31, 2015. Therefore, nursing facilities will be reimbursed the less of their new rate calculated annually on January 1, or their previous rate (effective December 31, 2015). In addition, after the first year of the new rate system, a nursing facility is subject to a reduction in their Care Related rate limit, in any one year, greater than 5.0% of the median used in calculating that limit. According to Minnesota Rate Setting Professionals, only five facilities in the state are still utilizing the hold harmless provision.

The average weighted nursing home rate in Minnesota effective January 1, 2019 is \$261.59. This rate represents a 6.1% increase from the prior weighted average rate (\$246.54) effective January 1, 2018. The weighted rate effective January 1, 2017 was \$226.38. The increase in these rates reflects the state's policy of annual rebasing rates utilizing more current cost report data.

OTHER RATE PROVISIONS

The state's Medicaid program will reimburse a nursing facility 30% its total base rate for a maximum of 36 days for holding a bed for a resident that required therapeutic care at another facility or a maximum of 18 days for a resident requiring a hospital stay. In order for a nursing facility with 25 or more beds to receive reimbursement for a bed hold day, the facility must possess an occupancy percentage of greater than 96%. Effective July 1, 2011, the Medicaid program reduced the payment from 60% of a nursing facility's total rate to 30%. In addition, the eligibility test used to determine if a facility may bill for a leave day was increased from 93% to 96% occupancy. Nursing facilities with 24 or fewer licensed beds will not receive payment if a licensed bed has been vacant for 60 consecutive days prior to the first leave day.

Nursing homes may also be able to negotiate an adjustment to the operating payment rate for a resident who is ventilator-dependent. The negotiated adjustment must reflect only the actual additional cost of meeting the specialized care needs of a ventilator-dependent person. The negotiated payment rate must not exceed 300 percent of the case mix adjusted operating payment rate for the highest case mix classification.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

On April 25, 2019, the Minnesota House of Representatives passed House Bill 2414 (Omnibus health and human services bill). This bill would alter the state's nursing home Medicaid rate calculation. This would include changes to both non-property and property rate components. The calculation of property rates will consist of converting to an FRV system. According to Care Providers of Minnesota, while there could be some facilities that could potentially see a rate increase under this new system, the new calculation will result in an approximate \$68 million dollar reduction in nursing home reimbursement.

Since the bill passed, it has received significant opposition from the Minnesota Senate. The Senate has proposed alternative legislation, which would not result in a reduction in reimbursement. As of the date of this overview, the negotiations between the house and senate appear to be deadlocked. The Minnesota Legislative Session ends on May 21, 2019. If an agreement is not reached, the state would have to enter a special session. As of the date of this overview, the likelihood of House Bill 2414 being implemented is unclear. In addition, any significant changes to the state's rate methodology would have to be submitted to the Centers of Medicare and Medicaid (CMS) for approval as a State Plan Amendment.

MINNESOTA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	50.00	50.00	50.00		70.00	70.00	65.00		101.00	101.00	98.00
Average Daily Census	45.34	43.24	43.42		66.14	63.28	62.18		97.29	94.44	90.68
Occupancy	80.6%	78.4%	78.9%		88.1%	86.8%	87.9%		92.8%	92.3%	92.7%
Payor Mix Statistics											
Medicare	6.4%	6.2%	6.5%		9.1%	9.0%	9.1%		13.2%	13.5%	13.2%
Medicaid	43.6%	42.7%	41.0%		51.1%	52.2%	50.3%		61.0%	61.7%	61.1%
Other	30.8%	31.7%	29.0%		40.2%	39.1%	38.2%		50.4%	55.0%	47.3%
Avg. Length of Stay Statistics (Days)											
Medicare	25.30	25.75	24.93		32.80	33.56	31.23		43.01	45.32	42.14
Medicaid	263.15	241.85	239.96		373.21	394.94	400.58		634.68	675.07	644.33
Other	69.07	71.79	69.10		120.07	114.86	123.61		204.40	189.47	218.37
Revenue (PPD)											
Inpatient	\$178.49	\$216.94	\$223.32		\$200.12	\$237.96	\$243.40		\$229.33	\$263.55	\$267.62
Ancillary	\$32.70	\$32.72	\$34.61		\$49.90	\$49.44	\$51.54		\$79.85	\$83.41	\$86.49
TOTAL	\$218.88	\$257.72	\$258.00		\$257.28	\$291.28	\$288.78		\$310.64	\$340.84	\$352.94
Expenses (PPD)											
Employee Benefits	\$20.31	\$22.47	\$25.67		\$25.74	\$29.24	\$31.48		\$34.86	\$38.23	\$40.83
Administrative and General	\$30.16	\$33.62	\$35.73		\$37.09	\$41.90	\$41.82		\$47.83	\$51.80	\$53.53
Plant Operations	\$10.37	\$10.73	\$11.64		\$12.10	\$12.91	\$13.77		\$15.07	\$16.01	\$16.94
Laundry & Linens	\$2.36	\$2.50	\$2.23		\$3.15	\$3.43	\$3.07		\$3.97	\$4.37	\$4.04
Housekeeping	\$4.57	\$4.85	\$5.01		\$5.86	\$6.26	\$6.52		\$7.18	\$7.58	\$8.28
Dietary	\$18.31	\$18.85	\$20.60		\$20.99	\$22.27	\$23.46		\$24.22	\$25.83	\$27.59
Nursing & Medical Related	\$81.69	\$93.47	\$96.07		\$94.27	\$107.27	\$110.30		\$106.42	\$121.48	\$125.34
Ancillary and Pharmacy	\$15.27	\$15.43	\$15.75		\$22.87	\$22.45	\$22.10		\$35.34	\$34.82	\$33.85
Social Services	\$2.94	\$3.36	\$5.03		\$6.73	\$7.43	\$8.54		\$9.04	\$9.89	\$10.72

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Mississippi



INTRODUCTION

Nursing facilities in Mississippi are licensed by the Mississippi State Department of Health (MDH) - Division of Health Facilities Licensure and Certification (DHFLC) under the category of "Nursing Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MISSISSIPPI	
Licensed Nursing Facilities*	173
Licensed Nursing Beds*	16,313
Beds per 1,000 Aged 65 >**	34.78
Beds per 1,000 Aged 75 >**	86.10
Occupancy Percentage - 2017*	87.30%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

In 1990, the Mississippi legislature imposed a permanent moratorium that prohibits the MDH from issuing a Certificate of Need (CON) to an individual proposing the new construction of, addition to, or expansion of a nursing facility. This includes the conversion of hospital beds to nursing home beds. The development of a replacement nursing facility is exempt from the moratorium, so long as the construction of the facility does not result in an increase in total licensed beds.

If the legislative moratorium is ever removed, the state has a comprehensive standby health planning methodology. Under this methodology, a CON would be required for the following:

- The development of nursing home services if the capital expenditure exceeds \$5,000,000.
- Any increase in licensed bed capacity.
- Any addition of nursing facility services not provided on a regular basis by the proposed provider within the 12-month period prior to the time such services would be offered.
- The construction, development or otherwise establishment of new nursing facility beds regardless of capital expenditure.

BED NEED METHODOLOGY

MDH currently utilizes a bed need calculation when considering CON applications. A CON applicant must document a need for additional nursing facility beds using this methodology. The prevalence rates utilized in the calculation have been in place since August 1, 2008.

The need for nursing facility beds is established for four specific, long-term care planning districts representing the northwestern, northeastern, southwestern and southeastern portions of the state. The following nursing facility use rates are applied to the populations of the long-term care planning districts:

- 0.5 beds per 1,000 population aged 64 and under;
- 10 beds per 1,000 population aged 65-74;
- 36 beds per 1,000 population aged 75-84;
- 135 beds per 1,000 population aged 85 and older.

The most recent bed need calculation completed by MDH is included in the fiscal year 2018 State Health Plan. The MDH utilized 2018 population projections prepared by the State Data

Center of Mississippi, University of Mississippi Center for Population Studies to project bed need. The sum of the product of these calculations equates to gross bed need. Total licensed and CON-approved nursing facility beds are deducted from gross bed need to calculate net bed need. The 2018 State Health Plan estimates a surplus of 3,581 additional nursing facility beds in 2018. The calculation is based on the previously displayed prevalence rates and the current nursing facility bed inventory.

QUALITY ASSESSMENT FEE

Mississippi nursing facilities are assessed a quality assessment fee, known as a nursing facility assessment reimbursement. From July 1 to December 31, 2007, the nursing facility assessment fee (NFAF) was increased from \$9.27 to \$11.14. From January 1, 2008, to December 31, 2010, the NFAF was \$10.63 per licensed and occupied bed day. The NFAF was increased to \$12.09 effective January 1, 2010, and was increased to \$14.08 effective October 1, 2011. The NFAF has not changed since that date. A nursing facility's assessment fee expense is included as an allowable cost in the Administrative and Operating cost component.

MEDICAID RATE CALCULATION SYSTEM

Mississippi Medicaid utilizes a case mix adjusted, cost-based, facility-specific rate setting system to calculate Medicaid rates.

COST CENTERS

The costs are separated into the following four cost categories as defined in the cost reports:

- The Direct Care cost component consists of salaries and benefits for registered nurses, licensed practical nurses, nursing aides, respiratory therapists, feeding assistants, contracted expenses for registered nurses, licensed practical nurses, respiratory therapists, feeding assistants and nursing aides, medical and other direct care supplies, over-the-counter drugs and medical waste.
- The Care Related cost component consists of salaries and fringe benefits for activities, directors of nursing, assistant director of nursing, resident assessment instrument coordinator, the medical director, pharmacy, social services, allowable barber and beauty expenses, supplies used in the provision of care related services, raw food, food supplements, consultants for activities, nursing, pharmacy, social services and therapies.
- The Administrative and Operating cost component consists of salaries and fringe benefits for the administrator, assistant administrator, dietary, housekeeping, laundry, maintenance, medical records, owners and other administrative staff. This cost component also includes contract costs for dietary, housekeeping, laundry and maintenance, dietary and medical records consultants, as well as accounting fees, non-capital amortization, bank charges, board of director fees, dietary supplies, depreciation expenses for vehicles and for assets purchased (that are less than the equivalent of a new bed value), dues, education seminars, housekeeping supplies, professional liability insurance, non-capital interest, laundry supplies, legal fees, linens and laundry alternatives, management fees and home office costs, office supplies, postage, repairs and maintenance, taxes other than property

taxes, telephone and communications, travel and utilities.

- The Property cost component includes a fair rental value (FRV) allowance, property insurance and property taxes.

INFLATION AND REBASING

Mississippi rebases Medicaid rates annually based on cost reports for the period ending in the second calendar year prior to the beginning of the rate year. The rate year is from January 1 to December 31. Rates effective January 1, 2019, were based on 2017 cost report data. Nursing facility rates are adjusted quarterly for case mix.

Non-property related expenses are inflated from the midpoint of the cost report period to the midpoint of the rate period utilizing component-specific trend factors determined by the state. These trend factors are calculated utilizing actual cost report data for all applicable facilities, and various national and state inflation indexes. For rates effective January 1, 2019, the trend factors were 4.46% of Direct Care and Care Related costs, and 2.4% for Administrative and Operating costs.

A trend factor is not developed for Property costs because the value of each nursing facility bed utilized to determine a facility's FRV rate is indexed using the RS Means Construction Index five-year moving average for Jackson, Mississippi. Allowable property tax and property insurance are not inflated.

RATE METHODOLOGY

Mississippi utilizes the RUG IV, 48 RUG Grouper to classify nursing home residents to determine facility-specific average case mix indexes (CMIs). The state converted from the RUG III to the RUG IV system effective January 1 2015.

The facility-specific per diem costs for the Direct Care and Care Related cost components are determined by dividing total allowable costs by total patient days. Total patient days utilized to determine facility-specific Care Related per diem costs are subject to an 80% minimum occupancy requirement. The facility-specific component per diems are summed and inflated to the current rate period in order to determine a nursing facility's maximum allowable reimbursement for the rate components.

Prior to summing and inflating the component per diems, the facility-specific Direct Care cost component per diem is case mix neutralized. This is accomplished by dividing the per diem cost by the nursing facility's average CMI for the base cost report year. The average CMI for the base year (for all payors) is calculated by dividing the sum product of patient days by RUG group and the respective M3PI by total patient days.

After Direct Care costs have been case mix neutralized, the facility-specific combined per diem costs are arrayed and a median cost is determined. This median is utilized to calculate the rate ceiling and floor. The ceiling rate for the combined component per diem costs equates to 120% of the median and the floor equates to 90% of the median. Based on the calculated rate ceiling and floor, a nursing facility is assigned a standard rate. If a nursing facility's per diem cost is greater than the rate ceiling, that facility's standard rate is the ceiling rate. If a nursing facility's per diem cost is below

the rate floor, then the rate floor is that facility's standard rate. A nursing facility's per diem cost is its standard rate if that rate is within the range of the rate floor and ceiling.

The standard rate is allocated between the two cost components based on the ratio of each component's expenses to total expenses for both components (prior to determining the standard), which results in the standard Direct Care and Care Related cost component rates. A nursing facility's standard Direct Care cost component rate is adjusted quarterly, by multiplying the rate by the facility's average CMI (for all payors) for the period two calendar quarters prior to the start date of the rate being calculated.

In order to determine a nursing facility's Administrative and Operating cost component rate, all applicable nursing facilities are categorized into two classes, small and large facilities. Small facilities are nursing facilities with fewer than 60 beds, and large facilities are nursing facilities with greater than 60 beds. The facility-specific per diem costs for the Administrative and Operating cost components are determined by dividing total allowable inflated costs by total patient days (subject to the minimum occupancy requirement, if necessary). The facility-specific component per diems are arrayed by class to determine the class rate ceiling. The rate ceiling equates to 109.0% of the median per diem cost. In addition, if a nursing facility's per diem cost is below the ceiling, the facility receives an add-on equating to 75.0% of the difference between the greater of trended cost or median and the ceiling.

Property cost component rates for nursing facilities are determined utilizing the FRV system. The FRV rate is the sum of the property tax and insurance per diems, plus the per diem cost determined through the FRV system. The initial FRV of a nursing facility is based on the new construction costs per year, calculated utilizing state standard values and the facility's age. The facility's age is a weighted average age that factors in the date and amount of any substantial renovations or additions to the facility. The first step in the FRV calculation is to multiply the state-established new construction value per bed by the facility's total number of beds. The new construction value per bed effective January 1, 2019, is \$95,540. The new construction value per bed is annually indexed forward to January 1 of the rate year utilizing the RS Means Construction Index five-year moving average for Jackson, Mississippi.

The total new construction value for the nursing facility is then deducted for depreciation, assuming a depreciation rate of 1.75% per year (based on the weighted average age of the facility). The maximum allowable amount of depreciation is 50.0%. The total new construction value adjusted for depreciation is multiplied by the rental factor to determine the FRV. The rental factor equates to 5.35% plus a 2.0% risk factor for a total rental factor of 7.35%. The FRV per diem cost is determined by dividing the total FRV by total patient days (adjusted for the minimum occupancy requirement, if necessary).

Property tax and property insurance are direct pass-through expenses. Per diem costs for both cost centers are calculated utilizing the most recent cost report data available. Uninflated allowable property tax and property insurance expenses are

divided by total patient days (adjusted for the minimum occupancy requirement, if necessary) to calculate the respective per diem costs for each category. In addition, nursing facilities that have experienced an increase in property taxes of greater than 15% may submit a copy of their recent tax bill in order to have their rate adjusted. The per diem costs for property taxes, property insurance and the FRV are summed to calculate the total FRV rate.

Nursing facilities are also eligible for a return on non-property equity per diem. A nursing facility's average net working capital required to provide patient care activities (for the base cost report period) is multiplied by the rental factor utilized to determine the FRV rate. The product is divided by total patient days to determine the non-property equity per diem return rate. The facility's net working capital is limited to two months of the facility's allowable costs, including property-related costs (related to patient care).

The average Medicaid rates in Mississippi effective January 1, 2019 is \$210.44, which is a 1.3% increase from the average rate (\$207.64) effective October 1, 2019.

MINIMUM OCCUPANCY STANDARDS

Facility-specific Care Related, Administrative and Operating, and FRV per diem costs are all calculated utilizing the greater of the facility's actual total patient days or 80.0% of the facility's total allowable patient days.

OTHER RATE PROVISIONS

Newly constructed nursing facilities receive the component rate ceiling for the Direct Care and Care Related cost components and the class rate ceiling for the Administrative and Operating cost component. The Direct Care portion of the rate is determined assuming a CMI of 1.0, until a quarter of CMI data is accumulated. The facility's Property component rate is based on the FRV system. The new facility's interim rate is recalculated utilizing the state's rate setting methodology after the facility has accumulated three months of case mix and cost report data.

Nursing facilities that undergo a change of ownership must file a cost report from the date of change of ownership through the end of standard year, or any other approved year end. The cost report for the former owner will be utilized to determine the Medicaid base rate for the nursing facility until such time that the new owner's initial cost report is used under the regular rate setting schedule. Asset additions will be incorporated into the property rate using the regular schedule each January 1. The rate for the nursing facility will be rebased for the second calendar year following the end of the new owner's initial cost report. Under this methodology, the new owner will no longer be eligible to receive the maximum per diem rate for the interim period.

Mississippi Medicaid reimburses nursing facilities for reserving a bed for hospitalization or therapeutic leave. Nursing facilities are reimbursed up to 15 days per occurrence for a qualifying hospitalization leave at an adjusted rate for the facility. The rate that a nursing facility receives for holding a bed is the nursing facility's current rate, adjusted for the lower CMI for the resident on leave or 1.0.

Nursing facilities are reimbursed up to 52 days per state fiscal year (July 1 to June 30) for qualified therapeutic leave at the same rate a facility receives for reserving a bed for a resident requiring hospitalization.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, there are no significant changes planned or proposed for the Medicaid rate calculation.

MISSISSIPPI COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	60.00	60.00	60.00		91.00	88.00	89.00		120.00	120.00	120.00
Average Daily Census	55.46	55.83	55.62		77.50	75.94	74.69		104.94	101.69	104.51
Occupancy	82.9%	81.6%	83.2%		90.3%	90.4%	90.2%		93.3%	93.2%	93.7%
Payor Mix Statistics											
Medicare	10.5%	10.1%	9.8%		14.8%	13.6%	13.2%		19.3%	19.0%	17.6%
Medicaid	67.6%	68.4%	68.7%		75.9%	75.8%	76.7%		81.6%	81.7%	81.9%
Other	7.0%	7.2%	7.4%		11.9%	10.7%	11.4%		19.2%	16.1%	17.3%
Avg. Length of Stay Statistics (Days)											
Medicare	41.62	40.29	38.42		54.20	51.39	49.46		77.24	66.90	62.65
Medicaid	588.91	631.41	563.75		786.17	849.60	803.11		1067.72	1214.43	1152.97
Other	83.09	75.34	67.78		150.79	124.91	132.52		313.67	278.41	237.81
Revenue (PPD)											
Inpatient	\$201.12	\$208.61	\$209.64		\$217.00	\$221.49	\$225.16		\$234.73	\$239.56	\$240.75
Ancillary	\$40.42	\$40.36	\$42.45		\$55.85	\$61.51	\$58.27		\$104.50	\$104.44	\$91.50
TOTAL	\$245.18	\$252.56	\$254.72		\$273.66	\$285.48	\$286.94		\$332.67	\$347.55	\$335.17
Expenses (PPD)											
Employee Benefits	\$13.06	\$12.74	\$12.59		\$17.61	\$17.26	\$17.32		\$20.66	\$21.59	\$21.55
Administrative and General	\$41.17	\$42.18	\$42.32		\$45.86	\$47.13	\$47.56		\$51.38	\$52.04	\$52.62
Plant Operations	\$9.06	\$9.11	\$8.96		\$10.73	\$10.91	\$11.28		\$12.68	\$13.55	\$13.48
Laundry & Linens	\$2.33	\$2.37	\$2.41		\$2.98	\$3.00	\$3.02		\$3.58	\$3.77	\$3.58
Housekeeping	\$4.35	\$4.53	\$4.48		\$5.15	\$5.41	\$5.35		\$6.42	\$6.27	\$6.33
Dietary	\$14.89	\$15.48	\$15.49		\$16.31	\$16.49	\$16.87		\$18.42	\$18.71	\$19.00
Nursing & Medical Related	\$68.39	\$71.66	\$73.43		\$74.19	\$78.78	\$79.78		\$82.99	\$86.39	\$88.87
Ancillary and Pharmacy	\$21.68	\$21.90	\$22.14		\$29.91	\$28.68	\$29.06		\$38.45	\$38.42	\$37.18
Social Services	\$1.90	\$2.07	\$1.98		\$3.16	\$3.21	\$3.26		\$4.58	\$4.76	\$4.79

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Missouri



INTRODUCTION

Nursing facilities in Missouri are licensed by the Department of Health and Senior Services under the designation “Skilled Nursing Facility.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MISSOURI	
Licensed Nursing Facilities*	510
Licensed Nursing Beds*	51,548
Beds per 1,000 Aged 65 >**	50.41
Beds per 1,000 Aged 75 >**	120.97
Occupancy Percentage - 2017*	70.40%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

In Missouri, the Certificate of Need (CON) program was enacted in 1980 for the purpose of containing costs, improving quality and increasing access to healthcare services.

A CON is required for the following:

- Any new nursing facility costing over \$600,000, including the construction of a replacement facility.
- Additional long-term care beds in a nursing facility costing \$600,000 or more, up to the lesser of 10 beds or 10.0% of that facility’s existing capacity.
- Major medical equipment costing \$1,000,000 or more acquired for use in any location.

BED NEED METHODOLOGY

Missouri utilizes a bed need methodology when considering CON applications. Bed need is determined for the service area in which the proposed new facility/renovation/addition is planned when a CON application is submitted to the state. A service area is defined as a 15-mile radius from the location of the proposed project. Gross bed need is calculated by multiplying a use rate of 53 beds per 1,000 population by the age 65 and older population in the service area.

Population estimates utilized in the current bed need calculation are for 2020. The most current projection also determines bed need by county, which the state utilizes for the purpose of internal planning. Effective September 5, 2019, the state determined that there will be an approximate surplus of 1,393 beds by the year 2020, with an anticipated bed need in 46 of 114 counties and a surplus of beds in the state’s one independent city (St. Louis).

Net bed need is calculated by subtracting the current supply of nursing beds in the service area (including licensed, CON-approved beds in skilled nursing and intermediate care facilities) from gross demand. In addition, to qualify for a CON, the average occupancy for all licensed and available nursing beds located within the county and service area of the proposed site must exceed 90% during at least the four most recent consecutive calendar quarters.

There are currently no proposed changes to Missouri’s bed need methodology.

QUALITY ASSURANCE FEE

The quality assurance fee in Missouri is known as the nursing facility reimbursement allowance (NFRA). The NFRA was enacted January 1, 1995. Effective January 1, 2010, the state increased the NFRA to \$9.27 per occupied patient day, a 2.2% increase from the previous year (\$9.07). Nursing facilities are reimbursed the NFRA per Medicaid day as an add-on to Medicaid rates. Effective October 1, 2011, the state increased the NFRA to \$11.70 per occupied patient day. This increase corresponded with the sunset of the Tax Relief and Health Care Act of 2006 on the same date. This act reduced the maximum quality assurance fee that states could charge from 6.0% to 5.5% of total revenue. Given this factor, the ceiling increased to 6.0% on October 1, 2011.

The NFRA add-on was also increased to \$11.70. In addition, the state utilized the additional revenue generated from the NFRA increase to provide nursing facilities with a \$6.00 rate increase effective October 1, 2011.

Effective July 1, 2012, the NFMA was increased to \$12.11. The state used this change to provide nursing facilities with a \$6.00 rate increase effective July 1, 2012. In addition, since the NFRA is reimbursed as an add-on, it resulted in an additional \$0.41 rate increase effective the same date. Effective July 1, 2015, the NFRA was increased to \$13.40, which resulted in an equivalent increase (\$1.29 per Medicaid day) in the NFRA add-on. This NFRA and add-on have not changed since that effective date.

MEDICAID RATE CALCULATION SYSTEM

Missouri uses a prospective, cost-based, facility-specific Medicaid rate setting system. However, with the exception of calculating prospective rates for new nursing facilities, the state has not utilized the rate setting methodology since it last rebased Medicaid rates on July 1, 2004.

COST CENTERS

Missouri utilizes the following four cost components to calculate its facility-specific Medicaid rates:

- The Patient Care cost component includes nursing, activities, social services and dietary expenses.
- The Ancillary cost component includes therapies, pharmacy, billable medical supplies, laundry and housekeeping expenses.
- The Administration cost component includes plant operations, medical records and administrative expenses.
- The Capital cost component is primarily determined utilizing a fair rental value (FRV) system. The rate component also includes pass-through expenses for property insurance, real estate taxes and personal property taxes.

In addition to the rates for these cost components, nursing facilities receive a working capital allowance add-on that is calculated based on the above component rates.

INFLATION AND REBASING

There is no legislation in Missouri that mandates that the state rebase Medicaid rates at any set frequency. Nursing facility rates

Missouri

were last rebased for the rates effective July 1, 2004. These rates were based on 2001 cost report data that was trended forward to 2004 by increasing 2001 allowable costs by a Medicaid rate adjustment (11.2%). Missouri had planned to phase in the rebase over a three-year period, but discontinued the phase-in after the first year.

Nursing facility rates were adjusted effective April 1, 2005, by increasing the minimum occupancy requirement utilized to calculate the Capital cost component rates from 73.0% to 85.0% and applying an 85.0% minimum occupancy requirement to the calculation of Administration cost component rates. Allowable costs have not been inflated/deflated since April 1, 2005, and facility-specific Medicaid rates have been periodically increased by the state legislature by specific statewide per diem adjustments. These Medicaid rate increases are as follows:

Effective Rate Date	Trend Adjustment (per diem)
February 1, 2007	\$3.00
July 1, 2007	\$6.00
July 1, 2008	\$6.00
July 1, 2009	\$5.50
July 1, 2011	\$6.00
July 1, 2012	\$6.00

In addition, nursing facilities also received additional rate increases of \$0.65 on July 1, 2009, \$0.20 on January 1, 2010, \$2.43 on July 1, 2011, and \$0.41 on July 1, 2012, which reflect increases in the NFRA on the same effective dates. Based on this factor, the historical effective rate increases are as follows:

Effective Rate Date	Effective Rate Increase (per diem)
February 1, 2007	\$3.00
July 1, 2007	\$6.00
July 1, 2008	\$6.00
July 1, 2009	\$6.15
January 1, 2010	\$0.20
July 1, 2011	\$8.43
July 1, 2012	\$6.41

Effective July 1, 2013, the state provided a trend adjustment that equated to a 3.0% overall rate increase, excluding certain fixed items. Effective July 1, 2014, the state provided a \$1.25 overall rate increase. Effective July 1, 2015, nursing facilities received a \$1.29 rate increase, which is equivalent to the state's increase of the NFRA. Effective January 1, 2016, the state increased nursing facility rates by \$2.09 per Medicaid day for a trend adjustment. Effective July 1, 2016, the state increased rates by a \$2.83 trend adjustment.

In fiscal year 2018 (effective July 1, 2017) the state approved a \$4.83 rate reduction. However, this reduction was not implemented until August 1, 2017. To reflect that the state was not able to implement the rate cut for the first month (July 1 to July 31, 2017) of the rate year, the reduction was increased to \$5.37 for the period of August 1, 2017 through June 30, 2018.

However, in fiscal year 2018, Missouri state legislature passed

House Bill 1102, which provides nursing facilities with an additional \$25 million in funding for fiscal year 2019. This bill was projected to result in an \$8.30 rate increase for all facilities effective July 1, 2018. However, the implementation of the bill was delayed because of the unexpected transition of state's governorship and some questions/confusion about the language of the bill.

As previously mentioned, the state issued a \$4.83 rate reduction on 7/1/17. However, the state was slow to implement the cut. Because of this delay, the reduction was implemented at a higher amount (\$5.37) on 8/1/17 to account for the month (July) that passed by before the state could implement the cut. Effective July 1, 2018, nursing facilities were reimbursed the rates that they should have initially been paid on July 1, 2017, if the \$4.83 had been implemented on time. This results in a \$0.54 rate increase. In addition, the state recently submitted a State Plan Amendment to the Centers for Medicare and Medicaid (CMS) that would implement a \$7.76 rate increase that will be retroactive to July 1, 2018. This increase, combined with the \$0.54 increase, results in an increase of \$8.30 ($\$0.54 + \$7.76 = \8.30).

The state eventually started paying out a portion of the rate increase on January 1, 2019 (it was supposed to be effective July 1, 2018). Only a portion of the rate increase was provided because of technical difficulties. The state also made supplemental payments for the funds that should have been paid from July 1 to December 31 assuming the partial increase had occurred in July.

On May 1, 2019, the state overcame the difficulties and paid out rates with the full \$8.36 increase. The state also made supplemental payments to back-fill the portion of the increase that was not paid from July 1, 2018 to April 30, 2019.

The state recently submitted a state plan amendment to the Centers for Medicare and Medicaid (CMS) for a 1.0% rate increase effective August 1, 2019. It is currently unclear when CMS will have a decision on this State Plan Amendment. However, representatives for the state are confident that the rate increase will be implemented.

RATE METHODOLOGY

The rate setting methodology described below is based on the state's current regulations and is the methodology Missouri utilized to rebase rates on July 1, 2004. The only significant change is the increase in the minimum occupancy requirement effective April 1, 2005. It is assumed the state will utilize the basic parameters of this methodology when it next rebases rates.

The per diem rates for the Patient Care, Ancillary and Administration cost components are the lesser of a nursing facility's component-specific per diem costs or the component rate ceiling. Per diem costs for each component are determined by dividing allowable inflated costs by total patient days. Total patient days utilized to calculate the Administration cost component per diem costs are the greater of a nursing facility's actual patient days or 85% of a nursing facility's total allowable patient days.

The per diem costs for all applicable nursing facilities are arrayed by

cost component, and median costs are determined. The rate ceilings for the Patient Care and Ancillary cost components are 120% of the applicable median. The rate ceiling for the Administration cost component is 110% of the applicable median.

Special per diem rate adjustments can be added to a facility's rate without regard to the cost component ceiling. A Patient Care incentive enables facilities to receive a per diem adjustment equal to 10% of the facility's allowable Patient Care cost component per diem, subject to a maximum of 130% of the component median when added to the Patient Care cost component per diem. Since there are no additional requirements to be eligible, all nursing facilities with adjusted Patient Care cost component rates below 130% of the median receive this add-on.

An Ancillary incentive per diem adjustment enables nursing facilities to receive a per diem adjustment to the Ancillary cost component rate under the following scenarios:

- If a nursing facility's Ancillary cost component per diem is below 90% of the Ancillary cost component median, then the adjustment is equal to half the difference between 120% and 90% of the Ancillary cost component median.
- If a nursing facility's Ancillary cost component per diem is between 90% and 120% of the Ancillary cost component median, then the adjustment is equal to half the difference between 120% of the Ancillary cost component median and the nursing facility's Ancillary cost component per diem cost.

Nursing facilities are eligible for a multiple component incentive per diem adjustment if the sum of the facility's Patient Care and Ancillary cost component per diems is greater than or equal to 60.0%, but less than or equal to 80.0% of the nursing facility's total per diem. The adjustments are as follows:

Percent of Total Per Diem Rate	Incentives
< 60%	\$0.00
> or = 60% but < 65%	\$1.15
> or = 65% but < 70%	\$1.30
> or = 70% but < 75%	\$1.45
> or = 75% but < or 80%	\$1.60

A nursing facility is eligible for an additional incentive if it receives the adjustment described previously, and the facility's total Medicaid days divided by the licensed nursing facility patient days (derived from the facility's audited cost report) is more than 75%. The adjustment is as follows:

Calculated Percentage	Incentives
< 75%	\$0.00
> or = 75% but < 80%	\$0.15
> or = 80% but < 85%	\$0.30
> or = 85% but < 90%	\$0.45
> or = 90% but < 95%	\$0.60
> or = 95%	\$0.75

The first-tier high volume adjustments were initially granted to nursing facilities that met the following criteria (state owned or operated facilities are not eligible for this adjustment):

- Had a full 12-month cost report that ended on the third

calendar year prior to the state fiscal year in which the adjustment was being determined, or had two partial year cost reports that, when combined, covered a full 12-month period.

- The nursing facility's total Medicaid patient days (determined from the cost report) exceeded 85% of the total patient days for all of the nursing facility licensed beds.
- The allowable per-patient-day costs for Patient Care, Ancillary and Administration cost components exceeded the per diem ceiling for each cost component in effect at the end of the cost report period.

The adjustment equated to 10% of the sum of per diem ceilings for the Patient Care, Ancillary and Administration cost components in effect on July 1 of each year. In addition, if a nursing facility was eligible for the high volume adjustment for two straight years, the high volume adjustment was doubled. Missouri has not calculated a high volume adjustment in several years. The most recent high volume adjustment was \$7.18 per day, or \$14.96 per day, if the facility was eligible for a second straight year. In fiscal year 2003, the state passed legislation eliminating the cumulative high volume adjustment. However, facilities that had previously received the cumulative high volume add-on still received the cumulative rate. Nursing facilities' high volume adjustments have been frozen at fiscal year 2006 levels for five years. The state has not indicated whether it will determine new high volume adjustments.

A second-tier high volume adjustment was available for facilities that qualified for the first-tier high volume adjustment if the following criteria were met:

- A nursing facility's total Medicaid patient days exceeded 93.0% of the total patient days for all of the nursing facility's licensed beds.
- The allowable per diem cost per cost component exceeded 120% of the per diem ceiling for the Patient Care cost component in effect at the end of the cost report period.
- The allowable per diem cost for the Administration cost component was less than 150% of the per diem ceiling for the Administration cost component in effect at the end of the cost report period.

The second-tier high volume adjustment is calculated by multiplying a specific percentage determined by the Missouri Department of Social Services by the sum of the per diem ceilings for the Patient Care, Ancillary and Administration cost components in effect on July 1 of each year. The adjustments are distributed quarterly and are separate from the Medicaid rate. In recent years, only one nursing facility in the state was eligible for a second-tier high volume adjustment. This facility's payment has been frozen since July 1, 2005. While both the high volume and second-tier high volume adjustments are still included in the state reimbursement methodology, it is unclear if the state will ever recalculate the adjustments.

The Capital cost component per diem rate is determined using the FRV system, which consists of five subcomponents: the Rental Value, the Return, Computed Interest, Financing Fees and Pass-Through expenses. The first step in determining the facility's FRV rate is to determine the facility's total asset value. This is accomplished by multiplying the nursing facility's equivalent

number of beds by the statewide standard asset value (currently \$52,042). The asset value utilized is originally based on the 2004 publication of the RS Means Building Construction Cost Data. The nursing facility's equivalent number of beds is based on the facility's current number of licensed beds, adjusted upward for any substantial renovations completed during the base cost report year. The total asset value is then decreased for depreciation. Total depreciation is calculated by multiplying the age of the facility by 1%, up to a maximum depreciation of 40%. The age of the facility is calculated based on a weighted average of the years of construction of the facility's licensed beds.

After the total asset value has been reduced for depreciation, the Rental Value for the nursing facility is calculated by multiplying the facility's total asset value by 2.5%, based on a 40-year life. This amount is divided by total patient days (adjusted for the occupancy requirement, if necessary) to determine a nursing facility's Rental Value per diem cost.

The total asset value is also utilized to calculate the Return. This is accomplished by multiplying the total asset value reduced by the facility's capital asset debt (debt related to capital assets determined from audited cost reports) by a rate of Return. The rate of Return equates to the yield for the 30-year U.S. Treasury Bond, plus two percentage points. The amount of Capital Asset Debt utilized in this analysis is the facility's current amount of debt detailed in the base year cost report. The product of the above-described calculation is divided by total patient days (adjusted for the occupancy requirement, if necessary) to determine a nursing facility's Return per diem cost.

Capital Asset Debt estimates for nursing facilities are utilized to calculate nursing facilities' Compound Interest per diem costs. A nursing facility's Compound Interest Expense is determined by multiplying its current capital asset debt amount by a standard statewide interest rate. The standard statewide interest rate utilized in determining the Compound Interest Expense is the prime rate plus 2%. If a nursing facility's capital asset debt is greater than the facility's total asset value, then the total asset value amount is used to determine Compound Interest Expense. The product of the above-described calculation is divided by total patient days (adjusted for the occupancy requirement, if necessary) to determine a nursing facility's Compound Interest per diem cost.

Allowable financing fees are capitalized and amortized over the life of the loan on a straight-line basis. If loans for capital asset debt exceed the facility asset value, the financing fees associated with the portion of the loan or loans that exceed the facility asset value will not be allowable. Total allowable financing fees are divided by patient days (adjusted for the occupancy requirement, if necessary) to determine a nursing facility's Allowable Financing Fees per diem cost.

Pass-through expenses include costs associated with property insurance, real estate taxes and personal property taxes. These allowable inflated pass-through expenses are divided by patient days (adjusted for the occupancy requirement, if necessary) to determine a nursing facility's Pass-Through per diem cost.

The Capital cost component per diem rate is the sum of the per diem costs for the Rental Value, Return, Computed Interest, Allowable Financing Fees and Pass-Through cost subcomponents.

The Working Capital Allowance is equal to one and one-tenth months of the sum of each facility's per diem rate for Patient Care, Ancillary and Administration multiplied by a statewide standard interest rate. The standard statewide interest rate utilized in determining the Working Capital Allowance is the prime rate plus 2%. Nursing facilities are also reimbursed the current NFRA (\$12.11 per diem) as an add-on to Medicaid rates.

The last rate rebasing (effective July 1, 2004) was initially planned to be phased in over a three-year period. During the initial rebasing year, if a facility's calculated rate effective July 1, 2004, was greater than the prior year's rate, the difference between the two rates was to be phased in by granting one-third of the total increase each year. However, since Missouri canceled the rebasing phase-in after the first year, only the first third was included in the add-on rate trended forward periodically by the state.

In addition, there were several other rate add-ons or incentive payments utilized by the state prior to the last rebasing. These included, but were not limited to, a quality improvement adjustment, a nursing facility operations adjustment and a life safety code incentive. State professionals were unsure if these add-ons/incentive payments would be utilized during the next rebasing. However, if any of these add-ons/incentive payments were included in the calculation of a nursing facility's July 1, 2004, Medicaid rate, then these payments were included in the rate that has been trended forward periodically by the state.

In a rebasing year, a nursing facility's reimbursement rate is the sum of the allowable per diem costs for all of the cost components, any relevant add-ons/incentive payments, the Working Capital Allowance and the NFRA add-on. Effective July 1, 2018 (assuming the rate increases were retroactively provided to nursing homes), the weighted average nursing facility rate was \$160.97. This represents a 5.4% rate increase from the statewide weighted average rate as of August 1, 2017 (\$152.18). The August 1, 2017 statewide weighted average rate reflects the increase in the rate reduction (\$0.54) to account for the delay in the implementation of the reduction from July 1, 2017, to August 1, 2017. Excluding the \$0.54 additional reduction, the weighted average effective July 1, 2017, equates to \$152.72. This represents a 3.2% reduction from the previous weighed average (\$157.55) effective July 1, 2016. The previous weighted average rates are as follows: July 1, 2015 - \$152.64; July 1, 2014 - \$151.33; July 1, 2013 - \$150.08; July 1, 2012 - \$146.40; and October 1, 2011 - \$139.99.

MINIMUM OCCUPANCY STANDARDS

Per diem costs for the Administration and Capital cost components are calculated utilizing the greater of the facility's actual total patient days or 85% of the facility's total allowable patient days.

OTHER RATE PROVISIONS

Reimbursement for hospital leave days is authorized for days in which a Medicaid recipient is absent due to admission to a hospital for services and is reimbursed at the facility's per diem rate. However, the occupancy rate must be at or above 97% for Medicaid-certified beds for the quarter prior to the first day of services provided. The payment for hospital leave days is provided for qualified hospital stays of three days or less.

Nursing facilities are reimbursed up to 12 days per six months for qualified therapeutic leave at the same rate a facility receives for reserving a bed for a resident requiring hospitalization. However, nursing facilities are not required to meet a Medicaid occupancy requirement to be eligible for reimbursement for holding a bed for a resident requiring therapeutic leave. Also, accumulated hospital leave days are deducted from the number of therapeutic days allowed per six months, at a rate of two therapeutic leave days per hospital leave day.

In the case of a change of ownership of an ongoing facility already participating in the Medicaid program, the rates in effect at the

time of the change of ownership will continue to be utilized until the next statewide rate rebasing.

A newly constructed nursing facility will receive an interim rate upon entering the Medicaid program and will have its prospective rate calculated based on its second full 12-month cost report following the initial date of certification. The interim rate will equate to the sum of 100% of the Patient Care cost component rate ceiling, 90% of the Ancillary and Administrative cost component rate ceilings, 95% of the median Capital cost component per diem cost for all applicable nursing facilities, and the Working Capital Allowance calculated utilizing the previously mentioned component rates.

The prospective rate will be calculated based on the current rate setting methodology in place during the facility's prospective rate setting period.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is no current or proposed state legislation affecting the current Medicaid reimbursement methodology in Missouri.

MISSOURI COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	61.00	63.00	64.00		97.00	96.00	96.00		120.00	120.00	120.00
Average Daily Census	57.28	56.29	56.41		75.55	75.76	75.25		99.94	99.35	98.41
Occupancy	65.3%	65.3%	64.3%		75.9%	76.5%	75.2%		85.1%	84.7%	83.7%
Payor Mix Statistics											
Medicare	5.5%	4.8%	4.7%		8.2%	6.8%	7.1%		11.7%	10.3%	9.9%
Medicaid	47.8%	48.7%	49.5%		60.8%	63.1%	63.3%		71.1%	72.4%	72.2%
Other	20.2%	20.1%	20.5%		31.5%	30.8%	29.9%		50.2%	46.5%	47.2%
Avg. Length of Stay Statistics (Days)											
Medicare	27.38	27.11	28.49		38.02	36.75	38.41		53.05	52.04	54.14
Medicaid	203.82	212.85	220.44		290.64	307.70	305.43		416.16	465.33	522.88
Other	82.99	84.00	83.35		130.33	131.60	119.87		228.66	213.90	204.74
Revenue (PPD)											
Inpatient	\$154.04	\$157.08	\$158.96		\$168.43	\$172.38	\$173.47		\$193.94	\$196.59	\$200.43
Ancillary	\$27.64	\$25.61	\$26.52		\$41.91	\$41.33	\$38.78		\$60.73	\$61.71	\$60.05
TOTAL	\$185.92	\$187.08	\$187.60		\$215.99	\$216.98	\$214.33		\$260.28	\$258.83	\$254.98
Expenses (PPD)											
Employee Benefits	\$9.40	\$9.59	\$9.52		\$12.12	\$12.03	\$11.74		\$18.10	\$19.17	\$18.46
Administrative and General	\$33.60	\$35.24	\$35.75		\$38.35	\$39.52	\$39.74		\$44.55	\$46.32	\$45.76
Plant Operations	\$8.45	\$8.78	\$8.90		\$9.86	\$10.22	\$10.42		\$11.83	\$12.26	\$12.56
Laundry & Linens	\$1.96	\$1.86	\$1.80		\$2.51	\$2.54	\$2.47		\$3.07	\$3.15	\$3.11
Housekeeping	\$4.16	\$4.32	\$4.33		\$5.02	\$5.21	\$5.31		\$6.11	\$6.35	\$6.56
Dietary	\$13.78	\$13.98	\$14.11		\$15.28	\$15.53	\$15.62		\$17.65	\$18.13	\$18.54
Nursing & Medical Related	\$51.71	\$53.15	\$53.89		\$58.56	\$60.69	\$62.75		\$68.26	\$72.11	\$73.85
Ancillary and Pharmacy	\$13.73	\$13.17	\$13.52		\$19.00	\$18.46	\$17.97		\$27.44	\$26.21	\$26.70
Social Services	\$1.44	\$1.52	\$1.47		\$2.09	\$2.30	\$2.24		\$3.50	\$3.71	\$3.70

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Montana



INTRODUCTION

Nursing facilities in Montana are licensed by the Montana Department of Public Health and Human Services (DPHHS), Quality Assurance Division, Licensure Bureau under the designation of "Long-Term Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN MONTANA	
Licensed Nursing Facilities*	52
Licensed Nursing Beds*	4,443
Beds per 1,000 Aged 65 >**	22.90
Beds per 1,000 Aged 75 >**	58.03
Occupancy Percentage - 2017*	63.40%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

Montana has operated a Certificate of Need (CON) program since 1975. The Licensure Bureau of the Quality Assurance Division of DPHHS administers the CON program. A CON is required for a long-term care facility in the following scenarios:

- Any capital expenditure that exceeds \$1.5 million, other than to acquire an existing healthcare facility;
- A change in bed capacity of a healthcare facility through an increase in the number of beds or a relocation of beds from one healthcare facility or site to another, unless the number of beds involved is 10 or fewer, or 10% or less of the licensed beds, if fractional, rounded down to the nearest whole number, whichever figure is smaller, and no beds have been added or relocated during the two years prior to the date on which the letter of intent for the proposal is received;
- The addition of a health service by a facility that would result in additional operating and amortization expenses of \$150,000 or more;
- The incurring of an obligation for a capital expenditure by any person or persons to acquire 50% or more of an existing healthcare facility;
- The use of hospital beds (five or more) for skilled nursing care.

Any applicant seeking to provide nursing home services must address review criteria in its CON application, including an evaluation of the proposal based on guidelines considered by the CON approval committee. These guidelines include analysis of the state's bed need methodology, existing occupancy levels, proposed services offered, long-term care alternatives, facility size and proposed location.

BED NEED METHODOLOGY

The bed need methodology is used only as a guideline and is not the basis for automatic approval or disapproval of a proposed CON project. Need methodology for nursing homes is used to calculate the bed need for each community that contains at least one nursing home. These calculations are revised annually. Bed need is determined utilizing the following steps:

- Data on the number of patient bed days for each community for the last three years is collected from the individual

nursing home reports in the Annual Survey of Long-Term Care Facilities.

- The community's three-year total patient days (including community swing bed days) are divided by three to determine the average yearly patient days.
- Average yearly patient days are then divided by 365 days to determine the average daily census (ADC).
- ADC is divided by an occupancy factor of 85% (0.85) to determine the projected total bed need for that community for the most recent year.
- Any of the additional rules (see below) are applied, when appropriate, to adapt the total bed need to particular community situations.
- Finally, unmet bed need is determined by subtracting the number of licensed beds in the community from the total bed need.

The following rules are used in addition to the standard methodology:

- A three-year average is used, unless the total patient days for the community for one year fall 10% or more below the three-year average. In this case, that year is removed and a two-year average is used.
- If the beds in the community have had a three-year average occupancy of 95% or more, 5% is added to the total bed need.
- In a community with only one nursing home that has operated for less than one year, bed need is shown as the number of beds at that facility. In a community with multiple nursing homes, the bed days for the first year of operation will be used as the average for the facility that has operated for less than one year.

The most current bed need calculation in the state (effective June 2018) resulted in the determination of moderate demand for additional nursing facility beds in 10 of 50 communities with an existing nursing facility. However, only two of these communities (Columbia Falls and Hardin) has bed need for more than 10 beds. The Columbia Falls area has the greatest amount of bed need (17 beds).

QUALITY ASSURANCE FEE

Montana imposes a per-bed-day provider fee that is referred to as a nursing facility bed tax (NFBT). The NFBT was enacted in 1991. From state fiscal year 2007 until June 30, 2017, the NFBT remained unchanged at \$8.30 per bed day. However, in fiscal year 2017, the state passed House Bill 618, which increased the NFBT to \$11.30 per bed day effective July 1, 2017, and further increased the fee to \$15.30 per bed day effective July 1, 2018. The purpose of these increases was to generate additional revenue to increase nursing home rates and create a wage increase for direct care workers. As part of this agreement, nursing facilities in fiscal years 2018 and 2019 are required to increase certified nursing assistant wages \$0.25 per hour every six months and \$0.50 every year.

The increased revenue generated from the increase in the NFBT was able to offset budget reductions in nursing home reimbursement in fiscal years 2018 and 2019. These reductions will be detailed in the Inflation and Rebasement section of this overview. However, the Montana Health Care Association has indicated that by utilizing the NFBT revenue to offset the reductions (effectively applying

the reduction to additional reimbursement generated from the NFBT) the state is violating House Bill 261. The association is currently pursuing litigation vs. the state to not allow the state to apply any reductions to the revenue generated via the increases in the NFBT. However, the litigation only applies to the period of January 1, 2018, to June 30, 2018. Effective July 1, 2018, all revenue derived from the NFBT is directed to nursing home rates. The outcome of this litigation and the time frame in which it will be resolved is currently unclear.

MEDICAID RATE CALCULATION SYSTEM

Skilled nursing facilities in Montana are reimbursed under a facility-specific, price-based system. Reimbursement rates are determined based on legislative funding. As of 2004, each facility is reimbursed according to this system.

COST CENTERS

Each nursing facility's rate is comprised of the Operating cost component including Capital and Direct Resident Care.

INFLATION AND REBASING

The statewide price for nursing facility services is determined each year through a public process, and is based on the appropriated nursing facility budget from the most recent biennium with no inflation factors applied. Factors that could be considered in the establishment of legislative funding include utilization patterns over the prior year and historical trends, as well as other factors approved through the legislative process, including wage additions and provider fee increases.

Rates currently in effect as of July 1, 2012, are based on the bi-annual budget for SFYs 2012 and 2013. The funding for nursing home reimbursement was increased 2% in SFY 2010 and was scheduled to increase 2% in SFY 2011. However, no increase in funding was applied to nursing home rates in SFY 2011. The state provided additional funding for a wage initiative in SFYs 2010 and 2011 that will be addressed in the upcoming Rate Methodology section. The wage initiative was originally allocated in House Bill 645 as a one-time appropriation. However, it has been extended each year since SFY 2010.

Based on budget appropriations, nursing facility Medicaid rates were reduced 2% in SFY 2012 (effective July 1, 2011) and were frozen at SFY 2012 levels in SFY 2013. The 2% reduction essentially removed the previous increase in fiscal year 2010. In SFYs 2012 and 2013, this rate reduction was offset by the continuation of the wage initiative and the increase in payment through the state's Intergovernmental Transfer Program (IGT). The IGT will be addressed further in the Rate Methodology section. Funding for the wage initiative was reduced 32.6% in SFY 2012 but was maintained at a similar level to SFY 2012 in SFY 2013.

The state increased nursing facility Medicaid rates approximately 2.0% per year in the two prior bi-annual budgets (state fiscal years 2014 and 2015 and state fiscal years 2016 and 2017). The state was initially proposing to leave rates flat in the fiscal years 2018 and 2019 bi-annual period, but based on additional revenue generated via the increase in the NFBT, nursing facility rates increased on average by six percent from approximately \$170.27 per diem

(effective July 1, 2016) to \$186.60 per diem (effective July 1, 2017).

However, rates were eventually adjusted after the state passed Senate Bill 261. Senate Bill 261 revised the state's budget laws and impacts all healthcare providers that utilize Medicaid. Essentially, if the state revenue levels are below expected/budgeted expenses, all Medicaid providers (including nursing homes) receive an across the board rate reduction. This reduction is determined based on a mathematical formula determined by the bill. For fiscal year 2018 (effective July 1, 2017), the state determined that all Medicaid providers would receive an annual cut of approximately 1.495%. However, since the state was not able to implement this reduction until January 1, 2018, the state applied a 2.99% rate reduction to all nursing home providers to account for the prior six months (July 1, 2017 to December 31, 2017) in which the reduction was not applied. This reduced the average rate in the state to \$181.01 per diem effective January 1, 2018. However, this rate was still 2.8% greater than the rate (\$170.27) effective July 1, 2016. This reflects that the increased revenue generated from the increase in the NFBT more than offset the cut.

The state initially applied the 2.99% reduction to rates effective July 1, 2018 to September 30, 2018, but then eliminated the reduction and reimbursed nursing facilities for the previous lost revenue through a lump sum payment. The average rate (\$202.06) effective July 1, 2018, is 8.2% greater than the average rate (\$186.60) effective July 1, 2017. This increase was generated from additional funding resulting from the increase in the NFBT

RATE METHODOLOGY

The statewide price for nursing facility services is calculated by dividing the estimated program expenditures (legislative funding dollars for nursing facilities) by the total statewide Medicaid days. For state fiscal year 2017, approximately \$139,600,000 of revenue was utilized to fund nursing facility reimbursement. The amount increased to \$144,100,000 in fiscal year 2018 and is anticipated to moderately increase in fiscal year 2019.

Each nursing facility receives the same Operating component rate, which is 80% of the statewide price for nursing services. Effective July 1, 2018, that amount is \$158.53, which represents an 11.8% increase from the prior price (\$141.82 – effective January 1, 2018). The Direct Resident Care component of each facility's rate is 20% of the overall statewide price for nursing services. Effective July 1, 2018, the portion of the statewide price attributed to the Direct Resident Care component was \$39.63, which represents an 11.8% increase from the prior price (\$35.45 – effective January 1, 2018).

It is adjusted for the acuity of the Medicaid residents served in each facility. The acuity adjustment increases or decreases the Direct Resident Care component in proportion to the relationship between each facility's Medicaid average case mix index (CMI) and the statewide average Medicaid CMI. In order to calculate the adjusted rate, a facility's CMI is divided by the statewide CMI. The resulting acuity ratio is then multiplied by 20% of the statewide price.

The Medicaid average CMI for each facility used in rate setting is the simple average of each facility's four Medicaid CMIs calculated for the periods of February 1 of the current year and November

1, August 1 and May 1 of the year immediately preceding the current year. The statewide average Medicaid CMI will be the weighted average of each facility's four-quarter average Medicaid CMI used in rate setting.

The department assigns each resident a RUG III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter, as amended during the correction period.

For purposes of calculating rates, case mix weights are developed for each of the 34 RUG III groupings. The department computes a Montana-specific Medicaid case mix utilizing average nursing times from the 1995 and 1997 Centers for Medicare & Medicaid Services (CMS) case mix time study. The average minutes per day per resident are adjusted by Montana-specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

In previous years, Montana incentivized nursing facilities to increase direct care staff wages through a direct care wage add-on. The add-on amount was a flat per diem dollar amount established at the beginning of each biennium. The add-on was established in SFY 2009 and was a pro rata share of appropriated funds allocated for increases in direct care wages and benefits. To receive the add-on, a nursing facility had to submit a request stating how the additional funds will be spent at the facility. Essentially, the add-on provided nursing facilities with funding to increase direct care workers' hourly wages to established state standards. This program has been discontinued; however, nursing facilities that participated in this program will continue to receive the add-on in the future. This reflects that the expenses that were required to increase a nursing facility's wages to the state standards are now part of a nursing facility's base costs. This add-on can vary from facility to facility, but at a minimum nursing facilities' that participated with the program can receive \$4.20 per Medicaid day.

In addition to the per diem rate calculated above, facilities are eligible for a supplemental payment related to the state's wage initiative. The allocations are facility-specific. In the 2015 legislative session, the Montana Legislature approved funding (House Bill 2) for a wage initiative for direct care and ancillary workers in nursing facilities for the current biannual budget. The program provides up to a \$0.25 hourly increase in combined wages and benefits. According to Myers and Stauffer, the average per diem reimbursement is \$11.70 for SFY 2019. However, nursing

facilities are required to provide a plan on how facilities will distribute these funds to direct care and ancillary workers as well as documentation that wages will be continue to be sustained.

Montana utilizes an Intergovernmental Transfer Program (IGT) to generate federal matching dollars on the Medicaid shortfall relative to county facilities. Historically, some of these funds have been used to provide per diem increases to non-county facilities. Professionals from the state and the Montana Healthcare Association indicated that in recent years the average incentive has ranged from \$6.00 to \$8.00. It is anticipated that the incentive average will equate to approximately \$6.00 in SFY 19

MINIMUM OCCUPANCY STANDARDS

There are no minimum occupancy standards applied under Montana's Medicaid reimbursement system.

OTHER RATE PROVISIONS

For new providers acquiring or otherwise assuming the operations of an existing nursing facility, the rate will be the same rate in effect for the prior owner/operator. These rates will be adjusted at the start of the next fiscal year. Newly constructed nursing facilities, or existing nursing facilities participating in the Medicaid program for the first time, will receive the statewide average nursing facility rate. The Direct Resident Care component of the rate will not be adjusted for acuity until there are three or more quarters of Medicaid CMI information available at the start of a state fiscal year.

Nursing facilities are reimbursed their full Medicaid rate for bed hold days. Therapeutic home visit days are limited to 24 days per state fiscal year. Hospital leave days are not limited as long as the resident is potentially able to return to the bed. However, nursing facilities must be fully occupied with a waiting list to be eligible for reimbursement for hospital bed hold days.

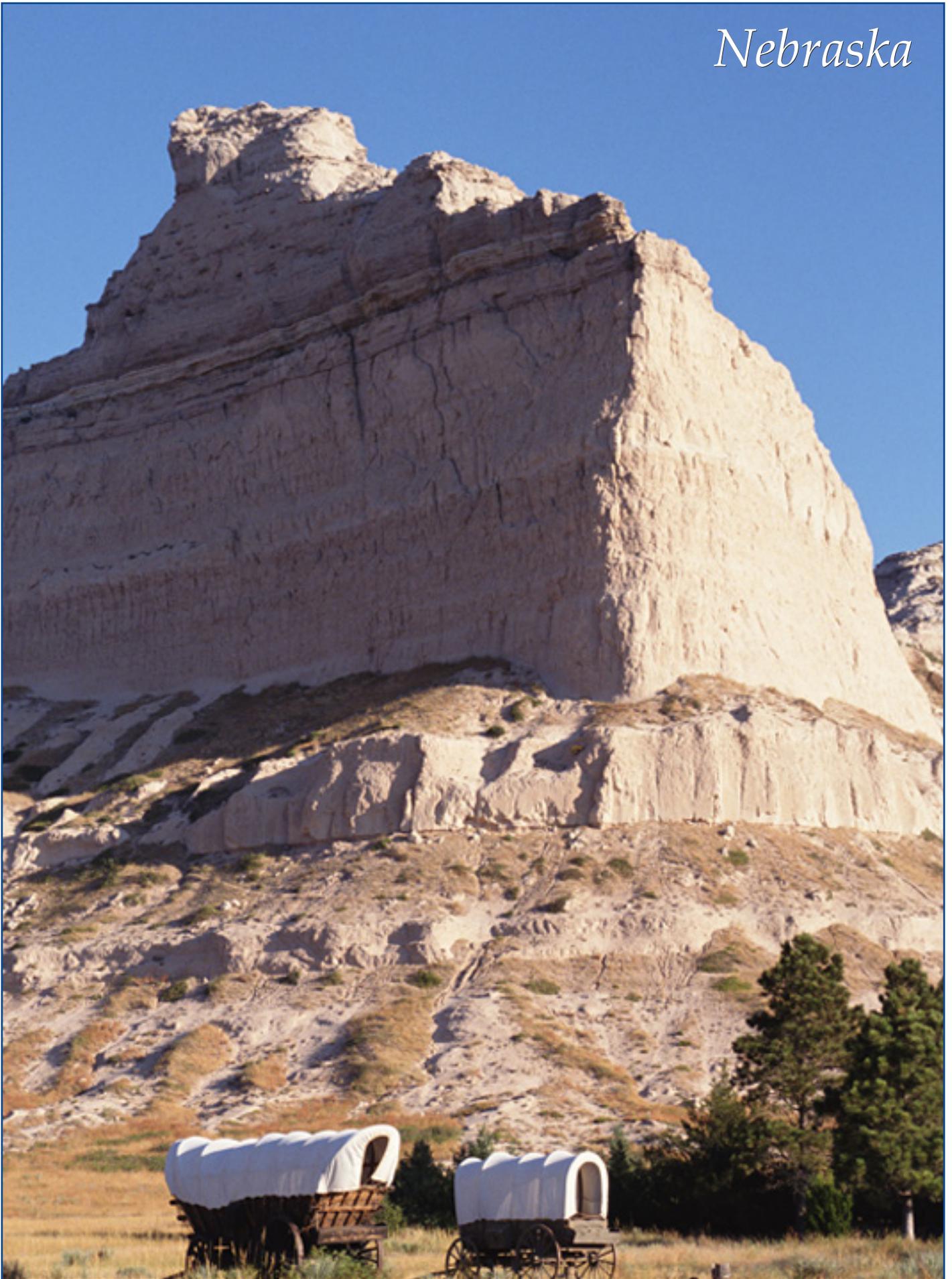
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

In addition, in prior years, the state was considering converting from the RUG III to the RUG IV classification system for the purpose of adjusting Medicaid rates for case mix. According to rate setting officials, this is still under consideration, but there is currently no legislation proposed to enact this change.

MONTANA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	52.75	53.00	59.00		84.50	86.00	85.00		100.25	103.00	104.00
Average Daily Census	43.58	42.92	43.77		59.16	56.01	59.78		74.65	72.35	70.95
Occupancy	62.1%	61.7%	62.9%		71.9%	71.6%	71.0%		82.4%	77.7%	75.9%
Payor Mix Statistics											
Medicare	5.6%	6.1%	6.2%		11.3%	10.9%	11.9%		16.4%	16.2%	17.2%
Medicaid	56.2%	54.4%	56.3%		64.9%	67.0%	66.7%		71.8%	75.2%	72.6%
Other	15.9%	13.8%	13.6%		20.1%	19.2%	21.3%		30.8%	32.1%	28.8%
Avg. Length of Stay Statistics (Days)											
Medicare	27.46	34.17	30.81		40.61	42.26	38.68		51.82	51.04	53.98
Medicaid	345.40	354.46	308.80		458.12	445.38	411.81		761.78	748.77	697.30
Other	66.08	71.92	56.34		131.52	107.11	92.75		271.46	233.62	213.21
Revenue (PPD)											
Inpatient	\$188.21	\$193.88	\$200.61		\$200.99	\$217.29	\$241.86		\$236.46	\$255.53	\$279.96
Ancillary	\$24.25	\$28.50	\$32.58		\$49.04	\$51.45	\$60.47		\$88.43	\$90.87	\$89.43
TOTAL	\$204.04	\$211.44	\$245.51		\$262.06	\$268.32	\$289.88		\$305.59	\$316.22	\$352.35
Expenses (PPD)											
Employee Benefits	\$17.74	\$16.84	\$18.04		\$20.10	\$19.95	\$19.83		\$22.17	\$23.26	\$22.35
Administrative and General	\$33.71	\$37.67	\$39.92		\$40.13	\$46.86	\$49.07		\$49.58	\$53.43	\$54.53
Plant Operations	\$8.91	\$8.78	\$9.36		\$11.46	\$11.58	\$10.73		\$13.39	\$13.65	\$13.02
Laundry & Linens	\$2.27	\$1.55	\$2.13		\$2.91	\$2.99	\$2.73		\$3.58	\$3.91	\$3.62
Housekeeping	\$4.31	\$4.46	\$4.27		\$5.22	\$5.29	\$5.18		\$6.19	\$7.37	\$6.30
Dietary	\$16.42	\$17.06	\$17.34		\$18.13	\$20.19	\$19.56		\$21.13	\$21.61	\$21.87
Nursing & Medical Related	\$65.82	\$74.39	\$79.77		\$78.68	\$86.35	\$87.22		\$85.88	\$101.86	\$97.80
Ancillary and Pharmacy	\$10.52	\$13.42	\$13.97		\$22.94	\$24.78	\$26.37		\$41.83	\$42.21	\$39.49
Social Services	\$4.11	\$3.86	\$4.17		\$4.74	\$5.42	\$5.26		\$6.68	\$6.74	\$6.54

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Nebraska



INTRODUCTION

Nursing facilities in Nebraska are licensed by the Department of Health and Human Services (DHHS), Regulation and Licensure Unit, Credentialing Division under the designation of “Nursing Facilities” and “Skilled Nursing Facilities.”

A nursing facility is defined by the state as a facility where medical care, nursing care, rehabilitation or related services, and associated treatment are provided for a period of more than 24 consecutive hours. The definition of a skilled nursing facility is the same, except that skilled nursing facilities provide skilled nursing care. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEBRASKA	
Licensed Nursing Facilities*	175
Licensed Nursing Beds*	12,867
Beds per 1,000 Aged 65 >**	42.86
Beds per 1,000 Aged 75 >**	99.29
Occupancy Percentage - 2017*	74.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Nebraska has operated a Certificate of Need (CON) program since 1979. The CON review process is administered by DHHS. For the purpose of the review of CON applications, nursing facilities are designated into 26 health planning regions. A CON is required for the following scenarios:

- The initial establishment of long-term care beds or rehabilitation beds.
- An increase in the long-term care beds of a healthcare facility by more than 10 long-term care beds or more than 10% of the total long-term care bed capacity, whichever is less, over a two-year period.
- An increase in the rehabilitation beds of a healthcare facility by more than 10 rehabilitation beds or more than 10% of the total rehabilitation bed capacity, whichever is less, over a two-year period.

A CON is not required for a change in classification between an intermediate care facility, nursing facility or skilled nursing facility. Additionally, a CON is not required for the transfer or relocation of long-term care beds from one facility to another entity in any health planning region in the state.

Effective June 12, 1997, all long-term care and rehabilitation beds that require a CON are subject to a moratorium unless one of the following exceptions applies:

- If DHHS establishes that the medical and nursing needs of individuals requiring long-term care are more complex or intensive than the services ordinarily provided in a long-term care bed and are not currently being met by the long-term care beds licensed in the health planning region.
- If the average occupancy for all licensed long-term care beds located in a 25-mile radius of the proposed site exceeded 90% occupancy during the three most recent, consecutive calendar

quarters to the date the application is filed, and there is a long-term care bed need as determined by the formula in the bed need methodology detailed below.

BED NEED METHODOLOGY

The DHHS determines need for additional long-term care beds based on the following formula:

$$BN = (P \times U) \div O, \text{ where}$$

BN = Long-Term Care Bed Need

P = Population of the Health Planning Region

U = Utilization Rate of Long-Term Care Beds within the Health Planning Region

O = Minimum Occupancy Rate of Long-Term Care Beds within the Health Planning Region

CON applications are only approved if the current supply of licensed long-term care beds in the health planning region of the proposed site exceeds the long-term care bed need for that health planning region. The following data is used to calculate nursing facility bed need:

- Population is the most recent projection of population for the health planning region for the year closest to the fifth year immediately following the date of the application.
- The utilization rate is the number of people using long-term care beds living in the health planning region in which the proposed project is located, divided by the population of the health planning region.
- The minimum occupancy rate is 95% for health planning regions that are part of or contain a metropolitan statistical area as defined by the United States Bureau of the Census. For all other health planning regions in the state, the minimum occupancy rate is 90.0%.

According to state officials, the above calculation has not been required to be utilized in recent years. In order to facilitate the review and determination of CON applications, healthcare facilities are required to report census to DHHS on a quarterly basis.

QUALITY ASSURANCE FEE

Effective July 1, 2011, Nebraska approved the implementation of a Nursing Facility Quality Assurance Assessment (NFQAA). All non-exempt nursing facilities are required to pay a \$3.50 assessment fee per non-Medicare day. Exempt facilities include state-operated veteran’s homes, nursing facilities with 26 or fewer beds and nursing facilities within continuing care retirement communities. In addition, the state will reduce the NFQAA for certain high-volume nursing facilities.

Each applicable nursing facility will pay the NFQAA on a quarterly basis. Reimbursement for paying the NFQAA will be included in a nursing facility’s overall Medicaid rate as an additional cost component. The Medicaid portion of a nursing

facility's NFQAA fees is reimbursed as a direct pass-through. This pass-through rate is calculated by dividing the anticipated assessment payments by total anticipated nursing facility patient days, including bed hold and Medicare days. This per diem rate is reimbursed per Medicaid day.

Patient days for the four most recent calendar quarters available when rates are determined are utilized to calculate NFQAA assessment and component rates.

MEDICAID RATE CALCULATION SYSTEM

Nebraska uses a prospective, cost-based, resident-specific, case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

Nebraska uses the following three cost components to calculate its facility-specific Medicaid rates:

- The Direct Nursing component includes salaries, payroll taxes, employee benefits and purchased services related to direct nursing care.
- The Support Services component includes costs associated with administration, dietary, housekeeping, laundry, maintenance, activities and social services.
- The Fixed cost component includes a facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax and other fixed costs.
- The NFQAA cost component includes reimbursement for paying the assessment fee.

INFLATION AND REBASING

The rate year in Nebraska is from July 1 to June 30. Nursing facility rates are rebased annually, using the most recent cost report data available. This is the practice of DHHS, although they are not regulatory or statutorily bound to do so. Rates effective July 1, 2017, were calculated utilizing fiscal year 2016 cost report data.

The Direct Nursing and Support Services costs are adjusted for inflation. The state "backs-in" to the inflation factor by determining the availability of appropriations after accounting for occupancy changes and estimated expenditure growth after rebasing. The inflation factor is determined from spending projections computed utilizing the following:

- Audited cost and census data following the initial desk audits.
- Budget directives from the Nebraska Legislature.

Based on this methodology, the state initially imposed a 3.91% rate reduction to Direct Nursing and Support Services rate components in fiscal year 2012. However, once the NFQAA was implemented (effective July 1, 2011) the state retroactively adjusted nursing facilities' rates to reflect an actual inflation adjustment of 3.03%. In the prior fiscal year (2011), the state imposed a 1.54% rate reduction. The state provided a 2.25% inflation adjustment in fiscal year 2013.

The state provided a 2.5% inflation adjustment in fiscal year 2014. In addition, effective August 1, 2013, to June 30, 2014, the state provided a \$0.90 additional reimbursement related to the implementation of policies directed by CMS. The inflation adjustment for fiscal years 2015, 2016 and 2017 were 2.13%, 0.46% and 0.47%. However, nursing facility rates were applied a 2.65% reduction after rebasing rates effective July 1, 2017. This reflects that budget appropriations for nursing facility reimbursement remained relatively flat, and a negative adjustment was required given the increase in calculated Medicaid rates as the result of the rebasing of costs. In addition, even with the negative inflation adjustment, the average rate in the state still increased 2.1%.

Rates effective July 1, 2018, were rebased utilizing 2017 cost report data. However, funding for nursing home reimbursement remained relatively unchanged. Given the increased cost per facility resulting from the more updated cost report data, a larger rate reduction (7.17%) was applied to non-fixed cost components to keep nursing facility rates budget neutral. However, whether or not a facility received a rate increase or decrease depended on this facility's individual costs. According to Nebraska rate setting officials, the state has budgeted an additional \$7.4 million for nursing home reimbursement for nursing homes in fiscal year 2020 (effective July 1, 2019). This will result in an approximate 2.0% increase to nursing home rates.

No inflation adjustment is applied to the Fixed cost component.

RATE METHODOLOGY

Each facility's base rate is calculated as the sum of the facility-specific, inflation adjusted Direct Nursing and Support Services cost component rates and the non-inflated, adjusted Fixed cost component rate, subject to the rate limitations and component maximums of the system. Effective July 1, 2010, Nebraska converted to a 34-Group, 5.20 version resident utilization group (RUG) III classification system, which utilizes the minimum data set (MDS) 2.0 resident assessment tool.

The Direct Nursing component is calculated by dividing the allowable direct nursing costs by the weighted resident days for each facility. DHHS assigns each resident to a level of care based on information gathered from his/her most recent assessment. Each resident's level of care is appropriately updated from each assessment to the next (the admission assessment, a significant change assessment, the quarterly review and the annual assessment).

Residents are assigned to one of 39 levels of care, which are assigned weight levels based on the intensity of services required by residents for each level of care. For each reporting period, the total number of residents in each level of care is multiplied by the total number of corresponding days for each resident at that level. This product is multiplied (weighted) by its corresponding weight. The resulting product is the weighted resident days for that level. The weighted resident days for all levels are summed to determine the total number of weighted resident days for the facility, which is the divisor for the Direct Nursing component.

This component is subject to a ceiling equal to 125% of the median Direct Nursing component for all facilities in the same care

classification. For each care classification, the median of the Direct Nursing component is computed using nursing facilities within that care classification having an average occupancy of 40 or more residents.

The lower of the facility-specific Direct Nursing component or the ceiling is then multiplied by the appropriate weight for each level of care to determine resident-specific rates for each of the 39 care levels. The weights utilized in this calculation are from RUG III, version 5.20 effective July 2010.

The Support Services component is calculated by dividing the allowable costs for support services, medical-related resident transportation, and respiratory therapy by the total inpatient days. Inpatient days are days on which:

- A patient occupies a bed at midnight, or
- The bed is held for hospital leave or therapeutic home visits.

This component is subject to a ceiling equal to 115% of the median Support Services component for all facilities in the same care classification.

The Fixed cost component is calculated by dividing a facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax and other fixed costs by the facility's total inpatient days. This component is subject to a per diem ceiling of \$27.00 (excluding personal property and real estate taxes) for fiscal year 2019.

Statewide average Medicaid reimbursement daily rates are determined by the state on a calendar year basis. The average rate in 2019 is \$186.31, which is 3.1% greater than the 2018 average rate (\$180.78). The average rate in 2018 is 2.4% greater than the 2017 average rate (\$176.56). The average rates in 2016, 2015 and 2014 were \$172.92, \$168.51 and \$163.26, respectively.

MINIMUM OCCUPANCY REQUIREMENTS

There are currently no minimum occupancy requirements used in the Nebraska Medicaid rate calculation.

OTHER RATE PROVISIONS

For new providers entering Medicaid as a result of a change of ownership from July 1, 2012, to June 30, 2013, the interim rates for the rate period beginning July 1, 2012, through June 30, 2013, are the seller's rates in effect on the sale date. For all other new providers entering Medicaid from July 1, 2012, to June 30, 2013, the interim rates for the rate period beginning with the sale date through June 30, 2013, are the average base rate components effective as of the beginning of the rate period of all other providers in the same care classification, computed using the applicable audited data following initial desk audits. Interim rates will be retroactively settled based on the new provider's cost reports.

A provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year report period will not file a cost report. The rate paid will be the average base rate components, effective July 1, 2012, of all other providers in the same care classification, computed using audited data following the initial desk audits.

Payment for holding beds for patients in acute-care hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bed holding is allowed for 15 days per hospitalization and for up to 18 days of therapeutic home visits per calendar year. Nebraska has recently approved the reduction of reimbursement for bed hold days to the applicable reimbursement rate for assisted living services (Level of Care 105).

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no firm additional planned or proposed changes to the rate system. However, the state has established a Medicaid Long-Term Care Redesign Project that is projected to publish suggested changes to the Medicaid rates calculation by January 1, 2020. It is anticipated that these changes would include partially linking reimbursement to quality of care. Any approved changes are proposed to be implemented on July 1, 2020. As of the date of this overview, the details on changes to the reimbursement system and the likelihood of any changes being implemented is unclear.

NEBRASKA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	47.00	48.00	47.00		62.00	62.00	62.00		86.00	87.00	87.00
Average Daily Census	39.06	37.66	36.14		52.67	50.40	49.70		78.53	76.96	73.14
Occupancy	70.4%	68.0%	66.7%		80.5%	78.2%	76.1%		87.6%	86.8%	84.4%
Payor Mix Statistics											
Medicare	5.1%	5.6%	5.8%		7.6%	7.8%	8.3%		11.9%	11.0%	11.5%
Medicaid	39.7%	37.1%	37.3%		49.2%	48.4%	46.0%		59.5%	61.8%	58.7%
Other	32.5%	28.1%	30.5%		45.6%	43.8%	45.0%		58.5%	52.9%	53.7%
Avg. Length of Stay Statistics (Days)											
Medicare	37.29	34.60	33.33		51.03	46.43	47.85		72.04	68.11	67.79
Medicaid	394.67	398.59	372.67		531.03	569.09	541.27		748.14	752.04	816.30
Other	162.26	140.17	152.59		293.09	266.37	270.56		467.87	432.91	438.15
Revenue (PPD)											
Inpatient	\$182.93	\$190.16	\$200.22		\$204.98	\$214.50	\$226.09		\$232.98	\$246.52	\$260.80
Ancillary	\$17.66	\$20.40	\$24.44		\$33.99	\$39.40	\$44.67		\$61.97	\$65.53	\$74.61
TOTAL	\$201.89	\$217.51	\$227.50		\$237.76	\$254.01	\$271.89		\$285.67	\$313.31	\$322.38
Expenses (PPD)											
Employee Benefits	\$17.17	\$17.46	\$18.33		\$19.78	\$21.39	\$23.09		\$27.72	\$30.62	\$32.62
Administrative and General	\$22.36	\$22.93	\$25.32		\$28.85	\$29.24	\$29.64		\$35.12	\$36.10	\$35.06
Plant Operations	\$9.43	\$9.83	\$9.28		\$11.04	\$12.01	\$11.39		\$13.27	\$14.73	\$14.00
Laundry & Linens	\$2.08	\$1.73	\$1.75		\$2.82	\$2.49	\$2.61		\$3.52	\$3.38	\$3.53
Housekeeping	\$4.03	\$4.07	\$4.12		\$5.08	\$5.11	\$5.22		\$6.20	\$6.84	\$6.49
Dietary	\$15.78	\$17.26	\$17.55		\$19.36	\$20.44	\$20.55		\$23.05	\$24.14	\$25.14
Nursing & Medical Related	\$71.13	\$77.77	\$80.42		\$85.22	\$92.07	\$95.91		\$99.02	\$106.13	\$112.42
Ancillary and Pharmacy	\$11.68	\$13.43	\$12.69		\$19.18	\$18.62	\$19.18		\$27.80	\$28.44	\$29.53
Social Services	\$2.21	\$2.80	\$2.90		\$5.13	\$6.02	\$5.96		\$7.10	\$7.52	\$8.07

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Nevada



INTRODUCTION

Nursing facilities in Nevada are licensed by the Department of Health and Human Services (DHHS), Health Division, Bureau of Health Care Quality and Compliance, under the designation of "Facilities for Skilled Nursing." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEVADA	
Licensed Nursing Facilities*	46
Licensed Nursing Beds*	5,549
Beds per 1,000 Aged 65 >**	11.79
Beds per 1,000 Aged 75 >**	31.15
Occupancy Percentage - 2017*	81.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Nevada has operated a Certificate of Need (CON) program for new health facility construction since 1972. The program is administered by DHHS. New construction is defined as a new health facility, construction that increases the square footage in an existing facility, or the redesign or renovation of an existing building that is not currently being used as a health facility.

Currently, a CON is required for the construction of a new health facility at a cost of over \$2,000,000 in counties where the population is less than 100,000. Washoe and Clark counties have been exempt since 1991. However, in 2015, rural communities within these counties are no longer exempt from this process. Specifically, in an incorporated city or unincorporated town whose population is less than 25,000 and is located in a county whose population is 100,000 or more (Clark or Washoe), no person may undertake any proposed expenditure for new construction a health facility in excess of \$2,000,000, without first applying for a CON.

CON applications are reviewed based on the following criteria:

- Whether a need for the proposed project exists in the community.
- Whether the proposed project is financially feasible.
- The effect of the proposed project on the cost of healthcare.
- The appropriateness of the proposed project in the community.

There are no proposed changes to Nevada's CON program.

BED NEED METHODOLOGY

Nevada does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

Nursing facilities in the state of Nevada are assessed a quality assurance fee known as the Fee to Increase the Quality of Nursing Care. To determine the fee, DHHS establishes a uniform rate per non-Medicare patient day equal to 6.0% of the total annual accrual basis gross revenue for services provided to patients of all freestanding nursing facilities. The fee owed by individual facilities

is calculated by multiplying the total non-Medicare patient days at a facility by the uniform rate.

Effective October 1, 2011, Nevada altered the state's fee methodology. Prior to this date, two classifications were utilized to determine a nursing facility's fee, nursing facilities with 75,000 or less total patient days and nursing facilities with greater than 75,000 total patient days. Effective July 1, 2011, only two facilities in the state had greater than 75,000 total patient days. Given this factor, the majority of facility's in the state were assessed a fee of \$22.95 per non-Medicare day. The prior rates (effective July 1, 2010) were \$22.84 and \$26.40, respectively.

Effective October 1, 2011, nursing facilities are now charged a fee based on their Medicaid payor percentage. Nursing facilities with Medicaid payor percentages of 65.0% and higher were assessed a fee of \$15.46 per non-Medicare day and nursing facilities with a Medicaid payor percentage less than 65.0% were charged \$31.48 per non-Medicare day. Rates for the most recent years are as follows:

Fee to Increase the Quality of Nursing Care		
Effective Date	Fee for facilities w/Medicaid Occupancy of 65% or greater	Fee for facilities w/Medicaid Occupancy of lower than 65%
7/1/2016	\$18.70	\$35.34
10/1/2016	\$19.78	\$36.64
1/1/2017	\$19.55	\$39.10
4/1/2017	\$19.80	\$38.73
7/1/2017	\$20.55	\$40.57
10/1/2017	\$20.81	\$40.47
1/1/2018	\$18.46	\$39.10
4/1/2018	\$20.48	\$40.66
7/1/2018	\$20.33	\$41.31
10/1/2018	\$21.06	\$46.70
1/1/2019	\$20.91	\$45.97

Hospital-based nursing facilities are exempt from paying the quality assurance fee. Nursing facilities are reimbursed their fees as part of the Operating cost component.

MEDICAID RATE CALCULATION SYSTEM

From July 1, 2003, to September 30, 2011, skilled nursing facilities in Nevada are reimbursed under a price-based system with rates adjusted for acuity based upon the Resource Utilization Group III (RUG III) system. These rates were adjusted down to reflect existing funding levels. This is referred to as a "budget-neutrality adjustment."

Effective October 1, 2011, the state converted to a new rate methodology. This methodology includes two components, a facility-specific per diem and a quarterly supplemental payment. Under the new methodology, nursing facilities' facility-specific per diems were still adjusted for a budget-neutrality factor.

The summary below describes how the state calculated Medicaid rates prior to October 1, 2011. The state still utilizes

this methodology to calculate facility-specific rates, which are then adjusted by the budget-neutrality factor. A summary of the budget-neutrality adjustment and a description of the calculation of the quarterly supplemental payments will be included at the end of the Rate Methodology Section.

COST CENTERS

Individual facility rates are developed from prices established for the following three cost centers:

- The Operating component is comprised of all allowable costs excluding direct care costs, capital costs and direct ancillary service costs.
- The Direct Healthcare component is comprised of allowable RN, LPN and nursing aide salaries and wages, a proportionate allocation of allowable employee benefits, and the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.
- The Capital component is comprised of allowable depreciation, capital related interest, rent/lease and amortization expenses.

INFLATION AND REBASING

New cost report information is brought into the rate setting process on a periodic basis. The cost report information used to establish the Operating and Direct Healthcare medians, and ultimately prices, are rebased at least once every two years. Since the new system's inception, rebasing has occurred in two-year intervals.

When establishing the medians for the Operating and Direct Healthcare components, cost is adjusted from the midpoint of each provider's base year cost report to the midpoint of each state fiscal year using the National Forecast - Nursing Home Market Basket published by Global Insight. If this index becomes unavailable, a comparable index will be used. In non-rebasing years, the medians and price levels from the most recent rebasing period are indexed forward to the midpoint of the current rate year.

The state most recently rebased rates in fiscal year 2018 (effective July 1, 2017) utilizing predominantly calendar year 2015 cost report data. However, while the state has rebased and inflated rates on periodic basis, these increases were limited by the budget neutrality adjustment. The most recent significant rate increase occurred on April 1, 2018, when the state increased the budget neutral rate that is utilized to determine by the budget neutrality adjustment by 10.0%. This resulted in an approximate 5.1% increase in total reimbursement. More detail on the budget neutrality adjustment will be disclosed later in this document.

RATE METHODOLOGY

The facility-specific per diem operating cost is calculated by dividing allowable inflated costs by total patient days. The facility-specific per diem costs are arrayed and a median is determined. The statewide price for the Operating component is set at 105% of the Medicaid day weighted median. The median calculation does not include the costs of hospital-based nursing facilities.

For the Direct Healthcare component, the RUG-III, 34-group index maximization model is used as the resident classification system

to determine the case mix index (CMI) from data submitted from each facility on the Minimum Data Set (MDS) resident assessments. The CMIs assigned to each of the 34 classification groups are developed using the 1995-1997 time study minutes and are assigned a specific weight used to calculate average CMI.

Each resident in a facility is assigned to a RUG-III classification group on the first day of each calendar quarter. These RUG-III assignments are based upon each resident's most current MDS assessment available on the first day of each calendar quarter. Using the facility's simple average of the individual resident's CMIs, two CMIs are calculated for the facility. One is a facility-wide CMI based on all of the facility's residents, and the other is the Medicaid CMI, which is calculated using only the Medicaid residents for each facility.

In order to determine the statewide price for the Direct Healthcare component, the facility-specific per diem direct healthcare costs are determined by dividing allowable inflated costs by total patient days. The next step is to determine the facility-specific case mix adjusted costs based upon a case mix at the Medicaid statewide average. This is determined by dividing the facility-specific per diem costs by the result of the facility-specific cost report CMI (the four quarter average), and then multiplying the product of this calculation by the statewide Medicaid average CMI. The facility-specific case mix adjusted per diem costs are then arrayed and a median is determined. The statewide price is established at 110% of Medicaid day-weighted median case mix adjusted costs. On a quarterly basis, a facility's specific Direct Healthcare component is determined by multiplying the statewide price by the ratio of the facility's most recent quarterly Medicaid CMI score to the statewide Medicaid average CMI used in establishing the statewide price.

A fair rental value (FRV) reimbursement system is utilized to determine each facility's Capital component using the following items:

- Value of new beds – Effective July 1, 2017, the base value is \$130,000 per bed. When the system was implemented in July 2003, the base value per bed was \$73,000. The bed value is indexed (inflated) annually using Marshall & Swift.
- Rate of depreciation – The rate is set at 1.5% per year for the initial facility. The cost of renovation/replacement projects is depreciated at 5% per year.
- Maximum age – For the FRV calculation is 40 years. The actual age of a facility can be adjusted to reflect major renovation/replacement projects. For the latter to be considered major, it must exceed \$1,000 per licensed bed. The adjustment will be made at the start of the rate year following project completion.
- Rental rate – This is a flat rate set at 9.0% annually.
- Minimum occupancy percent – For the purposes of the FRV calculation, a minimum occupancy percentage of 92.0% is utilized. For those facilities with occupancy rates above 92.0%, the actual occupancy rate is used.

A nursing facility's total number of licensed beds is multiplied by the value per bed, which is then adjusted for depreciation and multiplied by the rental rate. The product of this calculation is divided by total patient days (adjusted for the minimum occupancy requirement) to calculate the FRV rate.

A sample calculation for a 20-year-old, 100-bed facility is presented below:

Licensed Beds	100
Times Value per Bed	<u>\$113,000</u>
Gross Value	\$11,300,000
Depreciation Rate (1.5% x 20 years)	30.0%
Depreciated Value (70.0%)	<u>\$7,910,000</u>
Rental Rate	<u>9.0%</u>
FRV Payment (Gross)	\$711,900
Divided by Greater of Actual or Minimum Days (at least 92.0%)	<u>33,580</u>
Fair Rental Value Payment	<u>\$21.20</u>

The above facility's Capital component for the current year would be \$21.20. This figure changes annually as a result of inflation associated with value per bed, as well as any allowable major renovation/replacement projects.

Effective October 1, 2011, the budget-neutrality adjustment is based on the statewide average Medicaid rate that was effective for the fiscal year (fiscal year 2003) prior to the implementation of the price-based system. This rate was \$121.66. However, based on budget shortfalls, this rate was reduced to \$116.66. The budget neutral rate remained unchanged until April 1, 2018, when it was increased 10.0% to \$128.33. Based on the above described methodology, the weighted average Medicaid rate is determined for the state. Once this is determined, the previously defined budget neutral rate is divided by the statewide weighted average rate to calculate the budget adjustment factor.

For fiscal year 2019 (effective July 1, 2018), the weighted average rate was \$243.06, which results in a budget adjustment factor of 0.5279 ($\$128.33/\$243.06 = 0.5279$). This percentage is multiplied by the previously determined facility-specific rate to equate to each nursing facility's Medicaid per diem rate. This equates to the daily rate that nursing facilities are reimbursed. This rate is adjusted quarterly for case mix. The budget adjustment factors for the most recent issued rates are as follows: January 1, 2019 - 0.5299; October 1, 2018 - 0.5294; July 1, 2018 - 0.5279, April 1, 2018 - 0.54545; January 1, 2018 - 0.4967, October 1, 2017 - 0.4962 and July 1, 2017 - 0.4978. As previously mentioned, the increase in the budget neutral rate effective April 1, 2018, had a significant impact on the budget adjustment factor. However, these per diem rates it does not represent the full reimbursement the nursing facilities receive from the state.

As previously mentioned, nursing facilities receive quarterly supplemental payments from the state. These supplemental payments are calculated to reflect the additional Medicaid funding that nursing facilities have received from the Fee to Increase the Quality of Nursing Care since July 1, 2003. Fifty percentage of the supplemental payment is based on Medicaid occupancy, MDS accuracy, and Quality measures. The remaining 50% is based on acuity.

The amount available for supplemental payments is calculated each quarter based on actual net revenues from patient services and actual patient days for each Base Quarter as follows:

- The Base Quarter is defined as the quarter beginning six months prior to the quarter in which the supplemental payments are being distributed;
- The total amount available for supplemental payments is calculated by multiplying the net revenues from patient services in the Base Quarter by six percent;
- One percent (1.0%) of this amount each quarter is retained by Nevada Medicaid to pay for administrative costs associated with the Supplemental Payment Program. The remaining funds plus \$2.50 per Medicaid nursing facility and long-term care (LTC) hospice bed day in the Base Quarter is the amount available to pay the state share of supplemental payments to free-standing nursing facilities. This amount increased by the federal matching funds.

The portion (50%) of the supplemental payments paid out based on Medicaid occupancy, MDS Accuracy and Quality components are calculated by assigning points to each facility for each component as follows:

Medicaid Occupancy Component:

The Medicaid Occupancy component provides incentives for nursing facilities to provide services to Medicaid beneficiaries by allocating points based on Medicaid occupancy levels. Funding available for this component represent 82% of the total funding available for the Medicaid Occupancy, MDS Accuracy and Quality component of total supplemental payments. Each nursing facility gets supplemental payments based on the following formula:

Medicaid Occupancy Supplemental Payment	
Medicaid Occupancy Rate	= (Medicaid Nursing Facility Patient Days + LTC Hospice Patient Days) / Total Patient Days
Medicaid Occupancy Rate	x 100 = Medicaid Occupancy Modifier
Medicaid Occupancy Modifier	x (Medicaid Nursing Facility Patient Days + LTC Hospice Patient Days) = Medicaid Points
Medicaid Points	x Unit Value for Medicaid Occupancy = Medicaid Occupancy Supplemental Payment

MDS Accuracy:

Funding available for this component represent nine percent of the total funding available for the Medicaid Occupancy, MDS Accuracy and Quality component of total supplemental payments. To qualify for the MDS Accuracy Supplemental Payment the facility must have a MDS accuracy rate of 70% or higher. Accuracy rates will be rounded to the nearest whole percentage. Nursing facilities that qualify for MDS accuracy payments will be assigned and MDS Accuracy Modifier as follows:

Accuracy Rate	Modifier
0% - 69%	0
70% - 79%	1
80% - 89%	3
90% - 100%	5

The MDS Accuracy Modifier is multiplied by the number of Medicaid nursing facility and LTC hospice patient days to determine MDS Accuracy points. Each nursing facilities MDS accuracy points is multiplied by the pre-determined unit reimbursement value to calculate the facility's total MDS Accuracy Supplemental Payment.

Quality Component:

The Quality component provides incentives for nursing facilities to improve the quality of care to nursing facility residents. Funding available for this component represent nine percent of the total funding available for the Medicaid Occupancy, MDS Accuracy and Quality component of total supplemental payments. There are four measures of quality of care utilized in this analysis as follows:

- Percentage of high risk long-stay residents who have pressure ulcers;
- Percentage of long-stay residents who had a urinary tract infection;
- Percentage of long-stay residents who had falls that resulted in major injuries; and
- Percentage of residents whose need for help with ADLs has increased.

Nursing facilities receive one quality point for each percentage point they are better than the Nevada MDS average for each measure. The total quality points are multiplied by a pre-determined quality unit value to equate to a nursing facility's Quality Component Supplemental Payment.

The supplemental payments for these three components are summed to calculate the total Medicaid Occupancy, MDS Accuracy and Quality Supplemental Payment.

As previously mentioned, the remaining 50% of the total supplemental payments is based on Acuity. The distribution of this supplemental payment is based on the methodology utilized to calculate the standard per diem rates. The first step in determining this supplemental payment is calculating a Budget Adjustment Factor as follows:

Budget Adjustment Factor for Supplemental Payment	
Weighted Average Total Amount of Reimbursement Based on Acuity	= Total Supplemental Payments for Acuity Available / (Medicaid Nursing Facility Patient Days + LTC Hospice Patient Days)
Weighted Average Portion of Reimbursement Based on Acuity	= Weighted Average Total Amount of Reimbursement Based on Acuity + Standard Per Diem (\$116.66)
Budget Adjustment Factor For Supplemental Payment	= Weighted Average Portion of Reimbursement Based on Acuity/Weighted Average Full Rate Per Diem

The Weighted Average Full Rate Per Diem utilized in the above calculation is determined by dividing the total number of Medicaid nursing facility and LTC hospice patient days for the Base Quarter for all facilities receiving supplemental payments into the total amount of reimbursement these facilities would have received if they were paid at the full per diem amount.

The next step is to determine the Facility-Specific Unit Reimbursement Value Based on Acuity as follows:

Facility-Specific Unit Reimbursement Value Based on Acuity	
Facility-Specific Full Rate Per Diem	= The rate nursing facilities would have received if a budget adjustment was not applied to non-capital rates
Facility-Specific Unit Reimbursement Value Based on Acuity	= Facility-Specific Full Rate Per Diem - Budget Adjustment Factor for Supplemental Payment

Based on these factors, the facility-specific quarterly supplemental payment received by each nursing facility is calculated as follows:

Facility-Specific Quarterly Supplemental Payment Based on Acuity	
Facility-Specific Nursing Facility Per Diem Rate	= Facility Specific Full Rate Per Diem x Budget Adjustment Factor for Base Nursing Facility Rates utilized in the initial per diem calculation (0.5283 effective April 1, 2016)
Facility-Specific Unit Value of Supplemental Payment Based on Acuity	= Facility-Specific Unit Reimbursement Value Based on Acuity - Facility Specific Nursing Facility Per Diem Rate
Facility-Specific Quarterly Supplemental Payment Based on Acuity	= Facility-Specific Unit Value of Supplemental Payment Based on Acuity x Medicaid Nursing Facility and LTC Hospice Patient Days in the Base Quarter

This amount is added to the previous supplemental payments for Medicaid Occupancy, MDS accuracy and Quality to determine total supplemental payments. Supplemental payments for fiscal year 2013 were adjusted upward to reflect that the state was providing the additional funding required to increase the budget neutral rate back to \$121.66. This additional funding was eliminated in fiscal year 2014, which resulted in a \$5.00 per Medicaid day reduction. However, this was partially offset by additional funding resulting from an increase in Nevada's federal matching percentage. In addition, it is estimated that in fiscal year 2014, the supplemental payments back-fill by approximately 75.0% of the budget adjustments made to Medicaid rates. Also, as of April 1, 2018, the budget neutral rate was increased 10% to \$128.33

The statewide average rate that factors in both the per diem rate and supplemental payment equates to \$227.11 effective July 1, 2018, which is 7.5% greater than the equivalent rate (\$211.27) effective July 1, 2017.

MINIMUM OCCUPANCY STANDARDS

There are no occupancy standards associated with the Operating or Direct Healthcare components. As previously mentioned, the Capital component utilizes a minimum occupancy standard of 92.0%.

OTHER RATE PROVISIONS

In the event that a nursing facility does not incur direct care costs equal to at least 94.0% of the direct care median, DHHS has the option to recoup an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage

adequate direct care staffing.

New freestanding facilities are reimbursed an interim rate from the following rate components in effect on the date of the facility's Medicaid certification:

- The FRV per diem is determined based upon an initial capital survey the new provider completes and submits to the Division of Health Care Financing and Policy.
- The Operating component for the rate is the Operating Statewide Price.
- The Direct Healthcare Component is the statewide Direct Healthcare price.
- The budget adjustment factor is applied to determine the facility's Medicaid rate.

This interim rate is paid until the subsequent rebasing period.

Rates paid to freestanding nursing facilities that have undergone a change of ownership are based upon the base rate and acuity data of the previous owner. The new owner's acuity data will be used to adjust the facility's rate following the rate adjustment schedule previously discussed. A new cost reporting period for the buyer will start on the effective date of the transaction.

Nursing facilities are reimbursed their per diem rate for reserving beds for Medicaid residents who are absent from the facility on therapeutic leave up to a maximum of 24 days annually (January 1 to December 31). Therapeutic leave does not include hospital emergency room visits or hospital stays.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no significant changes proposed to the Medicaid rate calculation.

NEVADA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	95.75	97.25	89.00		120.00	120.00	120.00		181.50	180.50	173.50
Average Daily Census	84.77	79.35	78.12		108.19	106.49	108.32		154.28	143.31	145.71
Occupancy	80.3%	75.0%	75.6%		86.8%	85.8%	88.6%		92.4%	89.4%	92.1%
Payor Mix Statistics											
Medicare	9.7%	9.7%	9.8%		16.3%	17.5%	15.8%		30.9%	29.2%	28.0%
Medicaid	45.6%	44.5%	45.7%		60.7%	60.3%	60.2%		70.6%	71.4%	72.9%
Other	10.5%	11.9%	11.8%		20.8%	20.3%	20.0%		28.9%	28.5%	31.2%
Avg. Length of Stay Statistics (Days)											
Medicare	27.63	25.05	23.70		32.31	30.99	31.17		41.69	43.89	38.39
Medicaid	210.25	191.28	192.08		272.44	252.57	252.64		351.50	323.90	356.08
Other	28.88	24.82	21.30		34.74	34.30	27.70		50.18	56.03	59.63
Revenue (PPD)											
Inpatient	\$231.80	\$238.23	\$246.31		\$259.74	\$272.59	\$296.96		\$305.53	\$312.03	\$335.72
Ancillary	\$69.54	\$65.19	\$69.86		\$128.64	\$132.74	\$136.63		\$183.44	\$200.26	\$186.36
TOTAL	\$295.81	\$295.74	\$307.52		\$422.85	\$433.26	\$462.38		\$499.57	\$498.96	\$550.98
Expenses (PPD)											
Employee Benefits	\$19.53	\$18.67	\$18.48		\$23.93	\$24.71	\$24.77		\$28.94	\$37.93	\$36.51
Administrative and General	\$55.80	\$55.15	\$56.98		\$63.33	\$67.84	\$75.96		\$78.40	\$80.29	\$82.68
Plant Operations	\$8.47	\$8.01	\$8.67		\$9.76	\$9.74	\$10.30		\$11.28	\$11.94	\$13.94
Laundry & Linens	\$1.64	\$1.71	\$1.30		\$2.39	\$2.39	\$2.46		\$2.72	\$2.99	\$2.90
Housekeeping	\$5.12	\$5.45	\$5.36		\$5.80	\$6.34	\$5.93		\$6.51	\$6.97	\$6.87
Dietary	\$15.90	\$16.06	\$16.23		\$16.91	\$17.58	\$17.82		\$18.35	\$19.49	\$19.27
Nursing & Medical Related	\$85.23	\$90.70	\$93.05		\$95.57	\$104.33	\$107.80		\$113.69	\$121.73	\$126.23
Ancillary and Pharmacy	\$25.43	\$27.40	\$27.95		\$57.13	\$62.48	\$56.27		\$77.84	\$74.60	\$73.81
Social Services	\$3.18	\$3.45	\$3.42		\$4.43	\$4.53	\$4.78		\$5.97	\$6.02	\$6.79

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

New Hampshire



INTRODUCTION

Nursing facilities in New Hampshire are licensed by The Department of Health and Human Services (DHHS) - The Health Facility Licensing Unit. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW HAMPSHIRE	
Licensed Nursing Facilities*	72
Licensed Nursing Beds*	6,971
Beds per 1,000 Aged 65 >**	29.30
Beds per 1,000 Aged 75 >**	74.19
Occupancy Percentage - 2017*	86.30%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The state's CON program was eliminated on June 30, 2016. However, the state has decided to maintain the moratorium on the construction of new nursing home beds indefinitely.

BED NEED METHODOLOGY

As part of the CON program the HSPR Board previously calculated unmet bed need for nursing facilities. However, with the end of the program, and the indefinite moratorium on new nursing homes beds, the state no longer utilizes a bed need methodology.

QUALITY ASSESSMENT FEE

The New Hampshire provider quality assessment fee (QAF) went into effect in 2004. Effective January 1, 2008, the QAF was reduced from 6.0% to 5.5% of net patient revenues in order to conform to the Tax Relief and Healthcare Act of 2006. Although this act expired on October 1, 2011, the QAF has remained at 5.5%. The funds collected from the QAF are placed into a nursing facility trust fund, which is used to partially fund Medicaid reimbursement to nursing facilities. Once the state receives the federal match for these funds, the state uses the total funds obtained from the QAF to offset the negative budget neutrality adjustment applied to a nursing facility's calculated Medicaid rate.

The negative budget neutrality adjustment will be discussed further in the Inflation and Rebasing section. After the state has reimbursed nursing facilities to offset the negative budget neutrality adjustment, the remaining funds obtained from the QAF are distributed to nursing facilities on a per-Medicaid-day basis. This is accomplished by calculating a positive budget neutrality factor. The positive budget neutrality factor is calculated by dividing the remaining funds by the state's Medicaid budget for nursing facility reimbursement. This factor, which is displayed as a percentage, is then multiplied by the facility's total Medicaid resident days for the period (quarter) to determine the additional reimbursement the facility receives. This is also referred to as the Medicaid Quality Incentive Program (MQIP) payment. This is reimbursed to nursing facilities separate from the calculated Medicaid rate as a supplemental payment.

Effective July 1, 2011, New Hampshire changed the state law to allow the state to only reimburse 75% of the funding generated from the QAF to nursing facilities (through the MQIP payment). However, in state fiscal year 2014 this percentage increased back to 100.0% and remains at that level.

MEDICAID RATE CALCULATION SYSTEM

New Hampshire Medicaid uses a prospective, case mix adjusted, cost-based, facility-specific rate setting system.

COST CENTERS

The rate setting system is comprised of the following five components of cost determined from nursing facility cost reports as of the date specified by the DHHS:

- Patient Care costs are attributed to the direct care of resident nursing salaries, nursing supplies and ancillary services.
- Administrative costs are attributed to the general management and support of the facility, including owner's compensation, administrator's salary, consultant fees, management fees, accounting, legal fees and travel.
- Other Support costs include housekeeping, laundry, dietary, central supply, pharmacy, medical records, social service and recreation.
- Plant Maintenance costs include plant maintenance costs, salaries and benefits, supplies, utilities and property taxes.
- Capital costs include allowable depreciation and interest.

INFLATION AND REBASING

The rate year in New Hampshire is from July to June and the state utilizes a biennial budget. The DHHS reviews and rebases nursing facility rates at least every five years subject to the following limitations:

- Costs are only inflated when rates are rebased.
- The total reimbursement rate is subject to budget neutrality, which is the adjustment to rates made by the DHHS to accommodate the difference between the calculated allowable acuity-based Medicaid rates and the amount that the state has budgeted in order to fund that care. This adjustment is a standard percentage determined from a comparison of total Medicaid funding in the state to the total estimated cost of reimbursing all applicable nursing facilities in the state.

With the exception of fiscal year 2008, New Hampshire has rebased their Medicaid rates on a yearly basis. However, not all of the eligible nursing facilities in New Hampshire submitted their fiscal year 2007 cost reports in time for DHHS to calculate Medicaid rates for fiscal year 2008. Therefore, fiscal year 2006 Medicaid rates (updated for acuity/case mix) were used to determine the facility-specific 2008 Medicaid rates. Given budgetary limitations, the state did not rebase or inflate rates for fiscal year 2009 and rates equated to un-inflated fiscal year 2008 rates. However, the state did rebase Medicaid rates from fiscal years 2010 to 2013. Cost reports within fiscal year 2010 were utilized to rebase fiscal year 2013 rates. The state did not rebase rates in fiscal year 2014 but provided the state's standard inflation adjustment detailed below. The state rebased rates in fiscal year 2015 (effective July 1, 2014) utilizing cost reports within state fiscal year 2012. The

state inflated rates for the period of July 1, 2015, to December 31, 2015, utilizing the below described inflation index. The state then rebased rates effective January 1, 2016, utilizing 2013 cost report data.

The state did not rebase rates effective July 1, 2016. Given that the state is in the second year of its bi-annual budget, with the exception of changes related to case mix, nursing facilities rates remained relatively unchanged from January 1, 2016. The state also did not rebase rates on July 1, 2017; the primary changes to rates are related to case mix adjustments. Rates were again adjusted for case mix on January 1, 2018. The state rebased rates and adjusted them for case mix on July 1, 2018, utilizing 2016 cost report data. However, the state also rebased rates and adjusted them for case mix on January 1, 2019, utilizing 2017 cost report data. This was the result finalizing cost reports for rates calculated on July 1, 2018.

Under state regulations, all nursing facility costs, excluding Capital costs, are to be calculated by inflating costs in the base year from the midpoint of the cost report to the midpoint of the rate period using the Centers for Medicare & Medicaid Services (CMS) Prospective Payment System (PPS) Input Price Index by Expense Category Index.

RATE METHODOLOGY

A facility-specific prospective per diem rate is calculated by summing the five rate components. All the costs, excluding Capital costs, are calculated by inflating costs in the base year from the midpoint of the cost report to the midpoint of the rate period using the CMS PPS Input Price Index by Expense Category Index. The per diem rates established for a nursing facility are calculated by dividing allowable costs by the greater of the facility's actual resident days (including reserved bed days) or the total available resident days multiplied by 85.0%.

The resulting rate is paid to the nursing facility until rates are updated with new MDS data and/or upon rebasing. An acuity adjustment occurs at least every six months.

The Patient Care cost component is based on the lower of each facility's case mix adjusted direct care cost per diem amount or the statewide median value. In order to determine the all-payers case mix adjustment, resident acuity is classified using the minimum data set (MDS) and Resource Utilization Groups IV (RUG-IV). The state converted from the RUG III to RUG IV system effective July 1, 2017.

The applicable date on the MDS used to determine inclusion is March 31 or September 30. Each resident is categorized into one of 34 RUG-III resident classifications, with each classification having a relative weight representing the nursing resource requirements of patients in that class in relation to patients in other classes.

The facility all-payor case mix index for each facility is calculated by multiplying the number of residents by the relative weight for each of the RUG-III classifications, then dividing the sum of the values across each resident grouping by the total number of residents. The all-payor case mix index is updated and

synchronized with the Medicaid cost report year.

A facility's case mix adjusted Patient Care costs per diem are divided by the all-payor case mix resulting in a case mix-neutral Patient Care per diem cost, which is then compared to the statewide case mix-neutral median. The statewide median value for the Patient Care cost component is calculated by dividing total patient care from each facility's cost report by resident days (adjusted to inflation if necessary), inflated to the midpoint of the rate year. The resulting amount is divided by the all-payor case mix index to determine the case mix adjusted Patient Care cost component per diem amount. Then the facility-specific amounts are arrayed and the statewide median is determined. The facility is then paid the lower of the statewide case mix-neutral ceiling or their case mix-neutral Patient Care costs, multiplied by its Medicaid case mix.

The Administrative, Other Support and Plant Maintenance cost components are reimbursed at the statewide median values for these components. Each individual nursing facility's Administrative, Other Support and Plant Maintenance inflated per diem costs are calculated by dividing the facility's specific costs by the facility's specific patient days (adjusted for occupancy if necessary). The facility-specific amounts are arrayed and the statewide median value is determined.

The Capital cost component of the prospective per diem rate is calculated by dividing the facility's actual capital costs by the facility's resident days for the same period (adjusted for occupancy if necessary). A nursing facility's Capital cost per diem rate is subject to an aggregate 85th percentile ceiling. The ceiling is derived from a listing of the Capital cost components for all applicable nursing facilities in the state. In addition, the DHHS conducts a review of acuity-based rates at least every six months, using the most recently available MDS data.

In addition to the previously described reimbursement, nursing facilities are also eligible for reimbursement of QAF charges. The methodology used to calculate this additional reimbursement is detailed in the Quality Assessment Fee section.

A nursing facility's Medicaid rate cannot exceed the facility's established rate to the public (private pay rate) or the Medicare upper limit of reimbursement. The average Medicaid rates effective January 1, 2019 is \$201.79. This represents a 4.2% rate increase from the prior rate (\$193.64).

MINIMUM OCCUPANCY STANDARDS

The cost component per diem rates established for a nursing facility are calculated by dividing allowable costs by the greater of the facility's actual resident days (including reserved bed days), or the total available resident days multiplied by 85.0%.

OTHER RATE PROVISIONS

The initial prospective per diem rate for new facilities that have completed reported costs of operations for periods of time of less than 12 months at the time of rate setting or reconstruction of an existing facility with completed reported costs of operations for

less than six months at the time of rate setting is calculated as follows:

- The rate for variable operating costs is determined at a rate comparable to the most recently calculated rates for other facilities of a similar size, geographic region and level of care that have operated for a full year.
- The rate for fixed capital costs is determined at a rate based on allowable costs/statistics (new facilities only).
- Where an HSPR Board review is not required, the rate is based on the allowable costs/statistics submitted by the nursing facility provider.

When a nursing facility has changed ownership, the rate is a continuation of the old rate until a new rate is set. However, for the purpose of calculating the Medicaid rate, the historical capital

costs remain the same unless there is a recapture of depreciation. Upon a recapture of depreciation from the seller, the buyer's cost basis for Medicaid reimbursement purposes is historical costs. The state's Medicaid program reimburses a nursing facility at its current rate for a maximum of 30 days per state fiscal year for holding a bed for a resident that requires therapeutic care.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, there are no planned or proposed changes to the nursing home rate calculation. In prior years the state had proposed to convert to a Managed Care Medicaid reimbursement for nursing facilities, but this did not occur.

NEW HAMPSHIRE COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	70.00	70.00	69.50		99.00	87.00	90.50		112.00	114.00	112.00
Average Daily Census	71.41	67.83	67.51		87.21	83.40	85.67		114.31	113.38	107.03
Occupancy	87.2%	84.3%	85.3%		91.0%	92.2%	91.0%		94.3%	95.0%	94.6%
Payor Mix Statistics											
Medicare	10.9%	8.8%	9.6%		17.3%	15.4%	14.7%		20.9%	20.4%	19.8%
Medicaid	51.9%	58.6%	54.2%		64.7%	65.3%	66.0%		70.0%	71.1%	76.1%
Other	12.7%	13.2%	12.7%		18.7%	18.7%	16.7%		31.6%	28.4%	30.4%
Avg. Length of Stay Statistics (Days)											
Medicare	28.79	27.67	28.59		34.22	35.27	33.84		43.27	41.23	42.92
Medicaid	320.43	332.18	285.98		432.92	413.09	423.26		578.53	610.82	546.00
Other	77.39	71.89	68.33		125.75	123.57	109.47		289.08	238.85	205.40
Revenue (PPD)											
Inpatient	\$279.62	\$281.23	\$291.92		\$318.54	\$323.22	\$336.95		\$338.75	\$342.95	\$360.60
Ancillary	\$44.23	\$44.27	\$48.83		\$74.11	\$74.21	\$75.95		\$95.60	\$90.74	\$95.13
TOTAL	\$339.09	\$341.50	\$349.64		\$379.84	\$393.35	\$405.51		\$445.49	\$450.36	\$473.34
Expenses (PPD)											
Employee Benefits	\$19.06	\$19.48	\$16.68		\$22.68	\$23.56	\$21.23		\$33.49	\$35.90	\$35.75
Administrative and General	\$45.76	\$44.21	\$45.80		\$50.86	\$50.15	\$51.40		\$62.59	\$64.30	\$61.30
Plant Operations	\$10.37	\$10.06	\$10.69		\$12.40	\$12.23	\$12.78		\$16.05	\$15.75	\$16.52
Laundry & Linens	\$2.52	\$2.83	\$2.84		\$3.54	\$3.68	\$3.78		\$4.22	\$4.31	\$4.42
Housekeeping	\$4.30	\$4.27	\$4.28		\$5.21	\$5.36	\$5.41		\$7.78	\$7.51	\$8.13
Dietary	\$15.62	\$15.42	\$16.81		\$19.59	\$19.63	\$21.31		\$25.61	\$26.82	\$27.79
Nursing & Medical Related	\$88.01	\$91.87	\$98.61		\$97.56	\$100.51	\$109.14		\$115.03	\$118.14	\$131.88
Ancillary and Pharmacy	\$23.34	\$21.90	\$23.67		\$32.15	\$32.79	\$30.57		\$43.85	\$45.41	\$43.57
Social Services	\$2.92	\$3.03	\$3.10		\$3.77	\$3.78	\$3.97		\$4.85	\$4.69	\$5.24

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

New Jersey



INTRODUCTION

Nursing facilities in New Jersey are licensed by the Department of Health and Senior Services (DHSS), Division of Health Facilities Evaluation and Licensing as “Long-Term Care Facilities.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW JERSEY	
Licensed Nursing Facilities*	355
Licensed Nursing Beds*	52,296
Beds per 1,000 Aged 65 >**	36.44
Beds per 1,000 Aged 75 >**	86.22
Occupancy Percentage - 2017*	82.60%

*Source: 2017 Medicare Cost Reports

**Source: *EnviroNics Analytics- 2018 Population*

CERTIFICATE OF NEED

New Jersey has operated a Certificate of Need (CON) program for all healthcare facilities and services since 1971. The Division of Health Facilities Evaluation and Licensing administers the CON program. A CON is required in the following scenarios:

- The establishment, modification, replacement or expansion of any healthcare service or facility, regardless of the amount of capital or operating expenditures.
- The reopening of beds, facilities, or services that had closed or substantially ceased operations for any consecutive two-year period (provided the beds, facilities or services required a CON to be initiated).
- Any increase in the number of licensed beds, including the conversion of licensed beds to another use. CON applicants proposing the addition of long-term care beds at nursing homes with an annual occupancy rate of less than 90% of the licensed bed capacity for the most recent calendar year will not be approved.
- The relocation of a portion of a facility’s licensed beds to another facility. This transfer can only occur if the receiving facility is located in the same planning area as the sending facility. Planning areas are typically defined as the county in which the sending facility is located and contiguous counties.

Only facilities with 240 or fewer beds can receive CON approval for general or specialized long-term care beds. However, facilities that are currently licensed for more than 240 beds can be approved for the development of additional beds if the design of the project results in two or more separately licensed facilities, each in compliance with the maximum size requirement.

A CON is valid for a period of five years following approval. Long-term care facilities are allowed one increase in a five-year period of 10 licensed long-term care beds or 10% of their licensed long-term care capacity, whichever is less, without CON approval.

CON applications are reviewed in order to determine the following:

- Whether the proposed action is necessary to provide required healthcare in the area to be served.
- If the proposed action can be financially accomplished and licensed in accordance with applicable regulations.
- Whether the proposed action will have an adverse impact on

access to healthcare services in the region or statewide.

- Whether the proposed action will contribute to the orderly development of adequate and effective healthcare services.

In making these determinations the following criteria are considered:

- The availability of facilities or services that may serve as alternatives or substitutes.
- The need for special equipment and services in the area.
- The adequacy of financial resources and sources of present and future revenues.
- The availability of sufficient manpower in the several professional disciplines.

Although the state does possess a CON program, with exception of the above-mentioned one-time increase, the state will not approve new long-term care beds unless it issues a “call” for new beds. This includes pediatric long-term care beds.

BED NEED METHODOLOGY

New Jersey does not possess a bed need methodology and is not in the process of developing a bed need calculation.

The state of New Jersey has not issued a “call” for new nursing facility beds since 1991. The state is required to consider a call for new skilled nursing beds every three years. The most recent scheduled consideration date was on July 1, 2016. The next scheduled date in which the state will consider issuing a call for new nursing homes beds will be on July 1, 2019. However, it is unlikely that the state will actually allow for the development of new nursing facility beds on this date.

The state did issue a call for 17 new specialized pediatric long-term care beds (Ventilator beds) on January 1, 2018. Specifically, 14 of these beds were dedicated to the northern section of New Jersey and three beds were dedicated to the southern section. Children’s Specialized Hospital – Mountainside, which is located in Mountainside, Union County, New Jersey, was granted the CON for the development of 14 new beds in northern New Jersey. Voorhees Pediatric Facility, which is located in Voorhees, Camden County, New Jersey, was granted the CON for three southern New Jersey area.

No new calls for pediatric long-term care have been made since that date. In addition, it is currently unclear when (or if) any new calls will be made the future.

QUALITY ASSURANCE FEE

Nursing facilities in New Jersey are assessed a Quality Assurance Fee (QAF). The QAF went into effect on July 1, 2004. The initial QAF was \$11.89 per non-Medicare patient day. The QAF was increased to \$11.92 on July 1, 2006, and had remained unchanged until July 1, 2019, when it increased to \$14.67. New Jersey is in compliance with the federal QAF ceiling (6.0% of total revenue). County managed nursing homes, CCRCs, and certain high volume Medicaid providers are exempt from paying the fee.

Nursing facilities are reimbursed a portion of the QAF as an

add-on to their Medicaid rate. Effective July 1, 2007, the add-on for nursing facilities that pay the QAF was \$17.52 per Medicaid patient day. This amount was increased to \$20.91 on October 1, 2008, and \$22.37 on April 1, 2009. However, the amount was decreased to \$18.50 on July 1, 2009. This per diem included \$9.64 for reimbursement of the fee and an \$8.86 patient quality add-on. Effective July 1, 2010, New Jersey converted to a new rate methodology system that adjusts nursing facility rates for acuity. This resulted in an increase of direct care rates. To fund this increase, the state eliminated the patient quality add-on. Effective July 1, 2013, the QAF add-on is \$8.30, which decreased from \$8.91 effective July 1, 2012. The QAF add-on remained unchanged until October 1, 2014, when it was increased to \$8.32 per day. However, it was reduced to \$8.09 per day effective October 1, 2015. Effective October 1, 2016, the add-on increased to \$8.21 per day and has since increased to \$8.89, effective October 1, 2017. Effective July 1, 2018, the add-on increased to \$8.89 per day and again increased to \$9.57, effective October 1, 2018. As a result of the increase in the actual QAF, effective July 1, 2019 the add-on significantly increased to \$13.67.

MEDICAID RATE CALCULATION SYSTEM

Effective July 1, 2010, New Jersey converted to a prospective, cost- and price-based, case mix, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. This system was phased in over a two-year period. However, the utilization of this system ended on June 30, 2014, when the state began the conversion to a managed care reimbursement system. This system is referred to as the New Jersey Medicaid Managed Long Term Services and Supports (MLTSS) system. MLTSS is administered by five managed care organizations (MCOs). The MCOs are directly responsible for coordinating long-term care services in New Jersey and directly reimbursing nursing facilities.

Effective July 1, 2014, Medicaid-eligible residents who enter a nursing home for the first time will have their acute and primary health care managed by one of the MCOs. Nursing home residents on Medicaid that were within the facility prior to July 1, 2014, remained in a fee-for-service environment. Nursing facilities are reimbursed their April 1, 2014, fee-for-service rates for these residents. These rates represent the last rates that were calculated utilizing the rate methodology effective July 1, 2010. However, some facilities received moderate increases (average increase of \$5.26 per day) in their rates effective July 1, 2014, and all nursing facilities received a \$1.06 rate increase effective July 1, 2015. However, after factoring in the \$0.23 decrease in the QAF add-on, this equated to a net increase of \$0.83. The details of which facilities received rate increases on July 1, 2014, will be provided in the Inflation and Rebasing Section of this overview.

For any new residents, nursing facilities will receive one specific rate that will be solely based on contractual negotiation between the facility and the MCO. These rates will not be published or available to the public. Originally, nursing facilities were only supposed to be guaranteed that their rates would not be lower than their last fee-for-service rate (effective April 1, 2014) until June 30, 2016. This policy was extended through fiscal years 2017, 2018 and 2019 (effective July 1, 2018 to June 30, 2019). The state

has since extended this policy. Nursing facilities that do not have a contact with a specific MCO are reimbursed their fee-for-service rates calculated by state. However, nursing facility Medicaid fee-for-service rates have been moderately inflated since April 1, 2014.

This reflects that the state did not fully convert to the managed care system on July 1, 2017, as was previously proposed. It is currently unclear how long this policy will be continued.

Effective July 1, 2019, the state approved a \$30 million funding increase for nursing homes. As such, each nursing facility in the state will receive a \$3.01 rate add-on effective July 1, 2019. In addition, all nursing facilities in the state will be guaranteed that the rate they receive on July 1, 2019 will equate to at least their rate effective June 30, 2019 or \$188.35. It is estimated this will impact 27 facilities in the state. In addition, the \$3.01 add-on will be applied to either of these rates. Therefore, a facility that receives the \$188.35 rate will actually be reimbursed at a rate of \$191.36 ($\$188.35 + \$3.01 = \191.36).

The remainder of this overview will focus on how rates were last calculated (April 1, 2014) utilizing the prospective cost- and price-based system that was implemented on July 1, 2010.

COST CENTERS

The reimbursement rate for a nursing facility is the sum of the following components:

- The Direct Health Care cost component is a facility-specific rate that includes salaries, payroll taxes and general benefits for registered nurses, licensed practical nurses, nursing aides' salaries, medical directors, patient activities, social services and pharmaceutical staff, non-legend drugs, routine medical supplies and routine oxygen and expenses related to contracted staff (no overhead expenses allowed).
- The Operating and Administrative cost component is a standard price including all allowable costs that are not directly recognized in the Direct Health Care and Fair Rental Value cost components listed as follows: management, administrator, assistant administrator, other administrative, home office and/or management company, dietary and food, laundry and linen, housekeeping, contract staffing costs, maintenance (non-capital portion), utilities, property insurance, other property costs, and property taxes for land and building.
- The Fair Rental Value (FRV) cost component is a facility-specific allowance that reimburses nursing facilities based on the estimated depreciated value of their capital assets in lieu of direct reimbursement for allowable depreciation, amortization, capital related interest, rent expense and lease expense.

INFLATION AND REBASING

Under the system implemented on July 1, 2010, the Direct Health Care cost component rate was rebased annually utilizing the most current cost report data available as of May 1 preceding the last year, covering at least a six-month period for each Class I and Class II nursing facility in operation. The Operating and Administrative cost component price was to be rebased every

three years beginning July 1, 2013, utilizing the most current cost report data available as of May 1 preceding the last year and covering at least a six-month period for each Class I and Class II nursing facility in operation. The FRV cost component rate was calculated annually. In addition, the state adjusted a portion of nursing facilities' Direct Health Care cost component rate quarterly based on each facility's Medicaid case mix index (CMI). The state utilized the RUG III, 5.12 Version, 34-RUG Grouper to adjust rates for Medicaid CMI based on the following schedule:

- For rates effective July 1 to September 30, the CMI was obtained from the previous January 1 to March 31 period.
- For rates effective October 1 to December 31, the CMI was obtained from the previous April 1 to June 30 period.
- For rates effective January 1 to March 31, the CMI was obtained from the previous July 1 through September 30 period.
- For rates effective April 1 to June 30, the CMI was obtained from the previous October 1 to December 31 period.

The Direct Health Care case mix cost component rate and the Operating and Administrative cost component price effective July 1, 2010, were calculated utilizing cost reports for Class I and Class II nursing facilities that were available on May 1, 2010, with a cost reporting period of at least six months ending on or before November 30, 2007.

Under the regulations for the system implemented on July 1, 2010, the state was supposed to adjust all allowable costs utilizing an index factor from the midpoint of each cost reporting period to the midpoint of the rate year for which the limit is used to estimate rates. The index factor was determined by dividing the index (Global Insight Market Basket without Capital) associated with the quarter ending on the midpoint of the rate year for which the index is being established by the index associated with the quarter ending on the midpoint of the cost reporting period. No inflation was applied to the new construction value per bed utilized to determine the FRV cost component rate.

For rates effective July 1, 2011, the state rebased Direct Care cost component rates utilizing 2009 cost report data. These costs as well as the Operating and Administrative Class prices were inflated utilizing the above described methodology. However, effective the same date, Governor Chris Christie approved a \$60 million (3.3% reduction) funding cut to Medicaid. This budget cut was initially applied through the previously mentioned budget adjustment factor. However, this budget reduction had to be realized in context with the previously mentioned Gain/Loss Provision. Those facilities whose rates had dropped by \$10 since June 30, 2010, could not absorb any more of the budget reduction. Therefore, the initial budget reduction factor only saved the state \$15 million. Given this factor, the majority of the budget reduction had to be absorbed by only a segment of facilities through the implementation of a greater (8.0%) budget adjustment factor.

Based on the state's fiscal year 2013 budget, the state restored \$10 million of the previous rate reduction, effective July 1, 2012. This equated to an approximate \$0.95 per diem increase in funding. In addition, the state implemented a new Gain/Loss Provision in fiscal year 2013. Based on this provision, a nursing facility's Medicaid rate, effective July, 1, 2012, prior to the QAF add-on,

could not exceed or be less than \$5.00 of its rate, effective July 1, 2011.

The state restored a significant portion (\$40 million) of the previous rate reduction effective July 1, 2012. In addition, the state implemented a new loss provision in fiscal year 2013. Based on this provision, a nursing facility's Medicaid rate effective July 1, 2012, prior to the QAF add-on, could not be lower than its rate effective June 30, 2012. The loss provision was supposed to be eliminated on July 1, 2013. However, July 1, 2013, rates, prior to the QAF add-on, were not be allowed to be below June 30, 2013, rates.

Effective July 1, 2013, Direct Health Care and Operating and Administrative component rates were rebased utilizing 2011 cost report data. In addition, the state restored the remaining portion (\$20 million) of the previous rate reduction effective July 1, 2012, during this rate period. Effective July 1, 2014, nursing facility rates for current fee-for-service residents were guaranteed to not be below rates effective April 1, 2014, for two years.

This policy has since been extended in fiscal years 2017 (effective July 1, 2016) and 2018 (effective July 1, 2017). In addition, April 1, 2014, rates have been moderately inflated on July 1, 2014 (average increase of \$5.26 per day), and July 1, 2015 (increase of \$0.83 per facility per day), respectively. No inflation was applied to the July 1, 2016 rates, but approximately \$10.5 million of additional funding was provided to nursing facilities effective July 1, 2017. This resulted in a \$1.07 rate increase per facility. No additional funding was provided for nursing facility rates in fiscal year 2018; therefore, with the exception of changes in the QAF, add-on rates remained relatively flat.

Effective July 1, 2019, the state provided the funding (\$30 million) for a \$3.01 rate increase per facility.

The following is the methodology that was utilized to determine nursing facility rates prior to the implementation of MLTSS and any budget reductions.

RATE METHODOLOGY

The Direct Health Care cost component rate contained two rate sub-components: case mix adjusted costs and non-case mix adjusted costs. Rates for these two sub-components were determined separately and then combined to determine the overall rate. Facility-specific inflated case mix adjusted and non-case mix adjusted costs were determined by dividing allowable costs by total resident days. Facility-specific case mix adjusted costs were then multiplied by a "normalization adjustment." The normalization adjustment was determined by dividing the statewide average CMI by the facility-specific cost report CMI. The normalized case mix per diem cost is then added to the non-case mix adjusted per diem cost to equate to the total normalized Direct Health Care per diem. Each facility's Medicaid resident days from the cost report were then used to array the per diems by class to calculate the class-specific Medicaid day weighted median. The Direct Health Care rate limit was set at 115% of the median for Class I nursing facilities and 105% of the median for Class II nursing facilities.

Once the limit is established, facility-specific percentages of case mix adjusted costs and non-case mix adjusted costs to total Direct Health Care costs were determined. These percentages were applied to the previously determined Direct Health Care class limit to calculate the facility-specific case mix adjusted and non-case mix adjusted limits. A nursing facility's case mix adjusted and non-case mix adjusted rates were the lesser of the facility-specific non-normalized inflated per diem cost or the facility-specific limits. For each rate quarter, a nursing facility's case mix adjusted rate was multiplied by the ratio of the facility's average Medicaid CMI to the CMI of the cost report period. The factor of this calculation was then added to the facility-specific non-case mix adjusted rate to determine the facility's total Direct Health Care cost component rate.

Class I and II nursing facilities are reimbursed one specific Operating and Administrative cost component price for their class. To determine this price, facility-specific inflated operating and administrative costs for Class I nursing facilities were divided by total resident days to determine the facility-specific Operating and Administrative per diems. Each facility's Medicaid resident days from the cost report were then used to array the per diems by class to calculate the Class I nursing facility Medicaid day weighted median. The Class I price equated to 100% of the Medicaid day weighted median and the Class II price equated to 104.5% of the Class I price.

A nursing facility under the FRV system was reimbursed on the basis of the estimated value of its depreciated capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. This calculation assumed a new construction value per bed of \$89,000, a maximum facility age of 40 years and 2% depreciation per year. The effective age of the facility was utilized to adjust the new construction value per bed for depreciation.

For years subsequent to 2010, the age of each facility was adjusted every July 1 to make the facility one year older up to the maximum age of 40 years. If any nursing facility placed new beds in service during the cost report period, these new beds were averaged into the adjusted age of the prior existing beds to arrive at the facility's re-age. In addition, the effective age of a facility was adjusted to reflect any significant renovations.

The new construction value per bed was multiplied by the facility-specific depreciation percentage to determine the facility-specific value per bed. The depreciation percentage equated to the effective age of the facility multiplied by 2%. The nursing facility's total value was then determined by multiplying the facility-specific value per bed by the facility's total number of licensed beds. The FRV value allowance was then calculated by multiplying the facility's total value by an 8.0% rental factor and dividing the product of this calculation by the greater of the facility's actual resident days, or 95.0% of available resident days, from the cost report utilized to determine the Direct Health Care cost component limit.

The final portion of New Jersey nursing facilities' Medicaid rates was an add-on for reimbursement of the state's QAF. Effective July 1, 2019, nursing facilities are reimbursed for the QAF with a

\$13.67 add-on per Medicaid day. The prior add-on was \$9.57. This results in a \$4.10 rate increase per nursing facility.

Effective July 1, 2019, nursing facilities are also eligible for five quality add-ons. Each add-on equates to \$0.60 per day. Nursing facilities receive the add-on if their averages for certain quality metrics are equal to or greater than the national average for these metrics. These metrics include antipsychotic medication use, incidence of pressure ulcers, use of physical restraints, falls with major injury and CoreQ composite score of 75.0% or greater. Data utilized to determine the metrics scores for the nursing facilities was derived from the period of September 1, 2016 to October 1, 2017. Effective July 1, 2019, the average quality add-on payment in the state equates to \$1.99.

A nursing facility's total Medicaid rate equated to the sum of the facility-specific Direct Health Care and FRV cost component rates, the Operating and Administrative price, the QAF add-on, the rate increase add-on (\$3.01) and the quality add-ons.

In addition, each year under the current system the state compared the statewide weighted average rate (exclusive of the QAF add-on) for Class I, II and III nursing facilities to a target rate determined from the legislative appropriations for the fiscal rate year. If the Medicaid day weighted average comparison rate for all classes exceeded the target rate, each class's Medicaid rates were adjusted as follows:

- The Operating and Administrative price was reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal the target rate up to a maximum reduction to 95.0% of the Class I median.
- If after the prior adjustment the statewide Medicaid day weighted average comparison rate still exceeded the target rate, the Direct Health Care Class I limit (115% of the Class I median) was reduced by as much as is needed to have the statewide Medicaid day weighted average comparison rate equal the target rate up to a maximum reduction to 112.0% of the Class I median.
- If after the prior adjustments the statewide Medicaid day weighted average comparison rate still exceeded the target rate, a budget adjustment factor was determined. This factor was determined by dividing the target rate by the statewide Medicaid day weighted average comparison rate. This budget adjustment factor was then multiplied by each nursing facility's rate (exclusive of the QAF add-on) to determine adjusted nursing facility rates effective July 1 of each rate year. These rates were still adjusted for a nursing facility's Medicaid CMI on a quarterly basis.

The average rate in the state effective July 1, 2019 equates to \$222.69.

OCCUPANCY STANDARDS

As previously mentioned, FRV rates are calculated utilizing the greater of the facility's actual total patient days or 95.0% of the facility's total allowable patient days for the applicable cost report period.

OTHER RATE PROVISIONS

For any facility that transfers ownership, the rate, cost reports and case mix indices established for the old owner were passed to the new owner. Rates for new Class I and II nursing facilities were established as follows:

- The Direct Health Care limit of the applicable class was used to establish the Direct Health Care component rate.
- The nursing facility's case mix and non-case mix portion percentages was the simple average of all Class I nursing facilities.
- For each rate quarter, the case mix portion of the Direct Health Care rate was multiplied by the ratio of the facility average Medicaid CMI to the statewide average CMI and then added to the non-case mix portion of the rate.
- The state used the statewide average Medicaid CMI for the first quarter to establish the Direct Health Care rate.

- The nursing facility received the applicable Operating and Administrative price

Previously, nursing facilities were reimbursed at 50% of their per diem rate for bed hold days caused by hospital admission (not to exceed 10 days). However, New Jersey eliminated any bed hold reimbursement in fiscal year 2012.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATIONS

As previously mentioned, the state has indicated that it will eventually fully convert to the managed care system. However, it is currently unclear when this will occur. .

NEW JERSEY COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	104.00	107.75	107.00		128.00	129.00	128.00		180.00	180.00	180.00
Average Daily Census	98.04	96.19	94.90		116.81	115.70	113.92		164.18	161.49	157.42
Occupancy	82.5%	80.4%	78.6%		88.6%	87.1%	85.3%		92.4%	92.1%	91.0%
Payor Mix Statistics											
Medicare	9.4%	9.4%	8.2%		15.1%	13.8%	13.2%		22.4%	21.8%	20.5%
Medicaid	48.1%	46.6%	46.3%		64.9%	66.5%	67.2%		74.2%	76.3%	75.8%
Other	11.7%	10.8%	11.5%		20.7%	18.2%	18.7%		32.6%	35.4%	39.7%
Avg. Length of Stay Statistics (Days)											
Medicare	29.63	27.82	27.17		35.24	34.29	33.82		45.90	43.05	44.32
Medicaid	294.03	305.36	278.19		433.27	445.20	396.84		823.12	682.61	621.64
Other	45.13	35.32	36.23		82.22	64.91	62.66		186.41	142.66	162.33
Revenue (PPD)											
Inpatient	\$267.77	\$269.81	\$271.50		\$324.44	\$329.06	\$332.15		\$397.00	\$399.96	\$410.48
Ancillary	\$33.74	\$35.34	\$34.62		\$55.79	\$53.78	\$54.52		\$87.70	\$86.69	\$86.86
TOTAL	\$307.72	\$313.31	\$311.75		\$387.35	\$398.72	\$405.08		\$503.53	\$501.26	\$518.27
Expenses (PPD)											
Employee Benefits	\$21.13	\$21.12	\$21.34		\$30.16	\$28.15	\$28.35		\$40.23	\$38.96	\$37.46
Administrative and General	\$42.38	\$43.60	\$44.81		\$50.44	\$52.13	\$54.77		\$63.27	\$67.75	\$69.44
Plant Operations	\$11.16	\$10.71	\$10.88		\$13.60	\$12.75	\$12.97		\$17.56	\$16.31	\$16.21
Laundry & Linens	\$1.74	\$1.77	\$1.53		\$3.26	\$3.01	\$2.85		\$5.16	\$5.32	\$5.23
Housekeeping	\$6.28	\$6.52	\$6.61		\$7.99	\$7.97	\$8.19		\$10.43	\$10.46	\$10.54
Dietary	\$18.39	\$18.33	\$18.69		\$21.36	\$21.55	\$21.83		\$26.61	\$26.66	\$27.55
Nursing & Medical Related	\$88.75	\$89.33	\$92.26		\$100.92	\$101.21	\$103.07		\$119.83	\$122.66	\$125.12
Ancillary and Pharmacy	\$20.94	\$21.54	\$21.25		\$30.93	\$31.39	\$31.03		\$44.91	\$46.02	\$44.97
Social Services	\$1.77	\$1.86	\$1.92		\$2.66	\$2.69	\$2.88		\$3.61	\$3.75	\$3.72

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

New Mexico



INTRODUCTION

Nursing facilities in New Mexico are licensed by the New Mexico Department of Health, Public Health Division, Health Facility Licensing under the designation of “Skilled Nursing Facilities.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW MEXICO	
Licensed Nursing Facilities*	65
Licensed Nursing Beds*	6,073
Beds per 1,000 Aged 65 >**	17.34
Beds per 1,000 Aged 75 >**	43.52
Occupancy Percentage - 2017*	79.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

New Mexico does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility. In addition, there is no moratorium on the construction of nursing facility beds in New Mexico.

BED NEED METHODOLOGY

New Mexico does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

Nursing facilities in New Mexico are currently not assessed with a quality assurance fee. A provider fee went into effect on July 1, 2004, and was repealed in March 2006 (despite an original sunset of June 30, 2007). The tax was known as the Daily Bed Surcharge and was applied at a rate of \$8.82 per occupied bed day.

However, in March 2019 the New Mexico Governor signed Senate Bill 246, which will implement a new quality assessment that will be known as the Health Care Quality Surcharge. The state recently submitted a state plan amendment to the Centers for Medicare and Medicaid (CMS) for the approval of the surcharge. However, the surcharge methodology is still in the conceptual phase given that the state is waiting on CMS approval/recommendations before finalizing it. Based on Senate Bill 246, the surcharge would be effective July 1, 2019, and would be assessed on a non-Medicare basis. The fee would be paid quarterly. In addition, nursing facilities with more than ninety thousand annual Medicaid patient days may be able to claim an exemption in which they would only be charged a fee that equates to 65.0% of the current surcharge.

In addition, it is anticipated that at 80.0% of the funding that is generated by the surcharge will be utilized to increase existing nursing home Medicaid rates (fee-for-service and managed care), provide supplemental payments based on nursing facilities' proportionate share of Medicaid utilization in the state, and other supplemental payments based on quality measures.

The actual fees, the surcharge methodology and likelihood of the surcharge being implemented on July 1, 2019 are still undetermined.

MEDICAID RATE CALCULATION SYSTEM

Effective July 1, 2008, New Mexico began converting to a Medicaid managed long-term care program that coordinates services to certain Medicaid recipients. This includes long-term care services. The program is identified as the Coordination of Long-Term Services (CoLTS). CoLTS was administered by two managed care organizations (MCOs), AMERIGROUP and Evercare. The MCOs were directly responsible for coordinating long-term care services in New Mexico and directly reimbursing nursing facilities. All Medicaid-eligible residents in the state were enrolled in the program on April 1, 2009.

Prior to the implementation of the CoLTS system, New Mexico used a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. Based on the implementation of nursing home reform requirements in 1990, nursing facilities received two rates based on level of care: High NF and Low NF. The MCOs still reimbursed nursing facilities at High NF and Low NF rates. Level of care determinations are performed by the medical assistance division's utilization review contractor.

After the final counties were brought into CoLTS, there have been conflicting reports of how the system was being implemented. According to New Mexico's Department of Human Services, all rates are being negotiated with the MCOs. According to the New Mexico skilled nursing providers, the MCOs were effectively reimbursing facilities their fiscal year 2008 rates from fiscal years 2008 to 2012. However, the actual rate each nursing facility receives is solely based on contractual negotiation between the facility and the MCO. These rates are not published or available to the public.

Members of the New Mexico Health Care Association (NMHCA) have also indicated that their accounts receivable have increased because of the MCOs' delays in processing payments. After the implementation of the managed care system, the state annually has its auditor (Myers and Stauffer) calculate what Medicaid rates would have been utilizing this system. However, Myers and Stauffer professionals have indicated that they no longer utilize the previous rate calculation. New calculated rates that they provide the MCOs are prior year rates increased by specific inflation rates provided by the states. Based on discussions with representatives of nursing facilities and their state association, it does not appear that the MCOs consider this data when determining Medicaid rates. However, it is currently unclear if the MCOs will utilize this methodology to determine Medicaid rates in the future.

The state is restructuring its managed care system effective January 1, 2014, which included new contracts with MCOs. The state's new system (Centennial Care) consolidated nine MCOs into three MCOs. These MCOs are Presbyterian Health Plan, Blue Cross and Blue Shield of NM and Western Sky Community Care. Under the new system the MCOs still have the authority to negotiate rates with nursing facilities. Rates paid by the MCOs are not published or available to the public.

Effective January 1, 2014, the state (with the assistance of the MCOs) changed the criteria utilized to determine if a resident is categorized as a “Low” or “High” acuity resident. According to the NMHCA, this resulted in a sharp decline in the number of

nursing facility residents in the state that were categorized as “High” acuity residents. NMHCA also estimates that this has resulted in a \$30 million loss in Medicaid reimbursement for nursing facilities. The state did implement additional changes to criteria (effective November 1, 2014) that was proposed to restore approximately five to ten million dollars of the lost funding. It is unclear if this legislation had an impact.

COST CENTERS

Prior to the implementation of the managed care system, New Mexico used the following two components to calculate its facility-specific Medicaid rates:

- The Operating cost component includes all operating costs including, but not limited to, dietary and nursing services, medical and surgical supplies, use of equipment and facilities, laundry and administration.
- The Facility cost component includes only depreciation, lease costs and long-term interest.

It is assumed that Myers and Stauffer still utilizes these cost centers when determining rates for the MCOs.

INFLATION AND REBASING

Prior to the implementation of the managed care system, reimbursement rates were rebased once every three years. The last rebasing occurred for the rate year July 1, 2007, to June 30, 2008. This rebasing utilized the most recent cost report data (varying based on a nursing facility’s fiscal year end). During non-rebasing years, rates can be inflated subject to budget availability and the discretion of the Department of Human Services.

As dictated by state regulations, the inflation factor is based on the CMS Market Basket Index (MBI) or a percentage up to the MBI. However, the inflation rate is dependent on state appropriations. For the 2006-2007 rate year, the inflation factor was only 1.0%, while the 2005-2006 rate year’s inflation factor was only 2.7%. Given budgetary restraints, nursing facilities were reimbursed their un-inflated fiscal year 2008 rates in fiscal year 2009. A limited number of nursing facilities received small rate increases in fiscal year 2010. No rate increases were applied to Medicaid rates in fiscal years 2011 and 2012. However, due to significant lobbying efforts from the New Mexico Health Care Association, the state mandated that the MCOs provide nursing facilities with an 11.2% rate increase effective July 1, 2012. This rate increase was reimbursed as an add-on to nursing facility rates last effective June 30, 2012. Unless individual facilities were able to negotiate an increased rate from the MCOs, nursing facility rates remained frozen at July 1, 2012, levels until July 1, 2014. Effective July 1, 2014, the state increased nursing facility rates 3.65%. This increase is also reimbursed as a direct pass-through/add-on and it did not require the state to rebase rates. Low Rates were last increased 4.0% on July 1, 2015. The state most recently increased calculated nursing home rates 2.7% effective January 1, 2018 and 7.84% effective July 1, 2018. It is currently unclear if these rate increases were passed on to nursing facilities or was just utilized by Myers and Stauffer to determine new rates for the MCOs. However, in the past, the some MCOs have utilized rates determined by Myers

and Stauffer as minimum rates of nursing facilities.

The development of the surcharge will result in an increase in Medicaid funding; however, it is currently unclear how that will translate to increases in nursing facility Medicaid rates.

RATE METHODOLOGY

As previously stated, the state no longer utilizes a rate calculation to determine nursing facility rates. This includes those rates calculated by Myers and Stauffer and then sent to the MCOs. Given this factor, no rate analysis section was included in this overview.

Since the nursing facility fiscal year 2008 rates have essentially been frozen since the last rebase, the High NF and Low NF rates for fiscal year 2008 remained relatively unchanged until the 11.2% rate increase effective July 1, 2012. The MCOs continue to pay nursing facilities separate High NF and Low NF rates. The average Low and High NF rates effective July 1, 2012, were \$160.50 and \$251.46, respectively. Given that rates remained frozen through fiscal year 2014 (July 1, 2013, to June 30, 2014), the average rate did not change. No estimates of average rates have been available since this period. However, Myers and Stauffer fee-for-service high rates did increase 3.65% effective July 1, 2014, 2.7% effective January 1, 2018, and 7.84% effective July 1, 2018.

OTHER RATE PROVISIONS

For newly constructed facilities, the provider’s interim prospective per diem rate is the sum of the applicable Facility cost ceiling and the Operating cost ceiling. After six months of operation or at the provider’s fiscal year end, whichever comes later, the provider submits a completed cost report. The report is audited to determine the actual operating and facility cost, and retroactive settlement takes place. The provider’s prospective per diem rate is the sum of the lower of allowable facility costs or the applicable Facility cost ceiling and the lower of allowable operating costs or the Operating cost ceiling. These providers are not eligible for incentive payments until the next rebasing year.

When a change of ownership occurs, the provider’s prospective per diem rate is the sum of the lower of allowable facility costs, or the Facility cost ceiling and the Operating cost established for the previous owner/operator, or the median of operating costs for its category, whichever is higher. These providers are not eligible for incentive payments until the next rebasing year.

When a replaced facility re-enters the Medicaid program either under the same ownership that existed prior to the replacement or under different ownership, facility costs per day are limited to the lower of actual allowable facility costs or the median of facility costs for all other existing facilities in the same category.

When Medicaid payment is made to reserve a bed while the resident is absent from the facility (bed hold), the reserve bed day payment is equal to 50% of the regular payment rate. Medicaid will reimburse nursing facilities up to six days per

calendar year for a resident requiring hospitalization. Medicaid will also cover three bed hold days per calendar year for home visits. However, if it is determined as part of the resident's discharge plan that a resident will require additional days absent from the nursing facility to adjust to a new environment, the state will reimburse nursing facilities for up to six additional days.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, there are no significant changes planned in the near future regarding how the state and the MCOs determine Medicaid rates. However, as previously mentioned,

the state has approved the development of a quality assessment fee that will be known as Health Care Quality Surcharge. The state is still awaiting CMS approval of the surcharge prior to finalizing the methodology for the fee. The surcharge also was supposed to be effective July 1, 2019. However, it is currently unclear when the surcharge will be implemented and what impact it will have on New Mexico nursing homes.

NEW MEXICO COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	65.00	66.00	66.00		100.00	100.00	100.00		120.00	120.00	120.00
Average Daily Census	56.74	59.45	58.66		86.46	89.86	88.40		104.85	101.52	100.59
Occupancy	73.2%	75.5%	74.0%		82.6%	83.3%	83.4%		89.7%	89.3%	89.4%
Payor Mix Statistics											
Medicare	7.8%	6.8%	6.4%		11.0%	10.8%	10.6%		15.0%	14.0%	14.1%
Medicaid	62.1%	63.6%	63.1%		74.0%	73.7%	71.6%		79.6%	82.5%	78.6%
Other	9.3%	8.8%	11.0%		14.6%	14.1%	16.4%		28.2%	26.0%	26.5%
Avg. Length of Stay Statistics (Days)											
Medicare	31.67	27.62	24.49		37.07	35.66	33.85		48.12	46.82	45.51
Medicaid	227.37	227.59	214.58		321.68	299.10	268.25		430.22	414.57	332.09
Other	43.00	30.07	32.56		63.05	56.04	53.73		135.83	117.29	95.66
Revenue (PPD)											
Inpatient	\$198.16	\$200.67	\$210.41		\$222.10	\$225.82	\$232.81		\$251.64	\$252.62	\$259.11
Ancillary	\$55.38	\$52.90	\$55.86		\$90.62	\$75.00	\$76.83		\$126.87	\$121.67	\$130.28
TOTAL	\$275.20	\$261.46	\$269.91		\$342.13	\$323.86	\$336.56		\$396.94	\$382.69	\$381.17
Expenses (PPD)											
Employee Benefits	\$13.81	\$13.31	\$12.42		\$17.46	\$16.12	\$15.41		\$20.87	\$19.40	\$17.65
Administrative and General	\$44.08	\$40.20	\$44.46		\$54.45	\$53.27	\$56.69		\$62.37	\$59.19	\$61.72
Plant Operations	\$7.84	\$7.56	\$7.56		\$8.95	\$8.46	\$9.05		\$13.46	\$10.50	\$11.16
Laundry & Linens	\$2.16	\$2.20	\$2.18		\$2.77	\$3.23	\$3.31		\$3.84	\$4.05	\$4.17
Housekeeping	\$3.89	\$3.92	\$4.03		\$4.72	\$4.46	\$4.58		\$5.91	\$5.35	\$5.87
Dietary	\$14.21	\$14.19	\$14.70		\$15.77	\$15.55	\$16.30		\$18.86	\$18.61	\$18.84
Nursing & Medical Related	\$75.21	\$76.98	\$81.03		\$79.22	\$85.63	\$90.16		\$88.25	\$92.41	\$98.28
Ancillary and Pharmacy	\$22.98	\$22.43	\$25.47		\$29.68	\$30.92	\$31.07		\$34.12	\$35.59	\$36.28
Social Services	\$2.11	\$2.12	\$2.11		\$3.17	\$3.21	\$3.21		\$4.46	\$4.86	\$5.08

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

New York



INTRODUCTION

Nursing facilities in New York are licensed by the New York Department of Health's Bureau of Project Management under the designation of "Residential Health Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NEW YORK	
Licensed Nursing Facilities*	582
Licensed Nursing Beds*	106,271
Beds per 1,000 Aged 65 >**	33.71
Beds per 1,000 Aged 75 >**	79.63
Occupancy Percentage - 2017*	93.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

New York State maintains a Certificate of Need (CON) program, which is administered by the New York Department of Health's Bureau of Project Management – Division of Health Facility Planning. CON applications are reviewed based on the following criteria: public need; financial feasibility; character and competence; and construction.

Specifically, a full CON review is required for the following scenarios:

- Any addition of nursing facility beds (regardless of cost).
- A change in the method of the delivery of services at a nursing facility.
- A construction/renovation project over \$25,000,000.
- Purchases of major medical equipment. The purchase of replacement equipment costing less than \$25,000,000 does not require a CON review.
- Change in ownership of a nursing facility.
- The construction of a new nursing facility, including the construction of a replacement facility.
- The addition of any highly specialized services.

Proposals for any construction/renovation projects less than \$15,000,000 are eligible for an administrative review. Also any construction/renovation projects or purchases of major medical equipment greater than \$15,000,000 are eligible for an administrative review if not resulting in a change in clinical service or space. A limited CON review is required for construction/renovation projects less than \$6,000,000 and the decertification of licensed beds. New York does not possess a moratorium on the construction of new nursing facility beds.

BED NEED METHODOLOGY

New York utilizes a bed need methodology when considering CON applications. Gross bed need is calculated for each county by multiplying age-specific statewide use rates by the aged 0 to 64 and aged 65 and older populations in each county for the planning target year. Statewide use rates are determined by dividing the total number of individuals served by residential healthcare facilities (categorized by age cohort) in the base year by the base year population cohorts. The product of these

calculations are summed to determine total gross bed need. For the most recent bed need methodology, the base year utilized was 2016 and the planning target year was 2016. Gross bed need by county is compared to the total inventory of nursing county beds in the county to determine if there is need for additional nursing facility beds in the county. Based on the state's methodology, it is estimated that the state will possess a shortage of 16,416 beds in 2016. Approximately 37 counties, the Nassau-Suffolk area and New York City demonstrated bed need. In particular, New York City is projected to have a new demand for 9,778 beds by 2016.

QUALITY ASSURANCE FEE

New York assesses nursing facility providers in the state a quality assurance fee called an assessment fee, effective as of 2002. The assessment fee is calculated as 6% of total non-Medicare cash receipts. Effective April 1, 2011, the state increased the assessment fee by 0.8% as an alternative to implementing a 2.0% rate reduction. This increase was effective until March 31, 2013. In addition, the state implemented a "temporary nursing home stability contribution," effective the same date. This contribution equated to an additional 0.4% assessment fee, which, combined with current assessment fee, equates to a total assessment fee of 7.2%. The 0.4% temporary assessment fee was effective until March 31, 2012, and decreased to 0.2%, effective April 1, 2012, and was eliminated on November 1, 2012. Federal law mandates that states reduce their maximum quality assurance fee to 6.0% of total cash receipts. Since 7.2% (and 6.8%) of non-Medicare cash receipts is less than 6.0% of total revenues, New York complies with the federal limits. The Centers for Medicare and Medicaid (CMS) approved the implementation of these temporary changes.

As previously mentioned, the 0.8% temporary increase in the quality assessment fee was scheduled to terminate on March 31, 2014. This did not occur and the state is still utilizing the 6.8% assessment. In addition, the temporary increase will be maintained to fund the Universal Settlement Agreement, which will be paid out until March 31, 2020. This agreement will be detailed further in the rate methodology section of this report.

Nursing facilities are reimbursed the approximate Medicaid portion of total assessment fees. The total assessment fees a nursing facility pays for the prior year are divided by the total non-Medicare patient days for the same period. Nursing facilities are reimbursed this per diem amount per Medicaid day as an add-on to their Medicaid rates.

MEDICAID RATE CALCULATION SYSTEM

Effective January 1, 2012, New York State converted to a price-based, facility-specific, case mix adjusted reimbursement system. Prior to this date, the state utilized a prospective, facility-specific, case mix adjusted, modified pricing system, which incorporated the principles of both a pure pricing system and a cost-based system. The former system was phased in on April 1, 2009. This was delayed from January 1, 2009, the originally scheduled phase-in date.

Non-specialty nursing facilities transitioned to the cost over a five-year period (2012 to 2016). This analysis will focus on the reimbursement system that was implemented on January 1, 2012.

COST CENTERS

New York State utilizes the following four cost centers to calculate its facility-specific Medicaid rates:

- **The Direct** cost component includes nursing administration, activities, social services, transportation, physical therapy, occupational therapy, speech therapy, central service supply and residential healthcare facility.
- **The Indirect** cost component includes fiscal services, administrative services, plant operations and maintenance, grounds, security, laundry and linen, housekeeping, patient food services, cafeteria, non-physician education, medical education, housing and medical records.
- **The Non-Comparable** cost component includes laboratory services, ECGs, EEGs, radiology, inhalation therapy, podiatry, dental, psychiatric, hearing therapy, medical director, medical staff services, utilization review, other ancillary, utilities, real estate taxes and non-prescription pharmacy.
- **The Capital** cost component includes depreciation, leases and rentals, interest on capital debt and/or major movable equipment, return of equity, return on equity, and any capital costs report in any other cost centers under the classification of depreciation, leases or rentals. These expenses are all direct pass-through expenses. Only for-profit facilities are reimbursable for return of equity and return on equity.

INFLATION AND REBASING

Under the old Medicaid rate calculation system (effective April 1, 2009), the state rebased the operating portion of Medicaid rates (Direct, Indirect and Non-Comparable Cost component rates) utilizing 2002 cost report data. Prior to that date, the state had not rebased rates for several years, and rates had been calculated utilizing 1983 cost report data. However, Capital cost component rates were rebased annually utilizing expense data from the period two years prior to the rate period.

The new non-capital prices/rates effective January 1, 2012, were calculated utilizing 2007 cost report data. Medicaid rates were not rebased during the phase in (January 1, 2012, to December 31, 2016). During the transition, Direct and Indirect prices were only altered by case mix adjustments (Direct only) and changes in allowable cost adjustments. Non-comparable rates remained unchanged during the transition period. Under the current system, Capital cost component rates continue to be rebased annually utilizing costs from two years prior to the rate effective date.

The effective rate period in New York is from January 1 to December 31. Allowable costs are inflated from the cost report period to the rate period utilizing a roll factor. The roll factor is the cumulative result of multiplying one year's trend (inflation) factor by one or more other years' trend factor(s), which is used to inflate costs from a base period to a rate period. Based on state regulations, the trend factors are determined utilizing the Consumer Price

Index (CPI) for All Urban Consumers as published by the U.S. Department of Labor, Bureau of Statistics. New York State adjusts Medicaid rates quarterly for nursing facility's CMI. However, no trend factor was applied to the cost utilized to determine rates since January 1, 2012.

In addition to inflation, allowable direct and indirect costs are adjusted by wage equalization factors (WEFs), which neutralize the differences in wage and fringe benefit costs between and among the regions caused by differences in the wage scale of each level of employee. New York determines WEFs for 16 regions of the state. WEFs are based on regional wage differences for each region relative to such variations for all other regions. The state has adjusted Medicaid rates for updated WEFs periodically in the past. However, effective January 1, 2012, the direct and indirect prices are adjusted by a blended WEF that will be a weighted average that equates to 50% of a facility-specific WEF and 50% of a regional WEF. The WEFs utilized to calculate January 1, 2012, Medicaid rates were based on 2009 cost report data. The WEFs were not recalculated during the transition period or for rates effective January 1, 2017, January 1, 2018, and January 1, 2019.

Both facility-specific and regional Direct and Indirect WEFs are calculated utilizing the following formula:

$$1 / ((\text{Facility-Specific (or Regional) Wage Ratio} / \text{Facility-Specific (or Regional) Wage Index}) + \text{Facility-Specific (or Regional) Non-Wage Ratio})$$

For facility-specific and regional Direct and Indirect WEFs, the Wage Ratio is calculated by dividing the sum of total salaries and fringe benefits related to these cost components by total operating expenses from these cost components. The wage index for facility-specific and regional Direct and Indirect WEFs are determined by dividing facility-specific labor costs per hour by labor costs per hour for registered nurses (RNs), licensed practical nurses (LPNs), aides and orderlies, and therapists and therapist aides.

In the 2012-2013 budget, New York State indicated that the Department of Health had to make a \$40 million funding reduction to be generated by a reduction in bed hold reimbursement. However, only \$16 million of this goal will be achieved by reducing bed hold reimbursement. This will be further detailed in the Other Rate Provisions section of this overview. The department achieved the rest of this goal by implementing a per diem reduction effective January 1, 2013, to March 31, 2013. This reduction saved the state \$24 million in funding. This resulted in an approximate \$3.20 per day reduction over this period.

A separate rate reduction was applied on April 1, 2013, to March 31, 2014, which saved the state \$19 million in funding. This resulted in an approximate \$0.80 per day reduction over this period. For both rate adjustments, each facility's per diem reduction was calculated by multiplying the total funding reduction by the facility's percentage of total Medicaid days in the state. This data was derived from each facility's most recent cost report. Both of these reductions were applied after the stop/loss adjustment that will be detailed in the Rate Methodology section.

A slight bed hold per diem adjustment continues to be made as

part of the overall rate calculation. Effective January 1, 2017, the average reduction per nursing facility was \$0.62 per Medicaid day.

Effective January 1, 2013, New York was supposed to implement a Quality Pool Program, which was proposed to be partially funded through a small rate reduction. The rate reduction reflected that nursing facilities could potentially receive additional reimbursement from the program through supplemental payments. However, this program was not implemented until 2018. The delay in the implementation of the program was the result of litigation against the state regarding this program.

Nursing facility non-Capital rates effective January 1, 2015, to December 31, 2015, January 1, 2016, to December 31, 2016, were not inflated or rebased. Any changes to the rates were predominantly the result of case mix adjustments. Effective January 1, 2017, the state has issued its first rates since the phase-in was completed. Non-capital rates were not rebased or inflated. With the exception of changes resulting from the end of the phase-in, case mix adjustments, or a small minimum wage adjustment effective January 1, 2017, (on average, \$0.26 per Medicaid day), these rates only moderately changed. In addition, the state did not rebase or inflate rates on January 1, 2018 and January 1, 2019. Therefore, with the exception of adjustment for case mix, nursing facility rates will remain relatively unchanged.

RATE METHODOLOGY

The operating portion of Medicaid rates in New York equates to the sum of the Direct, Indirect and Non-Comparable cost components. Direct and Indirect rates are price-based rates that equate to a blend of a statewide price and a peer group price. Non-Comparable rates are calculated as facility-specific rates.

For the purpose of determining Direct and Indirect cost component rates, New York state classifies nursing facilities into one of two peer groups as follows:

- All non-specialty hospital-based facilities and non-specialty freestanding facilities with certified beds of 300 or more; and
- All non-specialty hospital-based facilities and non-specialty freestanding facilities with certified beds of less than 300.

For the purpose of calculating prices, the state also refers to all facilities in the state as a separate peer group. As previously mentioned, Direct and Indirect prices will be adjusted by WEFs.

Both the Direct Care and Indirect Care prices for nursing facilities equate to 50% the statewide price and 50% of the appropriate peer group price. The peer group prices (including the statewide price) are calculated by dividing allowable costs for the specific peer group by the equivalent total patient days for the peer group and time period utilized. As previously mentioned, January 1, 2012, rates were calculated utilizing cost report data for 2007. Prices were not rebased during the phase in. However, prior to completing the above described calculation, allowable costs were reduced by the following percentage:

Effective Date	Allowable Cost Percentage Reduction
January 1, 2012	19.545660%
January 1, 2013	14.963800%
January 1, 2014	11.339480%
January 1, 2015	10.305120%
January 1, 2016	9.832500%
January 1, 2017	9.485290%

Given that these percentages are decreasing over time, it resulted in increases in both Direct and Indirect prices.

Direct Care prices also are subject to semi-annual adjustments for case mix, utilizing the RUG III, 53-Grouper system. RUG weights are adjusted to reflect New York State wage and fringe benefits and are based on Medicaid only patient data. Effective January 1, 2012, the case mix index (CMI) utilized to adjust Direct Care prices was calculated by dividing the facility-specific Medicaid only case mix calculated using data for January 2011 by the all-payor case mix for the base year 2007. The all-payor case mix is a blending of 50% of the CMI for all facilities and 50% of CMI for the applicable peer group. Subsequent case mix adjustments to be effective after January 1, 2012, were/are made on the July 1 and January 1 of each calendar year and use Medicaid-only case mix data applicable to the previous case mix period. For example, July 1, 2012, rates were based on January 2012 Medicaid-only case mix data. New York State also analyzes CMI increases from period to period. Specifically, if a nursing facility's CMI increases by more than 5.0% from the previous period, the state will audit that facility's CMI.

The Non-Comparable and Capital components of the Medicaid rate are based on a direct pass-through of allowable expenses. Total allowable inflated costs are divided by the facility's patient days (adjusted for a minimum occupancy requirement, if necessary) to determine the Non-Comparable and Capital cost component rates. The Non-Comparable and Capital components are not subject to any base or ceiling rates.

A nursing facility's rate is equal to the sum of the operating portion of the rate and the Capital component of the Medicaid rate, plus applicable add-ons. The state provides several rate add-ons. This includes bariatric, dementia/ and traumatic brain injury add-ons. A nursing facility can receive an \$8.00 per day add-on if a resident qualifies under both the RUG III impaired cognition and the behavioral health categories or has been diagnosed with Alzheimer's disease or dementia. The bariatric add-on will be \$17 for each patient whose body mass index is greater than 35. A per diem add-on of \$36 will be provided to nursing facilities for each patient requiring extended care for traumatic brain injuries. Effective January 1, 2019, the combined average add-on for these three facilities is \$2.85 per day.

During the transition period beginning January 1, 2012, and ending December 31, 2012, facilities were eligible for transitional rate adjustment based on the state's stop/loss program. Nursing facilities Medicaid rates (excluding rate add-ons) effective January 1, 2012, were not permitted to decrease or increase by more than 1.75% a nursing facility's July 7, 2011, rate. These

percentages increased to 2.5% in 2013 and 5.0% in 2014, and to 7.5% in 2016. The transition adjustment equated to the numerical rate adjustment required to fulfill the stop/loss provision.

Final Medicaid rates are also reduced for Medicare Part B offsets. Part B offset is based upon Part B fee screens. Prior to July 7, 2011, final Medicaid rates were also reduced for Medicare Part D offsets. However, given that pharmacy services are now reimbursed outside of the Medicaid rate on a fee-for-service basis, this adjustment is no longer required.

The average rate effective January 1, 2019 (\$246.98) is greater than the rate effective January 1, 2018 (\$240.34). Prior average rates are as follows: January 1, 2017 (\$234.59), January 1, 2016 (\$228.55), January 1, 2015 (\$220.86), January 1, 2014 (\$214.16), April 1, 2013 (\$210.96), January 1, 2013 (\$208.60) and January 1, 2012 (\$204.73). The above data displays a consistent trend of nursing facility rates increasing in the state.

MINIMUM OCCUPANCY STANDARDS

Nursing facilities older than five years are subject to a minimum occupancy requirement. The per diem costs for Non-Comparable and Capital cost components are calculated utilizing the greater of the facility's actual patient days or 90.0% of the facility's allowable patient days.

OTHER RATE PROVISIONS

New York State began the conversion of specific counties to a Medicaid managed care reimbursement system effective October 1, 2013. The complete conversion of the state has since been completed. Although the managed care plans can negotiate nursing facility rates, nursing facilities are guaranteed that their rates do not fall below their current fee-for-service rates calculated by the state. This arrangement was scheduled to end in mid-2018. However, according to representatives of the New York State Health Facilities Association (NYSHFA), this condition was extended to March 31, 2020.

As previously mentioned, New York State was initially going to be implementing a Quality Pool program effective January 1, 2013; however, implementation of this system did not occur until late 2018.

This program consists of a pool of \$50 million per year in quality payments. The pool is funded by the nursing facilities in the state utilizing the following calculation:

((The facility effective Medicaid rate for the applicable year)*(total Medicaid days for the applicable year))/Statewide Medicaid Nursing Home Revenue for the applicable year

The next step in the quality pool process is to score nursing homes into one of five quintiles based on a point system that includes three categories: a quality component, a compliance component and an efficiency component. The analysis is based on CMS data for the year prior to the effective rate year.

The Quality Measures include 14 categories that all are worth a maximum of five points (for a total of 70 points) as follows: percentage of contract/agency staff; staffing hours per day; percentage of employees vaccinated for influenza; percentage of long-stay residents with pressure ulcers; percentage of long stay residents who received the pneumococcal vaccine; percentage of long stay residents who received the seasonal influenza vaccine; percentage of long stay residents experiencing one or more falls with major injury; percentage of long stay residents who have depressive symptoms; percent of long stay low risk residents who lose control of their bowel or bladder; percent of long stay residents who lose too much weight; percentage of long stay residents with dementia who received an antipsychotic medication; percentage of long stay residents who self-report moderate to severe pain; percentage of long stay residents whose need for help with daily activities has increased; and percentage of long stay residents with a urinary tract infection.

The Compliance Component (20 Points) includes the CMS Five-Star Quality Rating for Health Inspections (regionally adjusted), timely submission of employee influenza vaccination data and timely submission of certified and complete nursing home cost reports. The Efficiency Component (ten points) includes data on preventable hospitalizations.

Once the facilities are ranked for the above categories, they are assigned a final quintile and are awarded their share of the \$50 million by first determining the award amounts as follows:

- Quartile 1 Facilities = Facility Medicaid Revenue for the applicable year * 3.0
- Quartile 2 Facilities = Facility Medicaid Revenue for the applicable year * 2.25
- Quartile 3 Facilities = Facility Medicaid Revenue for the applicable year * 1.5
- Quartile 4 and 5 = Receive no reward.

In addition, facilities that receive a J/K/L Health Inspection Deficiency receive no reward.

Once the facility specific award is determined, each facilities share of the \$50 million is determined as follows:

Facility Specific Award / Total Statewide Awards * \$50,000,000.

Given that all facilities (with limited exceptions for specialized facilities) contribute to the pool of funds, there are winners and losers in the program. Specifically, losers would be facilities that contributed the pool, but received no rewards. Given the previously mentioned delays in implemented the program, in 2018 nursing facilities were retroactively paid (or charged) for quality pool payments for 2013 through 2017. For 2017, only 45.9% of nursing facilities received a net positive (Facility Specific Award > Facility Specific Contribution) for an average net payment of \$57,679. The remaining facilities (54.1%) received an average net loss of \$68,562. Payments in 2019 will be based on 2018 data.

In addition to the above rates, nursing homes are also eligible for supplemental payments related to the previously mentioned

Universal Settlement Agreement effective January 1, 2016. An agreement was reached between the state and nursing facilities to settle all appeals of nursing facility rates prior to 2012. The settlement resulted in nursing facilities receiving \$850 million in additional reimbursement over a five-year period (\$150 million per year). The final payment for the settlement is due by March 31, 2020. NYSHFA estimated that the average annual reimbursement is \$240,000 per facility.

In addition, beginning in 2018 nursing facilities are eligible for additional supplemental payments as part of a one percent rate cut restoration. This essentially is the repayment of a previous 2.0% rate reduction that occurred in 2013 and 2014. Half of this reduction (1.0%) is utilized to partially fund the Universal Settlement. The remaining 1.0% is reimbursed to nursing homes via this supplemental payment. Nursing facilities will receive a combined total of \$560 million in additional reimbursement (as supplemental payments), that will be paid out at \$140 million per year for the first four years. However, this reflects that nursing homes will be receiving payments retroactively for previous periods, which will result in the total reimbursement of \$140 million in each of the first four years. In 2022/2023, reimbursement will be based on only one year of data and will total \$70 million.

The first step in the calculation is to determine the facility's Medicaid revenue for the period utilized to determine the supplemental. This is accomplished by multiplying the facility's Medicaid rate for the period by the facility's total Medicaid days for the same period. This amount is then divided by total Medicaid nursing home reimbursement. The factor of this calculation is multiplied by the allowable pool of funds to determine the facility-specific supplemental payment. In 2018/2019, the average payment received by nursing facilities was \$204,678. However, this includes two years of payment (one retroactive). Assuming \$70 million in funding per year, the average per year is \$102,339.

The appointment of a receiver or the establishment of a new operator or replacement or renovation of an existing facility on or after January 1, 2012, will not result in a revision to the operating component of the price.

Nursing facilities in New York are eligible for Medicaid reimbursement for holding a bed for a resident requiring therapeutic leave. However, the state recently (May 2019) eliminated bed hold reimbursement for hospitalization.

Prior to this decision, payments for a reserved bed related to a hospitalization are made at 50.0% of a facility's Medicaid rate (effective July 1, 2012). Payment for a reserved bed related to a non-hospitalization remained at 95.0% of a facility's Medicaid rate. To achieve any reimbursement, a facility must possess an occupancy level greater than 95.0% as of when the resident was first absent from the facility. Bed hold reimbursement for a non-hospitalization or eligible therapeutic leave may not exceed 10 days in any 12-month period.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Recently the state submitted a state plan amendment to the Centers for Medicare and Medicaid (CMS) that proposes to alter how the state adjusts nursing facility rates for case mix. These changes would be retroactive effective July 1, 2019. The state currently adjusts rates semiannually for case mix, on January 1 and July 1 of the rate year, utilizing the CMI for the facilities' Medicaid residents on one specific "snapshot" data in January and July, respectively. However, the state is proposing to utilize Medicaid CMI data from the period of August 8, 2018 to March 31, 2019 to adjust rates. The state estimates that this will result in an approximate \$246 million reduction in nursing home reimbursement. All of the major healthcare associations in the state are opposed to this legislation and are currently lobbying to both CMS and the state legislature not to implement these changes. If CMS does approve the amendment and the state chooses to implement it, it could result in legal challenges. As of the date of this overview, it is currently unclear if this new system will be implemented. The issuing of rates effective July 1, 2019 will be delayed until this issue is resolved.

In addition, as previously mentioned, the Universal Settlement is set to end in 2020. However, it is the goal of nursing facility providers to have the funds for the settlement dedicated to nursing home reimbursement in the future.

NEW YORK COST REPORT STATISTICS									
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Number of Beds	120.00	120.00	120.00	176.00	180.00	163.50	240.00	242.50	240.00
Average Daily Census	110.44	109.21	108.87	167.05	166.84	154.50	227.88	228.74	225.09
Occupancy	90.2%	90.2%	90.5%	94.1%	94.1%	94.0%	96.2%	96.4%	96.4%
Payor Mix Statistics									
Medicare	6.6%	6.2%	5.3%	10.8%	10.8%	9.1%	15.9%	16.6%	15.1%
Medicaid	62.4%	56.7%	48.4%	71.8%	64.7%	57.6%	80.3%	74.0%	67.9%
Other	11.0%	15.4%	21.2%	15.6%	22.4%	30.5%	22.4%	29.7%	40.1%
Avg. Length of Stay Statistics (Days)									
Medicare	36.77	35.70	33.30	43.77	42.85	42.70	58.25	57.49	57.92
Medicaid	288.72	289.22	298.54	418.30	415.45	435.37	675.55	649.13	675.78
Other	55.67	71.42	85.91	81.56	111.48	133.41	153.81	185.95	206.75
Revenue (PPD)									
Inpatient	\$298.98	\$310.31	\$317.69	\$361.42	\$375.97	\$377.82	\$434.03	\$449.12	\$450.40
Ancillary	\$3.63	\$5.38	\$7.20	\$15.57	\$19.88	\$16.82	\$44.54	\$47.26	\$47.54
TOTAL	\$310.48	\$325.18	\$330.58	\$373.64	\$389.16	\$389.95	\$449.55	\$466.71	\$473.72
Expenses (PPD)									
Employee Benefits	\$29.85	\$29.37	\$29.12	\$41.99	\$42.89	\$42.36	\$56.77	\$57.56	\$57.69
Administrative and General	\$42.93	\$44.77	\$46.71	\$51.11	\$53.58	\$56.00	\$60.83	\$65.70	\$67.27
Plant Operations	\$10.84	\$10.67	\$10.40	\$12.95	\$12.95	\$13.14	\$16.57	\$16.64	\$16.84
Laundry & Linens	\$2.75	\$3.18	\$3.22	\$3.60	\$4.04	\$4.09	\$4.67	\$4.97	\$5.02
Housekeeping	\$6.52	\$6.75	\$6.81	\$8.86	\$9.03	\$8.90	\$11.16	\$11.36	\$11.23
Dietary	\$19.73	\$19.94	\$20.30	\$23.03	\$22.98	\$22.97	\$27.76	\$27.59	\$27.50
Nursing & Medical Related	\$89.16	\$91.28	\$93.09	\$101.97	\$104.09	\$105.84	\$117.59	\$119.26	\$121.94
Ancillary and Pharmacy	\$17.79	\$19.45	\$19.86	\$25.26	\$26.48	\$27.53	\$34.71	\$36.76	\$36.35
Social Services	\$2.77	\$2.94	\$2.86	\$3.96	\$4.10	\$3.90	\$5.54	\$5.84	\$5.78

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

North Carolina



INTRODUCTION

Nursing facilities in North Carolina are licensed by the North Carolina Department of Health and Human Services, Division of Health Service Regulation under the designation of "Nursing Care Home." In North Carolina, nursing homes may also be licensed as combination homes, which contain both adult care beds and nursing home beds within one facility. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN NORTH CAROLINA	
Licensed Nursing Facilities*	439
Licensed Nursing Beds*	46,447
Beds per 1,000 Aged 65 >**	27.96
Beds per 1,000 Aged 75 >**	71.37
Occupancy Percentage - 2017*	79.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

In North Carolina, the Certificate of Need (CON) program was implemented in 1978 to prohibit healthcare providers without the prior approval of the Department of Health and Human Services (the Department) from acquiring, replacing or adding to facilities and equipment. The basic principle of the CON is to control increasing healthcare costs caused by the unnecessary duplication of medical facilities.

In North Carolina, a CON is required for the following:

- Establishment of a new nursing facility (including the development of a replacement facility).
- Any capital expenditure in excess of \$2,000,000.
- Change in bed capacity.
- The relocation of beds from one facility to another facility at a different location.
- Change in project that includes cost overrun of 15% of the capital expenditure amount of an approved CON project or addition of a health service to an approved project.
- The acquisition of major medical equipment in excess of \$750,000 (including costs of studies, design, construction, renovation and installation).

In addition, a CON may be required if an existing nursing home requests to change or expand its existing services. Exemptions to the CON process are handled by the Department on a case-by-case basis.

Continuing care retirement communities (CCRCs) are exempt from need determinations for beds, but must file CON applications. In addition, a CCRC must demonstrate that its current and future non-skilled nursing residents will need skilled nursing services as they age in place.

There is no moratorium on the construction of new beds in North Carolina. In addition, there are no proposed changes to the CON program. The North Carolina State Facilities Medical Plan methodology projects very little additional need based on declining utilization.

BED NEED METHODOLOGY

North Carolina utilizes a bed need methodology to review CON applications. The calculation encompasses a three-year planning horizon and determines nursing home bed need based on bed-to-population ratios.

Effective fiscal year 2017, the state altered its bed need methodology. Prior to 2017, a county's projected bed utilization was calculated by multiplying standard age-specific use rates by each county's projected age-specific civilian population (in thousands) for the target year, and then adding the products of the four age-specific projections of beds. However, now one use rate (no age group) is calculated specifically for each county based the calculated beds per 1,000 population per county. Each county bed rate is calculated using a five-year annual change projected forward for 36 months.

The specific county bed use rate is multiplied by each county's projected civilian population for the target year (currently 2022) to calculate bed utilization. This amount is then divided by a 95.0% vacancy factor to calculate gross bed need.

A county's bed need is then determined by subtracting the planned inventory from the projected bed utilization. Planning inventories are determined based on licensed beds adjusted for CON approved/license pending beds, available beds that have not been CON approved and beds excluded for the following reasons:

- Specialty care units (beds converted to care for head injuries or ventilator-dependent patients).
- Beds occupied by out-of-area patients served by facilities operated by religious or fraternal organizations.
- Nursing home beds transferred from state psychiatric hospitals.
- One hundred percent of the qualified nursing home beds in continuing care retirement communities (CCRCs).

For each county, the most current planning inventory estimate is subtracted from the projected bed need that results in either a deficit or surplus of beds. When the average occupancy of licensed beds in a county, excluding CCRCs, is 90% or greater based on utilization data, the need determination is 90 beds for a county with a deficit of 71 to 90 beds. For counties with an average occupancy of licensed beds (excluding CCRCs) of 90% or greater, a deficit of 91 or more beds or a deficit of 10% or more of its total projected need, the need determination is the deficit rounded to 10. The maximum need determination for each county is 150 beds.

Based on the above calculation, there are no counties in the state that are projected to possess nursing home bed need in 2022. In addition, the proposed 2020 State Medical Facilities Plan (SMFP) projects no population-based need for nursing home beds in 2023.

QUALITY ASSESSMENT FEE

In North Carolina, the provider fee is referred to as a nursing home assessment fee. The fee was established on October 1, 2003. The current fee (effective April 1, 2012) is \$13.68 for facilities with fewer than 48,000 bed days, which represents a \$0.93 increase from the prior rate (effective October 1, 2010). The fee effective October 1, 2010, (\$12.75) represents a \$1.25 increase from the previously utilized fee. The increase enabled the state to reduce the rate cut for fiscal year 2010 rates. This will be discussed in the

upcoming Inflation and Rebasing section.

The current fee (effective April 1, 2012,) is \$7.18 for facilities with 48,000 or more bed days, which represents a \$0.93 increase from the prior rate (effective October 1, 2010). The fee effective October 1, 2010 (\$6.25), represents a \$1.25 increase from the previously utilized fee. A nursing facility's total bed days are used to determine which category applies to a nursing facility. However, nursing facilities only pay the assessment fee on non-Medicare days.

CCRCs are exempt from paying the assessment fee. Nursing facilities are reimbursed their applicable nursing home assessment fee per Medicaid day as an add-on to the Medicaid rate.

MEDICAID RATE CALCULATION SYSTEM

North Carolina uses a prospective, price-based, facility-specific case mix adjusted rate setting methodology to calculate the Direct Care and Indirect rates. North Carolina converted to a fair rental value (FRV) system to reimburse nursing facilities for property related expenses. The FRV system provides a payment in lieu of reimbursement for property related expenses such as depreciation, interest, rent and/or lease payments on property, plant and equipment, working capital interest, all other interest, and equipment depreciation and/or lease payments.

COST CENTERS

The Direct Care cost component is comprised of two parts: case mix adjusted costs and non-case mix adjusted costs.

Case mix adjusted costs include:

- Registered nurse (RN), licensed practical nurse (LPN) and nurse aide wages and related payroll taxes and benefits.
- Direct allowable cost of contracted services for RN, LPN and nurse aide staff.

Non-case mix adjusted costs include:

- Nursing supplies.
- Dietary or food services.
- Patient activities.
- Social services.
- Direct or proportionate allocation of allowable payroll taxes and employee benefits.
- Medicaid cost of direct ancillary service.

The Indirect cost component includes costs associated with administrative and general, laundry and linen, housekeeping, operation and plant and maintenance/non-capital, and Medicaid cost of indirect ancillary services.

The Capital cost component utilizes an FRV system to determine facility-specific reimbursement rates for property and related costs. This payment covers costs related to land, land improvements, renovations, repairs, building and fixed equipment, major moveable equipment and any other capital related costs. The payment made under this methodology will be the only payment for capital related costs, and no separate payment will be made for depreciation or interest expense, lease costs, property taxes,

insurance or other capital related costs.

INFLATION AND REBASING

The rate year in North Carolina is from October 1 to September 30. There is no required rebasing frequency in North Carolina and the state last rebased rates effective October 1, 2008. Prior to this rebasing, rates were half rebased on January 1, 2008. Half of the January 1, 2008, rate was calculated utilizing 2001 cost report data and the other half was calculated utilizing 2005 cost report data. The state did not rebase rates for the fiscal years 2010 to 2016 rate periods.

Nursing facility rates are determined quarterly for each facility. FRV rates will be effective from April 1 to March 31. In the state's regulations, it indicates that if Direct Care and Indirect costs/rates are inflated, it is done utilizing the Skilled Nursing Facility Market Basket Without Capital Index published by Global Insight. However, the state is not required to inflate costs/rates.

Prior to the most recent rebase, rates had not been inflated since January 17, 2005, due to the lack of state funding. Allowable costs utilized to calculate rates effective October 1, 2008, were supposed to be indexed from the midpoint of the 2005 cost report year to the midpoint of the 2008 cost report year. However, given budgetary issues, the state did not apply any inflation adjustments. According to the North Carolina Health Care Facilities Association, this only had a limited impact on reimbursement due to the rebasing.

No inflation adjustment is applied to fiscal year 2010 rates. For rates initially determined effective October 1, 2009, the state reduced rates by 6.3% and the Direct Care ceiling price was reduced from 103.5% to 102.6%. However, by increasing the nursing home assessment fee, the state was able to reduce the rate cut. The state reissued Medicaid rates effective October 1, 2009, without the rate cut, but with the reduction of the ceiling. However, rates effective November 1, 2009, were reduced 1.3%. Effective January 1, 2011, the state increased the Direct Care and Indirect cost components by 2.3%.

During fiscal year 2012 (July 1, 2011, to June 30, 2012) North Carolina implemented various rate reductions that resulted in an annual weighted average non-capital rate reduction of 2.17%. This included a 3.51% rate reduction from September 1, 2011, to March 31, 2012, and a 3.13% rate reduction from April 1, 2012, to June 30, 2012. Effective July 1, 2012, to December 31, 2014, the state reimbursed nursing facilities their July 1, 2011, rates, minus the 2.17% non-capital rate reduction.

Effective January 1, 2014, the state reduced non-capital rates 3.0%. This reflects that the state was facing a \$120 million Medicaid shortfall. With the exception of case mix adjustments, the state did not alter non-capital rates until June 1, 2015. Effective June 1, 2015, the state back-filled the previous 3.0% rate reduction. With the exception of case mix adjustments, these rates remained frozen until October 1, 2016.

As part of the state's "Restore our Rates Program", the state effectively increased nursing facility rates by back-filling the previous 1.3% and 2.17% rate reductions. The state also increased

rates by increasing the percentage utilized to determine the statewide Direct Care ceiling/price from 102.6% of the median cost to 105.0% of the median cost. In addition, the state inflated non-capital rates by approximately 2.77% on October 1, 2017, and again by 2.73% on October 1, 2018, utilizing the abovementioned Global Insight index. As of the date of this overview, North Carolina does not possess a finalized budget. Therefore, it is currently unclear how (or if) that state will inflate rates effective October 1, 2019.

The FRV payment is determined on April 1 of each year utilizing the data available from the Capital Data Surveys as of the previous September 30. Capital Data Surveys will be submitted annually with each year's cost reports. The most recently available cost report data is utilized to calculate the FRV. In addition, the total building replacement cost utilized to calculate FRV rates is based on the 2007 RS Means Historical Cost Factor, which is inflated annually by the RS Means Historical Cost Index Factor. However, for FRV rates effective April 1, 2015, the state did not provide an inflation adjustment to the historical cost factor. In addition, the state did apply an additional year of depreciation, which without the offsetting inflation adjustments resulted in slight decreases in FRV rates for several facilities. However, this was partially done because the state did not apply any adjustments for depreciation on April 1, 2014.

No inflation was applied to the historical cost factor that was being utilized to determine April 1, 2016, FRV rates. However, the state did provide inflation adjustments (based on the RS Means Cost Index Factor) to the historical cost factor utilized to determine FRV rates on April 1, 2017, April 1, 2018 and April 1, 2019.

The state also froze case mix adjustments effective January 1, 2015. This freeze remained in place until October 1, 2016, when the state resumed adjusting rates quarterly for case mix

RATE METHODOLOGY

The following methodology is utilized by the state when rebasing rates. However, given that state has not rebased rates since October 1, 2008, portions of this rate methodology have not been utilized in several years. The Resource Utilization Groups III (RUG-III) Version 5.12b, 34-group, index maximizer model is used as the resident classification system to determine all case mix indices, using data from the minimum data sets (MDS) submitted by each facility. The case mix indices are the basis for calculating facility average case mix indices to be used in determining the facility's Direct Care rate.

The per diem Case Mix Adjusted cost is determined by dividing the facility's Case Mix Adjusted base year cost by the facility's total base year inpatient days, trended forward using the above referred index factor (if funding is available). A per diem neutralized Case Mix Adjusted cost is then calculated by dividing each facility's Case Mix Adjusted per diem cost by the facility cost report period case mix index (CMI), which is the resident-weighted average of quarterly facility-wide average CMIs. The quarters used in this average are the quarters that most closely coincide with the facility's base year cost reporting period. However, effective January 1, 2015, the state froze CMI adjustments. Rates effective January 1, 2015, and thereafter would be calculated utilizing

the same CMI snapshot data (June 30, 2014) that was utilized to determine October 1, 2014, rates. This freeze remained in place until October 1, 2016, when the state resumed adjusting rates quarterly for case mix.

The per diem Non-Case Mix Adjusted cost is determined by dividing the facility's Non-Case Mix Adjusted base year cost (not including Medicaid cost of direct ancillary services) by the facility's total base year inpatient days plus the facility's Medicaid cost of direct ancillary services base year cost divided by the facility's total base year Medicaid resident days, trended forward using the index factor described previously (if funding is available).

Each facility's base year Direct Care per diem is then determined by summing the base year per diem neutralized Case Mix Adjusted cost and the base year per diem Non-Case Mix Adjusted cost. The results are then arrayed from low to high to determine the Medicaid day weighted median cost. Also, for each facility, the percentage that each of these components represents of the total cost is determined.

Effective October 1, 2016, the statewide Direct Care ceiling/price is established at 105.0% of the base year neutralized Case Mix Adjusted and Non-Case Mix Adjusted Medicaid day weighted median cost. This percentage was increased from 102.6%, which had been effective since August 1, 2009. Using the facility-specific percentages determined above, the statewide Direct Care price for each facility is allocated between the per diem Case Mix Adjusted component and the per diem Non-Case Mix Adjusted component. Each facility's Direct Care per diem rate is adjusted quarterly to account for changes in the facility's Medicaid average CMI for the quarter previous to the rate period.

Similar to the Direct Care component, North Carolina determines one statewide Indirect cost component price for all nursing facilities. The first step in this process is to determine the facility-specific Indirect cost component per diem cost. Facility-specific Indirect per diem costs for all applicable nursing facilities are calculated as follows:

- The facility's indirect base year cost, excluding the Medicaid cost of indirect ancillary services, divided by the facility's total base year inpatient days; plus
- The facility's Medicaid cost of indirect ancillary services base year cost divided by the facility's total base year Medicaid resident days.

Facility-specific per diem Indirect costs are trended forward using the index factor previously mentioned (if funding is available), and are then arrayed from low to high to determine the Medicaid day weighted median cost. The statewide Indirect cost component price is established at 100% of the Medicaid day weighted median cost.

North Carolina utilizes an FRV system rate to reimburse nursing facilities for property-related expenses. The FRV system rate includes components for building, land and equipment calculated as follows:

- The initial total building replacement costs for all participating nursing facilities is based on the 2007 RS Means Historical Cost Factor of \$127 per square foot. For rates effective April

1, 2008, and later, the cost factor will be inflated annually utilizing the RS Means Historical Cost Index Factor. The total replacement cost is calculated by multiplying the cost factor times a facility-specific location factor times 450 square feet per bed.

- A nursing facility's land value is estimated to be 15.0% of the total replacement value of the building (prior to depreciation).
- The initial equipment value per bed is \$5,000, also inflated annually by RS Means Equipment Inflation Factor.

For FRV rates effective April 1, 2015, the state did not apply any inflation adjustments to the RS Means Historical Cost Factor. In addition, no inflation adjustments will be utilized to calculate FRV rates effective April 1, 2016. However, the state did provide inflation adjustments (based on the RS Means Cost Index Factor) to the historical cost factor utilized to determine FRV rates on April 1, 2017, and April 1, 2018 and April 1, 2019.

The replacement value of the building and equipment is summed and is then reduced for depreciation at a rate of 2.0% per year, not to exceed 65.0%. In calculating facility age, new and/or replacement beds and renovations reduce the effective age and the corresponding depreciation percentage.

The land value is added to the depreciated replacement cost of the building and equipment and then multiplied by the FRV rate to determine the rental amount. The FRV rate will be based on the 10-year U.S. Treasury Bond rate plus 300 basis points, with a floor of 7.5% and a ceiling of 9.5%. The rental amount is divided by total resident days to determine the FRV rate, subject to a minimum occupancy percentage of 90.0%.

Nursing facilities are reimbursed their applicable nursing home assessment fee per Medicaid day as an add-on to the Medicaid rate. Effective July 1, 2012, statewide average Medicaid increased 2.7% to \$159.28 from a rate of \$155.12 effective July 1, 2011. This reflects increases in FRV rates, acuity adjustments and an increase in the nursing Home assessment fee add-on. The average rate increased 1.1% to \$161.10 effective July 1, 2013. However, the average rate decreased 1.4% to \$157.05 effective April 1, 2014, which reflects the 3.0% rate reduction implemented on January 1, 2014. The average rates effective July 1, 2014, (\$158.05) and January 1, 2015, (\$159.89) have increased slightly from previous levels. The average rate effective June 1, 2015, is \$163.75, which represents a 2.4% increase from the January 1, 2015, average rate. This reflects that the state backfilled the previous 3.0% rate reduction effective that date. The average rate remained relatively unchanged on April 1, 2016 (\$163.81), but increased to \$170.40 and \$178.12 on October 1, 2016, and October 1, 2017. These increases reflect the policy changes implemented as part of the "Restore or Rates Program". The average rate effective July 1, 2018 was \$178.96. The average rate increased 3.5% to \$185.29 effective July 1, 2019.

MINIMUM OCCUPANCY STANDARDS

The lesser of the facility's actual patient days or 90.0% of total allowable patient days is used to calculate the FRV per diem rate.

OTHER RATE PROVISIONS

North Carolina Medicaid may negotiate Direct Care rates that exceed the facility's specific Direct Care ceiling if a resident is ventilator dependent or is a head injury patient.

The per diem rate for a transfer of ownership is equal to the previous owner's per diem Medicaid rate. However, this rate is adjusted quarterly to account for changes in its Medicaid average CMI. Until the new owner has a cost report included in a base year rate setting, the old provider's base year cost report is utilized as the new facility's base year cost report.

The Medicaid per diem rate for a new facility is calculated as the sum of the statewide Medicaid day weighted average Direct Care rate that is calculated effective the first day of each calendar quarter, the statewide Indirect Care price, a Capital cost component rate calculated utilizing the FRV system and the applicable nursing home assessment fee.

After the second full calendar quarter of operation, the statewide Medicaid day weighted Direct Care rate in effect for a facility is adjusted to reflect the facility's Medicaid acuity. The nursing facility's Direct Care rate will be calculated as follows:

- The facility's Direct Care rate is calculated as the sum of 65.0% of the statewide Medicaid day weighted average Direct Care rate multiplied by the ratio of the facility's Medicaid average CMI (numerator) to the statewide Medicaid day weighted average Medicaid CMI (denominator); plus
- The statewide Medicaid day weighted average Direct Care rate multiplied by 35.0%.

Nursing facilities are not reimbursed for holding a bed for a resident requiring hospitalization. However, North Carolina will reimburse nursing facilities for holding a bed for a resident absent from the facility due to therapeutic leave. Nursing facilities will be reimbursed at their current Medicaid rate for no more than 15 consecutive days per absence and 60 days per calendar year.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

According to representatives of the North Carolina Health Care Facilities Association, North Carolina was projected to enter into a managed care system effective November 2019. However, implementation maybe delayed. In addition, Medicare-Medicaid dual-eligible residents are excluded from managed care for five years, as will be residents with stays anticipated to be greater than 90 days. Therefore, at least initially, the vast majority of Medicaid-eligible residents will be excluded from the system. The state will eventually decide if these residents will be included in the system. It is currently unclear if this will occur. Nursing facilities are also projected to still receive their fee-for-service rates calculated by the state for several years.

As of the date of this overview, there are no significant changes planned to the state's nursing home rate calculation methodology.

NORTH CAROLINA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	82.00	80.00	80.00		105.00	100.50	101.00		127.00	125.00	125.00
Average Daily Census	77.31	75.90	74.54		95.25	94.00	92.03		114.72	112.75	110.85
Occupancy	76.5%	77.5%	74.0%		85.8%	85.3%	83.7%		90.8%	90.5%	89.8%
Payor Mix Statistics											
Medicare	9.1%	8.3%	7.8%		12.6%	12.2%	11.3%		17.9%	17.1%	16.4%
Medicaid	52.2%	51.1%	52.0%		63.6%	64.1%	65.7%		72.8%	73.6%	74.5%
Other	14.3%	13.8%	14.0%		23.0%	22.9%	22.3%		36.7%	36.0%	34.3%
Avg. Length of Stay Statistics (Days)											
Medicare	31.11	30.21	28.98		38.52	38.71	35.09		47.27	48.83	45.88
Medicaid	265.38	285.67	265.47		366.24	396.05	365.00		495.54	591.85	521.60
Other	60.04	52.59	44.52		95.31	91.01	68.79		179.66	160.71	128.96
Revenue (PPD)											
Inpatient	\$198.34	\$202.66	\$207.12		\$219.14	\$224.45	\$232.74		\$248.70	\$259.68	\$269.88
Ancillary	\$48.79	\$47.32	\$48.19		\$67.85	\$66.61	\$67.62		\$93.82	\$94.25	\$90.21
TOTAL	\$258.99	\$260.23	\$268.47		\$290.68	\$298.10	\$308.81		\$354.40	\$371.08	\$387.18
Expenses (PPD)											
Employee Benefits	\$14.79	\$14.93	\$14.72		\$17.46	\$18.45	\$18.18		\$23.08	\$22.71	\$23.05
Administrative and General	\$34.93	\$34.97	\$35.94		\$41.68	\$43.56	\$45.54		\$51.02	\$53.49	\$56.74
Plant Operations	\$7.87	\$7.86	\$8.44		\$9.24	\$9.27	\$9.83		\$11.13	\$11.81	\$11.99
Laundry & Linens	\$2.02	\$1.87	\$1.99		\$2.54	\$2.49	\$2.63		\$3.26	\$3.17	\$3.27
Housekeeping	\$4.36	\$4.50	\$4.57		\$5.41	\$5.68	\$5.80		\$7.35	\$7.48	\$7.32
Dietary	\$14.46	\$14.47	\$14.89		\$15.79	\$16.07	\$16.41		\$18.43	\$19.18	\$19.59
Nursing & Medical Related	\$67.59	\$70.97	\$75.60		\$76.01	\$78.14	\$83.24		\$86.28	\$90.06	\$96.58
Ancillary and Pharmacy	\$27.03	\$25.81	\$27.01		\$35.49	\$34.09	\$33.94		\$44.23	\$41.98	\$41.27
Social Services	\$1.81	\$1.78	\$1.94		\$2.60	\$2.65	\$2.84		\$3.57	\$3.51	\$3.87

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

North Dakota



INTRODUCTION

Nursing facilities in North Dakota are licensed by the North Dakota Department of Health, Division of Health Facilities, under the designation of "Nursing Facility." The following table summarizes the total number of nursing facilities within the state:

NURSING FACILITIES IN NORTH DAKOTA	
Licensed Nursing Facilities*	55
Licensed Nursing Beds*	3,920
Beds per 1,000 Aged 65 >**	34.01
Beds per 1,000 Aged 75 >**	76.65
Occupancy Percentage - 2017*	92.20%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

North Dakota does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility.

The state has a moratorium on the expansion of the statewide long-term care bed capacity. The moratorium was first enacted by legislature for the 1995-1997 biennium, and has been reenacted by every legislature since on a bi-annual basis. The moratorium was recently extended through July 31, 2021.

Nursing facility beds may not be added to the state's licensed bed capacity. However, the transfer of beds from one facility to another entity is permitted. Transferred nursing facility beds must become licensed within 48 months of transfer.

As part of House Bill 1325, North Dakota approved a "bed banking" program. A nursing facility in North Dakota can temporarily de-license (bank) a maximum of 50% of its licensed capacity, with the option of being able to re-license these beds within a 48-month period. The nursing facility will forfeit its banked beds if the facility does not re-license these beds by the end of the 48-month period. The state also operates a "bed layaway" program. Under this program a nursing facility lays beds away for a maximum of 48 months. At the end of this period the nursing facility has the following three options:

- Re-license the beds as nursing facility beds;
- License the beds as basic care beds within a nursing home. Basic care facilities provide a congregate residential setting and a lower level of care than nursing facilities. The facilities are not certified for Medicare and often contain residents who have impaired mental health status; and
- Sell the beds as either nursing facility or basic care beds.

De-licensed beds are not included in the total licensed capacity utilized to determine a nursing facility's minimum occupancy requirement for Medicaid reimbursement. Further detail of the minimum occupancy requirement is provided in the Rate Methodology section of this overview.

BED NEED METHODOLOGY

North Dakota does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSESSMENT FEE

Nursing facilities in the state of North Dakota are currently not assessed with a quality assessment fee.

MEDICAID RATE CALCULATION SYSTEM

North Dakota uses a prospective, cost-based, facility- and patient-specific, case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The Direct Care Cost Component portion of a nursing facility's rate is patient specific, and the remaining cost component rates are facility specific. The case mix-based reimbursement program was implemented January 1, 1990, and established rates for each facility based on intensity of service.

COST CENTERS

The determination of rates is the sum of the following four components:

- The Property component includes depreciation, interest expense on capital debt, property taxes, lease and rental costs, start-up costs and reasonable legal expenses.
- The Direct Care component is based on costs associated with nursing and therapy services, including compensation, supplies, equipment and training.
- The Indirect Care component includes costs (including compensation and supplies) associated with administration, plant operation, housekeeping, medical records, chaplain, pharmacy services and dietary.
- The Other Direct Care component is based on costs for food, dietary supplements, laundry, social services and activities, including compensation, supplies and contract services.

INFLATION AND REBASING

The rate period is from January 1 to December 31, while the cost report year is from July 1 to June 30. North Dakota rebased rates in calendar year 2017 utilizing 2014 cost report data. Rates and rate limits for the Direct Care, Indirect Care and Other Direct Care components are rebased at least every four years. The state previously rebased rates and rate limits in calendar year 2014 utilizing cost report data for the period ending June 30, 2010.

In 2005 the state legislature repealed the statute requiring that the state utilize the Global Insight index to inflate allowable costs. The state has the authority to set specific inflation rates, which have been as follows since this change: 2.65% per year - 2006 and 2007; 4.0% - 2008; 6.0% per year - 2010 and 2011; 3.0% per year - 2012 through 2016. There was no inflation applied to allowable costs in 2017, 2018 and 2019. However, in 2020 and 2021, rates and rate limits will be increased 2.0% and 2.5%, respectively. In addition, limits effective July 1, 2021 will be based on June 30, 2018 cost reports.

Property limits are increased annually by the Consumer Price

Index (CPI). Effective July 1, 2019, the per bed limitation basis is \$168,864 for double occupancy and \$253,297 for single occupancy.

RATE METHODOLOGY

The determination of a facility's Medicaid rate is the sum of the applicable rate for each of the four components. The Property component rate is established on the basis of allowable costs with no limitations applied. The rate is calculated by dividing total allowable inflated costs by total resident days. A per-bed cost limitation based on single and double occupancy is used to determine the total allowable cost basis of buildings and fixed equipment for a facility with construction, renovation or remodeling. The average property component rate in 2019 was \$22.13 per resident per day.

The facility-specific rate for the Direct Care, Indirect Care and Other Direct Care cost components is the lesser of the facility's per diem cost and the cost component's rate limit. The per diem cost for each cost component is calculated by dividing allowable inflated costs per component by total resident days. The resident days utilized to calculate the Direct Care per diem cost are adjusted for case mix.

The facility-specific per diem costs per cost component that are utilized to calculate the component limits are calculated using the above methodology. The facility-specific per diem costs are arrayed by cost component and a median cost is determined. The limit is calculated as a percentage above the median. However, the median is only calculated in rebasing years and is indexed annually.

The Direct Care component is based on the RUG IV, 48-group classification system. North Dakota converted from RUG III to RUG IV on January 1, 2013. The resident's classification is based on information contained in the minimum data set (MDS). Each of these RUG categories is assigned a specific weight. A nursing facility's resident days per RUG category are multiplied by the specific RUG's weight to calculate case mix adjusted resident days. The case mix adjusted total resident days are utilized to calculate the facility-specific per diem Direct Care costs.

The Direct Care limit was established at 120% of the median, which has been indexed annually since the last rebasing. The limit for the Direct Care component for 2017 is \$178.18 per day, which represents a 3.0% increase from 2016 (\$172.84). This limit did not change in 2018 and 2019, but is anticipated to increase 2.0% in 2020 and 2.5% in 2021. The lesser of the facility-specific per diem cost or the Direct Care limit is multiplied by the case mix weight for each RUG category to determine the patient-specific rate for that classification.

An operating margin is then added to arrive at the Direct Care rate for each facility. The operating margin is 3.0% of the lesser of the actual Direct Care per diem cost or the Direct Care limit for the preceding year. A temporary operating margin consisting of 3.74% began on January 1, 2018 and will continue through 2019. The operating margin is projected to increase 4.4% in 2020 and to decrease to 3.0% in 2021. The facility-specific Direct Care per diem cost utilized to determine the operating margin is calculated utilizing un-inflated allowable costs and case mix adjusted patient

days.

The Indirect Care limit was established at 110% of the median, which has been indexed annually since the last rebasing. The limit for the Indirect Care component for 2017 is \$77.29 per day, which represents a 4.5% increase from 2016 (\$73.82). This limit did not change in 2018 and 2019, but is anticipated to increase 2.0% in 2020 and 2.5% in 2021.

There is an incentive for cost containment. If a facility's Indirect Care per diem cost is less than the limit rate, 70.0% of the difference is added to the Indirect Care rate. However, there is a ceiling on the incentive factor equal to the lesser of \$2.60 per diem or the difference between the actual rate, inclusive of the incentive and the component limit. The facility-specific Indirect Care per diem cost utilized to determine the incentive for this cost containment is calculated utilizing un-inflated allowable costs.

The Other Direct Care limit was established at 120.0% of the median, which has been indexed annually since the last rebasing. The limit for the Other Direct Care component for 2017 is \$28.15 per day, which represents a 1.9% increase from 2016 (\$28.70). This limit did not change in 2018 and 2019, but is anticipated to increase 2.0% in 2020 and 2.5% in 2021.

A temporary operating margin consisting of 3.74% began on January 1, 2018 and will continue through 2019. For 2018 and 2019, 3.74% of the lesser of the actual Other Direct Care per diem cost or the Other Direct Care limit for the preceding year was added to arrive at the facility's Other Direct Care component rate. The operating margin is projected to increase 4.4% in 2020 and to decrease to 3.0% in 2021. The facility-specific Other Direct Care per diem cost utilized to determine the operating margin is calculated utilizing un-inflated allowable costs. The average operating margin per diem (Direct Care and Other) in 2019 is \$6.36.

The statewide weighted average rate was \$152.33 in 2006, \$159.96 in 2007, \$165.59 in 2008, \$179.27 in 2009 and \$195.55 in 2010, \$205.07 in 2011, \$213.82 in 2012, unavailable in 2013, \$238.94 in 2014, unavailable in 2015, \$258.78 in 2016, \$265.35 in 2017, \$270.71 in 2018 and \$269.26

MINIMUM OCCUPANCY STANDARDS

For the Indirect Care and Property cost components, per diem costs must be the lesser of the rate established using either the actual cost report census for the year or 90.0% of licensed bed capacity. As previously mentioned North Dakota has a bed banking and bed layaway methodology, which allows nursing facilities to temporarily de-license beds for up to 48 (bed layaway) and 48 (bed banking) months. These banked beds are not included in the licensed bed capacity utilized in the minimum occupancy standard calculation.

OTHER RATE PROVISIONS

The North Dakota Medicaid system employs rate equalization. The rate equalization feature ensures that non-Medicare residents within a given nursing facility, with similar health conditions

and service needs, are charged the same amount regardless of the source of payment.

For a new facility, North Dakota Medicaid establishes an interim rate equal to the limit rates for Direct Care, Other Direct Care and Indirect Care in effect for the rate year in which the facility begins operation, plus the Property rate. The Property rate is calculated using projected property costs and projected census, imputed at 95.0%. The interim rate remains in effect for no less than 10 months and no more than 18 months. Costs for the period in which the interim rate is effective are used to establish a final rate.

For a facility changing ownership, the rates established for the Direct Care, Indirect Care and Other Direct Care cost components, the operating margins and incentives for the previous owner are retained through the end of the rate period. The rates for the next rate period following the change in ownership must be established either through use of a cost report for the period (for a facility with four or more months of operation under the new ownership during the report year) or by indexing the rates established for the previous owner using the adjustment factor (for a facility with less than four months of operation under the new ownership during the report year). The rate established for the Property cost component is retained through the end of the rate period. The Property rate for the next rate period following the change in ownership must be established either through use of a cost report for the period (for a facility with four or more months of operation under the new ownership during the report year) or by using the rate established by the previous owner for the previous rate year.

Specific property costs are limited after the acquisition of a nursing facility. The cost basis utilized to calculate pass-through depreciation costs for a nursing facility that has changed ownership is limited to the lowest of the following:

- The purchase price paid by the borrower;
- The fair market value at the time of the sale; and
- The seller's cost basis, increased by one-half of the increase in the Consumer Price Index for All Urban Consumers (United States City Average, All Items), from the date of acquisition by the seller to the date of acquisition by the buyer, less accumulated depreciation recognized for cost reporting purposes.

Pass-through interest expenses for a nursing facility that has changed ownership are limited to the amount of interest associated with borrowing (occurring at the time of sale), that does not exceed 90.0% of the cost basis (see previous paragraph).

A maximum of 15 days per occurrence are allowed for hospital leave days. The payment rate may not exceed the established rate for RUG Category PA1 under the reduced physical functioning category (the lowest category). A maximum of 24 therapeutic leave days, calculated at the lowest rate, are allowed annually.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There have not been significant changes to the state's Medicaid reimbursement system in 2019.

NORTH DAKOTA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	57.00	63.50	62.50		88.00	88.00	99.00		129.50	138.00	127.25
Average Daily Census	60.25	60.97	64.11		82.71	79.68	85.53		121.89	123.29	122.97
Occupancy	87.7%	87.1%	86.0%		95.3%	93.1%	91.9%		97.9%	97.7%	96.4%
Payor Mix Statistics											
Medicare	4.5%	4.6%	4.0%		6.6%	7.0%	6.5%		10.2%	9.7%	9.8%
Medicaid	38.4%	42.0%	43.9%		48.4%	50.0%	49.4%		55.9%	52.0%	53.6%
Other	35.2%	37.1%	35.8%		44.9%	43.2%	42.4%		57.7%	50.7%	48.8%
Avg. Length of Stay Statistics (Days)											
Medicare	43.44	40.37	41.63		56.84	57.08	47.89		78.07	71.30	55.41
Medicaid	453.62	579.60	400.46		674.46	847.53	640.36		1005.96	1156.56	1026.71
Other	235.95	251.15	170.38		332.65	388.64	304.95		562.18	596.35	471.07
Revenue (PPD)											
Inpatient	\$198.84	\$213.02	\$237.12		\$254.26	\$255.02	\$266.82		\$286.39	\$287.77	\$298.26
Ancillary	\$8.56	\$9.66	\$9.46		\$16.09	\$14.18	\$14.06		\$28.67	\$24.97	\$43.45
TOTAL	\$218.99	\$220.48	\$242.03		\$272.26	\$274.95	\$292.66		\$318.41	\$322.91	\$342.22
Expenses (PPD)											
Employee Benefits	\$21.67	\$21.45	\$23.99		\$28.76	\$28.11	\$31.40		\$35.94	\$35.63	\$37.50
Administrative and General	\$23.45	\$24.73	\$25.73		\$27.43	\$28.48	\$30.20		\$30.69	\$33.72	\$34.99
Plant Operations	\$9.05	\$10.02	\$10.95		\$11.58	\$12.12	\$12.79		\$13.89	\$14.85	\$14.88
Laundry & Linens	\$2.81	\$2.77	\$2.76		\$3.46	\$3.57	\$3.31		\$4.88	\$4.92	\$4.71
Housekeeping	\$4.84	\$5.21	\$5.70		\$6.33	\$6.66	\$6.68		\$8.18	\$8.35	\$7.65
Dietary	\$20.08	\$20.24	\$21.17		\$22.75	\$22.07	\$23.69		\$26.81	\$27.04	\$27.71
Nursing & Medical Related	\$99.92	\$98.63	\$105.28		\$114.74	\$116.89	\$125.60		\$141.56	\$137.84	\$140.71
Ancillary and Pharmacy	\$4.77	\$5.65	\$5.38		\$10.14	\$10.43	\$11.88		\$15.14	\$17.32	\$19.28
Social Services	\$2.34	\$2.56	\$2.65		\$3.49	\$3.60	\$3.42		\$8.10	\$8.36	\$8.19

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Ohio



INTRODUCTION

Nursing facilities in Ohio are licensed by the Ohio Department of Health, Division of Quality Assurance, Bureau of Long Term Care under the designation of "Nursing Home." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN OHIO	
Licensed Nursing Facilities*	993
Licensed Nursing Beds*	92,219
Beds per 1,000 Aged 65 >**	46.73
Beds per 1,000 Aged 75 >**	112.40
Occupancy Percentage - 2017*	80.90%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

In Ohio, the Certificate of Need (CON) program was enacted in 1973. A formal moratorium on the construction of new nursing facility beds was in place since 1993. This moratorium prohibited the department from issuing CONs for new nursing facility beds. The state typically decided whether or not to extend the moratorium when the bi-annual budget was set. In the past, the state extended the moratorium every two years since 1993. The formal moratorium ended on June 30, 2011. The state did not extend the official moratorium, but did alter the law to create an effective moratorium in the state. Under the Ohio Revised Code, there are only three possible opportunities for an increase of capacity, but none involve the creation of new nursing home beds. These opportunities include:

- Relocation or replacement of beds to a nursing facility within the same county.
- Replacement or relocation of nursing facility beds in a county with excess bed need to a county with fewer nursing facility beds than the county bed need. The determination of nursing facility bed need will be detailed further in the Bed Need section of this overview.
- Relocation of a maximum of 30 nursing facility beds from one existing facility to another existing facility in a contiguous county.

A minimum unmet demand of 100 beds must be left in any county from which beds are being relocated. Facilities in counties with an excess of less than 100 beds will not be approved.

Excluding the three possible opportunities to increase bed capacity, Ohio state law indicates that CON review and approval are also needed for the following activities:

- The establishment, development or construction of a new nursing facility (including the re-opening of a facility not currently providing care). However, no new facility will be granted a CON unless it will contain 50 or more beds or demonstrates that it can operate with less than 50 beds in a cost-effective manner, and:
 - (1) The proposed facility's size is essential to serve a special health care need that otherwise will not be served, or will serve a special health care need in accordance with current, evidence-based standards of care;
 - (2) The proposed facility is the only feasible alternative for

cost-effective correction of physical plant deficiencies; or
 (3) The proposed facility is part of a continuing care retirement or life care community and the application demonstrates the following:

- (a) The applicant will be contractually obligated to provide long-term care to current residents of the continuing care retirement or life care community; and
 - (b) The continuing care retirement or life care community currently provides and will continue to provide preference in admission to contractual residents of the community.
- Replacement of an existing facility. The state will not grant a CON for a replacement facility of more than 150 beds.
 - A renovation and/or addition to a nursing facility involving a capital expenditure of \$2,000,000 or more (does not include expenditures for equipment, staffing or operational costs).
 - An increase in bed capacity or the relocation of beds from one facility or site to another.
 - The expenditure of more than 110% of the maximum expenditure specified in an approved CON application.

However, the state recently approved House Bill 166, which made major changes to the CON program. Specifically, the bill enacted a temporary moratorium on CON approvals through June 30, 2021. Exceptions to the moratorium include the following:

- Bed that are relocated to contiguous counties;
- Bed replacements, assuming there is no change of operator, and the county is determined to possess unmet demand (based on the bed need methodology); and
- The addition or renovation of beds in counties that are determined to possess unmet demand.

BED NEED METHODOLOGY

Ohio implemented a nursing bed need methodology in 2010. This methodology determines a state bed need rate, which is multiplied by the 65 and older population in each county to determine gross county bed need. The state bed need rate is calculated as follows:

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- Total statewide inpatient days / total bed days available = statewide long-term care bed occupancy rate
 - Statewide long-term care bed occupancy rate x total statewide long-term care bed supply = total statewide number of beds occupied
 - Total statewide number of beds occupied / 90.0% = total statewide number of beds needed
 - (Total statewide number of beds occupied / projected statewide population aged 65 and older) x 1,000 = state bed need rate

The total supply of existing nursing facilities in the county is subtracted from the gross bed need estimate to determine net bed need in the county. However, even if the calculation estimates bed need, the state will determine there is no bed need if the weighted average occupancy percentage in the county is below 85%. If the weighted average occupancy percentage in the state is greater than 90%, the state may approve an increase in beds equal to up to 10% of total bed supply in the county.

If the calculation estimates a bed need of 100 beds or less, the state will determine there is no excess demand. If the calculation

estimates unmet demand of over 100 beds, the state will determine that unmet demand equates to the original calculated net demand estimate minus 100. The most recent bed need for each county in Ohio was published in 2016 and will be published every four years after. The state calculation initially indicates that there are 28 counties with projected bed need, for a total projected shortage of 4,647 beds in Ohio. However, only seven of these counties meet the state's occupancy standard of 85.0%, which is required for there to be a consideration of unmet demand in the area. The total combined unmet demand for these seven counties is 1,207 beds.

QUALITY ASSURANCE FEE

In Ohio, the quality assurance fee is known as a franchise permit fee (FPF). Effective July 1, 2009, the state significantly increased the FPF for a nursing facility's first 200 beds from \$6.25 to \$11.95 per licensed bed day. The fee for beds in excess of 200 was \$9.81 per licensed bed day. This increase enabled the state to fund the Medicaid rate calculation for fiscal year 2010. In addition, the increase in the FPF allowed facilities to be reimbursed for incentive measures. However, the state was granted a budget neutral waiver from CMS to exclude four charitable facilities from paying the FPF. Given this factor, a fee of \$12.01 per licensed bed day was determined for a facility's first 200 beds, with a fee of \$9.99 per licensed bed for every bed in excess of 200.

Of all payments and penalties paid by nursing homes under this program, 16% are deposited into a Home- and Community-Based Services for the Aged fund. The Department of Aging uses the monies to fund the PASSPORT program and the Residential State Supplement program. Residential state supplement funding is used to provide personal care services to supplemental security income recipients (typically, adult-care facility residents) that are at risk of needing institutional care. All payments and penalties not deposited into the Home- and Community-Based Services for the Aged fund are deposited into the Nursing Facility Stabilization fund and used to make Medicaid payments to nursing facilities.

Effective April 1, 2010, the 200 or less FPF was increased to \$12.06. However, effective July 1, 2010, the FPF was slightly reduced to \$12.00 per licensed bed day for a nursing facility's first 200 beds and \$9.81 per licensed bed day for each bed over 200. Effective July 1, 2011, the FPF was reduced to \$11.52 per licensed bed day for a nursing facility's first 200 beds and \$9.37 per licensed bed day for each bed over 200. The FPT for fiscal year 2013 increased to \$11.73 per licensed bed day for a nursing facility's first 200 beds and \$9.66 per licensed bed day for each bed over 200. In fiscal year 2014, the FPT increased to \$12.00 per licensed bed day for a nursing facility's first 200 beds and \$9.80 per licensed bed day for each bed over 200. The state calculates the FPT to equate to 6.0% of total revenue, which is the federal maximum allowable amount. The FPF effective July 1, 2014, was \$12.10 per licensed bed day for a nursing facility's first 200 beds and \$9.85 per licensed bed day for each bed over 200. Effective July 1, 2016, the rates for a facility's first 200 beds increased to \$12.44. However, the rate per licensed bed day for each bed over 200 decreased by \$9.02. Effective July 1, 2017, the rate per licensed bed for the first 200 beds increased to \$12.75 and the rate for every bed greater than 200 decreased to \$9.50. The fees changed on July 1, 2018, to

\$12.77 for the first 200 beds and \$11.15 for every bed greater than 200. The state is still in the process of determining the FPTs that will be effective July 1, 2019.

In fiscal year 2012, Ohio's Medicaid reimbursement system included the permit fee as an \$11.47 add-on to the nursing facility's Medicaid rate, which was a significant increase from the previous addition (\$6.25). This reflected that the previous increase in the FPF (\$5.70) was reimbursed to nursing facilities as a separate add-on (Workforce Development Incentive Payment). This add-on was eliminated in fiscal year 2012. Effective July 1, 2012, the state has eliminated the FPT add-on. The FPT is now utilized to fund the state's quality incentive program, which will be detailed in the Rate Methodology section of this overview.

Effective July 1, 2011, the state is required to recalculate the FPT semiannually if nursing facilities within the state decertify beds.

MEDICAID RATE CALCULATION SYSTEM

Ohio uses a prospective, price-based, case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The state converted from a cost-based system to a price-based system on July 1, 2006. Medicaid rates for Ohio nursing facilities are a combination of facility-specific and all-inclusive, non-facility-specific component prices. The state phased in the price-based system from July 1, 2006, to July 1, 2012, by holding nursing facilities' rates harmless to their slightly adjusted prior year rate. The state fully converted all facilities to price-based rates effective July 1, 2012.

COST CENTERS

Ohio uses four cost centers to calculate Medicaid prices::

- **The Direct Care** cost component includes costs for nurses, direct care staff, medical directors, respiratory therapists, quality assurance, employee benefits and other costs. In addition, effective July 1, 2011, the consolidated services add-on was included in the direct care price. More details on this change will be included in the Rate Methodology section.
- **The Ancillary and Support** cost component includes costs for activities, social services, pharmacy consultants, rehabilitation supervisors, incontinence supplies, dietary supplies, food, housekeeping, insurance, laundry, security, travel, utilities, dues, subscriptions and other costs not included with the Direct Care or Capital cost components.
- **The Capital** cost component includes actual expenses incurred for the following: depreciation and interest on any capital asset with a cost of \$500 or more per item, amortization and interest on land improvements and leasehold improvements, amortization of financing costs, and the lease and rent of land, building and equipment.
- **The Tax** cost component includes costs for real estate taxes, personal property taxes, corporate franchise taxes and commercial activity taxes.

Effective January 1, 2014, transportation, oxygen and custom wheelchair expenses are no longer considered allowable costs for the Direct Care cost component. According to HW & Co., this

resulted in a \$1.02 reduction of the Direct Care cost component price prior to adjusting for case mix. However, given that providers of these services will be directly reimbursed by Medicaid and that nursing facilities are no longer required to pay for these costs, this adjustment had no real impact on nursing facility reimbursement.

INFLATION AND REBASING

The rate period for Ohio nursing facilities is from July 1 to June 30. The last official rebasing of nursing facility prices was for the rate period effective July 1, 2005, which was based on 2003 cost report data. The July 1, 2005, to June 30, 2006, rate period represents the last rate period that was based on the cost-based system. Ohio is required to rebase nursing facility prices every 10 years. It is unclear when Ohio will next rebase prices. Since the last rebasing, the state has not increased base costs for inflation. Pursuant to House Bill 119, the state has inflated the facility-specific and non-facility-specific component prices established on July 1, 2005. The state has inflated the rate components utilizing inflation rates that reflect the state's budget appropriations. In fiscal years 2006 and 2007, the rate components were increased 2%. In fiscal year 2008, the rate components were increased 1%. No inflation was provided for fiscal year 2009. For fiscal year 2010, the total price before the Stop Loss/Gain Provision was increased by 0.73%. No inflation was provided for fiscal year 2011.

Facility-specific Medicaid rates are adjusted semiannually for case mix, but were limited to a Stop Loss/Gain Provision established by House Bill 119 during the phase-in of the price-based system. Specifically, each facility is paid a Medicaid rate equal to its price, calculated as set forth below. In previous years, the per diem rate for fiscal years 2008 and 2009 was not permitted to increase by more than 2.75% from the previous fiscal year's rate. If the facility's Medicaid rate was lower than the rate the nursing facility was paid at the end of fiscal year 2007, the facility was reimbursed the rate in effect at the end of fiscal year 2007. The implementation of the pricing system began with rates effective July 1, 2006, with each facility's price being compared to its June 30, 2006, rate. If the price was greater than the rate, the rate was increased by 2.0%. If the price was less than the rate, the rate was reduced 2.0%. Therefore, the Stop Loss/Gain Provision for fiscal year 2007 was $\pm 2\%$. Since the stop-loss for fiscal years 2008 and 2009 was 0%, a nursing facility's Medicaid rate could not be lower than the Medicaid rate the facility received for June 30, 2007, during this biennium. For fiscal year 2010, a nursing facility's rate could not be greater than 1.75% of its June 30, 2008, rate or less than 99% of its June 30, 2008, rate. The gain provision increased to 2.25% in fiscal year 2011 and the loss provision remained at 99%.

In fiscal year 2012, the state inflated prices by 5.08%. However, these inflation adjustments were offset by House Bill 153, which reduced prices through other aspects of the calculation. Overall, the Ohio Health Care Association estimated that this resulted in an average rate reduction of 5.6%. However, the actual percentage change in rates varied greatly from facility to facility.

In fiscal year 2012, the state eliminated the gain provision and altered the loss provision to equate to a maximum loss of 10/0% plus half the difference greater than 10.0%. The loss provision was eliminated on July 1, 2012, when all nursing facilities were

converted to the price-based system.

With the exception of adjustments for case mix, prices have been frozen in fiscal years 2013 through 2016. However, the state rebased nursing facility rates effective July 1, 2016, utilizing 2014 cost report data. This rebasing, combined with the to-be-mentioned conversion to the RUG IV system, resulted in a statewide average rate increase of nearly \$15

However, effective July 1, 2016, the state applied a \$1.79 across the board rate reduction, which was utilized to fund the state's new quality pool add-on. This add-on will be described later in this document. However, the average reimbursement for the add-on (\$1.85) effective January 1, 2019 is slightly greater than the rate reduction. The state did not rebase or inflate rates on July 1, 2017 and July 1, 2018. The only changes in nursing facility rates were due to case mix adjustments and slight changes in the quality incentive.

As part of the recently approved House Bill 166, the state is going to increase nursing facility rates (excluding the quality incentive) by 2.4% from July 1, 2019 to December 31, 2019. However, effective January 1, 2020, this rate increase will be linked to an additional quality incentive.

RATE METHODOLOGY

The methodology described below was utilized to calculate Medicaid prices during the last rate rebasing (July 1, 2016). In non-rebasing years, the base prices utilized for the Direct Care, Ancillary and Support, and Capital cost components were inflated by the above-mentioned percentages.

Ohio calculates non-facility-specific base prices for the Direct Care, Ancillary and Support, and Capital cost components. The Direct Care price is adjusted by each facility's Medicaid case mix score to calculate a facility-specific Direct Care price.

In order to determine the initial flat base price for the Direct Care cost component, the Department of Job and Family Services (DJFS) categorizes nursing facilities into one of three peer groups. The peer groups are based on the county in which the nursing facility is located and are delineated as follows:

- **Peer Group One:** Brown, Butler, Clermont, Clinton, Hamilton and Warren.
- **Peer Group Two:** Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Mahoning, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Stark, Summit, Union and Wood.
- **Peer Group Three:** Adams, Allen, Ashland, Athens, Augaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams and Wyandot.

Effective October 1, 2013, the state moved Mahoning and Stark counties from Peer Group Three to Peer Group Two. Peer Group Two contains the majority of the state's metropolitan areas, while Peer Group Three consists of the state's rural counties. By moving facilities in these counties to Peer Group Two, HW & Co. estimates that these facilities received a \$16 to \$20 rate increase. This reflects that facilities in these counties benefitted from higher prices that were derived from metropolitan areas with higher costs of living.

DJFS determines a case mix neutralized Direct Care base price for each of these peer groups. Facility-specific Direct Care cost component per diem costs and prices are adjusted for a facility's specific Medicaid case mix score. Previously, DJFS had used the Resource Utilization Groups III (RUG III) Version 5.12b, 34-group, index maximizer model to calculate a nursing facility's annual and semiannual case mix scores. However, effective July 1, 2016, the state converted from using the RUG III model to the RUG IV, 57-group to adjustment direct care rates for case mix.

The per diem Direct Care costs for each nursing facility are determined by dividing allowable inflated costs by total patient days. These facility-specific Direct Care per diem costs are then case mix neutralized by dividing the facility's per diem cost by the facility's annual case mix score for all payors. The annual case mix score is derived from the same period as the cost report data. DJFS arrays the case mix neutralized per diem costs and determines the mean per diem cost for each peer group. DJFS then arrays the facility-specific per diem costs that are within one standard deviation of the mean for each peer. DJFS will then identify which nursing facility in the new array represents the 25th percentile of the case mix neutralized per diem costs. The 25th percentile per diem cost is then increased by 2% to determine the Direct Care cost component base price. The Direct Care cost component base price is only calculated during rebasing years. However, the price effective July 1, 2011, was reduced to reflect changes in the calculation. Specifically, in prior years, the price was calculated to equate to the 25th percentile per diem cost increased by 7.0%.

The facility-specific Direct Care cost component price is calculated semiannually by multiplying the Direct Care cost component base price for a facility's peer group (trended forward during non-rebasing years) by the facility-specific semiannual case mix score for Medicaid residents. The facility-specific Medicaid case mix score utilized to adjust January 1 rates is derived from the prior quarters ending June 30 and September 30, and case mix score utilized to adjust July 1 rates is the prior quarters ending December 31 and March 31. Therefore, prices effective July 1 are based on Medicaid case mix data from January 1 to June 30 and prices effective January 1 are based on Medicaid case mix data from July 1 to December 31.

Effective January 1, 2012, rates were calculated utilizing updated case mix data. In addition, effective July 1, 2012, the state began to reimburse nursing facilities a set per diem rate (\$130) for the two lowest acuity RUG (PA1 and PA2) patients. However, these residents are not included in case mix indices

used to adjust the Direct Care price semiannually.

Effective July 1, 2016, the state reduced the per diem reimbursement rate for these two categories to \$115 per day. In addition, nursing facilities that the state determines are not sufficiently contributing to the state's effort to repatriate patients back into the community will receive a decreased rate of \$91.70. The primary reason for this change is that it is anticipated the RUG IV system will result in a greater number of PA1 and PA2 patient days than RUG III. These changes were offset by rate increases resulted from greater CMI scores that will occur from excluding the lower acuity (PA1 and PA2) days from the calculation.

In order to calculate the base prices for the Ancillary and Support and Capital cost components, DJFS categorizes nursing facilities into six peer groups. The six peer groups are based on the three peer groups established for the Direct Care cost component, which are then further separated based upon the number of beds within the facility (0 – 99 beds or 100-plus beds). Effective January 1, 2014, the state utilizes licensed beds as the measurement used to determine in which peer group a nursing facility should be included. Prior to this change, the state utilized only beds certified by Medicaid to determine the appropriate peer group for a nursing facility.

The facility-specific Ancillary and Support cost component per diem cost is determined by dividing allowable inflated costs by total patient days (adjusted for the occupancy required, if applicable). DJFS arrays the per diem costs and determines the mean per diem cost for each peer group. DJFS then arrays the facility-specific per diem costs that are within one standard deviation of the mean for each peer group. DJFS will then identify which nursing facility in the new array represents the 25th percentile of the case mix neutralized per diem costs. The peer group-specific 25th percentile per diem cost equates to the Ancillary and Support cost component base price, which is the rate that each nursing facility in the peer group is reimbursed. The Ancillary and Support cost component base rate is only calculated during rebasing years. However, the price effective July 1, 2011, was reduced to reflect changes in the calculation. Specifically, in prior years, the price was calculated to equate to the 25th percentile per diem cost increased by 3.0%.

The facility-specific Capital cost component per diem cost is determined by dividing allowable inflated costs by total available patient days. The facility-specific per diem costs are arrayed by peer group using the same peer groups as for the Ancillary and Support cost component and the base price is determined to be the median rate for each peer group. The peer group specific base price is the rate that each nursing facility within the peer group is reimbursed. The Capital cost component base rate is only calculated during rebasing years.

DJFS reimburses costs included in the Tax cost component as direct pass-through expenses. In a rebasing year, a facility's total tax costs are divided by the facility's total available patient days. In non-rebasing years, the facility-specific Tax cost component rate is inflated by a rate determined by the state.

In fiscal year 2012 Ohio reimbursed nursing facilities for the FPT as an \$11.47 add-on. However, the add-on was eliminated in fiscal year 2013. The loss of this add-on is offset by changes in the state's quality assessment add-on. Nursing facilities are also eligible to receive a quality incentive payment if these facilities meet certain quality and performance standards.

The quality incentive payment is determined utilizing a point system. Prior to fiscal year 2013, DJFS annually awarded each nursing facility participating in the Medicaid program one point for each of the following accountability measures:

- No health deficiencies on the most recent standard survey.
- No health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, are present on the most recent standard survey.
- Resident satisfaction is above the statewide average.
- Family satisfaction is above the statewide average.
- The number of hours the facility employs nurses is above the statewide average.
- Employee retention rate is above the average for the facility's peer group.
- Occupancy rate is above the statewide average.
- Medicaid utilization rates are above the statewide average.
- Case mix score is above the statewide average.

For fiscal year 2012, the quality incentive payment was \$0.58 per point awarded. A nursing facility was awarded one point for each of the accountability measures except the Medicaid utilization rate, which is awarded three points. In fiscal year 2012, the average quality incentive add-on was \$3.03 per day.

Effective July 1, 2012, the state implemented a new quality incentive program based on Senate Bill 264. Nursing facilities are reimbursed a maximum of \$16.44 per Medicaid day based on 20 quality measures. These quality measures consist of standards that measure the following: overall performance on an existing quality measurement framework, resident choice, clinical performance, environmental characteristics and staffing. A nursing facility is eligible to receive the full add-on (\$16.44) if it scores at least five points out of 20. In addition, a nursing facility will have the add-on reduced by 20.0% for each point below five. The new quality incentive program is funded by the FPT, which resulted in the elimination of the previous FPT add-on (\$11.47 per day). Based on data for fiscal year 2012, the maximum quality incentive add-on (\$16.44) equates to approximately \$1.94 greater than the previous FPT add-on plus the current average quality incentive add-on for fiscal year 2012 (\$16.44 - \$11.47 - \$3.03 = \$1.94). If a nursing facility scores poorly on the quality measures it could experience a significant rate reduction. However, for rates effective January 1, 2019, every facility in the state received the maximum payment (\$16.44).

If not all facilities in the state receive the full quality incentive add-on (\$16.44) and there is surplus budgeted funding, the state will distribute this surplus funding to nursing facilities that earned greater than five points. This reimbursement will be determined proportionately based on a nursing facility's number of points

and total Medicaid days.

HB 153 also enacted a Critical Access Facility add-on that equates to 5% of a nursing facility's total rate. Nursing facilities are eligible if they are located within a federally designated empowerment zone and meet both the minimum occupancy and Medicaid utilization requirements. However, to earn this add-on these nursing facilities must have received the maximum quality incentive payment and have at least one clinical quality point. As of January 1, 2019, only one nursing facilities in the state have qualified for this add-on, with an average add-on of \$9.44 per day.

As previously mentioned, the state imposed a rate reduction (\$1.79 per Medicaid day) effective July 1, 2016, to finance the state's new quality incentive add-on. Initially, nursing facilities were eligible for an add-on if they meet at least one of five quality indicators. Nursing facilities are reimbursed \$0.64 for each quality indicator they meet with a maximum add-on of \$3.20. However, effective July 1, 2018, the number of quality indicators increased to seven and the maximum add-on decreased to \$2.80 (\$0.40 for each quality indicator). The seven quality indicators are as follows:

- The state establishes a target percentage that nursing facilities must be below for the following conditions: short-stay residents with new or worsened pressure ulcers; or long-stay residents at high risk for pressure ulcers that had pressure ulcers;
- short-stay residents that newly received antipsychotic medication; or long-stay residents that received antipsychotic medication;
- The number of residents who had avoidable inpatient hospital admissions did not exceed the state target rate;
- The nursing facility's employee retention rate is at least equal to the state target rate; and
- The nursing facility utilized the nursing home version of the preferences for everyday living inventory for all of its residents.

Effective January 1, 2019, every nursing facility in the state was able to receive at least a \$1.20 add-on (meeting two standards). The average add-on in the state was \$1.90. This average is slightly greater the \$1.79 rate reduction. Based on the state law, it is assumed that the state will continue with this add-on (and the equivalent rate reduction) in future physical years.

Facility-specific Medicaid rates are initially equal to the sum of the price for the Direct Care cost component, the base per diem price for Ancillary and Support and Capital cost components (based on the facility's peer group), the facility-specific per diem rate for the Tax cost component, the original quality incentive payment, the critical access add-on and the new quality incentive add-on.

The average rate effective January 1, 2019 is \$196.32, which is only slightly greater than the average rate (\$195.21) effective January 1, 2019. The average rate effective July 1, 2017 was \$194.40, which was only slightly greater than the rate (\$192.20) effective July 1, 2016. The average nursing facility Medicaid rate effective July 1, 2016 (\$192.20) represented a 7.7% rate increase from the rate effective January 1, 2016 (\$177.31). This increase reflects the rate rebase that occurred on July 1, 2016. The January 1, 2016 rate

(\$177.31) does not significantly vary from the average rate (\$176.01) effective July 1, 2015. The previous average rates were as follows: January 1, 2015 - \$176.01; January 1, 2014 - \$174.10 and July 1, 2013 - \$173.97.

MINIMUM OCCUPANCY STANDARDS

A 90.0% minimum occupancy adjustment is applied to the Ancillary and Support cost component. The facility-specific per diem costs for this component are determined utilizing the lesser of the facility's total patient days or 90.0% of its total available patient days. Total available patient days (100% occupancy) are utilized to calculate the facility-specific Capital cost component per diem cost and the Tax cost component per diem rate.

OTHER RATE PROVISIONS

A nursing facility with a change of ownership is reimbursed at the same rate established for the nursing facility prior to the change of ownership.

Newly constructed nursing facilities are reimbursed the applicable peer group average price for the Direct Care, Ancillary and Support and Capital cost components and the statewide average rate for the Tax cost component. A new facility's Direct Care cost component price is adjusted by the peer group average Medicaid case mix score until six months of case mix data is accumulated for the facility.

A new nursing facility also receives the statewide average quality incentive payment. The facility receives these rates until the facility submits its first cost report.

Nursing facilities in Ohio are eligible to be reimbursed by Medicaid for holding a bed for a resident that required hospitalization or therapeutic leave. Bed hold reimbursement is limited to a maximum of 30 days per calendar year. Nursing facilities are reimbursed 50.0% of their current per diem rate under both scenarios. However, effective January 1, 2012, if a nursing facility's occupancy percentage in the preceding calendar year was 95.0% or less, the facility is only reimbursed 18.0% of its current rate for both types of leave.

Effective March 1, 2014, the state began the conversion to a managed care reimbursement system for dually eligible (Medicare/Medicaid) residents in urban communities. However, nursing facilities will still be reimbursed their current rates calculated by the state for Medicaid-eligible stays.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, the state is planning to establish a new quality incentive effective January 1, 2020. The previously mentioned 2.4% rate increase will be linked to this incentive. While the details of the program are still in the process of being finalized, categories will include long-stay pressure ulcers, catheters, urinary tract infections and ability to move decreases. The facilities will receive quality points based on these measures that will be paid out at approximately \$0.35 per point. A facility that does not get at least 15 quality points or does not have an occupancy percentage greater than 80% is not eligible for any quality payments. The quality metrics will be based on data for 2018 derived from the Centers for Medicare and Medicaid (CMS) Five-Star Rating System. The quality incentive methodology will be altered on July 1, 2020. The details of these potential alterations have not yet been finalized.

OHIO COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	67.00	68.00	67.00		97.00	96.00	96.00		120.00	117.00	114.00
Average Daily Census	59.30	59.65	59.53		81.38	79.76	78.07		105.50	102.52	99.86
Occupancy	78.3%	77.7%	76.9%		86.5%	86.0%	85.4%		91.6%	91.3%	90.4%
Payor Mix Statistics											
Medicare	5.7%	5.5%	5.1%		8.8%	8.7%	8.1%		12.4%	12.4%	12.1%
Medicaid	26.9%	28.2%	27.8%		52.8%	51.2%	52.8%		68.1%	68.5%	67.8%
Other	22.7%	22.2%	23.8%		35.9%	37.3%	35.8%		62.2%	62.2%	63.4%
Avg. Length of Stay Statistics (Days)											
Medicare	27.91	27.84	26.94		34.05	34.83	33.81		44.09	43.89	43.00
Medicaid	160.70	172.27	140.36		267.23	273.04	252.65		489.02	489.41	465.76
Other	59.30	60.04	55.65		93.23	97.18	89.12		153.63	162.49	155.27
Revenue (PPD)											
Inpatient	\$202.56	\$208.79	\$214.49		\$226.00	\$231.45	\$239.10		\$255.16	\$264.27	\$274.55
Ancillary	\$48.44	\$46.43	\$46.46		\$70.83	\$66.70	\$71.89		\$102.27	\$99.23	\$102.85
TOTAL	\$258.05	\$262.57	\$268.10		\$300.69	\$304.93	\$314.38		\$358.09	\$360.49	\$371.83
Expenses (PPD)											
Employee Benefits	\$14.30	\$14.49	\$14.97		\$18.06	\$18.05	\$18.87		\$24.65	\$25.70	\$26.12
Administrative and General	\$37.35	\$36.04	\$37.38		\$44.45	\$45.35	\$46.97		\$51.95	\$53.21	\$54.33
Plant Operations	\$8.96	\$9.19	\$9.45		\$10.54	\$10.61	\$11.00		\$12.42	\$12.83	\$13.24
Laundry & Linens	\$1.50	\$1.62	\$1.58		\$2.23	\$2.29	\$2.30		\$3.12	\$3.12	\$3.24
Housekeeping	\$4.05	\$4.06	\$4.10		\$4.90	\$5.01	\$5.17		\$6.17	\$6.31	\$6.43
Dietary	\$14.38	\$14.62	\$15.12		\$16.04	\$16.18	\$16.78		\$18.42	\$18.38	\$19.11
Nursing & Medical Related	\$64.34	\$68.08	\$70.75		\$72.79	\$76.59	\$80.32		\$83.00	\$86.77	\$90.66
Ancillary and Pharmacy	\$20.64	\$20.29	\$20.36		\$28.26	\$27.56	\$27.92		\$37.74	\$37.26	\$38.04
Social Services	\$2.36	\$2.62	\$2.79		\$3.76	\$4.04	\$4.17		\$5.38	\$5.50	\$5.64

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Oklahoma



INTRODUCTION

Nursing facilities in Oklahoma are licensed by the Oklahoma Department of Health (DOH) under the designation of "Long-Term Care Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN OKLAHOMA	
Licensed Nursing Facilities*	310
Licensed Nursing Beds*	24,917
Beds per 1,000 Aged 65 >**	40.25
Beds per 1,000 Aged 75 >**	98.18
Occupancy Percentage - 2017*	73.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

The above displayed occupancy estimate was derived solely from Medicare cost report data and underestimates the average occupancy within the state. Based upon fiscal year 2013 cost report data provided by the Oklahoma Healthcare Authority, the overall occupancy percentage of nursing facilities within the state was 66.41%.

CERTIFICATE OF NEED

Oklahoma established a Certificate of Need (CON) program in 1971, which is administered by the Oklahoma DOH. In Oklahoma, nursing facilities and hospital-based skilled nursing units must be approved or exempted under Oklahoma's CON laws before:

- Constructing a new nursing facility;
- An increase to the licensed beds at an existing nursing facility;
- Acquiring ownership or operation of a facility; and
- Any capital investment or lease of \$1,000,000 or more.

A CON requirements exception may be issued for the following:

- An increase of no more than 10 beds or 10% of the facility's licensed beds, whichever is greater, if the capital cost of the increase is less than \$1,000,000 and the occupancy of the facility averaged 93% or more for the 12 months prior.
- Construction of a replacement facility or the relocation of all or part of a licensed facility if: the project involves no increase in licensed beds; the new facility is constructed no farther than three miles from the original location, if located in a rural community; and the new facility is constructed no farther than seven and one-half miles from the original location, if located in an urban community.
- The acquisition of management of a nursing facility under the following conditions: the management entity must disclose the management experience for the previous 36 months (regardless of location) for persons with controlling interest therein; and if the management entity has less than 36 months of experience, it must not have a history of noncompliance with any relevant agencies.
- Any changes of ownership resulting from the operation of law, including, but not limited to, divorce, probate, reversions and bankruptcy (if the transfer of interest is to any already existing stockholder or person or entity listed on the license application disclosure statement), as well as cancellations and expirations of leases.

BED NEED METHODOLOGY

Oklahoma utilizes a bed need methodology when considering CON applications. Applicants must demonstrate that existing licensed nursing facility beds are not and will not be 15 miles from the location of the facility. However, the service area shall be a radius of seven and one-half miles for any facility located in the corporate limits of Tulsa or Oklahoma City, and any municipality contiguous with boundaries of Tulsa or Oklahoma City.

The optimal target ratio is 152 beds per 1,000 persons over the age of 75 in a service area. Applicants must demonstrate that the proposed new beds will not cause the statewide ratio to exceed 179 beds per 1,000 persons over the age of 75. The most recent population data published at the time the application is filed is used. The source of population projections for current and future years is based on year 2010 census data as published by the Oklahoma Department of Commerce.

The development of additional nursing facility beds will be considered if an overall mean occupancy rate of 85% is maintained for licensed nursing facility beds in a particular service area. The mean is calculated using data for the most recent six-month period for which reports are published by the DOH. The area bed capacity used to calculate the occupancy rate is reduced by the number of beds that are not available because rooms licensed for multiple occupants have been reserved for single occupants throughout the six-month period.

QUALITY ASSURANCE FEE

Oklahoma nursing facilities are assessed a quality assurance fee known as the quality of care fee. The quality of care fee (QCF) was established in 2000, and nursing facilities are charged this fee for each resident day. When the state developed a new Medicaid reimbursement methodology in 2005, the fee was frozen at \$6.70 per day. The QCF is not reimbursed as an add-on to a facility's Medicaid rate. However, QCF expenses were included in the costs used to calculate Oklahoma's flat base rate.

Oklahoma was recently granted a waiver from the Centers of Medicare and Medicaid (CMS) regarding its QCF. Effective November 1, 2012, CMS will allow the state to freeze the QCF for continuing care retirement communities at \$6.70 per day, while increasing the QCF to \$9.79 per day for all other nursing facilities. This increase was initially supposed to be effective October 1, 2011; however, the implementation was delayed. Effective July 1, 2013, the QCF was increased to \$10.74 for all non-CCRCs, while the fee for CCRCs remained at \$6.70. The QCF for non-CCRCs remained at \$10.74 until July 1, 2015, when it increased to \$10.79. The fees for CCRCs has remained at \$6.70. Effective July 1, 2016, the QCF increased to \$11.07 per day, but the fee for CCRCs remained at \$6.70. Effective July 1, 2017, the QCF for non-CCRCs increased to \$11.29 per day. The fee increased to \$11.48 on July 1, 2018, and increased again to \$11.62 on October 1, 2018. The fee for CCRCs has remained at \$6.70.

MEDICAID RATE CALCULATION SYSTEM

Oklahoma utilizes a combination of a flat prospective rate and prospective, facility-specific add-on rates to calculate per diem Medicaid rates for nursing homes.

In 2005, the state developed a new reimbursement methodology for determining Medicaid per diem rates. Prior to 2005, the Oklahoma rate system was a price-based prospective rate setting system and consisted of three rate components: Primary Operating Costs, Administrative Services Costs and Capital Costs. Effective July 1, 2005, the new reimbursement methodology established a flat base rate, which encompasses all costs included in the previous cost components. The base rate reflects the statewide average rate that was in effect on June 30, 2005, and was determined using 2003 cost report data. This base rate was frozen at \$103.20 from July 1, 2005, to August 31, 2012. Effective September 1, 2012, the base rate was increased to \$106.29 based on additional funding generated from the increase in the QCF. In addition, the base rate was increased to \$107.24 on July 1, 2013. The base rate will remain unchanged through fiscal year 2016 (effective July 1, 2015). Effective July 1, 2016, the base rate increased by \$107.57. The fee again slightly increased to \$107.79, effective July 1, 2017. The base rate increased to \$108.12 on October 1, 2018.

A nursing facility's Medicaid per diem rate is determined as the sum of the statewide base rate plus a statewide average add-on for Other Costs (non-Direct Care) plus facility-specific add-ons for Direct Care Costs and the Oklahoma Focus on Excellence Quality of Care Rating System (FOE).

COST CENTERS

Costs utilized to determine Oklahoma's Direct Care add-on include employment costs (wages, professional fees and benefits) and training costs for registered nurses, licensed practical nurses, nurse aides and certified medication aides.

INFLATION AND REBASING

Nursing facilities' Direct Care and Other add-on rates are determined annually using previous year cost report data. The rate year in Oklahoma is supposed to be from July 1 to June 30; however, the state has often established new rates on different effective dates based on legislation passed. Rates effective November 1, 2010, were calculated utilizing cost report data for the fiscal year ending June 30, 2009. These rates were determined after the state had implemented a 2.67% rate reduction on April 1, 2010, due to a constitutional requirement that Oklahoma has a balanced budget. Prior to this reduction, the state had rebased rates on January 1, 2010. This reduction was implemented by reducing the total funding available for establishing the Direct Care and Other add-ons from \$115,979,147 for the rate period beginning January 1, 2010, to \$99,248,541 for the rate period beginning April 1, 2010. The funding available for rates established November 1, 2010, was \$97,607,577.

Under the state regulations, allowable costs should be inflated from mid-cost report to the mid-rate year, using the Global Insight Market Basket. However, Oklahoma typically bases its Direct Care and Other add-on rates on non-inflated costs and the state appropriations budget. Inflated costs are only utilized as an analysis tool by the state legislature to determine the Medicaid appropriations for nursing homes.

Rates remained frozen until January 1, 2012, when a slight increase

in funding resulted in an average 0.9% rate increase. Effective September 1, 2012, the state rebased the Direct Care and Other rate add-ons and increased the base rate utilizing additional funding generated from the increase in the QCF. Similarly, effective July 1, 2013, the state rebased the Direct Care and Other rate add-ons (based on cost report data for the year ended June 30, 2012) and increased the base rate utilizing additional funding generated from the increase in the QCF.

No inflation was utilized to determine the Direct Care and Other rate add-ons effective July 1, 2014. Therefore, these add-ons remained relatively unchanged. Funding for nursing facility reimbursement remained relatively flat in fiscal year 2016, with no changes in the Base Rate or Other add-ons. However, the state enacted a 3.0% rate reduction across all providers effective January 1, 2016. The state was able to enact this reduction without actually decreasing nursing home Medicaid rates. Oklahoma pays for a percentage of Medicare co-pays for dual eligible residents. The state paid approximately 80% of the co-pay prior to January 1, 2016. Effective that date, the state reduced this percentage to 20%. However, nursing facilities can get 65% percent of this reduction back by claiming it as bad debt. Based on this adjustment, the state was able to maintain the funding to essentially freeze Medicaid rates. However, effective October 1, 2018, the state implemented a 4.0% rate increase.

RATE METHODOLOGY

As previously mentioned, a nursing facility's Medicaid per diem rate is determined as the sum of the statewide base rate (\$107.57), the statewide average add-on for Other Costs, plus the facility-specific add-ons for Direct Care and FOE.

The Direct Care and Other add-on rates for each facility are established annually through two pools (the Other Cost pool and Direct Cost pool) of funds. These pools are based on funding remaining after the state has reimbursed nursing facilities for the statewide facility base rate and deducted the estimated cost for funding the FOE (explained below). The Other Cost pool equates to 30.0% of the remaining available funds and the Direct Care Cost pool equates to 70.0% of the remaining available funds. The Other Cost add-on is a uniform rate for all nursing facilities that is determined by dividing the allowable pool of funds for Other Care by the total estimated Medicaid days for all participating facilities.

The current Other add-on (effective October 1, 2018) is \$11.90 per day. The previous add-on was \$10.42 per day, effective July 1, 2017. Prior to this date, the add-on had been frozen since July 1, 2016, at \$10.28 per day.

The Direct Care facility-specific add-on is determined as follows:

- The Oklahoma Health Care Authority (OHCA) constructs an array based on all the allowable Direct Care per diem costs for all participating nursing facilities, with each facility's value (Direct Care Value) determined to be the lesser of its actual per diem costs or a ceiling set at the 90th percentile of the array of facilities.
- The Direct Care value for each facility is then multiplied by its estimated annual Medicaid days and added together to

calculate the facility-specific aggregate estimated Medicaid Direct Care cost. The aggregate estimated direct care costs for all participating nursing facilities are summed to determine the total aggregate estimated direct care cost.

- An add-on percentage for Direct Care is then determined by dividing the Direct Care pool of available funds by the total aggregate estimated Medicaid Direct Care cost.
- The Direct Care add-on for each facility is determined by multiplying its Direct Care value by the add-on percentage. The current average Direct Care add-on is \$27.96 per day (effective October 1, 2018) and the add-on ranges from \$16.25 to \$35.67 per day. This averages a \$3.64 increase from the average (\$24.32) effective July 1, 2017, which was a \$0.17 increase from the July 1, 2016 (\$24.15) estimate. The July 1, 2016, average was a \$1.02 increase from the average (\$23.13) effective July 1, 2015. The July 1, 2015 average (\$23.13) is a \$0.30 decrease from the average (\$23.49) effective July 1, 2014. However, the slight decrease in the average Direct Care add-on reflects an increase reimbursement for the FOE program rather than any decrease in funding for the Direct Care add-on. As previously mentioned, the Direct Care and Other Cost add-ons are established with the funds remaining after the Base rate and FOE program have been funded. Therefore, when the FOE required more funding, it left less funding for the Direct Care add-on. The average add-on effective July 1, 2013, (\$23.46) was an 8.7% increase from the average (\$21.58) effective September 1, 2012. The September 1, 2012, average (\$21.58) was a 56.0% increase from the average (\$13.83) effective November 1, 2010.
- Oklahoma established its Focus on Excellence Quality of Care Rating System on July 1, 2008. Effective July 1, 2012, the state converted to a new version of the program. Under the previous version, nursing facilities could earn from 1 to 10 points based on 10 quality measures. Nursing facilities were reimbursed \$1.09 per point, with a maximum of \$5.45 per patient day.
- The new system is based on a point system that scores facilities from 1 to 500 points for meeting the established thresholds, and payment will be established at \$0.01 per point, with a maximum add-on of \$5.00 per day.

Points are awarded to facilities that meet or exceed established thresholds on a range of nine quality measures, which are listed below:

- Person Centered Care - point value of 120 - the facility must meet six out of 10 established standards to receive points for this threshold.
- Direct Care Staffing - point value of 50 - the facility must maintain a direct care staffing ratio of 3.5 hours per patient day to receive points for this threshold.
- Resident/Family Satisfaction - point value of 80 - the facility must maintain a weighted score of 72.0 to receive points for this threshold.
- Employee Satisfaction - point value of 50 - the facility must maintain a weighted score of 65.0 to receive points for this threshold.
- Licensed Nurse Retention - point value of 50 - the facility must maintain a one-year tenure rate for 60% or better of its licensed nursing staff to receive points for this threshold.
- CNA Retention - point value of 50 - the facility must maintain

a one-year tenure rate for 50% or better of its CNA staff to receive points for this threshold.

- Distance Learning Program Participation - point value of 35 - the facility must sign up and use an approved distance learning program for its direct care staff to receive points for this category. A threshold based on the percentage of participation will be established after adequate data is collected.
- Peer Mentoring Program Participation - point value of 30 - the facility must sign up and use an approved peer mentoring program for its direct care staff to receive points for this category. A threshold based on the percentage of participation will be established after adequate data is collected.
- Leadership Commitment - point value of 35 - the facility must meet six out of 10 established standards to receive points for this threshold.

A facility must earn a minimum score of 100 points to receive any payments. In addition, a facility will forfeit any payments if it receives a citation of Severity Level I or greater or is placed on an admission ban by CMS. The average payment effective January 1, 2019, was \$3.06.

Effective October 1, 2018, the average rate was \$150.91, which is a \$5.62 increase from the prior rate (July 1, 2017). On July 1, 2017, the average Medicaid rate in the state was \$145.29, which is a \$0.58 increase from the previous average rate (\$144.81 – Effective July 1, 2016). Effective July 1, 2015, the average Medicaid rate in the state was \$143.70. The average rate effective July 1, 2015, is \$0.18 greater than the average rate effective July 1, 2014 (\$143.52). The July 1, 2014, average rate was only \$0.10 greater than the average rate (\$143.42) effective July 1, 2013. The July 1, 2013, rate is 2.5% greater than the rate effective September 1, 2012 (\$139.91). The average rate effective September 1, 2012, (\$139.91) represented a 10.5% increase over the weighted average rate (\$126.33) for state fiscal year 2012 (July 1, 2011 to June 30, 2012). The weighted average rate for the previous state fiscal years are \$125.75 in 2011, \$128.39 in 2010, \$123.38 in 2009 and \$123.29 in 2008.

MINIMUM OCCUPANCY STANDARDS

Minimum occupancy standards are not applied in Oklahoma.

OTHER RATE PROVISIONS

Effective September 1, 2012, nursing facilities that have ventilator dependent residents are eligible for a rate add-on that equates to \$135.43 per resident day. The state also has a standard per diem rate that nursing facilities can receive for the treatment of patients with HIV/Aids. Effective October 1, 2018, this rate is \$207.86 per day, which is \$7.85 increase from the rate (\$200.01) effective July 1, 2017. The rate effective January 1, 2017, was \$199.29 per day. In addition to this rate, facilities are also reimbursed for the FOE add-on.

Oklahoma Medicaid reimburses nursing facilities for reserving a bed for residents absent from the facility due to therapeutic leave. Nursing facilities are reimbursed a maximum of seven days per calendar year for a therapeutic leave for each Medicaid beneficiary. Payment for reserving a bed equates to 50.0% of a nursing facility's

per diem rate. Effective September 1, 2014, the state eliminated reimbursement for holding a bed for residents absent from the facility due to hospitalization. Previously, the state reimbursed up to five hospital bed hold days per calendar year at a rate that equated to 50.0% of a nursing facility's per diem rate. It is currently unclear if the state will consider reestablishing hospitalization bed hold reimbursement.

A nursing facility with a change of ownership is reimbursed at the same rate established for the nursing facility prior to the change of ownership, until the facility submits its first cost report. For new facilities beginning operations in the current rate period, the rate will be the median of those established rates for the year. A new rate for the facility will be established when it has produced adequate cost report data.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

Oklahoma has submitted a state plan amendment to the Centers of Medicare and Medicaid (CMS) for the development of an Upper Payment Limit (UPL)/Intergovernmental Transfer (IGT) program. The state is proposing to link reimbursement from this program to quality of care standards. Rate setting officials have also indicated that in order to accomplish this goal, the state would be required to gather case mix index (CMI) data. This could potentially result in the state utilizing some type of acuity adjustment system to calculate Medicaid rates. The likelihood that CMS will approve these programs and the time frame of implementation of these programs is unclear. However, representatives of the Oklahoma Health Care Authority have recently indicated that they expect to receive a rejection letter from CMS in the near future.

OKLAHOMA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	65.00	65.00	68.75		89.00	93.50	98.50		112.00	114.50	117.25
Average Daily Census	49.65	50.24	50.08		61.99	66.86	64.54		82.47	84.30	84.91
Occupancy	60.9%	61.0%	60.9%		69.9%	71.4%	69.1%		82.5%	81.8%	81.3%
Payor Mix Statistics											
Medicare	5.8%	5.8%	5.5%		8.8%	8.4%	8.7%		13.0%	11.7%	12.5%
Medicaid	62.8%	65.2%	65.7%		72.0%	73.7%	72.9%		80.4%	79.7%	80.7%
Other	10.8%	10.9%	11.0%		18.7%	17.9%	18.1%		26.0%	25.6%	25.2%
Avg. Length of Stay Statistics (Days)											
Medicare	30.80	31.21	29.29		39.99	41.22	37.71		52.71	49.67	50.85
Medicaid	225.30	210.01	190.51		314.66	268.87	289.25		489.64	550.08	614.02
Other	82.11	72.22	69.99		142.97	122.97	119.68		252.94	231.11	202.78
Revenue (PPD)											
Inpatient	\$150.25	\$149.82	\$151.20		\$163.34	\$163.71	\$165.97		\$182.06	\$176.84	\$183.54
Ancillary	\$21.02	\$20.57	\$21.49		\$33.97	\$33.11	\$37.37		\$57.85	\$61.79	\$60.68
TOTAL	\$167.19	\$166.32	\$171.58		\$189.04	\$187.47	\$200.61		\$222.85	\$223.93	\$234.93
Expenses (PPD)											
Employee Benefits	\$10.43	\$10.54	\$9.95		\$12.03	\$11.58	\$11.64		\$14.09	\$14.48	\$14.18
Administrative and General	\$26.56	\$27.94	\$29.71		\$32.56	\$34.03	\$36.92		\$38.16	\$40.80	\$42.31
Plant Operations	\$7.13	\$7.23	\$7.34		\$8.23	\$8.12	\$8.69		\$9.99	\$9.59	\$10.49
Laundry & Linens	\$1.68	\$1.82	\$1.82		\$2.35	\$2.40	\$2.37		\$2.92	\$2.83	\$2.96
Housekeeping	\$3.77	\$3.76	\$3.79		\$4.56	\$4.46	\$4.61		\$5.40	\$5.28	\$5.46
Dietary	\$14.18	\$13.76	\$14.04		\$15.61	\$15.15	\$15.83		\$17.73	\$17.20	\$17.94
Nursing & Medical Related	\$56.26	\$56.83	\$59.52		\$64.07	\$65.07	\$66.21		\$71.51	\$71.88	\$74.85
Ancillary and Pharmacy	\$10.34	\$10.74	\$10.59		\$15.76	\$16.01	\$17.05		\$24.51	\$22.59	\$25.81
Social Services	\$1.49	\$1.43	\$1.47		\$2.42	\$2.27	\$2.38		\$3.54	\$3.35	\$3.51

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Oregon



INTRODUCTION

Nursing facilities in Oregon are licensed by the Oregon Department of Human Services (DHS), Seniors and People with Disabilities Division under the designation of “Nursing Facilities.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN OREGON	
Licensed Nursing Facilities*	121
Licensed Nursing Beds*	9,927
Beds per 1,000 Aged 65 >**	13.54
Beds per 1,000 Aged 75 >**	34.91
Occupancy Percentage***	65.50%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

***Source: AHCA/NCAL Research Division. Casper Data. September 20, 2018

CERTIFICATE OF NEED

Oregon has operated a Certificate of Need (CON) program since 1971. The CON program is administered by the Health Systems Planning Division within DHS. With the exception of certain religious institutions, any new hospital, skilled nursing facility, or intermediate care service or facility is required to obtain a CON prior to an offering or development.

A new skilled nursing facility includes any of the following:

- An increase in the skilled nursing bed capacity by more than 10 beds or more than 10.0% of the current bed capacity, whichever is less, within a two-year period after the most recent previous increase in beds at the facility. Based on the recently approved House Bill 2216, these additions will only be allowed if the state has determined that there is unmet need in the facility’s immediate area.
- The rebuilding of an existing long-term care facility. Rebuilding is considered to include any construction project in which at least 50% of the square footage of the existing building or buildings is demolished and replaced through new construction, remodeling that is so extensive that the cost of the remodeling is at least 50.0% of the estimated replacement cost of the facility, or remodeling that involves replacement through new construction of at least 50.0% of the facility’s structural bed capacity.
- The relocation of an existing long-term care facility to a new site.
- The relocation of existing long-term care beds from one licensed healthcare facility to another.

A change in the ownership of a long-term care facility does not constitute the need for a CON. A change in services of an existing nursing facility does not constitute the submission of an application for a CON, unless the new service is outside the scope of services allowable under a nursing facility license.

A CON cannot be transferred. A transfer is considered to have occurred if there is a change in ownership of a service, item of equipment or facility. These changes must occur prior to the completion of the project for which the CON has been issued, provided that the change in ownership results in the provision of

affected services in a substantially different manner or different location from that indicated in the CON application.

As previously mentioned, the Oregon Assembly has recently passed House Bill 2216, effective October 7, 2013. The goal of this legislation is to reduce the long-term care facility bed capacity in Oregon by 1,500 beds by December 31, 2015, except for bed capacity in nursing facilities operated by the Department of Veterans Affairs and facilities for which the Oregon Health Authority approved a CON between August 1, 2011, and December 1, 2012. As of September 30, 2016, the state achieved a reduction of 1,210 beds.

In order to reduce the long-term care facility bed capacity statewide, DHS may permit an operator of a long-term care facility to purchase another long-term care facility’s bed capacity if:

- The long-term care facility bed capacity being purchased is not an essential long-term care facility.
- The long-term care facility’s entire bed capacity is purchased and the seller agrees to surrender the long-term care facility’s license.
- If a long-term care facility’s bed capacity is purchased, the facility may not admit new residents to the facility except in accordance with criteria adopted by the DHS by rule.
- Long-term care bed capacity purchased under this section may not be transferred to another long-term care facility.

Any long-term care facility for which a license was surrendered shall obtain a CON from the Oregon Health Authority prior to an offering or development.

Oregon also has an expedited review process for an application for a CON to rebuild a long-term care facility, relocate buildings that are part of a long-term care facility or relocate long-term care facility bed capacity from one long-term care facility to another. The authority shall issue a proposed order no later than 120 days after the date a complete application for expedited review has been received by the authority. As of July 1, 2018, the state has reduced over 1,350 beds.

BED NEED METHODOLOGY

The following determination of need principles are applied in the review of CON applications:

- The determination of need is calculated for the specific service area that the CON applicant will be serving. The geographic service area considered will be the county in which the facility is located, unless the applicant proposes an alternative service area and demonstrates, to DHS’ satisfaction, the appropriateness of the alternative service area.
- No county is to exceed a ratio of 40 beds per 1,000 persons age 65 or older.
- The service area must demonstrate a minimum occupancy of 95.0% before DHS will consider adding beds. However, a 90.0% minimum occupancy percentage may be allowable under the following conditions: state agencies plan on utilizing the new beds; anticipated population changes; and, considerations of maintaining access at reasonable cost indicate that 90.0% is appropriate.

- Need is projected on the basis of forecasted elderly population in three years. This time period is extended for counties with population densities below the state median. It is shortened when utilization of beds by state agencies has declined, and compensating utilization of alternative care has occurred and is projected to continue.
- Projected use rates (including an applicant's beds and other proposed nursing facilities' beds) are calculated and compared to historical use rates for the service area.
- Proposed beds are evaluated in relation to the entire local long-term care system, to resources in the local service area and the health service areas as a whole, to plans of state and local agencies and to state policies expressed by the legislature. Additional beds will not be approved simply on the basis of "need" at a specific facility.

and amortization.

- Administrative and General Expenses include wages and benefits associated with administration, as well as advertising, management fees, liability insurance, bad debt and assessments paid for the LTCFT.
- Other Operating Support Expenses include wages, benefits, and supplies associated with maintenance; laundry, housekeeping and dietary; and utilities and property tax.
- Food Expenses include raw food.
- Direct Care Compensation Expenses include wages and benefits associated with nursing, ancillary services, activities and social services.
- Direct Care Supply Expenses cover all supplies associated with nursing, ancillary services, activities and social services.

These cost components are all combined into one flat facility-specific cost that is utilized to calculate the state's basic rate.

QUALITY ASSESSMENT FEE

Nursing facilities in Oregon are assessed a quality assessment fee known as the "long-term care facility tax" (LTCFT). The tax is assessed for each patient day at long-term care facilities as reported by the facilities on a quarterly basis. The LTCFT is established annually and is effective each July 1. Effective July 1, 2018, the tax rate is \$24.46. This represents a \$0.58 increase from the previous rate effective July 1, 2017 (\$23.58). The July 1, 2017, rate represented a \$0.59 increase from the prior rate (\$22.99). The July 1, 2016, tax (\$22.99) represented a \$0.43 increase from the tax effective July 1, 2015 (\$22.56). The rate effective July 1, 2015, (\$22.56) represented a \$3.09 increase from the tax effective July 1, 2014, (\$19.37).

The total LTCFT is calculated by multiplying total patient days by \$24.46. Facilities are reimbursed for the tax through higher statewide reimbursement rates. The costs associated with the tax are included in nursing facilities' annual cost reports, which are used to determine reimbursement rates through the method described below. The LTCFT was scheduled to sunset on June 30, 2014, but House Bill 2216 extended the LTCFT until June 30, 2020.

Prior to House Bill 2216, long-term care facilities that are exempt from the assessment included continuing care retirement communities (CCRCs), the Oregon's Veterans Home, and facilities with Medicaid patient days in excess of 85.0% of their total patient days. However, effective January 1, 2014, only the Oregon's Veteran Home is exempt from paying the LTCFT.

MEDICAID RATE CALCULATION SYSTEM

Oregon uses a prospective, price-based rate setting methodology to calculate one specific, flat, per diem Medicaid rate for nursing facilities. This rate is referred to as a basic rate. In addition, each facility is eligible to receive a Complex Medical Needs add-on rate. This add-on is only applied to specific residents. Oregon does not adjust the basic rate for a facility's or resident's case mix index (CMI).

COST CENTERS

Costs reported in the state's Nursing Facility Financial Statements (NFFS) are allocated to the following six expense categories:

- Property Expenses include interest, rent/lease, depreciation

INFLATION AND REBASING

The basic rate is calculated utilizing NFFS filed annually by all nursing facilities. Prior to House Bill 2216, the basic rate was rebased semiannually based on the NFFS filed for the fiscal reporting period ending June 30 of even-numbered years. However, effective fiscal year 2013, the basic rate will be rebased on an annual basis. For example, for the rate period beginning July 1, 2016, statements for the period ending June 30, 2015, were used. This represents the second fiscal year in a row that the state rebased rates. Prior to July 1, 2013, given budgetary limitations, the state had not rebased the basic rate since July 1, 2010.

After allowable costs are determined for a facility, they are inflated from the midpoint of the facility's fiscal reporting period to the midpoint of the first year of the biennium by the annual change in the Global Insight DRI Index, or its successor (as measured in the previous fourth quarter).

Prior to House Bill 2216, on July 1 of each non-rebasing year, the basic rate is inflated by the annual change in the Global Insight DRI Index, or its successor, as measured in the previous fourth quarter. The inflation rate was 1.87% for fiscal year 2011. Given budgetary limitations, Oregon Medicaid rates were frozen in fiscal years 2012 and 2013 at fiscal year 2011 levels. These rate freezes were enacted based on legislation approved by the Oregon Assembly.

As previously mentioned, in fiscal year 2014 (effective July 1, 2013) the state rebased rates and applied the required inflation adjustments. Given that rates had not been rebased since July 1, 2010, and had only received limited inflation adjustments, the subsequent rebase and inflation resulted in a 20.9% increase in the state basic rate. In addition, effective July 1, 2014, there was a 3.5% funding increase in Oregon for all community-based facilities. However, the state basic rate only increased by 0.2%. The base rate increased 5.6% and 3.3% in fiscal years 2016 and 2017, respectively. The basic rate increased 7.3% in fiscal year 2018.

The rebase in fiscal year 2017 more than offset the changes required to rate calculation as a result of House Bill 2216. These changes will be discussed later in this overview.

RATE METHODOLOGY

In order to determine the allowable costs per Medicaid day for each facility, a facility's total allowable inflated costs are divided by the facility's Medicaid days. There are no floors or ceilings applied to facilities' allowable costs per cost component.

The basic rate is determined by ranking the allowable costs per Medicaid day for all facilities from highest to lowest and identifying the allowable cost per day at the applicable percentage. For the biennium beginning July 1, 2009, the applicable percentage is at the 63rd percentile. Historically, the applicable percentage was at the 63rd percentile for the biennium beginning July 1, 2007, and the 70th percentile for the biennium beginning July 1, 2005. If there is no allowable cost per day at the applicable percentage, the basic rate is determined by interpolating the difference between the allowable costs per day just above and just below the applicable percentage.

The Complex Medical Needs rate add-on is calculated to be 40.0% of the basic rate for the rebasing year as well as the non-rebasing year. This add-on reflects the additional costs of providing nursing specific services to certain residents as needed. Facilities are reimbursed at the Complex Medical Needs rate for days that residents need one or more of the procedures, treatments or services listed in the following table:

Medication Procedures	
M-1	Administration of medication(s) at least daily requiring skilled observation and judgment for necessity, dosage, and effect, for example new anticoagulants, etc.
M-2	Intravenous injections or infusions, heparin locks used daily or continuously for hydration or medication.
M-4	Intramuscular medications for unstable condition used at least daily.
M-5	External infusion pumps used at least daily. This does not include external infusion pumps when the resident is able to self bolus.
M-6	Hypodermoclysis, daily or continuous use.
M-7	Peritoneal dialysis, daily. This does not include residents who can do their own exchanges.
Treatment Procedures	
T-1	Nasogastric, gastrostomy, or jejunostomy tubes used daily for feedings.
T-2	Nasopharyngeal suctioning, twice a day or more. Tracheal suctioning, as required, for a resident who is dependent on nursing staff to maintain airway.
T-3	Percussion, postural drainage, and aerosol treatment when all three are performed twice per day or more.
T-4	Ventilator dependence. Services for a resident who is dependent on nursing staff for initiation, monitoring, and maintenance.
Skin/Wound	
S-1	Limited to Stage III or IV pressure ulcers that require aggressive treatment and are expected to resolve.
S-2	Open wound(s) as defined by dehisced surgical wounds or surgical wounds not closed primarily that require aggressive treatment and are expected to resolve.
S-3	Deep or infected stasis ulcers with tissue destruction equivalent to at least a Stage III.

Insulin Dependent Diabetes Mellitus (IDDM)	
O-4	Unstable IDDM in a resident who requires sliding scale insulin, exhibits signs or symptoms of hypoglycemia and/or hyperglycemia, requires nursing or medical interventions (extra feeding, glucagon or additional insulin, transfer to emergency room), and is having insulin dosage adjustments. While all three criteria do not need to be present on a daily basis, the resident must be considered unstable.
Other	
O-1	Professional Teaching. Short-term, daily teaching pursuant to discharge or self-care plan.
O-2	Emergent medical or surgical problems, requiring short-term licensed nursing observation and assessment.
O-3	Emergent behavior problems. Emergent behavior is a sudden, generally unexpected change or escalation in behavior of a resident that poses a serious threat to the safety of self or others and requires immediate intervention, consultation and a service plan.
R-1	Rehabilitation services. Any combination of physical therapy occupational therapy, speech therapy, and/or respiratory therapy at least five days every week qualifies. Respiratory services must be authorized by Medicare, Medicaid Oregon Health Plan, or a third party payor.

Nursing facilities are reimbursed based on their mix of basic rate resident days and complex medical needs rate add-on resident days. The following table presents the historical nursing facility rates:

Oregon Nursing Facility Rates			
Fiscal Year/Period	Basic	Complex	Increase
7/1/2018	\$312.94	\$438.12	3.7%
7/1/2017	\$301.70	\$422.38	7.3%
1/1/2017	\$281.28	\$393.79	0.1%
7/1/2016 to 12/31/2016	\$281.08	\$393.52	3.3%
2016	\$272.00	\$380.80	5.6%
2015	\$257.56	\$360.38	2.2%
10/1/2013 to 6/30/14	\$257.00	\$359.59	4.4%
7/1/13 to 9/30/13	\$256.47	\$359.07	20.9%
2013	\$212.12	\$295.59	0.0%
2012	\$212.12	\$295.59	0.0%
2011	\$212.12	\$295.59	1.8%
2010	\$208.29	\$290.34	5.1%
2009	\$198.17	\$277.44	5.9%

As previously mentioned, July 1, 2013, rates represent the first rate rebasing since July 1, 2010, which results in a substantial increase (20.9%) in the basic rate, and a subsequent increase (21.5%) in the complex medical needs rate. The basic rate previously includes a \$3.44 Certified Nursing Aide (CNA) add-on. This add-on was established to allow nursing facilities to increase CNA staffing

ratios to levels required by the state. This basic rate was rebased prior to adding the CNA add-on to the rate. The base rate effective July 1, 2013, does not include this add-on. However, effective October 1, 2013, the state established a new CNA add-on that equates to \$0.53 per resident. This increased the base rate to \$257.00 per day. In addition, the complex medical needs rate was increased \$0.52 per resident to \$359.59 effective October 1, 2013. The basic rate effective July 1, 2014 (\$257.56) represents 0.2% increase from the prior rate. This included a \$0.52 CNA add-on. There was no CNA add-on in fiscal year 2016, and state rate setting officials do not envision one in the future. The base rate effective July 1, 2015 (\$272.00), represents a 5.6% increase from the prior rate. .

The state has established a goal to reduce the long-term care facility bed capacity in Oregon by 1,500 beds by December 31, 2015. In order to encourage nursing facility operators to achieve this goal, the state would begin to reduce Medicaid reimbursement levels on July 1, 2016, if this goal is not achieved. This will be accomplished by reducing the percentile (63rd) used to determine the basic rate by sliding scale as follows:

Oregon Nursing Facility Rates	
Number of Beds Reduced	Percentile Used to Calculate the Basic Rate
= or > 1,500	63rd
= or > 1,350	62nd
1,200 to 1,350	61st
1,050 to 1,199	60th
900 to 1,049	59th
750 to 899	58th
600 to 749	57th
450 to 599	56th
300 to 449	55th
150 to 299	54th
1 to 49	53rd

July 1, 2016 rates were based on the total number reduced in the state effective March 31, 2016. Based on the number of beds reduced by that date, the July 1, 2016, base rate was calculated at the 60th percentile. However, given that July 1, 2016, rates were calculated with more current cost report data and were adjusted for inflation, the base rate and complex medical needs rates both increased by 3.3%, respectively.

Since July 1, 2017, the state has continued to reduce the number of beds, which has resulted in the state utilizing a higher percentile in the calculation. This and the annual rate rebase resulted in an increase in both rates on July 1, 2017. In addition, by July 1, 2018, the state had reduced over 1,350 beds, increasing the basic rate to the 62nd percentile. This resulted in a 3.7% increase in the basic rate.

House Bill 2216 also provides additional payments of \$9.75 per Medicaid resident to nursing facilities that purchased long-term care bed capacity on or after October 1, 2013, and on or before December 31, 2015. The payments may be made for a period of four years from the date of purchase. DHS may not make additional payments under this section until the Medicaid-certified long-term care facility is found by DHS to meet quality standards adopted by the department by rule. The goal of this add-on is to reduce overall nursing home capacity in the state, by encouraging facilities located in higher need areas to purchase beds from facilities that have excess capacity.

MINIMUM OCCUPANCY STANDARDS

Minimum occupancy standards are not applied in Oregon.

OTHER RATE PROVISIONS

There are no bed hold provisions in Oregon’s Medicaid system. Nursing facilities are not reimbursed for any time a resident spends outside of the facility.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no changes expected to the Medicaid rate methodology in the immediate future.

OREGON COST REPORT STATISTICS

General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	59.00	54.00	54.00		80.00	80.00	81.00		105.00	103.25	100.00
Average Daily Census	45.22	44.42	45.86		60.59	61.10	62.15		85.18	89.11	93.69
Occupancy	57.3%	58.6%	61.2%		68.5%	70.2%	72.7%		79.9%	81.7%	84.4%
Payor Mix Statistics											
Medicare	6.7%	7.0%	6.3%		10.9%	10.7%	11.3%		17.1%	16.3%	16.8%
Medicaid	44.7%	41.3%	41.4%		55.1%	54.8%	56.6%		65.8%	65.6%	66.5%
Other	23.0%	21.8%	21.5%		32.0%	30.5%	29.3%		52.0%	53.7%	54.0%
Avg. Length of Stay Statistics (Days)											
Medicare	24.04	23.06	23.69		27.31	26.67	26.75		32.01	32.29	31.42
Medicaid	147.85	153.13	146.44		192.32	189.62	187.67		238.94	287.47	290.96
Other	27.61	27.47	27.26		36.90	35.83	36.67		73.75	75.19	86.94
Revenue (PPD)											
Inpatient	\$254.57	\$276.07	\$264.57		\$286.79	\$305.27	\$309.55		\$327.45	\$347.89	\$350.98
Ancillary	\$72.53	\$70.57	\$73.30		\$122.27	\$127.43	\$129.80		\$202.11	\$188.48	\$212.79
TOTAL	\$357.36	\$383.16	\$380.68		\$415.49	\$442.04	\$441.15		\$533.85	\$535.83	\$520.39
Expenses (PPD)											
Employee Benefits	\$22.26	\$24.52	\$24.97		\$28.60	\$29.27	\$31.54		\$33.01	\$32.27	\$35.05
Administrative and General	\$56.56	\$60.29	\$61.00		\$63.68	\$65.15	\$68.76		\$68.45	\$73.72	\$74.56
Plant Operations	\$9.21	\$9.33	\$9.98		\$10.17	\$10.77	\$11.36		\$12.44	\$13.12	\$13.67
Laundry & Linens	\$2.36	\$2.57	\$2.48		\$2.93	\$3.27	\$3.47		\$3.57	\$3.84	\$4.08
Housekeeping	\$4.48	\$4.60	\$4.87		\$5.15	\$5.41	\$5.57		\$6.45	\$6.91	\$7.18
Dietary	\$16.41	\$16.81	\$17.49		\$17.98	\$18.23	\$18.83		\$20.40	\$20.95	\$21.35
Nursing & Medical Related	\$94.72	\$101.05	\$103.41		\$108.34	\$112.61	\$117.94		\$119.96	\$128.70	\$131.37
Ancillary and Pharmacy	\$30.21	\$32.21	\$31.58		\$46.83	\$44.91	\$43.83		\$66.70	\$60.35	\$59.97
Social Services	\$3.05	\$3.29	\$3.30		\$4.83	\$5.05	\$5.26		\$5.96	\$6.47	\$6.76

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Pennsylvania



INTRODUCTION

Nursing facilities in Pennsylvania are licensed by the Pennsylvania Department of Health, Division of Nursing Care Facilities under the designation of "Nursing Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN PENNSYLVANIA	
Licensed Nursing Facilities*	703
Licensed Nursing Beds*	91,201
Beds per 1,000 Aged 65 >**	39.39
Beds per 1,000 Aged 75 >**	90.96
Occupancy Percentage - 2017*	84.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Pennsylvania eliminated its Certificate of Need (CON) program in 1996. After the sunset of the CON, the Pennsylvania Department of Public Welfare (PDPW) has established a Statement of Policy regarding the certification of Medicaid beds. The PDPW certifies an extremely limited number of new or existing beds.

BED NEED METHODOLOGY

Pennsylvania does not possess a bed need methodology.

PROVIDER ASSESSMENT FEE

The PDPW assesses nursing facilities with a provider assessment fee. The PDPW began assessing nursing facilities in the state with a provider assessment fee on July 1, 2003. The fee varies dependent on facility type. Effective July 1, 2018, the fee is \$7.40 per non-Medicare resident day for nursing facilities in a continuing care retirement community (CCRC), county-owned facilities, nursing facilities with a Medicaid payor percentage of 94% or greater for the last four quarters, and facilities with 44 or less beds. The fee is \$31.49 for all other nursing facilities. These fees represented a \$0.61 decrease from the equivalent fiscal year 2018 rates (\$8.01 and \$32.10). The fiscal year 2018 rates (effective July 1, 2017) did not change from the fiscal year 2017 rates (effective July 1, 2016). In addition, prior to July 1, 2014, nursing facilities with less than 50 beds were only assessed the lower fee. However, this standard was changed from less than 50 beds to 44 or less beds in fiscal year 2015. Also, the lower fee for nursing facilities with a Medicaid payor percentage of 94% or greater was implemented in fiscal year 2016.

Nursing facilities are reimbursed a portion of their assessment fee, which is further detailed in the Rate Methodology section. Pennsylvania's provider assessment fee is below the federal ceiling (6.0% of total revenue) established by the Centers for Medicare and Medicaid. Since Pennsylvania revises its model every year, the state can ensure that its assessment fee and law comply with federal requirements.

MEDICAID RATE CALCULATION SYSTEM

Pennsylvania uses a prospective, cost-based, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. However, effective January 1, 2018, the state began the transition to Managed Care Reimbursement System (Community Health Choices). Nursing homes in the southwestern portion of the state (Allegheny; Armstrong; Beaver; Bedford; Blair; Butler; Cambria; Fayette; Greene; Indiana; Lawrence; Somerset; Washington and Westmoreland Counties) entered the system on January 1, 2018. The southeastern portion of the state (Bucks; Chester; Delaware; Montgomery and Philadelphia Counties) entered the system effective January 1, 2019. The remaining facilities in the state are proposed to enter the system on January 1, 2020.

The state will continue to calculate fee-for-service rates for all nursing facilities for two scenarios. To reimburse nursing facilities in areas that have entered the program for Medicaid-pending residents and to reimburse nursing facilities that are located in areas that will not enter the system until January 1, 2020. The methodology utilized to determine these rates (and was used to determine prior rates) is detailed in the next section.

Although the managed care organizations (MCOs) will have the authority to negotiate rates with nursing facilities, nursing facilities will be guaranteed a minimum rate for 36 months after entering the system. A facility's minimum rate will equate to the community's average fee-for-service rates for the four quarters prior to entering the system.

As of the date of this report, the impact that this new system will have on nursing facilities has yet to be determined. Below is the methodology that is currently utilized to determine fee-for-service rates.

COST CENTERS

Pennsylvania uses the following four cost centers to calculate its facility-specific Medicaid rates:

- **The Resident Care** cost component includes expenses related to wages and related benefits for the following: nursing staff, the directors of nursing, related clerical staff, practitioners, medical directors, utilization and medical review staff, social services and resident activity staff. The component also includes medical supplies, over-the-counter drugs, therapy services (contract and/or employed), oxygen expense and other social service expenses.
- **The Other Resident Related** cost component includes wages, related benefits and supplies for the dietary, laundry, housekeeping and plant operation and maintenance departments; and repairs, maintenance and service of movable property.
- **The Administrative** cost component includes administrative salaries and related benefits, management fees, home office costs, professional services, advertising expenses, travel/entertainment expenses, insurance expenses, allowable interest expense, legal fees, amortization of administrative costs, other supplies and minor movable equipment. The allowable administrative costs cannot exceed 12% of total net operating costs.

- The Capital cost component includes the fair rental value (FRV) of fixed property, movable property and real estate tax expenses.

INFLATION AND REBASING

Nursing facility rates are rebased annually using the three most recent cost reports available. All participating nursing facilities have their initial Medicaid rate established on July 1. However, the overall Medicaid rates are re-established (adjusted for case mix) on a quarterly basis.

Cost report data is inflated from the end-point of the cost report period to the midpoint of the rate period. The Pennsylvania rate period is from July 1 to June 30. The index factor used to inflate the cost report data is the first quarter issue of the CMS Nursing Home Without Capital Market Basket Index. However, the state typically reduces calculated nursing facility rates to reflect budget appropriations.

The most recent cost report data used to calculate the final fiscal year 2019 rates were predominantly derived from 2013 to 2016 cost report data, depending on the nursing facility's fiscal year end. The state determines fee-for-service rates quarterly, with the most recently calculated rates being effective April 1, 2019. The rate calculation described below is based on the current regulations and was utilized to calculate final fiscal year 2019 rates.

RATE METHODOLOGY

For the purpose of calculating facility-specific rates for the Resident Care, Other Related Care and Administrative cost components, nursing facilities are separated into 14 different peer groups. Two of the peer groups are for special rehabilitation facilities and hospital-based nursing facilities, while the remaining 12 peer groups are based on geographic location and facility size. Non-special rehabilitation and hospital-based nursing facilities are first separated into one of four geographic categories based on the facility's location as follows: Metropolitan Statistical Area I (areas of one million residents or more); Metropolitan Statistical Area II (areas between 250,000 to 999,999 residents); Metropolitan Statistical Area III (areas between 100,000 to 249,999 residents); and Non-Metropolitan Statistical Area (areas with less than 100,000 residents). Once nursing facilities are grouped into a geographic category, the nursing facilities are further categorized by total bed capacity as follows: nursing facilities with greater than or equal to 270 beds; nursing facilities between 120 to 269 beds; and those between three to 119 beds. Peer groups with fewer than seven facilities are collapsed into the adjacent peer group with the same bed size. County nursing facility costs were completely phased out of the median calculations for the peer groups in fiscal year 2013.

The total allowable inflated costs for the Other Resident Related and Administrative cost components for each cost report period are divided by the total actual resident days for that period to calculate the per diem costs. The total patient days utilized to calculate the facility-specific Administrative per diem cost is subject to a minimum occupancy standard.

For each facility and for each rate component, the PDPW calculates the arithmetic mean of the per diem costs for the three cost report periods. The facility-specific per diems are then arrayed within their respective peer groups, and a median is determined for each peer group of each cost component. The maximum allowable rates (peer group prices) for these components are calculated as a percentage above these medians.

The medians of each peer group in the Other Resident Related and Administrative cost components are multiplied by 1.12 and 1.04, respectively. This results in the peer group price per component assigned to every nursing facility in the peer group. The facility-specific Other Resident Related cost component rate is the lesser of the following: the Other Resident Related peer group price; or 103% of the facility's Other Resident Related per diem cost plus 30.0% of the difference between the 103% calculation and the facility's Other Resident Related peer group price. A nursing facility's Administrative cost component rate is the lesser of the facility's per diem cost or the Administrative peer group price.

Effective July 1, 2010, the PDPW uses the Resource Utilization Group III (RUG III) 5.12, 44 Grouper system to adjust payments for resident care services based on the classification of nursing facility residents into 44 groups. The total facility and Medicaid case mix index (CMI) averages from the quarterly CMI reports will be used to determine case mix adjustment for each price setting and rate setting period. Prior to this date, the state utilized the RUG III, 5.01, 44 Grouper system. However, the state gradually phased in the new RUG system over a three-year period by determining a weighted average of Residential Care component rates calculated using both RUG systems. Effective July 1, 2013, nursing facility rates have been calculated utilizing only the RUG III, 5.12, 44 Grouper System.

An individual resident's CMI is assigned to the resident according to the RUG-III classification system. A nursing facility's total CMI is the arithmetic mean of the individual CMIs for all residents identified on the nursing facility's CMI report for the picture date. The picture date is defined as the first calendar day of the second month of each calendar quarter. A nursing facility's total Medicaid CMI is the arithmetic mean of the individual CMIs for Medicaid residents identified on the nursing facility's CMI report for the picture date.

A nursing facility's total allowable inflated resident care cost is divided by the total CMI available as of the picture date to determine the case mix neutralized total Resident Care cost for the cost report year. The picture date utilized is the closest February 1 date to the midpoint of the cost report period. The case mix neutralized total Resident Care costs are then divided by the facility's total resident days for the cost report period to determine the case mix neutralized Resident Care cost per diem for the specific cost report period. The PDPW completes this calculation for all three cost report period used in the Medicaid rate calculation methodology. The PDPW then calculates the arithmetic mean of the three cost reports periods used to determine the facility-specific overall Resident Care per diem.

The facility-specific Resident Care per diems are then arrayed within their respective peer groups, and a median is determined

for each peer group. The median of each peer group is then multiplied by 1.17, and the result is the peer group price assigned to every nursing facility in the peer group. The facility-specific Resident Care cost component rate is the lesser of the following: the Residential Care peer group price; or 103% of the nursing facility's average case mix neutralized Resident Care per diem cost plus 30.0% of the difference between the 103% calculation and the nursing facility's Residential Care peer group price. The Resident Care peer group price is adjusted quarterly for a nursing facility's Medicaid CMI.

The per diem rate for a nursing facility's Capital cost component is calculated by dividing the sum of the facility's fixed property, movable property and real estate tax subcomponents by total resident days, adjusted for 90.0% occupancy, if applicable. The major moveable property and real estate tax costs are derived from the nursing facility's most recent cost report.

The fixed property subcomponent is calculated by multiplying the nursing facility's total number of allowable beds by \$26,000 to determine the nursing facility's allowable fixed property cost. This amount is then multiplied by the financial yield rate to determine the FRV for the nursing facility's fixed property. The financial yield rate is based on the five-year moving average yield rate for AAA Corporate Bonds. The financial yield rates utilized to determine fiscal year 2011 and 2012 fixed property subcomponents were 5.46% and 5.39%, respectively. The rates that are used to determine fiscal year 2013, 2014, 2015 and 2016 rates are 5.14%, 4.76%, 4.52% and 4.24% respectively. A financial yield rate of 4.06% was utilized to determine fiscal year 2017 rates. The yield rate utilized to determine fiscal year 2018 and 2019 (for the first three quarters) rates was 3.93%. Prior to fiscal year 2010, a nursing facility's fixed property subcomponent was derived from depreciated replacement costs determined through an appraisal of the facility. Overall nursing facility Medicaid rates equate to the sum of all of the applicable component rates.

In addition to the above mentioned rate components, Pennsylvania reimburses nursing facilities for two additional supplemental payments. The first supplemental payment is for the state's disproportionate share incentive, program. This program is based on a facility's Medicaid census. The supplemental program is reimbursed annually. To be eligible for this incentive program, nursing facilities need to maintain an overall occupancy of 90.0% and Medicaid must represent at least 80.0% of a facility's census. The most recent supplemental payments (June 30, 2018) were determined as follows:

- Group A - 90% overall occupancy and a Medicaid occupancy greater than 90% - \$4.51 per diem;
- Group B - 90% overall occupancy and a Medicaid occupancy ranging from 88% to > 90% - \$3.04 per diem;
- Group C - 90% overall occupancy and a Medicaid occupancy ranging from 86% to > 88% - \$1.81 per diem;
- Group D - 90% overall occupancy and a Medicaid occupancy ranging from 84% to > 86% - \$1.10 per diem;
- Group E - 90% overall occupancy and a Medicaid occupancy ranging from 82% to > 84% - \$0.57 per diem;
- Group F - 90% overall occupancy and a Medicaid occupancy ranging from 80% to > 82% - \$0.41 per diem.

Disproportionate share incentive payments will be inflated forward using the Health Care Financing Administration Nursing Home Without Capital Market Basket Index to the end of the rate setting period for which the payments are made. New reimbursement rates for disproportionate share incentive will not be determined until the state finalizes its budget.

Nursing facilities are also reimbursed on a quarterly basis for the facility's reported Medicaid portion of its total assessment fees plus an additional add-on. This reimbursement is separate from the standard reimbursement that a nursing facility receives for providing services to Medicaid-eligible residents. The portion of the fee applicable to Medicaid residents is determined by multiplying a nursing facility's allowable assessment cost from the prior quarter by the facility's Medicaid percentage of its payor mix (based on patient-day data for the quarter). Privately owned nursing facilities and nursing facilities within CCRCs are reimbursed the percentage of the assessment fee applicable to Medicaid residents plus an additional \$15.26 per Medicaid patient day for state fiscal year 2019. This fee for the prior fiscal year was \$15.65. Traditionally, this rate has changed annually based on calculations made by the PDPW and approved by CMS.

Since the inception of the assessment fee, these rates have changed annually based on calculations made by the PDPW and approved by CMS. The add-on for county facilities is determined at the beginning of the fiscal rate year and may change quarterly depending on the number of county facilities participating in the payment of the assessment fee in each quarter.

Nursing facilities are eligible for semi-annual Nonpublic Medical Assistance Day One Incentive (MDOI) Payments. To qualify for a payment, the facility must be a nonpublic nursing facility during the entire resident day quarter used to obtain the resident days for calculating the payment, have an overall occupancy rate of at least 85% and have an Medicaid occupancy rate of at least 65%.

For nursing facilities that meet the qualifying criteria, their nonpublic Medical Assistance Day One Incentive (MDOI) payment for the quarter is calculated as the total Pennsylvania Medicaid days times the quarterly MDOI per diem. The MDOI per diem varies by quarter based on the total funds available for the quarterly nonpublic MDOI payment divided by the sum of the total Pennsylvania Medicaid days for all qualifying facilities. In fiscal year 2019, the total of funds available for the first payment is \$8,337,890 and total qualified nursing facility days is 2,743,756, which results in a MDOI of \$3.04.

In recent fiscal years, the state's budget has not been sufficient to fully fund the reimbursement system. Therefore, a nursing facility's initially calculated rate (excluding add-ons) is adjusted downward by a quarterly budget adjustment factor. The initial rate, multiplied by the budget adjustment factor, equates to a nursing facility's final rate. The budget adjustment factors for finalized fiscal year 2015 rates are as follows: 0.84265 from July 1, 2014, to March 31, 2015; and 0.85297 from April 1, 2015 to June 30, 2015. The budget adjustment factors for fiscal year 2016 were as follows: July 1, 2015 to March 31, 2016 - 0.83015; and April 1, 2016 to June 30, 2016 - 0.84094. The budget adjustment factors for fiscal years 2017 and 2018 were as follows: July 1, 2016 to March 31, 2017

– 0.82958; and April 1, 2017 to June 30, 2017 – 0.83554; July 1, 2017 to September 30, 2017 - 0.81460; October 1, 2017 to March 31, 2018 - 0.8106; and April 1, 2018 to June 30, 2018 – 0.80693. The budget adjustment factors utilized in fiscal year 2019 (by effective date) are as follows: July 1, 2018 – 0.80326; October 1, 2018 – 0.80706; January 1, 2019 – 0.80665; and April 1, 2019 – 0.80525.

The average rates in Pennsylvania effective July 1, 2010, July 1, 2011, July 1, 2012, July 1, 2013, July 1, 2014, July 1, 2015, July 1, 2016, and July 1, 2017 were \$175.34, \$177.37, \$185.89, \$190.08, \$194.00, \$194.49, \$195.64 and \$197.71, respectively. The average rate effective July 1, 2018, is \$199.01, which represents a 0.9% increase from the prior fiscal year.

MINIMUM OCCUPANCY STANDARDS

A 90% minimum occupancy adjustment is applied to the Administrative and Capital cost components. Per diem costs for each of these components is determined by dividing total costs of that component by the greater of the nursing facility's total patient days or 90% of the facility's total available patient days.

OTHER RATE PROVISIONS

Under state regulations, new nursing facilities will be assigned the appropriate peer group price for the Residential Care, Other Residential Care and Administrative cost components, until at least one audited cost report is available to be used in the rebasing process. New nursing facilities will also be assigned the statewide average Medicaid CMI until adequate assessment data is collected for the facility.

The fixed property subcomponent of a new nursing facility's Capital cost rate will be determined utilizing the same FRV methodology as that used for existing nursing facilities. A new nursing facility's movable property acquired prior to enrollment in the Medicaid program will be added to the remaining book value of any used movable property (as of the date of enrollment in the Medicaid program) to determine the facility's total movable property cost. A new nursing facility's Real Estate Tax Subcomponent Rate will be based on the nursing facility's audited actual real estate tax cost. Newly constructed nursing facilities are exempt from the adjustment to 90% occupancy until the nursing

facility has participated in the Medicaid program for one full annual price setting period and until a CMI report for each of the three picture dates to calculate overall occupancy is available for the rate quarter.

The sum of the Residential Care, Other Residential Care, Administrative and Capital cost component rates is then multiplied by the budget adjustment factor. However, Pennsylvania has not certified a significant number of new nursing facility beds for construction in recent years. For cases in which the state has allowed new construction, the nursing facility was able to negotiate its initial Medicaid rate with the state.

If a nursing facility changes ownership, the facility will receive the rate received by the previous operator. In the future, the nursing facility rates will be calculated utilizing a combination of cost report data for the old and new operator until the new operator has generated sufficient cost report data.

Nursing facilities in Pennsylvania are eligible to receive payments for reserved beds when a resident is absent from the facility for a continuous 24-hour period because of hospitalization or therapeutic leave. Nursing facilities are eligible to be reimbursed up to 15 consecutive days for residents that require hospitalization. The rate for these days equates to one-third of the nursing facility's current Medicaid rate. However, in fiscal year 2010, to be eligible for reimbursement a nursing facility must have an overall occupancy rate of 75% or greater for the rate quarter in which the hospital reserved bed day occurs. Effective July 1, 2010, this percentage increased to 85%.

Nursing facilities will also be reimbursed up to 30 days per calendar year for residents that require therapeutic leave outside of the nursing facility. Nursing facilities will receive their current per diem rate for these days.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this report, with the exception of the changes related to the development of the states Managed Care Reimbursement System, there are no significant proposed or planned changes the state's rate setting system.

PENNSYLVANIA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	80.00	81.00	77.00		120.00	120.00	120.00		152.25	154.00	154.75
Average Daily Census	85.85	86.60	83.82		111.46	112.49	111.88		155.44	153.60	153.59
Occupancy	85.0%	84.1%	82.8%		90.0%	89.7%	89.4%		93.9%	93.1%	92.8%
Payor Mix Statistics											
Medicare	5.3%	4.9%	4.6%		8.1%	7.3%	6.8%		12.1%	11.3%	10.3%
Medicaid	51.2%	52.9%	50.1%		70.2%	70.7%	69.9%		78.7%	79.4%	80.6%
Other	12.9%	12.6%	12.9%		23.7%	23.2%	23.5%		54.5%	52.7%	52.3%
Avg. Length of Stay Statistics (Days)											
Medicare	31.28	28.76	27.31		41.62	38.42	36.15		55.26	54.76	47.05
Medicaid	344.95	327.03	304.78		538.74	508.65	516.06		764.35	736.36	731.16
Other	46.15	41.62	42.62		89.84	84.72	86.69		207.14	217.12	206.37
Revenue (PPD)											
Inpatient	\$238.99	\$242.86	\$243.40		\$278.95	\$290.31	\$294.15		\$331.78	\$346.32	\$355.92
Ancillary	\$43.21	\$43.02	\$43.19		\$64.21	\$62.04	\$64.82		\$91.88	\$85.82	\$85.98
TOTAL	\$303.38	\$307.52	\$307.84		\$350.08	\$360.60	\$360.89		\$443.59	\$444.23	\$464.50
Expenses (PPD)											
Employee Benefits	\$18.43	\$19.88	\$20.29		\$24.67	\$25.64	\$26.16		\$33.52	\$34.15	\$35.32
Administrative and General	\$34.42	\$34.78	\$36.87		\$50.60	\$49.83	\$53.79		\$65.77	\$68.16	\$70.46
Plant Operations	\$9.40	\$9.61	\$9.80		\$11.84	\$12.42	\$13.03		\$17.73	\$18.42	\$20.94
Laundry & Linens	\$2.23	\$2.28	\$2.10		\$3.19	\$3.19	\$3.02		\$4.41	\$4.37	\$4.31
Housekeeping	\$5.12	\$5.04	\$5.02		\$6.85	\$6.97	\$6.88		\$9.23	\$9.42	\$9.93
Dietary	\$16.64	\$17.08	\$17.70		\$20.01	\$20.24	\$21.21		\$27.20	\$28.15	\$29.88
Nursing & Medical Related	\$83.33	\$86.87	\$89.13		\$99.90	\$102.89	\$102.86		\$121.21	\$121.28	\$124.61
Ancillary and Pharmacy	\$23.23	\$22.54	\$22.12		\$30.68	\$29.63	\$28.48		\$39.92	\$40.11	\$38.54
Social Services	\$1.82	\$1.93	\$2.08		\$2.63	\$2.77	\$2.89		\$3.95	\$4.32	\$4.45

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Rhode Island



INTRODUCTION

Nursing facilities in Rhode Island are licensed by the Rhode Island Department of Health Office of Facilities Regulation as "Nursing Facilities". The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN RHODE ISLAND	
Licensed Nursing Facilities*	86
Licensed Nursing Beds*	8,637
Beds per 1,000 Aged 65 >**	47.55
Beds per 1,000 Aged 75 >**	110.16
Occupancy Percentage - 2017*	92.90%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Health Services Council, an advisory body of the Rhode Island Department of Health, administers the state's Certificate of Need (CON) program. There is currently a moratorium on new nursing facility licensed beds and on increases to the capacity of existing nursing facility licenses. However, nursing facilities are allowed a one-time increase in their licensed capacity as of August 21, 1996. This increase cannot exceed the greater of 10 beds or 10% of the facility's licensed capacity. Moreover, the current owner of a nursing facility is allowed to construct a replacement nursing facility with the same or lower bed capacity. The moratorium was initially set to expire on July 1, 2004, but has been extended periodically, most recently until July 1, 2016. The moratorium applies to all existing licensed nursing facilities, including any nursing facility approved for change in ownership.

From July 1, 2009, through June 30, 2010, a nursing home member of a multifamily group was allowed to transfer its entitlement to add up to 10 beds through the "10 beds or 10% of capacity" exception to another nursing facility in the same multifamily group, provided that: 1) the beds added are designed to provide enhanced quality of life to nursing facility residents through the adoption of principles and building designs established by the "Eden alternative" or "Greenhouse" programs or other like means; 2) the nursing facility applying to receive the transferred beds has fewer than 50 licensed beds and has at least a 94% bed occupancy rate at the time of application to receive these additional beds; 3) the transferred beds shall be limited to a maximum total of 10 beds per multifamily group; and 4) the transfer of beds results in a reduction in the number of nursing facility beds in the state, including the beds transferred. The term "multifamily group" means two or more nursing facilities that are controlled by, or are in control of, or are in common control with each other.

Rhode Island law permits a nursing facility to take any or all of its licensed beds out of service, but allows the nursing facility to place them back into service without impediment at a future date. This has routinely occurred in prior years. However, notwithstanding any other provision of law to the contrary (including the moratorium on new nursing facility beds), only beds taken out of service due to facility closure after January 1, 2010, will be available for facility expansion under the Cultural Change initiative. The Cultural Change criteria will be established

through regulation to provide enhanced quality of life to nursing facility residents through the adoption of principles and building designs established under the Eden Alternative or Green House programs. The total number of beds that may be licensed to increase capacity under the initiative will be limited to 90% of the first 50 beds that are taken out of service, 70% of the next 50 beds that are taken out of services and 50% of any additional beds taken out of service.

A CON is required for, but not limited to, the following activities:

- The construction, development and establishment of a new facility.
- Any capital expenditure in excess of \$5,720,877, including the construction or renovation of an existing facility.
- Any capital expenditure resulting in an increase in bed capacity of a nursing facility in excess of 10 beds or 10% of a facility's licensed bed capacity, whichever is greater.
- The purchase of any healthcare equipment in excess of \$2,451,805.
- The acquisition of an existing facility if the services change or bed capacity increases.
- The offering of a new health service with annualized operating costs in excess of \$1,634,000.

The one-time increase in total licensed capacity described above (the greater of 10 beds or 10% of the facility's licensed capacity) is exempt from CON review if it is less than the capital expenditure maximum (\$2,000,000).

BED NEED METHODOLOGY

There is currently no bed need methodology due to the existing moratorium.

QUALITY ASSESSMENT FEE

The quality assessment fee in Rhode Island is known as the nursing facility provider assessment and is calculated per month at 5.5% of patient revenues. Nursing facilities in Rhode Island are reimbursed for a portion of their nursing facility provider assessment as part of their Medicaid rate. This is further detailed in the Rate Methodology section.

MEDICAID RATE CALCULATION SYSTEM

Rhode Island uses a prospective, price-based, case-mix adjusted, Rhode Island uses a prospective, cost-based, case-mix adjusted, facility-specific rate setting system. Although the state still waiting for approval by the Centers for Medicare and Medicaid (CMS), Rhode Island converted to a price-based system on October 1, 2012. Prior to the conversion to this new system, the state utilized a prospective cost-based, case-mix adjusted, facility-specific rate setting system. The state initially began adjusting nursing facility rates for case mix effective February 1, 2010. Similar to the old system, the new system utilizes a Fair Rental Value (FRV) system to determine property rates. As part of the conversion to the new system, effective June 1, 2013, the state also converted to the RUG IV, 48 Grouper patient classification system.

In 2009, Rhode Island adopted a Global Medicaid Waiver (Section

1115) that establishes Medicaid expenditure ceilings for the state and allows the state to group all Medicaid eligible residents and programs under a single waiver. This waiver is designed to provide an integrated system of care that focuses on the changing, diverse needs of individual beneficiaries throughout their lives. It provides the state with flexibility to tailor Medicaid services to the individual needs of the beneficiaries. Specifically, this waiver allows the state to offer home and community-based services to individuals that require a lower level of care, with the goal of preventing or delaying admission to a nursing facility. The waiver also permits the state to fund treatment services for individuals that are currently not eligible for Medicaid, the objective being to prevent or delay an individual from becoming eligible for Medicaid. This will generate long-term Medicaid cost savings.

COST CENTERS

The per diem reimbursement rate is the sum of the following six cost centers: Direct Care, Other Direct Care, Indirect Care, Fair Rental, Property Taxes and Health Care Provider Assessment. The state has yet to publish the detail of what specific allowable costs are included in each cost component. Given this factor, the following is a summary of the type of costs included in each cost center:

- The Direct Nursing Care cost component includes costs related to nursing services;
- The Other Direct Care cost component includes other direct labor;
- The Indirect Care cost component includes utilities and insurance;
- Fair Rental cost component consists of an FRV system, which provides a payment in lieu of reimbursement for depreciation, interest, rent and/or lease payments on property, plant and equipment, working capital interest, all other interest and vehicle depreciation and/or lease payments.
- Property Taxes cost component includes property taxes; and
- Health Care Provider Assessment cost component consists of reimbursement derived from the state's nursing facility provider assessment.

INFLATION AND REBASING

Based on the rate calculation methodology approved effective October 1, 2012, the Direct Nursing Care, Other Direct Care and Indirect Care prices are required to be rebased utilizing expenses from the most recent cost report data available every three years beginning October 1, 2015. However, this rebase may not result in automatic per diem revisions. Given budget issues, the state did not rebase rates on October 1, 2015.

Rates and cost ceilings effective October 1, 2009, utilize cost report data for 2008. Rates and cost ceilings effective October 1, 2009, were rebased utilizing cost report data for 2008. Rates effective October 1, 2010, were rebased utilizing cost report data for 2009. In addition, the Direct Labor cost ceiling was rebased to account for the implementation of the case mix adjustment. Rates effective October 1, 2011 were calculated utilizing the state's "current" rate setting methodology and were based on 2010 cost report data. However, no inflation will be applied to facility-specific costs utilized to determine October 1, 2011 rates.

When the Rhode Island Assembly approved the development of the case mix system in fiscal year 2010, it determined that it wanted the Medicaid program to save \$2.6 million. Based on this requirement, on July 1, 2010, the state applied a 1.768% rate reduction over the final six-month period of state fiscal year 2011. The state had initially decided to impose the 1.768% rate cut during fiscal year 2012. However, The Rhode Island Health Care Association was able to convince the state to abandon this reduction.

The state converted to a priced-based methodology on October 1, 2012. As previously mentioned, this resulted in the establishing of three non-property cost components (Direct Nursing Care, Other Direct Care and Indirect Care) that are all price based. Specifically, one single rate for all facilities is established for these cost components. These prices were calculated utilizing 2011 cost report data. Under the new methodology, the state is required to inflate the costs utilized to determine these prices annually utilizing national nursing home inflation indexes as follows: Direct Nursing Care, Other Direct Care and Indirect Care prices are inflated utilizing the Global Insight/CMS Skilled Nursing Facility Market Basket and FRV rates are increased utilizing the Global Insight Nursing Home Capital Cost Index.

Specifically, these Direct Nursing Care, Other Direct Care and Indirect Care prices were inflated 2.5% on October 1, 2012; however, no inflation was applied to rates effective October 1, 2013, and October 1, 2014, rates. Since June 1, 2013, the direct care price is adjusted for case mix based on the patient specific RUG category per resident assessment (every 90 days). Prior to this change, the direct care portion of nursing home rates were adjusted semiannually for case mix. Effective October 1, 2012, facility's FRV rates equated to each facility's July 1, 2012, FRV rate. FRV rates remained unchanged on October 1, 2013, and October 1, 2014. Property Tax rates were based on actual expenses derived from the facility's most recent cost report and were recalculated during those periods.

The state did inflate Direct Nursing Care, Other Direct Care and Indirect Care prices 2.5% and FRV rates approximately 1.8% effective April 1, 2015, respectively. However, as part of the Reinventing Medicaid Act of 2015, the state eliminated any rate increases effective October 1, 2015, and actually applied a 2.0% rate reduction to nursing home per diem rates effective the same date (October 1, 2015). The act indicates that the state will resume inflation adjustments on October 1, 2016, but as of the date of this overview it is unclear if any inflation adjustments, or rebasing costs, will occur on that date.

Rhode Island's budget for healthcare services is also based on a "caseload estimating conference" that occurs twice a year. The Rhode Island General Assembly then either enacts the budget appropriating the conference numbers or enacts a budget reflecting less than the conference numbers if it wants the state to spend less. In addition, although the state's rate year is from October 1 to September 30, the state operates on a July 1 to June 30 fiscal year end. Therefore, funding for nursing home reimbursement is typically allocated to the state's fiscal year.

The following summarizes the current reimbursement system that was utilized to calculate rates effective October 1, 2012.

RATE METHODOLOGY

The per diem costs for the Direct Nursing Care, Other Direct Care and Indirect Care cost components are calculated by dividing total allowable inflated patient days (adjusted for minimum occupancy levels, if necessary). The allowable inflated per diem costs for all certified, participating nursing facilities are arrayed in descending order. Based on this array, a standard, state-wide price for each component is determined. Based on the original draft of the pricing methodology, the prices for these three components (effective October 1, 2012) are to equate to the follows:

- Direct Nursing Care - \$97.99 (equal to 101.54% of the day-weighted median costs). The day-weighted median cost is the cost point whereby half the Medicaid days are at costs higher than this and half with are at lower.
- Other Direct Care - \$23.16 (equal to 100% of the day-weighted median costs).
- Indirect Care - \$52.22 (equal to 93.48% of the day-weighted median costs).

However, based on the final state plan amendment approved by CMS (June 25, 2013) the actual prices (effective October 1, 2012) were determined to be as follows:

- Direct Nursing Care - \$100.44.
- Other Direct Care - \$23.74.
- Indirect Care - \$53.53.

The state plan amendment approved by CMS does not provide any detail of the percentage of the final day-weighted median utilized to determine these prices. However, given that none of these prices greatly vary from the proposed rates it is assumed that a similar percentage was utilized to determine these prices. This was confirmed by Rhode Island Rate Setting Officials.

Effective June 1, 2013, the state converted from utilizing the RUG III, 34 Grouper to the RUG IV, 48 Grouper to adjust rates for case mix. Effective the same date, the state also transitioned from adjusting rates semiannually for case mix to adjusting rates every patient assessment (ever 90 days). This effectively also changed rates from facility specific to resident specific.

Each resident is assigned one of the 48 RUG categories utilizing the MDS 3.0 assessment tool. As previously mentioned, the resident's MDS record/assessment is updated every 90 days. Each RUG category is assigned a specific Medicaid case-mix weight. This weight is applied to only the Direct Nursing Care component by multiplying it to the Direct Nursing Care base.

The FRV system establishes a facility's value based on its age, which means that the older the facility, the less its value. Additions and renovations (subject to a minimum per-bed limit), as well as bed replacements, are recognized by lowering the age of the facility, which increases the facility's value. The facility's established value is not affected by a sale or transfer and new facilities are assigned a rate based upon a completed survey. The FRV per diem rate is calculated as follows:

- The initial age of each nursing facility participating in the Medicaid program utilizes a statewide survey that determines each facility's year of construction and date of entry into the

Medicaid program. This age is reduced for replacements, renovations and/or additions that have occurred since the facility was built. These changes are averaged into the age of the facility on July 1 following the year the major renovations were placed in service, or the year the beds were placed into service.

- The age of each facility is further adjusted each July 1 to make the facility one year older, up to the maximum age (35 years), and to reduce the age for those facilities that have completed and placed into service major renovations, bed additions or replacements.
- A bed value, based on a standard facility size of 450 square feet per bed, is determined using the R.S. Means Building Construction Data publication or a comparable valuation system adjusted by the location index for Providence, Rhode Island.
- The value is increased by a factor of 10% to approximate the cost of land and other soft costs.
- For each facility, the trended value is depreciated, except for the value portion assigned as land, at a rate of 1.5% per year based upon the weighted age of the facility. Bed replacements, additions and renovations will lower the weighted average age of the facility. The maximum age of a nursing home cannot exceed 35 years.
- The value assigned is trended forward annually to the midpoint of the rate year based on the percentage change in the R.S. Means Construction Cost Index, or comparable index, for the previous calendar year end up to a ceiling of 4%.
- A nursing facility's FRV is calculated by multiplying the facility's current value per bed (adjusted for depreciation) times the number of licensed beds (including beds approved as out of service) times a rental factor. The rental factor is the 20-year U.S. Treasury Bond rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year plus a risk factor of 3%, with an imposed floor of 9% and a ceiling of 12%. The recalculation of the rental factor will occur on July 1 of each year.
- The calculated FRV is divided by patient days for the cost reporting period. Patient days are based upon the higher of the actual census, or 98% of the statewide average, for all facilities included in the FRV calculation. For rate calculations, the census is predicated on the previous calendar year patient days, provided that such patient days are greater than 98% of the statewide average occupancy rate. The FRV system does not have a ceiling maximum.

The Property Taxes cost component is determined based on allowable tax payments and total patient days reported in each facility's most recently filed cost report. The Health Care Provider Assessment is calculated by multiplying the sum of the other cost components by 5.82%.

Given that the new pricing system is being phased in over a four-year period, the state implemented a transition plan. For nursing facilities whose direct care costs are greater than the Direct Care base (the sum of the Direct Nursing Care and Other Direct care rate components/prices), the state will provide a "policy adjustment" to compensate these facilities for their losses. The policy adjustment equates to \$5.82, which will remain unchanged

Rhode Island

for the transition period. This adjustment will be phased out on October 1, 2016.

The second policy adjustment applies to a nursing facility's overall rate. This adjustment is a gain/loss provision (exclusive of the direct care policy adjuster) that ensured that no nursing facility's overall rate increased or decreased by more than \$5.00 in the first year (effective October 1, 2012) of the transition. This policy will be phased out over the remaining periods. Specifically, a nursing facility's overall rate in year 2 (effective October 1, 2013) is not allowed to increase or decrease by more than 75% of the difference between the direct care base and the facility's actual cost. This percentage decreases as follows for the remainder of the transition period: October 1, 2014 - 50%; October 1, 2016 - 25% and October 1, 2017 - 0%. The above schedule reflects that the phase-in was suspended for a year on October 1, 2015.

MINIMUM OCCUPANCY STANDARDS

The greater of the individual facility's total resident days or the nursing facility's total potential resident days multiplied by 98% of the statewide occupancy rate is utilized when calculating the per diem costs for all of the cost components.

OTHER RATE PROVISIONS

The reimbursement rate for newly constructed facilities will be determined utilizing the parameters of the above rate calculation. There are no bed hold provisions in Rhode Island's Medicaid system. Nursing facilities are not reimbursed for any time a resident spends outside of the facility.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

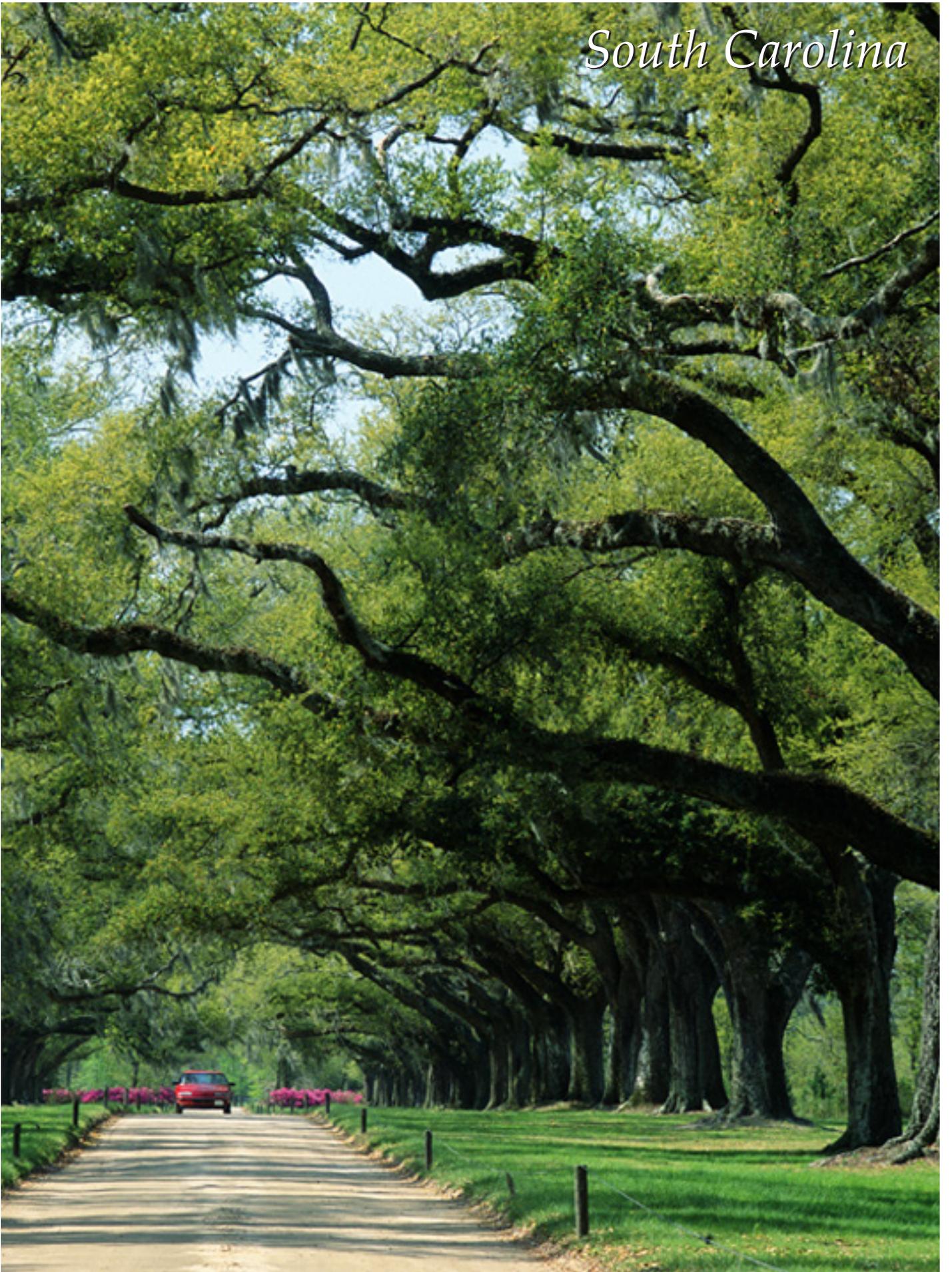
As part of the development of the new price-based system, the state was supposed to implement a quality incentive program and dementia care/behavior health add-on by October 1, 2013. However, this did not occur. According to Rhode Island Rate Setting Professionals, these programs are still in consideration and are in the process of being designed.

Rhode Island is also about to start the second phase (beginning in April or May 2016) of its Managed Care Dual Demonstration Project. Under this plan, nursing facilities are guaranteed their fee-for-service rates for covered dual eligible (Medicaid and Medicare) residents.

RHODE ISLAND COST REPORT STATISTICS									
General Statistics	Lower Quartile Values			Median Values			Upper Quartile Values		
	2015	2016	2017	2015	2016	2017	2015	2016	2017
Number of Beds	60.00	60.00	60.00	103.00	117.00	106.00	132.75	151.25	145.00
Average Daily Census	53.81	55.45	58.13	98.66	107.84	98.77	131.52	139.06	129.26
Occupancy	89.0%	89.2%	86.2%	91.8%	93.5%	91.6%	94.7%	95.8%	94.2%
Payor Mix Statistics									
Medicare	7.0%	5.7%	4.0%	9.9%	8.4%	6.1%	12.4%	11.5%	9.3%
Medicaid	54.1%	41.7%	41.6%	65.4%	57.5%	57.9%	74.6%	72.0%	67.5%
Other	17.8%	21.0%	27.4%	27.4%	34.2%	36.0%	34.2%	49.0%	50.3%
Avg. Length of Stay Statistics (Days)									
Medicare	24.46	22.85	21.96	31.01	27.82	24.91	35.12	33.48	29.76
Medicaid	309.63	269.51	241.28	445.66	412.69	358.89	708.02	676.34	495.75
Other	43.14	53.50	55.09	57.20	77.59	71.91	81.47	105.48	107.30
Revenue (PPD)									
Inpatient	\$265.22	\$278.75	\$277.21	\$300.90	\$313.01	\$303.08	\$337.05	\$348.27	\$337.46
Ancillary	\$39.10	\$35.27	\$31.96	\$56.23	\$53.88	\$51.97	\$79.44	\$79.72	\$72.36
TOTAL	\$317.53	\$328.64	\$321.46	\$356.88	\$383.64	\$361.61	\$414.73	\$421.87	\$415.69
Expenses (PPD)									
Employee Benefits	\$24.98	\$24.04	\$25.14	\$31.14	\$31.68	\$31.92	\$37.90	\$35.09	\$35.30
Administrative and General	\$44.57	\$44.25	\$45.56	\$49.50	\$49.79	\$55.97	\$56.23	\$56.13	\$63.97
Plant Operations	\$10.72	\$9.73	\$11.12	\$13.06	\$11.37	\$12.67	\$15.06	\$13.54	\$14.60
Laundry & Linens	\$2.67	\$2.79	\$2.62	\$3.60	\$3.54	\$3.50	\$4.43	\$4.68	\$4.54
Housekeeping	\$5.21	\$5.27	\$4.92	\$6.46	\$6.29	\$6.29	\$8.02	\$7.42	\$8.07
Dietary	\$17.02	\$17.20	\$17.83	\$19.65	\$19.56	\$19.65	\$22.79	\$22.74	\$24.95
Nursing & Medical Related	\$88.11	\$89.80	\$90.23	\$98.15	\$99.69	\$100.12	\$104.64	\$107.00	\$110.58
Ancillary and Pharmacy	\$20.49	\$19.45	\$17.99	\$28.69	\$29.18	\$24.67	\$36.58	\$32.83	\$30.29
Social Services	\$2.15	\$2.01	\$2.11	\$3.38	\$3.30	\$3.23	\$4.07	\$3.89	\$4.39

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

South Carolina



INTRODUCTION

Nursing facilities in South Carolina are licensed by the South Carolina Department of Health and Environmental Control (DHEC) under the designation of "Nursing Care Facility." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN SOUTH CAROLINA	
Licensed Nursing Facilities*	169
Licensed Nursing Beds*	17,906
Beds per 1,000 Aged 65 >**	20.37
Beds per 1,000 Aged 75 >**	53.98
Occupancy Percentage - 2017*	88.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Certificate of Need (CON) program in the state of South Carolina is administered by the DHEC. A CON is required for the following:

- The construction or establishment of a new healthcare facility.
- The addition of one or more beds or change in the classification of licensure of one or more beds.
- A capital expenditure in excess of \$2,000,000.
- A capital expenditure that is associated with the addition or substantial expansion of a health service.
- The offering of certain health services that were not previously offered by the facility in the preceding 12 months, with an annual operating cost in excess of \$1,000,000.
- The acquisition of medical equipment in excess of \$600,000.
- The acquisition or change in ownership or controlling interest of a healthcare facility.

There is currently no moratorium on new beds in the state of South Carolina. However, due to fluctuations in Medicaid funding, the state cannot guarantee that funds will be available for proposed nursing homes. Therefore, the state will not approve applications proposing to provide Medicaid patient days. Applicants are required to sign a memorandum of agreement that they will not seek Medicaid funding. This does not preclude applications for Medicare or private pay beds.

The DHEC requires nursing facilities that participate in the Medicaid program to estimate their Medicaid utilization for the upcoming year. If these nursing facilities indicate that they intend to reduce their Medicaid volume, licensed beds at these communities can be redistributed to other nursing facilities (including unlicensed facilities) in the area. Prior to the start of the rate year, the South Carolina General Assembly, in its annual appropriations act, determines the maximum number of allowable Medicaid days for that rate year. The DHEC then individually communicates to nursing facilities the maximum allowable number of Medicaid days these facilities will be allowed to accumulate during the rate year. Should the maximum number of Medicaid patient days authorized by the General Assembly be decreased from the prior year, the number of Medicaid patient days allocated to each nursing facility will decrease by the same percentage as the percentage reduction in the total number of patient days authorized by the General Assembly. However, the days authorized by the state have

remained unchanged from fiscal years 2013 to 2019.

BED NEED METHODOLOGY

The bed need methodology developed and utilized by the state of South Carolina was enacted in 1972. The nursing home bed need methodology is calculated at the county level using a factor of 39 beds per 1,000 population age 65 and older. The factor (per 1,000) is multiplied by the total age 65 and older population in a county to calculate gross bed need.

Net bed need is obtained by subtracting the number of existing beds (greater of licensed or surveyed capacity) from the bed need. The following policies are applied to provide a more reasonable distribution of nursing home beds throughout the state:

- Additional beds may be approved in counties with a positive bed need up to the need indicated.
- When a county has more beds than the projected need, additional beds will not be approved.
- An exception to the policies stated above can be made for an individual nursing home to add additional nursing home beds in order to make more economical nursing units. This exception will not be approved if it results in three- and/or four-bed wards. A nursing home may add up to 16 additional beds to create either 44- or 60-bed nursing units, regardless of the projected bed need for the county. Depending on when the facility was built, each unit must have one nursing station for every 44 or 60 beds. The nursing home must document how these additional beds will make a more economical unit(s). Unless there is a need in the particular county, no more than 16 additional beds will be approved for a specific facility.

The most recent bed need calculation detailed in the 2018-2019 State Health Plan (utilizing projected 2020 population data) estimated a demand for 17,222 additional beds.

QUALITY ASSURANCE FEE

Nursing facilities in South Carolina are currently not assessed with a quality assurance fee.

MEDICAID RATE CALCULATION SYSTEM

South Carolina uses a prospective, cost-based, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

South Carolina uses the following 10 cost components to calculate its facility-specific Medicaid rates:

- General Services (nursing, social workers and activity director and related costs);
- Dietary;
- Laundry, Maintenance and Housekeeping;
- Administration and Medical Records and Services;
- Utilities;
- Special Services (physical, occupational and speech therapies);

- Medical Supplies and Oxygen;
- Property Taxes and Insurance– Building and Equipment;
- Legal Fees;
- Capital.

INFLATION AND REBASING

Nursing facility rates are rebased annually using the most recent cost report data. The rate cycle is October 1 through September 30. Medicaid rates effective October 1, 2015, October 1, 2016, and October 1, 2017 were based on cost report data for the fiscal year ended September 30, 2014, 2015 and 2016, respectively.

All cost components (excluding Capital) are adjusted by an inflation factor. The maximum inflation factor that can be used is provided by the State of South Carolina, Division of Research and Statistical Services. The inflation rate is determined by calculating the percentage change in the total Proxy Index derived from the previous year's cost report data to the most recent cost report data. The Proxy Index is a weighted average index of 11 major nursing home cost categories.

For rates effective October 1, 2010, an inflation factor of 2.0% was applied to non-capital costs. Based on the state's rate methodology, the inflation factor was supposed to be 4.1% for fiscal year 2011 rates. However, the inflation factor was reduced to 2.0% due to budget shortfalls. In addition, effective April 1, 2011, the state reduced nursing facility rates by 3.0% due to the lack of funding. The inflation adjustment for the prior rate year (fiscal year 2010) was 4.7%. No inflation was applied to fiscal years 2012 and 2013 non-property rates. However, non-property rates were increased 3.6%, effective October 1, 2013, 3.5% effective October 1, 2014, 3.0% effective October 1, 2015, 2.4% effective October 1, 2016 and 2.9% effective October 1, 2017.

The Capital cost component is determined by inflating the base period market value by the Consumer Price Index (CPI) for homeowner's rent, which measures the increase in the amount that homeowners could get for renting their home on average.

Due to turnover and staff limitations, the South Carolina Department of Long-Term Reimbursement was not able to rebase rates effective October 1, 2018. Effective October 1, 2018, nursing facilities' non-capital rates were increased 2.8% from rates effective September 30, 2018. Capital rates were frozen at September 30, 2018 levels. In addition, nursing facilities' rates were adjusted for a facility-specific cost adjustment factor that is based on the difference between their fiscal year 2016 (ending September 30, 2016) and fiscal year 2017 (ending September 30, 2017) cost reports. This calculation was also adjusted to remove any outstanding costs (Hurricane Matthew costs, liability claim costs over \$50,000, etc.).

According to the South Carolina Health Care Association, the state will resume the normal rebasing calculation effective October 1, 2019.

RATE METHODOLOGY

In South Carolina, facilities are grouped according to bed size for the purpose of establishing cost standards (or cost ceilings). The bed groups are: 0 – 60 beds, 61 – 99 beds and 100 plus beds. The following four cost components are subject to a cost standard for each bed size group:

- General Services;
- Dietary;
- Laundry, Maintenance and Housekeeping;
- Administration and Medical Records and Services.

The lower of the actual allowable cost per day or the cost standard is utilized in determining a facility's rate. The cost standards for all of these cost components are calculated by first accumulating all costs associated with the specific cost component for all facilities in each bed size, and then determining total patient days for all facilities by multiplying the total beds for all facilities in each group by (365 x 96%). The mean cost per patient day is then calculated by dividing the total costs by total patient days with the cost standard, then multiplying the mean by 105%. The General Services cost standard for all nursing facilities (except state-owned facilities) is further adjusted based on the average of the percentage of skilled nursing Medicaid patients (as opposed to intermediate care Medicaid patients) divided by total Medicaid patients served. The General Services standard for each separate facility is determined in relation to the percentage of skilled nursing Medicaid patients served.

Effective October 1, 2012, the minimum occupancy requirement utilized to calculate the General Services cost standard and facility-specific rates was reduced from 96.0% to 92.0%. Effective October 1, 2016, the minimum occupancy percentage decreased to 90.0%.

Except for the General Services standard, all standards for proprietary and nonprofit facilities (excluding state-owned) are computed using proprietary facilities only. Hospital-based proprietary nursing facilities are excluded from the computation of all cost standards, except for General Services.

Costs for Utilities, Special Services, Medical Supplies, Property Taxes and Insurance – Building and Equipment, and Legal Fee cost components are not subject to cost standards. These cost components are calculated by dividing allowable cost by actual days (subject to the minimum occupancy requirement). The actual allowable cost per day is utilized in determining a facility's rate for these cost components. The sum of the non-capital components is then adjusted for inflation.

The Capital cost component is determined by first estimating a reasonable fair market rental value (FMRV) for nursing home beds and then assigning a deemed asset value based on its number of beds and the FMRV of a bed. The FMRV of a bed is determined by inflating the base period market value (the average of the original costs for facilities established during 1980 and 1981, initially calculated as \$15,618 per bed) by the CPI index for homeowner's rent, which measures the increase in the amount that homeowners could get on average for renting their home. The deemed asset value of a facility is then calculated by multiplying the fixed per bed value by the number of beds. The current fixed value per-bed

utilized in this calculation is \$55,236 (effective October 1, 2017). Capital rates did not change on October 1, 2018.

A deemed depreciated value is then determined for an individual facility by subtracting the amount of depreciation costs from the deemed asset value of the facility, then adding the value of improvements to the deemed asset value. As of 1981, operators who have made capital improvements to their facilities are permitted to add the amount of the investment or the cost or future additions and upgrades to the deemed asset value. This provides an incentive to operators to maintain and improve the level of service at a facility. The deemed depreciated value is then multiplied by a market rate of return to determine the annual return for the facility. The market rate of return is set equal to the long-term average of the 30-year U.S. Treasury Bond rates for the three completed calendar years prior to the current fiscal year. Effective October 1, 2017, this rate is 2.92%. The Capital cost component per diem rate is determined by dividing the capital costs by actual patient days, subject to a 92% minimum occupancy standard. Effective October 1, 2012, the minimum occupancy requirement will be reduced from 96% to 92%. The minimum occupancy percentage again decreased to 90.0% effective October 1, 2016.

The Capital component cannot exceed the capital and return on equity per diem payment that was reimbursed prior to July 1, 1989, by more than \$3.00 per patient day. As of October 1, 1996, the cap was frozen at \$3.99. However, the cap was increased to \$5.00 effective October 1, 2016. New beds online on or after June 30, 1989, are not subject to the cap. The Capital cost for nursing facilities sold or leased after July 1, 1989, is limited to the capital reimbursement received by the prior owner.

Nursing facilities are eligible for cost and profit incentives. If the facility's actual allowable costs for General Services, Dietary, and Laundry, Maintenance and Housekeeping are below the sum of these three allowable cost standards, the facility is eligible for a cost incentive equal to the difference between the sum of its cost standards and the sum of its actual costs, not to exceed 7% of the sum of the cost standards.

Nursing facilities are also eligible for a profit incentive for the Administration and Medical Records and Services cost component. The incentive is equal to the difference between the standard and allowable costs for this cost component. The incentive cannot exceed 3.5% of a nursing facility's allowable costs. The sum of this incentive with the cost incentive for the General Services, Dietary and Laundry, Maintenance and Housekeeping cost components cannot exceed \$1.75 per patient day.

The Medicaid reimbursement rate is the total allowable costs accumulated for all components, cost incentives and profit. However, South Carolina also utilizes a budget neutrality adjustment to insure that the state's weighted average Medicaid rates based on the state's rate methodology does not exceed the state's nursing facility budget target rate for the fiscal year. If this occurs, all nursing facility rates are adjusted downward by the variance between the two rates. Fiscal year 2012 nursing facility rates were adjusted downward by a budget neutrality adjustment factor of 3.02%. Effective October 1, 2012, this adjustment increased

to 3.805%. The budget neutrality factor decreased to 2.9241% on October 1, 2013. No budget neutrality rate was applied to October 1, 2014, and October 1, 2015, October 1, 2016, October 1, 2017, or October 1, 2018 rates.

Effective October 1, 2010, nursing facilities with an annual Medicaid utilization of 3,000 days or less will receive a prospective payment rate, represented by the weighted average industry rate (the sum of the October 1 rate of each facility divided by the total number of facilities) at the beginning of each rate cycle.

The weighted average rate in the state is projected to be \$181.77 effective October 1, 2018, approximately 3.1% greater than the weighted average rate (\$176.29) effective October 1, 2017. The weighted average rate effective October 1, 2013, October 1, 2014, October 1, 2015 and October 1, 2016 are \$160.67, \$167.20, \$169.01 and \$176.29, respectively.

MINIMUM OCCUPANCY STANDARDS

A minimum occupancy level of 90% is utilized when setting the Medicaid rate. Medicaid rates for nursing facilities located in counties with an occupancy rate less than 85% are established based upon the following policies:

- The 90% minimum occupancy is waived, but standards remain at the 90% minimum occupancy level.
- The affected nursing facility's Medicaid reimbursement rate is calculated based upon the greater of the nursing facility's actual occupancy or the average of the county where the facility is located.
- The Medicaid reimbursement rate for a nursing facility located within a county with only one contracted nursing facility is based upon the greater of the nursing facility's actual occupancy or 85%.

Effective October 1, 2012, the state reduced the minimum occupancy requirement from 96% to 92%. The state again reduced the percentage to 90.0% effective October 1, 2016. Effective October 1, 2013, the state reduced the county occupancy qualification factor from 90% to 85%.

OTHER RATE PROVISIONS

The DHEC requests quarterly reports from the State Health and Human Services Finance Commission indicating the number of Medicaid patient days for which Medicaid reimbursement was received by each nursing home. Based on these reports, the DHEC determines each nursing home's compliance with its Medicaid nursing home permit. Nursing homes are subject to a penalty for violating these regulations. Violations include:

- A nursing home exceeding by more than 10% the number of Medicaid patient days stated in its permit.
- A nursing home failing to provide at least 90% of the number of Medicaid patient days stated in its permit.
- The provision of any Medicaid patient days by a nursing home without a Medicaid nursing home permit.

Each Medicaid patient day above or below the allowable range is considered a separate violation. Nursing homes that exceed by more than 10% the number of Medicaid patient days stated in its permit are fined based on the number of Medicaid patient

South Carolina

days exceeding the permit days, times their daily Medicaid per diem times 30%. Nursing homes that fail to provide at least 10% fewer days than the number of Medicaid patient days stated in its permit are fined based on the number of Medicaid patient days under the permit days, times their daily Medicaid per diem times 30%. A fine assessed against a nursing home is deducted from the nursing home's Medicaid reimbursement.

The Medicaid reimbursement rate for a new facility, or a facility that changes its bed capacity by more than 50%, is based on a six-month projected budget of allowable costs covering the first six months of operation or through the last day of the sixth full calendar month of operation. The same rate setting methodology is used, except that all cost standards to be used are 120% of the standards (for the appropriate facility category) to account for the facility's initial lower occupancy.

After the first six months, a new prospective rate will be determined using the same methodology, except that payment for the first six months is retrospectively adjusted to actual costs not to exceed 120% of the standards and actual occupancy. No inflation adjustment is made for the first six months' cost. In addition, effective the first day of the seventh month of operation through the September 30 rate, the per diem rate is adjusted to reflect the higher of the actual occupancy at the last month of the initial cost report or 90% occupancy.

The Medicaid reimbursement rate for a replacement facility or a change in ownership is based on a six-month projected budget of allowable costs covering the first six months of operation. The interim rate is determined using the same methodology previously discussed for existing nursing facilities, except that no inflation adjustment is made for the first six months' cost. Payment for the first six months is retrospectively adjusted to actual costs not to exceed the standards. Effective the first day of the seventh month of operation, a new prospective rate is determined using the same methodology previously discussed for existing nursing facilities. South Carolina Medicaid will reimburse nursing facilities for a maximum of 10 bed hold days per occurrence of qualifying hospitalization leave at the prevailing rate for each facility. Nursing facilities are reimbursed a total of 18 days per state fiscal year (July 1 to June 30) for qualified therapeutic leave at the prevailing rate for each facility. No single therapeutic leave occurrence may be more than nine days.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

According to representatives of the South Carolina Health Care Association, the state is proposing to alter its Cost of Capital rate component calculation effective October 1, 2019. However, as of the effective date of this overview, no new methodology has yet to be approved by the state.

SOUTH CAROLINA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	85.00	88.00	88.00		102.00	104.00	104.00		132.00	132.00	132.00
Average Daily Census	74.16	78.91	78.28		95.34	99.47	98.92		126.10	124.89	123.46
Occupancy	84.0%	84.1%	83.9%		90.5%	91.1%	91.3%		94.1%	93.9%	94.4%
Payor Mix Statistics											
Medicare	9.8%	8.1%	8.5%		13.5%	12.8%	12.2%		21.4%	19.3%	18.7%
Medicaid	51.7%	52.1%	54.4%		69.4%	71.0%	72.0%		77.2%	78.0%	80.3%
Other	13.1%	13.9%	11.7%		21.2%	21.5%	19.8%		37.3%	41.5%	37.1%
Avg. Length of Stay Statistics (Days)											
Medicare	30.09	30.02	28.01		38.75	36.21	35.49		58.87	52.80	55.41
Medicaid	294.41	336.81	313.61		433.00	554.71	500.47		775.72	822.01	929.21
Other	51.58	51.16	53.48		92.11	85.47	86.39		166.42	188.54	161.60
Revenue (PPD)											
Inpatient	\$193.61	\$201.24	\$201.53		\$214.19	\$224.13	\$222.41		\$244.12	\$254.87	\$262.31
Ancillary	\$44.43	\$42.32	\$40.92		\$68.98	\$73.87	\$71.67		\$121.53	\$118.65	\$114.31
TOTAL	\$252.36	\$256.87	\$256.32		\$305.72	\$302.54	\$305.96		\$381.87	\$381.78	\$384.86
Expenses (PPD)											
Employee Benefits	\$14.56	\$13.74	\$14.20		\$20.96	\$20.39	\$20.53		\$28.64	\$29.89	\$28.39
Administrative and General	\$26.27	\$25.66	\$28.01		\$34.88	\$35.08	\$35.53		\$45.33	\$42.55	\$45.20
Plant Operations	\$8.66	\$8.35	\$8.31		\$10.12	\$10.45	\$10.11		\$13.98	\$13.85	\$14.23
Laundry & Linens	\$2.03	\$1.92	\$1.99		\$2.74	\$2.65	\$2.60		\$3.40	\$3.26	\$3.30
Housekeeping	\$5.23	\$4.92	\$5.07		\$6.22	\$6.27	\$6.20		\$7.86	\$7.49	\$7.46
Dietary	\$15.61	\$15.34	\$15.55		\$17.35	\$17.39	\$17.83		\$21.49	\$21.28	\$22.01
Nursing & Medical Related	\$73.09	\$74.61	\$76.08		\$85.63	\$87.13	\$90.85		\$101.28	\$104.84	\$104.41
Ancillary and Pharmacy	\$23.98	\$21.95	\$22.80		\$32.97	\$30.42	\$31.07		\$53.91	\$50.62	\$45.11
Social Services	\$2.28	\$2.46	\$2.40		\$3.62	\$3.51	\$3.72		\$4.90	\$5.11	\$5.07

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

South Dakota



INTRODUCTION

Nursing facilities in South Dakota are licensed by the South Dakota Department of Health (DOH), Office of Licensure and Certification under the designation of "Nursing Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN SOUTH DAKOTA	
Licensed Nursing Facilities*	75
Licensed Nursing Beds*	4,435
Beds per 1,000 Aged 65 >**	30.51
Beds per 1,000 Aged 75 >**	70.36
Occupancy Percentage - 2017*	85.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

South Dakota does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility or increase the capacity and services offered at an existing facility.

There has been a moratorium on new nursing facility beds since 1988. The moratorium restricts the building of any new facility and the increase of any beds in an existing facility. The moratorium was renewed indefinitely in 2005.

BED NEED METHODOLOGY

South Dakota does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSURANCE FEE

Nursing facilities in the state of South Dakota are currently not assessed a quality assurance fee. There are currently no proposals to implement a provider fee.

MEDICAID RATE CALCULATION SYSTEM

South Dakota uses a prospective, cost-based, facility-specific case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

South Dakota uses the following two cost components to calculate Medicaid reimbursement rates:

- The Direct Care component includes wages and benefits associated with routine nursing and therapies (registered nurses, licensed practical nurses and nurse aides) as well as nursing supplies.
- The Non-Direct Care component consists of the following three cost subcomponents:
 - The Health and Subsistence subcomponent includes director of nursing wages, medical records, activities, social services, dietary costs, housekeeping, laundry and plant operations.

- The General Administrative subcomponent includes office-related wages and benefits, office supplies, professional liability insurance and central office expenses.
- The Capital subcomponent includes building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and pre-operating costs, mortgage interest, rent on facility and grounds, equipment rental and return on net equity (for proprietary facilities only).

INFLATION AND REBASING

Reimbursement rates are effective from July 1 to June 30. The cost reporting year is from April 1 to March 31. Rates are rebased annually and utilize cost reports submitted five quarters prior. For example, the most recently calculated per diem rates, effective July 1, 2009, are based on cost reports submitted for the cost report year ending March 31, 2008.

The Direct Care component, Health and Subsistence subcomponent, and General Administrative subcomponent are all inflated from the end of the cost reporting period to the beginning of the rate year utilizing an inflation rate based on budget appropriations. The inflation factor used to calculate fiscal year 2009 rates was approximately 3.0%. Given budget limitations, the state did not apply an inflation factor to the fiscal year 2010 rebased costs. Nursing facility Medicaid rates were frozen at fiscal year 2010 levels in fiscal year 2011. South Dakota reduced nursing facility Medicaid rates in fiscal year 2012. These rate cuts were based on each facility's percentage of Medicaid patients determined utilizing calendar 2010 MDS and claims data. The percentage rate reductions for fiscal year 2012 are detailed in the following table:

Medicaid %	% Cut
0%-50%	4.0%
51%-56%	3.8%
57%-66%	3.0%
67% +	1.8%
Access Critical	1.8%

In fiscal year 2013, the state will increase Medicaid rates slightly based on its Medicaid percentage of patients. Nursing facilities with a Medicaid percentage from 0% to 56% received a 0.5% rate increase and nursing facilities with a Medicaid percentage 57% and greater received a 1.5% increase. Access critical facilities also receive a 1.5% rate increase. The state did not backfill the previous rate reduction. Therefore, these rate increases were applied to fiscal year 2012 rates that were previously reduced by the percentages in the above tables.

In fiscal year 2014, the state provided a 1.1% rate increase to nursing facilities with a Medicaid payor percentage of 67.0% or greater. In fiscal year 2015, the state determined that it did not have the funds required to complete a full rebase. However, the state did provide an increase in funding/rates that equated to 50.0% of the increase in funding that would have resulted from a full rebase. This equated to an average rate increase of 8.1%.

The following is the rate methodology that South Dakota would utilize to determine rates in fiscal years not impacted by budget limitations.

RATE METHODOLOGY

The Direct Care component is case mix adjusted, with payments made subject to the residents' level of care needs. Case mix weights assigned to each classification are based on the South Dakota M3PI Index System, which is modeled after the Resource Utilization Group (RUG) III system. Based on this system, residents are assigned to one of 34 RUG categories. The Direct Care component is adjusted for case mix as follows:

- Calculate the average case mix score for each facility during the cost reporting period;
- Determine the per diem Direct Care component cost for each facility from the cost report; then
- Divide each facility's per diem Direct Care component cost by its case mix score to arrive at the facility's case mix adjusted per diem cost.

The case mix adjusted per diem Direct Care cost for all facilities is then used to establish minimum ceilings equal to 115% of the median and maximum ceilings equal to 125% of the median for all facilities. The median is based on all nursing facilities that have a case mix acuity level of 1.00 or more. The Medicaid program only pays for 80% of all costs in excess of 115%. Any costs in excess of 125% are not recognized.

Health and Subsistence subcomponent costs are calculated by dividing a facility's allowable inflated costs by its total patient days. These costs are subject to a minimum ceiling equal to 105% of the median and a maximum ceiling equal to 110% of the median. Again, the Medicaid program only pays for 80% of all costs between the minimum and maximum ceilings. The median cost is based on all nursing facilities with a case mix acuity level of 1.00 or more.

General Administrative component costs are calculated by dividing a facility's allowable inflated costs by its total patient days, with the same ceiling levels and percentage of cost reimbursement between the ceilings as in the Health and Subsistence component. However, the median of administrative costs is based only on the administrative costs of all freestanding nursing facilities.

Capital component costs are calculated by dividing a facility's allowable inflated costs (excluding return on net equity allowable costs) by its total patient days. These costs would be subject to a ceiling equal to \$14.82 per resident day for all participating nursing facilities (if a rebase were completed in fiscal year 2015). The Capital cost limitation is inflated annually by one-half the annual percentage of cost change from the previous year to the current year, calculated by using the Means Building Index for South Dakota. A nursing facility's Capital cost component rate is the lesser of the facility's actual per diem cost or the Capital cost limitation.

Proprietary nursing facilities are entitled to a return on net equity add-on to their Capital cost component rates. This add-

on is calculated by multiplying the equity balance derived from a facility's balance sheet by an allowable rate of return. The allowable rate of return is the sum of the average midpoint of the prime interest rate and the average rate of the 180-day U.S. Treasury Bill as reported on the last business day of June, September, December and March, divided by two. The allowable rate of return may not exceed 10%. The product of this calculation is divided by total patient days to calculate the return on net equity add-on. The allowable rate of return in the last rebasing year (fiscal year 2010) was 5.25%. A rate of 1.69% would be utilized in fiscal year 2015 if the state rebased rates.

Nursing facilities in South Dakota may be eligible for an add-on payment for residents requiring extraordinary care in order to recognize and compensate providers for patients who require an inordinate amount of resources due to the intensive labor involved in their care. Extraordinary recipients are defined as chronic ventilator dependent individuals, chronic wound care recipients, behaviorally challenging individuals, and traumatic brain or spinal cord injured individuals. This is typically a negotiated rate based on estimates to cover the additional cost of medically necessary services and supplies. The additional costs paid by an add-on payment are not allowable in the cost report.

The statewide weighted average Medicaid reimbursement rate was \$115.79 for fiscal year 2007, \$120.49 for fiscal year 2008, \$126.99 for fiscal year 2009, \$130.16 for fiscal year 2010, and approximately \$130.00 for fiscal year 2011 and \$127.00 for fiscal year 2012. The average rate for fiscal year 2013 is \$127.87, which represented slightly less than a 0.1% rate increase. In fiscal year 2014, the weighted average rate increased slightly to \$127.91. However, the weighted average rate increased 8.1% to \$138.26 in fiscal year 2015.

MINIMUM OCCUPANCY STANDARDS

The occupancy factor used in calculating per diem rates for all components and subcomponents is the greater of actual occupancy, based on total patient days, or 3% less than the statewide average for all nursing facilities.

The occupancy factor is waived for the first 12 months of operation for a newly built facility. For the second 12 months of operation, the occupancy factor used to establish the facility's rate is the greater of 3% less than the statewide average or the last quarter of the first year of operation, prorated to 12 months.

OTHER RATE PROVISIONS

Effective July 1, 1999, individual nursing facilities are limited to no greater than an 8% annual rate increase in their overall combined Direct Care case mix adjusted rate and Non-Direct Care rate. If the facility's rate exceeds this limitation, the Department of Social Services (DSS) amends the facility's Non-Direct Care rate to equalize the rates to the allowable limit.

Any nursing facility that elects to participate in the Medicaid program must notify DSS of its average per diem charge to individuals who are not presently receiving nursing facility

benefits under Medicare, Medicaid or Veterans Affairs programs. Medicaid reimbursement is limited to the lower of the facility's average private pay per diem charge or the facility's Medicaid per diem rate (Direct and Non-Direct Care rate), as established by DSS prior to July 1 of each year. Pro rata adjustments are made to both the Direct Care rate and the Non-Direct Care rate in limiting the Medicaid per diem rate.

Provisional per diem rates are established for newly constructed facilities or for facilities experiencing major expansion, based upon projected costs submitted prior to the opening date of a newly constructed facility. Provisional per diem rates are effective for six months, with rates being adjusted retroactively on the basis of actual costs.

For a facility acquired through purchase or a capital lease, the rate of reimbursement is the facility's most recent rate received by the prior owner. This rate is adjusted by inflation or other increases as appropriated by the South Dakota Legislature until the facility's new required financial reports are used to calculate rates.

Facilities are reimbursed at the full per diem rate for reserved bed days during an eligible resident's temporary absence. Reserved bed days are limited to a maximum of five hospital days and 15

consecutive therapeutic home visits. After 15 days, the resident is considered a new admission.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this document, there is no current or proposed state legislation affecting the current Medicaid reimbursement methodology in South Dakota. The facility's new required financial reports are used to calculate rates.

Facilities are reimbursed at the full per diem rate for reserved bed days during an eligible resident's temporary absence. Reserved bed days are limited to a maximum of five hospital days and 15 consecutive therapeutic home visits. After 15 days, the resident is considered a new admission.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this document, there is no current or proposed state legislation affecting the current Medicaid reimbursement methodology in South Dakota.

SOUTH DAKOTA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	50.00	50.00	46.00		59.00	59.50	53.00		81.00	78.75	74.00
Average Daily Census	44.55	43.59	41.68		55.18	55.06	49.30		68.72	71.77	66.84
Occupancy	86.7%	82.7%	84.3%		92.5%	91.0%	88.8%		94.9%	92.7%	91.7%
Payor Mix Statistics											
Medicare	6.5%	5.7%	6.2%		8.9%	8.1%	7.8%		13.8%	12.7%	11.9%
Medicaid	42.1%	43.4%	47.1%		49.9%	51.3%	53.2%		59.3%	63.7%	63.3%
Other	33.4%	30.7%	27.2%		47.3%	47.7%	35.8%		80.9%	84.8%	45.2%
Avg. Length of Stay Statistics (Days)											
Medicare	43.75	42.19	41.73		53.16	63.20	54.18		71.83	87.03	66.86
Medicaid	302.13	479.06	437.69		473.09	627.42	560.52		742.00	791.38	707.62
Other	131.00	151.50	134.14		212.56	252.78	178.54		427.14	378.71	312.59
Revenue (PPD)											
Inpatient	\$196.18	\$198.28	\$199.88		\$212.87	\$218.40	\$214.50		\$237.13	\$239.31	\$234.35
Ancillary	\$26.57	\$28.49	\$32.36		\$36.03	\$34.64	\$48.12		\$58.80	\$57.59	\$65.11
TOTAL	\$223.31	\$229.45	\$230.59		\$252.48	\$250.54	\$254.13		\$302.44	\$308.28	\$300.00
Expenses (PPD)											
Employee Benefits	\$17.09	\$14.67	\$15.97		\$19.91	\$18.25	\$18.61		\$22.28	\$22.28	\$22.81
Administrative and General	\$24.71	\$25.78	\$26.08		\$28.39	\$29.68	\$30.24		\$31.65	\$33.96	\$35.42
Plant Operations	\$8.62	\$8.73	\$8.74		\$9.95	\$10.12	\$10.36		\$11.38	\$12.17	\$11.83
Laundry & Linens	\$2.71	\$2.82	\$2.09		\$3.10	\$3.15	\$2.83		\$3.47	\$3.70	\$3.44
Housekeeping	\$3.85	\$4.17	\$3.96		\$4.58	\$4.63	\$4.59		\$5.81	\$5.62	\$5.48
Dietary	\$16.12	\$16.96	\$18.49		\$18.82	\$19.32	\$20.01		\$20.86	\$21.32	\$21.69
Nursing & Medical Related	\$68.32	\$72.84	\$77.28		\$77.13	\$82.11	\$86.18		\$84.81	\$91.35	\$95.10
Ancillary and Pharmacy	\$13.36	\$14.24	\$15.56		\$19.21	\$18.14	\$19.60		\$30.10	\$27.11	\$29.34
Social Services	\$1.85	\$2.11	\$2.25		\$2.62	\$2.64	\$2.78		\$4.63	\$5.31	\$5.81

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Tennessee



INTRODUCTION

Nursing facilities in Tennessee are licensed by the Department of Health, Division of Health Care Facilities (DHCF) under the category of "Nursing Home." There are two types of licensed nursing homes in the state, Level I (Intermediate Care Facilities) and Level II (Skilled Nursing Facilities). Level I patients must have a medical condition that requires 24-hour availability of licensed nursing services on an inpatient basis and must have a disability or impairment that renders them incapable of self-execution of needed nursing care and incapable of performance of at least one activity of daily living. Level II patients require skilled nursing care, which is defined as a licensed nursing service that is furnished to a person pursuant to a physician's order and that, because of the inherent complexity of the service, can only be safely and/or effectively provided directly by a registered nursing or licensed practical nurse. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN TENNESSEE	
Licensed Nursing Facilities*	311
Licensed Nursing Beds*	35,153
Beds per 1,000 Aged 65 >**	31.70
Beds per 1,000 Aged 75 >**	81.47
Occupancy Percentage - 2017*	75.30%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Tennessee Health Services and Development Agency (the Agency) is responsible for regulating the healthcare industry in Tennessee through the Certificate of Need (CON) program.

Currently, there is an indefinite moratorium on the development of nursing home beds in the state. This moratorium supersedes the state's CON requirements and bed need methodology. If the moratorium was not in place, a CON would be required for any change in bed capacity that increases the total number of licensed beds, redistributes beds from acute to long-term care, or relocates beds to another facility or site. However, the Agency will allow a total of 125 nursing home beds to be developed per year. This includes new nursing home beds, conversion of hospital beds to nursing home beds, and swing beds. In addition, all approved beds must be certified for Medicare and the number of approved beds cannot exceed 30 beds per facility. All of the beds can be dually certified for Medicaid and Medicare. If the bed pool is not depleted prior to June 30 of the fiscal year, the remaining beds will be available to facilities that apply before June 30 of each fiscal year.

Based on state laws, the following actions still require a CON:

- Modification, renovation or any addition to a healthcare facility (excluding hospitals) in excess of \$2,000,000.
- Any change in the bed complement that increases the total number of licensed beds, redistributes beds from acute to long-term care, or relocates beds to another facility or site.
- Any change in location or replacement of existing or certified facilities providing healthcare services or institutions.
- The acquisition of major medical equipment in excess of \$2,000,000, or a change in location or replacement of such equipment.

Prior to the moratorium, the Agency utilized a bed need calculation when considering CON applications for the development of new nursing facility beds. However, the state has not utilized this methodology in recent years due to the moratorium. This methodology determined if there is a shortage or surplus of nursing home beds within a service area. The service area is the county or counties represented on an application as the reasonable area to which a healthcare institution intends to provide services and/or in which the majority of its service recipients reside. A majority of the population of a service area for any nursing home should reside within 30 minutes' travel time from that facility. The state's bed need methodology will be detailed later in this document. However, it is currently unclear if the state will utilize this methodology in the future.

Prior to the moratorium, the Commission considered approving new nursing home beds in excess of the need standard for a service area if all outstanding CON projects in the proposed service area resulting in a net increase in beds were licensed and in operation, and if all nursing homes that served the same service area population as the applicant had an annualized occupancy in excess of 90%.

State law indicates that the Agency will use the following occupancy and size standards when considering a CON application:

- A nursing home should maintain an average annual occupancy rate for all licensed beds of at least 90% after two years of operation.
- There must not be additional nursing home beds approved for a service area unless each existing facility with 50 beds or more has achieved an average annual occupancy rate of 95.0%.
- A nursing home seeking approval to expand its bed capacity must have maintained an occupancy rate of 90.0% for the previous year. The state reduced this standard from 95% to 90% in the 2014 State Health Plan.
- A freestanding nursing home must have a capacity of at least 30 beds in order to be approved, unless the Agency makes an exception.
- A facility of less than 30 beds may be located in a sparsely populated rural area where the population is not sufficient to justify a larger facility.
- A project may be developed in conjunction with a retirement center where only a limited amount of beds are needed for the residents of that retirement center.

BED NEED METHODOLOGY

As previously mentioned, the state is not currently utilizing its bed need methodology given the indefinite moratorium on the development of new nursing home beds. However, if the moratorium is removed, the need for nursing home beds will be determined by applying the following population-based statistical methodology:

County Bed Need = .0005 x pop. 65 and under, plus
.0120 x pop. 65-74, plus
.0600 x pop. 75-84, plus
.1500 x pop. 85, plus

The DHCF projects the need for nursing home beds two years into the future from the current year. The source of the current supply and utilization of licensed and CON approved beds is the inventory of beds maintained by the DHCF.

In general, the occupancy rate for each nursing home currently and actively providing services within the applicant's proposed Service Area should be at or above 90% to support the need for any project seeking to add new nursing home beds within the Service Area, and to ensure that the financial viability of existing facilities is not negatively impacted.

QUALITY ASSURANCE FEE

The Tennessee Department of Health, Bureau of Administrative Services currently assesses nursing homes in the state with a quality assurance fee, which was previously referred to as a bed tax. Effective July 1, 2014, the state converted from a bed tax per licensed bed to an assessment fee that is calculated on a per non-Medicare resident day basis.

Prior to this change, nursing homes in the state were charged a \$2,225 bed tax per licensed bed per year. This tax had been in place since 1992. Nursing facilities with 50,000 or more Medicaid days still paid a per bed tax until July 1, 2018. This tax was \$1,460 per licensed bed (effective July 1, 2016) and \$2,225 (effective July 1, 2017). Effective July 1, 2018, the standard was changed to nursing homes with 40,000 or greater Medicaid days. These facilities now pay per non-Medicare day fee of \$8.29.

Effective July 1, 2018, nursing facilities with 50 or less beds or within continuing care retirement facilities (CCRCs) pay \$9.95 per non-Medicare day. The fee (\$9.86) is an increase from the rate effective July 1, 2017. The prior rate effective July 1, 2016, was \$9.68.

Effective July 1, 2018, the remaining nursing facilities pay \$16.92 per non-Medicare day. The prior rates effective July 1, 2017, and July 1, 2016 were \$16.51 and \$16.23, respectively. The assessment fee for all nursing facility categories equates to 4.5% of net patient revenue.

Effective July 1, 2015, nursing facilities with 50 or less beds or within continuing care retirement facilities (CCRCs) pay \$9.16 per non-Medicare day and the remaining nursing facilities pay \$15.20 per non-Medicare day. The assessment fee for nursing

facilities with 50 or less beds or within CCRCs equates to 3.0% of net patient revenue and the assessment fee of all other nursing facilities (excluding facilities with 50,000 or greater Medicaid days) equates to 4.5% of net patient revenue.

Nursing homes in the state are reimbursed through an add-on payment to their Medicaid rate attributed to reimbursement of the assessment fee. Effective July 1, 2018, nursing facilities with 50 beds or less and nursing facilities within CCRCs are reimbursed \$7.67 per Medicaid day, nursing facilities with 40,000 or more Medicaid patient days are reimbursed \$7.04 per Medicaid day and all other nursing facilities are reimbursed \$13.37 per Medicaid day. The add-on for nursing homes with 40,000 or more Medicaid patient days is greater than the add-on (\$4.15) for nursing homes with 50,000 or greater days, effective July 1, 2017. The add-ons for nursing facilities with 50 or less beds and nursing facilities within CCRCs and all other nursing facilities were \$7.41 and \$13.03 per Medicaid day (effective July 1, 2017), respectively.

In addition, funds generated from the new quality assessment fee have been utilized to provide nursing facilities with supplemental payments for acuity and quality. The methodology utilized to determine these payments will be detailed in the Rate Methodology section of this overview.

MEDICAID RATE CALCULATION SYSTEM

Prior to July 1, 2018, the Tennessee Medicaid reimbursement system is prospective, cost based and facility specific. The state calculates Medicaid rates for two separate peer groups, Level I and Level II facilities. Rates for Level I facilities are calculated using Medicaid cost reports. Rates for Level II facilities were calculated utilizing data derived from Medicare cost reports, utilizing a step-down cost reporting system.

However, effective July 1, 2018, the state converted to an acuity-based system. This system is prospective, cost- and price-based and facility-specific, but now adjusts rates semiannually for acuity utilizing the RUG IV, 48 Grouper assessment system. However, the state now only calculates one rate per nursing facility (there are no longer any Level I and II rates). This system also includes quality of care add-on payments. Initially, this new system was supposed to be implemented effective July 1, 2015, but was not implemented until July 1, 2018.

In order to transition to a new system, the state utilized a "bridge process" that provided nursing facilities with additional supplemental revenue mainly generated from the increase in the state's quality assessment fee. This includes supplemental payments for acuity and quality.

Since 2010, all TennCare services are offered through managed care entities. Medical and behavioral services are covered by "at risk" Managed Care Organizations (MCOs) in each region of the state. However, MCOs are required to reimburse contract nursing facility providers at the per diem rate specified by TennCare.

COST CENTERS

Under the prior system, the Tennessee reimbursement system consists of one cost center that encompasses all reimbursable

expenses allowed by the state. The new system includes five cost components as follows:

- The Direct Care Component, including the Case Mix Adjusted sub-component, the Direct Care Non-Case Mix Adjusted sub-component and Direct Care Spending Floor Adjustment. The Case Mix Adjusted sub-component includes costs that are attributable to salaries, contract labor, and direct/apportioned payroll tax and employee benefit expense for registered nurses (RN), licensed practical/vocational nurses (LPN/LVN), and certified nurse aides (CNA) or orderlies that are providing direct SNF/NF patient care services. The Case Mix Adjusted component is attributable to salaries, contract labor, and direct/apportioned payroll tax and employee benefit expense associated with director of nursing and assistant director of nursing duties, the cost of raw food and special dietary supplements reported on the Medicaid supplemental cost report (includes those dietary supplements used for tube feeding or oral feeding).
- The Administrative and Operating Component. This component includes costs attributable to the general administration and operation of the nursing facility.
- The Capital (Fair Rental Value) Component. This component is determined by calculating a Fair Rental Value (FRV) rate, which is in lieu of reimbursement for capital costs such as depreciation, amortization, interest, rent/lease expense, etc.
- The Cost-Based Component, including the property tax sub-component and assessment fee add-on.
- A Stand-Alone Quality Incentive Payment Per Diem.

INFLATION AND REBASING

Under the prior system, nursing facility rates were rebased annually using the most recent cost report data available. All participating nursing facilities have their initial Medicaid rate established on July 1. Fiscal year 2010 Medicaid rates were calculated using cost reports completed during 2008. However, due to budgetary constraints, facilities are to receive only 20% of their scheduled rate increases. In fiscal year 2011 the state rebased rates utilizing 2009 cost report data and applied the full inflation adjustment. The average rate increase in fiscal year 2011 was approximately 5.7%.

Effective July 1, 2011, the state froze fiscal year 2012 rates at fiscal year 2011 levels. Initially, the state proposed to reduce rates by 4.25% effective July 1, 2011. However, the state planned to use additional funding it was supposed to receive from the Centers for Medicare & Medicaid Services (CMS) due to funding errors to offset this reduction. The state did not receive this funding and implemented the 4.25% rate reduction effective January 1, 2012. However, the state reduced this reduction to 2.5% effective January 1, 2012.

The state rebased rates effective July 1, 2013, but nursing facilities received only 63% of the Level I rate increase they were due. Level II rates were fully funded. The state also rebased rates effective July 1, 2014, utilizing predominantly 2013 cost report data. Initially, the state was going to implement a 2.0% rate reduction, but instead utilized state reserve funds to provide the funding required to eliminate half of this reduction. Funds generated from

the changes to the state's quality assessment fee (effectively July 1, 2014) were utilized to eliminate the remaining portion of the rate reduction. Given these factors, the rebase effective July 1, 2014, was eventually fully funded. However, costs utilized to rebase rates for fiscal year 2015 did not significantly increase from the costs utilized to determine fiscal year 2014 rates. Therefore, despite the rebase, calculated nursing facility rates remained relatively flat.

The state rebased nursing facility rates for fiscal year 2016 (effective July 1, 2015) and fiscal year 2017 (effective July 1, 2016) utilizing 2014 and 2015 cost report data, respectively. Rates effective July 1, 2017, were based on 2016 cost report data.

Under the new system, nursing facility rates shall not be rebased at an interval longer than every three years. Cost reports ending December 31, 2015, were utilized to calculate July 1, 2018, rates. In the initial rebasing year, non-capital costs are inflated from the midpoint of the nursing facilities' base cost report year to the midpoint of the rate year. In non-rebasing years, non-capital costs are inflated from the mid-point of the previous rate year to the mid-point of the prospective rate year. The inflation index utilized in both scenarios is SNF Market Basket without Capital Index Factor.

The below summary is a description of how nursing facility rates are calculated utilizing the new rate setting system.

RATE METHODOLOGY

The Direct Care Rate is initially calculated as state-wide prices for both sub-components, the Direct Care Case Mix Adjusted sub-component and the Direct Care Non-Case Mix Adjusted sub-component. Both components equate to 106.0% of the statewide median cost (case mix adjusted cost and non-case mix adjusted cost). The Direct Care Case Mix Adjusted price is made facility-specific by multiplying it by the nursing facility's Medicaid average case mix index (CMI). This adjustment is made semi-annually. The Direct Care Case Mix Adjusted facility-specific rate is added to the Non-Case Mix Adjusted price to determine the facility's Direct Care Rate prior to adjustment for the spending floor.

Also, prior to adding the Non-Case Mix Adjusted to the Direct Care Case Mix adjusted rate, the Non-Case Mix Adjusted price is adjusted to include the facility's non-case mix adjusted quality incentive. This is accomplished by multiplying the Non-Case Mix Adjusted price by the facility's quality incentive multiplier, depending on each facility's quality score (there are three quality tiers in which a facility can be placed). Each facility's quality score can range from 0 to 100, based on how the community scores in the following categories:

- Patient and Family Satisfaction (35 points);
- Culture Change and Quality of Life (30 points);
- Staffing and Staff Competency (25 points); and
- Clinical Performance (10 points).

Nursing facilities with the following scores will be placed in the following Quality Tiers:

Quality Tier	Point Range
Quality Tier II	75-100
Quality Tier 2	50-74.99
Quality Tier 3	0-49.99

The multiplier used to adjust the Non-Case Mix Adjusted price based on the quality tier is as follows:

- Quality Tier 1 – 105.00%;
- Quality Tier 2 – 102.50%; and
- Quality Tier 3 – 100.00%

After the final Direct Care Rate is determined, it is then multiplied by the current spending floor to determine each facility's spending requirement. The spending floor required for July 1, 2018, can range from 82.5% to 87.5%, depending on each facility's quality tier. The percentages will increase each year until reaching 90.0% to 94.0% effective July 1, 2021, as follows:

Effective Date	Quality Tier 1	Quality Tier 2	Quality Tier 3
July 1, 2018	82.50%	85.00%	87.50%
July 1, 2019	85.00%	87.50%	90.00%
July 1, 2020	87.50%	90.00%	92.50%
July 1, 2021	90.00%	92.00%	94.00%

If the facility's cost is above the spending floor, no adjustment is required. If the facility's cost is below the spending floor, then the rate is reduced by the amount the facility is below the spending floor.

The Administrative and Operating Cost Component Rate is one state-specific rate that equates to 101.0% of the median statewide per diem cost. The Capital Cost Component Rate is calculated utilizing a Fair Rental Value (FRV) system.

As part of the determination of FRV rates, nursing facilities receive an appraisal from a state contracted appraiser. Nursing facility appraised values will be subject to a statewide mandatory reappraisal process in conjunction with the second rebase following the implementation of the new stateside appraised values. Nursing facilities can also request a re-appraisal for the following reasons: a nursing facility has relocated to a new location; the nursing facility has moved more than 10.0% of its bed capacity to a new location; or the facility has completed a renovation/improvement greater than or equal to 15% of its current net depreciated facility appraisal value.

The state approved appraisers will utilize the Marshall and Swift Building Valuation System (or its successor) for nursing facilities. The fee simple replacement cost of building and site improvements are calculated utilizing the cost approach method. The Land values are calculated utilizing the sales comparison approach. The building and site improvement values are adjusted downward for the impact of depreciation. The sum of the depreciated-adjusted building and site improvements and the allowable land value equates to the total facility base value. The maximum allowable base facility value threshold equates to the nursing facility's total number of licensed beds multiplied by a value of \$75,000 per bed. Nursing facilities may increase their

per bed value threshold based on their specific Medicaid private room resident day percentage. Nursing facilities with 10.0% or greater Medicaid private room days receive a \$3,000 increase to their maximum allowable per bed value. Nursing facilities whose private room Medicaid days are in between 5.0% to 9.99% of total Medicaid days receive a \$1,500 per bed increase.

The lessor of the total facility base value or the maximum allowable base facility value is added to the moveable equipment value. Movable equipment is determined to be \$7,500 per licensed bed. The sum of this calculation is multiplied by a rental factor to determine the nursing facility's FRV. The rental factor utilized for a nursing facility is determined based on the previously mention nursing facility quality tier as follows: Tier 1 – 8.70%; Tier 2 – 8.35% and Tier 3 – 8.00%. The FRV is then divided by the greater of the facility's total actual resident days, or the minimum occupancy percentage threshold of 85.0% of the nursing facility's total potential licensed nursing facility resident days.

The Cost-Based Cost Component Rate is a facility-specific rate that equates to the facility's cost report base year property tax expense (inflated to the mid-point of the rate year) plus the facility's provider assessment add-on. Similar to the calculation of the Capital rate, the Cost-Based Cost Component rate is determined by dividing the applicable cost by the greater of the facility's total actual resident days, or the minimum occupancy percentage threshold of 85.0% of the nursing facility's total potential licensed nursing facility resident days.

Nursing facilities are also eligible for a quality incentive payment. Funding for the program will equate to no less than \$40 million, or 4.0% of total nursing home funding. Each facility receives a quality score based on specific categories and nursing facilities will receive a proportionate share of the funding based on a percentage of their quality adjusted Medicaid days from total quality adjusted Medicaid days in the state. This system and the Quality Tiers are previously detailed in this overview. In each subsequent year, the amount of funding set aside for the quality-based component of the reimbursement methodology will increase at two times the rate of inflation of the index factor. Index factor inflation shall be calculated from the midpoint of the prior state fiscal year to the midpoint of the new state fiscal year.

The total rate for a nursing facility equates to the five cost component rates. However, on a semi-annual basis, total nursing facility rates are adjusted for a Budget Adjustment Factor (BAF). The BAF is multiplied by the calculated total rate to determine the BAF adjusted total rate. This adjustment reflects any budget shortages that result based on the rate calculation. On July 1, 2018, the BAF was 100.0%. However, effective January 1, 2019, nursing facility rates were slightly reduced by a BAF of 99.5044%.

Lastly, nursing facility rates are adjusted for the phase-in of the new rate calculation. For the rate setting periods in-between July 1, 2018, and June 30, 2020, nursing facilities will receive a phase-in adjustment. A nursing facility's base reimbursement rate will be established as the Medicaid average of the Level I and Level 2 nursing facility reimbursement rates in effect for each nursing facility on July 1, 2017. For each rate period, the current base rate will be inflated from the mid-point of the previous rate year

to the mid-point of the current rate year by the inflation index. This rate will be utilized to determine a gain/loss adjustment for each nursing facility. The facility's nursing facility rate calculated utilizing the new methodology for the rate period effective July 1, 2018, can exceed or be less than \$6.00 of the base reimbursement rate. For rates effective July 1, 2019, this amount increases to \$12.00. The phase-in adjustment is eliminated on July 1, 2020.

The average Level I nursing facility Medicaid rate was \$131.25 for fiscal year 2007, \$137.85 for fiscal year 2008, \$142.00 for fiscal year 2009, \$144.39 for fiscal year 2010 and \$154.07 in fiscal year 2011. The average Level I rate for fiscal year 2012 (\$154.15) is relatively unchanged from the prior fiscal year. The average Level II nursing facility Medicaid rate was \$160.01 for fiscal year 2007, \$156.65 for fiscal year 2008, \$155.33 for fiscal year 2009, \$151.83 for fiscal year 2010 and \$160.27 in fiscal year 2011. The average Level II rate for fiscal year 2012 (\$160.64) is relatively unchanged from the prior fiscal year. However, based on the 2.5% rate reduction, the average rate is estimated to be approximately \$156.62.

THCA was able to provide estimates of statewide average rates for fiscal years 2013 through 2015. However, these estimates were for all facilities and are not broken out by Level I or II care. Including the bed tax add-on, the average rates for fiscal years 2013 and 2014 were \$154 and \$160, respectively. However, the average rate in fiscal year 2015 (\$175) increased 9.4% from the prior rate. This reflects that a larger percentage of nursing facilities received a \$4.22 increase in the bed tax/assessment fee add-on as well as an increase of revenue generated from the acuity and quality supplemental payments. Average rates for fiscal year 2016 and 2017 were \$172.38 and \$176.48, respectively. An overall average rate was not available for rates to be effective July 1, 2017, and July 1, 2018.

MINIMUM OCCUPANCY STANDARDS

The state utilizes a minimum occupancy requirement of 85.0% for the calculation of the Capital and Cost rates.

OTHER RATE PROVISIONS

The reimbursement rate for new facilities will be determined utilizing the methodology previously defined with the following exceptions. The provider's semi-annual CMI will be determined as the statewide annualized Medicaid resident day-weighted CMI until the new provider has completed one semi-annual rate period. The provider will be exempt from the direct care spending floor until the following July 1. The facility will be included in Quality Tier III for rate setting purposes until the facility has submitted six consecutive months of quality performance data. If the provider pays real estate taxes, it will receive the statewide annualized Medicaid resident day-weighted average inflated real estate tax cost value. If the facility has not yet had an appraisal completed, the facility will receive the maximum total facility value possible. Nursing facilities that have changed ownership will receive rates based on the acuity, costs, days, appraisal data and quality information of the prior owner.

Effective July 1, 2018, Tennessee Medicaid no longer reimburses nursing facilities for holding a bed under any scenario. Prior to this date, Tennessee reimbursed Level I nursing facilities for residents who are Medicaid eligible, but temporarily require hospitalization or therapeutic leave. The state reimbursed nursing facilities for a maximum of ten bed hold days at 100% of a nursing facility's current Medicaid rate. However, to receive reimbursement for bed hold days, 85.0% of the nursing facility's total beds must have been occupied. Tennessee did not reimburse Level II nursing facilities for bed hold days.

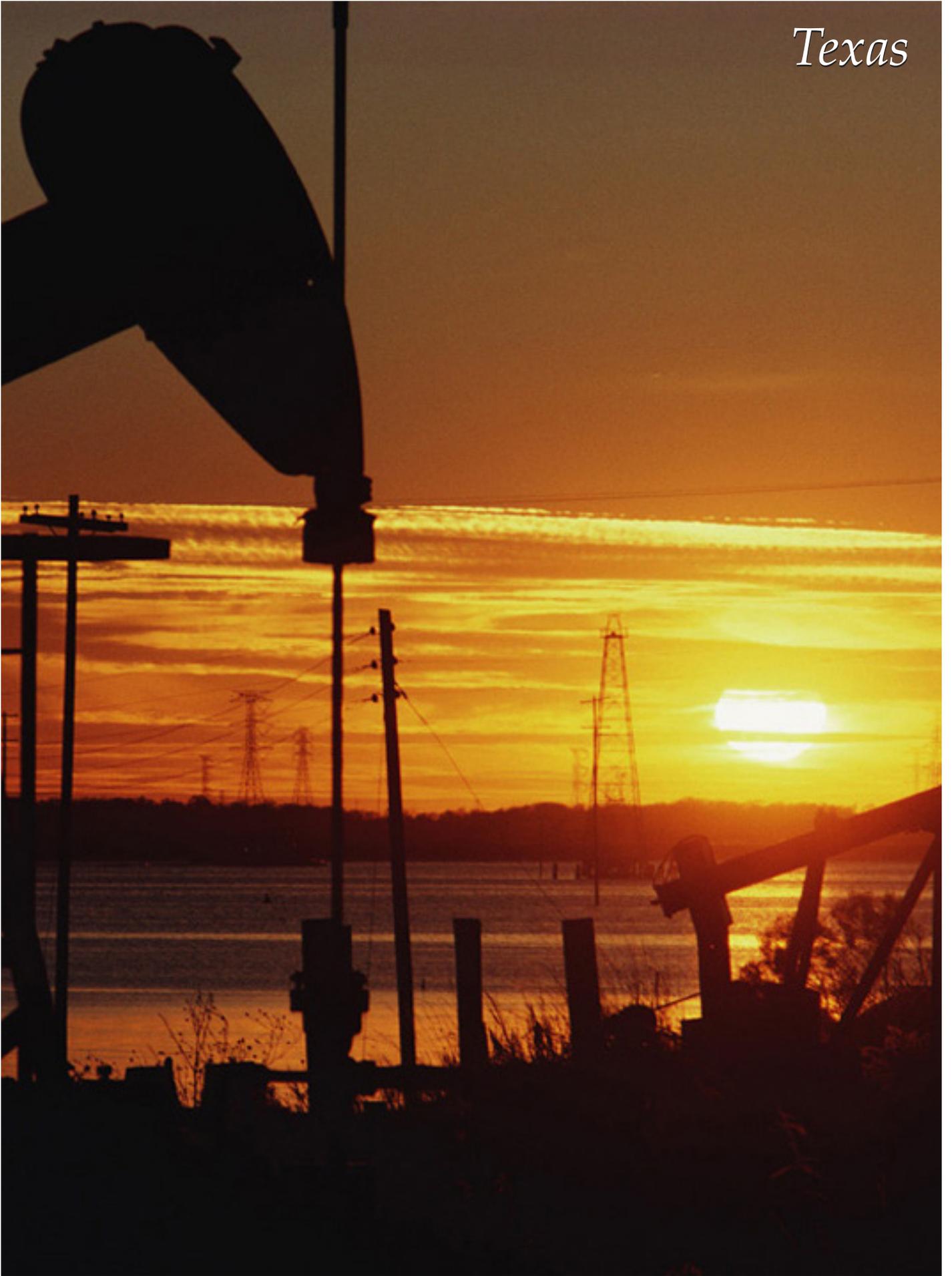
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

With the exception of the continued phase-in of the new reimbursement system, there are no planned or proposed changes to the rate calculation methodology.

TENNESSEE COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	75.00	79.75	80.00		109.50	114.00	110.00		132.00	133.25	130.50
Average Daily Census	70.51	68.91	68.94		90.71	90.14	87.04		108.88	109.84	105.37
Occupancy	69.6%	69.0%	67.4%		81.6%	80.2%	80.2%		89.2%	87.5%	87.4%
Payor Mix Statistics											
Medicare	10.5%	10.3%	9.2%		14.8%	13.4%	12.6%		19.8%	19.3%	19.3%
Medicaid	39.7%	46.9%	46.0%		60.1%	61.6%	59.3%		69.9%	71.1%	70.1%
Other	17.6%	17.6%	20.7%		31.4%	28.3%	34.8%		78.5%	76.1%	79.2%
Avg. Length of Stay Statistics (Days)											
Medicare	31.40	31.21	29.45		39.51	38.91	37.31		52.19	49.21	48.70
Medicaid	173.04	215.12	204.48		282.36	314.23	321.60		451.38	449.16	509.14
Other	52.23	47.98	46.91		84.54	73.43	79.33		223.63	219.77	245.40
Revenue (PPD)											
Inpatient	\$185.56	\$188.65	\$194.38		\$201.12	\$203.48	\$207.64		\$226.75	\$236.66	\$231.89
Ancillary	\$65.09	\$61.56	\$61.96		\$91.55	\$91.80	\$89.35		\$130.08	\$133.91	\$139.80
TOTAL	\$257.24	\$262.46	\$268.31		\$299.93	\$310.54	\$310.54		\$349.37	\$347.52	\$362.60
Expenses (PPD)											
Employee Benefits	\$13.84	\$13.84	\$14.61		\$18.71	\$19.30	\$20.21		\$23.44	\$24.00	\$24.67
Administrative and General	\$38.90	\$39.78	\$39.27		\$45.74	\$45.90	\$47.79		\$52.76	\$54.24	\$56.53
Plant Operations	\$9.32	\$9.42	\$9.71		\$10.66	\$10.86	\$11.12		\$12.61	\$12.66	\$13.01
Laundry & Linens	\$2.15	\$2.28	\$2.30		\$2.77	\$2.85	\$2.96		\$3.40	\$3.35	\$3.42
Housekeeping	\$4.65	\$4.68	\$4.65		\$5.35	\$5.44	\$5.50		\$6.47	\$6.51	\$6.83
Dietary	\$14.74	\$15.13	\$15.54		\$16.39	\$17.12	\$17.23		\$18.74	\$19.21	\$20.23
Nursing & Medical Related	\$65.27	\$69.09	\$72.38		\$73.24	\$77.28	\$80.74		\$85.39	\$90.16	\$94.44
Ancillary and Pharmacy	\$27.05	\$27.88	\$27.55		\$34.77	\$34.92	\$34.58		\$45.85	\$45.41	\$46.14
Social Services	\$1.72	\$1.81	\$2.03		\$2.99	\$3.19	\$3.75		\$5.02	\$5.40	\$6.00

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Texas



INTRODUCTION

Nursing facilities in Texas are licensed by the Texas Department of Aging and Disability Services (DADS) under the designation of "Nursing Facility." A nursing facility is also designated as a "Skilled Nursing Facility" if it participates with Medicare. The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN TEXAS	
Licensed Nursing Facilities*	1284
Licensed Nursing Beds*	146,616
Beds per 1,000 Aged 65 >**	40.70
Beds per 1,000 Aged 75 >**	103.95
Occupancy Percentage - 2017*	67.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

In 1985, Texas eliminated the Certificate of Need (CON) program by abolishing the Texas Health Care Facilities Commission, the agency that issued CONs. In addition, the state established a moratorium on the contracting of additional Medicaid nursing facility beds to regulate the development of new Medicaid nursing beds and/or the relocation of existing Medicaid nursing beds. As of the date of this document, there is no end date set on the moratorium. Texas currently uses a bed allocation waiver program that controls the number of nursing facility beds that are eligible to become Medicaid certified in each nursing facility.

An exception may be allowed if it is determined that granting a Medicaid bed allocation waiver or exemption will best serve the needs of Medicaid recipients in a local community. DADS may grant an exemption under the following circumstances:

- Currently allocated Medicaid beds may be replaced through the construction of one or more new nursing facilities. Applicants must either own the physical plant to which the beds are allocated or possess a valid assignment of rights to the Medicaid beds. Replacement facilities will be granted an increase of up to 25.0% of the currently allocated Medicaid beds if the applicant complies with the history of quality-of-care requirements. The replacement nursing facility must be located in the same county in which the Medicaid beds are currently allocated. The history of quality-of-care requirements indicates that an applicant has not received any of the following sanctions within the preceding 24 months:
 - Termination of Medicaid and/or Medicare certification.
 - Denial, suspension or revocation of nursing facility license.
 - Cumulative Medicaid and/or Medicare civil monetary penalties totaling more than \$5,000 per facility.
 - Other civic penalties pursuant to the Texas Health and Safety Code.
 - Denial of payment for new admissions.
- Allocated Medicaid beds currently certified or certified previously may be transferred to another physical plant. The replacement nursing facility must be located in the same county in which the Medicaid beds currently are allocated.
- Medicaid-certified nursing facilities with high occupancy rates may periodically receive bed allocation increases. The

occupancy rate of the Medicaid beds must be at least 90.0% for nine of the previous 12 months. Additional Medicaid beds may be no greater than 10.0% of the current number of Medicaid-certified nursing facility beds.

- Licensed nursing facilities that do not have Medicaid-certified beds may receive an initial allocation of Medicaid beds. The application for Medicaid beds may be no greater than 10.0% of the current licensed nursing facility beds.
- Nursing facilities with a Medicaid bed capacity of less than 60 may receive additional Medicaid beds to increase their capacity up to a total of 60 Medicaid beds.
- Licensed nursing facilities may receive temporary spend-down Medicaid beds for residents who have spent down to become eligible for Medicaid, but for whom no Medicaid bed is available.

Waivers may be granted by DADS if it is determined that Medicaid beds are necessary for the following circumstances:

- High Occupancy Waiver - The high occupancy waiver is designed to meet the needs of counties and certain precincts that have high occupancy rates for multiple months. If DADS determines that a county or precinct occupancy rate is equal to or exceeds 85.0% for at least 12 months, DADS may initiate a waiver process by placing a public notice in the Texas Register and the Electronic State Business Daily (ESBD) to announce an open solicitation period. The public notice would announce that DADS may allocate 90 additional Medicaid beds in the county or precinct. Community Needs Waiver -- intended to meet the needs of communities that do not have reasonable access to quality nursing facility care.
- Criminal Justice Waiver -- intended to meet the needs of the Texas Department of Criminal Justice.
- Under-Served Minority Waiver - intended to meet the needs of minority communities that do not have adequate nursing facility care.
- Alzheimer's Waiver -- intended to meet the needs of communities that do not have reasonable access to Alzheimer's nursing facility services.
- Teaching Nursing Facility Waiver -- intended to meet the statewide needs for providing training and practical experience for healthcare professionals.
- Rural County Waiver -- intended to meet the needs of rural areas of the state that do not have reasonable access to quality nursing facility care.
- Small House Waiver - designed to promote the construction of smaller nursing facility buildings that provide a homelike environment.

As of the date of this overview, the state is considering legislation (Senate Bill 890) that would restrict some of the exceptions to the state's moratorium. Under this legislation, with certain exceptions, the state would not allow the licensure of any new Medicaid beds unless the statewide occupancy rate of Medicaid certified beds is more than 90.0%. Previous exceptions that are proposed to continue are the small house nursing facility waiver, the construction of a replacement facility and the high-occupancy waiver.

It should be noted that as of the date of this overview the legislation has not been approved and is still in the review/development phase. It is currently unclear if any changes to the moratorium or

exceptions will be implemented.

BED NEED METHODOLOGY

Texas does not possess a bed need methodology and is not in the process of developing a bed need calculation. However, as previously mentioned, the state does consider area occupancy levels (see the previously mentioned High Occupancy Waiver) when considering the allocation of new Medicaid-eligible beds.

QUALITY ASSURANCE FEE

Nursing facilities in Texas are not currently assessed with a quality assurance fee. In previous legislative sessions, legislation was introduced to implement a quality assurance fee in Texas. The legislation has failed each session. As of the date of this document, there are no plans to submit additional legislation for the development of a quality assurance fee.

MEDICAID RATE CALCULATION SYSTEM

The Texas Medicaid reimbursement system is a flat rate, case mix adjusted system that is prospective and resident specific. Effective September 1, 2008, the state converted from a Texas Index of Level of Effort (TILE) classification system to a Resource Utilization Group (RUG) based classification system to adjust for case mix. In addition, effective March 1, 2015, the state has converted to a managed care reimbursement system. The managed care organizations (MCOs) the state has selected to operate the system have the authority to negotiate rates with nursing facilities.

However, the MCOs are not allowed to reimburse nursing facilities any less than rates calculated utilizing the above described fee-for-service rate calculation. Below is a summary of how the state determines fee-for-service rates.

COST CENTERS

Reimbursements are comprised of the following five cost-related components:

- The Direct Care Staff cost component encompasses compensation for employee and contract labor, including registered nurses (RNs), directors of nursing (DONs), assistant directors of nursing (ADONs), licensed vocational nurses (LVNs), medication aides and certified nurse aides (CNAs) performing nurse-related duties for Medicaid contracted beds.
- The Other Recipient Care cost component includes medical supplies, social and activities wages and associated benefits, social and activities supplies, laundry and housekeeping wages and associated benefits, laundry and housekeeping supplies, resident consultant and contracted services, and other non-medical ancillary expenses.
- The Dietary cost component includes food, dietary equipment and supplies, food service, ancillary nutrition therapy supplements, and dietitian wages and associated benefits.
- The General/Administration cost component includes administrative, clerical and maintenance salaries and related benefits, management fees, insurance costs (excluding liability insurance), supplies, advertising expense, travel and

educational expenses, and central office expenses.

- The Fixed Capital Asset cost component includes facility and building equipment expenses, lease/rental expenses, mortgage interest, leasehold improvement amortization, building equipment expenses and land improvement depreciation.

INFLATION AND REBASING

Nursing facility Medicaid rates in Texas are set for a two-year period, which coincides with the state's biannual appropriations budget. The legislature goes into session every other year from January to May (140 days). The standard rate year runs from September to August. Although the state does possess a specific rate setting methodology, for the last several biennia, nursing facility rates have been determined by the funding levels provided by the Texas Legislature.

Based on the state's regulations, the initial audited allowable costs that the Texas Health and Human Services Commission (HHSC) submits to the Texas Legislature during odd year cost reports are intended to be used to rebase the rates according to the published methodology. This calculation is submitted by HHSC to the Texas Legislature during odd year cost reports. Although HHSC submits this information to the state legislature every two years to rebase rates, due to limited budgetary appropriations, the state has not allowed recognition of the more current cost data since approximately 1999.

The total per diem rate represents the audited allowable costs, as applied to the reimbursement methodology, that HHSC submits to the Texas Legislature for approval. Based on a comparison of this cost estimate to the state's appropriations budget, the legislature determines the base rate for all nursing facilities in the state. Based on regulations in place, the Medicaid rates for September 1, 2009, to August 31, 2011, budget period should be based on 2007 cost report data. However, the 2007 cost report data was not used to set the amount of the rate increase, but to allocate the increase across the different rate components. Final proposed rates were standardized to the September 1, 2008, through February 28, 2009, statewide average case mix index.

Prior to submitting the expenses to the legislature, HHSC inflates non-nursing expenses to the current year using the Personal Consumption Expenditures (PCE) Chain-Link Price Index derived from the Bureau of Economic Analysis. Nursing expenses are inflated based on internal inflation indexes created by HHSC from historical nursing home costs.

The 2010-2011 General Appropriations Act appropriated \$55.6 million in General Revenue Funds and \$79.5 million in Federal Funds for a provider rate increase effective September 1, 2009. This represented a 2.7% biennial increase for nursing facility reimbursement funding. The subsequent proposed rate increase was 7.12% (48.24% of the fully funded increase) distributed proportionally across all cost centers based on each cost center's ratio of costs as reported in the 2007 cost report data. Final proposed rates were standardized to the September 1, 2008, through February 28, 2009, statewide average case mix index. However, given budgetary restrictions, the state was forced to

implement a 1% rate reduction on September 1, 2010, and an additional 2% rate reduction on February 1, 2011, for a cumulative 3% rate reduction. These rate reductions were also applied to all rate add-ons.

Based on budget limitations, nursing facility Medicaid rates were frozen at February 1, 2011, levels for the past bi-annual period (September 1, 2011, to August 31, 2013). This also included adjustments for acuity levels. If the statewide average rate increased during the biannual period due to changes in the distribution of residents across all the RUG categories, no adjustments were made by the state to keep the rate budget neutral.

In late June 2013, the governor signed Senate Bill One, which will implement a total 6.0% rate increase over the biannual period beginning September 1, 2013. Rates effective September 1, 2013, were inflated 2.0%. Rates were inflated 4.0% effective September 1, 2014. Senate Bill One was approved with a companion bill, Senate Bill 7. Senate Bill 7 required that the state convert to a managed care reimbursement system for nursing homes effective September 1, 2014. However, the state did not implement the managed care system until March 1, 2015.

Texas nursing facility Medicaid rates will remain frozen at September 1, 2014 rates through the current biannual period (September 1, 2015, to August 31, 2017).

RATE METHODOLOGY

Both the Direct Care Staff and Other Recipient Care rates are adjusted for case mix. The following is a summary of how the state calculates nursing facility rates in a rebasing/non-frozen rate year. It is currently unclear when the state will next calculate new nursing facility rates.

The Direct Care Staff per diem rate is calculated by first determining the sum of recipient care costs from the Direct Care Staff cost center in all nursing facilities included in the Texas Nursing Facility Cost Report (TNFCR) database. This estimate is adjusted for inflation and then divided by the sum of recipient days of service in all facilities in the initial TNFCR database and multiplied by 1.07. The result is the average Direct Care Staff cost component for all facilities.

The Direct Care Staff rates are adjusted for case mix changes using a 34-group version of the RUG III system. The Direct Care Staff rate for all facilities for each of the 34 RUGs is calculated by multiplying the average Direct Care Staff base rate component by each of the standardized statewide CMIs. The per diem base rate is calculated for the RUG III case mix groups and default groups by dividing the RUG III index by 0.9908, then multiplying it by the average Direct Care Staff base rate component. Given that Texas Medicaid rates are patient specific, Medicaid rates are adjusted for any change in a resident's acuity that requires a new assessment. Case mix weights will be derived from a combination of CMS standard time measurements for each RUG category weighted by Texas-specific nursing salary differentials. The base rates for the Direct Care Staff cost component are adjusted by these case mix weights to determine the final rates for these components.

In May 2000, an enhanced staffing level incentive was introduced that provides incentives for nursing facilities to increase direct care staffing and direct care staff wages and benefits. Participation in the program is voluntary. Facilities choosing to participate in the Direct Care Staffing Enhancement agree to maintain a certain staffing level in return for increased direct care staff revenues. All times are expressed in terms of LVN-equivalent minutes and are determined for each facility. Facilities request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments. There are currently 27 enhanced staffing levels, with minimum staffing requirements based on the statewide average of direct care staff hours related to the Direct Care Staff component for nursing facilities, adjusted for each facility's case mix and Medicaid, Medicare and private pay census. Determination of a facility's staffing level is made on an annual basis. If a participating facility fails to meet its staffing requirement, all direct care staff revenues associated with unmet staffing goals are recouped.

The total Direct Care Staff rate for a facility is equal to the Direct Care base rate plus any add-on payments associated with the enhanced staffing level incentive.

Similar to the Direct Care Staff rate, the Other Recipient Care rates vary according to case mix class of service. The average Other Recipient Care cost component is calculated by adjusting the sum of the other care costs in order to account for disallowed costs and inflation. The adjusted total sum is then divided by the sum of the recipient's days of service in all facilities in the current base rate. The resulting weighted average per diem cost of Other Recipient Care is then multiplied by 1.07, resulting in the average Other Recipient Care cost component.

The Other Recipient Care cost component is adjusted for case mix changes using a 34-group version of the RUG III system. The Other Recipient Care cost component rate for all facilities for each of the 34 RUGs is calculated by multiplying the average Other Recipient Care base rate component by each of the standardized statewide CMIs.

The Direct Nursing Staff and Other Recipient Care rates calculated using the RUG III classification system for the second year of the September 1, 2008, to August 31, 2009, budget period were subject to a conversion based on a comparison of the average case mix weights determined using the RUG III system to the average case mix weights determined using the TILE system. Rates during this period were also subject to a hold harmless provision. The hold harmless provision directed that a nursing facility's weighted average reimbursement for the case mix portions of the Medicaid rate under the RUG III system in fiscal year 2009 could be no less than the weighted average reimbursement for the case mix portions of the Medicaid rate under the TILE system in fiscal year 2008. This was in effect for 12 months after implementation of the RUG system. The hold harmless provision expired as of August 31, 2009, and final settlements have been paid out.

The Dietary rate and General/Administration cost component are constant across all case mix classes. These components are calculated at the median cost (weighted by Medicaid days of service in the rate base) in the array of projected allowable per diem costs for all contracted nursing facilities included in the base

rate, multiplied by 1.07.

The Fixed Capital Asset rate is also constant across all case mix classes. A use fee per bed is calculated by determining the 80th percentile in the array of allowable appraised property values (as determined by local property taxing appraisals) per licensed bed, including land and improvements, and projecting this by one-half the forecasted increase in the PCE Chain-Type Price Index from the cost reporting year to the rate year. An annual use fee per bed is then determined by multiplying the projected 80th percentile of appraised property values per bed by an annual use rate of 14.0%. The per diem use fee per bed is then determined by dividing the annual use fee per bed by annual days of service per bed at the higher of 85.0% occupancy, or the statewide average occupancy rate. The per diem use fee per bed is limited to the lesser of the fee as calculated above, or the fee as calculated by inflating the fee from the previous rate period by the forecasted rate of change in the PCE Chain-Type Price Index.

The allowed appraised property values for a proprietary and tax exempt facility are determined by local property taxing appraisals. The appraisal must value land and improvements using the same basis used by the local taxing authority under Texas laws regarding appraisal methods and procedures. Tax exempt properties not provided an appraisal from a local property taxing authority must provide documentation certifying exemption and must contact an independent appraiser to appraise the facility's land and improvements.

Texas also offers a liability and property insurance add-on. Reimbursement for liability insurance is not included in the base rate and is paid only to facilities that purchase liability insurance. Effective September 1, 2015, the add-on for general and professional liability insurance coverage is \$1.67 per diem. The add-on for professional liability insurance coverage only is \$1.53 per diem and the add-on for general liability insurance only is \$0.14 per diem. These add-ons did not change from the add-ons for the prior fiscal year.

The total per diem rate is the sum of the case mix group's total Direct Care Staff and Other Recipient Care rates, the Dietary rate, the General/Administration rate, the Fixed Capital Asset use fee rate and the liability and property insurance add-on. This represents the audited allowable costs that HHSC submits to the Texas Legislature for approval. Based on a comparison of this cost estimate to the state's appropriations budget, the legislature determines the base rate for all nursing facilities in the state. This amount is then adjusted for case mix.

Based on the original budget allocations, the average daily Medicaid rate (including the weighted average liability insurance add-on and the impact of the rate enhancement for Direct Care Staff compensation) was estimated to be \$127.99 in fiscal year 2011, a projected increase of 6.1% from the fiscal year 2010 rate of \$120.65. However, this average rate Medicaid after the rate reduction was \$123.16. This still represents a 2.1% rate increase from fiscal year 2010. Effective September 1, 2011, the average rate increased 3.3% to \$127.17. This rate increase is attributed to changes in patient acuity levels. The weighted average rates effective September 1, 2013, and September 1, 2014, were \$139.42 and \$145.00, respectively.

MINIMUM OCCUPANCY STANDARDS

Texas uses an occupancy standard when determining the allowable per diem costs used in calculating the medians for each of the components. The minimum occupancy standard equates to the statewide average nursing facility occupancy rate. If a nursing facility's occupancy level is below the statewide average, the facility's allowable costs used to calculate the median are reduced by the percentage that the facility's occupancy is below the statewide average. In addition, if the statewide average is above 85.0%, then the facility's allowable costs used to calculate the median will be reduced by the percentage that the facility's occupancy is below 85.0%. However, if the statewide average is below 85.0%, the facility's allowable costs are adjusted to the statewide average. These adjusted allowable costs are used to calculate the medians per component.

OTHER RATE PROVISIONS

Given that Texas uses a flat rate reimbursement system, the state does not treat newly constructed, recently purchased or replacement nursing facilities any differently when determining a facility's reimbursement.

Texas also reimburses nursing facilities for residents that are Medicaid eligible, but temporarily require therapeutic leave. The state reimburses nursing facilities for a maximum of three therapeutic leave days per absence. The nursing facility will be reimbursed at the equivalent rate that the facility was receiving for the resident prior to the resident leaving the facility. If a resident requires an absence longer than three days, the resident must be re-admitted to the nursing facility. The total number of allowable reimbursable therapeutic leave days is not detailed in the state's regulations. Therefore, it is dealt with on a case-by-case basis. Texas does not reimburse nursing homes for holding beds for residents that require hospitalization.

INTERGOVERNMENTAL TRANSFERS

In 2012, the Centers for Medicare and Medicaid (CMS) approved the implementation of an Intergovernmental Transfer (IGT) Program for Texas. Under this system eligible nursing facilities (non-state government-owned nursing facilities) were eligible to receive supplemental payments in addition to fee-for-service rates. Similar to quality assessment fees (i.e. provider taxes) this is another mechanism that states use to draw extra matching funds from the CMS. This typically involves temporarily transferring funds from local/county hospitals to the state. The state claims this as Medicaid funding provided by the state, which CMS matches at the state's Federal Medical Assistance Percentage (FMAP). After collecting the matching funds from CMS, the state reimburses county hospitals for their contributions and provides them with a portion of the additional funds generated through the IGT program.

The first step in determining this reimbursement is to calculate each facility's Upper Payment Limit (UPL). States pay hospitals under Medicaid reimbursement methodologies established in the State Plan, and then estimate how much more the hospitals would have been paid for the services under Medicare principles. The difference between the payments and the estimate is the amount that is available for additional reimbursement and referred to as the UPL.

Under this program, county hospitals have been buying nursing facility licenses that allow the hospitals to draw down additional federal dollars based on the difference between the Medicaid UPL and the Medicaid rate. Typically, the previous nursing home owner manages the facility. The UPL is determined individually for each non-state government owned (NSGO) nursing facility by taking the difference between each facility's estimated Medicare and Medicaid rate multiplied by Medicaid resident days.

Supplemental payments are made to the hospitals and never directly to the nursing homes. Typically, nursing facilities are reimbursed a specific pre-agreed upon portion of IGT revenue. However, prior to determining this amount, the county hospitals first reimburse themselves for the funds that they temporarily transferred to the state. The remaining IGT generated revenue is then divided between that county hospital and the skilled nursing facility. Representatives of the Texas Health Care Association indicated that skilled nursing facilities typically receive 50% of the remaining funds.

Effective March 1, 2015, the state converted to a managed care reimbursement system, in which MCOs operate the system and directly reimburse nursing facilities. However, by implementing the managed care system, the state was prohibited by federal regulations from continuing its IGT/UPL program. These regulations do not allow for funding generated from the program to go directly to the MCOs, who would in turn reimburse the nursing facilities. Effective April 1, 2015, the state resolved this issue with CMS and the IGT/UPL system was extended until August 31, 2016. Under this system, IGT funds first go through the state's Medicaid Agency, which then funnels the funding to the MCOs, who in turn reimburse the nursing facilities. This new system is referred to as the Minimum Payment Amounts Program (MPAP). Presently, the Texas Health Care Association estimates that on average the program generates an additional \$70 per day of Medicaid reimbursement, which equates to approximately \$35 (50%) per Medicaid day of additional funding for nursing facilities.

Effective September 1, 2016, the state had planned to alter the system. Alterations to the program were to consist of linking IGT reimbursement to quality and improvement standards and goals to be developed as part of the state's Quality Incentive Payment Program (QIPP). Given that the methodology and standards for QIPP were still in the process of being developed, the proposed implementation of QIPP was to be delayed until March 1, 2017. This reflects that CMS has some concerns about the QIPP program that were not resolved. Therefore, the implementation of the program was to be delayed for six months. However, prior to September 1, 2016, CMS rejected the QIPP program, essentially leaving the state without an UPL/IGT program after that date.

The state had proposed to pay nursing facilities their previous MPAP reimbursement through March 1, 2017 (the extended date for implementation of QIPP). However, this was also rejected by CMS and no nursing facility in the state has received any reimbursement from the program since August 31, 2016.

Since that date, the state and various nursing home associations in the state have worked together to devise a new version of the QIPP program that CMS would find acceptable. This new "QIPP" program is proposed to be effective September 1, 2017.

Under this program the state will continue to use the NSGOs (facilities owned by the county hospitals) to generate UPL/IGT funds from matching dollars from CMS. The state will then distribute these funds into three components. However, nursing facility payments will be determined based on four quality metrics used to determine Medicare's Star Ratings. They will include use of antipsychotic drugs, pressure ulcers, patient falls for long-term care residents and use of restraints. It will be based on four CMS quarters prior to UPL determination. The funding for the program has yet to be determined. The components are as follows:

- Component 1 – This component is restricted to NSGOs (facilities that have transferred ownership to the county hospitals) that will get 110% of the non-federal share. Payment will be based on Medicaid utilization, but will be subject to the quality metrics. Payments will be monthly.
- Component 2 – Privately owned nursing facility – 35% of the remaining funding after Component 1 will go to Component II. To be eligible to receive funds from this component a nursing facility will have to possess a Medicaid payor percentage above a state determined standard (it will be 78% for the first period). Payments will also be initially based on Medicaid utilization, but will be adjusted based on improvements in quality metrics. Payments will be quarterly.
- Component 3 – both component 1 & 2 – 65% of the remaining funding after Component I. This payment will be based on Medicaid utilization and will be adjusted for improvements in quality measures. Payments will be quarterly.

The state currently published the proposed regulations (January 20, 2017) and is in the process of taking public comments and finalizing the regulations. The program will also require CMS approval. Both representatives of the state and the healthcare associations have indicated they are confident that they will receive approval for the program. However, as of the date of this overview, it is currently unclear if this will occur.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, with the exception of the previously mentioned proposed changes to the IGT/UPL system, there are no planned or proposed changes to the state's reimbursement system.

TEXAS COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	90.00	92.00	90.00		120.00	120.00	120.00		128.00	128.00	126.50
Average Daily Census	65.67	65.23	65.06		84.67	84.61	84.73		102.61	101.27	102.17
Occupancy	62.9%	62.6%	63.0%		72.8%	73.0%	73.0%		82.2%	82.1%	82.6%
Payor Mix Statistics											
Medicare	8.5%	7.9%	7.9%		11.4%	11.0%	10.8%		15.8%	15.5%	15.7%
Medicaid	55.1%	54.1%	55.0%		65.9%	65.1%	66.8%		74.9%	74.4%	76.2%
Other	14.9%	15.1%	14.0%		23.3%	23.7%	22.0%		34.0%	33.8%	33.2%
Avg. Length of Stay Statistics (Days)											
Medicare	36.97	35.73	33.11		47.85	45.52	45.12		63.61	63.05	64.30
Medicaid	256.03	240.41	239.85		342.67	331.29	345.00		509.52	531.15	561.86
Other	61.77	51.87	47.33		94.00	87.63	78.31		173.53	156.16	154.45
Revenue (PPD)											
Inpatient	\$155.95	\$158.66	\$161.46		\$183.12	\$191.02	\$190.50		\$224.81	\$236.86	\$244.85
Ancillary	\$41.13	\$41.48	\$42.42		\$72.52	\$66.02	\$67.02		\$117.00	\$107.30	\$118.42
TOTAL	\$202.65	\$203.49	\$206.11		\$247.09	\$252.94	\$261.43		\$335.15	\$336.84	\$350.04
Expenses (PPD)											
Employee Benefits	\$9.00	\$9.44	\$9.08		\$11.45	\$11.37	\$11.63		\$14.08	\$14.02	\$14.03
Administrative and General	\$26.47	\$26.90	\$27.51		\$32.37	\$33.55	\$34.21		\$38.76	\$42.13	\$41.61
Plant Operations	\$7.65	\$7.64	\$7.65		\$8.79	\$8.96	\$9.49		\$10.82	\$10.87	\$11.27
Laundry & Linens	\$1.70	\$1.73	\$1.68		\$2.19	\$2.28	\$2.16		\$2.87	\$3.01	\$2.96
Housekeeping	\$3.76	\$3.89	\$3.99		\$4.54	\$4.53	\$4.76		\$5.46	\$5.52	\$5.89
Dietary	\$12.77	\$13.02	\$13.30		\$13.89	\$14.26	\$14.53		\$15.92	\$16.03	\$16.34
Nursing & Medical Related	\$63.12	\$64.90	\$65.78		\$69.46	\$71.37	\$73.16		\$77.25	\$79.30	\$81.18
Ancillary and Pharmacy	\$22.08	\$22.31	\$24.08		\$29.72	\$29.68	\$30.58		\$40.28	\$40.44	\$39.99
Social Services	\$1.42	\$1.44	\$1.41		\$1.95	\$1.90	\$1.85		\$3.00	\$2.96	\$2.78

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Utah



INTRODUCTION

Nursing facilities in Utah are licensed by the Utah Department of Health (UDOH), Bureau of Health Facility Licensing, Certification, and Resident Assessment, under the designation of "Nursing Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN UTAH	
Licensed Nursing Facilities*	73
Licensed Nursing Beds*	5,767
Beds per 1,000 Aged 65 >**	16.85
Beds per 1,000 Aged 75 >**	42.41
Occupancy Percentage - 2017*	66.30%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

Utah does not require an individual or organization to obtain a Certificate of Need (CON) to construct or acquire a nursing facility to increase the capacity and services offered at an existing facility. The state's CON program ended in 1985.

In January 1989, UDOH implemented an emergency moratorium on the certification of new nursing home beds for participation in the state Medicaid program in order to discourage the rapid growth of nursing facility beds and stabilize the industry. The moratorium legislation addresses the renewal, transfer or increase of Medicaid certified programs.

With regards to the transfer of Medicaid program certification, a current owner may transfer certification to another owner provided the facility program operates within the same physical facility. Also, UDOH may issue Medicaid certification to a nursing facility program that was formerly certified but currently resides in a new or renovated physical facility, provided the program meets the following requirements:

- The nursing care facility program met all applicable requirements for Medicaid certification at the time of closure.
- The new or renovated physical facility is in the same county or within a five-mile radius of the original facility.
- The time between which the certified program ceased to operate in the original facility and will begin to operate in the new physical facility is not more than three years.
- The bed capacity has not been expanded.

Additional beds can be approved for Medicaid certification if there is insufficient bed capacity among certified programs in a service area. Insufficient bed capacity is determined based on reasonable evidence provided by a facility indicating an inadequate number of beds in a county or group of counties based on the following criteria:

- Current demographics that demonstrate nursing facility occupancy levels of at least 90.0% for all existing and proposed facilities within a prospective three-year period.
- Current nursing facility occupancy levels of at least 90.0%.
- No other nursing facility within a 35-mile radius requesting additional certification.

UDOH also considers whether a facility requesting additional beds will provide specialized or unique services that are underserved in the service area, and considers any certified beds subject to a claim by a previously certified program that may reopen.

Effective February 28, 2007, an additional moratorium was put into place regarding non-Medicaid nursing facility beds. The legislation limits the licensing of new non-Medicaid nursing care facilities. The non-Medicaid nursing facility moratorium was scheduled to sunset on July 1, 2016. However, the moratorium was extended to July 1, 2018. Effective July 1, 2017, the state effectively changed the statute to reflect that the state would not improve any new non-Medicaid beds unless the beds were first certified for Medicaid. Given that the state has a moratorium on the development of new Medicaid beds in the state, it effectively extends the moratorium to non-Medicaid beds.

BED NEED METHODOLOGY

Utah does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSESSMENT FEE

Nursing facilities in the state of Utah are currently assessed with a quality assessment fee known as the nursing care facility assessment (NCFA). Effective July 1, 2018, the fee is assessed at \$23.04 per non-Medicare patient day. Prior to the recent increase, the fee was assessed at \$20.98 per non-Medicare patient day effective July 1, 2017, \$18.74 per non-Medicare patient day effective July 1, 2016, and \$18.32 effective July 1, 2015. The original NCFA was assessed at \$6.18 per non-Medicare patient day, and was enacted July 1, 2004. The assessment is collected on a monthly basis.

Funds collected through the NCFA are put into a restricted account that is used by the legislature in determining the Medicaid reimbursement budget. Costs associated with the NCFA are treated as allowable costs and are included in the Flat Rate component of the Medicaid rate calculation system discussed in the upcoming Cost Centers section. There are currently no plans to alter or eliminate the NCFA. Funds generated from the increase in the NCFA were used to offset the rate reduction implemented from October 1, 2008, to June 30, 2009 and to maintain reimbursement levels through fiscal years 2010 and 2019.

MEDICAID RATE CALCULATION SYSTEM

Utah uses a price-based, facility-specific, case mix adjusted rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The current system went into effect for the 2004-2005 (fiscal year 2005) rate year.

COST CENTERS

Reimbursement rates are comprised of the following three cost components:

- The Resource Utilization Groups (RUGs) component is based on direct nursing costs, including raw food and dietary supplements.
- The Flat Rate component includes costs associated with

general and administrative (which includes the NCFA), plant operations and maintenance, dietary (excluding raw food and dietary supplements), laundry, linen, housekeeping and recreational activities.

- **The Property** component uses a fair rental value (FRV) system to calculate costs in lieu of direct reimbursement for depreciation, amortization, interest, and rent or lease expenses. This component also includes a pass-through subcomponent for a facility's property tax and property insurance costs.

INFLATION AND REBASING

There is no set time period for rebasing in the reimbursement system. There has not been a rebasing since the early 1990s, though rates were reestablished using the RUG system effective July 1, 2004. Nursing facility rates have traditionally been set based on budget appropriations. Specifically, the state first funds the Flat Rate component and then the Property Rate Component. The remaining funds are utilized to fund the RUG Rate component. The Medicaid rate year in Utah is from July 1 to June 30.

Reimbursement rates are scheduled to be adjusted for inflation each July 1. The inflation factor is determined annually by legislative appropriation increases. The inflation adjustment is applied to the RUG and Flat Rate cost components. Pass-through expenses included in the Property cost component are not inflated.

In fiscal years 2012 and 2018, the RUG rate component has only moderately changed. However, the flat rate component was increased 13.4% from \$43.64 in fiscal year 2011 to \$49.50 in fiscal year 2012. This resulted in an approximate average rate increase of 2.6%. In fiscal year 2013, the flat rate component increased 11.3% from \$49.50 in fiscal year 2012 to \$55.07 in fiscal year 2013. This resulted in an approximate average rate increase of 3.4%. The flat rate remained at \$55.07 in fiscal year 2014, but was increased approximately 5.0% to \$57.83 in fiscal year 2015. The flat rate remained at \$57.83 in fiscal year 2016, but increased to \$61.20 in fiscal year 2017. Based on increased budget appropriations, the Flat Rate increased 14.1% to \$69.80 in fiscal year 2018. In fiscal year 2019, the Flat Rate increased 4.2% to \$72.24.

The following methodology is what the state would utilize if it updated nursing facility rates.

RATE METHODOLOGY

RUG is a severity-based payment system that adjusts facility rates quarterly. A facility case mix system is employed in the computation of the RUG component of the per diem payment rate. The overall objective is to establish a Medicaid case mix index (CMI) for each facility. The RUG component was based on historical costs at the 96th percentile.

Minimum data set (MDS) data, based on the RUG III 34-group model, is used in calculating each facility's CMI. This information is submitted by each facility. Case mix is determined by establishing a RUG weight for each Medicaid patient. Available RUG scores for each patient are combined with the scores of all other patients to establish a composite weight for all Medicaid patients in the facility. The composite weight is multiplied by a dollar conversion factor to arrive at a per diem amount for the

facility payment rate. The dollar conversion factor is defined as the rate established quarterly by the state that is determined as a result of consideration of the average case mix changes and the necessary resources to maintain proper care levels for the patients. The factor is used to link RUG reimbursement to legislative funding. Medicaid funds appropriated by the state are first used to reimburse the Flat Rate and Property components. The dollar conversion factor is determined based on monies remaining from the appropriations after these two components have been reimbursed. Raw food is included in this component.

In developing RUG component payment rates, UDOH periodically adjusts urban and non-urban rates to reflect differences in urban and non-urban labor costs. The urban labor cost reimbursement cannot exceed 106% of the non-urban costs.

The Flat Rate cost component is a fixed amount paid for all Medicaid patients and reflects the proportion of the overall nursing home rate that is not considered variable in nature. Individual per diem costs for all participating nursing facilities are arrayed and the 50th percentile is determined, which is used as a baseline for reasonable costs for the Flat Rate cost component. This component is increased annually for inflation and is the same amount for all facilities.

The Property cost component is calculated and reimbursed based on an FRV system. Under this system, a facility is reimbursed based on the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent or lease expenses. The FRV system establishes a nursing facility's bed value based on the age of the facility and total square footage.

The initial age of each nursing facility used in the FRV calculation was determined as of September 15, 2004, using each facility's initial year of construction. The age of each facility is adjusted each July 1 to make the facility one year older. The age is reduced for replacements, major renovations or additions placed into service since the facility was built, provided there is sufficient documentation to support the historical changes. If a facility adds new beds or replaces beds, the new or replaced beds are averaged into the age of the original beds to arrive at the facility's age.

If a facility completes a major renovation, the cost of the project is represented by an equivalent number of new beds. Renovations unrelated to either the direct or indirect functioning of the nursing facility are not to be used to adjust the facility's age. The equivalent number of new beds is determined by dividing the cost of the project by the accumulated depreciation per bed of the facility's existing beds immediately before the project.

A nursing facility's FRV per diem is calculated as follows:

- The base value per licensed bed is established annually using the R.S. Means Building Construction Cost Data adjusted by the weighted average total city cost index for Salt Lake City, Utah. It assumes a standard facility size of at least 450 square feet. The base value was initially set at \$50,000 on July 1, 2004. The current base value is \$68,890.39.
- The bed value is adjusted upward by 20% (10% for land and 10% for movable equipment).
- Each nursing facility's total licensed beds are multiplied by

- this amount to arrive at the total bed value.
- Each year, the total bed value is trended forward by multiplying it by the capital index (the percent change in the nursing home “Per bed or person, total cost” from the two most recent annual R.S. Means Building Construction Cost Data as adjusted by the weighted average total city cost index for Salt Lake City, Utah) and adding it to the total bed value to arrive at the newly calculated total bed value.
 - The newly calculated total bed value is depreciated, except for the portion related to land, at 1.5% per year according to the weighted age of the facility. The maximum age of a nursing facility is 35 years. There shall be no recapture of depreciation.
 - The newly calculated total bed value is then multiplied by a rental factor to arrive at the annual FRV. The rental factor is the sum of the 20-year U.S. Treasury Bond rate as published in the Federal Reserve Bulletin using the average for the calendar year preceding the rate year and a risk value of 3.0%. Regardless of the result produced, the rental factor shall not be less than 9.0% or more than 12.0%.

The facility’s annual FRV is divided by the greater of:

- The facility’s annualized actual resident days during the cost reporting period; or
- 75% of the annualized licensed bed capacity of the facility. In prior years, nursing facilities in Utah were permitted to bank beds or take beds offline in order to reduce operational capacity without reducing licensed capacity. However, House Bill 336 eliminated the banking of beds for the purpose of Medicaid reimbursement.

The FRV per diem determined under the FRV system is subject to a floor of \$8.00 per patient day.

The pass-through subcomponent of the Property cost component is calculated by dividing the sum of the facility’s allowable property tax and property insurance costs by the facility’s actual total patient days. This amount is added to the FRV per diem in order to determine the total Property component.

A sole community provider that is financially distressed may apply for a payment adjustment that is above the case mix index established rate. This exception is awarded only after consideration of historical payment levels and need. The maximum increase is the lesser of the facility’s reasonable costs or 7.5% above the average of the most recent Medicaid daily rate for all Medicaid residents in all freestanding nursing facilities in the state. The maximum duration of this adjustment is for no more than a total of 12 months per facility in any five-year period.

Funds are set aside annually (\$1,000,000) to reimburse facilities that meet the criteria for an available quality improvement incentive (Q11). The funding is designated for facilities that have a quality improvement plan that includes the involvement of residents and family, a process of assessing and measuring that plan, quarterly customer satisfaction surveys conducted by an independent third party, and no violations that are at an immediate jeopardy level, as determined by UDOH, at the most recent re-certification survey and during the incentive period. Funding is divided on a pro rata share among qualified facilities at the end of the fiscal year.

Behaviorally complex patients may qualify for a special add-on payment rate. This rate was determined after extensive onsite time studies at providers’ facilities. The study determined the administrative time involved by all levels of nursing care for these entities, and applied an average amount per hour. This add-on amount is updated on an as-needed basis. Effective July 1, 2009, the add-on rate is \$7.52. This add-on remained consistent through fiscal year 2019.

An add-on is also available for approved specialized rehabilitation services (SRS) residents. Because the SRS rate is paid in addition to the facility-specific rate, the additional payment provided to a facility may not exceed the reasonable and documented cost of providing the services involved. The add-on for rates effective July 1, 2009, is \$21.88. This add-on remained consistent through fiscal year 2019.

Additional add-on rates are available for ventilator dependent and tracheostomy residents. For rates effective July 1, 2009, the add-on rate for ventilator dependent residents is \$657.01. For rates effective July 1, 2009, the add-on rate for tracheostomy residents is \$441.84. These add-ons have remained consistent through fiscal year 2019. A resident qualifying for one of the four special intensive skilled rates discussed above cannot receive any other add-on rate.

The state annually allocated \$4,275,900 in funding for the following quality improvement initiatives (Q12): the purchase or enhancement of a nurse call system; the purchase of new patient lift systems; the purchase of new patient bathing systems; the purchase of life enhancing devices; quality education; new or upgraded HVAC equipment; vans and van equipment; clinical information software and hardware; worker immunization; or improved resident dining experiences.

In fiscal year 2015, a third quality improvement initiative was established. The intent of this initiative was to ensure availability of patient choices. Funding for the initiative equates to any monies remaining after paying out Q12 initiatives. To be eligible for the initiative, facilities must meet the following criteria: nursing facilities must possess 100% qualification for the first quality initiative; nursing facilities must have received at least one of the Q12 initiatives; and nursing facilities must document a residents’ choice of awake time, meal time and bathing time.

The sum of the three rate components and any appropriate add-ons equates to a nursing facility’s Medicaid per diem rate. Historically, the statewide weighted average Medicaid reimbursement rate was \$133.91 in fiscal year 2006, \$139.70 in fiscal year 2007, \$151.68 in fiscal year 2008, \$154.14 in fiscal year 2009, \$157.32 in fiscal year 2010, \$168.92 in fiscal year 2011 and \$168.67 in fiscal year 2012. Effective July 1, 2014, the weighted average rate was \$174.82, which represents a 3.7% increase from the rate (\$168.92) effective July 1, 2013. The weighted average Medicaid rates effective July 1, 2015, and July 1, 2016, were \$180.83 and \$184.49, respectively. The weighted average increased to \$189.73 effective July 1, 2017. Effective July 1, 2018, the weighted average rate is \$196.69.

MINIMUM OCCUPANCY STANDARDS

As discussed above, the FRV subcomponent of the Property component is subject to a minimum occupancy requirement of 75.0%. The pass-through subcomponent is not subject to minimum occupancy standards. Additionally, no minimum occupancy standards are applied to the RUG or Flat Rate components.

OTHER RATE PROVISIONS

For newly constructed or newly certified facilities, component rates are calculated as follows:

- RUG – This component is reimbursed using the average CMI. This average rate remains in place for a new facility until adequate MDS data exists for the facility to establish the provider's case mix index. At the following quarter's rate setting, a new case mix adjusted rate is issued.
- Flat Rate – This component is the same for all facilities.
- Property – For a newly constructed facility, the per diem property tax and property insurance is the average daily property tax and property insurance cost of all facilities in the FRV calculation.

An existing facility acquired by a new owner continues at the same case mix index and property cost payment established for the facility under the previous ownership. The subsequent quarter's CMI is then established using the prior facility ownership's MDS data combined with the new facility ownership's MDS data. The Property component is calculated for the facility at the beginning of the next fiscal year.

The Medicaid reimbursement system does not contain regulations regarding bed hold days or therapeutic leave.

INTERGOVERNMENTAL TRANSFERS

In 2016 Utah implemented an Intergovernmental Transfer (IGT) Program. Similar to the quality assessment fees (i.e. provider

taxes), this is another mechanism that states use to draw extra matching funds from the Centers of Medicare and Medicaid (CMS). This typically involves temporarily transferring funds from county or municipal hospitals or non-state governmental organizations (NSGOs) to the state. The state claims this as Medicaid funding provided by the state, which CMS matches at the state's Federal Medical Assistance Percentage (FMAP). After collecting the matching funds from CMS, the state reimburses NSGOs for their contributions and provides them with a portion of the additional funds generated through the IGT program.

The first step in determining this reimbursement is to calculate each facility's Upper Payment Limit (UPL). States pay NSGOs under Medicaid reimbursement methodologies established in the State Plan, then estimate how much more the hospitals would have been paid for the services under Medicare principles. The difference between the payments and the estimate is the amount that is available for additional reimbursement, and is referred to as the UPL.

Under this program, county or municipal hospitals or non-state governmental organizations (NSGOs) have been buying nursing facility licenses that allow the hospitals to draw down additional federal dollars based on the difference between the Medicaid UPL and the Medicaid rate. Typically, the previous nursing home owner manages the facility. Currently there are 61 nursing facilities in Utah that participated in the program. For the second quarter of fiscal year 2019 (October 1, 2018 to December 31, 2018), the average reimbursement under the program was approximately \$456,937 per facility. Nursing facilities are reimbursed through quarterly supplemental payments. In 2017, the state developed a methodology that links IGT revenue to quality measures.

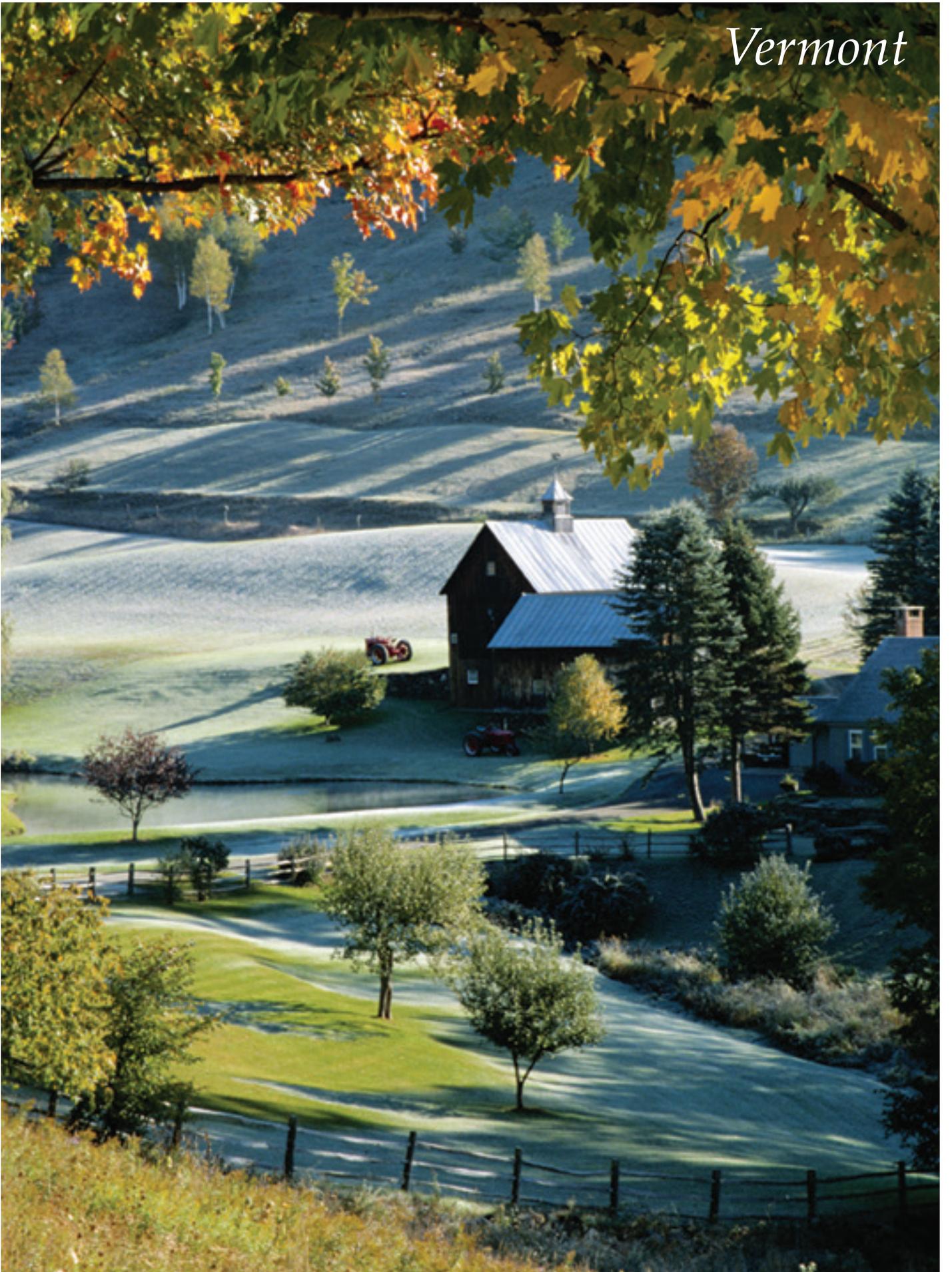
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no changes expected to the Medicaid rate methodology in the immediate future.

UTAH COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	42.50	40.50	43.00		82.00	82.00	76.00		120.00	114.00	107.50
Average Daily Census	35.65	35.87	36.47		57.16	58.30	57.66		76.87	73.26	73.18
Occupancy	56.9%	57.7%	58.3%		70.1%	71.2%	71.6%		83.2%	86.2%	89.6%
Payor Mix Statistics											
Medicare	7.1%	8.3%	7.7%		10.9%	12.0%	11.9%		22.1%	25.3%	32.0%
Medicaid	45.2%	43.7%	46.5%		55.5%	58.2%	57.7%		65.7%	64.4%	66.8%
Other	25.3%	22.6%	23.8%		32.2%	30.1%	29.5%		40.0%	42.1%	44.2%
Avg. Length of Stay Statistics (Days)											
Medicare	24.80	25.93	25.23		28.69	29.24	29.93		36.12	39.70	37.89
Medicaid	204.18	223.48	242.67		295.28	341.63	342.73		451.95	548.86	598.25
Other	35.23	30.43	25.58		43.86	44.84	49.17		85.00	88.91	150.57
Revenue (PPD)											
Inpatient	\$191.00	\$199.50	\$198.44		\$216.16	\$220.74	\$248.45		\$282.35	\$299.96	\$312.21
Ancillary	\$46.57	\$49.85	\$58.24		\$74.14	\$88.53	\$80.67		\$147.46	\$147.73	\$156.48
TOTAL	\$242.84	\$246.32	\$260.65		\$283.94	\$304.31	\$318.01		\$381.93	\$479.05	\$480.49
Expenses (PPD)											
Employee Benefits	\$16.55	\$18.16	\$14.58		\$20.22	\$23.88	\$24.00		\$29.48	\$34.72	\$36.99
Administrative and General	\$51.18	\$51.91	\$57.54		\$57.78	\$62.38	\$66.18		\$66.53	\$74.73	\$87.02
Plant Operations	\$8.19	\$8.95	\$9.08		\$9.24	\$10.71	\$10.85		\$13.06	\$13.06	\$13.70
Laundry & Linens	\$1.44	\$1.51	\$1.11		\$2.09	\$2.33	\$2.22		\$2.87	\$2.97	\$2.66
Housekeeping	\$4.30	\$4.71	\$4.91		\$5.15	\$5.48	\$5.64		\$6.44	\$6.82	\$7.41
Dietary	\$16.77	\$17.95	\$16.75		\$19.06	\$20.42	\$18.79		\$22.58	\$22.67	\$21.34
Nursing & Medical Related	\$71.75	\$78.58	\$79.47		\$88.18	\$90.74	\$95.55		\$112.20	\$117.78	\$112.50
Ancillary and Pharmacy	\$26.17	\$24.37	\$27.62		\$36.55	\$37.53	\$34.29		\$65.53	\$71.89	\$64.88
Social Services	\$2.35	\$2.62	\$3.05		\$4.08	\$4.02	\$6.11		\$5.66	\$5.71	\$8.48

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Vermont



INTRODUCTION

Nursing facilities in Vermont are licensed by the Agency of Human Services - Department of Disabilities, Aging and Independent Living, Division of Licensing and Protection (DLP) as “nursing homes.” The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN VERMONT	
Licensed Nursing Facilities*	33
Licensed Nursing Beds*	2,509
Beds per 1,000 Aged 65 >**	21.40
Beds per 1,000 Aged 75 >**	54.57
Occupancy Percentage - 2017*	83.80%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

Implemented in 1979 by the Vermont legislature, the Certificate of Need (CON) review process establishes a set of statutory criteria to guide the development of new healthcare facilities and services. Effective January 1, 2013, the Green Mountain Care Board (GMCB) was given the authority to oversee the CON process. Prior to the this date, The Department of Financial Regulation (formerly The Health Care Administration division of the Department of Banking, Insurance, Securities and Health Care Administration was responsible for the CON process. With the exception of this change, the regulations regarding the requiring or issuing of a CON did not change. Currently, there is an unofficial moratorium on new bed construction that is in place for an indefinite period, but construction for replacement beds is allowed. In addition, a CON is required for the following projects:

- The construction, development, purchase, renovation or other establishment of a healthcare facility, or any capital expenditure by or on behalf of a healthcare facility, for which the capital expenditure exceeds \$1,500,000.
- A change from one licensing period to the next in the number of licensed beds of a healthcare facility through addition, conversion, or relocation from one physical facility or site to another.
- The offering of a healthcare service or technology with an annual operating expense that exceeds \$500,000 for either of the next two budgeted fiscal years if the service or technology was not offered or employed by the healthcare facility within the previous three fiscal years.
- The purchase or lease of any piece of diagnostic and therapeutic equipment with a capital expenditure in excess of \$1,000,000 (including a donation).

The unofficial moratorium on new bed construction is related to the state’s “Shift the Balance” policy, which was established by ACT 160 in 1996. The goal of ACT 160 was to encourage the development of community-based alternatives to nursing home care, such as home healthcare. To further this goal, in 2004 the state established the Choices for Care 1115 Medicaid Waiver Program that allowed Vermont to pool its Medicaid funds for nursing homes together with its funds for community-based alternatives. This provided Vermont seniors with the option of using Medicaid funds to pay for community-based care options that would allow

them to age-in-place at home, as opposed to receiving care in a nursing home.

The current goal of the program is to achieve a 50/50 balance between the utilization of nursing home care and community-based care alternatives. Overall, the state has not approved a significant number of new nursing home beds over the last decade.

A CON applicant is also required to show that its application is consistent with the health resource allocation plan (HRAP). The HRAP identifies Vermont needs in healthcare services, programs, and facilities, the resources available to meet those needs and the priorities for addressing those needs on a statewide basis. Because of the variety of CON projects that are submitted for review, not all of its requirements must be met for any given project.

BED NEED METHODOLOGY

Vermont does not possess a bed need methodology and is not in the process of developing a bed need methodology. However, Vermont’s regulations indicate that the state is supposed to complete an annual batching cycle that determines the need for proposed increases in nursing bed capacity. Due to the unofficial moratorium on the construction of new nursing home beds as well as the state’s emphasis on the “Shift the Balance” initiative, the state has not completed a batching cycle since 1996.

QUALITY ASSURANCE FEE

Vermont’s current quality assurance fee (QAF) is \$4,919.53 per bed per year and equates to the current federal allowable limit (6.0% of total revenue). The QAF was increased to its current level on October 1, 2011. Prior to this increase, the QAF was \$4,059.77 per bed from July 1, 2011, to September 30, 2011, which equated to 5.5% of total revenue. This was an increase from the prior rate of \$3,962.66. The increase in the QAF from \$4,059.77 to \$4,919.53 reflects that the Tax Relief and Health Care Act of 2006 sunset on September 30, 2011. This act reduced the maximum QAF that states could charge from 6.0% to 5.5% of total revenue. Once this act expired, the ceiling defaulted back to 6.0%. Nursing facilities in Vermont are not guaranteed reimbursement of provider fees paid.

Nursing facilities are reimbursed for paying the QAF as an add-on to Medicaid rates. This add-on is facility-specific and is determined by dividing a nursing facility’s total QAF cost by total patient days. The result of this calculation is reimbursed on a per-Medicaid-day basis.

MEDICAID RATE CALCULATION SYSTEM

Vermont uses a prospective, cost-based, facility-specific case mix adjusted payment system.

COST CENTERS

The costs are divided into the following six cost categories:

- The Nursing Care cost component includes actual costs of licensed personnel providing direct resident care including, but not limited to, wages and related benefits for the

following: registered nurses (RNs), licensed practical nurses (LPNs), certified or licensed nurse aides, contract nursing and the MDS coordinator. This component will also include reimbursement related to initial and ongoing nurse training.

- **The Resident Care** cost component includes reasonable costs associated with expenses related to direct care, which include, but are not limited to, food, supplements, utilities, direct activity supplies, and wages and related benefits for activities personnel, recreational therapists, the medical director, pharmacy consultants, geriatric consultants, psychological/psychiatric consultants, counseling personnel, social service workers and feeding/dining assistants.
- **The Indirect** cost component includes, but is not limited to, expenses related to the following: fiscal services, administrative services, professional fees, plant operation, maintenance, security, laundry and linen, housekeeping, medical records, cafeteria costs, seminars, conferences and other inservice training, dietary (excluding food), motor vehicle, clerical, transportation (excluding depreciation), insurances and EDP bookkeeping/payroll. All expenses not specified for inclusion in another cost category will be included in the Indirect cost component, unless the Vermont Medicaid director specifies otherwise.
- **The Director of Nursing** cost component includes costs associated with the Director of Nursing (DON) position, including reasonable salary for one position and associated fringe benefits.
- **The Property and Related** cost component includes, but is not limited to, depreciation on buildings and fixed equipment, major movable equipment, minor equipment, computers, motor vehicle, land improvements, amortization of leasehold improvements and capital leases, interest on capital indebtedness, real estate leases and rents, real estate/property taxes, all equipment, fire and casualty insurance, and amortization of mortgage acquisition costs. For a change in services, facility, or a new healthcare project with projected property and related costs of \$250,000 or more, providers must give written notice to the HCA division that includes a detailed description of the project and detailed estimates of the costs.
- **The Ancillaries** cost component includes, but is not limited to, therapies (physical, speech, occupational, respiratory) and supplies (excluding oxygen and rented or leased equipment).

INFLATION AND REBASING

The Medicaid director determines the frequency of rebasing and selects the base year, which is the calendar year, January through December. However, rebasing for Nursing Care costs occurs no less than once every two years and once every four years for other costs. For the purposes of rebasing, the Vermont Medicaid director may require individual facilities to file special cost reports covering the calendar year when this is not the facility's fiscal year, or the DLP may use the facility's fiscal year cost report adjusted by the inflation factors to the base year. The Medicaid rate period for nursing facilities in Vermont is from July 1 to June 30. Vermont rebased all of the cost components on July 1, 2011, utilizing 2009 cost report data. The state had previously rebased the Nursing Care cost component effective July 1, 2009, utilizing 2007 cost report data. However, the state did not apply

any inflation adjustment to nursing care allowable costs. This has resulted in a net loss for Nursing Care cost component rates. The state has rebased the Nursing Care cost component on July 1, 2013, utilizing 2011 cost report data.

The Vermont Medicaid director also determines the specific publication of each index used in the calculation of inflation factors. Different inflation factors are used to adjust different rate components. Subcomponents of each inflation factor are weighted in proportion to the percentage of average actual allowable costs incurred by facilities for specific subcomponents of the relevant cost component.

The Nursing Care cost component is adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of nursing costs: wages and salaries, and benefits.

The Resident Care cost component is adjusted by an inflation factor that uses five price indexes to account for estimated economic trends with respect to four subcomponents of Resident Care costs: wages and salaries, employee benefits and utilities, food and all other Resident Care costs.

The Indirect cost component is adjusted by an inflation factor that uses three price indexes to account for estimated economic trends with respect to three subcomponents of Indirect costs: wages and salaries, employee benefits, and all other Indirect costs.

The Director of Nursing cost component is adjusted by an inflation factor that uses two price indexes to account for estimated economic trends with respect to two subcomponents of Director of Nursing costs: wages and salaries and employee benefits.

The price indexes for all of the subcomponents are the specific portion of the Health-Care Cost Nursing Home Market Basket that applies to that subcomponent. As previously mentioned, given budgetary constraints, no inflation was applied to the calculation of July 1, 2009, rates. In addition, only 50% of the inflation adjustment was applied to July 1, 2008, rates. For rates effective July 1, 2010, the weighted overall blended inflation rate for the Nursing Care, Director of Nursing, Resident Care and Indirect cost components was 2.537%. However, this inflation adjustment reflects that nursing care costs were only inflated from the beginning of the previous rate year (July 1, 2009) to July 1, 2010. Therefore, nursing facility rates were never adjusted for the inflation excluded in the calculation of July 1, 2009, rates. According to state rate setting professionals, nursing facility Medicaid rates effective July 1, 2011, were calculated assuming a weighted overall blended inflation rate of 5.525%. This reflects that nursing care will be inflated from the beginning of the base cost report year (January 1, 2009) to July 1, 2011.

For rates effective July 1, 2012, the weighted inflation percentage increased to 7.559%, but this also reflects that these rates were not rebased. The inflation percentage was increased to effectively increase costs from the beginning of the cost report year (2009) to July 1, 2012. Effective July 1, 2014, nursing facility rates were calculated assuming a weighted overall blended inflation rate of 9.061%. However, this percentage reflects that these rates were

not rebased. The inflation percentage was increased to effectively increase costs from the middle of the base cost report year (2009 or 2011) to the midpoint of the rate year (December 31, 2014).

Rates were rebased on July 1, 2015, utilizing 2013 cost report data. A weighted average inflation rate of 6.143% was applied to 2013 cost reports to effectively increase costs from the middle of the cost report period to July 1, 2015. Rates were not rebased on July 1, 2016, but a weighted average inflation increase of 8.157% was applied to adjust costs from the mid-point of the cost report period to July 1, 2016. It is currently unclear if the state will rebase rates on July 1, 2017.

The Property and Related costs and Ancillaries cost components are not adjusted for inflation, but are adjusted annually based on nursing facilities' settled cost reports.

RATE METHODOLOGY

A per diem rate is set for each facility based on its inflated historical allowable costs. Per diem costs for each cost component, excluding the Nursing Care and Ancillaries cost components, are calculated by dividing allowable costs for each component by the greater of actual bed days of service rendered, including revenue generating hold/reserve days, or the number of resident days computed using the minimum occupancy at 90% of the licensed bed capacity during the cost period. The Nursing Care and Ancillaries cost components are calculated similarly, but are not subject to a minimum occupancy requirement.

The basis for reimbursement within the Nursing Care cost component is a resident classification system that groups residents into 48 case mix resident classes according to their assessed conditions and the resources required to care for them. The Vermont resident classification system is based on the Resource Utilization Group (RUG) IV system. Each of the 48 RUG categories has a specific predetermined case mix weight. Effective July 1, 2013, the state converted to the RUG IV, 48-Grouper model and the MDS 3.0 assessment tool to classify patients by case mix category. Prior to this change, the state utilized the RUG III, 45-Grouper and MDS 2.0 assessment tool to adjust Nursing Care cost component rates for case mix.

The DLP will also certify to the Division of Rate Setting (DRS) the average case mix score for the residents of each facility whose room and board are paid for solely by the Medicaid program. The average case mix score for all residents is set by the DLP for the base year. Based on this data, each facility's Nursing Care cost per case mix point will be calculated as follows:

- Using each facility's base year cost report, the total inflated nursing care costs shall be determined in accordance with allowable Nursing Care component costs.
- Each facility's standardized resident days shall be computed by multiplying total base year resident days by that facility's average case mix score for all residents for the four quarters of the cost reporting period.
- The per diem Nursing Care cost per case mix point shall be computed by dividing allowable inflated total Nursing Care costs by the base year standardized resident days.

The HCA division arrays all nursing care facilities' base year per diem Nursing Care costs per case mix point, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high, and identifies the median. The per diem limit per case mix point shall be set for all privately owned nursing homes participating in the Vermont Medicaid program; the limit equates to the 90th percentile of all of the arrayed costs. Each facility's base year per diem Nursing Care rate per case mix point will be the lesser of the limit discussed above or the facility's per diem Nursing Care cost per case mix point.

The per diem Nursing Care cost component rate must be updated quarterly for changes in the average case mix score of the facility's Medicaid residents. The update is calculated as follows:

- The Nursing Care cost component (or rate adjustment) in the current rate of reimbursement for a facility is divided by the average case mix score used to determine the current Nursing Care cost component. This quotient is the current Nursing Care rate per case mix point.
- The current Nursing Care cost component per diem rate per case mix point is multiplied by the new average case mix score. This product is the new per diem Nursing Care cost component rate.

Resident Care base year rates will be computed as follows:

- Using each facility's base year cost report, the provider's total inflated Resident Care costs will be determined in accordance with allowable Resident Care component costs.
- The base year per diem allowable resident care costs for each facility will be calculated by dividing the base year total allowable resident care costs by total base year resident days (adjusted for the occupancy requirement).
- The HSA division will array all nursing facilities' per diem inflated resident care costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high and identify the median.
- The per diem limit will be set for all privately owned nursing homes participating in the Vermont Medicaid program; the limit will be calculated at 105% of the median. Each facility's base year Resident Care per diem rate must be the lesser of the limit discussed above or the facility's base year per diem allowable Resident Care costs.

Indirect base year rates will be computed as follows:

- Using each facility's base year cost report, each provider's base year total inflated indirect costs shall be determined in accordance with allowable Indirect Care component costs.
- The base year per diem allowable indirect costs for each facility will be calculated by dividing the base year total allowable Indirect costs by total base year resident days (adjusted for the occupancy requirement).
- The HCA division arrays all nursing facilities' per diem allowable Indirect costs, excluding those for state nursing facilities and nursing facilities that are no longer in the Medicaid program at the time the limits are set, from low to high, and identifies the median.
- The per diem limit shall be set at 105% of the median.
- Each provider's base year Indirect per diem rate shall be the lesser of the limit discussed above or the facility's base year

per diem allowable Indirect costs.

The DON base year rates will be computed as follows:

- Using each facility's base year cost report, total inflated base year DON costs will be determined in accordance with allowable DON component costs.
- Each facility's base year per diem allowable DON costs will be calculated by dividing the base year total allowable DON costs by total base year resident days (adjusted for inflation).
- The DON per diem rate will be the facility's calculated base year per diem allowable DON costs. There is no cost ceiling for this component.

The Ancillaries per diem rate will be computed as follows:

- Using each facility's most recent cost report, the per diem Ancillary rate will be the sum of the per diem costs for therapy services, dialysis transportation, and medical supplies.
- Costs for therapy services per diem, including IV therapy and dialysis, will be calculated by dividing allowable Medicaid costs for these categories by the number of related Medicaid resident days less Medicaid hold days. Costs for medical supplies, over the counter drugs, and incontinence supplies and personal care items per diem shall be calculated by dividing allowable costs by total resident days less hold days. There is no cost ceiling for this component.
- Any change to the Ancillary per diem rate shall be implemented at the time of the first quarterly case mix rate recalculation after the cost report is settled.

The Property and Related per diem rate will be computed as follows:

- Using each facility's most recent annual cost report, total Property and Related costs must be determined in accordance with allowable Property and Related component costs.
- Using each facility's most recent cost report, the per diem property and related costs will be calculated by dividing allowable property and related costs by total resident days (adjusted for the occupancy requirement). Any change to the property and related per diem rate shall be implemented at the time of the first quarterly case mix rate recalculation after the cost report is settled. There is no cost ceiling for this component.

The total per diem rate for any nursing facility shall be the sum of the rates calculated for all the components, adjusted in accordance with inflation factors, plus the QAF add-on. Payment rates for state nursing facilities shall be determined retrospectively by the HCA division based on the reasonable and necessary costs of providing those services.

Vermont rate setting professionals indicated that the weighted average Medicaid reimbursement rate in the state for fiscal year 2014 is approximately \$210.87 per patient day. This rate represents a 3.4% increase from the weighted average fiscal year 2013 rate of \$203.97 per patient day. The weighted average rates in fiscal years 2012 and 2011 were \$196.97 and \$188.27, respectively. The average rate per facility for fiscal year 2015 was \$216.52. The average rates effective July 1, 2015, and July 1, 2016, were \$216.78 and \$222.92, respectively.

MINIMUM OCCUPANCY STANDARDS

A facility should maintain an annual average level of occupancy at a minimum of 90% of the licensed bed capacity. For facilities with less than 90% occupancy, the number of total resident days at 90% of licensed capacity will be used in determining the per diem rate for all categories except the Nursing Care and Ancillaries cost components. The minimum occupancy provision shall be waived for facilities with 20 or fewer beds or terminating facilities.

OTHER RATE PROVISIONS

For facilities that are newly constructed, newly operated as nursing facilities or new to the Medicaid program, the prospective case mix rate shall be determined based on budgeted cost reports submitted to the DLP and the greater of the estimated resident days for the rate year or the resident days equal to 90% occupancy of all beds used or intended to be used for resident care at any time within the budgeted cost reporting period. This rate shall remain in effect no longer than one year from the effective date of the new rate. The principles on allowability of costs and existing limits apply. At the end of the first year of operation, the prospective case mix rate must be revised based on the provider's actual allowable costs as reported in its annual cost report for its first full fiscal year of operation.

Upon the change of ownership of a nursing home, the new owners have no more than 30 days after the execution of the purchase to submit an application for a change in ownership of depreciable assets. Based on this application, the state may make changes in the facility's Property and Related cost component. If a seller did not own the facility during the entire 12-year period immediately preceding the change in ownership, or the seller's facility did not receive Vermont Medicaid reimbursement during the entire 12-year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lower of:

- The fair market value of the assets;
- The acquisition cost of the asset to the buyer; or
- The original basis of the asset to the seller as recognized by the DRS, less accumulated depreciation.

If a seller did own the facility during the entire 12-year period immediately preceding the change in ownership or the seller's facility did receive Vermont Medicaid reimbursement during the entire 12-year period immediately preceding the change in ownership, the depreciable cost basis of the transferred asset for the new owner shall be the lower of:

- The fair market value of the assets;
- The acquisition cost of the asset to the buyer; or
- The amount determined by the revaluation of the asset. An asset is revalued by increasing the original basis of the asset to the seller, as recognized by DRS, by an annual percentage rate.

The annual percentage rate will be limited to the lower of:

- One-half the percentage increase in the Consumer Price Index (CPI) for all urban consumers (U.S. city average); or
- One-half the percentage change in the appropriate construction cost index as determined by DRS, which shall not equate to be greater than one-half of the percentage

increase in the Dodge Construction Index (or another reasonable index) for the same period.

A payment will be made to a nursing home for up to six successive days when the bed of a resident is retained because the resident is admitted as an inpatient to a hospital. However, the nursing home will only be reimbursed for holding this bed if the facility was operating at full capacity prior to the admission of the resident to the hospital. Payment to the nursing home equates to the current certified Medicaid per diem rate established for the facility. No payment will be made if the physician/discharge planner determines that the resident will be hospitalized for more than 10 days or will never return to the nursing home.

A payment will be made to a nursing home for up to 24 days per calendar year for residents that are absent from the facility for the purpose of a home visit.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is no current or proposed state legislation affecting the current Medicaid calculation in Vermont.

VERMONT COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	46.00	43.50	43.25		90.00	71.00	69.00		125.00	110.00	104.50
Average Daily Census	51.92	48.61	42.53		80.36	63.28	60.76		96.83	92.75	91.65
Occupancy	83.9%	81.6%	81.7%		88.7%	87.3%	86.2%		91.5%	90.9%	90.8%
Payor Mix Statistics											
Medicare	6.6%	6.0%	6.0%		13.7%	13.7%	12.4%		19.9%	17.8%	20.9%
Medicaid	63.4%	57.0%	54.1%		70.9%	66.8%	68.8%		75.0%	73.8%	76.6%
Other	71.9%	67.4%	71.2%		85.9%	85.6%	84.9%		93.4%	93.7%	93.2%
Avg. Length of Stay Statistics (Days)											
Medicare	31.51	30.15	29.13		36.21	34.47	33.96		46.14	45.13	43.83
Medicaid	342.14	384.56	345.44		349.66	410.88	403.25		379.85	469.47	461.90
Other	193.74	188.15	162.34		319.27	292.66	229.76		532.22	470.49	407.47
Revenue (PPD)											
Inpatient	\$260.61	\$268.33	\$263.51		\$288.73	\$286.06	\$300.55		\$329.68	\$331.81	\$353.39
Ancillary	\$30.74	\$28.57	\$33.22		\$55.80	\$47.23	\$44.48		\$78.29	\$76.74	\$71.44
TOTAL	\$306.52	\$299.64	\$298.19		\$364.01	\$357.76	\$360.23		\$393.87	\$404.29	\$423.01
Expenses (PPD)											
Employee Benefits	\$24.78	\$26.99	\$23.22		\$30.65	\$31.53	\$33.26		\$36.83	\$38.66	\$38.12
Administrative and General	\$40.93	\$41.41	\$42.77		\$50.37	\$54.44	\$52.74		\$58.14	\$63.31	\$64.88
Plant Operations	\$11.04	\$10.99	\$11.30		\$13.10	\$13.45	\$13.75		\$15.69	\$14.49	\$14.96
Laundry & Linens	\$2.34	\$2.43	\$2.60		\$3.11	\$3.70	\$3.33		\$4.10	\$4.32	\$4.68
Housekeeping	\$4.74	\$4.98	\$5.01		\$5.63	\$6.26	\$6.65		\$7.34	\$7.96	\$9.10
Dietary	\$16.68	\$17.85	\$18.55		\$21.72	\$22.43	\$22.97		\$23.04	\$25.84	\$26.30
Nursing & Medical Related	\$85.17	\$89.01	\$89.64		\$96.00	\$101.82	\$103.51		\$114.39	\$118.27	\$127.62
Ancillary and Pharmacy	\$19.64	\$16.49	\$18.74		\$29.29	\$25.56	\$26.45		\$38.29	\$36.59	\$38.22
Social Services	\$2.64	\$3.09	\$3.13		\$4.16	\$4.80	\$5.18		\$7.95	\$8.32	\$9.34

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Virginia



INTRODUCTION

Nursing facilities in Virginia are licensed by the Virginia Department of Health, Office of Licensure and Certification (OLC), Long-Term Care Division, under the designation of "Nursing Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN VIRGINIA	
Licensed Nursing Facilities*	265
Licensed Nursing Beds*	29,859
Beds per 1,000 Aged 65 >**	23.09
Beds per 1,000 Aged 75 >**	58.86
Occupancy Percentage - 2017*	87.80%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Virginia updates its State Medical Facilities Plan (SMFP) every four years. The most significant change in the recent Certificate of Need update for nursing facilities includes a 2% reduction in the required planning district average occupancy from 95% to 93%. Key provisions of the SMFP are summarized below.

The Certificate of Need program in Virginia was enacted in 1973 and is referred to as the Certificate of Public Need (COPN). There are eight criteria used in determining whether public need exists. The criteria includes, but is not limited to, the following:

- The need for enhanced facilities to serve the population of an area.
- The extent to which the project is accessible to all residents in the proposed area.
- The immediate economic impact and financial feasibility of the project.
- The extent to which the program service or facility fosters competition and improves access to care.
- The state's bed need methodology.

Virginia requires a COPN for:

- The establishment of a new facility.
- A capital expenditure (effective 2019) in excess of \$19,241,208, increased annually by an appropriate inflation index. (CPI from the Medical Care Expenditure Category from the Bureau of Labor Statistics).
- The introduction of certain services into a facility.
- Any increase in the number of beds in a facility.
- For the relocation at the same site of more than 10 beds or 10% of existing beds, whichever is less, from one existing physical facility to another within a two-year period.

It is unclear whether the development of a replacement facility with construction costs below the capital expenditure standard would require a COPN. State COPN professionals indicate that this scenario would be decided on a case-by-case basis. In addition, representatives of the Virginia Board of Health indicate that in 2013 there was a change in the state's regulations that could potentially allow the internal Planning District bed transfer. However, these representatives also indicate that this change is open to interpretation and has yet to be tested. Proposals for the development of a new nursing facility or the

expansion of an existing nursing facility within a continuing care retirement community (CCRC) will be considered in accordance with the following standard:

The total number of nursing facility beds after the development of the new beds does not exceed 20% of the combined total of independent and assisted living beds within the community (new CCRCs may develop no more than 60 nursing home beds initially, regardless of the CCRC's size).

BED NEED METHODOLOGY

Virginia's bed need methodology was enacted in 1992 and determines nursing bed need three years ahead of the current year for 22 planning districts for COPN purposes. Virginia's planning districts are established by the Department of Planning and Budget.

Bed need is determined by applying bed usage rates to population projections (for the third year after the current year) in each of the 22 planning districts. Bed usage rates for six age groups (0-64, 65-69, 70-74, 75-79, 80-84 and 85 plus) are derived from the most recent patient origin survey and population projections provided by the Virginia Employment Commission. The product of each of these calculations (by planning district) are summed to determine total planning district gross bed need.

The state most recently determined bed need estimates for 2017. The calculation estimates a total unmet demand for 3,165 beds in the state. However, only one of the planning districts (District 18 – Middle Peninsula Planning District) currently meets the occupancy requirement. The state estimates that this planning district has unmet demand for 30 new beds.

The need for additional nursing beds will only be considered under the following conditions:

- The bed need for nursing facility beds in a planning district is greater than the current inventory of non-federal licensed and authorized beds in that planning district.
- When the average occupancy percentage for all existing non-federal Medicaid-certified nursing facility beds in a planning district is at least 93% for the most recent three years for which bed utilization has been reported.

Exceptions to this are considered for facilities that have a rehabilitative or other specialized care focus hindering the facility from achieving an average annual occupancy of 93%. Any planning district that contains unconstructed Medicaid-certified nursing facility beds will not be considered to have a need for additional nursing home beds. This presumption of "no need" for additional beds extends for three years from the issuance date of the certificate.

QUALITY ASSURANCE FEE

Nursing facilities in the state of Virginia are currently not assessed a quality assurance fee.

MEDICAID RATE CALCULATION METHODOLOGY

Effective July 1, 2014, Virginia converted to a price-based, resident-specific system for determining non-capital rate components. This system was fully phased in on July 1, 2017. Prior to the conversion, Virginia used a prospective, cost-based, case-mix adjusted facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

The cost centers utilized to determine nursing facility Medicaid rates in Virginia are the same for the old and new systems.

The three cost components to calculate its facility-specific Medicaid rates are as follows:

- The Operating cost component is divided into two cost centers:
 - The Direct Patient Care cost center includes all costs associated with nursing service expenses such as salaries, nursing employee benefits, contract nursing services, professional fees, minor medical and surgical supplies, and ancillary services.
 - The Indirect Patient Care cost center includes all costs associated with administrative and general, employee benefits, dietary, housekeeping, laundry, maintenance and operation of plant, medical records, social services, patient activity expense, educational activities expenses, other nursing administrative costs and home office costs.
- The Capital cost component rates are determined utilizing the FRV system. The FRV system includes the cost elements of depreciation, interest, financing costs, rent and lease costs for property, building and equipment, and actual costs for property insurance and property taxes.
- The Nurse Aide Training and Competency Evaluation Program (NATCEP) cost component includes salaries and related benefits for professionals conducting nurse aid training, as well as contract services, supplies and other expenses related to the operation of the training program.

INFLATION AND REBASING

Prior to the development of the price-based system effective July 1, 2014, facility-specific per diem costs were calculated annually using cost report data for the previous year. Peer group ceilings were supposed to be rebased every two years using cost report data from three years prior trended to the rate year. However, prior to the development of the price-based system, the state had not rebased facility-specific per diem costs and peer group ceilings since July 1, 2008, using trended 2005 cost report data.

The inflation index utilized is the moving average of the percentage change of the Virginia-Specific Nursing Home Input Price Index, updated quarterly and developed and published by Global Insight using both Virginia-specific wage and insurance costs and other economic data. Non-capital rates, cost ceilings and facility-specific costs are adjusted for inflation each year from the midpoint of the cost report year to the midpoint of the rate year. As a result of budgetary issues, non-capital rates were not inflated during fiscal years 2009 to 2012. Prior to this period, the most

recent inflation adjustment utilized to calculate non-property rates (approximately 2.8%) was effective July 1, 2008. This adjustment was reduced by a budget reduction factor of 1.329%. In addition, a 3.0% rate reduction was applied to non-capital rates for the first quarter (July 1, 2010, to September 30, 2010) of fiscal year 2011. However, when the temporary increase to the Federal Medical Assistance Percentage (FMAP) was extended to June 30, 2011 (at declining rates), the state was able to eliminate the rate reduction for the remainder of the fiscal year. In addition, in fiscal year 2011 the state reduced the FRV rental rate floor from 9.0% to 8.0%, which resulted in an average reduction of \$1.83 to Capital component rates.

Effective July 1, 2012, the state inflated non-capital costs 2.2% and non-capital cost component ceilings 3.2% in fiscal year 2013. In addition, the FRV rental floor was increased to 8.5%, which resulted in an average rate increase of \$0.91 to Capital component rates. The state did not rebase non-capital costs in fiscal year 2014 (effective July 1, 2013), but did inflate non-capital costs and ceilings 2.2%. As part of a conversion to the price-based system, the state rebased non-capital rates effective July 1, 2014, utilizing 2011 cost reports trended to state fiscal year 2015 (effective July 1, 2014). The costs were trended utilizing the previously mentioned inflation index. This adjustment equated to an approximate 1.7% inflation of costs. With the exception of changes related to the phase-in or case mix adjustment, non-capital rates remained unchanged on July 1, 2015. Effective July 1, 2014, the FRV rental floor was reduced to 8.0%. No limitations were applied to the inflation index used to determine the FRV rates for fiscal years 2014, 2015 and 2016.

The state rebased rates on July 1, 2017, utilizing 2014 cost report data, and the state will rebase rates every three years thereafter using the most recent calendar year settled cost reports. Nursing facilities received the full effective of inflating costs, which were increased by an inflation rate of 3.2%. On July 1, 2018, allowable costs were inflated an additional 3.6% as dictated by state law. Allowable costs are anticipated to be increased by 2.9% effective July 1, 2019.

Under the old system, Medicaid rates were adjusted semiannually for changes in case mix of Medicaid residents. The case mix data utilized to adjust rates is for the two and three calendar quarters prior to the effective day of the rate. However, effective November 1, 2014, the state removed the case mix adjustment from the direct patient care cost component of the cost-based rate because the case mix adjustment was now applied on an individual claim basis. In addition, effective July 1, 2017, the state converted to utilizing the RUG IV, 48-RUG Grouper to adjustment rates for CMI.

FRV rates are calculated annually based on the prior calendar year information aged to the fiscal year and using RS Means Factors. FRV rates effective July 1, 2018, were calculated utilizing calendar year 2017 data.

RATE METHODOLOGY

Medicaid rates for nursing facilities in Virginia are the sum of the prospective rates for the Direct Patient Care and Indirect Patient Care cost centers, and the Capital cost component plus payment for

NATCEP related costs.

The price-based system contains the same cost components as the previously noted cost-based system, but the operating portion of the rate (the Direct Patient Care and Indirect Patient Care sub-components) was converted from facility-specific cost-based rates to prices. The calculation of the remaining cost component rates (capital and NATCEPS) remained the same. In addition, nursing facilities are eligible for a criminal record checks (CRC) rate component. Medicaid rates for nursing facilities in Virginia are the sum of the prospective rates/prices for the Direct Patient Care and Indirect Patient Care cost centers, and the Capital cost component plus payment for NATCEP and CRC related costs.

Direct Patient Care and Indirect Patient Care sub-components are adjusted for regional cost differences. Peer groups based on Medicare wage regions and Medicaid rural and bed size modifications were determined. Direct Patient Care peer groups are as follows: Northern Virginia MSA; Other MSAs; Northern Rural and Southern Rural. Indirect Patient Care sub-components are as follows: Northern Virginia MSA; Other Portions of the State - greater than 60 beds; Other MSAs; North Rural; Southern Rural and Other Portions of the State - 60 or less beds.

The first step in calculating the prices is the determination of Medicaid day-weighted median costs for each cost component by peer group. The prices are calculated as a percentage of the applicable Medicaid day-weighted cost. These prices can potentially be adjusted by a budget neutrality adjustment based on state funding levels. The Direct Patient Care Median is calculated to equate to 106.8% of the Medicaid day-weighted median for freestanding nursing facilities and the Indirect Patient Care median is calculated to equate to 101.3% of the Medicaid day-weighted median. Unlike the previous methodology, direct care costs are not case mix normalized prior to determining the Direct Patient Care Price.

Effective November 1, 2014, the new system began adjusting the Direct Patient Care price based on facility-specific patient acuity levels utilizing the RUG III, 34-Grouper model. It was proposed during the second year of the phase-in that the state will convert from the RUG III, 34-Grouper model to the RUG IV, 48-Grouper model for the purpose of determining the CMI used to adjust rates. However, this did not occur until July 1, 2017.

Effective November 1, 2014, the Direct Patient Care price/base rate is adjusted on each claim by the resident's current Medicaid RUG score. Nursing facilities may choose to bill weekly or monthly.

The nursing facility bills the Medicaid (RUG-IV, 48 RUG Grouper) RUG assessment code determined by the MDS assessment for each resident during the billing period. The RUG code submitted for the billing period is mapped to the RUG weight (CMI score). The RUG score should reflect the RUG code applicable to the dates of service in the billing period as calculated on the MDS assessment.

The state reimburses nursing facilities for their capital costs utilizing an FRV system. FRV rates are based on the prior calendar

year's information aged to the state fiscal year adjusted by the RS Means Index and applicable rental rate (8.0%).

The FRV system includes costs associated to land, buildings and fixed equipment, major movable equipment, and any other capital-related items. The FRV per diem rate is determined yearly using the most recent available data from settled cost reports and is equal to the sum of the facility's FRV rental amount and the facility's allowable property tax and insurance cost from the most recent settled cost report, divided by total patient days (adjusted for the minimum occupancy requirement, if necessary).

The FRV rental amount is equal to the facility's prospective year total value, which is the facility's prospective year replacement cost minus FRV depreciation, times the rental rate. Virginia's FRV methodology includes components for building, land and equipment calculated as follows:

- The initial total building replacement costs for all participating nursing facilities were based on the R.S. Means 75th percentile nursing construction cost per square foot published in the 59th Annual Edition of the R.S. Means Building Construction Cost Data, 2001. The cost factor will be inflated annually utilizing the R.S. Means historical cost index factor. The initial total replacement cost is calculated by multiplying the cost factor by the facility's estimated gross square footage. A nursing facility's gross square footage is determined by multiplying the gross square footage per bed estimates by the facility's total number of licensed beds. The gross square footage per bed estimate is 461 for facilities with 90 or fewer beds, and 438 for facilities with more than 90 beds.
- A nursing facility's land value and soft costs are estimated by multiplying 1.429 by the total replacement value of the building (prior to depreciation).
- The initial proposed equipment value per bed is \$3,475, which has been inflated annually by the same index utilized to inflate the building.

The replacement value of the building and equipment is summed and then reduced for depreciation at a rate of 2.86% per year (based on the average age of the facility's beds), not to exceed 60%. In calculating facility age, new and/or replacement beds and renovations reduce the effective age and the corresponding depreciation percentage.

The land value is added to the depreciated replacement cost of the building and equipment and then multiplied by the FRV rental rate to determine the rental amount. The FRV rental rate is equal to two percentage points plus the U.S. Treasury Bonds with maturity over 10 years, averaged over the most recent three calendar years for which data is available. The FRV rental rate is updated annually and may not fall below 8.5% or exceed 11%. The rental amount is divided by total resident days (subject to the minimum occupancy requirement) to determine the FRV per diem rate. The state reduced the minimum rental rate from 9% to 8% in fiscal year 2011. This resulted in an average decrease of \$1.83 to Capital component rates. However, effective July 1, 2012, the state increased the minimum rental rate to 8.5%, which resulted in an average increase of \$0.91 to Capital component rates. Effective July 1, 2014, the FRV rental floor was decreased to 8.0%.

NATCEP reimbursement rates equate to the applicable per diem rate calculated in the base year inflated to the current rate year based on inflation used in the operating rate calculations. July 1, 2018, NATCEP rates were based on CY 2015 costs inflated to the current rate year. Rates for Criminal Records Checks (CRC) are calculated by dividing associated costs for criminal records checks by total patient days. These costs are not inflated. CRC rates effective July 1, 2018, were based on 2015 cost report data.

The state also utilizes spending floors. All nursing facilities receive the full price if their costs (inflated to the appropriate fiscal rate year) are at or above 95% of the price. Facilities with projected costs below 95% of the price have an adjusted price equal to the price minus the difference between their projected cost and 95% of the unadjusted price. The state contends that by limiting the potential gain of low cost facilities, it is possible to implement higher adjustment factors for other facilities at a lower overall expenditure level and reduce the amount of transition losses for higher cost facilities.

Minimum Occupancy Standards

For the purpose of computing the allowable Capital per diem cost, the greater of the actual number of patient days in the cost reporting period, or 88% of the facility's maximum annual patient days, is used in the calculation.

OTHER RATE PROVISIONS

In addition, in fiscal year 2015 the state began a Dual Eligible Demonstration that converted a significant number of current and future nursing home residents to managed care. However, the managed care organizations that operate the system are required to pay no less than the calculated fee-for-service Medicaid rates for Medicaid covered days.

A nursing facility with a change of ownership is reimbursed at the same rate established for the nursing facility prior to the change of ownership until the facility submits its first cost report.

The state requires new facilities to provide a complete new FRV report to establish the FRV rate and will request licensing for NATCEP services. The state will calculate all other rate components for a new facility as follows: Direct Patient Care and Indirect Care will equate to 100% of the state-wide price; a statewide average NATCEP rate based on facilities with NATCEP cost and a statewide average CRC rate.

Nursing facilities in Virginia are eligible to be reimbursed by Medicaid for holding a bed for a resident that requires a therapeutic leave. Therapeutic leave payment is limited to a maximum of 18 days in any 12-month period and is not available to cover bed holds for hospitalized residents. The nursing home is reimbursed its current per diem rate.

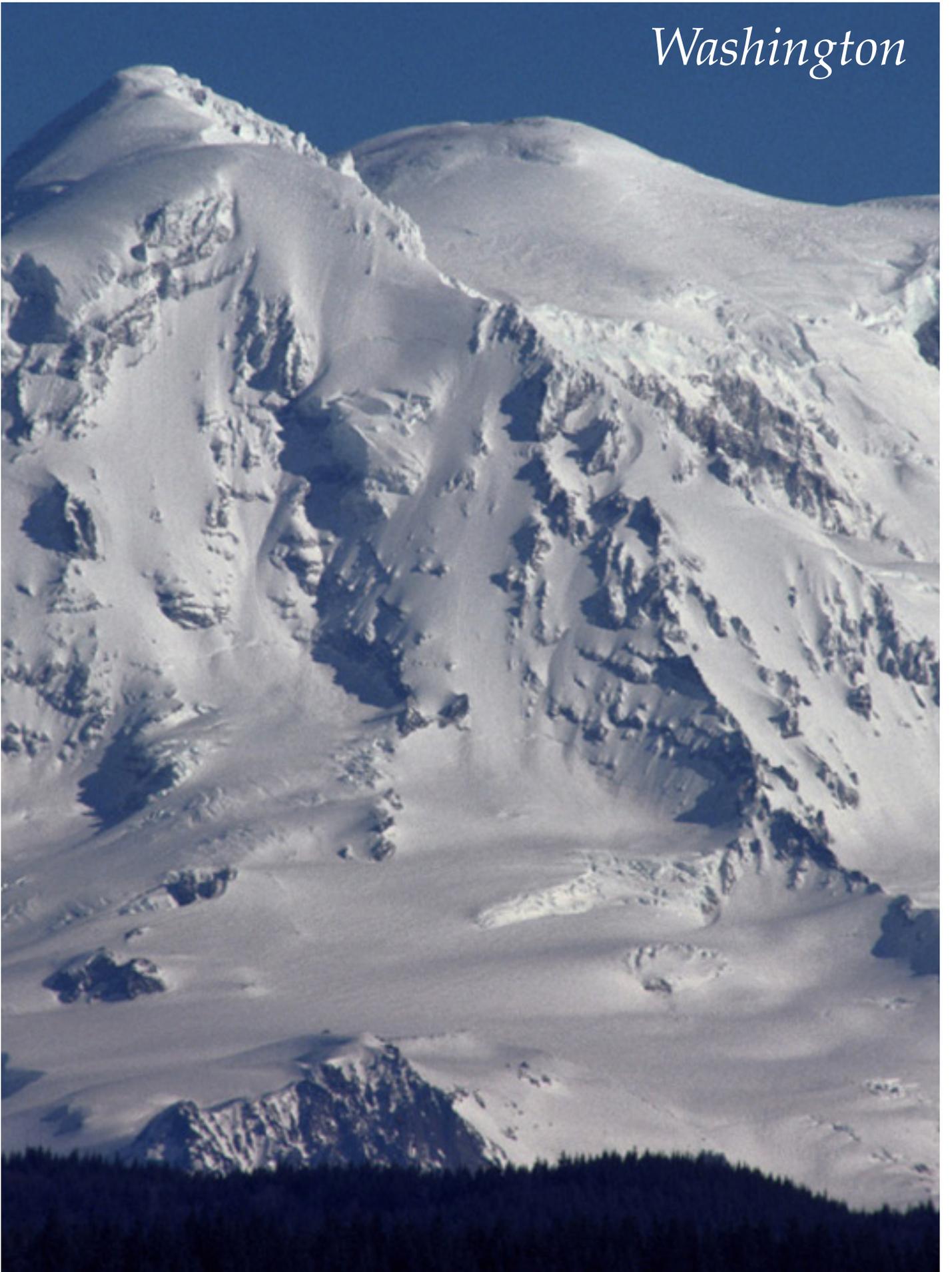
PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this overview, there are no proposed or planned changes to the Medicaid rate calculation.

VIRGINIA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	60.50	60.00	61.50		117.00	117.00	116.50		136.75	135.00	130.00
Average Daily Census	81.24	81.89	81.23		108.16	107.16	106.46		143.36	141.22	141.65
Occupancy	85.0%	83.6%	83.6%		90.3%	90.0%	89.7%		93.2%	93.0%	92.9%
Payor Mix Statistics											
Medicare	9.1%	8.7%	8.4%		13.7%	13.2%	13.4%		21.9%	20.8%	20.3%
Medicaid	38.5%	38.8%	31.8%		49.8%	52.5%	44.9%		65.2%	65.0%	59.2%
Other	20.6%	20.0%	25.7%		37.0%	34.3%	39.8%		50.1%	50.7%	54.6%
Avg. Length of Stay Statistics (Days)											
Medicare	28.57	27.73	27.30		35.33	34.18	32.80		43.65	41.42	39.63
Medicaid	224.82	213.19	221.29		307.02	311.51	301.15		454.51	450.42	412.38
Other	71.86	75.84	78.27		125.63	143.24	127.84		238.01	264.62	247.13
Revenue (PPD)											
Inpatient	\$204.19	\$208.49	\$216.06		\$233.59	\$242.80	\$252.91		\$280.28	\$289.61	\$299.05
Ancillary	\$53.82	\$52.64	\$54.52		\$82.82	\$83.35	\$90.98		\$118.65	\$123.81	\$130.35
TOTAL	\$273.78	\$277.59	\$288.74		\$321.72	\$341.68	\$349.38		\$409.05	\$431.96	\$441.80
Expenses (PPD)											
Employee Benefits	\$13.14	\$13.72	\$12.01		\$19.06	\$19.12	\$18.37		\$25.42	\$25.32	\$24.80
Administrative and General	\$29.41	\$28.43	\$28.03		\$34.81	\$35.30	\$35.95		\$41.54	\$43.29	\$42.83
Plant Operations	\$8.74	\$8.70	\$8.70		\$10.09	\$9.79	\$10.18		\$12.35	\$12.72	\$12.56
Laundry & Linens	\$1.74	\$1.70	\$1.69		\$2.29	\$2.31	\$2.24		\$2.84	\$2.97	\$3.05
Housekeeping	\$4.46	\$4.52	\$4.57		\$5.44	\$5.40	\$5.76		\$6.42	\$6.51	\$6.77
Dietary	\$14.76	\$14.79	\$15.21		\$16.26	\$16.56	\$16.84		\$18.65	\$19.55	\$20.20
Nursing & Medical Related	\$68.00	\$70.00	\$73.73		\$78.91	\$81.95	\$84.24		\$90.07	\$96.87	\$99.78
Ancillary and Pharmacy	\$25.22	\$25.05	\$24.29		\$34.33	\$34.13	\$33.07		\$48.11	\$47.78	\$47.11
Social Services	\$1.56	\$1.59	\$1.59		\$2.36	\$2.51	\$2.91		\$4.34	\$4.63	\$5.31

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Washington



INTRODUCTION

Nursing facilities in Washington are licensed by the Washington Department of Social and Health Services (DSHS) under the designation of "Nursing Homes." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN WASHINGTON	
Licensed Nursing Facilities*	217
Licensed Nursing Beds*	19,944
Beds per 1,000 Aged 65 >**	17.21
Beds per 1,000 Aged 75 >**	44.68
Occupancy Percentage - 2017*	77.80%

*Source: 2017 Medicare Cost Reports

**Source: EnviroNics Analytics- 2018 Population

CERTIFICATE OF NEED

Washington maintains a Certificate of Need (CON) program within the Health Professionals and Facilities division of the Washington Department of Health. The Department requires the acquisition of a CON for the following scenarios:

- The construction of a new nursing facility (including replacement facilities).
- An increase in the number of licensed beds.
- Any capital expenditures in excess of \$2,663,342 (effective October 1, 2018) for the construction, renovation or alteration of a nursing home.
- Nursing home bed banking transactions.

An exemption from CON requirements exists for the construction, development or other establishment of a nursing home, or the addition of beds to an existing nursing home, within a continuing care retirement community (CCRC). There is also a replacement exemption to the CON requirements that requires beds being replaced to be developed in the same planning area as the closed facility. In such cases, the licensee must be the same at all affected facilities and must have been the licensee for at least one year immediately preceding the replacement exemption request.

The state has allowed nursing homes a provision to convert licensed nursing beds into either unlicensed alternate use beds or full facility closure beds. This process is referred to as banking beds. Alternate use beds enable nursing homes to admit lower acuity patients and reduce the number of patients in the banked units, thus absorbing otherwise unused nursing beds. Nursing homes with this provision will be approved for an initial four-year period for good cause and may be extended for another four-year period depending on a review of how the facility utilized the alternate use beds. Full facility closure beds, by definition, involve all of a facility's licensed beds. The beds are put out of operation rather than being converted to an alternate use. These bed closures are approved for one eight-year period with no extension available. Banked beds (both alternative use and full facility closure) may be reconverted to nursing use and re-licensed within a 90-day period. . As of April 2018, 945 beds were banked.

BED NEED METHODOLOGY

The need for long-term care beds is estimated by the Department for the state's designated 37 planning areas, 33 of which are single counties. The CON program estimates bed need at 40 beds per 1,000 persons age 70 and older. Prior to October 5, 2008, bed need was calculated based on the 65-plus population. However, this was changed to more accurately reflect the population served by nursing homes. This ratio is applied to the state's total 70-plus population to determine total gross nursing facility bed need. The total number of licensed nursing beds in the state is then subtracted from this number to determine total net nursing bed need. According to the Nursing Home Bed Projection prepared by the Department effective December 31, 2018, based on the projected 70-plus population and current number of licensed beds (including banked beds), there will be a statewide shortage of 13,231 beds in 2020, 14,985 beds in 2021 and 16,738 in 2022. However, it should be noted that the state implemented an additional need methodology in 2012.

This methodology was designed to reflect that state law requires the Department to consider the availability of home and community-based long-term care services (assisted living, adult residential care homes, adult family homes, hospice, etc.) as an alternative to nursing home services. This methodology has two components and was last updated in May 2018. The first component determines the number in-home residents who possess an acuity level that is similar to that of a nursing home resident. The next component determines the number residents within existing community-based facilities who possess an acuity level equal to or above the level typical for a nursing home resident. Based on these components, the state has estimated that 23.6% of Medicaid in-home clients and 25.3% of community-based care clients receive a similar level of care to that provided by a nursing home.

CON officials have indicated that the Department has and will continue to consider this methodology when reviewing new CON applications. In addition, these professionals also indicated that this methodology is updated every two years and the state will most likely be updated in 2020.

QUALITY MAINTENANCE FEE

Washington's quality maintenance fee that was established in 2004 was discontinued as of July 1, 2007. The discontinuation was the result of an intense lobbying effort by the not-for-profit nursing homes that serve a proportionately lower percentage of Medicaid residents. Those providers serving a majority of private pay residents were unable to recoup the fee through their Medicaid rates. The fee, prior to discontinuation, was \$5.25 per non-Medicare patient day. In return, providers received a rate pass-through of \$5.25 per Medicaid day.

Effective July 1, 2011, Washington implemented a quality assessment fee known as the Skilled Nursing Facility Safety Net Assessment. This assessment was improved as part of Senate Bill 5581, which also significantly alters the state's Medicaid rate calculation. Continuing care retirement communities, nursing facilities with less than 35 beds, state, county and tribal operating

facilities, and hospital-based nursing facilities are excluded from paying the assessment.

Nursing facilities with more than 32,000 Medicaid patient days or more than 203 licensed beds are assessed \$1.00 per non-Medicare day. Initially, the remaining nursing facilities in the state were assessed \$11.00 per non-Medicare day. However, this fee has changed periodically since its inception.

The current fee (effective October 1, 2018) for nursing facilities with 32,000 or fewer Medicaid patient days and 203 or fewer licensed beds is \$23.00. Nursing facilities with more than 32,000 Medicaid patient days or more than 203 licensed beds are still assessed a \$1.00 fee per non-Medicare day. The prior fee for nursing facilities with 32,000 or fewer Medicaid patient days and 203 or fewer licensed beds was \$21.50 (effective January 1, 2018). From July 1, 2015 to December 31, 2017, the fee was \$21.00. The prior fee, effective February 1, 2015, was \$18.00 per non-Medicare day, which represented a decrease from the fee (\$21.00) effective July 1, 2014. This fee was increased from the previous fee of \$14.00 per non-Medicare day effective February 1, 2013. Nursing facilities that pay the Safety Net Assessment are reimbursed their applicable assessment fee as an add-on to their Medicaid rates.

MEDICAID RATE CALCULATION SYSTEM

Effective July 1, 2016, Washington converted to a new prospective, facility-specific, cost and priced based, case mix rate setting methodology. The prior methodology was also prospective, cost-based and adjusted rates for acuity. The following is a description of the rate methodology that has been utilized to determine nursing facility rates since July 1, 2016.

COST CENTERS

Each nursing facility receives one rate that is currently comprised of the following three components:

- **The Direct Care** component includes costs related to nursing care, including direct care supplies, physical, speech, occupational and other therapies, as well as food, laundry and dietary expenses.
- **The Indirect Care** component includes administrative expenses, maintenance costs and housekeeping services.
- **The Capital** component which utilizes a Fair Rental Value (FRV) based on the facility's total square footage.

INFLATION AND REBASING

The direct care and indirect care components are rebased in even-numbered years, beginning with rates paid on July 1, 2016. On a percentage basis, in rebasing years, the department must confirm that the statewide average daily rate has increased at least as much as the average rate of inflation, as determined by the skilled nursing facility market basket index published by the centers for Medicare and Medicaid Services (CMS), or a comparable index. If after rebasing, the percentage increase to the statewide average daily rate is less than the average rate of inflation for the same time period, the department is authorized to increase rates by the difference between the percentage increase after rebasing and the average rate of inflation. However, Washington adjusts Medicaid

rates to reflect budget appropriations. This is referred to as a budget dial adjustment, and will be discussed further in the next section of this overview.

In non-rebasing years, direct and indirect care costs are not inflated. Non-capital rates paid on July 1, 2016, were based on the 2014 calendar year cost report. The state did not rebase non-capital rates on July 1, 2017. Rates were again rebased on July 1, 2018, utilizing 2016 cost report data. The state will next rebase non-capital rates on July 1, 2020. The Capital cost component is calculated annually.

RATE METHODOLOGY

The Direct Care component comprises the majority of the total facility rate. With the exception of semiannual adjustments for CMI, Direct Care component rates are only calculated in rebasing years. The first step in the calculation of Direct Care rates is to divide inflated allowable costs by the total patient days. After the facility-specific per diem cost is determined, it is then increased by the Direct Care rate cap of 118%. The product of this calculation is then comparable to the facility-adjusted statewide Direct Care rates.

The statewide Direct Care rate equates to the median Direct Care per diem cost in the state, multiplied by the facility's county-specific regional wage index and the facility Medicaid Average Case Mix Index (MACMI). This rate is adjusted semiannually for the facility's MACMI on July 1 and January 1 of the rate year. For July 1 rates, Medicaid case mix index (CMI) data for the six-month period ending on the March 31 prior to the rate effective date is utilized to determine the MACMI. For rates effective January 1, CMI data for the six month period ending the September 30th prior to the rate effective date is utilized to pay the MACMI. Nursing facilities receive the lesser of their rate-cap facility-adjusted Direct Care rate or the facility-adjusted statewide Direct Care rate.

As part of the new methodology, effective July 1, 2016, facilities must provide a minimum of 3.4 hours per resident day of direct care.

The first step in the calculation of the Indirect component rate is to determine the facility-specific Indirect per diem cost. The Indirect component rate is a statewide price that equates to 90.0% of the median inflated indirect per diem cost in the state. Facility-specific Indirect per diem expenses that are utilized to determine the median are calculated by dividing the facility-specific inflated Indirect care costs by the greater of the facility's total patient days or 90.0% of the facility's maximum annual patient days. This rate is only calculated in rebasing years and is not adjusted for inflation in non-rebasing years.

The Capital component rate is facility-specific and is calculated on an annual basis utilizing a Fair Rental Value (FRV) system. The calculation is based on a nursing facility's square footage. The facility's total square footage is divided by total licensed beds to determine the facility's square footage per bed estimate. The estimate is not allowed to exceed 450 square feet per bed.

After this is determined, the facility-specific building value is estimated. The RS Means Estimated Median Price per bed is

divided by the maximum square footage per bed (450 square feet) to calculate the price per square foot. The price per square foot is then multiplied by the facility's RS Means Location Zip Code Index, total licensed beds and allowable square footage per bed to calculate the facility building value. As part of the calculation, a facility equipment value is determined by multiplying the facility building value by ten percent. The equipment value is then added to the building value to equate to the Facility Total and Building Value. The Facility Total and Building Value is then reduced for depreciation. Depreciation is determined by multiplying the Total and Building Value by the facility's depreciation percentage. The depreciation percentage is determined by multiplying the facility-adjusted age by the depreciation rate (1.5%). The facility-adjusted age is reduced for any significant renovations.

The next step is to estimate the facility's land value, which is calculated by multiplying the depreciation-adjusted Total and Building Value by ten percent. The land value is then added to the depreciated-adjusted Total and Building Value to equate to the Total Building, Equipment and Land Value. This estimate is then multiplied by rental rate of 7.5% to yield an FRV for the facility. The FRV is then divided by the greater of the facility's total patient days or 90.0% of the facility's maximum annual patient days to determine the Capital Rate.

As part of the new system, the state determines two quality enhancement add-ons on a semiannual basis. The first quality incentive component is determined by calculating an overall facility quality score composed of six quality measures as follows:

- the percentage of long-stay residents who self-report moderate to severe pain;
- the percentage of high-risk long-stay residents with pressure ulcers;
- the percentage of long-stay residents experiencing one or more falls with major injury;
- the percentage of long-stay residents with a urinary tract infection;
- the percentage of short-stay residents who newly received an antipsychotic medication; and
- the percentage of direct care staff turnover.

The state increased the number of quality measures from four to six effective July 1, 2017. The facility's quality score is point based, and is determined utilizing the facility's most recent three-quarter average Centers For Medicare and Medicaid (CMS) quality data.

Facilities meeting or exceeding the highest performance threshold (top level) for a quality measure receive twenty-five points. Facilities meeting the second highest performance threshold receive twenty points. Facilities meeting the third level of performance threshold receive fifteen points. Facilities in the bottom performance threshold level receive no points. Points from all quality measures must then be summed into a single aggregate quality score for each facility. A nursing facility can receive a maximum of 150 points. Based on the facility's total quality score, they receive a rate add-on. These add-ons can change on a semiannual basis.

The current add-ons effective January 1, 2019 per quality score are as follows:

- > 120 - \$4.69;
- 105 - 119 - \$3.52;
- 90 - 104 - \$2.35
- 75 - 89 - \$1.17
- < 75 - \$0.00

The average add-on effective July 1, 2019 is projected to increase from \$2.32 to \$3.67.

If sufficient data is not available to calculate the quality measures, the system defaults to the CMS Star Rating System as follows:

- Five Stars - \$4.69;
- Four Stars - \$3.52;
- Three Stars - \$2.35
- Two Stars - \$1.17
- One Star - \$0.00

Effective January 1, 2018, nursing facilities were eligible for a second quality add-on that equates to 12.5% of the first quality add-on. Total funding for this add-on has ranged from \$500,000 to \$1,000,000. State rate setting professionals indicated that the state will not pay out this add-on on July 1, 2019, but have communicated that nursing facilities will receive the second quality incentive in January 1, 2020 rates.

Effective July 1, 2016, the state also has two current hold harmless add-ons that are known as Stabilizer Calculations. The first Stabilizer Calculation indicates that a nursing facility rate (not including the Safety Net add-on) cannot be greater than 5.0% less than its rate effective June 30, 2016 (excluding the Safety Net add-on).

The second add-on is actually a potential rate reduction. It is referred to as the Stabilizer "Take Back" add-on. For rates effective January 1, 2019, it assumes that nursing facility rate gains from June 30, 2016 rates cannot exceed 40.49%. Both of these add-ons will be eliminated on July 1, 2019.

The state also provides a minimum wage add-on. The current add-on is \$0.57 effective July 1, 2018. The add-on is projected to be \$0.76 effective July 1, 2019.

To ensure that total Medicaid nursing facility spending does not exceed the amount appropriated by the Legislature, the Biennial Appropriations Act sets a weighted average maximum nursing facility payment rate, or budget dial, for each fiscal year. If the state's weighted average rate is above the maximum payment rate (the annual statewide weighted average nursing facility rate based on budget appropriations), the Medicaid rate for each facility (regardless if the facility's rate is above/below the maximum payment rate) is adjusted downward by the percentage that the total weighted average rate is above the maximum payment rate. The state has not been required to utilize the budget dial for several years.

MINIMUM OCCUPANCY STANDARDS

The greater of the facility's total patient days or 90.0% of the facility's maximum annual patient days is utilized to determine Indirect Care and Capital rates.

OTHER RATE PROVISIONS

Facilities that experience a change of ownership receive the previous owner's rates until a new rate is calculated. The determination of how a new facility would be reimbursed is unclear. However, based on conversations with rate setting officials, newly constructed facilities would most likely receive a rate consisting of the standard Indirect Care rate, a FRV rate based on the facility's square footage, the standard Direct Care rates adjusted for the average CMI (until such time that CMI data is available for the facility) and the safety net add-on. This rate would be until such time the new provider had accumulated enough cost report, CMI and Medicare quality data to have its rate calculated during a normal rate cycle

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no proposed or planned changes to the state's rate setting methodology.

WASHINGTON COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	67.75	73.00	69.25		96.00	98.00	96.50		120.00	120.00	120.00
Average Daily Census	59.51	60.13	55.38		79.13	77.83	77.02		101.98	97.70	98.18
Occupancy	75.0%	74.2%	72.2%		85.0%	81.7%	82.5%		90.9%	87.6%	88.7%
Payor Mix Statistics											
Medicare	8.3%	9.2%	9.3%		15.5%	14.2%	14.7%		24.0%	24.4%	25.1%
Medicaid	49.9%	48.4%	48.6%		61.6%	61.5%	61.3%		70.0%	70.2%	69.6%
Other	14.4%	15.2%	14.3%		20.2%	22.2%	21.0%		28.2%	34.4%	30.0%
Avg. Length of Stay Statistics (Days)											
Medicare	27.98	27.70	27.21		32.77	35.03	33.27		40.34	41.47	39.38
Medicaid	239.35	223.68	212.61		302.49	314.63	290.27		390.89	458.47	411.85
Other	37.76	40.72	38.36		59.65	62.75	57.81		91.64	105.32	100.53
Revenue (PPD)											
Inpatient	\$244.13	\$251.77	\$270.60		\$269.50	\$280.73	\$307.00		\$321.70	\$330.85	\$369.91
Ancillary	\$51.36	\$55.45	\$54.03		\$86.44	\$87.40	\$90.95		\$124.74	\$123.12	\$125.59
TOTAL	\$314.15	\$322.95	\$349.95		\$374.00	\$382.50	\$416.10		\$449.96	\$453.67	\$484.66
Expenses (PPD)											
Employee Benefits	\$21.59	\$22.48	\$22.24		\$27.25	\$28.70	\$27.32		\$35.23	\$36.15	\$34.34
Administrative and General	\$46.40	\$51.53	\$50.42		\$56.26	\$61.65	\$63.06		\$65.48	\$69.98	\$72.36
Plant Operations	\$8.79	\$9.20	\$9.31		\$10.54	\$10.82	\$11.27		\$13.04	\$13.02	\$13.77
Laundry & Linens	\$2.20	\$2.39	\$2.45		\$2.99	\$3.16	\$3.29		\$4.07	\$4.20	\$4.32
Housekeeping	\$4.94	\$5.15	\$5.38		\$6.23	\$6.33	\$6.82		\$7.33	\$7.81	\$8.31
Dietary	\$15.85	\$16.26	\$16.77		\$17.66	\$18.42	\$19.35		\$20.85	\$21.89	\$23.13
Nursing & Medical Related	\$87.22	\$94.78	\$100.47		\$99.71	\$106.99	\$113.46		\$113.88	\$127.71	\$134.93
Ancillary and Pharmacy	\$28.20	\$27.23	\$26.86		\$40.31	\$38.91	\$41.65		\$52.00	\$52.71	\$55.67
Social Services	\$3.76	\$3.80	\$4.40		\$5.29	\$5.37	\$6.00		\$6.64	\$6.81	\$7.58

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

West Virginia



INTRODUCTION

Nursing facilities in West Virginia are licensed and regulated by the Department of Health and Human Resources, Office of Health Facility Licensure and Certification (OHFLC) under the designation of "Skilled Nursing Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN WEST VIRGINIA	
Licensed Nursing Facilities*	78
Licensed Nursing Beds*	7,418
Beds per 1,000 Aged 65 >**	20.94
Beds per 1,000 Aged 75 >**	52.45
Occupancy Percentage - 2017*	88.70%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

The Certificate of Need (CON) review process includes the determination of need, uniformity with the State Health Plan and financial feasibility. CON standards, which include population-based quantifiable need methodologies, are used to determine need. Financial feasibility determines whether expense and revenue projections demonstrate financial viability for a proposed project and evaluates the reasonableness of proposed charges to patients. The West Virginia Healthcare Authority operates the state's CON program. However, as of 2016, the authority is no longer reviewing nursing homes as part of the CON process. As such, there are no longer any established CON standards for nursing homes in West Virginia.

Nursing homes are now subject to an exemption from the CON process. The construction, expansion or acquisition of a nursing home can now potentially be approved as an exemption from the CON. In addition, the purchasing and transferring of nursing home beds is now allowable within the state.

BED NEED METHODOLOGY

In prior years, West Virginia has calculated nursing home bed need separately for each of the 42 nursing service areas. With a target rate of 30 beds per 1,000 residents age 65 years or older, the methodology projects a current surplus of beds in the state. Given that nursing homes projects are no longer reviewed as part of the CON process (and there are no longer any nursing home CON standards), it is unclear if this methodology will be utilized in the future.

QUALITY ASSURANCE FEE

The quality assurance fee (QAF) in West Virginia was enacted in 1993 at 5.5% and is a broad-base fee based upon revenue. The QAF was increased to 5.95% in 2004 to generate additional revenue. However, the fee was reduced to 5.5% effective December 2007 to comply with the Tax Relief and Health Care Act of 2006. Although this act expired on October 1, 2011, the QAF has remained at 5.5% until October 1, 2015, when the QAF increased to 5.72%. However, the fee reverted back to 5.5% on July 1, 2016.

MEDICAID RATE CALCULATION SYSTEM

West Virginia uses a prospective, cost-based, case mix adjusted, resident- and facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities.

COST CENTERS

West Virginia uses the following four cost centers to calculate its facility-specific Medicaid rates:

- The Standard Services cost component is separated into four categories: Dietary, Laundry and Housekeeping, Medical Records and Administration.
- The Mandated Services cost component is separated into four categories: Activities, Maintenance, Utilities, and Taxes and Insurance.
- The Nursing Services cost component includes nursing and related services costs, including restorative service costs. The cost standard for Nursing Services is derived as the sum of factors associated with registered nurses (RNs), licensed practical nurse (LPNs), aide, supplies and directors of nursing (DONs).
- The Cost of Capital cost component is determined on a facility-by-facility basis using an appraisal technique to establish a standard appraisal value (SAV). The value includes the necessary real property and equipment associated with the actual use of the property as a nursing facility.

A cost standard is developed for each cost center, which becomes the maximum allowable cost for reimbursement purposes.

INFLATION AND REBASING

Nursing facility rates and cost standards are rebased every six months. Rates are issued for six-month periods beginning April 1 and October 1, with all participating nursing facilities having their initial Medicaid rate established on October 1.

The Consumer Price Index (CPI) is used to inflate costs. The inflation rate used is determined based on the increase in the CPI over the cost report period. If the CPI has decreased over the cost report period, no inflation adjustment is made.

The inflation adjustments for the prior periods were 2.5996% on October 1, 2009, 0.9336% on October 1, 2010, 0.5569% on April 1, 2011, 0.029852% on October 1, 2011, no inflation adjustment on April 1, 2012, 1.6870%, on October 1, 2012, 0.000538% on April 1, 2013 and 0.016999% on October 1, 2013. No inflation adjustment was applied to April 1, 2014, rates. Rates effective April 1, 2015, received no inflation adjustment. However, a 2.27% inflation adjustment was previously applied to October 1, 2014, rates.

Effective October 1, 2015, the state applied an inflation adjustment of 1.63%, which was the direct result of the increase in revenue generated from the increase in the QAF. However, to reflect current funding levels, the state applied a temporary \$2.75 rate reduction to non-state owned nursing facilities effective from October 1, 2015, to June 30, 2016. The state rebased rates on July 1, 2016, utilizing cost report data for the period of July 1, 2015, to December 31, 2015. These rates equate to the rates the state would have calculated if the state had completed its normal rebasing on

West Virginia

April 1, 2016. However, based on the cost report data, no inflation was applied. In addition, given a slight reduction in costs, nursing facility rates on average decreased 0.3% on July 1, 2016. Prior to July 1, 2016, rates were last rebased on October 1, 2015, using cost report data for the six-month period of January 1 to June 30, 2015.

Since July 1, 2016, the state has consistently rebased rates every April 1 and October 1, as described above. The inflation adjustments utilized in recent years are as follows: 0.019080% on October 1, 2016; 0.001718 on April 1, 2017; 0.014592% on October 1, 2017; 0.006405% on April 1, 2018; 0.022168% on October 1, 2018 and no inflation on April 1, 2019.

Appraisals required to calculate Cost of Capital rates are completed annually from January 1 to June 30. The appraisal is first used to determine Cost of Capital rates on the first October 1 rate period after the appraisal is completed. The appraisal is also utilized for the following April 1 rate.

RATE METHODOLOGY

For the purpose of calculating nursing facility Medicaid rates, facilities are separated into separate bed groups based upon two bed sizes (0–90 beds and 91+ beds). Separate rates and rate ceilings are calculated for both of the bed groups for each of the cost centers.

For the Standard Services cost component, facility-specific per patient day (PPD) allowable inflated costs by cost center and bed group are calculated assuming 100% occupancy. A cost average point (CAP), also known as average cost per bed, is established by eliminating those PPD values that fall within plus or minus one standard deviation. The CAP is then adjusted to reflect a 90.0% occupancy level, which equates to the ceiling. The Standard Services cost component ceiling is derived by summing the cost center ceiling for Dietary, Laundry and Housekeeping, Medical Records and Administration by bed group.

The Standard Services cost component per diem rate is determined by comparing the total reported allowable Standard Services costs per diem (total allowable costs/total patient days) against the total cost ceiling for the appropriate bed group for the facility. The facility rate is limited to the standard services cost ceiling if the total reported allowable costs per diem exceed the total cost ceiling.

When the Standard Services cost component's allowable cost per diem is less than the total of the cost ceiling, an efficiency incentive of 50.0% of the difference between the total allowable cost and the total cost ceiling will be applied to the prospective rate for the Standard Services cost component rate. The total efficiency incentive may not exceed \$2.00 per patient day. Qualifying facilities may not have any deficiencies during the reporting period related to standard services or substandard care, quality of life or care.

As mentioned, the Mandated Services is also separated into four categories: Activities, Maintenance, Utilities, and Taxes and Insurance. Each of these cost centers has a separate cost ceiling calculated by bed group. The PPD allowable costs are

arrayed from highest to lowest within each cost center. The 90th percentile value for each cost center is then selected as the ceiling. The Mandated Services cost ceiling is derived by summing the cost center ceiling for Activities, Maintenance, Utilities, and Taxes and Insurance. The maximum allowable cost by bed group for the Mandated Services cost component is the lesser of the total allowable costs per diem or the cost ceiling.

The cost ceiling for Nursing Services is shown as the resident assessment calculation on the rate sheet and takes into account professional staffing levels and supply costs necessary for the delivery of residents' needs. The resident assessment calculations provide a benchmark and are held constant over time for professional staffing hours (excluding DON salaries). Also, factors are included in LPN and aide hours for restorative services. The standard hours PPD, by bed group, for each professional level of nursing staff are shown in the following table:

Nursing Services		
Staff	1 - 90 Beds	91+ Beds
RN	0.20	0.20
LPN	0.85	0.80
Aides	1.85	1.85
Total Hours PPD	2.90	2.85

Source: West Virginia Department of Health and Human Resources

The cost reports for each facility are utilized to derive hourly wage rates by professional level. The rates are arrayed from highest to lowest in each bed group, with the 70th percentile value utilized as the bed group rate. The cost ceiling for each salary cost center of the Nursing Services cost component is derived by multiplying the rate by the hour benchmark.

Nursing and restorative supply costs per patient day are arrayed by bed group from highest to lowest, with the 70th percentile being selected as the cost center's CAP (cost ceiling).

The DON salary cost ceiling is calculated to be the 70th percentile of all arrayed per diem costs for all applicable nursing facilities per bed group. The ceiling is then adjusted to reflect each individual facility's total bed capacity. The cost ceiling is divided by each facility's total maximum allowable patient days for the cost report period. The factor of this calculation is then added into the cost ceiling to create a facility-specific cost ceiling.

The cost ceiling for Nursing Services is the sum of the factors for RN, LPN, aide, supplies and DON. Based upon the facility's Medicaid MDS score from the six-month reporting period, the cost ceiling is then adjusted to a facility-specific cost ceiling. The adjusted Nursing Services cost ceiling for each facility is derived by dividing the average Medicaid MDS score by 2.5 and then multiplying it by the cost ceiling. This adjusted Nursing Service cost ceiling cannot exceed 112% (MDS average of 2.8) or be less than 80.0% (MDS average of 2.0) of the base constant, with each facility's PPD nursing costs reimbursed up to the level of the Nursing Services cost ceiling. A nursing facility's Nursing Services cost component rate is the lesser of the adjusted ceiling or the facility's actual per diem costs.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the rate period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a specific resident. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing rate to derive a PPD Nursing Services add-on.

As mentioned, the Cost of Capital cost component is determined on a facility-by-facility basis using an appraisal technique to establish an SAV. SAV is calculated annually by an independent appraisal company contracted by the state. This value includes all real property and equipment associated with a nursing facility. This allowance replaces leases, rental agreements, depreciation, mortgage interest and return on equity in the traditional approach to capital cost allowance.

The model nursing facility standard is updated periodically to reflect changes that foster improved resident care or cost effective measures. The model is a composite of current regulations and criteria derived from several sources, including Minimum Requirements of Construction and Equipment for Hospitals and Medical Facilities - HHS Publication No. (HRS) 81-14500 and the West Virginia Department of Health and Human Services Nursing Home License Rules. The model also sets an upper reasonable cost limit for constructing a nursing facility.

SAV is derived by estimating the replacement or reproduction cost of the improvements, deducting from them the estimated accrued depreciation and adding the market value of the land. Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are *Marshall & Swift Valuation Services* and *Boeckh Building Valuation Manual*.

The per diem Cost of Capital rate for a nursing facility is determined by applying a capitalization rate for the mortgage and equity components, and an appraisal factor to the value of the facility determined by the SAV.

The capitalization rate is calculated using a band of investment approach to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital using a 75:25 debt service to equity ratio). This produces a rate semi-annually that reflects current money values in the mortgage market. The capitalization rate for the mortgage component used in the calculation is the 10-year average of the prime rate plus 3.0%. The capitalization rate is limited to a floor of 10.0% and a ceiling of 12.0%. The capitalization rate for the equity portion is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The appraisal factor is based on the CPI for the cost reporting period in which the facility is appraised.

The per diem Cost of Capital rate is calculated by multiplying the

value of the facility by the capitalization rates and the appraisal factor, and dividing this factor by total patient days (adjusted for the minimum occupancy requirement).

The average daily Medicaid effective April 1, 2019 is \$227.16, which is slightly less than the average rate (\$233.09) effective October 1, 2018. The average rate has fluctuated during the prior rate periods as follows: April 1, 2018 - \$219.37; October 1, 2017 - \$221.16; April 1, 2017 - \$215.56 and October 1, 2016 - \$220.10.

The July 1, 2016 average rate is \$213.11, which is slightly less than the average daily Medicaid rate effective October 1, 2015 (\$213.75). This rate was 3.0% greater than the average rate April 1, 2015 (\$207.53). This April 1, 2015, average daily rate was less than the rate (\$211.33) effective October 1, 2014. This reflects that no inflation adjustment was applied to April 1, 2015, rates. The average rate effective April 1, 2014, was \$200.50

MINIMUM OCCUPANCY STANDARDS

Cost adjustments are made by applying a minimum occupancy standard of 90.0% to all cost centers. If a facility's occupancy is equal to or greater than 90.0%, the actual facility occupancy is used to determine allowable costs per patient day. If a facility's occupancy is less than 90.0%, the per-patient-day allowable cost is adjusted to assume a 90.0% occupancy level.

OTHER RATE PROVISIONS

When there is a change in ownership and control of a nursing facility and the new owners have no previous management experience in the facility, a projected rate is established. A projected rate will last no longer than 18 months from the opening date of the facility. The facility may choose to go off the projected rate at any time after a full six months of operating experience in a cost reporting period has been established. Each facility on a projected rate must submit the calendar semiannual cost reports during the projected rate period, even if the first report is a partial report (less than six months).

A projected rate for a new facility or a facility with a recognized change of ownership and control will be established as follows:

- Standard Services - The cost standard (CAP) established for the bed group.
- Mandated Services - The cost standard (CAP) established for the bed group.
- Nursing Services - The average of the cost established for the bed group.
- Cost of Capital - The SAV methodology is applied to a new facility or the SAV established for the facility if a change of ownership occurs.

Nursing facilities are paid their established rate to reserve a resident's bed (bed hold). However, the facility's occupancy must be 95.0% or greater the midnight before the resident leaves and there must be a waiting list for admission. The medical leave of absence must be for a resident who is admitted to an acute-care hospital for services that can only be provided on an inpatient basis, who is expected to return to the facility, and whose stay is 24 hours or longer. The maximum number of medical leave of

absence days, which may be reimbursed for an individual for a medical leave of absence, is 12 days in a calendar year. A bed may be reserved for a therapeutic leave of absence such as a home visit and must be a part of the resident's plan of care. The maximum number of therapeutic leave of absence days, which may be reimbursed for an individual resident for a therapeutic leave of absence, is six days in a calendar year.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

As of the date of this document, we are unaware of any current or proposed state legislation affecting the current Medicaid calculation in West Virginia.

WEST VIRGINIA COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	62.00	62.00	60.00		90.00	90.00	94.00		119.75	120.00	120.00
Average Daily Census	58.76	58.22	57.31		82.01	84.80	84.11		103.28	107.14	105.44
Occupancy	89.6%	89.2%	85.7%		94.1%	93.9%	93.1%		95.9%	96.1%	95.5%
Payor Mix Statistics											
Medicare	7.6%	6.7%	6.5%		10.0%	10.1%	9.5%		13.1%	13.4%	12.5%
Medicaid	7.7%	72.5%	70.9%		78.9%	79.7%	78.8%		84.0%	84.3%	83.7%
Other	6.0%	5.6%	6.8%		10.1%	9.8%	11.4%		17.6%	18.1%	18.8%
Avg. Length of Stay Statistics (Days)											
Medicare	35.42	30.80	30.58		41.00	38.86	39.29		55.01	52.01	53.69
Medicaid	235.11	257.48	253.24		350.55	364.25	335.14		618.55	536.83	521.68
Other	40.79	39.56	33.59		62.73	56.58	48.49		122.19	111.71	102.18
Revenue (PPD)											
Inpatient	\$270.16	\$276.37	\$286.30		\$318.38	\$324.74	\$321.53		\$347.66	\$369.38	\$381.07
Ancillary	\$43.45	\$45.46	\$40.32		\$59.93	\$59.77	\$52.88		\$76.20	\$73.48	\$75.86
TOTAL	\$318.38	\$328.03	\$338.86		\$378.60	\$391.95	\$386.97		\$419.96	\$431.51	\$438.51
Expenses (PPD)											
Employee Benefits	\$16.61	\$16.06	\$20.65		\$22.11	\$25.22	\$27.21		\$32.71	\$31.39	\$30.15
Administrative and General	\$45.96	\$46.19	\$46.28		\$51.37	\$50.92	\$52.96		\$59.73	\$62.36	\$63.19
Plant Operations	\$8.81	\$8.93	\$10.35		\$10.52	\$10.80	\$13.05		\$13.57	\$13.27	\$15.01
Laundry & Linens	\$3.14	\$3.12	\$3.01		\$3.79	\$3.93	\$3.50		\$4.35	\$4.71	\$4.22
Housekeeping	\$4.39	\$4.61	\$4.31		\$5.10	\$5.57	\$5.87		\$6.09	\$6.76	\$7.26
Dietary	\$14.62	\$15.05	\$17.05		\$16.49	\$17.20	\$19.41		\$19.12	\$19.99	\$21.57
Nursing & Medical Related	\$76.77	\$76.65	\$82.73		\$80.72	\$83.91	\$87.52		\$85.73	\$91.70	\$95.20
Ancillary and Pharmacy	\$21.61	\$24.34	\$23.76		\$29.40	\$29.88	\$28.88		\$37.05	\$36.43	\$37.66
Social Services	\$3.29	\$3.38	\$5.25		\$5.33	\$5.68	\$8.30		\$7.68	\$8.42	\$9.68

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Wisconsin



INTRODUCTION

Nursing facilities in Wisconsin are licensed by the Department of Health Services (DHS) under the designation of "Nursing Home." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN WISCONSIN	
Licensed Nursing Facilities*	377
Licensed Nursing Beds*	31,897
Beds per 1,000 Aged 65 >**	32.94
Beds per 1,000 Aged 75 >**	79.08
Occupancy Percentage - 2017*	75.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Wisconsin enacted a moratorium on the development of new skilled nursing facility beds in 1981 to control the increasing cost of providing nursing care. There are no plans to lift the moratorium in the near future. At the same time, Wisconsin started the Community Options Program (COP). The COP is designed to provide cost effective alternatives for people who need long-term care by allowing them to stay in their own homes and communities. The COP ended on June 30, 2018, and was replaced by the Family Care program, a Medicaid managed care and aging and disability resource allocation program.

In addition to the moratorium on the construction of new nursing facility beds, Wisconsin has a Certificate of Need (CON) program, which is referred to as the Resources Allocation Program (RAP). These regulations would only apply if the moratorium were lifted. However, according to professionals from the DHS, these regulations are predominantly not enforced due to the moratorium.

If Wisconsin chose to enforce the CON law, a CON would be required for the following scenarios:

- The construction of a new skilled nursing facility.
- An increase in the bed capacity of a skilled nursing facility.
- A capital expenditure, other than a renovation or replacement, that exceeds the state mandated amount.
- An expenditure, other than a renovation or replacement, that exceeds the state mandated amount.
- The partial or total conversion of a skilled nursing facility to a facility primarily serving the developmentally disabled, or vice versa.

The state-determined capital thresholds have not been updated in several years due to the moratorium. An exemption may be granted for the construction of a replacement facility.

BED NEED METHODOLOGY

Given the moratorium on the construction of new nursing facility beds, the state does not utilize a bed need methodology.

QUALITY ASSURANCE FEE

Wisconsin established a quality assurance fee on nursing home beds as part of the 1991 Wisconsin Act 269. Nursing homes are required to pay a \$170 per-month assessment for such licensed bed. This fee has not changed in recent years and represents a \$20 per-month increase from the prior fee (effective fiscal year 2010) of \$150, and a \$95 per month increase from the fiscal year 2009 fee (\$75). Nursing facilities receive an \$9.65 add-on to Medicaid rates as reimbursement for the quality assurance fee. This add-on has not changed in recent years and represents a 13.3% increase from the prior add-on (effective fiscal year 2010) of \$8.52 and a 161.5% increase from the fiscal year 2009 add-on of \$3.69.

MEDICAID RATE CALCULATION SYSTEM

Wisconsin uses a prospective, cost- and price-based, case mix adjusted facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. In addition, effective July 1, 2011, the state converted from the RUG III to RUG IV system for adjusting Direct Care component rates for acuity.

COST CENTERS

Wisconsin uses the following four costs centers to calculate its facility-specific Medicaid rates:

- The Direct Care cost component consists of two subcomponents:
 - The Nursing Service cost subcomponent includes costs associated with registered nurses, nurse practitioners, licensed practical nurses, qualified mental retardation professionals (nursing), resident living staff, feeding assistants, nurse aide training, nurse aide training supplies, nurse aides, nurse assistants and resident living staff.
 - The Other Supplies and Services cost subcomponent includes costs associated with ward clerks, non-billable physician services, active treatment, volunteer coordinator, social service personnel, religious services and other special care, qualified mental retardation professionals (other), purchased laundry/diaper, diapers and underpads, catheter and irrigation supplies, other medical supplies, non-billable/lab, X-ray, pharmacy, therapies, dental, psychiatric services, respiratory services, physician supplies, qualified mental retardation professionals (nursing), qualified mental retardation (other), active treatment, volunteer coordinator, social service, recreation, religious services and other special care (supplies).
- The Support Services cost component includes costs associated with dietary service expenses, environmental service expenses, administrative and general services, central office costs, management service contract fees, nursing home valuations, and fuel and other utility expenses.
- The Property Tax cost component includes real and personal property taxes, as well as municipal service fees.
- The Property cost component includes costs associated with a nursing home's expenses related to ownership and/or rental of the land, land improvements, buildings, fixed and movable equipment, and other physical assets.

INFLATION AND REBASING

Wisconsin partially rebases Medicaid rates annually utilizing the most recent cost report data available, with the exception of property tax data. Property tax data is based on the most recent tax bill information available at the beginning of the rate year. The rate year for Wisconsin is from July 1 to June 30. The state has rebased rates every year since July 1, 2010. The state most recently rebased rates in fiscal year 2019 (effective July 1, 2018) utilizing 2017 cost report data.

Wisconsin adjusts Medicaid rates quarterly for a nursing facility's reimbursement period case mix index (CMI). The Other Supplies and Services cost subcomponent and Support Services cost component rates are standard, statewide, price-based rates that are predominantly determined based on budget appropriations. The state also determines a standard statewide Nursing Service cost subcomponent base rate; this is compared to the facility specific per diem Nursing Service expense in determining rates.

Given budget limitations, the state calculated fiscal year 2012 rates to be budget neutral. The state inflated the Direct Care cost component rates to offset facilities' lower anticipated CMI scores under RUG IV. The standard statewide Support Services price was frozen at the July 1, 2010, level. In addition, the statewide standard value per bed utilized to determine of the Property cost component rates was frozen at the July 1, 2010, level. With the exception of a 0.8% budgeted funding increase for acuity adjustments, nursing facility rates were budget neutral in fiscal year 2013. Rates in fiscal year 2014 (effectively July 1, 2013) were also limited by budget appropriations. The state's budget allowed for an approximate 2.2% increase for acuity adjustments. According to rate setting professionals, in fiscal year 2015 the state budgeted an approximate 2.0% overall funding increase for nursing facility Medicaid rates. This increase was determined to cover rate increases related to acuity adjustments. However, a zero increase budget was applied to fiscal year 2016 nursing facility Medicaid rates. In order to account for potential rate increases related to acuity adjustments, the state slightly reduced to the Support Services statewide price effective July 1, 2015. This will be further detailed in the Rate Methodology section of this overview. However, state rate setting officials have indicated that the state will pay for any rate increases above the budgeted amount related to acuity adjustments.

In fiscal year 2018 (effective July 1, 2017), the state budgeted an approximate 1.0% increase in funding for nursing facility Medicaid rates. Similar to prior years, in order to fund increases related to acuity adjustments, the Support Services statewide price remained unchanged from the prior rate effective July 1, 2015. In addition, state rate setting officials have indicated that the state will pay for any rate increases above the budgeted amount related to acuity adjustments.

In a normal rebasing year, Wisconsin utilizes the Global Insight Market Basket Index to determine specific inflation and deflation factors for non-property nursing services expenses based on a nursing facility's fiscal year (cost report) year-end.

The most recent inflation and deflation factors effective July 1, 2018 are displayed as follows:

Inflation Factors by Quarter of Cost Report Year End				
	January February March-17	April May June-17	July August September-17	October November December-17
Direct Care:				
Wages	7.3%	6.3%	5.3%	4.5%
Fringe Benefits	1.3%	1.5%	1.9%	2.4%
Supplies	4.8%	4.3%	3.8%	3.3%
Purchased Services	6.9%	6.2%	5.5%	4.5%
Composite Support Services Expenses	5.9%	5.1%	4.4%	3.9%

According to state rate setting professionals, the state increased nursing facility Medicaid rates in fiscal years 2018 (effective July 1, 2017) and 2019 (effective July 1, 2018) by approximately 2.0%, respectively. Based on the approved state budget, nursing facilities will receive an approximately 7.0% rate increase effective July 1, 2019. As of the date of this overview, how this will be accomplished is still in the process of being determined.

RATE METHODOLOGY

Wisconsin converted from a level of care case mix classification system to the RUG system on July 1, 2008. Effective July 1, 2011, the state began utilizing CMI data derived from the RUG IV, 48 RUG Grouper. The initial RUG system was based on the RUG III system, and includes 34 RUG categories. The minimum data set (MDS) assessment instrument will be utilized to gather case mix data for residents and to categorize residents into one of 48 specific RUG categories.

The Direct Care cost component is calculated utilizing two CMIs, the all-resident facility CMI (for all payors) and the reimbursement period CMI (for Medicaid residents only). In addition, nursing facilities with 50 or less beds will have their CMIs increased by 20%. Separate Direct Care allowances will be calculated for facilities certified as Intermediate Care Facilities for People with Mental Retardation (ICF/MRs), or the distinct ICF/MR portion of a combined operation, and for facilities certified as nursing facilities. The targets and CMIs for Direct Care services may differ for nursing facilities and ICF/MRs.

Prior to July 1, 2014, the all-resident facility CMI is the average RUG CMI for the last days of those calendar quarters ("picture dates") that occur during the cost reporting period. However, effective July 1, 2014, the state now adjusts Direct Care cost component rates quarterly utilizing average CMIs for the entire cost report quarter.

The RUG reimbursement period CMI is based on the average CMI for Medicaid residents (non-developmentally disabled) as of the specific cost report quarter. The cost report quarters utilized for the current rate period are as follows:

- Rates effective July 1, 2018: Picture Quarter - October 1, 2017 to December 31, 2017;
- Rates effective October 1, 2018: Picture Quarter - January 1, 2018, to March 31, 2018;
- Rates effective January 1, 2019: Picture Quarter - April 1, 2018, to June 30, 2018;
- Rates effective April 1, 2019: Picture Quarter - July 1, 2018, to September 30, 2018.

A facility-specific nursing per diem cost figure is determined by dividing total allowable inflated nursing services expenses (including allocated fringe benefits expenses) by total patient days. The facility-specific nursing per diem cost is then neutralized for case mix by dividing it by a facility-specific all-resident RUG CMI. The result is then compared to a facility-specific nursing services cost target per diem figure. If a nursing facility's case mix neutralized nursing per diem cost figure is greater than or equal to the target per diem cost figure, then the facility is reimbursed the target per diem cost figure. If a nursing facility's case mix neutralized nursing per diem cost figure is less than or equal to the target per diem, then the facility is reimbursed the case mix neutralized nursing per diem cost figure.

The target per diem cost figure is calculated by multiplying a state base rate by a facility-specific labor factor. The current state base rate effective July 1, 2018, is \$84.25 per resident day, which represents a 1.4% increase from the prior base of \$83.69 (effective July 1, 2017). The July 1, 2017 rate represents a 7.1% increase from the rate (\$78.14) effective July 1, 2016. Effective July 1, 2014 to June 30, 2016 the base rate was \$77.28. The prior base rate of \$75.83 was effective July 1, 2013. Labor factors are calculated annually based on differences in nursing facility wage rates by geographic regions, which generally correspond to Medicare's PPS core-based statistical areas (CBSAs).

Effective July 1, 2018, the above determined amount is increased by a flat dollar price of \$14.26 to cover the Other Supplies and Services per diem costs. This represents a \$0.60 increase from the prior price (\$13.66) effective July 1, 2017. The price effective July 1, 2016 was \$13.12. Prior to this rate, the Other Supplies and Services flat dollar price had been frozen at \$12.70 since July 1, 2013. The total sum of these allowances is multiplied by a facility-specific Medicaid RUG CMI to arrive at the final Medicaid per diem rate for Direct Care.

The final Medicaid Nursing component per diem rate is adjusted quarterly for changes in the acuity of Medicaid residents by updating the facility-specific Medicaid RUG CMI. The facility-specific Medicaid RUG CMIs are based on average CMIs for the cost report quarter three quarters prior to the rate effective date. A special 20% adjustment in allowable levels is available to facilities with 50 beds or less.

The Support Services cost component rate is a standard statewide price for all applicable nursing facilities. The rate is determined by summing the statewide Support Services cost component target rate and the per resident day inflation increment. The Support Services target rate is determined by budget appropriations and cost report data, including the cost data for the base year and the most recent cost reports available. Effective July 1, 2018, the statewide target rate is \$47.38, which is moderately greater than the rate (\$46.21) effective July 1, 2017. The rate effective July 1, 2016 (\$44.95) remained unchanged from the prior rate (effective July 1, 2015). This rate represented a 2.8% decrease from the price (\$46.21) effective July 1, 2014.

As previously mentioned, in fiscal year 2016 (effective July 1, 2015) the budget for nursing home Medicaid reimbursement was frozen. The Support Services price was reduced in order to provide

the state with funds to pay for any increases in acuity. Prior to this decrease, the price had increased from \$45.60 (effective July 1, 2010) to \$46.21 effective July 1, 2014. Given the limited budgetary increase (1.0%) for nursing home rates in fiscal year 2017, this price remained frozen effective July 1, 2016.

The Property Tax cost component is reimbursed based on actual costs. A tax-paying facility's allowable property tax expense is based on the tax due when the payment rate year begins, increased by an inflation factor (currently 0.7%) to adjust payment and expense to the payment rate year. For tax-exempt facilities, the property tax allowance may include the cost of needed municipal services, with the cost being the expense for the services provided to the facility in the calendar year prior to the beginning of the payment rate year as appropriately accrued to that period. The Property Tax cost component rate is calculated by dividing allowable inflated property tax expenses by total patient days. Prior to calculating the per diem rate, allowable expenses are adjusted to eliminate expenses that are unrelated to a nursing facility's operations.

The Property cost component rate is intended to provide payment for ownership, and/or rental of land, land improvements, buildings, fixed and movable equipment and any other long-term, physical assets. Allowable property costs are subject to a maximum based on the appraised equalized value of the nursing home.

The equalized value is determined by an independent contractor under contract with the state using the Marshall and Swift Building Valuation System - Commercial (BVS). A valuation of applicable nursing facilities is completed once every three years. Equalized values are inflated in non-valuation years.

The equalized value represents depreciated replacement costs. Prior to reducing the replacement value by depreciation, the nursing facility's replacement value per bed is compared to a statewide maximum. The statewide maximum value per bed effective July 1, 2018, is \$75,900. This value has been frozen since July 1, 2010. If the facility-specific value per bed exceeds the maximum, the equalized value is reduced proportionately.

A nursing facility's property-related expenses are comparable to a facility-specific property-related target, which equates to 7.5% of a nursing facility's equalized value. If allowable property-related expenses (depreciation and amortization, interest, leases and property insurance) are greater than the target amount, the facility is reimbursed its costs plus an incentive share. The incentive share equates to 20% of the difference between the nursing facility's actual costs and the target amount. If allowable property-related expenses are less than the target amount, the facility receives its actual costs. Annual allowable property-related expenses are limited to 15.0% of the equalized value of the facility. The per-patient-day property payment allowance is the property allowance divided by patient days. If a nursing facility contains 50 or less beds, the incentive share is increased to 40.0%. In addition, Property cost component rates effective July 1, 2018, were not reduced by more than \$3.50 from the rate effective June 30, 2016, unless a facility is recently constructed or renovated.

Wisconsin offers several incentive add-ons to nursing home providers. These incentives include two behavior/cognitive impairment incentives (BEHCI-13 and BEHCI-14), a bariatric equipment incentive (BEI), an exceptional Medicaid/Medicare utilization incentive (EMMUI), a private room incentive (PRI), an innovative area incentive (IAI) and a Medicaid assessment incentive (MAI). The BEHCI-13 and BEHCI-14 provides additional reimbursement for costs associated with the care of patients with specific cognitive or behavioral difficulties. A Behavioral Score Incentive Score (BCIS) is calculated for each facility based on certain MDS data elements measuring patients' moods and behaviors. This BCIS score is multiplied by a base rate to calculate both incentives. Effective July 1, 2018, the BCHCI-13 incentive base is \$4.620 and the BCHCI-14 incentive is \$0.560.

The BEI add-on equates to the cost of acquisitions of bariatric moveable equipment during the base cost reporting period divided by total patient days and then multiplied by 50%.

The EMMUI is based upon the ratio of total Medicaid/Medicare patient days to total patient days. If this ratio is greater than or equal to 70.0%, the nursing facility is eligible to receive the EMMUI. The EMMUI is based upon the bed size of the facility and the location of the facility. Nursing facilities located in the city of Milwaukee receive a different incentive add-on than the remainder of the state. The following table displays the EMMUIs:

Min	Max	Incentive	Incentive	Incentive
MM%	MM%	>50 Beds	<=50 Beds	City of Milw.
95.00%	100.00%	2.70	4.20	4.60
90.00%	94.99%	2.45	3.65	4.00
85.00%	89.99%	2.20	3.10	3.40
80.00%	84.99%	1.90	2.50	2.75
75.00%	79.99%	1.70	2.00	2.20
70.00%	74.99%	1.50	1.50	1.65

The PRI is offered as a basic PRI or replacement private room incentive (RPRI). The basic PRI is the ratio of private rooms to total licensed beds multiplied by the basic base allowance of \$1.00. The total number of private rooms and licensed beds is the estimate as of the last day of the cost report used in the rate calculation. Nursing facilities are required to have at least 15.0% of their licensed beds in private rooms and Medicare and Medicaid patient days must equate to 65% or greater of total patient days.

The RPRI is the ratio of private rooms to total licensed beds multiplied by the basic base allowance of \$2.00. The RPRI requires private rooms divided by total licensed beds to be greater than or equal to 90.0%. Facilities can only receive one incentive and must have a Medicaid/Medicare ratio greater than or equal to 65.0% in order to be eligible for either incentive.

The IAI is an incentive for nursing facilities to allow for improvement of both the physical environment and the quality of resident life, through either renovation or replacement of the nursing home building. The methodology for calculating this incentive has been in place since July 1, 2012. There are four incentive options under the program as follows:

- Nursing Home Downsizing Program - a nursing facility plans to reduce its current census by 15% or more, reduce licensed beds and replace or renovate the facility. Medicaid payment levels will be frozen during the approved phase-down. After the phase-down is complete, Medicaid rates will be reestablished using a cost report that is based on the post-phase-down cost structure. The cost of increased reimbursement rates will not exceed documented saving to the state.
- Replacement Facility Program - the facility plans to replace its current facility, or partially replace its facility or reduce licensed beds. Once the new construction is completed, Medicaid rates will be adjusted to increase the un-depreciated replacement cost (URC) used to determine the Property component rates by \$75,900 to \$135,000. In the case of partial facility replacement, the URC on non-replacement beds would not change. The cost of increased reimbursement rates will not exceed documented saving to the state.
- Small Replacement Facility/Renovation Program - 60 beds - the facility plans to replace or renovate its current facility, resulting in a licensed bed capacity between 51 and 60 beds. Once the new construction is completed, Medicaid rates will be adjusted to increase the URC used to determine the Property component rates by \$75,900 to \$135,000. In the case of partial facility replacement, the URC on non-replacement beds would not change. Also, subject to approval by the state, the nursing facility could receive an additional add-on of up to \$5.00 per Medicaid day. The cost of increased reimbursement rates will not exceed documented saving to the state.
- Small Replacement Facility/Renovation Program - 50 beds - the facility plans to replace or renovate its current facility, resulting in a licensed bed capacity of 50 or fewer beds. Once the new construction is completed, Medicaid rates will be adjusted to increase the URC used to determine the Property component rates by \$75,900 to \$135,000. In the case of partial facility replacement, the URC on non-replacement beds would not change. Also, subject to approval by the state, the nursing facility could receive an additional add-on of up to \$10.00 per Medicaid day. The cost of increased reimbursement rates will not exceed documented saving to the state.

In addition, nursing facilities that had previously been granted approval for an IAI add-on under the previous year's methodology (prior to July 1, 2012) will continue to receive that add-on. Under the previous methodology nursing facilities were eligible for the add-on if they completed a partial or total replacement and meet the following criteria:

- The facility received approval from the state to complete the replacement or renovation.
- Construction started after the approval date.
- 80% of the facility's rooms are private rooms with private bathrooms.
- The facility contains 50 or more licensed beds.

The incentive was calculated by multiplying \$10.00 by the number of Medicaid patient days in the approved area and then dividing the sum of this calculation by total Medicaid patient days. However, effective fiscal year 2016, any facility that was

granted this add-on prior to July 1, 2012, that has not completed a renovation or replacement project has had this add-on taken away.

The MAI is the repayment of the quality assurance fee and has been set at \$9.65 since August 1, 2009.

The average nursing facility in Wisconsin was reimbursed \$158.73 in fiscal year 2011, \$164.99 in fiscal year 2012, \$165.08 in fiscal year 2013 and \$168.70 in fiscal year 2014. The most recent average rate (\$168.70) represents a 2.2% increase from the prior year rate. Average rate data is not yet available for fiscal years 2015, 2016 and 2017. However, total funds that were dedicated to Medicaid nursing facility reimbursement were increased 2.0% , 0.0% and 1.0% for these periods, respectively. The average rate effective July 1, 2018, is \$189.33. This rate represents a 3.4% rate increase from the average rate effective July 1, 2017 (\$183.11).

MINIMUM OCCUPANCY STANDARDS

Minimum occupancy standards are not applicable in Wisconsin.

OTHER RATE PROVISIONS

Bed hold days are paid to qualifying nursing facilities, and are payable up to 15 consecutive days for each hospitalization and an unlimited number of days for each therapeutic leave. In order to qualify, a provider's occupancy level must be 94.0% or greater during the calendar month prior to the bed hold leave days. Nursing facilities are reimbursed at a 0.25 RUG classification rate for qualifying nursing facilities.

There is no payment rate recalculation due to a change of ownership of a facility or operation that occurs during the payment rate year. The new provider is paid the rate that the former owner was paid or would have been paid if no change of ownership had occurred.

New facilities will receive an interim rate during the start-up period, which consists of the initial twelve months from the date of facility licensure. During the start-up period, a facility's minimum patient days for the property and property

tax allowances will be 50% occupancy of licensed beds. Actual patient days will be used if greater than the minimum. If an existing licensed facility becomes certified for Medicaid after the start-up period, the facility must provide a cost report covering at least six months for rates to be established.

Replacement facilities, or facilities that have replaced at least 25% of their licensed bed capacity or 50 beds, may request a property payment allowance adjustment based on a cost report covering at least six months of new property costs following the licensure of the replacement area. The adjusted property payment allowance will be effective as of the date of licensure. No phase-in or start-up provisions will apply to property payment allowances for facilities receiving adjustments for replacement facilities.

Wisconsin utilizes a managed care organization (Family Care program) to coordinate healthcare services (including long-term care) to many of its Medicaid-eligible residents. Managed care organizations, or MCOs, are reimbursed by the state a specific amount on a capitated basis (per member per month). Effective July 1, 2018, all counties in the state are participating in the program.

Although MCOs can negotiate rates with nursing facilities, the MCOs are still required by the state at a minimum to reimburse nursing facilities at rates determined utilizing the above described reimbursement methodology (fee for service rates). An MCO's rate for each nursing facility must be calculated at least quarterly and be based upon the MCO members' RUG classes.

Rates paid by MCOs to the nursing facility can be a weighted average of the 48 RUG rates for MCO residents in the nursing facility or can be resident specific, depending on what the nursing facility and MCO agreed upon in their contract.

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There is no proposed state legislation that will affect the current Medicaid calculation in Wisconsin.

WISCONSIN COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	58.50	50.00	50.00		87.00	81.00	81.00		120.00	110.00	108.50
Average Daily Census	46.59	43.49	43.28		67.28	63.53	61.78		94.17	86.32	82.54
Occupancy	72.6%	68.5%	68.4%		83.1%	80.7%	81.0%		90.1%	89.4%	87.7%
Payor Mix Statistics											
Medicare	7.7%	7.2%	6.6%		11.2%	10.8%	10.5%		15.4%	15.0%	14.8%
Medicaid	49.2%	49.4%	49.2%		58.5%	59.5%	61.6%		67.1%	68.0%	69.6%
Other	23.3%	23.5%	20.2%		33.9%	33.4%	30.2%		56.0%	55.6%	43.1%
Avg. Length of Stay Statistics (Days)											
Medicare	31.23	31.24	28.46		37.70	37.20	35.13		49.11	45.26	43.68
Medicaid	268.36	267.27	252.72		470.00	429.88	396.37		768.23	668.54	573.75
Other	69.06	59.51	50.40		108.05	99.65	91.14		176.78	167.82	152.35
Revenue (PPD)											
Inpatient	\$213.34	\$217.70	\$223.87		\$246.78	\$250.75	\$261.96		\$290.21	\$291.53	\$302.24
Ancillary	\$38.76	\$37.60	\$37.45		\$62.68	\$69.13	\$67.50		\$95.48	\$101.23	\$108.58
TOTAL	\$253.66	\$261.07	\$268.91		\$323.06	\$329.96	\$350.18		\$382.13	\$394.47	\$419.43
Expenses (PPD)											
Employee Benefits	\$19.10	\$19.12	\$20.19		\$25.09	\$28.28	\$27.81		\$40.22	\$41.17	\$41.42
Administrative and General	\$31.25	\$33.26	\$33.47		\$37.77	\$41.64	\$43.41		\$48.66	\$52.44	\$53.99
Plant Operations	\$9.81	\$10.53	\$10.06		\$11.84	\$12.54	\$12.44		\$14.86	\$15.47	\$15.31
Laundry & Linens	\$2.20	\$2.09	\$1.93		\$3.01	\$2.88	\$2.96		\$3.84	\$3.85	\$3.99
Housekeeping	\$4.78	\$5.09	\$4.95		\$5.94	\$6.44	\$6.28		\$7.60	\$8.07	\$8.01
Dietary	\$16.25	\$17.02	\$17.08		\$19.38	\$20.09	\$20.47		\$23.72	\$25.03	\$26.09
Nursing & Medical Related	\$82.45	\$88.36	\$88.15		\$92.64	\$100.81	\$103.09		\$106.15	\$117.30	\$119.31
Ancillary and Pharmacy	\$20.47	\$20.14	\$19.90		\$28.29	\$28.23	\$27.63		\$38.75	\$38.23	\$37.13
Social Services	\$2.15	\$2.36	\$2.41		\$3.22	\$3.38	\$3.49		\$4.80	\$4.82	\$5.30

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

Wyoming



INTRODUCTION

Nursing facilities in Wyoming are licensed by the Wyoming Department of Health (DOH), Healthcare Licensing and Surveys Division under the designation "Nursing Care Facilities." The following table summarizes nursing facilities within the state:

NURSING FACILITIES IN WYOMING	
Licensed Nursing Facilities*	24
Licensed Nursing Beds*	2,083
Beds per 1,000 Aged 65 >**	22.58
Beds per 1,000 Aged 75 >**	58.96
Occupancy Percentage - 2017*	81.60%

*Source: 2017 Medicare Cost Reports

**Source: Environics Analytics- 2018 Population

CERTIFICATE OF NEED

Wyoming does not require an individual or organization to obtain a CON to construct or acquire a nursing facility or to increase the capacity and services offered at an existing facility. In addition, there is no moratorium on the construction of nursing facility beds in Wyoming.

However, Wyoming healthcare facilities are subject to construction and expansion limits. Nursing facilities cannot be constructed or expanded if the average nursing facility occupancy (excluding Veteran's Affairs beds) within the construction area is 85.0% or below. The construction area is defined as 30 highway-miles from any existing nursing facility or hospital with swing beds. Wyoming's low statewide average nursing facility occupancy, in conjunction with this limitation, has minimized the construction of new nursing beds. Notwithstanding this limit, any nursing facility may increase its bed capacity by 10.0% (not to exceed 10 beds) over a two-year period.

BED NEED METHODOLOGY

Wyoming does not possess a bed need methodology and is not in the process of developing a bed need calculation.

QUALITY ASSESSMENT FEE

Effective April 1, 2011, Wyoming implemented a quality assessment fee known as the Nursing Facility Assessment (NFA). The state determines the NFA annually effective October of that year. The NFA was \$22.26 (effective October 1, 2017) per non-Medicare day. This represented a \$0.66 increase from the prior rate of \$21.60 (effective October 1, 2016). The NFA increased to \$22.81 effective October 1, 2018. The NFA effective October 1, 2019 is yet to be determined.

Wyoming nursing facilities are reimbursed for the assessment fee on a quarterly supplemental basis as determined by payor class (private nursing care facilities and non-state government-owned nursing facilities). The supplemental payment is based on the facility's actual Medicaid days. Effective October 1, 2018, the per-Medicaid-day amount used to determine supplemental payments is \$62.70 for private nursing care facilities and \$67.47 for non-state government owned nursing facilities.

MEDICAID RATE CALCULATION SYSTEM

Effective July 1, 2015, Wyoming converted to a prospective, cost- and price-based, case mix adjusted, facility-specific rate setting methodology to calculate per diem Medicaid rates for nursing facilities. The prior system utilized by the state was a prospective, cost-basis, facility-specific system that did not adjust rates for acuity.

COSTS CENTERS

Per diem reimbursement rates are based on the following three cost components:

- The Health Care cost component includes direct labor costs (including payroll taxes and employee benefits) associated with registered nurses, licensed practical nurses, nurse assistants and certified nurse assistants, and contracted nurses. The component also includes medical records and social services expenses.
- The Capital cost component is calculated in lieu of leasehold amortization, rent/lease expenses, straight-line depreciation and interest on real estate and personal property.
- The Operating cost component includes costs associated with plant operations, housekeeping, laundry, medical records, patient-related administration costs (including home office and management fees), dietary and nurse administration
- The Exempt cost component includes property taxes, property insurance and utilities.

INFLATION AND REBASING

Effective July 1, 2015, the state's Medicaid rate year was changed to July 1 to June 30. Prior to this date, the rate year was from October 1 to September 30. Statewide prices and Facility-specific Exempt rates are rebased annually utilizing the most recent cost report in the prior calendar year. July 1, 2016 prices and rates were determined utilizing 2014 cost report data. July 1, 2017, July 1, 2018 and July 1, 2019 prices and rates were determined utilizing 2015, 2016 and 2017 cost report data, respectively.

Prior to July 1, 2015, Medicaid rates had been frozen since October 1, 2009. Given this factor, the Centers for Medicare and Medicaid (CMS) directed the state to remove any obligation requiring inflation adjustments from its rate setting regulations. Rate increases are now budgeted for each biennium.

The state first funds the Property and Exempt cost component rates, and then utilizes the remaining balance of the budget to fund the Healthcare and Operating rate components. These remaining funds are allocated between the two remaining cost components based on each component's proportionate share of the combined total costs for both components

The following is the state's current reimbursement methodology.

RATE METHODOLOGY

The Healthcare rate component is initially determined as a fixed statewide price for all facilities. The price is calculated based on two factors, budgeted funding and current cost report data. The

current Healthcare price is \$85.64 (effective July 1, 2017). The Healthcare statewide price is adjusted quarterly by a nursing facilities case mix index (CMI), which converts to price into a facility-specific rate. The state utilizes the RUG IV, 48-RUG Grouper to adjust nursing facilities for CMI.

The Healthcare price is adjusted quarterly for each individual facility based on each community's Medicaid CMI. The CMI adjustment is calculated by multiplying the statewide price by the product of dividing the facility's weighted average Medicaid CMI by the statewide average Medicaid statewide CMI. The facility-specific and statewide Medicaid CMIs are determined based on case mix data for the quarter prior to the rate effective data. For example, July 1 rates will be based CMI data derived from January 1 to March 31.

As previously mentioned, the statewide operating price is determined based on budgeted funding and current cost report data. The current Operating price is \$79.50 (effective July 1, 2019).

The Property rate is paid to nursing facilities in lieu of leasehold amortization, rental/lease expense, depreciation and interest on real estate and personal property. Property rates are standard rates based on the age of the facility. Property rates were initially determined on July 1, 2015, based on each facilities age. Effective July 1, 2015, these rates could range from \$10.64 (facilities 40 years old or greater) to \$15.55 (new facilities - less than a year old). Building ages are increased each period by one year. These rates also are inflated (or deflated) annually using the "Annual Cost Changes" published in the "Current Building Cost Index" section of the Marshall Swift publication (or its successor). Specifically, the Annual Cost Changes for the Western Region, Class D is utilized to adjust property rates.

Nursing facilities that complete major repairs, remodelings, renovations or replacements may be eligible for a re-age adjustment. The re-age adjustment formula is as follows:

$$R = 40 \times E/S \times C$$

R = Re-age Adjustment

E = Actual expenses for the construction

S = Total square footage of the building

C = The cost of construction for the building in the year construction was completed.

If "R" is equal to or greater than 1.0, the age of the building will be reduced by this number.

Nursing facility Exempt cost component rates are reimbursed as a direct pass-through of expenses based on the most recent data available.

The initial Acuity Adjustment Rate equates to the sum of the acuity adjusted healthcare price, the operating price, the property rate and the exempt rate. However, nursing facility rates are than adjusted by bed range group. Each group will receive a percentage adjustment increase or decrease so the resulting cost coverage averages of each group are within three percent of each other. The bed ranges are as follows: 10 to 59 licensed beds; 60 to

100 licensed beds and 101 to 192 licensed beds.

Nursing facility rates effective July 1, 2015, were held harmless to June 30, 2015 rates. If a facility's July 1, 2015 rate was less than its June 30, 2015 rate, the facility was reimbursed its June 30, 2015 rate. In addition, if rates effective January 1, 2016, were less than rates effective June 30, 2015, nursing facilities were reimbursed 50.0% of this variance. The Hold Harmless provision was eliminated effective July 1, 2016.

The statewide weighted average rate effective July 1, 2017, is \$184.32, which represents a 1.3% increase from the rate (\$181.96) effective July 1, 2016. The prior rate effective July 1, 2015 was \$183.84. Statewide average rates were not available for July 1, 2018 and July 1, 2019.

MINIMUM OCCUPANCY STANDARDS

The state eliminated its minimum occupancy percentage effective July 1, 2015.

OTHER RATE PROVISIONS

Facilities may receive their current per diem Medicaid rate for reserved bed days during temporary absences if an appropriate bed is not available during the time for which reimbursement is sought. Reimbursement for temporary absences is limited to 14 days per calendar year. In addition, to be eligible for reimbursement, the facility must also maintain an occupancy level of at least 90.0% for the month in which the absence occurs.

New nursing facilities rate will equate to the sum of the following:

- The facility will receive the statewide Healthcare price with quarterly adjustments for CMI using the facility's CMI scores. If the nursing facility does not have the qualifying CMI data at the time the rate is calculated, the average statewide Medicaid CMI for the prior quarter will be utilized for the facility.
- The facility will receive the Property rate equivalent for the age of the building. If the building age cannot be determined at the time of rate setting, the provider will receive a Property rate based on a 40-year old building. The rate will be retroactively adjusted to reflect the revised age at the beginning of the next rate year.
- The facility's exempt rate will equate to the statewide average rate calculated in the previous quarter.

A new nursing facility's rate will be determined in this manner until the provider has a qualifying cost report on file that has been subject to an audit.

A facility that has a change of ownership essentially receives the per diem rate in effect for that facility on the date of the change of ownership. This rate will be utilized until the provider has a qualified cost report on file that has been subject to an audit. However, the rate will be adjusted quarterly for CMI. If the new owner does not have CMI data at the time rates are calculated, the prior owners CMI (for the previous quarter) will be utilized until updated CMI data is available.

Wyoming will also negotiate rates on a case-by-case basis for services provided to an extraordinary resident to cover the cost of medically necessary services and supplies that are included in the per diem rate.

INTERGOVERNMENTAL TRANSFERS

In 2017, Wyoming approved the Intergovernmental Transfer (IGT) Program. Similar to the quality assessment fees (i.e. provider taxes) this is another mechanism that states use to draw extra matching funds from the Centers of Medicare and Medicaid (CMS). This typically involves temporarily transferring funds from local/county hospitals to the state. The state claims this as Medicaid funding provided by the state, which CMS matches at the state's Federal Medical Assistance Percentage (FMAP). These percentages range from approximately 50.0% to 76.98% in fiscal year 2020. After collecting the matching funds from CMS, the state reimburses county hospitals for their contributions and provides them with a portion of the additional funds generated through the IGT program.

The first step in determining this reimbursement is to calculate each facility's Upper Payment Limit (UPL). States pay hospitals under Medicaid reimbursement methodologies established in the State Plan, then estimate how much more the hospitals would have been paid for the services under Medicare principles. The difference between the payments and the estimate is the amount that is available for additional reimbursement and is referred to as the UPL.

Under this program, county or municipal hospitals or non-state governmental organizations (NSGOs) have been buying nursing facility licenses that allow the hospitals to draw down additional federal dollars based on the difference between the Medicaid UPL

and the Medicaid rate. Typically, the previous nursing home owner manages the facility.

The UPL is determined individually for each nursing facility by taking the difference between each facility's estimated Medicare and Medicaid rate multiplied by Medicaid resident days. Based on this change, a nursing facility's IGT reimbursement equates to the facility's UPL (Adjusted Medicare Rate - Medicaid Rate x Total Medicaid Days). The state adjusts Medicare rates to exclude expenses (pharmacy, laboratory, radiology) not reimbursed by Medicaid.

Nursing home operators that have sold their facilities to county hospitals are typically engaged as management companies for facilities, and are typically reimbursed their portion of the IGT revenue through some type of pre-determined arrangement. There are currently five formerly private-owned facilities in the state that participate in the program. These facilities are typically reimbursed through supplemental payments; however, no information on the details of existing payment arrangements and average UPL/IGT reimbursement was available as of the date of this overview

PROPOSED CHANGES TO THE MEDICAID RATE CALCULATION

There are currently no planned changes to the state's reimbursement system.

WYOMING COST REPORT STATISTICS											
General Statistics	Lower Quartile Values				Median Values				Upper Quartile Values		
	2015	2016	2017		2015	2016	2017		2015	2016	2017
Number of Beds	59.00	52.25	60.50		86.00	72.00	86.50		118.00	114.75	119.50
Average Daily Census	47.51	43.79	51.35		62.74	56.27	69.10		93.31	97.89	99.58
Occupancy	73.6%	71.5%	73.0%		83.8%	81.8%	85.5%		89.0%	92.9%	89.0%
Payor Mix Statistics											
Medicare	10.3%	8.8%	7.6%		12.3%	11.2%	12.1%		14.3%	14.5%	16.4%
Medicaid	52.4%	55.1%	53.3%		60.5%	65.1%	62.0%		68.0%	71.1%	74.1%
Other	21.2%	20.4%	16.8%		24.1%	22.2%	22.3%		30.5%	31.1%	29.6%
Avg. Length of Stay Statistics (Days)											
Medicare	30.43	31.71	32.98		51.25	46.25	43.51		64.61	59.63	73.08
Medicaid	317.71	310.89	286.02		449.90	508.55	397.67		759.69	633.87	513.35
Other	149.11	108.70	88.28		229.19	162.17	122.62		362.75	308.47	201.85
Revenue (PPD)											
Inpatient	\$205.12	\$208.93	\$253.52		\$221.82	\$255.30	\$312.71		\$258.82	\$293.42	\$400.00
Ancillary	\$44.76	\$30.67	\$35.30		\$49.00	\$42.47	\$51.95		\$59.31	\$57.61	\$69.65
TOTAL	\$257.84	\$238.67	\$320.81		\$276.04	\$313.87	\$345.52		\$303.78	\$343.12	\$465.28
Expenses (PPD)											
Employee Benefits	\$20.07	\$24.22	\$22.46		\$28.13	\$31.26	\$30.30		\$35.22	\$35.14	\$32.30
Administrative and General	\$45.57	\$45.35	\$52.48		\$52.40	\$51.91	\$55.63		\$55.66	\$56.43	\$68.45
Plant Operations	\$9.78	\$10.20	\$10.05		\$11.56	\$11.38	\$12.00		\$13.48	\$13.87	\$13.16
Laundry & Linens	\$1.89	\$0.79	\$0.74		\$2.68	\$2.44	\$2.58		\$3.06	\$3.10	\$3.26
Housekeeping	\$4.82	\$4.71	\$4.75		\$5.34	\$6.03	\$6.77		\$6.80	\$7.84	\$8.20
Dietary	\$16.88	\$16.57	\$16.19		\$21.12	\$20.26	\$20.15		\$23.19	\$22.57	\$23.02
Nursing & Medical Related	\$77.11	\$76.10	\$82.14		\$83.74	\$82.80	\$91.45		\$101.83	\$99.41	\$105.36
Ancillary and Pharmacy	\$18.52	\$17.40	\$19.28		\$21.22	\$23.19	\$24.66		\$30.67	\$28.42	\$32.20
Social Services	\$2.49	\$3.07	\$2.86		\$3.55	\$4.07	\$4.70		\$6.81	\$6.13	\$5.97

The departmental expenses do not include capital-related expenses, management fees, certain insurances, miscellaneous expenses or non-reimbursable expenses.

■ *Star Rating System*

Star Rating System

STAR RATING SYSTEM

The Centers for Medicare and Medicaid Services (CMS) Five Star Quality Rating System is a comparative tool of nursing homes participating in the Medicare and Medicaid programs. The ratings are developed by CMS with the primary objective of helping consumers choose and compare nursing homes, within a state, for the placement of family members and loved ones. This system was initiated in 2008 and has been revised numerous times of the past eight years. CMS rates each nursing home within a state on three categories; State Health Inspection, Staffing Ratios, and Quality Measures. An overall rating, one to five stars, is then developed for each facility based on the results of the three independent star ratings. The three rating categories are summarized as follows:

- The first category utilized is state health inspection surveys, which are conducted to determine if a nursing home is meeting state and federal guidelines. Deficiencies are noted and if warranted a nursing home will receive a citation. Health inspection survey ratings are based on a state wide distribution with 20% of nursing homes receiving a 1-star rating, 2, 3 and 4 star ratings are equally distributed across the next 70%, and the final 10% of facilities receive a 5-star rating within the state.
- The next measurement is staffing ratios, which directly correlates the number of nurse hours per resident days. Adjustments are made for acuity of care and the different types of nurses. Staffing ratio data is self-reported from the prior two week period before the health inspection.
- Lastly, quality measures are taken into consideration. Currently CMS includes 11 measures, which are weighed equally. The different measures address short-term and long-term care patients and track patient's physical well-being, such as changes in mobility, pressure sores, mental illness, and injury from falls. Again, quality measures are produced from self-reported nursing home data.

The overall star rating begins with the health inspection rating, which is weighted higher than the other two measures. One star is added if the staffing ratio rating is above four stars, and one star is subtracted if the staffing ratio rating is a single star. Next, an additional star is added if the quality measure rating is five stars and one star is subtracted if the quality measure rating is one star. Thus, a facility with a two-star health inspection rating can achieve an overall four-star rating if the staffing ratio rating is four or five-star and the quality measures rating is five-star. Conversely, a facility with a four-star health inspection rating can have an overall two-star rating if the staffing ratio rating is one-star and the quality measure rating is also one-star.

Critics of the star-rating system cited the system's reliance on self-reported data and the ability of operators to manipulate staffing and quality measure reporting to achieve higher star ratings in these two categories, resulting in a higher overall star rating. For example, in 2015, 78% of nursing homes scored four- or five-stars in the Quality Measures category resulting in 54% of facilities with four- or five-star overall rating. The large shares of facilities with four- and five-star ratings resulted in the consumers' inability to easily compare and assess the relative performance of any one facility within a state.

In response to these concerns, CMS rebased the measurement system for both staffing ratios and quality measures in 2015. This rebasing changed the way staffing ratios were scored and required more points in the Quality Measures category to achieve two- or more stars. The intent of the rebasing was to make a greater and more identifiable distinction between three-, four-, and five-star facilities so that consumers could use the star rating system with greater confidence.

CMS made additional modifications to the Quality Measures category system in July 2016, with the changes being fully recognized beginning in January 2017. These modifications included a new measure for long-term residents and four new measures for short-term residents. They are summarized as follows:

- Percentage of long-term residents whose ability to move independently worsened
- Percentage of short-term residents whose physical function improves from admission to discharge
- Percentage of short-term residents who were re-hospitalized after a nursing home admission
- Percentage of short-term residents who have had an outpatient emergency department visit
- Percentage of short-term residents who were successfully discharged to the community

The addition of these quality measures were made to assist both consumers and hospitals in identifying nursing facilities with the most positive outcomes for residents. CMS will continue to monitor the star rating system and revise it as warranted to provide consumers with the most complete, current, and pertinent data necessary when deciding on a skilled nursing facility for either long-term or short-term care.

■ *Appendices*

Appendix A - State Summary Chart

Summary of States											
Operational Statistics				Licensing Factors			Medicaid Reimbursement System				
State	Number of facilities	Number of licensed beds	2017 Average Occupancy	Bed Need Calculation	Moratorium on new beds	Certificate of Need	Cost or Price Based?	Type of System?	Facility or Resident Specific?	Case Mix or Need/Acuity Adjusted?	Quality Assessment Fee
AK	6	249	91.10%	Yes	No	Yes	Cost	Prospective	Facility	No	No
AL	213	25,310	84.90%	Yes	Yes	Yes	Cost	Prospective	Facility	No	Yes
AR	224	23,574	72.10%	Yes	No	Yes	Cost & Price	Prospective	Facility	No	Yes
AZ	148	15,971	69.20%	No	No	No	Price	Prospective	Neither	Yes	Yes
CA	1,031	155,960	91.00%	No	No	No	Cost	Prospective	Facility	No	Yes
CO	211	19,599	81.40%	Yes	Yes	No	Cost	Prospective	Facility	Yes	Yes
CT	226	26,499	87.70%	No	Yes	Yes	Cost	Prospective	Facility	No	Yes
DC	13	2,062	91.60%	No	No	Yes	Cost	Prospective	Resident	Yes	Yes
DE	40	4,250	89.70%	Yes	No	Yes	Cost	Prospective	Resident	Yes	Yes
FL	677	81,915	86.60%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes
GA	335	37,008	85.30%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes
HI	31	3,016	76.80%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes
IA	402	27,891	77.50%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes
ID	73	5,990	66.00%	No	No	No	Cost	Prospective	Facility	Yes	Yes
IL	689	99,510	73.70%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes
IN	554	52,904	72.20%	No	Yes (Medicaid only)	No	Cost	Prospective	Facility	Yes	Yes
KS	288	19,941	80.00%	No	No	No	Cost	Prospective	Facility	Yes	Yes
KY	285	27,540	85.40%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes
LA	263	33,129	76.90%	No	Yes	Yes	Price	Prospective	Facility	Yes	Yes
MA	438	49,751	85.20%	Yes	Yes	Yes	Price	Prospective	Resident	Yes	Yes
MD	226	28,117	87.80%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes
ME	95	5,659	89.80%	Yes	No	Yes	Cost	Pro & Retro	Facility	Yes	Yes
MI	426	46,329	80.30%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes
MN	345	26,083	85.30%	No	Yes	No	Cost & Price	Prospective	Combination	Yes	Yes
MO	510	51,548	70.40%	Yes	No	Yes	Cost	Prospective	Facility	No	Yes
MS	173	16,313	87.30%	Yes	Yes	Yes	Cost	Prospective	Facility	Yes	Yes
MT	52	4,443	63.40%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes
NC	439	46,447	79.90%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes
ND	55	3,920	92.20%	No	Yes	No	Cost	Prospective	Combination	Yes	No
NE	175	12,867	74.60%	Yes	Yes	Yes	Cost	Prospective	Resident	Yes	Yes
NH	72	6,971	86.30%	No	Yes	No	Cost	Prospective	Facility	Yes	Yes
NJ	355	52,296	82.60%	No	No	Yes	Cost & Price	Prospective	Facility	Yes	Yes
NM	65	6,073	79.90%	No	No	No	Cost	Prospective	Facility	No	No
NV	46	5,549	81.80%	No	No	Yes	Price	Prospective	Facility	Yes	Yes
NY	582	106,271	93.80%	Yes	No	Yes	Price	Prospective	Facility	Yes	Yes
OH	993	92,219	80.90%	Yes	Yes	Yes	Price	Prospective	Facility	Yes	Yes
OK	310	24,917	73.90%	Yes	No	Yes	Cost & Price	Prospective	Facility	No	Yes
OR	121	9,927	82.60%	Yes	No	Yes	Price	Prospective	Neither	No	Yes
PA	703	91,201	84.90%	No	No	No	Cost	Prospective	Facility	Yes	Yes
RI	86	8,637	92.90%	No	Yes	Yes	Price	Prospective	Resident	Yes	Yes
SC	169	17,906	88.80%	Yes	Yes (Medicaid only)	Yes	Cost	Prospective	Facility	No	No
SD	75	4,435	85.80%	No	Yes	No	Cost	Prospective	Facility	Yes	No
TN	311	35,153	75.30%	Yes	Yes	Yes	Cost	Prospective	Facility	Yes	Yes
TX	1,284	146,616	67.60%	No	Yes	No	Price	Prospective	Resident	Yes	No
UT	73	5,767	66.30%	No	Yes	No	Price	Prospective	Facility	Yes	Yes
VA	265	29,859	87.80%	Yes	No	Yes	Price	Prospective	Resident	Yes	No
VT	33	2,509	83.80%	No	Yes	Yes	Cost	Prospective	Facility	Yes	Yes
WA	217	19,944	77.80%	Yes	No	Yes	Cost	Prospective	Facility	Yes	Yes
WI	377	31,897	75.60%	No	Yes	Yes	Cost & Price	Prospective	Facility	Yes	Yes
WV	78	7,418	88.70%	Yes	Yes	Yes	Cost	Prospective	Combination	Yes	Yes
WY	24	2,083	1	No	No	No	Cost & Price	Prospective	Facility	Yes	Yes

Appendix B - Beds per 1,000 Persons Aged 65 and 75 or Older by State

State	Beds	Beds Per 1,000 Aged 65+ Population	Beds Per 1,000 Aged 75+ Population
AK	249	2.97	7.54
AL	25,310	30.84	77.09
AR	23,574	46.38	113.04
AZ	15,971	13.15	31.81
CA	155,960	27.85	67.70
CO	19,599	24.41	64.59
CT	26,499	52.72	102.76
DC	2,062	24.07	59.01
DE	4,250	24.37	61.75
FL	81,915	18.93	43.62
GA	37,008	25.66	68.04
HI	3,016	12.06	28.25
IA	27,891	51.92	117.58
ID	5,990	22.35	56.74
IL	99,510	51.09	123.05
IN	52,904	50.81	124.49
KS	19,941	43.89	102.59
KY	27,540	37.87	95.70
LA	33,129	46.76	117.64
MA	49,751	43.82	104.21
MD	28,117	30.44	75.76
ME	5,659	21.14	52.78
MI	46,329	27.48	67.69
MN	26,083	29.85	71.30
MO	51,548	50.41	120.97
MS	16,313	34.78	86.10
MT	4,443	22.90	58.03
NC	46,447	27.96	71.37
ND	3,920	34.01	76.65
NE	12,867	42.86	99.29
NH	6,971	29.30	74.19
NJ	52,296	36.44	86.22
NM	6,073	17.34	43.52
NV	5,549	11.79	31.15
NY	106,271	33.71	79.63
OH	92,219	46.73	112.40
OK	24,917	40.25	98.18
OR	9,927	13.54	34.91
PA	91,201	39.39	90.96
RI	8,637	47.55	110.16
SC	17,906	20.37	53.98
SD	4,435	30.51	70.36
TN	35,153	31.70	81.47
TX	146,616	40.70	103.95
UT	5,767	16.85	42.41
VA	29,859	23.09	58.86
VT	2,509	21.40	54.57
WA	19,944	17.21	44.68
WI	31,897	32.94	79.08
WV	7,418	20.94	52.45
WY	2,083	22.58	58.96

*Source: Environics Analytics - 2018 Population

Appendix C - Weighted Average Days by RUG Classification

2017 RUG - CLASS	National Average	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	District Of Columbia	Florida	Georgia
RUC	17.78%	17.35%	13.44%	19.44%	21.37%	19.31%	20.43%	21.38%	14.26%	12.29%	22.02%	15.26%
RUB	23.70%	19.63%	12.90%	29.85%	18.94%	34.50%	27.38%	28.21%	27.83%	26.73%	34.47%	22.72%
RUA	13.49%	17.09%	7.86%	15.00%	20.44%	10.32%	15.88%	9.79%	15.76%	12.76%	12.93%	10.35%
RUX	1.08%	0.51%		1.05%	0.67%	0.80%	0.61%	0.20%	0.30%	0.38%	0.75%	0.42%
RUL	0.38%	0.36%		1.05%	0.77%	0.49%	1.25%	0.15%	0.25%	0.50%	0.75%	0.40%
RVC	9.01%	10.10%	10.93%	6.44%	10.08%	6.44%	6.70%	9.01%	8.01%	7.28%	6.23%	10.21%
RVB	9.38%	8.01%	12.89%	7.61%	6.37%	10.13%	7.58%	8.77%	10.70%	11.47%	6.77%	11.10%
RVA	7.07%	7.62%	8.91%	5.68%	6.42%	5.51%	6.72%	4.25%	6.59%	6.86%	3.37%	6.86%
RVX	0.30%	0.20%		0.34%	0.54%	0.19%	0.24%	6.00%	0.15%	0.20%	0.24%	0.28%
RVL	0.18%	0.23%	0.08%	0.41%	0.36%	0.18%	0.44%	0.07%	0.11%	0.17%	0.20%	0.25%
RHC	3.08%	3.49%	4.13%	1.60%	2.72%	1.31%	1.91%	3.05%	2.42%	2.22%	2.04%	3.98%
RHB	2.54%	2.23%	2.95%	1.54%	1.39%	1.67%	1.63%	2.20%	2.85%	2.40%	1.62%	3.39%
RHA	2.23%	2.05%	4.65%	1.45%	1.54%	1.27%	1.75%	1.42%	1.44%	1.98%	0.99%	2.36%
RHX	0.06%	0.09%	0.03%	0.12%	0.13%	0.03%	0.07%	0.03%	0.03%	0.08%	0.07%	0.16%
RHL	0.06%	0.06%	0.42%	0.10%	0.10%	0.03%	0.08%	0.03%	0.01%	0.10%	0.04%	0.09%
RMC	1.48%	2.09%	1.24%	0.55%	0.98%	0.56%	0.77%	1.48%	1.38%	1.52%	0.99%	1.78%
RMB	1.41%	1.26%	2.51%	0.52%	0.33%	0.56%	0.60%	0.98%	1.13%	0.95%	0.67%	1.30%
RMA	0.99%	1.31%	4.26%	0.50%	0.49%	0.31%	0.85%	0.82%	0.86%	0.90%	0.37%	0.94%
RMX	0.06%	0.06%		0.08%	0.05%	0.02%	0.03%	0.02%	0.02%	0.04%	0.04%	0.06%
RML	0.02%	0.01%		0.02%			0.01%			0.03%	0.01%	0.01%
RLB	0.10%	0.02%				0.01%		0.01%	0.01%			0.06%
RLA	0.17%											
RLX	0.00%											
CC2	0.02%		0.08%				0.02%	0.02%				0.02%
CC1	0.36%	0.26%	0.36%	0.49%	0.22%	0.38%	0.34%	0.55%	0.48%	0.40%	0.32%	0.38%
CB2	0.02%				0.01%		0.01%	0.01%				
CB1	0.27%	0.24%	0.88%	0.50%	0.17%	0.24%	0.24%	0.33%	0.42%	0.21%	0.17%	0.23%
CA2	0.04%	0.04%	0.64%	0.01%			0.03%	0.05%				0.02%
CA1	0.54%	0.26%	1.89%	0.86%	0.24%	0.30%	0.57%	0.74%	0.50%	0.54%	0.24%	0.30%
BB2	0.02%	0.01%										
BB1	0.08%	0.09%	0.48%	0.02%	0.07%	0.03%	0.08%	0.05%	0.06%	0.01%	0.03%	0.10%
BA2	0.01%											0.01%
BA1	0.06%	0.06%	0.24%	0.02%	0.09%	0.03%	0.07%	0.03%	0.02%	0.03%	0.02%	0.07%
PE2	0.01%											0.01%
PE1	0.08%	0.10%	0.05%	0.03%	0.10%	0.03%	0.05%	0.08%	0.05%	0.01%	0.07%	0.08%
PD2	0.01%	0.01%					0.01%					
PD1	0.21%	0.25%	0.44%	0.14%	0.22%	0.10%	0.11%	0.21%	0.20%	0.05%	0.19%	0.20%
PC2	0.02%	0.04%						0.01%				0.03%
PC1	0.28%	0.25%	0.27%	0.21%	0.22%	0.22%	0.16%	0.30%	0.35%	0.22%	0.25%	0.29%
PB2	0.01%											
PB1	0.14%	0.15%	0.34%	0.14%	0.11%	0.10%	0.09%	0.12%	0.20%	0.19%	0.11%	0.13%
PA2	0.00%											
PA1	0.16%	0.16%	0.41%	0.11%	0.08%	0.08%	0.22%	0.09%	0.16%	0.11%	0.09%	0.11%
ES3	0.24%	0.04%		0.66%		0.42%	0.02%	0.02%	0.16%		0.09%	0.18%
ES2	0.13%	0.10%		0.26%	0.02%	0.22%	0.09%	0.12%	0.14%	0.34%	0.12%	0.18%
ES1	0.08%	0.11%	0.14%	0.16%	0.29%	0.09%	0.10%	0.05%	0.01%	0.12%	0.12%	0.16%
HE2	0.06%	0.07%	0.07%	0.01%	0.01%		0.02%	0.05%	0.01%		0.01%	0.09%
HE1	0.23%	0.26%	0.27%	0.10%	0.28%	0.23%	0.15%	0.39%	0.12%	0.37%	0.30%	0.36%
HD2	0.08%	0.01%	0.05%	0.01%	0.02%	0.01%	0.02%	0.11%	0.04%	0.02%	0.02%	0.11%
HD1	0.31%	0.29%	0.31%	0.20%	0.30%	0.29%	0.22%	0.51%	0.11%	0.12%	0.29%	0.44%
HC2	0.07%	0.01%	0.03%		0.01%	0.01%	0.03%	0.03%	0.03%	0.01%	0.01%	0.10%
HC1	0.27%	0.17%	0.35%	0.18%	0.12%	0.27%	0.16%	0.43%	0.20%	0.09%	0.20%	0.37%
HB2	0.03%		0.09%		0.01%		0.01%	0.05%	0.01%			0.04%
HB1	0.31%	0.22%	0.82%	0.26%	0.16%	0.18%	0.25%	0.42%	0.19%	0.31%	0.14%	0.47%
LE2	0.05%	0.03%			0.03%		0.03%	0.06%	0.04%	0.01%	0.02%	0.14%
LE1	0.40%	0.66%	0.14%	0.16%	0.69%	0.45%	0.16%	0.49%	0.39%	0.94%	0.54%	0.57%
LD2	0.06%	0.02%	0.09%	0.01%	0.03%	0.01%	0.03%	0.05%	0.04%	0.13%	0.02%	0.10%
LD1	0.63%	0.89%	0.66%	0.49%	0.56%	0.89%	0.32%	0.63%	0.50%	1.33%	0.70%	0.91%
LC2	0.03%	0.01%	0.12%	0.01%	0.01%	0.01%	0.01%	0.03%	0.04%	0.10%	0.01%	0.07%
LC1	0.48%	0.55%	0.83%	0.41%	0.24%	0.71%	0.23%	0.67%	0.57%	1.09%	0.49%	0.58%
LB2	0.04%	0.01%	0.58%		0.01%		0.02%					0.02%
LB1	0.20%	0.17%	0.96%	0.28%	0.15%	0.23%	0.15%	0.28%	0.20%	0.17%	0.14%	0.17%
CE2	0.02%				0.01%		0.01%	0.01%				0.02%
CE1	0.10%	0.10%	0.19%	0.08%	0.16%	0.05%	0.09%	0.12%	0.04%	0.06%	0.09%	0.09%
CD1	0.30%	0.31%	0.36%	0.31%	0.34%	0.22%	0.32%	0.42%	0.25%	0.13%	0.23%	0.29%
Default	0.33%	0.08%	0.28%	0.27%	1.07%	0.25%	0.35%	0.25%	0.04%	3.76%	0.08%	0.21%

Appendix C - Weighted Average Days by RUG Classification

2017 RUG - CLASS	National Average	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland
RUC	17.78%	18.16%	18.58%	20.52%	18.97%	12.57%	15.61%	24.59%	17.76%	15.81%	17.87%
RUB	23.70%	32.36%	23.56%	29.22%	22.13%	12.42%	17.30%	18.35%	16.70%	17.71%	29.43%
RUA	13.49%	11.23%	12.05%	14.19%	13.03%	11.48%	16.40%	11.23%	16.91%	16.88%	13.18%
RUX	1.08%	0.16%	0.37%	0.74%	0.35%	0.15%	0.20%	0.18%	0.26%	0.13%	0.75%
RUL	0.38%	0.07%	0.40%	0.60%	0.16%	0.21%	0.27%	0.32%	0.28%	0.15%	0.23%
RVC	9.01%	7.65%	9.32%	8.28%	12.29%	12.73%	11.44%	12.66%	12.31%	10.82%	7.67%
RVB	9.38%	12.67%	8.60%	8.49%	8.83%	12.07%	8.56%	7.50%	8.86%	11.12%	9.48%
RVA	7.07%	4.24%	7.48%	6.03%	6.15%	13.92%	11.50%	5.22%	9.06%	10.54%	4.93%
RVX	0.30%	0.07%	0.23%	0.25%	0.17%	0.14%	0.16%	0.17%	0.29%	0.08%	0.19%
RVL	0.18%	0.10%	0.18%	0.19%	0.08%	0.20%	0.21%	0.15%	0.16%	0.08%	0.08%
RHC	3.06%	1.44%	3.13%	1.94%	4.49%	5.84%	4.01%	4.32%	3.19%	3.21%	2.29%
RHB	2.54%	2.54%	2.59%	1.49%	2.39%	3.87%	2.38%	2.09%	2.37%	2.69%	2.15%
RHA	2.23%	1.28%	2.91%	1.27%	1.75%	5.04%	3.34%	1.68%	2.57%	2.37%	1.24%
RHX	0.06%	0.05%	0.04%	0.06%	0.09%	0.07%	0.07%	0.07%	0.08%	0.01%	0.06%
RHL	0.06%	0.07%	0.03%	0.04%	0.03%	0.06%	0.07%	0.04%	0.05%	0.04%	0.02%
RMC	1.48%	0.70%	1.64%	0.78%	1.80%	1.54%	1.29%	2.79%	1.65%	1.13%	1.30%
RMB	1.41%	0.87%	1.03%	0.47%	0.98%	0.90%	0.65%	1.17%	0.71%	0.86%	0.93%
RMA	0.99%	0.44%	1.23%	0.45%	0.68%	1.17%	1.23%	0.82%	0.88%	0.76%	0.56%
RMX	0.06%		0.01%	0.03%	0.04%	0.02%	0.01%	0.05%	0.02%	0.03%	0.04%
RML	0.02%		0.03%			0.01%		0.01%			
RLB	0.10%	2.00%		0.05%	0.01%	0.02%	0.01%	0.03%		0.01%	
RLA	0.17%		0.02%								
RLX	0.00%										
CC2	0.02%		0.03%	0.02%	0.01%	0.02%	0.01%	0.01%		0.04%	0.03%
CC1	0.36%	0.45%	0.25%	0.21%	0.21%	0.30%	0.23%	0.33%	0.16%	0.39%	0.38%
CB2	0.02%		0.02%	0.01%			0.01%			0.01%	
CB1	0.27%	0.33%	0.22%	0.16%	0.17%	0.24%	0.26%	0.17%	0.14%	0.24%	0.29%
CA2	0.04%		0.01%	0.01%	0.01%	0.01%	0.02%	0.02%		0.02%	0.02%
CA1	0.54%	0.42%	0.76%	0.21%	0.24%	0.55%	0.44%	0.22%	0.23%	0.58%	0.05%
BB2	0.02%										
BB1	0.08%	0.02%	0.03%	0.02%	0.03%	0.08%	0.09%	0.05%	0.07%	0.05%	0.05%
BA2	0.01%										
BA1	0.06%		0.02%	0.01%	0.02%	0.05%	0.09%	0.04%	0.03%	0.09%	0.03%
PE2	0.01%		0.02%	0.01%						0.01%	
PE1	0.08%	0.05%	0.06%	0.03%	0.09%	0.06%	0.08%	0.13%	0.06%	0.05%	0.06%
PD2	0.01%			0.01%				0.02%		0.01%	
PD1	0.21%	0.07%	0.19%	0.09%	0.19%	0.22%	0.22%	0.27%	0.12%	0.23%	0.21%
PC2	0.02%		0.01%	0.02%			0.01%				0.03%
PC1	0.28%	0.18%	0.21%	0.12%	0.21%	0.19%	0.23%	0.29%	0.15%	0.31%	0.37%
PB2	0.01%										
PB1	0.14%	0.09%	0.11%	0.07%	0.12%	0.18%	0.17%	0.12%	0.08%	0.14%	0.15%
PA2	0.00%										
PA1	0.16%	0.04%	0.14%	0.12%	0.09%	0.22%	0.19%	0.09%	0.05%	0.13%	0.14%
ES3	0.24%	0.61%	0.19%	0.03%	0.20%	0.21%			0.18%	0.05%	0.52%
ES2	0.13%	0.27%	0.08%	0.15%	0.09%	0.02%	0.03%	0.13%	0.13%	0.05%	0.17%
ES1	0.08%	0.01%	0.06%	0.10%	0.01%	0.06%	0.05%	0.07%	0.05%		0.02%
HE2	0.06%		0.06%	0.15%	0.29%	0.04%	0.09%	0.04%	0.01%	0.03%	0.04%
HE1	0.23%	0.12%	0.23%	0.15%	0.28%	0.20%	0.13%	0.40%	0.35%	0.12%	0.22%
HD2	0.08%		0.07%	0.13%	0.25%	0.07%	0.10%	0.06%		0.03%	0.06%
HD1	0.31%	0.38%	0.51%	0.18%	0.23%	0.27%	0.27%	0.41%	0.27%	0.33%	0.29%
HC2	0.07%	0.11%	0.06%	0.12%	0.20%	0.07%	0.05%	0.03%		0.08%	0.06%
HC1	0.27%	0.25%	0.31%	0.16%	0.17%	0.16%	0.17%	0.24%	0.11%	0.27%	0.25%
HB2	0.03%		0.03%	0.07%	0.08%	0.06%	0.03%	0.01%		0.03%	0.02%
HB1	0.31%	0.17%	0.45%	0.16%	0.30%	0.36%	0.30%	0.23%	0.17%	0.36%	0.26%
LE2	0.05%	0.01%	0.02%	0.15%	0.07%	0.02%	0.06%	0.04%	0.03%	0.06%	0.06%
LE1	0.40%	0.27%	0.16%	0.31%	0.32%	0.28%	0.25%	0.65%	1.02%	0.10%	0.53%
LD2	0.06%		0.04%	0.11%	0.08%	0.02%	0.07%	0.05%	0.02%	0.08%	0.08%
LD1	0.63%	0.45%	0.62%	0.38%	0.42%	0.33%	0.43%	0.78%	0.92%	0.44%	0.85%
LC2	0.03%	0.01%	0.01%	0.06%	0.03%	0.01%	0.01%	0.02%		0.02%	0.06%
LC1	0.48%	0.65%	0.37%	0.30%	0.23%	0.24%	0.22%	0.48%	0.48%	0.23%	0.71%
LB2	0.04%		0.01%	0.01%	0.01%	0.01%	0.01%				
LB1	0.20%	0.16%	0.08%	0.11%	0.10%	0.17%	0.14%	0.12%	0.16%	0.14%	0.26%
CE2	0.02%	0.01%	0.05%	0.03%	0.04%	0.01%	0.01%	0.01%		0.01%	0.01%
CE1	0.10%	0.06%	0.11%	0.05%	0.10%	0.08%	0.08%	0.19%	0.10%	0.05%	0.07%
CD1	0.30%	0.07%	0.38%	0.16%	0.20%	0.33%	0.25%	0.45%	0.17%	0.35%	0.24%
Default	0.33%	0.37%	0.20%	0.06%	0.15%	0.12%	0.25%	0.11%	0.18%	0.10%	0.22%

Appendix C - Weighted Average Days by RUG Classification

2017 RUG - CLASS	National Average	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey
RUC	17.78%	20.49%	17.60%	11.69%	22.58%	11.61%	9.14%	13.06%	21.13%	14.88%	18.04%
RUB	23.70%	26.46%	23.33%	19.21%	16.64%	15.86%	18.96%	16.10%	29.50%	21.01%	40.23%
RUA	13.49%	8.84%	17.30%	12.20%	13.63%	17.64%	15.81%	15.19%	12.38%	16.59%	11.23%
RUX	1.08%	0.20%	0.72%	0.16%	0.18%	0.21%	0.05%	0.04%	1.15%	0.19%	0.69%
RUL	0.38%	0.10%	0.50%	0.13%	0.08%	0.22%	0.12%	0.11%	0.88%	0.13%	0.56%
RVC	9.01%	8.86%	8.73%	10.39%	13.64%	9.40%	6.65%	10.10%	6.27%	8.82%	5.11%
RVB	9.38%	10.44%	8.52%	13.20%	7.37%	10.40%	10.36%	10.74%	6.66%	8.84%	7.31%
RVA	7.07%	5.13%	7.13%	10.29%	7.06%	14.90%	12.22%	12.25%	3.79%	8.06%	2.98%
RVX	0.30%	0.06%	0.32%	0.07%	0.08%	0.16%	0.09%	0.06%	0.26%	0.12%	0.16%
RVL	0.18%	0.08%	0.18%	0.11%	0.05%	0.22%	0.31%	0.09%	0.37%	0.11%	0.12%
RHC	3.06%	2.75%	2.48%	4.49%	4.28%	3.10%	3.17%	4.46%	1.79%	2.75%	1.83%
RHB	2.54%	2.49%	1.78%	3.98%	2.05%	2.35%	4.69%	3.65%	1.62%	2.53%	2.01%
RHA	2.23%	1.40%	1.68%	3.59%	2.09%	4.06%	5.00%	4.69%	1.30%	2.47%	0.87%
RHX	0.06%	0.03%	0.08%	0.05%	0.06%	0.07%	0.03%	0.03%	0.09%	0.03%	0.07%
RHL	0.06%	0.01%	0.06%	0.03%	0.02%	0.06%	0.12%	0.05%	0.06%	0.01%	0.04%
RMC	1.48%	1.75%	1.13%	1.50%	2.75%	1.12%	1.65%	1.76%	1.18%	1.77%	0.96%
RMB	1.41%	1.34%	0.73%	1.15%	0.94%	0.75%	2.42%	10.04%	1.19%	1.61%	0.93%
RMA	0.99%	0.86%	0.56%	1.25%	1.16%	1.27%	2.43%	1.41%	0.77%	1.37%	0.43%
RMX	0.06%	0.02%	0.08%	0.02%	0.04%	0.03%	1.00%	0.02%	0.04%	0.01%	0.08%
RML	0.02%		0.04%	0.01%		0.02%	0.01%	0.03%	0.03%		0.01%
RLB	0.10%	0.01%						0.02%	0.01%		0.01%
RLA	0.17%							0.01%			
RLX	0.00%										
CC2	0.02%	0.02%	0.01%	0.02%		0.02%	0.05%	0.01%	0.02%	0.04%	0.01%
CC1	0.36%	0.53%	0.32%	0.36%	0.18%	0.30%	0.24%	0.25%	0.59%	0.37%	0.36%
CB2	0.02%		0.01%	0.02%		0.01%	0.02%	0.01%	0.01%	0.02%	
CB1	0.27%	0.32%	0.30%	0.32%	0.14%	0.32%	0.29%	0.23%	0.46%	0.22%	0.24%
CA2	0.04%	0.01%	0.01%	0.04%		0.01%	0.06%	0.01%	0.02%	0.04%	0.01%
CA1	0.54%	0.62%	0.57%	0.88%	0.12%	0.66%	0.78%	0.49%	0.61%	0.88%	0.38%
BB2	0.02%							0.01%			
BB1	0.08%	0.12%	0.08%	0.04%	0.05%	0.13%	0.10%	0.12%	0.13%	0.14%	0.02%
BA2	0.01%										
BA1	0.06%	0.08%	0.05%	0.04%	0.04%	0.09%	0.11%	0.09%	0.03%	0.10%	0.01%
PE2	0.01%										
PE1	0.08%	0.13%	0.05%	0.06%	0.14%	0.08%	0.07%	0.08%	0.07%	0.18%	0.02%
PD2	0.01%						0.01%		0.01%		
PD1	0.21%	0.36%	0.25%	0.21%	0.23%	0.22%	0.16%	0.22%	0.30%	0.29%	0.09%
PC2	0.02%										
PC1	0.28%	0.48%	0.30%	0.31%	0.18%	0.28%	0.20%	0.25%	0.42%	0.37%	0.21%
PB2	0.01%										
PB1	0.14%	0.21%	0.19%	0.18%	0.10%	0.19%	0.13%	0.15%	0.32%	0.17%	0.08%
PA2	0.00%										
PA1	0.16%	0.18%	0.23%	0.21%	0.11%	0.22%	0.24%	0.17%	0.30%	0.21%	0.05%
ES3	0.24%	0.11%	0.26%	0.06%					1.12%	0.03%	0.31%
ES2	0.13%	0.07%	0.22%	0.10%	0.16%	0.13%		0.02%	0.21%	0.04%	0.27%
ES1	0.08%	0.02%	0.08%	0.02%	0.01%	0.07%	0.04%	0.02%	0.21%	0.04%	0.06%
HE2	0.06%	0.06%	0.02%	0.07%	0.01%	0.03%	0.04%	0.03%		0.09%	0.03%
HE1	0.23%	0.46%	0.22%	0.18%	0.26%	0.17%	0.19%	0.13%	0.20%	0.32%	0.34%
HD2	0.08%	0.08%	0.03%	0.06%	0.01%	0.06%	0.05%	0.02%	0.03%	0.12%	0.05%
HD1	0.31%	0.56%	0.24%	0.20%	0.23%	0.28%	0.44%	0.28%	0.35%	0.50%	0.38%
HC2	0.07%	0.06%	0.03%	0.08%		0.03%	0.15%	0.03%	0.01%	0.12%	0.03%
HC1	0.27%	0.55%	0.20%	0.21%	0.08%	0.18%	0.48%	0.16%	0.27%	0.62%	0.31%
HB2	0.03%	0.02%	0.01%	0.03%		0.02%		0.02%		0.03%	0.01%
HB1	0.31%	0.43%	0.22%	0.28%	0.09%	0.38%	0.57%	0.29%	0.20%	0.58%	0.23%
LE2	0.05%	0.06%	0.04%	0.06%	0.04%	0.03%	0.04%	0.01%	0.01%	0.05%	0.05%
LE1	0.40%	0.51%	0.44%	0.27%	1.01%	0.36%	0.19%	0.18%	0.48%	0.18%	0.52%
LD2	0.06%	0.06%	0.05%	0.07%	0.03%	0.05%		0.04%	0.01%	0.05%	0.04%
LD1	0.63%	0.70%	0.75%	0.44%	0.90%	0.60%	0.53%	0.34%	0.92%	0.35%	0.77%
LC2	0.03%	0.03%	0.03%	0.04%	0.01%	0.02%	0.01%	0.01%	0.04%	0.03%	0.03%
LC1	0.48%	0.54%	0.55%	0.47%	0.36%	0.44%	0.48%	0.19%	0.83%	0.37%	0.62%
LB2	0.04%		0.01%	0.03%		0.01%	0.02%	0.01%		0.01%	
LB1	0.20%	0.21%	0.25%	0.26%	0.08%	0.22%	0.23%	0.18%	0.36%	0.21%	0.19%
CE2	0.02%	0.03%				0.01%	0.04%	0.02%	0.01%		
CE1	0.10%	0.13%	0.08%	0.05%	0.13%	0.08%	0.12%	0.06%	0.12%	0.12%	0.04%
CD1	0.30%	0.44%	0.33%	0.26%	0.26%	0.33%	0.27%	0.33%	0.42%	0.28%	0.19%
Default	0.33%	0.15%	0.28%	0.21%	0.06%	0.20%	0.11%	0.33%	0.15%	1.20%	0.06%

Appendix C - Weighted Average Days by RUG Classification

2017 RUG - CLASS	National Average	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina
RUC	17.78%	16.87%	26.55%	17.90%	10.74%	20.96%	15.84%	21.32%	23.80%	13.81%	13.01%
RUB	23.70%	30.65%	32.95%	23.14%	12.84%	26.02%	19.44%	23.04%	20.26%	22.53%	25.52%
RUA	13.49%	19.24%	7.35%	15.77%	3.80%	15.06%	17.23%	13.52%	12.19%	15.60%	13.36%
RUX	1.08%	0.40%	0.79%	34.00%	0.05%	0.58%	0.49%	0.43%	0.28%	0.10%	0.31%
RUL	0.38%	0.67%	0.25%	0.38%	0.04%	0.39%	0.63%	0.35%	0.13%	0.14%	0.34%
RVC	9.01%	5.28%	6.27%	8.02%	12.14%	8.61%	8.83%	8.91%	11.73%	8.14%	8.47%
RVB	9.38%	7.64%	5.61%	9.30%	16.46%	7.54%	8.27%	9.09%	7.65%	11.57%	13.04%
RVA	7.07%	5.36%	2.31%	7.02%	4.96%	5.60%	9.90%	6.87%	4.98%	10.78%	6.47%
RVX	0.30%	0.15%	0.09%	0.16%	0.12%	0.27%	0.34%	0.15%	0.15%	0.03%	0.17%
RVL	0.18%	0.19%	0.04%	0.17%	0.04%	0.14%	0.38%	0.24%	0.07%	0.08%	0.24%
RHC	3.06%	1.51%	3.77%	2.70%	7.11%	2.42%	2.69%	2.35%	4.06%	2.67%	2.92%
RHB	2.54%	1.86%	2.67%	2.51%	7.77%	1.77%	2.11%	2.18%	2.09%	2.52%	3.77%
RHA	2.23%	2.02%	1.24%	2.02%	3.53%	1.47%	2.75%	2.19%	1.38%	2.45%	1.67%
RHX	0.06%	0.02%	0.06%	0.05%	0.09%	0.07%	0.14%	0.04%	0.06%	0.01%	0.09%
RHL	0.06%	0.03%	0.02%	0.05%	0.09%	0.04%	0.10%	0.08%	0.02%	0.01%	0.07%
RMC	1.48%	0.52%	1.86%	1.91%	3.66%	1.19%	0.90%	1.11%	2.39%	1.02%	1.43%
RMB	1.41%	0.77%	1.00%	1.50%	3.18%	0.77%	0.72%	0.85%	1.07%	1.15%	1.55%
RMA	0.99%	0.72%	0.59%	0.91%	2.02%	0.78%	0.85%	0.99%	0.75%	0.93%	0.68%
RMX	0.06%		0.05%	0.05%	0.02%	0.04%	0.08%	0.01%	0.06%	0.02%	0.06%
RML	0.02%	0.02%		0.02%			0.02%	0.01%			0.02%
RLB	0.10%				0.01%	0.01%	0.01%		0.03%		0.01%
RLA	0.17%										0.73%
RLX	0.00%										
CC2	0.02%	0.01%	0.01%		0.06%	0.02%	0.02%	0.01%	0.01%	0.01%	0.01%
CC1	0.36%	0.48%	0.24%	0.37%	0.85%	0.23%	0.41%	0.38%	0.31%	0.31%	0.39%
CB2	0.02%				0.01%	0.01%	0.01%				
CB1	0.27%	0.26%	0.13%	0.28%	0.43%	0.17%	0.33%	0.39%	0.26%	0.36%	0.20%
CA2	0.04%		0.01%	0.01%		0.04%	0.01%			0.02%	
CA1	0.54%	0.67%	0.22%	0.42%	0.73%	0.45%	0.71%	1.18%	0.51%	0.83%	0.23%
BB2	0.02%				0.01%						
BB1	0.08%	0.11%	0.01%	0.04%	0.07%	0.05%	0.13%	0.03%	0.04%	0.11%	0.04%
BA2	0.01%										
BA1	0.06%	0.06%		0.02%	0.07%	0.07%	0.11%	0.02%	0.02%	0.07%	0.01%
PE2	0.01%										
PE1	0.08%	0.06%	0.03%	0.04%	0.30%	0.04%	0.09%	0.05%	0.07%	0.06%	0.04%
PD2	0.01%								0.01%		
PD1	0.21%	0.08%	0.09%	0.13%	0.49%	0.15%	0.30%	0.16%	0.23%	0.19%	0.18%
PC2	0.02%				0.02%				0.01%		0.01%
PC1	0.28%	0.28%	0.12%	0.25%	0.89%	0.17%	0.33%	0.26%	0.19%	0.38%	0.31%
PB2	0.01%									0.01%	
PB1	0.14%	0.10%	0.04%	0.12%	0.26%	0.08%	0.23%	0.15%	0.12%	0.17%	0.09%
PA2	0.00%										
PA1	0.16%	0.09%	0.02%	0.11%	0.36%	0.13%	0.26%	0.21%	0.20%	0.18%	0.09%
ES3	0.24%		0.83%	0.05%	0.06%	0.25%	0.20%		0.38%		
ES2	0.13%	0.10%	0.20%	0.14%	0.04%	0.16%	0.13%	0.04%	0.17%	0.14%	0.11%
ES1	0.08%	0.12%	0.02%	0.08%	0.11%	0.07%	0.25%	0.09%	0.02%	0.01%	0.07%
HE2	0.06%	0.01%	0.16%	0.01%	0.07%	0.17%	0.04%		0.03%	0.06%	0.01%
HE1	0.23%	0.18%	0.45%	0.13%	0.38%	0.25%	0.25%	0.05%	0.35%	0.14%	0.19%
HD2	0.08%	0.06%	0.12%	0.02%	0.18%	0.22%	0.06%	0.03%	0.05%	0.06%	0.27%
HD1	0.31%	0.16%	0.24%	0.23%	0.42%	0.36%	0.46%	0.30%	0.33%	0.23%	0.29%
HC2	0.07%	0.06%	0.08%	0.02%	0.17%	0.18%	0.06%	0.03%	0.03%	0.06%	0.01%
HC1	0.27%	0.24%	0.17%	0.23%	0.63%	0.27%	0.33%	0.29%	0.21%	0.32%	0.29%
HB2	0.03%	0.01%	0.02%	0.01%	0.03%	0.07%	0.02%	0.04%	0.01%	0.02%	
HB1	0.31%	0.20%	0.17%	0.20%	0.51%	0.32%	0.39%	0.43%	0.24%	0.44%	0.17%
LE2	0.05%	0.02%	0.21%	0.01%	0.07%	0.13%	0.05%	0.03%	0.05%	0.05%	0.01%
LE1	0.40%	0.24%	0.82%	0.36%	0.67%	0.29%	0.43%	0.18%	0.53%	0.17%	0.40%
LD2	0.06%	0.03%	0.09%	0.05%	0.05%	0.13%	0.07%	0.04%	0.06%	0.06%	0.04%
LD1	0.63%	0.56%	0.65%	0.85%	0.94%	0.45%	0.70%	0.39%	0.78%	0.40%	0.95%
LC2	0.03%	0.02%	0.04%	0.03%	0.01%	0.06%	0.04%	0.02%	0.03%	0.01%	0.02%
LC1	0.48%	0.56%	0.38%	0.74%	0.66%	0.30%	0.44%	0.43%	0.46%	0.50%	0.81%
LB2	0.04%		0.01%	0.01%	0.01%	0.02%					
LB1	0.20%	0.24%	0.16%	0.27%	0.29%	0.15%	0.26%	0.27%	0.21%	0.23%	0.21%
CE2	0.02%	0.01%	0.02%		0.05%	0.02%	0.03%		0.01%		
CE1	0.10%	0.13%	0.09%	0.05%	0.32%	0.06%	0.14%	0.06%	0.09%	0.07%	0.06%
CD1	0.30%	0.30%	0.22%	0.23%	0.57%	0.24%	0.37%	0.26%	0.34%	0.25%	0.21%
Default	0.33%	0.31%	0.12%	0.25%	0.08%	0.15%	0.28%	0.13%	0.13%	0.21%	0.08%

Appendix C - Weighted Average Days by RUG Classification

2017 RUG - CLASS	National Average	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
RUC	17.78%	12.37%	21.68%	21.30%	19.54%	14.35%	17.28%	25.88%	24.33%	14.65%	17.16%
RUB	23.70%	19.76%	24.11%	27.93%	36.30%	18.69%	25.04%	25.91%	17.54%	21.45%	25.77%
RUA	13.49%	13.01%	12.75%	17.23%	14.78%	12.32%	14.79%	10.36%	11.84%	11.99%	10.01%
RUX	1.08%	0.11%	0.60%	0.80%	0.71%	0.11%	0.43%	0.52%	0.18%	0.26%	0.05%
RUL	0.38%	0.25%	0.51%	0.68%	1.09%	0.06%	0.31%	0.30%	0.18%	0.37%	0.25%
RVC	9.01%	9.07%	9.95%	6.90%	6.80%	9.46%	8.64%	8.33%	13.10%	10.56%	5.68%
RVB	9.38%	11.02%	8.36%	6.81%	7.62%	9.31%	9.95%	7.89%	6.84%	13.34%	9.61%
RVA	7.07%	10.78%	4.65%	5.06%	4.27%	8.59%	6.69%	4.41%	5.83%	8.36%	6.09%
RVX	0.30%	0.10%	0.32%	0.29%	0.27%	0.03%	0.19%	0.12%	0.27%	0.21%	0.06%
RVL	0.18%	0.22%	0.30%	0.24%	0.21%	0.08%	0.19%	0.11%	0.09%	0.32%	0.06%
RHC	3.06%	3.79%	3.10%	1.70%	1.51%	4.26%	2.82%	2.31%	4.87%	3.33%	2.58%
RHB	2.54%	3.33%	2.05%	1.44%	1.44%	3.01%	2.49%	1.90%	2.22%	3.14%	3.51%
RHA	2.23%	4.50%	1.23%	1.15%	0.99%	3.60%	1.73%	1.31%	2.02%	2.13%	2.86%
RHX	0.06%	0.07%	0.11%	0.07%	0.06%	0.03%	0.05%	0.04%	0.05%	0.08%	0.07%
RHL	0.06%	0.11%	0.09%	0.06%	0.12%	0.06%	0.05%	0.03%	0.02%	0.07%	0.01%
RMC	1.48%	1.73%	1.71%	0.69%	0.58%	3.23%	1.52%	1.06%	2.80%	1.41%	1.44%
RMB	1.41%	1.41%	0.82%	0.51%	0.43%	1.64%	10.05%	0.78%	1.23%	1.02%	1.04%
RMA	0.99%	1.38%	0.52%	0.43%	0.34%	2.20%	0.69%	0.61%	1.19%	0.81%	1.67%
RMX	0.06%	0.02%	0.05%	0.04%	0.02%	0.04%	0.05%	0.02%	0.08%	0.04%	0.01%
RML	0.02%	0.02%	0.02%	0.02%	0.03%	0.01%	0.01%	0.01%	0.01%	0.01%	
RLB	0.10%		0.01%		0.04%	0.14%				0.05%	
RLA	0.17%					0.07%				0.01%	
RLX	0.00%										
CC2	0.02%	0.02%	0.01%	0.01%	0.01%	0.01%		0.05%	0.01%	0.03%	0.01%
CC1	0.36%	0.46%	0.36%	0.26%	0.24%	0.30%	0.30%	0.38%	0.29%	0.29%	1.07%
CB2	0.02%	0.01%			0.01%	0.04%		0.02%		0.01%	0.05%
CB1	0.27%	0.20%	0.21%	0.17%	0.18%	0.18%	0.23%	0.27%	0.14%	0.27%	0.59%
CA2	0.04%	0.04%		0.01%	0.02%	0.03%	0.01%	0.04%	0.01%	0.02%	0.04%
CA1	0.54%	0.80%	0.27%	0.24%	0.24%	0.85%	0.41%	0.67%	0.26%	0.75%	1.17%
BB2	0.02%					0.06%					
BB1	0.08%	0.09%	0.07%	0.09%	0.01%	0.05%	0.03%	0.06%	0.03%	0.03%	0.32%
BA2	0.01%					0.01%					
BA1	0.06%	0.01%	0.03%	0.07%	0.01%	0.12%	0.02%	0.03%	0.04%	0.02%	0.38%
PE2	0.01%		0.01%							0.01%	
PE1	0.08%	0.12%	0.16%	0.07%		0.19%	0.03%	0.09%	0.08%	0.06%	0.27%
PD2	0.01%		0.01%			0.01%	0.01%				
PD1	0.21%	0.25%	0.33%	0.18%	0.03%	0.24%	0.13%	0.30%	0.16%	0.16%	0.65%
PC2	0.02%	0.03%	0.02%			0.02%				0.01%	0.01%
PC1	0.28%	0.33%	0.38%	0.31%	0.08%	0.31%	0.20%	0.41%	0.18%	0.23%	0.89%
PB2	0.01%					0.01%					
PB1	0.14%	0.13%	0.12%	0.13%	0.20%	0.13%	0.09%	0.16%	0.04%	0.14%	0.22%
PA2	0.00%										
PA1	0.16%	0.35%	0.07%	0.13%	0.02%	0.09%	0.11%	0.24%	0.07%	0.12%	0.42%
ES3	0.24%		0.30%	0.15%	0.31%	0.12%	0.14%	0.12%		0.18%	
ES2	0.13%		0.13%	0.12%	0.07%	0.09%	0.15%	0.06%	0.06%	0.08%	
ES1	0.08%	0.15%	0.15%	0.16%	0.05%	0.08%	0.09%	0.04%	0.07%	0.05%	0.10%
HE2	0.06%	0.02%	0.03%	0.03%	0.03%	0.23%	0.04%	0.14%	0.05%	0.03%	0.05%
HE1	0.23%	0.18%	0.39%	0.22%	0.04%	0.24%	0.26%	0.18%	0.12%	0.20%	0.21%
HD2	0.08%	0.12%	0.03%	0.04%	0.03%	0.35%	0.06%	0.16%	0.14%	0.08%	0.11%
HD1	0.31%	0.30%	0.43%	0.24%	0.09%	0.64%	0.37%	0.32%	0.21%	0.37%	0.29%
HC2	0.07%	0.10%	0.01%	0.03%	0.04%	0.29%	0.04%	0.13%	0.12%	0.09%	0.11%
HC1	0.27%	0.46%	0.32%	0.17%	0.10%	0.69%	0.31%	0.35%	0.17%	0.35%	0.38%
HB2	0.03%	0.03%	0.01%	0.01%		0.11%	0.01%	0.03%	0.03%	0.05%	
HB1	0.31%	0.32%	0.19%	0.16%	0.18%	0.68%	0.31%	0.32%	0.19%	0.41%	0.39%
LE2	0.05%	0.06%	0.03%	0.03%		0.08%	0.04%	0.10%	0.07%	0.04%	0.03%
LE1	0.40%	0.23%	0.46%	0.43%	0.06%	0.20%	0.39%	0.25%	0.31%	0.21%	0.31%
LD2	0.06%	0.14%	0.04%	0.04%	0.03%	0.12%	0.05%	0.11%	0.15%	0.07%	0.08%
LD1	0.63%	0.53%	0.76%	0.49%	0.13%	0.64%	0.67%	0.61%	0.66%	0.43%	0.74%
LC2	0.03%	0.02%	0.03%	0.03%		0.04%	0.03%	0.06%	0.06%	0.05%	0.12%
LC1	0.48%	0.25%	0.55%	0.36%	0.14%	0.32%	0.53%	0.48%	0.43%	0.49%	0.54%
LB2	0.04%	0.02%					0.01%	0.02%	0.02%	0.01%	
LB1	0.20%	0.20%	0.13%	0.12%	0.07%	0.14%	0.18%	0.20%	0.09%	0.21%	0.18%
CE2	0.02%	0.03%	0.01%	0.01%	0.01%	0.06%		0.05%	0.01%	0.01%	0.05%
CE1	0.10%	0.22%	0.19%	0.07%	0.05%	0.17%	0.09%	0.09%	0.06%	0.07%	0.20%
CD1	0.30%	0.27%	0.38%	0.20%	0.16%	0.28%	0.27%	0.33%	0.34%	0.24%	0.93%
Default	0.33%	0.10%	0.10%	1.59%	0.03%	0.07%	0.10%	0.88%	0.32%	0.16%	0.59%

Appendix D - State Quality Assessment Fee Summary

State Quality Assessment Fee Summary		
State	Quality Assessment Fee Calculation	Exempt Facilities
Alabama	\$1,899.96 x total licensed bed. Effective September 1, 2010, the state imposed a supplemental provider privilege assessment. The current supplemental assessment is \$1,603.08 per licensed bed. Effective May 20, 2012, the state implemented an additional monthly supplemental surcharge privilege assessment, which is currently \$43.75 (\$525 per year). Effective October 1, 2015, the state implemented a 3rd supplemental surcharge of \$402.28 per month. Total Fee = \$4,429.32. Total Calculation = \$4,429.32 x total licensed beds.	None
Alaska	None	Not Applicable
Arizona	Effective January 1, 2017, nursing facilities with 43,500 or greater annual Medicaid days = \$1.80 per non-Medicare day. All remaining non-exempt facilities = \$15.63 per non-Medicare day.	Nursing facilities within Continuing Care Retirement Centers (CCRCs), nursing facilities with 58 or fewer beds, tribal owned facilities and the Arizona Veterans Home.
Arkansas	Effective July 1, 2018 - \$13.37 x total non-Medicare patient days.	Nursing facilities located within life care communities (LCC).
California*	Effective August 1, 2018, nursing facilities with < 100,000 total patient days = \$15.72 x total patient days. Nursing facilities with ≥ 100,000 total patient days = \$14.46 x total patient days.	Nursing facilities located within multi-level retirement communities.
Colorado	Effective July 1, 2018, nursing facilities with ≤ 55,000 Medicaid days = \$14.80 per non-Medicare day. Nursing facilities with > 55,000 Medicaid days = \$2.77 per non-Medicare day. The state caps the QAF at \$12.00 per non-Medicare day plus the inflation adjustment.	The following facilities are granted a waiver from paying the QAF: a nursing facility that is part of a continuing care retirement facility (CCRC); nursing facilities owned or operated by the state; hospital-based nursing facilities; and nursing facilities with 45 or less beds.
Connecticut*	Nursing facilities with ≤ 230 Beds = \$21.01 x total non-Medicare patient days. Nursing facilities with > 230 beds = \$16.13 x total non-Medicare patient days.	Nursing facilities located within CCRCs.
Delaware	Effective June 1, 2016, \$15.98 for facilities with > 44,000 Medicaid days and \$30.15 for all other non-exempt facilities.	Government owned facilities, nursing facilities that exclusively serve children, nursing facilities with fewer than 46 beds and nursing facilities within CCRCs.
Florida	Effective July 1, 2018, the fee is \$25.48 per non-Medicare day for nursing facilities with less than 53,000 Medicaid patient days and \$5.06 for nursing facilities with equal to or greater than 53,000 Medicaid patient days.	Nursing facilities within CCRCs, hospital-based facilities and nursing facilities with 45 or fewer licensed beds will not be required to pay the QAF.
Georgia	\$17.10 x total non-Medicare patient days.	Nursing facilities located within CCRCs, the 10 nursing facilities (public or not for profit) with the largest number of patient days, state and federally operated nursing facilities, and facilities that do not charge for services.
Hawaii	Effective January 1, 2016, nursing facilities with 65,000 or less Medicaid days = \$13.46 per non-Medicare day. Nursing facilities with more than 65,000 Medicaid patient days = \$5.85.	Nursing facilities with 28 or fewer beds, nursing facilities owned or operated by Hawaii Health Systems Corporation, and nursing facilities within continuing care retirement facilities.
Idaho	Effective July 1, 2016 - \$15.98 x total non-Medicare patient days.	State-owned nursing facilities.
Illinois	\$1.50 x total licensed nursing facility patient days. Illinois begin charging nursing facilities with a second quality assessment fee effective July 1, 2011. This fee is \$6.07 per non-Medicare patient (occupied) day.	None. Subpart T nursing facilities (mental health treatment facilities).
Indiana	Nursing facilities with < 62,000 total patient days = \$16.37 x total non-Medicare patient days. Nursing facilities with ≥ 62,000 total patient days or government owned = \$4.09 x total non-Medicare patient days.	Nursing facilities located within CCRCs, veterans homes and hospital-based nursing facilities.
Iowa	Effective July 1, 2015 - \$1.36 per non-Medicare patient day if the facility is licensed for less than or equal to 46 beds, designated as a continuing care retirement community (CCRC) or has annual Medicaid patient days of 26,500 or greater. \$7.13 for all other facilities.	Hospital-based and government owned nursing facilities.
Kansas	Nursing facilities with < 46 beds, nursing facilities with > 25,000 Medicaid days and nursing facilities within CCRCs (Tier I) = \$818 x total licensed beds. All other nursing facilities (Tier II) = \$4,950 x total licensed beds.	None
Kentucky	Effective July 1, 2013 - \$1.82 per non-Medicare day for non-hospital based nursing facilities with less than 60 bed, \$12.85 per non-Medicare resident day for non-hospital based nursing facilities with less than 60,000 resident days, \$4.12 per non-Medicare patient day for non-hospital based nursing facilities with 60,000 or more resident days and \$3.64 per non-Medicare resident day for hospital-based nursing facilities.	None
Louisiana	Effective September 1, 2016 - \$12.08 x total patient days.	None
Maine	6.0% x total patient service revenue.	None
Maryland	Effective July 1, 2016 - The five nursing facilities with the highest Medicaid volume = \$5.00 x total non-Medicare patient days. All other nursing facilities = \$25.00 x total non-Medicare patient days.	Nursing facilities located within CCRCs and nursing facilities with < 45 beds.
Massachusetts	Effective October 6, 2016 - Nursing facilities located within non-profit CCRCs = \$2.22 x total non-Medicare patient days. Nursing facilities with > 66,000 Medicaid patient days = \$2.22 x total non-Medicare patient days. All other nursing facilities = \$22.22 x total non-Medicare patient days.	Nursing facilities that meet the following three criteria: < 100 licensed beds; were constructed prior to July 30, 1965; and are not participating with Medicare or Medicaid.

Appendix D - State Quality Assessment Fee Summary

State Quality Assessment Fee Summary		
State	Quality Assessment Fee Calculation	Exempt Facilities
Michigan	Effective October 1, 2017, nursing facilities with < 40 beds = \$2.00 x total non-Medicare patient days. Nursing facilities with > 51,000 total Medicaid days = \$18.30 x total non-Medicare patient days. All other nursing facilities = \$26.15 x total non-Medicare patient days.	None
Minnesota	\$2,815 x total licensed beds.	None
Mississippi	\$14.08 x total patient days.	None
Missouri	\$13.40 x total patient days.	None
Montana	\$15.30 x total patient days.	None
Nebraska	Effective July 1, 2011, Nebraska approved the implementation of a Nursing Facility Quality Assurance Assessment (NFQAA). All non-exempt nursing facilities are required to pay a \$3.50 assessment fee per non-Medicare day.	State operated veterans homes, nursing facilities with 26 or less beds and nursing facilities within continuing care retirement communities. In addition, the state will reduce the NFQAA for certain high-volume nursing facilities.
Nevada*	Effective April 1, 2019, nursing facilities with < 65% Medicaid Payor Percentage = \$46.77 per non-Medicare day. Nursing facilities with > 65% Medicaid Payor Percentage = \$20.93 per non-Medicare day.	Hospital-based nursing facilities.
New Hampshire	5.5% of net patient revenues.	None
New Jersey	\$11.92 x Total Non-Medicare Patient Days.	County-owned facilities, CCRCs and certain exempt high volume Medicaid providers.
New Mexico	None	Not Applicable
New York	6.0% x Non-Medicare Revenue. Effective April 1, 2011, the state increased the assessment fee by 0.8% as an alternative to implementing a 2.0% rate reduction. This increase was scheduled to terminate effective March 1, 2014. However, this did not occur and the state is still utilizing the 6.8% assessment. The state has extended this assessment until March 31, 2021.	None
North Carolina*	Nursing Facilities with < 48,000 Total Patient Days = \$13.68 x Total Non-Medicare Patient Days. Nursing Facilities with ≥ 48,000 Total Patient Days = \$7.18 x Total Non-Medicare Patient Days.	Nursing facilities located within CCRCs.
North Dakota	None	Not Applicable
Ohio	Effective July 1, 2016, for a nursing facility's first 200 beds = \$12.44 x Total Licensed Beds x 365 days. For each licensed nursing bed greater than 200 = \$9.02 x Total Licensed Beds x 365 days.	None
Oklahoma	Effective July 1, 2018, \$11.48 per day for all non-CCRCs and \$6.70 per day for CCRCs.	None
Oregon	Effective July 1, 2018 - \$24.46 x Total Patient Days.	Nursing facilities located within CCRCs, the Oregon's Veterans Home, and facilities with Medicaid patient days in excess of 85% of their total patient days.
Pennsylvania	Effective July 1, 2018, nursing facilities located within CCRCs, county-owned nursing facilities, nursing facilities with a Medicaid payor percentage of 94% or greater for the last four quarters or nursing facilities with 44 or less beds = \$7.40 x Total Non-Medicare Patient Days. All Other Nursing Facilities = \$31.49 x Total Non-Medicare Patient Days.	None
South Carolina	None	Not Applicable
South Dakota	None	Not Applicable
Tennessee	Effective July 1, 2016, nursing facilities with 50 or less beds and nursing facilities within CCRCs are charged \$9.68 per non-Medicare day, nursing facilities with 50,000 or more Medicaid patient days are charged \$1,460 per licensed bed and all other nursing facilities are reimbursed \$16.23 per non-Medicare day.	None
Texas	None	Not Applicable
Utah	Effective July 1, 2018, \$23.04 x Total Non-Medicare Patient Days.	None
Vermont	\$4,919.53 x Total Licensed Beds.	None
Virginia	None	Not Applicable
Washington	Nursing facilities with more than 32,000 Medicaid patient days or more than 203 licensed beds are assessed \$1.00 per non-Medicare day. The remaining nursing facilities in the state are assessed \$21.00 per non-Medicare day.	Continuing care retirement communities, nursing facilities with less than 35 or less beds, state, county and tribal operating facilities, and hospital-based nursing facilities are excluded from paying the assessment.
Washington D.C.	\$5,575.88 x Total Licensed Beds.	None
West Virginia	5.5% x Patient Revenues.	None
Wisconsin	\$170 per month x Total Licensed Beds.	None
Wyoming	Effective April 1, 2011, Wyoming implemented a quality assessment fee known as the Nursing Facility Assessment (NFA). The NFA is currently \$21.60 (effective October 1, 2016) per non-Medicare day.	None

Appendix E - State Bed Need Methodology

STATE BED NEEDS METHODOLOGIES	
State	Bed Need Methodology
Alabama	Gross Bed Need (Per County) = (40/1,000) x (65 and older population) Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need
Alaska	The calculation of net bed need (Per Service Area) is a four-step process as follows: 1.) Long Term Care Caseload = The sum of, age-specific use rates per 1,000 x (total population for the following age cohorts: 0 to 64 years; 65 to 74 year; 75 to 84 years; and 85 years and over) x (projected population for that age group in the fifth year after the project implementation date); 2.) Long Term Care Caseload / nursing home target occupancy (90%) = projected number of nursing facility beds 3.) Gross Bed Need = (projected number of nursing facility beds) x (the proposed service area's current percentage of the aged 65+ population); and 4.) Net Bed Need = gross bed need - (current licensed nursing facility beds + approved licensed nursing facility beds)
Arizona	None
Arkansas	Net Bed Need (Per County) = ((0.70/1,000) x (below 65 population) + (10.0/1,000) x (65-74 population) + (39.3/1,000) x (75-84 population) + (160/1,000) x (85 and older population)) x 1.05 - total licensed nursing facility beds Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need
California	None
Colorado	Nursing Facilities must provide needed beds to an underserved geographical area per the following: The service area (no more than two contiguous counties in the state) must have a nursing facility bed to population ratio < 40 beds per 1,000 persons 75+; and the occupancy of existing nursing facilities in the proposed service area must be > 90% for the six months preceding the filing date of the application
Connecticut	The weighted average occupancy percentage of all nursing facilities within a 15-mile radius from the subject must be greater than 97.5% for there to be need.
Delaware	Gross Bed Need (Per County) = Average daily census (ADC) adjusted for a 90% occupancy factor for each county (Kent, Sussex and New Castle), where ADC = base year ADC x percentage change factor (PCF) PCF = weighted average factor of the projected population change for age cohorts: age 64 and under; 65 to 74; 75 to 84; and 85+ Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need
District of Columbia	None
Florida	The bed need calculation is projected over a three-year horizon within a given district or subdistrict and was initially supposed to be assessed twice a year (January 1 and July 1). Given that the state has had a moratorium on the issuance of CONs for nursing home beds for several years (July 1, 2001 to June 30, 2014), the state had not published bed need estimates. However, with the end of the moratorium on July 1, 2014, the state resumed the calculation of nursing home bed need. Gross Bed Need (Per District) = (Total 65-74 population x 65-74 bed need rate) + (Total 75+ population x 75+ bed need rate) Net Bed Need (Per Sub-District) = Gross bed need x (total licensed beds (Sub-District)/total licensed beds (District) x (average district occupancy/92%) - the total licensed and approved nursing facility beds (Sub-District). 65-74 Bed Need Rate = Total licensed beds (District)/((65-74 population) + (6 x 75+ population)) 75+ Bed Need Rate = 65-74 bed need rate x 6 If the average occupancy of all licensed nursing homes within a subdistrict is under 85%, then the net bed need is automatically zero.
Georgia	Gross Bed Need for 12 state service delivery regions is determined using a population-based formula, which is the sum of the following: Gross Bed Need = (0.43/1,000) x (below 65 population) (9.77/1,000) x (65-74 population) (32.50/1,000) x (75-84 population) (120/1,000) x (85 and older population) Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need In addition to the above bed need calculation, demand for services in a State Service Delivery Region is measured by the cumulative facility bed utilization rate, which is determined by dividing the bed days available for resident care by the actual bed days of resident care.
Hawaii	Hawaii has a bed methodology to be utilized when considering CON applications. This methodology consists of a three-step process that includes: 1) defining a target area for a nursing facility; 2) multiplying the population within the target area by national utilization rates to determine need, and; 3) comparing need estimates to current Hawaii licensed long-term care bed usage and supply. If calculated need is greater than the supply of beds, it is anticipated that there is unmet demand for services.
Idaho	None
Illinois	The bed need methodology is based on the expected utilization rates per 1,000 population for three age cohorts (ages 0 to 64, 65 to 74, and 75 and older) in the state's 11 Health Service Areas (HSAs), which include 95 smaller Planning Areas (PAs) The bed need calculation requires the determination of three use rates for each applicable age cohort, including: the PA use rate (PUR); the HSA minimum use rate (Min. UR); and HSA maximum use rate (Max. UR) Age-Specific PUR = Total Patient Days (from either the PA or HSA)/total population of the age cohort Min. UR - PUR x 0.6 Max. UR - PUR x 1.6 Applicable Age Specific Use Rate App. UR = PUR, if PUR is > Min. Use Rate & < Max. Use Rate = Max. UR, if PUR is > Max. UR = Min. UR, if PUR is < Min. UR Area Specific Gross Bed Need = App. UR x applicable age cohort population (area specific)/0.90 Net Bed Need = Gross bed need - total licensed nursing facility beds
Indiana	None
Iowa	Gross Bed Need (Per County) is calculated annually, using a five-year population projection as follows: In rural counties the total long-term bed need is equal to: [0.09 x (65+ population) + 0.0015 x (64 - population)] x 110% In urban counties total long-term bed need is equal to: [0.07 x (65+ population) + 0.0015 x (64 - population)] x 110% Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need
Kansas	None
Kentucky	Gross Bed Need = Total nursing facility residents from the applicants county of origin that were admitted to a nursing facility located in a contiguous county Net Bed Need = Gross bed need - the average number of empty beds (sum total for all the above mentioned counties).
Louisiana	None

Appendix E - State Bed Need Methodology

STATE BED NEEDS METHODOLOGIES	
State	Bed Need Methodology
Maine	Bed need exists if: the estimate of beds per 1,000 (65+ population) < 110 beds per 1,000
Maryland	Gross Bed Need (Per County or one of five state jurisdictions) = the sum of: age-specific use rates x total population by age cohort Age-Specific Use Rates = base year patient days (by age cohort)/total population (by age cohort) x 1,000 x 0.95 Net Bed Need = gross bed need - current inventory Current Inventory = total licensed nursing facility beds + de-licensed nursing facility beds + wavier nursing facility beds
Massachusetts	The methodology applies national age-specific nursing facility utilization rates (per 1,000 population) determined by the National Center for Health Statistics to populations for Massachusetts to determine bed need. Specifically, the age-specific utilization rates are multiplied by the Massachusetts total population per age cohort, which are then summed to calculate total gross bed need. The last step in the calculation is to determine total net bed need. Total net bed need is determined by deducting the total number of existing nursing facility beds in the state and the total number of nursing facility beds that have been approved for construction in the state (but are not yet licensed) from gross total bed need.
Michigan	Gross Bed Need (Per Planning District) = the sum of: age-specific use rates x total population by age cohort/365 (366 if a leap year)/0.90 (0.95 if the proposed nursing facility has greater than 100 beds) Net Bed Need = Gross bed need - total existing nursing facility beds (in the Planning District)
Minnesota	With the exception of the extreme hardship area standards, Minnesota does not possess a formal bed need methodology.
Mississippi	Net Bed Need (Per one of four Planning Districts) = (0.5/1,000 x aged 0-64 total population) + (10/1,000 x aged 65-74 total population) + (36/1,000 aged 75-84 total population) + (135/1,000 x aged 85+ total population) - (total licensed nursing facility beds + total CON approved new nursing facility beds)
Missouri	Net Bed Need (Per Service Area) = 53/1,000 x aged 65 and older population - total licensed nursing facility beds (including CON-approved new nursing facility beds)
Montana	Net Bed Need (in each community that contains a nursing facility) = Average total patient days (for a specific community) over a three year period/365/0.85 - total licensed nursing beds
Nebraska	The bed need methodology is based on the expected utilization rates per 1,000 population for four age cohorts. Bed need is also calculated separately by gender Net Bed Need (Per Health Planning Region) = the sum of (P x U) for each age cohort (by gender)/O - total licensed nursing facility beds P = Population by age cohorts (0 - 64 years, 65-74 years, 75-84 years, and 85+) U = Utilization rate goal (computed for each of the population categories) O = Minimum occupancy rate goal (95% for Health Planning Regions that are part of or contain a Metropolitan Statistical Area, and 90% for all other health planning regions in the state)
Nevada	None
New Hampshire	Net Bed Need (Per Region) = (Region Population Aged 65+ x 40) / 1000 - total licensed nursing facility beds Region population aged 65+ = the total number of persons aged 65+ residing in one of 10 designated regions
New Jersey	None
New Mexico	None
New York	Net Bed Need (Per County) = (Aged 0-64 use rate x aged 0-64 total population) + (aged 65+ use rate x aged 65+ total population) - total licensed nursing facility beds Use Rates = Total patients (by age cohort)/total population (by age cohort)
North Carolina	Net Bed Need (Per County) = 0.62/1,000 x aged 0-64 total population) + (7.38/1,000 x aged 65-74 total population) + (23.76/1,000 x aged 74-84 total population) + (82.52/1,000 x aged 85+ population) - total existing licensed nursing facility beds.
North Dakota	None
Ohio	Gross county bed need = state bed need rate x the 65 and older population in each county Net Bed Need (per county) = the gross bed need estimate - the total supply of existing nursing facilities in the county
Oklahoma	Any proposed additional nursing facility beds cannot cause the statewide ratio of beds to exceed 179 beds per 1,000. No proposed beds will be considered if a specific service area does not possess an occupancy percentage of at least 85%
Oregon	Bed Need (Per County) exists if: the estimate of beds per 1,000 (65+ population) < 40 beds per 1,000 and the county exhibits an occupancy of greater than 95%
Pennsylvania	None
Rhode Island	None
South Carolina	Net Bed Need (Per County) = (39/1,000) x (65 and older population) - total nursing facility beds (the greater of licensed beds or surveyed capacity)
South Dakota	None
Tennessee	Gross Bed Need (Per County) = (0.0005 x aged 0-64 total population) + (0.012 x aged 65-74 total population) + (0.06 x aged 75-84 total population) + (0.15 x aged 85+ total population) Gross bed need is compared to the current inventory of nursing facility beds to determine net bed need
Texas	None
Utah	None
Vermont	None
Virginia	The bed need methodology is based on the expected utilization rates per 1,000 population for six age cohorts Net Bed Need (Planning District) = (P x U) - Total Non-Federal Licensed Nursing Facility Beds P = Population by Age Cohorts (0-64 years, 65-69 years, 70-74 years, 75-79 years, 80-84 years and 85+) U = Use Rates (computed for each of the population categories) Demand is considered to only exist when the average occupancy percentage within a planning district is at least 93%
Washington	Net Bed Need = (Per Planning Area) = (40/1,000 x aged 70 and older population) - total licensed nursing facility beds (including banked beds)
West Virginia	Bed Need (Per Service Area) exists if: the estimate of beds per 1,000 (65+ population) < 30 beds per 1,000
Wisconsin	None
Wyoming	None

Appendix F - State CMS Weighted Average Occupancy Statistics

Weighted Average Occupancy By State			
State	2015	2016	2017
AK - Alaska	95.8%	90.0%	91.1%
AL - Alabama	88.9%	85.9%	84.9%
AR - Arkansas	78.3%	72.3%	72.1%
AZ - Arizona	79.0%	78.8%	69.2%
CA - California	89.9%	86.9%	91.0%
CO - Colorado	82.8%	82.0%	81.4%
CT - Connecticut	90.5%	86.9%	87.7%
DC - District of Columbia	90.2%	93.0%	91.6%
DE - Delaware	90.4%	89.0%	89.7%
FL - Florida	90.8%	87.7%	86.6%
GA - Georgia	88.7%	84.5%	85.3%
HI - Hawaii	92.4%	69.8%	76.8%
IA - Iowa	81.2%	78.9%	77.5%
ID - Idaho	74.5%	67.0%	66.0%
IL - Illinois	77.9%	74.8%	73.7%
IN - Indiana	78.8%	73.8%	72.2%
KS - Kansas	86.2%	80.3%	80.0%
KY - Kentucky	89.3%	85.8%	85.4%
LA - Louisiana	78.8%	76.4%	76.9%
MA - Massachusetts	89.6%	86.4%	85.2%
MD - Maryland	89.8%	88.3%	87.8%
ME - Maine	92.3%	91.4%	89.8%
MI - Michigan	86.7%	81.5%	80.3%
MN - Minnesota	88.1%	85.4%	85.3%
MO - Missouri	75.9%	71.8%	70.4%
MS - Mississippi	90.3%	86.6%	87.3%
MT - Montana	71.9%	63.3%	63.4%
NC - North Carolina	85.8%	82.0%	79.9%
ND - North Dakota	95.3%	90.1%	92.2%
NE - Nebraska	80.5%	76.9%	74.6%
NH - New Hampshire	91.0%	87.9%	86.3%
NJ - New Jersey	88.6%	83.6%	82.6%
NM - New Mexico	82.6%	80.9%	79.9%
NV - Nevada	86.8%	78.4%	81.8%
NY - New York	94.1%	92.0%	93.8%
OH - Ohio	86.5%	83.4%	80.9%
OK - Oklahoma	69.9%	73.3%	73.9%
OR - Oregon	68.5%	64.8%	82.6%
PA - Pennsylvania	90.0%	87.3%	84.9%
RI - Rhode Island	91.8%	91.1%	92.9%
SC - South Carolina	90.5%	88.5%	88.8%
SD - South Dakota	92.5%	88.9%	85.8%
TN - Tennessee	81.6%	76.0%	75.3%
TX - Texas	72.8%	68.6%	67.6%
UT - Utah	70.1%	62.7%	66.3%
VA - Virginia	90.3%	87.8%	87.8%
VT - Vermont	88.7%	83.9%	83.8%
WA - Washington	85.0%	79.1%	77.8%
WI - Wisconsin	83.1%	77.4%	75.6%
WV - West Virginia	94.1%	89.8%	88.7%
WY - Wyoming	83.8%	82.5%	81.6%

Footnotes

The occupancy is the weighted average occupancy derived from the Medicare Cost Report data. It does not include facilities reporting zero days. The formula is the sum of the total patient days divided by the sum of available total days.

Glossary

Ancillary Services – Medical items and/or services identifiable to a specific resident furnished at the direction of a physician and for which charges are customarily made in addition to the per diem charge.

Assistance with Daily Living (ADLs) – Activities performed for self care, which include feeding ourselves, bathing, dressing, grooming, work, homemaking and leisure. Health professionals refer to the ability or inability to perform ADLs as a measurement of the functional status of an individual. This measurement is useful for assessing the elderly, mentally ill and people with chronic diseases in order to evaluate what type of healthcare services they need.

Baby Boomer Generation – People born between 1946 and 1964 following World War II when many countries, most notably those in Europe, Asia, North America and Australia, experienced an unusual spike in birth rates, which was a phenomenon commonly known as the “baby boom.”

Base Year – The fiscal period that is the basis for the majority of allowable costs.

Bed Hold – The reserving of a bed in a nursing facility for a resident absent from the facility due to hospitalization or therapeutic leave. The reimbursement, as well as the number of days allowed to hold a bed for a patient, varies by state.

Case Mix Index (CMI) – CMIs, also referred to as “weights,” quantify the differences among assessment categories (RUGs, levels of care, etc.) in the costliness of their care needs provided by direct care nursing staff. Overall, CMIs increase as more care is needed because of poorer ADL functioning, greater medical complexity, need of nursing rehabilitation services or due to psychosocial problems. CMIs are based on nursing staff times determined either by state specific or large multistate research studies. A CMI is typically calculated as an average case mix score for all assessment categories (RUG, Level of Care, etc.) for a specific time frame (annually, semiannually, quarterly) and a specific patient population (all residents, Medicaid residents only, etc.).

Centers for Medicare & Medicaid Services (CMS) – The U.S. Department of Health and Human Services (HHS) agency responsible for developing and implementing policies governing the Medicare and Medicaid programs.

Certificate of Need (CON) – A regulatory process that requires certain healthcare operators or individuals to obtain state approval before proposing specific actions. These actions can vary by state, but typically include the following: the acquisition of a facility; the significant renovation or remodeling of a facility; the construction of a replacement facility; the development of any new service; and the acquisition of any substantial medical equipment. The CON process is intended to ensure appropriate access to new facilities or services within a particular region or community. The program is intended to prevent unnecessary duplication of services by selecting the best proposal among competing applicants who wish to provide a particular health service.

CMS COST REPORT STATISTICS

Administrative and General – The total expense for the administration of a nursing home. These expenses generally include administrator and other business office salaries and wages, office supplies, professional fees, data processing, postage, legal, accounting, bookkeeping, billing and telephone expenses.

Average Daily Census (ADC) – The mean census of one day over a given period of time.

Ancillary and Pharmacy – The total expenses for therapies, drugs, oxygen, radiology, laboratory, intravenous therapy and electro cardiology.

Dietary – The total expenses associated with food service. This expense typically includes salaries and wages of dietitians, cooks, food preparation (servers and/or raw food), supplies and/or contracted services.

Employee Benefits – The total expense for qualified retirement plan contributions, group health, dental and life insurance that are reported by a provider.

Housekeeping – The total expenses associated with housekeeping. This expense typically includes salaries and wages of housekeeping employees, supplies and/or contracted services.

Laundry and Linens – The total expenses associated with laundry. This expense typically includes salaries and wages of laundry employees, supplies and/or contracted services.

Nursing and Medical Related – The total expenses associated with nursing services and medical records. This expense typically includes salaries and wages of the director and assistant director of nursing (DON and ADON), registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), certified nursing aid (CNA) and medical records. The expense also includes medical related supplies.

Payor Mix Statistics – The percentage to total patient days attributed to specific payor sources (Medicare, Medicaid, Private/Commercial Insurance and Other Payor Sources).

Plant Operations – The total expense for building maintenance as well as utilities. The expenses typically include maintenance salaries and wages, minor repairs, contracted services, ground maintenance, electric, gas, water, sewer and trash.

Social Services – The total expenses associated with social services. This expense typically includes salaries and wages of social workers, supplies and/or contracted services.

Continuing Care Retirement Communities (CCRCs) – A retirement community (campus) that offers multiple levels of care. Traditional components include independent living, assisted living and skilled nursing care.

Cost Based Prospective Reimbursement System – A rate setting system that utilizes inflated allowable cost data from a prior period to calculate rates in a current rate period, with no settlement based upon the actual cost of providing services during the rate year.

Cost Components – Also called “cost centers.” For rate setting purposes, states often group similar characterized expenses into specific groupings. Cost components vary by state.

Cost Reports – A document submitted to Medicare or Medicaid by providers that details patient statistics as well as income and expenses over a period of time (usually 12 months).

Fair Rental Return (FRR) – Rental rate on current asset values that is used in calculating a fair rental capital payment.

Glossary

Fair Rental Value (FRV) System – The FRV system is used to reimburse nursing facilities for property costs. Under the FRV system, a facility is reimbursed on the basis of the estimated current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, rent/lease expenses and other property taxes. FRV systems typically establish a facility's bed value based on the age and total square footage of the facility. A nursing facility's FRV is typically calculated by multiplying the facility's value of capital assets by an established rental rate.

Fixed Cost – An expense that does not fluctuate based on the occupancy of a facility.

Fringe Benefits – Includes payroll taxes, qualified retirement plan contributions, group health, dental, and life insurance, cafeteria plans and flexible spending plans.

Health Maintenance Organization (HMO) – A type of private health insurance plan that is typically offered at a lower cost than traditional plans by negotiating contracts with providers at predetermined payments for services. In several occasions, healthcare providers are paid a specific amount per member per month (capitation), regardless if the member seeks services. There are several hybrids of this plan available.

Hospital-Based Nursing Facility – Skilled nursing units that are located within an acute-care hospital and are licensed separately from the hospital. The hospital-based skilled nursing units allow patients to remain in a hospital setting where emergency needs can be met quickly.

Managed Care – Systems that administer healthcare delivery with the aim of managing services and controlling costs. Managed care systems rely on a gatekeeper (typically a primary care physician or case manager), through whom the patient must contact to obtain other health services such as specialty medical care, surgery or therapies.

Medicaid – A federal/state entitlement program established by Title XIX of the Social Security Act, which reimburses healthcare providers for medical assistance provided to low-income individuals. Medicaid is a state-administered program and Medicaid guidelines and regulations vary from state to state. However, each state's Medicaid program is overseen by the Center for Medicare and Medicaid Services. Medicaid is the

largest source of funding for medical and health-related services for America's poorest people.

Medicare – A national insurance program for the aged and disabled established by Title XVIII of the Social Security Act and administered by the Center for Medicare and Medicaid Services. Medicare includes four sections (parts) that are responsible for the reimbursement of the healthcare providers as follows: Medicare Part A (predominantly inpatient hospital and skilled nursing care); Medicare Part B (predominantly physician services and outpatient hospital/therapy services); Medicare Part C (provides the option to select a financial intermediary that is contracted by Medicare to administer all of an individual's Medicare health benefits); and Medicare Part D (prescription drugs). Medicare is the single-largest insurance program in the United States.

Minimum Data Set (MDS) – A resident assessment tool that includes a set of screening, clinical and functional status elements, including common definitions and coding categories, which are the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicaid and Medicare. MDS data is typically utilized to categorize residents in groupings (Resource Utilization Groups, Levels of Care, etc.) based on the physical, medical and psychosocial needs of each resident. MDS categories are currently specified by the Centers for Medicare and Medicaid Services for use by nursing facilities.

Nursing Facility – An institution (or a distinct part of an institution), which is primarily engaged in providing skilled nursing care and related services to its residents. Services provided include medical or nursing care, and rehabilitation services that are provided on a regular or temporarily basis. Residents may include injured, disabled or sick persons, and individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. A nursing facility is not primarily for the care and treatment of mental diseases and has in effect a transfer agreement with one or more hospitals.

Patient Days – Number of days a bed is occupied by a patient.

Peer Groups – States often categorize nursing facilities into specific groupings in order to determine facility rates and rate ceilings. A nursing facility may be categorized into a specific peer group based on the facility's total number of beds, geographic location,

level of care provided, case mix index or ownership status (for-profit versus not-for-profit status, or government versus privately owned nursing facilities).

Price Based Reimbursement System – A rate calculation system that establishes one standard statewide rate (price) for nursing facilities established annually through a public process. Typically, prices are set for specific cost components and not a nursing facility’s total rate. In addition, statewide standard prices may be subject to facility-specific case mix adjustments.

Prospective Reimbursement System – A reimbursement system that establishes a payment for services in advance, regardless of the cost of providing services or level of services provided. Payment rates under a prospective system are typically determined utilizing inflated historical costs.

Quality Assurance Fee – A fee charged by states (or districts) to nursing facilities that is utilized to increase federal matching dollars for Medicaid programs. Federal law prohibits this fee to be used for anything but enhancing Medicaid reimbursements to nursing facilities. This fee is also known as a provider tax, facility privilege tax, nursing home user fee, nursing home license fee, quality assessment fee, nursing facility bed tax, long-term care facility tax, nursing facility provider assessment and quality maintenance fee.

Rebasing of Costs – The resetting of cost data utilized to calculate Medicaid rates.

Rate Period – A period of time in which a reimbursement rate for a provider is valid.

Resource Utilization Groups – A classification system based on a skilled nursing residents’ physical functioning, disease diagnoses, health conditions and treatments received, as recorded in the minimum data set, which is a lengthy and detailed data collection instrument filled out by staff. Using mathematical algorithms, the elements of the assessment tool (MDS) are grouped into RUG categories. RUG data is often utilized by state Medicaid agencies to predict resource utilization of healthcare services by residents and to determine appropriate reimbursement levels. States that adjust Medicaid rates for resident-specific required levels of care typically utilize either the RUG II (16 RUG categories) or RUG III (34 to 53 RUG categories) systems.

Retrospective Payment System – A system of payment that utilizes interim rates to reimburse nursing facilities until some period in the future when interim reimbursement is compared to the facility’s actual costs. Interim rates are calculated utilizing inflated historic costs, which typically are subject to ceilings. Reimbursement derived from interim rates is typically subject to a cost settlement process, in which either the nursing facility or state agency must reimburse the other party for the difference between the facility’s actual cost and interim reimbursement.

Social Security – A federal supplemental retirement program established in 1935 by President Franklin D. Roosevelt. The program has been amended several times since 1935 and now includes disabled persons.

Variable Cost – An expense that fluctuates depending upon the occupancy of a facility.





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ISBN 978-0-9818427-5-2

ISSN 1942-7433